Bundle Mental Health Act Committee 8 December 2020

To be held from 14:30pm - 16:30pm.
To be held virtually via Webex.

Agenda attachments

Agenda_Mental_Health_Act_Committee_8_December_2020 v4.0.docx

1 OPENING BUSINESS

1.1 14:30 - MHAC20/19 Welcome and apologies

Apologies received from: Cheryl Carlisle - Independent Member, Eifion Jones - Independent Member, Hilary Owen - Head of Governance and Compliance and Ruth Joyce - Criminal Justice Liaison Service Manager.

1.2 14:35 - MHAC20/20 Declaration of Interests

1.3 14:36 - MHAC20/21 Draft minutes of the meeting held on 19.10.20

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

MHAC20.21 Draft MHAC draft mins Oct 2020 v0.5 LR.TO.docx

1.4 MHAC20/22 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\.

MHAC20.22 MHAC Summary Action Plan live version as at 30.11.2020.doc

1.5 14:46 - MHAC20/23 Draft minutes of Power of Discharge Sub-Committee meeting held on 19.10.20 and verbal update from the earlier meeting

MHAC20.23 Draft PODSub C draft mins Oct 2020 v0.2.docx

2 14:56 - COMFORT BREAK

3 FOR DISCUSSION

3.1 15:01 - 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
Alison Cowell, Assistant Area Director – Children's Central Area

Recommendation:
That the Committee notes the children and young people's crisis pathway, number of S136 attendances, and the plans to improve services.

MHAC20.24 MHAC CAMHS - s136 and crisis pathway Nov 2020.docx

3.2 15:12 - MHAC20/25 Action Plan item/update - Approved Clinicians & Section 12(2) Doctors

Action plan items MHAC19.08 and MHAC20/14.2
Alberto Salmorigai, Consultant Psychiatrist/Medical Director, Mental Health & Learning Disabilities and Wendy Lappin, Mental Health Act Manager to present.
Recommendation:
The Committee is asked to:
1) Acknowledge the current position across Wales
2) Support the Mental Health & Learning Disabilities (MHLD) discussion to assist the Health Board's Medical Director and Executive Director of Primary Care and Community Services to progress the planning arrangements.

MHAC20.25 12(2) doctors - Status Update.docx

3.3 15:23 - MHAC20/26 Approval for All Wales Approved Clinicians and Section 12(2) Doctors)

Heulwen Hughes, all Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors
Recommendation: The Committee is asked 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.

MHAC20.26 Update on Approval Functions of Approved Clinicians Section 12-2 Doctors in Wales v0.2.docx

3.4 15:34 - MHAC20/27 Deprivation of Liberty Safeguards (DoLS) Update Report

Michelle Denwood, Associate Director of Safeguarding to present.
Recommendation: The Committee is asked to:
1. Receive and accept the report.
2. Accept and support the identified actions.

MHAC20.27 MHACommittee DoLS Report Nov 2020 v1.0.docx

3.5 15:45 - MHAC20/28 Mental Health Act Performance Report

Wendy Lappin, Mental Health Act Manager to present
Recommendation:
The Mental Health Act Committee is asked to note the Performance report.

MHAC20.28a MHA Performance Report v0.2.docx

MHAC20.28b Appendix 1 MHAct Activity Report.pdf

MHAC20.28c Appendix 2 Divisional S136 Report November 2020.pdf

MHAC20.28d Appendix 3 CAMHS S136 Report Nov 2020.pdf

3.6 15:56 - MHAC20/29 Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit

** Healthcare Inspectorate Wales (HIW) Monitoring Report - Wendy Lappin, Mental Health Act Manager, to present.*

Recommendation:
The Committee is asked to note the report.

MHAC20.29a HIW Monitoring Report v0.2.docx

MHAC20.29b Appendix 2 Quality Check Summary Bryn Y Neuadd Hospital – Carreg Fawr Unit.pdf

MHAC20.29c Appendix 3 Heddfan Inspection Report.pdf

3.7 16:07 - MHAC20/30 Hospital Manager's Update Report

Wendy Lappin, Mental Health Act Manager, to provide the verbal summary, based on feedback from earlier Power of Discharge Sub-Committee meeting.
Recommendation: The Committee is asked to note the verbal update.

4 CLOSING BUSINESS

4.1 16:17 - MHAC20/31 Any Other Business

4.2 16:27 - MHAC20/32 Issues of significance to inform the Chair's assurance report

4.3 16:29 - MHAC20/33 Date of next meeting

12th March 2021

Agenda Mental Health Act Committee

Date	08/12/2020
Time	14:30 - 16:30
Location	Virtual via Webex
Chair	Lucy Reid
Description	

1	**OPENING BUSINESS**
1.1	**MHAC20/19 Welcome and apologies**
14:30	Apologies received from: Cheryl Carlisle - Independent Member, Eifion Jones - Independent Member, Hilary Owen - Head of Governance and Compliance and Ruth Joyce - Criminal Justice Liaison Service Manager.
1.2	**MHAC20/20 Declaration of Interests**
14:35	
1.3	**MHAC20/21 Draft minutes of the meeting held on 19.10.20**
14:36	1. To confirm as a correct record the minutes of the previous meeting.
1.4	**MHAC20/22 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.
1.5	**MHAC20/23 Draft minutes of Power of Discharge Sub-Committee meeting**
14:46	**held on 19.10.20 and verbal update from the earlier meeting**
2	**COMFORT BREAK**
14:56	
3	**FOR DISCUSSION**
3.1	**MHAC20/24 Action Plan item/update - Regarding under 15's detentions and**
15:01	**of emergency assessments being undertaken by adult psychiatrists.**
	Action plan item:MHAC20/9.4
	Alison Cowell, Assistant Area Director – Children's Central Area
	Recommendation: That the Committee notes the children and young people's crisis pathway, number of S136 attendances, and the plans to improve services.

3.2 **MHAC20/25 Action Plan item/update - Approved Clinicians & Section 12(2)**
15:12 **Doctors**

Action plan items MHAC19.08 and MHAC20/14.2

Alberto Salmorigai, Consultant Psychiatrist/Medical Director, Mental Health & Learning Disabilities and Wendy Lappin, Mental Health Act Manager to present.

Recommendation:

The Committee is asked to:

1) Acknowledge the current position across Wales

2) Support the Mental Health & Learning Disabilities (MHLD) discussion to assist the Health Board's Medical Director and Executive Director of Primary Care and Community Services to progress the planning arrangements.

3.3 **MHAC20/26 Approval for All Wales Approved Clinicians and Section 12(2)**
15:23 **Doctors)**

Heulwen Hughes, all Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors

Recommendation: The Committee is asked 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.

3.4 **MHAC20/27 Deprivation of Liberty Safeguards (DoLS) Update Report**
15:34 Michelle Denwood, Associate Director of Safeguarding to present.

Recommendation: The Committee is asked to:

1. Receive and accept the report.
2. Accept and support the identified actions.

3.5 **MHAC20/28 Mental Health Act Performance Report**
15:45 Wendy Lappin, Mental Health Act Manager to present

Recommendation:

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

3.6 **MHAC20/29 Consideration of any HIW/Inspection reports/Audit reports etc as**
15:56 **appropriate to meetings remit**

- Healthcare Inspectorate Wales (HIW) Monitoring Report - Wendy Lappin, Mental Health Act Manager, to present.

Recommendation:

The Committee is asked to note the report.

3.7	**MHAC20/30 Hospital Manager's Update Report**	
16:07	Wendy Lappin, Mental Health Act Manager, to provide the verbal summary, based on feedback from earlier Power of Discharge Sub-Committee meeting. Recommendation: The Committee is asked to note the verbal update.	
4	**CLOSING BUSINESS**	
4.1	**MHAC20/31 Any Other Business**	
16:17		
4.2	**MHAC20/32 Issues of significance to inform the Chair's assurance report**	
16:27		
4.3	**MHAC20/33 Date of next meeting**	
16:29	12th March 2021	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Mental Health Act Committee (MHAC)

DRAFT Minutes of the Meeting Held on 19.10.20 via Webex

Present:

Mrs Lucy Reid	Health Board Vice Chair (Chair)
Cllr Cheryl Carlisle	Independent Member
Mr Eifion Jones	Independent Member

In Attendance:

Mr Frank Brown	Associate Hospital Manager
Mrs Jody Evans	Secretariat, Corporate Governance Officer
Mr Simon Evans-Evans	Interim Director of Governance, Corporate Office
Ms Claire Foreman	North Wales Police (part meeting)
Ms Heulwen Hughes	All Wales Approval Manager for Approved Clinicians & Section 12(2) Doctors, Office of the Medical Director (part meeting)
Mrs Liz Jones	Assistant Director, Corporate Governance
Ms Ruth Joyce	Criminal Justice Liaison Service Manager, Mental Health & Learning Disabilities (MHLD) (part meeting)
Mr Matthew Joyes	Acting Associate Director of Quality Assurance & Assistant Director
Mrs Wendy Lappin	Mental Health Act Manager, MHLD
Ms Teresa Owen	Executive Lead, MHLD
Mr Christopher Pearson	Safeguarding Specialist Practitioner/DoLS Manager, Safeguarding (part meeting)
Mr Steve Riley	Consultant Nurse, Child & Adolescent Mental Health (part meeting)
Mr Mike Smith	Interim Director of Nursing, MHLD
Mr Iain Wilkie	Interim Director, MHLD
Mr Mark Jones	Interim Senior Head of Service Adult Social Care, Wrexham County Borough Council

AGENDA ITEM DISCUSSED	ACTION BY
MHAC20/1 Welcome, opening remarks and apologies **MHAC20/1.1** The Chair welcomed everyone to the meeting and confirmed that apologies had been received from: Debra Hickman, Acting Executive Director of Nursing & Midwifery, Alberto Salmoiraghi, MHLD Medical Director, Marilyn Wells, Head of Nursing - East Area, Child & Adolescent Mental Health Services (CAMHS) and Alison Cowell, Assistant Area Director Centre, CAMHS. **MHAC20/1.2** The Committee also welcomed the new Executive Lead and Mental Health Team Leads to the Committee; Teresa Owen – Executive Lead, Mike Smith – Nursing Lead, Iain Wilkie - Interim Director, and Matthew Joyes – Governance Lead.	

MHAC20/1.3 It was reported that there was still an Associate Hospital Manager vacancy on the Mental Health Act Committee, therefore expressions of interest in relation to joining the Committee are to be sought again via the Secretariat. **MHAC20/1.4** The Chair explained that as a consequence of the ongoing Covid-19 situation and following advice provided by the Welsh Government, the Health Board had stood down all Committees with the exception of the Quality, Safety and Experience Committee and the Audit Committee. She confirmed that any governance, leadership, and quality and safety matters relating to mental health fell within the remit of the Quality, Safety and Experience (QSE) Committee. The Chair confirmed that key reports on performance had been circulated to members in June to enable members to remain. The Chair also explained that the decision to postpone the POD Sub-Committee and with the MHAC, which were due to take place on 18th September 2020, had been due to a number of changes in leadership and the need to review some key reports. **MHAC20/1.5** The Chair expressed her disappointment in the quality of various reports received by the Committee. She asked the Assistant Director, Corporate Governance, to ensure that the Office of the Board Secretary would take steps to liaise with authors and MHLD to improve the quality of papers submitted to the Committee in future.	JE LJ
MHAC20/2 Declarations of Interest The Chair, an Independent Member and the Head of Governance for MHLDS declared their positions as Justices of the Peace. The Committee noted the declarations.	
MHAC30/3 Previous minutes, matters arising and summary action plan **Draft minutes of the meeting held on 20.12.19, matters arising and summary action plan.** The minutes were confirmed as an accurate record of the previous meeting. The Summary Action Log was reviewed and updated accordingly.	
MHAC30/4 Items circulated to members since the previous meeting: **MHAC30/4.1** The Committee acknowledged the receipt of the reports previously emailed out to members: 11.03.2020 - Advisory reporting of errors - Action plan. 11.03.2020 - Forensic and rehabilitation processes – Action plan. 30.07.2020 - March and June 2020 Performance reports, Associate Hospital Manager (AHM) updates and Healthcare Inspectorate Wales (HIW) Monitoring Report. **MHAC30/4.2** The Chair expressed thanks to those staff who had produced the reports and confirmed that there are no plans to stand down the Committees during the predicted second wave of the pandemic.	

MHAC20/5 Draft minutes of the Power of Discharge Sub-Committee meeting held on 20.12.19 and verbal update from the earlier meeting The Mental Health Act Manager gave a summarised verbal account on relevant feedback from the Sub-Committee meeting held earlier that day. The Committee was also informed of a briefing provided by the Interim Director of Nursing, MHLD, in relation to recruitment challenges and how these were being managed.	
MHAC20/6 CANIAD – Patient Story **MHAC20/6.1** The Interim Director of Nursing, MHLD, presented the Committee with the verbal overview of the patient story on behalf of CANIAD. The Committee acknowledged the sensitivity of the experience that had been described. The Interim Director of Nursing informed the Committee that the patient story had also been presented to the Divisional Quality, Safety and Experience meeting and lessons would be learnt from the issues raised. The theme of young people transitioning through to adult services was discussed. It was noted that the Health Board did not have a joint strategy at present and this was a national issue. It was stated that the Division aims to address the points noted within the next 6 months as a phrased response. **MHAC20/6.2** The Head of Governance and Consultant Nurse for CAMHS also provided an update with regard to their ongoing work and on the Welsh Government Transition and Handover guidance for children and young people. It was confirmed that a passport tool was being implemented, along with co-working which is to be embedded into culture and practice. The Committee acknowledged the difficulties for young patients transitioning through to adult services and the need for this transitions to be improved. The Executive Lead referred to a recent discussion with the Community Health Council and stated that there was a need to understand the flow of transitions. It was acknowledged as an area to improve upon. Concerns were noted in relation to carers being impacted by the effects of the Covid-19 pandemic. **MHAC20/6.3** It was agreed for the Clinical Justice Liaison Nurse to liaise with the Consultant Nurse for CAMHS to link in at locality meetings. **MHAC20/6.4** A further discussion took place with regards to the learning from this patient story and it was highlighted that the report template was not suitable for capturing the follow up actions required. It was agreed for the QSE Patient Story template be shared with the Interim Director of Nursing, who would ensure that this format was adopted for future patient stories being presented to the MHAC so that the learning from patient stories is clearly identified and reported. The Executive Lead also stated that stories would be reviewed via the Division and it was confirmed that the Putting Things Right process would be utilised to support learning within the Division. **MHAC20/6.5** The Committee expressed their thanks for the presentation of the patient story. The Members also noted the renewed energy within MHLD. **MHAC20/6.6** The patient story was noted, as was the Chair's view that such stories should be acted upon rather than just received for information.	RJ/SR MJ/MS

MHAC20/7 Analysis of S136 update on the Criminal Justice Liaison Service **MHAC20/7.1** The Criminal Justice Liaison Service Manager (CJLSM) presented the quarterly report and provided the Committee with an update and background in relation to the service/s activity. It was confirmed that service provision had been affected by Covid-19, which had been reflected within the report. It was clarified that recently updated data showed that activity was increasing. It was noted that work was progressing with clinicians within probation offices, to assess and provide referrals. It was also confirmed that funding had allowed for the expansion of the team and that a new staff member was commencing imminently. The sharing of good news stories was noted in relation to care co-ordination and diversity of data. Strong relationships continue to be made with partner agencies, in order to raise awareness of the service. It was noted that future reports would include feedback from the S135/136 Monitoring Group and the Criminal Justice Liaison Steering group. **MHAC20/7.2** The Governance and Compliance Manager commented on the increase in consultations and the positive impacts of 136s, which had been previously reported upon. It was further recognised that continuous improvement was required along with the resurrection of the two day mental health training, which had been affected by the Covid-19 pandemic. It was confirmed that the training was to re-launch in November 2020. **MHAC20/7.3** The Chair invited questions from Independent Members. An Independent Member welcomed the work underway and noted attendance at the frequent networks. **MHAC20/7.4** An Independent Member requested clarity of communications with the Youth Justice Board and asked if data was harvested from the Courts along with any specialist care homes within the areas. It was clarified that the service did not have specialist liaison with care homes at present. It was confirmed that demand would be reviewed in the future by way of co-working with community care pathway leads, in order to address the requirements. **MHAC20/7.5** The Committee noted the report and thanked the CJLSM for the update.	
MHAC20/8 Comfort break	
MHAC20/9 Use of Section 136 for Young People under the age of 18 years **MHAC20/9.1** The Consultant Nurse for CAMHS presented the report. He provided the analysis and update on the work that supports young people presenting in crisis and of those being detained on S136s. Ongoing work and statistical data was presented in relation to crisis care, annual data relating to Section 136 (2010 – 2020), and information on the number of self-harm assessments in acute settings. **MHAC20/9.2** Following the presentation of the report, the Chair raised that the recommendations to the Committee on the cover sheet needed to be clear in future reports from the Division in order to demonstrate good governance.	

MHAC20/9.3 A discussion took place regarding out of hours arrangements for the on call psychiatric rota, along with incidents relating to additional management risks and appropriateness of support for out of hours assessments. **MHAC20/9.4** Particular concern was raised regarding under 15s detentions and of emergency assessments being undertaken by adult psychiatrists. It was agreed that there was an urgent need to address the concerns. It was confirmed that inappropriate use of age appropriate beds had been raised with Consultants throughout North Wales and that the Assistant Area Director for Central, CAMHS was taking the issue forward. The Executive Lead for Mental Health confirmed that funding bids relating to addressing the challenges were undergoing review. 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. **MHAC20/9.5** The Committee noted the report and it was also agreed to escalate the concerns to the Health Board in November via the Chair's Assurance Report.	SR
MHAC20/10 Deprivation of Liberty Safeguards (DoLS) **MHAC20/10.1** The Safeguarding Specialist/DoLS Manager presented the update report to the Committee, outlining the current position relating to DoLS activity, demand, training and challenges. **MHAC20/10.2** The Chair queried the section of the report regarding its prior scrutiny route. The information presented contained some inaccuracies. It was ascertained that the report had not received prior scrutiny. It was also advised that the Health Board did not have a Quality and Safety Executive. The Chair asked for such information to be correct in future reports. She also expressed disappointment regarding the overall content of the report. She explained that there was a high proportion of cases with no treatment plan, but no assurance provided by the report that action had been taken to address this and thus 'close the loop'. She also stated that she did not understand the figures presented in the report. It was therefore agreed that the Safeguarding Specialist/DoLS Manager would work with the Executive Lead to improve the quality and clarity of future reports. **MHAC20/10.3** Following discussion regarding DoLS applications, it was noted that a bid had been submitted to Welsh Government for part funding to create a bespoke training package. Training during the Pandemic had been offered via online access. The Chair expressed concerns regarding missing capacity assessments and discussion ensued regarding assurances on the current process. It was confirmed that a Standard Operating Procedure for DoLS had been created and that further review of the procedure would be undertaken.	CP/TO TO/CP

MHAC20/11 Draft MHAC Committee 2019/20 Annual Report **MHAC20/11.1** The Acting Associate Director of Quality Assurance presented the draft report for approval and invited members' comments. The members confirmed that they approved the levels of assurances set within section 6 of the report. An Independent Member referred to the red rated items. It was confirmed that the items would be addressed by the Executive Lead, via the risk based approach. The limited number of clinical audits conducted over the past year was also noted. The Executive Lead stated that there was an opportunity for the Division to re-focus the MHAC's cycle of business for the next 12 months. It was further stated that the Committee needed to be more tied in with overall governance arrangements going forward. The Interim Director of Governance, who was observing the meeting, noted this requirement. **MHAC20/11.2** The Committee approved its Annual Report 2019/20, which also included its terms of reference and cycle of business, as well as the agreed RAG assurance scores. It was confirmed that the report was to be submitted to the Audit Committee.	TO/SE-E
MHAC20/12 Associate Hospital Managers Update Report The Mental Health Act Manager provided a verbal summary, based on feedback from the earlier PoD Sub-Committee meeting. The Committee noted the verbal update.	
MHAC20/13 Mental Health Act Performance Report **MHAC20/13.1** The Mental Health Act Manager presented the overview of the performance report to the Committee. It was noted that the report also included data in relation to the S136 Divisional Report for Audit and the S136 CAMHS Report. **MHAC20/13.2** The Chair and members thanked the Mental Health Act Manager for the report, which had been discussed at the earlier POD Sub-Committee Meeting. The Chair commended the quality of the narrative provided. The Committee noted the report for information.	
MHAC20/14 Approval for All Wales Approved Clinicians and Section 12(2) Doctors) **MHAC20/14.1** The Committee received the report, which outlined data in relation to the additions and removals in respect of the All Wales register of Approved Clinicians, additions and removals in respect of the All Wales register of Section 12(2) Doctors, and the breakdown of Section 12(2) GPs currently approved in Wales as at 5 October 2020. **MHAC20/14.2** The Chair commented that whilst the report was helpful in setting out the situation with regards to numbers in relation to S12 (2) approvals, she was disappointed that the actions that had been agreed in the Committee meeting in December had not been progressed. The Committee had received a report previously regarding concerns about the availability of s12(2) doctors and had	

made suggestions on potential solutions. The Chair asked for an update on a recent meeting that had taken place with the mental health leads and the office of the medical director. It was accepted that there was no simple solution, but the Division was keen to work collaboratively to address the recruitment challenges. Further discussion ensued and significant concerns were raised by the Chair in relation to the recruitment situation, the progress to address this as it had been reported as a key risk for the Committee for over 12 months and the need to recognise that this was not just a GP recruitment issue. 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. **MHAC20/14.3** The Committee noted the report provided.	TO/AS/MS/IW
MHAC20/15 Healthcare Inspectorate Wales (HIW) Monitoring Report **MHAC20/15.1** The Head of Governance and Compliance presented the report which detailed updates in relation to the inspections conducted by HIW within the last 12 months. The report covered findings relating to the Mental Health Act and the Mental Health Measure, as detailed within appendix one. It was explained that the report highlighted that there had not been any immediate concerns identified by HIW. The inspections covered: • Heddfan Unit • Ty Llywelyn • Ty Derbyn • Cefni Hospital **MHAC20/15.2** The Committee also noted the Ty Llewelyn detailed report as appendix two within the report. **MHAC20/15.3** It was also confirmed that due to the Covid-19 Pandemic, HIW were moving into the tier 3 review model. The Committee was notified of the most recent inspection at Carreg Fawr. It was confirmed that the draft report had been received for factual accuracy, which included two draft actions relating to policy issues. **MHAC20/15.4** The Chair thanked the Head of Governance and Compliance for the update and stated that the detail was helpful. Discussion took place regarding detention papers and recurrent issues with regard to completion of documentation. It was confirmed that future update reports would include how processes were being specifically addressed. The Committee received and noted the report.	HO
16. FOR INFORMATION	
MHAC20/16.1 NAW - Health, Social Care and Sport Committee: Mental health in policing and police custody report **MHAC20/16.1** This item was noted for information only as the report had previously been communicated to the MHAC Chair and Executive Lead via email on 08/01/2020. The detail included that the – Senedd's Health, Social Care and Sport Committee had decided to hold a short enquiry on the partnership between	

police, health and social care. Documents relating to the matter had been attached to the agenda for the information of Committee members. **MHAC20/16.2** It was agreed that the original communication be forwarded to the Interim Director and Lead Nurse for Mental Health.	JE
MHAC20/17 Issues of significance to inform the Chair's assurance report **It was agreed to include:** CAMHS transitions to Adult Services and Section 136 concerns.	
MHAC20/18 Date of next meeting Friday 11th December 2020. **To be re-arranged due to a clash with the Regional Partnership Board meeting.**	

BCUHB MENTAL HEALTH ACT COMMITTEE Summary Action Plan – Live Document – last updated 01/12/2020 11:43				
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	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 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. **AS presented the report to the committee at the December Meeting. 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

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	**October update** – Email re-issued for expressions of interest. December meeting agenda item. **March 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.	Action to be closed.
20th December 2019				
SE-E/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	**January 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 27.11.2020 via SE-E**: MJ/SE-E recommend that these committees are combined – subject to wider governance review.	
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	Action to be closed.

			Work Force and Organisation Development Team. Issues are not unique to the mental health division.	
19th October 2020				
ALL/LJ	**MHAC20/1.5** Quality of various reports received by the Committee. The Assistant Director, Corporate Governance, to ensure that the Office of the Board Secretary take steps to liaise with authors and MHLD to improve the quality of papers submitted to the Committee in future.	December	**Update as at 30.11.2020** – • 3 virtual training sessions have taken place since the last meeting. • Assistant Director of Corporate Governance, has been supporting the process by undertaking early QA of papers/suggesting enhancements. Please note: Further training is available to those who have not attended a session so far. In order to register your need for training please contact the Secretariat (JE) to arrange.	
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		
MJ/MS	**MHAC20/6.4 Patient Story -** It was agreed for the QSE Patient Story template be shared with the Interim Director of Nursing, who would ensure that this format was adopted for future patient stories being presented to the MHAC.	December	**Update received 5.11.2020 via MJ:** The patient story template was shared with MHLD and the Corporate Patient and Carer Experience Team have been closely working with the new Divisional Patient and Carer Experience Group.	Action to be closed.
SR	**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	December	**Agenda Item Ref: MHAC20/24**	**Agenda Item**

	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.			
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 ~~December~~ **April 2021**	**Update received 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 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/SEE	**Draft MHAC Committee 2019/20 Annual Report** **MHAC20/11.1** Red rated items - It was confirmed that the items would be addressed by the Executive Lead, via the risk based	December	**Update received 27.11.2020 via SEE** - Meeting arranged for 09.12.2020 to discuss governance.	

	approach. The Interim Director of Governance also noted the overall governance arrangement needs going forwards.			
TO/AS/MS/IW	**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.	December	**Agenda Item Ref: MHAC20/25**	**Agenda Item**
HO	**MHAC20/15.4 Healthcare Inspectorate Wales (HIW) Monitoring Report** - It was confirmed that future update reports would include how processes were being specifically addressed.	December	**Update received 30.11.2020 via WL** – It was confirmed that the report now includes more detailed information.	
JE	**MHAC20/16.2 NAW - Health, Social Care and Sport Committee: Mental health in policing and police custody report** It was agreed that the original communication be forwarded to the Interim Director and Lead Nurse for Mental Health.	October	Update – 21/10/2020 - Item sent to the Interim Director and Lead Nurse as requested.	Action to be closed.

Power of Discharge Sub (POD) Committee

DRAFT Minutes of the Meeting Held on 19.10.20 via Webex

Present:

Mrs Lucy Reid	Vice Chair (Chair)
Cllr Cheryl Carlisle	Independent Member
Mr Eifion Jones	Independent Member
Mr Frank Brown	Associate Hospital Manager
Mrs Shirley Davies	Associate Hospital Manager
Mr Huw Jones	Associate Hospital Manager
Ms Jackie Parry	Associate Hospital Manager
Ms Satya Schofield	Associate Hospital Manager
Mr John Williams	Associate Hospital Manager

In Attendance:

Mrs Jody Evans	Secretariat, Corporate Governance Officer
Mrs Liz Jones	Assistant Director, Corporate Office
Mrs Wendy Lappin	Mental Health Act Manager, Mental Health and Learning Disabilities (MHLD)
Mrs Hilary Owen	Head of Governance, MHLD
Mr Mike Smith	Interim Director of Nursing, MHLD
Mr Iain Wilkie	Interim Director, MHLD

AGENDA ITEM DISCUSSED	ACTION BY
POD20/1 Welcome and apologies **POD20/1** The Chair welcomed everyone to the meeting and explained the virtual meeting etiquette standards to those present. **POD20/2** The Chair confirmed that apologies had been received from; Teresa Owen-Executive Director, Diane Arbabi-Associate Hospital Manager, Matthew Joyes-Acting Associate Director of Quality Assurance, Patient Safety and Experience, and Alberto Salmoiraghi-Consultant Psychiatrist/Medical Director, Mental Health & Learning Disabilities. **POD20/3** In the absence of Alberto Salmoiraghi the Interim Director of Nursing was to present item POD20.05 on behalf of the Mental Health Division.	
POD20/01 Update on Sub-Committee Membership **POD20/01.1** The Chair expressed her sincere condolences on the sad passing of Mrs Susan Roberts, Associate Hospital Manager. It was confirmed that Mrs Roberts had	

not been involved in the POD Sub-Committee nor Mental Health Act Committee directly, but was well respected by the rest of the team. The Head of Governance also expressed condolences and paid tribute to Mrs Roberts, particularly with regards to the significant and active contributions which Mrs Roberts had made in relation to scrutiny panels and the focused dedication she gave in relation to patient care. **POD20/1.2** The Sub-Committee welcomed the two newly appointed members to the Sub Committee; Ms Helena Thomas, Associate Hospital Manager and Mr Hugh Jones, Associate Hospital Manager. **POD20/1.3** Following the commencement of the Covid pandemic, it was confirmed that there had been 3 Associate Hospital Manager resignations from the Sub-Committee. The Sub-Committee expressed their sincere gratitude and thanks to those members for their long standing dedication and contributions made to date. It was confirmed that expressions of interest would be sought via the Corporate Governance Officer, in order to ensure the correct membership of the sub-committee. **POD20/1.4** The Sub-Committee noted the vacant Associate Hospital Manager position on the Mental Health Act Committee. The Corporate Governance Officer agreed to issue a call for expressions of interests, with the deadline confirmed as 13th November 2020.	JE JE
POD20/2 Previous minutes, matters arising and summary action plan **POD20/2.1** Confirmed as an accurate record. **POD20/2.2** The summary action log was reviewed and updates had been made accordingly.	
POD20/3 Items circulated to members since the previous meeting: **POD20/3.1** The Chair explained as a consequence of the ongoing Covid-19 situation; she had taken the decision to stand down the March and June 2020 meetings. It was confirmed that the governance, leadership, and quality and safety matters relating to mental health fell within the remit of the Quality, Safety and Experience (QSE) Committee, and It was confirmed that the QSE Committee had continued to meet throughout the first wave of the pandemic. The Chair confirmed that all key reports on performance had been circulated to members since the previous POD and MHA Committee meetings held back in December 2019. The Chair also expressed her sincere thanks to those staff who had produced the reports and confirmed that all Committee work would continue in light of the predicted 2nd wave of the pandemic. **POD20/3.2** It was also stated that the decision to postpone the POD Sub-Committee together with the Mental Health Act Committee; which was due to take place on 18th September 2020 had been due to a number of changes in leadership and report writing request updates.	

POD20/4 Associate Hospital Managers Update, to include periodic updates on training and appraisals

POD20/4.1 The Mental Health Act Manager provided an update on the activities of the Associate Hospital Managers during the quarter, April to June 2020. The update report included details in relation to hearings, training, recruitment, forums and Key Performance Indicators (as referred to within Appendix 1).

POD20/4.2 The Mental Health Act Manager explained that all hearings had taken place remotely due to the Covid 19 pandemic, with the option to use the telephone function within Skype or via the video link. The reduced number of hearings held over the time period due to the ongoing pandemic was noted. It was confirmed that guidance had been issued by Welsh Government regarding Hospital Managers discharge powers (S23) under the Mental Health Act. It was reported that a number of Associate Hospital Managers had stood down from participating in hearings, as only a handful wished to do so remotely. It had been confirmed that managers participating in hearings are having one to one reviews, along with training and support to ensure they can access the Electronic Staff Record (ESR) system. It was also recognised that there were a number of hearings not arranged within the set key performance indicators (KPIs) due to the ongoing pandemic.

POD20/4.3 It was confirmed that since April, scrutiny had been suspended, and sessions would be reinstated once it is safe for the Associate Hospital Managers to physically reconvene in the Health Board units.

POD20/4.4 It was explained that the third All Wales Associate Hospital Managers day was cancelled and that it had been postponed to a future date in 2021.

POD20/4.5 Recruitment data detail had also been clarified to date by the Mental Health Act Manager.

POD20/4.6 The Chair then invited questions from Independent Members:

POD20/4.6.1 An Independent Member expressed her thanks to all staff involved with hearings throughout the challenging pandemic crisis. The Independant Member raised three queries; in relation to I.T and hearing support, Associate Hospital Managers currently shielding and the suspension of scrutiny of paperwork in mental health units. The Mental Health Act Manager confirmed that support had been provided and any issues had been worked through together. It was explained that the hearing process had been adapted to include a total of four Associate Hospital Managers in attendance virtually, to allow slippage for technical difficulties. The technical challenges at the outset of the pandemic were noted by the Sub-Committee, but overall it was agreed that the system worked well. In relation to the Associate Hospital Managers shielding, it was confirmed that the hearings were not being held in Health Board units, until it becomes safe to do so. It was confirmed that all but the final step of the scrutiny of paperwork had continued during the pandemic. The Head of Governance confirmed that the final step was in a long process, and confirmed that all other required steps in relation to administration, pharmacy, medical and AMP scrutiny had continued to date.

POD20/4.7 Concerns were raised by the Chair regarding the use of telephones during hearings. It was confirmed that the telephones were utilised due to lack of broadband width for use of the Skype video system. It was confirmed that the telephone option is therefore there as a backup, and that the virtual video system is utilised predominantly. **POD20/4.8** The Chair thanked the team for the ongoing commitment in unprecedented times recognising the flexibility and adaptability of the systems in place. The Sub-Committee noted the report and update.	
POD20/5 Recruitment and Medical Staffing Vacancies in Mental Health and Learning Disabilities (MHLD) Division **POD20/5.1** The Chair informed the Sub-Committee that the update report had been requested at a previous Mental Health Act Committee meeting to brief the members on detail and to provide assurance in relation to the status update on the consultant workforce in MHLD, and on the availability of Approved Clinician doctors. It was raised that the report had not included the relevant detail, as previously sought, however the report brief was welcomed. **POD20/5.2** The Interim Director of Nursing presented the paper and informed the members of the recruitment issues on a national scale along with a demographic picture with regards to the filling of vacant posts. Retirements had also been noted along with financial impacts with regards to locum and agency staffing. It was confirmed that ongoing wider work continues with Workforce and Organisation Development colleagues. **POD20/5.3** Following the overview of the report the Interim Director of Nursing asked that the Sub-Committee accept the report content as assurance. An Independent Member raised a concern in relation to the impacts on hearings in relation to stability of permanent staffing involvement. A discussion took place, following which the Sub-Committee confirmed that the overall update did not provide an adequate level of assurance. Further discussion took place in relation to psychiatric recruitment along with changes to doctors' contracts and pensions. **POD20/5.4** An Associate Hospital Manager also raised a concern with regards to patient experience relating to consistency and turnover of locum and non-permanent staffing. The need for confidence was raised in relation to continuity of care. It was explained that the Division would incorporate this issue into the longer term strategy going forwards. **POD20/5.5** The Chair referred to recruitment issues regarding consultant psychiatrists within Child and Adolescent Mental Health Services (CAMHS) and explained that the tier four model was in place, which included nurse led functions. It was noted that the systems in place within Mental Health should conform to the Mental Health Act legislation and that the Division is working with Workforce and Organisational Development colleagues on the longer term strategy. **POD20/5.6** An Independent Member expressed concern in relation to the staffing issues raised and also asked for clarification on the financial costings in relation to	

agency workers. It was confirmed that all costs relating to agency staffing had been included in budgetary planning for the Division. **POD20/5.7** It was stated that work was ongoing with the Workforce and Organisational Development function in order to strengthen recruitment. It was also noted that a meeting had taken place within the Division to discuss concerns in relation to the availability of section 12{2} doctors across North Wales. It was noted that there was acceptance that there wasn't a simple solution, but the Division was keen to work collaboratively to address the problem going forwards. **POD20/5.8** The Sub-Committee noted the report update.	
6. FOR INFORMATION	
POD20/6 Mental Health Act Committee Performance Report **POD/6.1** The Mental Health Act Manager presented the performance report for information and explained that it included compliance with the Mental Health Act requirements and the Mental Health Measures. The report also included data in relation to the S136 Divisional Report for Audit and the S136 CAMHS Report. **POD/6.2** Members asked a range of questions relating to the information including the monitoring of exceptions data. The Mental Health Act manager confirmed that there had been five lapsed sections reported. It was also confirmed that the report did not include benchmarking data for the purposes of comparison of the Health Board against other similar organisations in Wales. This was due to no Wales benchmarking reports being issued during the reporting period as a result of the pandemic. It was confirmed that the number of Section 136 rectifiable errors had again reduced in the last quarter covered by the report. **POD/6.3** Concerns were raised in relation to CAMHS and transitions through to Adult Mental Health. It was confirmed that regular meetings in relation to transfers to adult services were taking place. An Associate Hospital Manager expressed concerns regarding section 5.2 - inappropriate transfer between wards. It was confirmed that the incident had been reported via the Datix system and dealt with accordingly. It was noted that the incident was investigated and lessons were learnt in relation to supervision. An issue with regards to an age appropriate bed was also commented upon by an Independant Member regarding the length of time taken to transfer the patient. The Mental Health Act Manager agreed to provide feedback to the Independent Member accordingly. Meanwhile for assurance it was confirmed that nursing huddles always escalate issues on a rapid basis. **POD/6.4** The Chair referred to a walk around visit to the Heddfan Unit and expressed concern with regards to the availability of Section 136 suites. The concern was noted and it was confirmed by the Head of Governance that there are three suites across North Wales (within acute hospitals). Clarification was given regarding the admission of under 18's and vacancies of beds and on the strict management controls in place. **POD/6.5** Significant improvements were also noted by the Head of Governance regarding the involvement of the Criminal Justice Liaison Team and data via the Policy	WL

regarding Section 136 admissions. It was noted that a further update would be provided at the Mental Health Act Committee meeting to follow. **POD/6.6** The Sub-Committee noted the report for information.	
POD20/7 Any other business Nothing further to note.	
POD20/8 Date of next meeting To be confirmed – December 2020.	

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee: 8th December 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Child and Adolescent Mental Health Services – Crisis Pathway and s136 detentions
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Alison Cowell Assistant Area Director – Children's Central Area
Craffu blaenorol: Prior Scrutiny:	Area Director Bethan Jones – Central Area Director Children's Service Group
Atodiadau Appendices:	Nil

Argymhelliad / Recommendation:

That the Committee notes the children and young people's crisis pathway, number of s136 attendances, and the plans to improve services.

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:

The purpose of this report is to provide an update to the Committee since the October meeting, to include;

- Annual Data reporting Section 136 attendances by age profile
- Progress in developing an action plan with Adult Mental Health as requested by the Committee
- WG crisis pathway successful bid

Cefndir / Background:

1. <u>Current Crisis Pathway - Two possible scenarios</u>

1.1 Young Person presents at the Emergency Department with suicidal behaviour or significant self-harm.

Measures in place:

- The young person will be assessed by Emergency Care practitioner and admitted to a Paediatric ward as per the Self-Harm and Suicidal Behaviour Protocol.

- There are CAMHS Practitioners based on the paediatric wards 09:00 – 17:00, seven days a week. Their role is to risk assess and support management on the ward, discharge home or facilitate admission to a Tier 4 bed supported by the Tier 4 CAMHS outreach team (Kite Team). A CAMHS Psychiatrist will attend, assess and support as required 7 days a week 09:00 – 17:00.

1.2 Young Person is detained by the Police Under s136 of the Mental Health Act and taken to one of the three designated places of safety for BCUHB.

- During the hours of 09:00 – 17:00, seven days a week – the young person will be assessed by the CAMHS Psychiatrist known to them or the CAMHS Psychiatrist on call if they are detained during the weekend

- Out of hours (after 17:00) the Adult Psychiatrist assigned to the s136 suite, will contact the CAMHS Consultant Psychiatrist on call by telephone who will provide consultation. All young people under the age of 16 years are seen by a Paediatrician, who is contacted by the s136 duty nurse.

- The Psychiatrist can only discharge a young person from the s136 suite home if this is safe. With many of the young people, home is fragile and the Local Authority role and its Corporate Parenting responsibility is key, to enabling safe discharge. This input is limited out of hours or at weekends, often resulting in delayed discharges and young people staying in the suite longer than they need to.

Across North Wales the number of s136 detentions reduced from a high of 50 in 2017/18 to 25 in 2018/19 but rose to 38 for 2019/20, however this was still lower than the 2017/18 figures. This year will be very difficult to gauge given the impact of lockdown.

Important to note that all young people in crisis are seen urgently, the Mental Health Measure target is 48 hours which is met, with most assessed within 24 hours, whether this is in the community, paediatric wards or s136 suites.

2. S136 Suite Attendances by age

In November there were 3 young people placed on s136, 2 aged 16 years and 1 aged 17 years. One of the16 year olds attended 3 times over an eleven day period.

The 17 year old was discharged home, no mental health disorder.
One 16 year old was admitted to the paediatric ward at Ysbyty Gwynedd.
The 16 year old who attended 3 times was admitted to NWAS on the 3rd attendance for a short admission while an alternative placement was found that would meet their needs.

All the young people presenting to police were reporting self-harm or suicidal threats.

On average the young people spent 12.17 hours on the s136 suite, ranging from 5 hours to 16 hours between detention and discharge/transfer.

Annual Data – Section 136 – Age profile					
Age	2016 - 2017	2017 - 2018	2018 - 2019	2019 - 2020	2020 – 2021 (end of Oct)
12	2	2	0	2	0
13	2	1	1	2	0

14	5	1	4	3	3
15	6	3	7	6	0
16	15	20	5	14	5
17	15	23	8	11	11
BCU Total	**45**	**50**	**25**	**38**	**19**

3. The Mental Health Act Committee requested CAMHS, Mental Health Learning Disabilities Division and primary care leads should work collectively to pull together an action plan to address the risks and needs associated with under 15 year olds being detianed and emergency OOH assessments being undertaken by adult psychiatrists.
It was agreed that the Consultant Nurse for CAMHS, would liaise with the appropriate senior individuals in the first instance and report back to the next meeting. A date (2nd December) has been set for this work to commence.

Asesiad / Assessment & Analysis

Strategy Implications

"Together for Mental Health in North Wales", is a system-wide, all age strategy setting out our goals for improving mental health and well-being services across North Wales from prevention through to a crisis response and recovery.

Within this multi-agency programme, CAMHS has been working collaboratively to support a whole system approach in delivering the emotional and mental health services provided for children, young people and their families across North Wales. This is in line with the principles of prudent health, the 5 ways to wellbeing, the Future Generations Act and the Crisis Care Concordat.

BCUHB submitted a successful bid to WG to develop the crisis pathway further. This bid is focussed on enhancing the crisis care and liaison 'out of hours offer' for young people who find themselves in acute emotional and mental health distress. The enhanced pathway, has been in development over the last 2 years with representatives from Adult Mental Health teams including Psychiatric Liaison as well as Local Authority representatives and Third Sector.

The enhanced Pathway is designed to achieve the following outcomes:

- Increased capacity, to have an enhanced offer for children and young people experiencing a mental health crisis across North Wales with consistent access to support through an extended out of hours' provision up to 8 pm 5 days a week.
- Provide earlier access to support thus preventing inappropriate and detrimental admissions to acute paediatric wards – Monday to Friday 9am to 5pm.
- Prevent delays for assessment thus identifying mental health issues at an earlier point
- Improve patient, families and carers' experience
- Ensure children and young people receive continued support following discharge
- Provide more access points for community provision (Monday to Friday 9am to 5pm).
- To develop greater partnerships with Adult Services so that young people aged 16 years and above can receive a seamless service and transition journey can be made without gaps in service provision.

Options considered
A task and finish group is being established to implement the aims of the bid, all options will be considered to ensure that the pathway meets the local differences and needs.

Financial Implications
Welsh Government allocated £1.488 recurrently to BCUHB for mental health service improvement, the successful crisis pathway bid for a share of this, is worth £445,000.

Risk Analysis
The risks associated with young people being detained on a s136 are on the Health Board's risk register with a score of 16, with the current mitigating measures in place:

- 7 day Consultant Psychiatry provision
- Out of hours (5pm – 9am) Consultant Psychiatry on call rota to provide telephone consultation
- Paediatric assessment of children under 16 years
- CAMHS practitioners on the paediatric wards 7 days a week
- Managers and on call support the process where possible
- Agency staffing to support 1:1 care if required
- Joint working with adult mental health to access the designated age appropriate bed

Legal and Compliance
The changes to the Police and crime Act in 2017 reduced the time a person can be detained on a s136 from 72 hours to 24 hours unless there are reasonable justifications to extend this and 'before exercising a section 136 power police officers must, where practicable, consult a health professional'.

Impact Assessment
EQIA has been completed for the recommendations to improve crisis services for children and young people. No impact assessment was required for the changes to Police & Crime Act 2017

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 8th December 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Section 12 (2) Doctors : Status Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (Interim)
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager Hilary Owen, Head of Governance Dr. Alberto Salmoiraghi, Medical Director MHLD
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	Appendix 1 – Table of Health Board (Wales) information

Argymhelliad / Recommendation:

The Committee is asked to:

1) Acknowledge the current position across Wales
2) Support the Mental Health & Learning Disabilities (MHLD) discussion to assist the Health Board's Medical Director and Executive Director of Primary Care and Community Services to progress the planning arrangements.

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:

This paper explores the position of all the Health Boards in Wales in relation to doctor provisions and the number of approved Section 12(2) medics who are available to facilitate assessments under the Mental Health Act.

Information noted also includes current practices and mitigation to ensure that the people who are experiencing mental health issues are assessed as quickly as possible.

Cefndir / Background:

BCUHB via the Office of the Medical Director manages the approval of 12(2) doctors on an all Wales basis.

It is widely recognised that there is a shortage of doctors nationally, together with a shortage of GPs, to assist the Health Boards in undertaking MHA assessments and provide recommendations for admission.

BCUHB currently has two non-medical approved clinicians. This number will increase to three shortly. Non-Medical Approved Clinicians are not able to initiate a Section of the MHA or provide a medical recommendation and can only renew someone's current detention.

Assessments in the community are coordinated by the Local Authority Approved Mental Health Professionals (AMHP) who access the lists that the Health Board holds which detail local GPs and S12(2) independent doctors. Community assessments can be more challenging to coordinate and have in the past resulted in waiting time or the use of S4 if only one doctor has been available.

Asesiad / Assessment & Analysis

Strategy Implications

The Mental Health and Learning Disabilities Division works towards the Health Board's strategy which aims to ensure persons are detained as a last option, working in line with the Code of Practice for Wales (2016) and ensuring the least restrictive option is preferred. In some instances, the use of the MHA is required to safeguard a person, and ensure that they are not a danger to themselves or others.

Options considered

The responsibility for S12(2) recruitment of GPs currently remains with the Health Board Medical Director and the Clinical Directors for Primary Care, not the Mental Health and Learning Disabilities Division. This paper provides an update on the provisions across Wales. Further work is needed to progress this area of work.

Financial Implications

Financial details are included within the table in Appendix A. All but one Health Board pays £173.37 for a S12(2) qualified assessment and £53.76 for a GP who is not S12(2) approved.

S12(2) training for BCUHB GPs is free to attend but an application is required to be submitted following the training attendance. The November 2020 training had no GP attendance, September 2020 had two GPs attend but no applications have been received following the attendance.

GPs are expected to pay their own indemnity.

Risk Analysis

The lack of Sec 12(2) doctors may pose a risk to people in need of urgent assessments under the MHA. In this situation, if no mental health teams have previously been involved, the AMHPs would look to family or friends to safeguard and if an imminent risk is identified, the emergency services would be asked to attend.

Legal and Compliance

Detention under the Mental Health Act as the most appropriate outcome requires two medical recommendations and an application by an AMHP. In the absence of two doctors, a Section 4 can be used to admit someone under an emergency, but only if it is felt they require immediate detention in hospital, and they are not willing to attend voluntarily or do not have the capacity to agree.

Impact Assessment

Not applicable as this is a paper to highlight the position of the Health Boards in relation to number of doctors available to conduct assessments.

Appendix 1

Health Board / Population	**Fees paid for assessments**	**Number of Doctors**	**Current practices/mitigation**
Betsi Cadwaladr UHB 698,369	12(2) £173.37 GP not S12(2) £53.76	12(2) GPs = 13 GPs not S12(2) = 0 12(2) Psychiatrists = 17 Approved Clinicians (AC) = 79 None Medic ACs = 2	Assessments are usually always conducted with an independent S12(2) or a GP as the second doctor for inpatient section conversions. For external /S136 assessments it will be a S12(2) doctor and a GP, or the on call consultant. In instances when a GP cannot be secured, a psychiatrist from the Health Board can be the 2nd medic providing they have no clinical connections to the patient and there is no conflict of interest i.e. from the same team within the hospital. (Being from the same unit or same area is not deemed a conflict, providing they are not the direct supervisor or both part of the treating team of the patient). In those instances in the community when there is no availability of a second doctor, then a Section 4 (S4) has been used (in an emergency situation) to bring the patient in, and then they would be converted as per the Mental Health Act (*eg converted into a Section 2, or into an Informal Status as appropriate).* It is standard practice that external GP/S12(2) doctors are the first port of call for assistance, prior to seeking internal assistance. (In some instances, it is perceived that internal doctors cannot be asked).

Cwm Taf UHB 445,190	As Above	12(2) GPs = 0 GPs not S12(2) = 0 12(2) Psychiatrists = 12 Approved Clinicians = 52 None medic Approved Clinicians = 2	Assessments are usually always conducted with the Responsible Clinician/Approved Clinician (RC/AC) psychiatrist from the Health Board, dependant on the area that the patient resides in alongside an independent Section 12 doctor. GP's are rarely used, only sometimes, if an assessment takes place in the community. In some instances if an independent Section 12 doctor is not available, another section 12 doctor from within the Health Board will be used as the 2nd medic, providing there is no clinical connection/no conflict of interest. In some instances in the community, if there is no second doctor then a Section 4 will be used in an emergency, and the patient the converted on admission as per the Mental Health Act.
Hywel Dda UHB 385,615	As Above plus travel Believes that the British Medical Associate set the rates.	12(2) GPs = 0 GPs not S12(2) = 0 12(2) Psychiatrists = 13 Approved Clinicians = 29 None Medic Approved Clinicians = 1	Assessments are usually conducted with the Section 12(2) doctor, and a psychiatrist (depending on where patient is). GPs are very rarely used and the Health Board is heavily reliant on 4 external Section 12 doctors. Section 4 is used on occasion, and the Hywel Dda Health Board is in agreement with the BCUHB statement on conflicts of interest.
Swansea Bay UHB 389,372	As above	12(2) GPs = 1 GPs not S12(2) = 0 12(2) Psychiatrists = 10 Approved Clinicians = not given None Medic Approved Clinicians = 0	Usually undertaken by a MH service group S12 psychiatrist, plus a non-Mental Health Section 12 medic for Mental Health Act assessments for detention. 136 assessments can be any Section 12 doctor plus AMHP. The Health Board has no real problems accessing Section 12 doctors but further recruitment is needed. The Health Board has 10 non service group Section 12 doctors. MH Act assessments are arranged by Crisis team or Emergency Duty Team (EDT). Everyone on the rota is Section 12 approved plus a number of the SAS doctors.

Cardiff and Vale UHB 496,413	£182.04 if assessment is completed £91.02 if patient is not seen and no report written	12(2) GPs = 5 GPs not S12(2) = 0 12(2) Psychiatrists = 18 Approved Clinicians = 38 None Medic ACs = 1	The Health Board has 2 GPs who are used very regularly, but this is due to availability. The Health Board uses its own Section12 doctors for in hours who can be called upon. We use the same rules around conflict of interests as BCUHB.
Aneurin Bevan UHB 591,225	Same as BCUHB	12(2) GPs = 7 GPs not S12(2) = 0 12(2) Psychiatrists = 9 Approved Clinicians = 30 None medic ACs = 0	During working hours, if the patient is known to CMHT, the psychiatrist of the local team would assess as the first doctor and supports a Section 12 doctor (GP). For 136, AMHP would utilise a Section 12 from outside the Health Board. During Out of Hours and weekends: the Health has a SPR/ Section 12 rota. The Section 12 doctors work either in ABUHB or other Health Boards around Gwent. Their names are included on the rota, and they get paid for each assessment (if they did not have any assessments they do not receive payment).
Powys UHB 132,447	Same as BCUHB plus travel.	12(2) GPs = 2 GPs not S12(2) = 0 12(2) Psychiatrists = 26 Approved Clinicians = 15 None Medic ACs = 1	The Health Board mainly uses its own 'in house' psychiatrists and rarely use GP's (especially in the South), as they often decline to be part of the assessment. During Out of Hours, the Health Board utilises a number of out of area Section 12 approved clinicians, alongside the Powys on-call psychiatrist. The Health Board has difficulties with travel times due to the geography, and have had difficulties accessing EDT out of hours.
Information from Office of Medical Director	• They are not responsible for recruiting GPs • S12(2) training information is shared with Primary Care for distribution with the GP surgeries. • Attendance at the training does not amount to someone being S12(2) approved an application requires submission.		

	• GPs are not able to go out during surgery times so AMHPs may not call as they cannot get hold of them. • GPs are required to have evidence of assessments for re-approval so if they do not have any calls and do not obtain the evidence then it is difficult for re-approval. • There is provision for GPs to do to supervised assessments to help with point above if there is a problem with re-approval. • There are complications with appraisals and revalidation. • Not all GPs are eligible and they have to meet a certain criteria to become 12(2) either by having MRCPsych or MRCPG for 2-4 years or been in a supervised psychiatry training post.

Cyfarfod a dyddiad: **Meeting and date:**	Mental Health Act Committee 8th December 2020
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 16 November 2020.

Argymhelliad / Recommendation:

The Committee are asked 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 November Induction and Refresher training session was held via Webinar. The next induction and refresher training will take place in February 2021, and this will be via Webinar also. The current training contract will come to an end in March 2021. A new tender specification is currently being processed by Procurement in readiness for training from April 2021 onwards.

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 Approved Clinicians (ACs) and Section 12 (2) Doctors [ACs/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.

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

6th October 2020 – 16th November 2020

New Applications Received	**4**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	0
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	2
Number of ACs already approved in England	2
Number of applications with panel (including portfolios)	6
Number of applications not approved	0
Re-approval Applications Received (5 Yearly)	**8**
Number of applications with panel	0
Number of applications approved	8
Number of applications not approved	0
Number of ACs reinstated	1
Number of re-approvals which have come to an end	**6**
Expired	1
Retirement	0
No longer working in Wales	5
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	0
Awaiting CCT	0
Total Number of Approved Clinicians	**376**
Total Number of Approved Clinicians from previous report	**369**

APPENDIX 2

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

6th October 2020 – 16th November 2020

New Applications Received	**2**
Applications from GPs	0
Applications from Psychiatrists	1
Application from Forensic Medical Examiner	0
Number of Applications Approved	1
Number of Applications Not Approved	0
Number of Applications with Panel	1
Re-approval Applications (5 years)	**3**
Applications from GPs	0
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	0
No longer working in Wales	1
longer registered	0
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	**164**
Total Number of S12(2) Doctors from previous report	**164**

APPENDIX 3

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

As at 16th November 2020

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	5	0	0	2	3	**13**
Section 12(2) Psychiatrists	1	2	6	2	3	3	**17**
Approved Clinicians	3	13	18	10	16	19	**79**

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 8th December 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Deprivation of Liberty Safeguards (DoLS) Update Report for Q1 and Q2
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Associate Director of Safeguarding Debra Hickman Interim Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Chris Pearson, Safeguarding DoLS Manager/Specialist Practitioner, supported by Michelle Denwood Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Due to cycle of business alignment, this report has not been presented through the usual scrutiny following the Safeguarding Governance and Reporting Framework. This report has been reviewed by; Michelle Denwood, Associate Director of Safeguarding and Debra Hickman, Interim Executive Director of Nursing and Midwifery
Atodiadau **Appendices:**	N/A

Argymhelliad / Recommendation:

The MHAct Committee is asked to

1. Receive and accept the report
2. Accept and support the identified actions

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:

The Health Board has a dual role when discharging its duties by following the Deprivation of Liberty Safeguards (DoLS) legislation and guidance. There are two key frameworks, the Supervisory Body, which is the Corporate Safeguarding Team, (DoLS Team) and the Managing Authority, which is the Ward Manager and ultimately the Executive Director, who has accountability for the delivery of the service responsible for the care of patients on the ward or unit.

DoLS legislation requires clear separation from the two different frameworks and BCUHB has a dual function, as both the Commissioner and Provider of services. The Supervisory Body function (Corporate Safeguarding Team) operates independently of those staff who are responsible for managing and providing the care and treatment for patients and service users.

This report includes information and data specific to the Deprivation of Liberty Safeguards (DoLS) for the organisation with specific reference to the Mental Health and Learning Disability Division, due to the interface between the use of the Mental Health Act and DoLS to detain individuals.

Deprivation of Liberty Safeguards is reported following the Corporate Safeguarding Governance and Reporting Framework and within the Mental Health and Learning Disability internal governance and reporting arrangements.

This report includes DoLS activity within COVID-19 pandemic timeframes, which has influenced some of the data findings and DoLS activities.

Cefndir / Background:

There are currently three (3) main organisational drivers, which have an influence upon the strategic priorities for 2020-2021. These are;

1. The Health and Social Care Advisory Service (HASCAS – Rec:12) and the Donna Ockenden (Rec:9)

The review identified DoLS as a high risk area and identified key recommendations. The HASCAS Implementation Group has monitored the implementation of the recommendations.

All of the recommendations from both reviews have been implemented with the exception of the outcome of the service review. Although additional Best Interest Assessors (BIAs) were included in the revised Safeguarding Structure in 2018, a further and more comprehensive review of the service has taken place. As a result of this activity, a business case has been developed which recommends the need for additional resources. The business case is awaiting final review by the Finance Team and will be presented to the Executive Team for consideration. The reporting arrangements for the S12 (2) doctors is included for consideration as they currently sit within the portfolio of the Office of the Medical Director.

2. DoLS Internal Audit (March 2020).

Positive feedback was received regarding the improvements and the strategic direction of the service since 2018. However, the outcome was reported as Limited Assurance. This was directed to areas of improvement required by the wards (Managing Authority) all recommendations have been implemented to support this improvement. The Corporate Safeguarding Team (Supervisory Body) have actioned the following;

- Appointment to the vacant position of a Best Interest Assessor (BIA).
- Standard Operating Procedure (SoP) has been developed and implemented to reinforce the DoLS Code of Practice for front line practitioners.
- Safeguarding Ambassadors are identified throughout the organisation. A governance and supervision framework supports their activity, which is to focus upon the continued implementation of the safeguarding recommendations of the HASCAS/DO reviews and key learning from audits. The organisation has 99 Safeguarding Ambassadors. The mental Health and Learning Disability Division have 20 Safeguarding Ambassadors in total, six in the West, three in Central and eleven in the East. There is an inconsistent number of Safeguarding Ambassadors across the Division but there is no evidence to report that this has resulted in a negative outcome.
- Increased number of DoLS Authorisers, a significant piece of work took place to increase the number of DoLS Authorisers who are supported by a governance and training framework. There are total of 54 DoLS Authorisers, seven (7) are from the MHLD Division. A further training programme is planned for December 2020.
- Bespoke MHLD MCA/DoLS Level 3 training was developed to focus upon the key omissions in the DoLS process by the wards (Managing Authority). The training was created in Q1 using a variety of IT platforms.
- Corporate Safeguarding Level 3 mandatory training also emphasises the DoLS agenda and bespoke MHLD training has been developed and delivered for the second time since the HASCAS /DO recommendations were published. A lay member is engaged as a critical friend when the training material was developed and provides constructive feedback, which influences future training packages.

3. Quality and Assurance activities and findings.

To gain assurance, audit activities and learning from data and the review of individual cases and incidents has influenced the strategic agenda. The Corporate Safeguarding Team (Supervisory Body) have developed;

- A process of scrutiny to cross-reference incidents with Datix to target trends, provide individual supervision, and ensure reporting compliance.
- Developed and implemented a DoLS COVID flowchart to ensure practice continued during the pandemic. This was reviewed and updated in September 2020; this activity is compliant with guidance published by the Department of Health & Social Care for Hospitals, Care Homes and Supervisory Bodies in England and Wales (2020).
- Implemented audit activity to scrutinise completed documentation by the wards (Managing Authority) within MHLD. The outcome evidences the East area has omissions with the documentation of 11 out of the 15 forms (73%) received by the Corporate Safeguarding Team. The scrutiny of applications includes both the application and supporting evidence. Reported in Table 3.

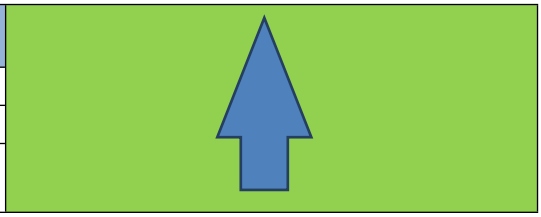
Asesiad / Assessment & Analysis

All applications for a DoLS are prioritised according to the risks and urgency identified within the application and accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the Corporate Safeguarding Team (Supervisory Body).

DoLS Applications 2014 to 2020 and Q1-and Q2 of 2020-2021

Table 1.

Year	Total DoLS Applications
2018/19	744
2019/20	1014
2020/21 Q1&Q2	556 (projected 1,052)

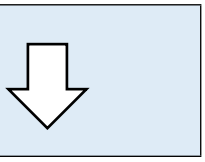


BCUHB have seen a consistent increase in the number of DoLS applications over the last seven years. This increase in activity has also resulted in an increase in complexity.

Applications Specific to MHLD Division

Table 2.

Year	MHLD DoLS Applications
2018-19	110
2019-20	117
2020-21 (Q1 – Q2)	49 (trajectory of 98)



Between Q1 to Q2 2020/21, there have been 49 applications for a DoLS from the MHLD Division, which gives a trajectory of around 100 applications in Q4. Table 2 illustrates a 15% decrease in activity on last year's data. This data trajectory will have been influenced by COVID-19 pandemic in Q1 and Q2.

DoLS applications across the Mental Health and Learning Disability Division equate to 8% of the total applications to the DoLS Team.

A fluctuation in applications for DoLS within a Mental Health Unit is expected and not seen as unusual, this is because the appropriate option for detention in this facility is under the Mental Health Act 1983, which replicates national data.

37% (n=18) of MHLD applications have come from Bryn y Neuadd 6 in Q1 and 12 in Q2. The Heddfan Mental Health Unit saw a higher number of applications in Q1 (n=9) than those received in Q2 (n=4).

In response to COVID-19, the Heddfan Unit became the regional admission unit for older person's mental health care. This service redesign by the Division, which altered the service delivery of patients across North Wales, is considered to have had an influenced upon the reported data for this period.

A DoLS application would only apply when a patient lacks capacity to consent to their care and treatment in a mental health setting and where the primary needs of the individual were physical care needs. The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) states, if a patient lacks capacity to consent to their treatment for their mental disorder and objects to it, the law then requires the Mental Health Act 1983 to be the only option available.

Audit and Assurance Activities

Improved data collection and analysis of the findings has continued to support the targeted approach to intervention.

- Audit activities are determined by the findings from the review of incidents or to provide assurance based upon the identification of trends or themes.
- The MHLD Safeguarding Forum reports on the DoLS activity. The audit activity is included in the Divisions audit cycle of business with full engagement and support.
- Included within the new safeguarding report and data analysis for Ward Accreditation are key questions relating to DoLS and guidance relating to locked doors and DoLS.
- DoLS activity and improvement plans are captured within the Heddfan Unit Safeguarding Quality Assurance Action Plan. Key themes will be audited throughout the Division to obtain greater assurance.
- The Corporate Safeguarding Risk Register monitors activity and mitigation to reduce the organisational risks relating to the unlawful detention of service users.

Audit Findings

Documentation is a key framework evidencing and guiding decision-making and compliance of process under the legislation. Poor quality documentation results in delay, duplication of activity, challenge in the Court of Protection (CoP) and ultimately it can cause the unlawful detention of patients resulting in harm and resulting in financial and reputational damage.

The Internal Audit reviewed and analysed DoLS applications sent by Wards (Managing Authority) across the Health Board and raised the following concerns:

- Out of 22 randomly selected cases, 9 applications submitted did not have an attached mental capacity assessment.
- Out of 22 randomly selected cases, only 1 case included the necessary care plan.

Further scrutiny of the applications received by the Corporate Safeguarding Team (Supervisory Body) was completed. This audit activity involved the review of applications by Wards (Managing Authority) including the MHLD Division. This audit has resulted in the identification of key themes.

The Identified Themes are:

- No mental capacity form to evidence the assessment has taken place
- No patient care and treatment plan
- No evidence of MHA Section details, reported or evidenced
- No named consultant recorded

Table 3 provides the number of MHLD applications received with omissions relating to the documentation by area.

Table 3

Q1 and Q2 2020	West	Central	East	England	Total
MHLD Applications Received	6	28	15	-	49
Issues with MHLD Forms	5	11	11	-	27
% of Forms with Issues	83%	39%	73%	-	55%

The overall Safeguarding training compliance for Level 1 is 86.2% and Level 2 is 87.4%, which is above the key performance indicator of 85%. The training compliance for all Level 3 training activity is reported within the Level 2 training compliance data on the Electronic Staff Record (ESR). The Workforce Mandatory Training Group are undertaking a data cleanse before they are able to separate the compliance data for Level 2 and Level 3 training. The Corporate Safeguarding Team have recently developed a process to capture the MCA/DoLS data in Q3 and Q4 to enable the scrutiny of the compliance data by training levels as this is a recognised barrier.

The improved training compliance reinforces best practice, reduces risk of unlawful detention by improved monitoring and the development of greater awareness at ward level (Managing Authority) by using a variety of blended training techniques. It is evident that the training compliance data alone does not always provide assurance or evidence that training guarantees a change in the learning culture and practice. It is envisaged by using a workshop and case review methodology a greater understanding is developed of the required actions and DoLS process, this is to take place in Q3 and Q4.

A key action is to continue to engage with BCUHB training department to ensure Corporate Safeguarding can obtain assurance against the compliance data of the Level 3 MCA/DoLS training activity in Q3 and Q4, and continue to evaluate, monitor and as necessary escalate reduced training compliance on the wards (Managing Authority) with specific consideration given to the training compliance of agency staff and bank staff.

<u>Hospice Care</u>

The COVID-19 pandemic 2020 has had a significant impact upon hospice care for young people (16/17 years) and young adults (18yrs – 20yrs). Resulting in young people with learning disabilities having reduced access to respite care. This was particularly evident during Q1 and Q2 with zero DoLS applications from the two hospice providers highlighting a local and national challenge.

North Wales respite care providers for adults and young people aged 16/17 year olds and young adults (18-20) years are due to recommence services by Q3, Corporate Safeguarding will require assurance from MHLD commissioning teams regarding compliance.

Legislation

In September 2019, the Supreme Court held that in the case of *D v Birmingham,* where a 16 or 17 year old person cannot (or does not) give their own consent to circumstances satisfying the 'acid test', the legal position is that they meet the criteria for a Deprivation of Liberty (DoL). The likelihood is there will be an increase in the number of cases referred to the Court of Protection. There have been 6 additional complex cases referred to the Court of Protection for this age group since 2019. Currently no cases have been reported from the MHLD Division, however it is recognised young people are admitted onto adult mental health wards. This will require further scrutiny in Q3 and Q4.

To support the implementation of the new legislation bespoke training has been provided to Paediatrics, CAMHS and during the National Safeguarding week workshops took place to increase awareness. Further activities are taking place during Q3 and Q4 and this will support the review of procedures and supporting documents relating to Young people admitted onto Adult MH wards

Liberty Protection Safeguards

When the new Code of Practice for the Mental Capacity Act and Liberty Protection Safeguards is produced during 2021, a new Impact Assessment will be undertaken at a national level and the Corporate Safeguarding Team (Supervisory Body) will be fully engaged. The recognised demand is included and considered within the Business Case.

Corporate Safeguarding (Supervisory Body) has included the new legislation on the agenda of Safeguarding Forums to prepare the organisation and key stakeholders of the intended challenges. It is proposed BCUHB will have an additional 1700 applications based upon the current data, this will also have an impact upon MHLD within community settings.

Actions identified for Q3 and Q4

All of the actions are monitored by the Safeguarding Quality and Performance Group and the MHLD Safeguarding Forum and will be reported by the Annual Corporate Safeguarding Report (2020-2021).

The actions identified are on target and have the full engagement of the Safeguarding Quality and Performance Group membership and the Mental Health and Learning Disability Division.

There are recognised financial implications for the Deprivation of Liberty Safeguards (DoLS) service provision due to the demand, complexity and the implementation of the revised legislation in 2021/2022, the implications are considered within the Corporate Safeguarding Business Case.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 08.12.2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health Act Committee Performance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Iain Wilkie, (Interim) Divisional Director of Mental Health and Learning Disabilities
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	MHLD Senior Leadership Team Quality Safety and Experience Group
Atodiadau Appendices:	Appendix 1 MHA Committee Performance Report July - October Appendix 2 S136 Divisional Report – November Appendix 3 S136 CAMHS Report – November

Argymhelliad / Recommendation:

The Mental Health Act Committee is asked to note the Performance 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 period, and update with October/November 2020 data.

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. This report details a four month period due to a change in the reporting schedule to ensure up to date information is provided wherever possible.

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 report is undertaken monthly, quarterly and annually. This report is therefore presented as an advisory report to the Mental Health Act Committee. The report 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 table and charts, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is included and 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 MHAC.

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 Health Board strategy, the MHLD gives consideration to care closer to home wherever possible, and in line with the wellbeing objectives, is increasingly focused on early intervention where possible.

Financial Implications

The rise of Mental Health Act Detentions has a financial implication, two doctors are required to assess for some of the sections and a conflict of interest between clinicians as specified under the Mental Health Act needs to be avoided. This results in the use of independent S12(2) doctors and those that work as GPs.

Legal advice is obtained in relation to some detentions and the use of the Mental Health Act. No specific budget is in place for this legal advice.

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 for validity and any invalid detentions are reported through Datix, investigated and escalated as appropriate.

Legal and Compliance

This report is generated quarterly. The Mental Health Act sections are monitored closely, 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.

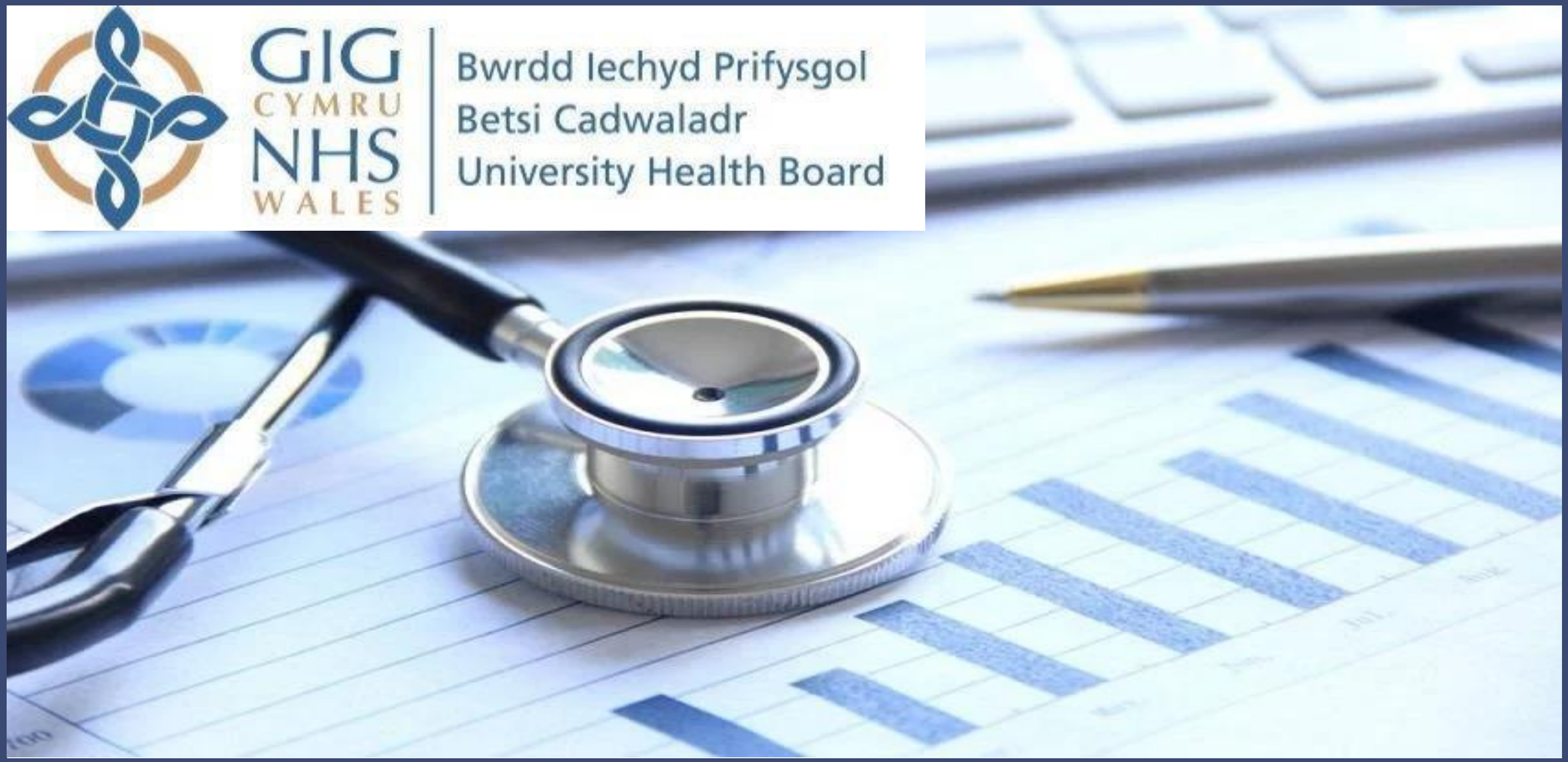
Impact Assessment

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

October 2020

Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

CONTENTS:

There are two exceptions to report this period.

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.

Advisory Reports & Exception reports

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

Reports for the Mental Health Measure are no longer included in the Mental Health act Committee Performance Report due to reporting being detailed at the Quality, Safety and Experience Group.

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

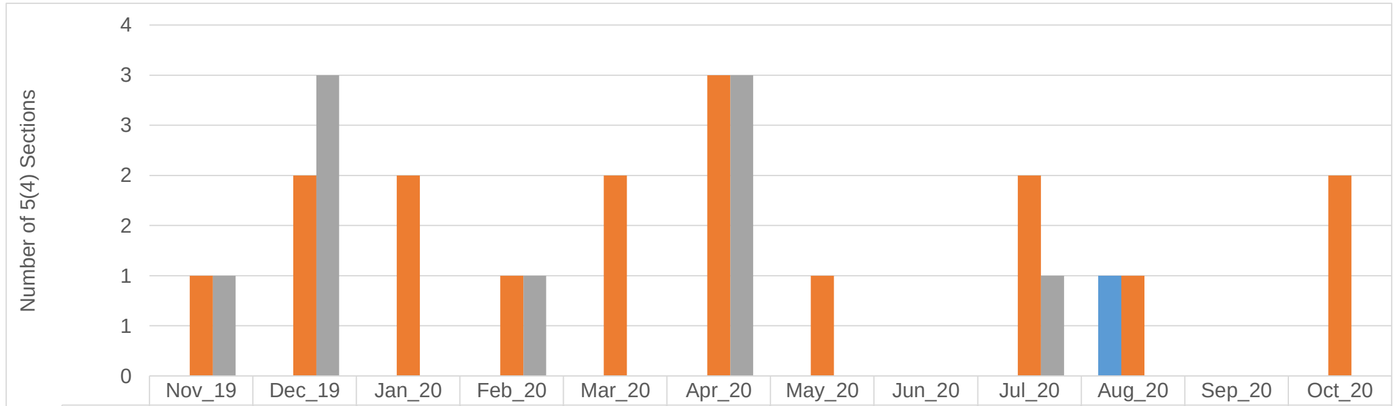
Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

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)	Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
4	4	→	7	1	Centre	3
				2	West	1
				3	East	0



	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	0	0	0	0	0	0	0	0	0	1	0	0
Centre	1	2	2	1	2	3	1	0	2	1	0	2
East	1	3	0	1	0	3	0	0	1	0	0	0

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.

There were two instances in Central where the section lasted for the full duration as the patients were noted to have become settled and there was no requirement for the doctor to progress. It is not acceptable to allow a section to run for the full timeframe without clear documentation that this is no longer in place. The policy has been reviewed to reflect this.

LAPSES

One section was noted to have lapsed, there is no evidence of consideration of section 5(2) or assessment under the MHA for further detention. INC241177

WEST

The data	Duration (hh:mm)	Outcome
Aug_20	04:40	DOLS

CENTRE

Month	Duration (hh:mm)	Outcome
Aug_20	06:00	Informal
Oct_20	00:20	Section 5(2)
Oct_20	06:00	Lapsed
Jul_20	04:05	Section 5(2)
Jul_20	06:00	Informal

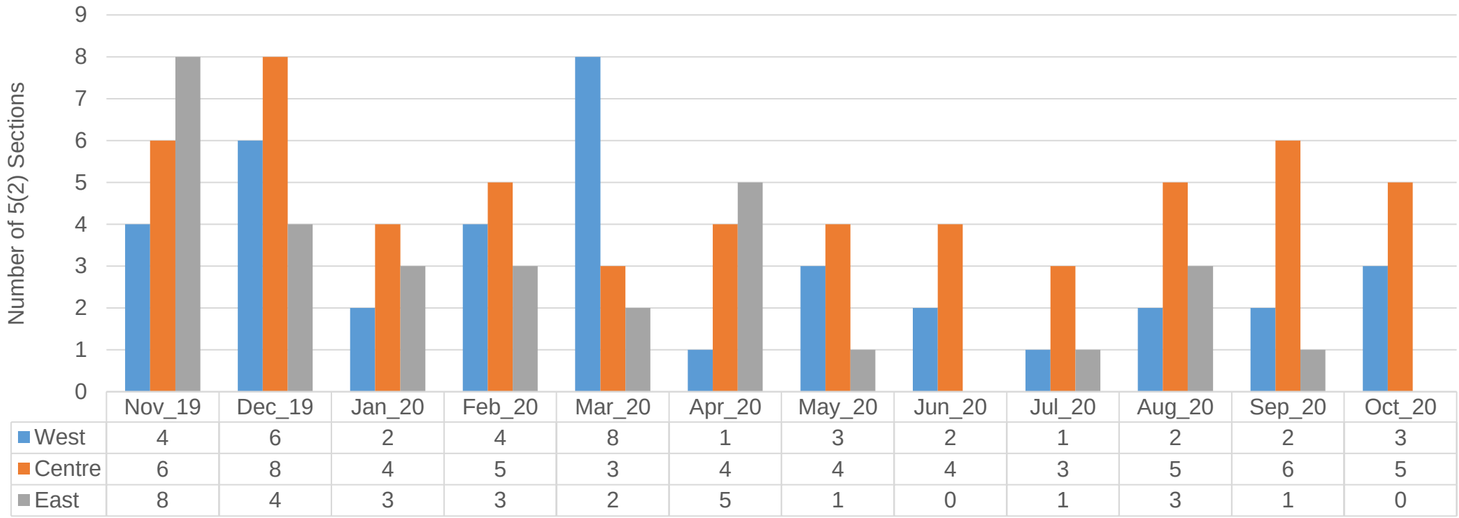
EAST

Month	Duration (hh:mm)	Outcome
Jul_20	05:30	Section 5(2)

Advisory Report - Section 5(2)

Section 5(2) - BCUHB	Latest Month	Previous Month	Monthly Trend
Section 5: Application in respect of patients already in hospital	8	9	↓

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
27	19	↑	32	1	Centre	16
				2	West	7
				3	East	4



	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	4	6	2	4	8	1	3	2	1	2	2	3
Centre	6	8	4	5	3	4	4	4	3	5	6	5
East	8	4	3	3	2	5	1	0	1	3	1	0

Section 5(2) Outcomes

	Aug 2020	Sep 2020	Oct 2020
Section 2:	5	3	2
Section 3:	0	2	4
Informal:	6	3	0
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	0	0	0
Other:	0	0	0

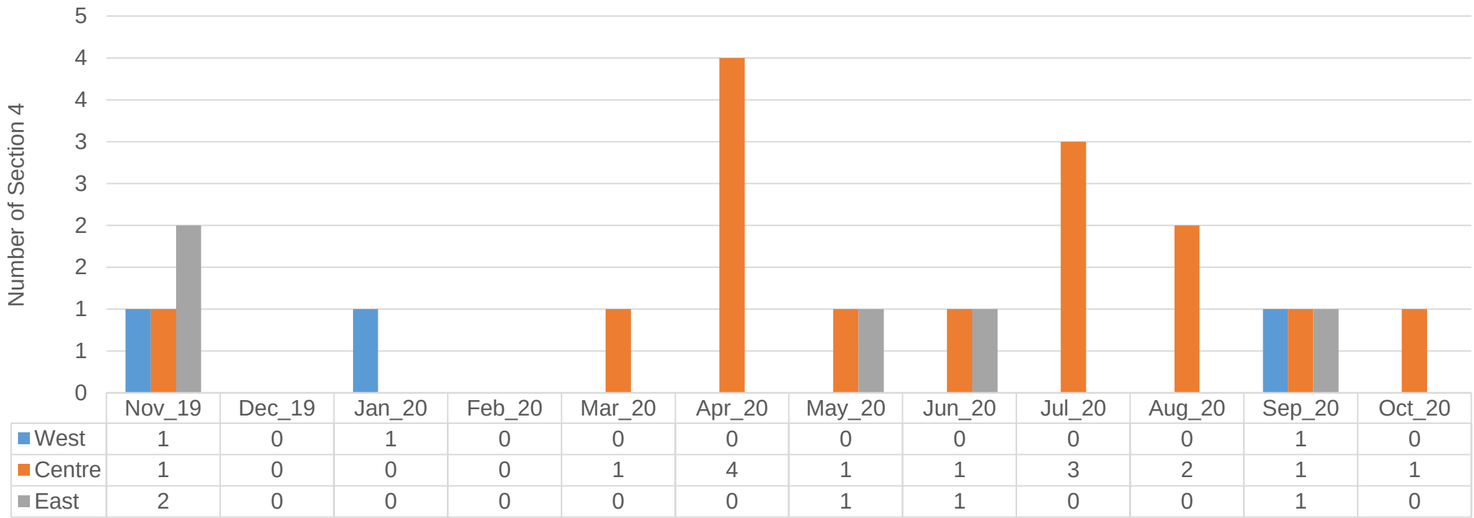
A Section 5(2) on occasions will be enacted within the acute hospital wards, during July - October there was one instance which resulted in the patient being detained under Section 2.

There are no exceptions to report for this period

Advisory Report - Section 4

Section 4 - BCUHB	Latest Month	Previous Month	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	1	3	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
6	7	↓	6	1	Centre	4
				2	East	1
				2	West	1



	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	1	0	1	0	0	0	0	0	0	0	1	0
Centre	1	0	0	0	1	4	1	1	3	2	1	1
East	2	0	0	0	0	0	1	1	0	0	1	0

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

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

There was a spike in April which may have been due to Coronavirus but this did not continue through to May and June, Central area has the highest number of S4s since March, the availability of S12(2) doctors potentially could be having an impact this is being considered by the Medical Director and avenues explored.

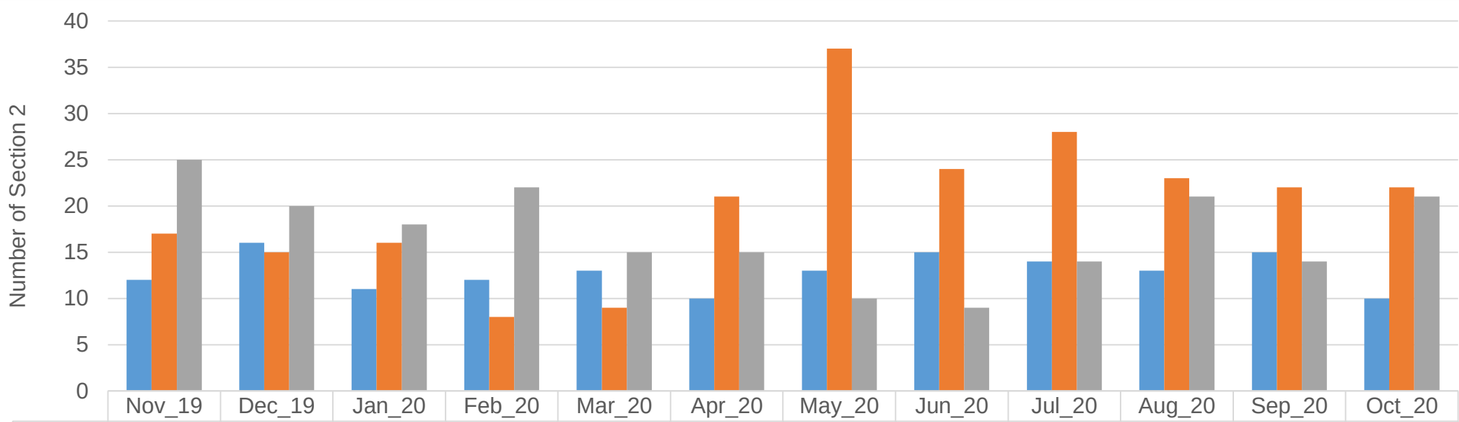
WEST		
The data	**Duration (hh:mm)**	**Outcome**
Sep_20	05:40	Section 2

CENTRE		
Month	**Duration (hh:mm)**	**Outcome**
Aug_20	21:35	Section 2
Aug_20	04:25	Section 2
Sep_20	18:30	Section 2
Oct_20	11:50	Section 2

EAST		
Month	**Duration (hh:mm)**	**Outcome**
Sep_20	63:05	Section 2

Advisory Report - 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	53	51	↑	161	164	↓	150	1	Centre	67
								2	East	56
								3	West	38



	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	12	16	11	12	13	10	13	15	14	13	15	10
Centre	17	15	16	8	9	21	37	24	28	23	22	22
East	25	20	18	22	15	15	10	9	14	21	14	21

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

Section 2 Outcomes

	Aug 2020	Sep 2020	Oct 2020
Section 3:	11	14	7
Informal:	14	16	21
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	7	6	8
Transferred:	12	13	16
Invalid and Other:	0	0	1

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 was one under 18 placed on a Section 2 this period admission was to an age appropriate bed in CAMHS.

EXCEPTIONS:

There are two exceptions to report this period.

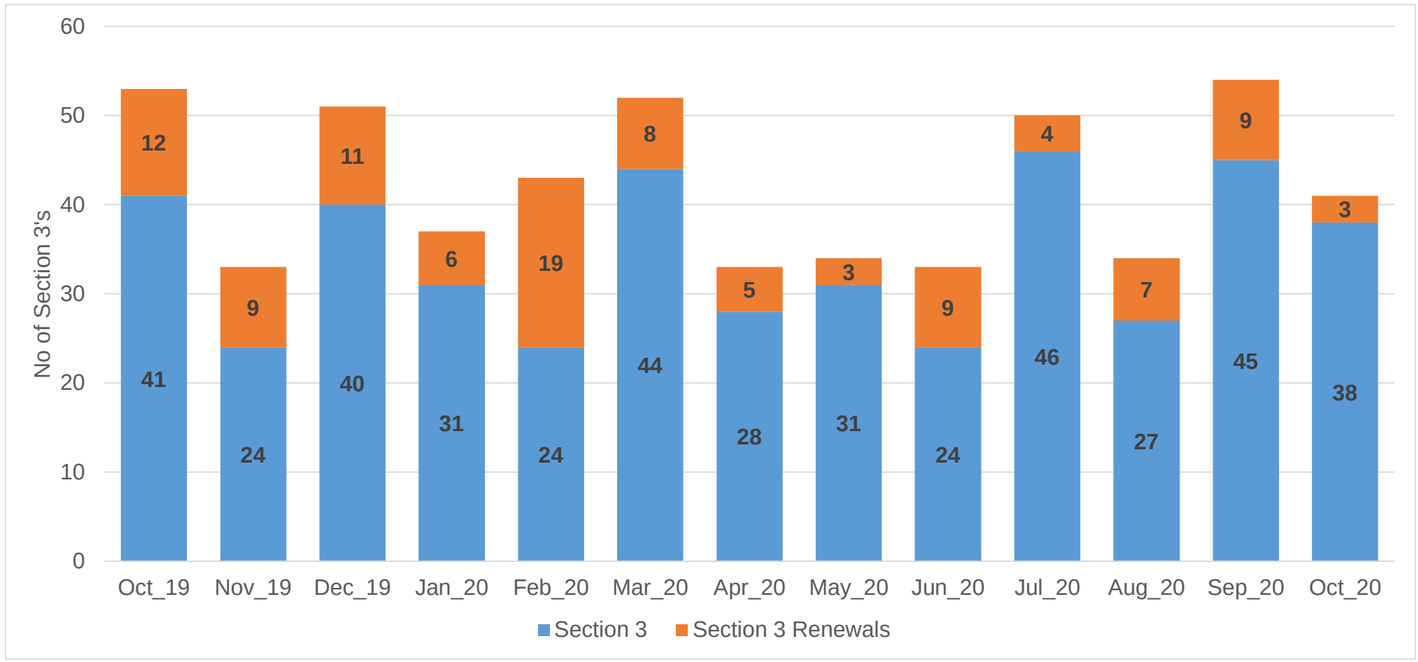
WEST: (July) A Section 2 expired as the AMHP did not complete the Section 3 paperwork in time INC232470.

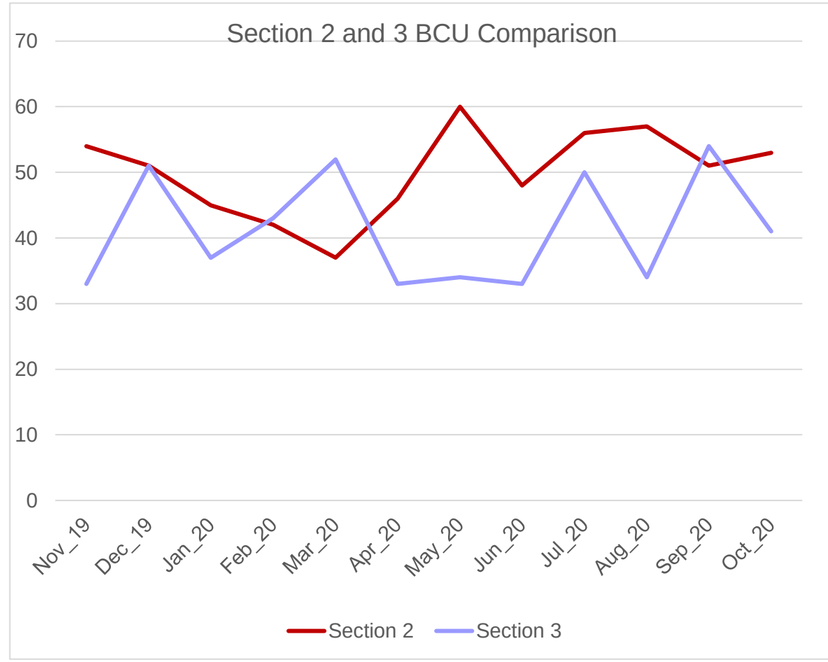
CENTRAL: A Section 2 was found to be invalid as the joint medical recommendation had not been signed by both doctors. INC239612.

Advisory Report - Section 3

Section 3 - BCUHB	Latest Month	Previous Month	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	41	54	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
129	117	↑	124	1	Centre	53
				2	East	41
				3	West	35





* 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.

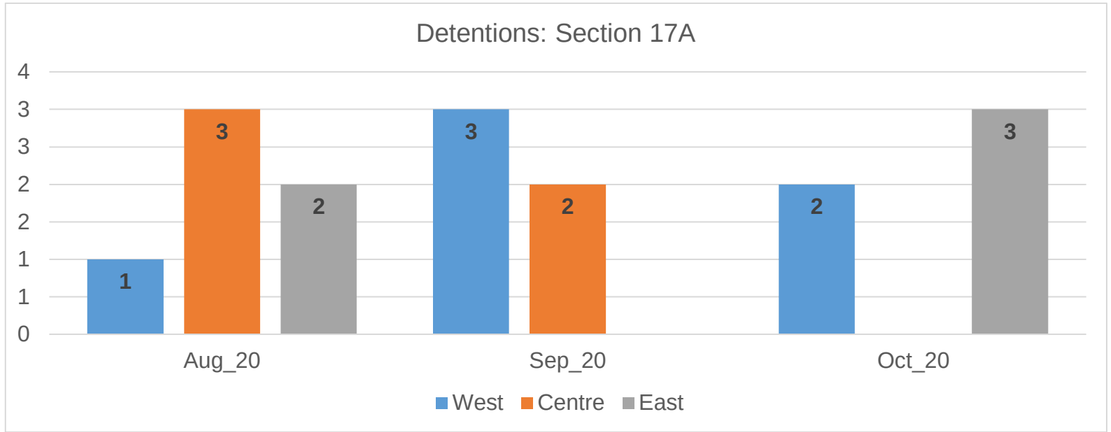
This period there were three under 18s made subject to a section 3 in an age appropriate setting. The trend for use of S2 and S3 at the end of October is showing as upward.

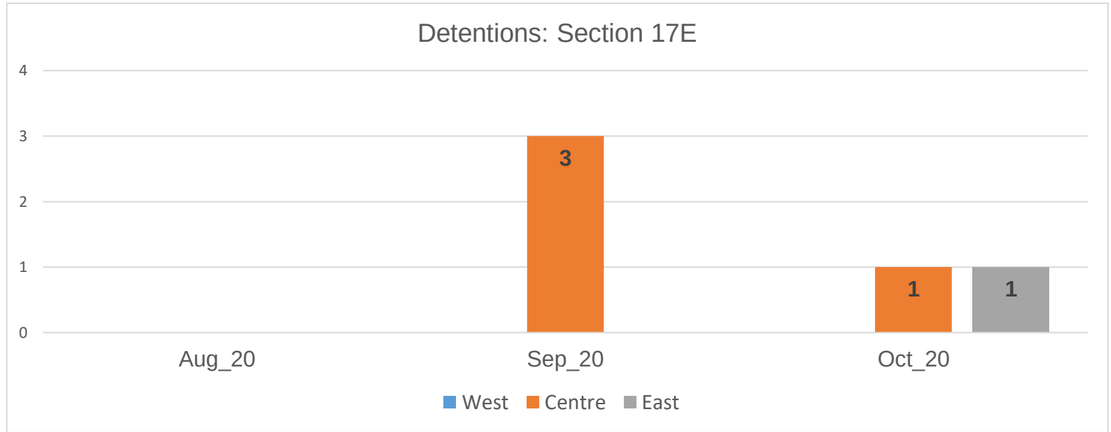
There was one exception to report this period initially completed in WEST which was discovered on transfer to the EAST, permission had not been obtained from one local authority for another to act on their behalf rendering the section invalid, INC238100.

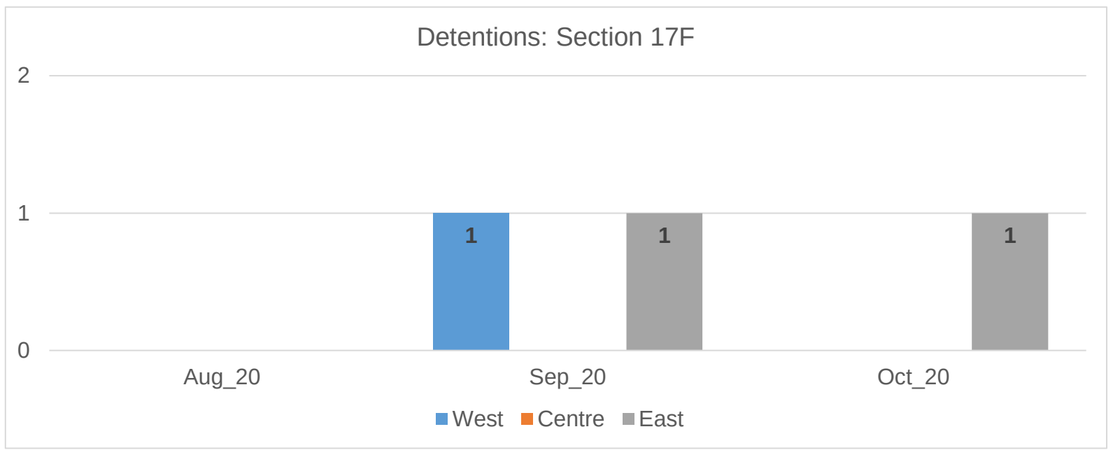
Advisory Report - Section 17A - F

Section 17 A-F - BCUHB	Latest Month	Previous Month	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	8	10	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
24	10	↑	16	1	Centre	9
				2	East	8
				3	West	7







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 October: West:10, Central: 10 and East: 9.

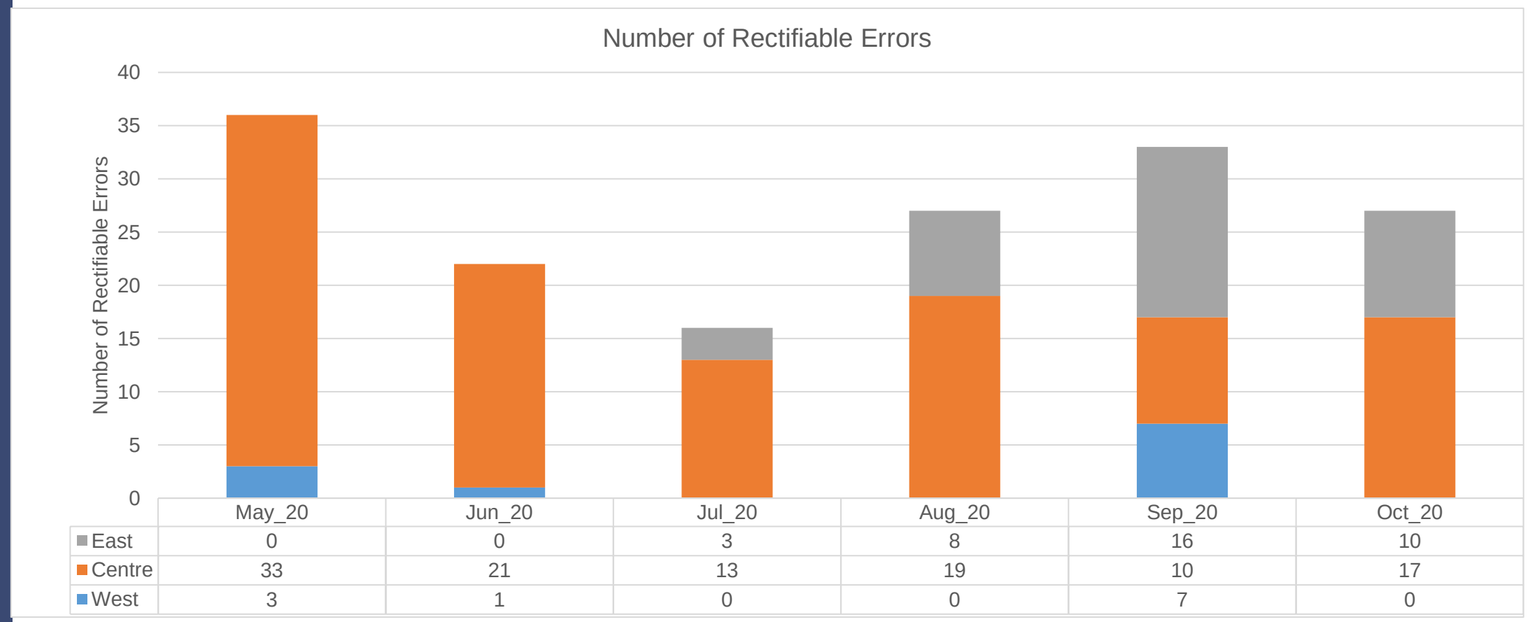
There has been a decrease in the number of patients subject to a CTO for each area from September to October.

Exceptions: There was one CTO which lapsed this quarter this has been datixed INC238205.

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	Latest Month	Previous Month	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	27	33	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	Centre	46
				2	East	34
				3	West	7



	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
East	0	0	3	8	16	10
Centre	33	21	13	19	10	17
West	3	1	0	0	7	0

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 so are not aware of our current position. data from BCUHB has been submitted at the required times. Scrutiny of BCUHB data for the reported quarters show that although the month on month (August to September) increased, 28% of the total detentions contained errors compared to 31% last quarter.
Central is identifying the majority of errors due to this area being the admission unit during the previous quarter and therefore the majority of detentions originate here.
October has again shown a decrease in errors and will be part of the reporting period Oct-Dec within the benchmarking data.

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

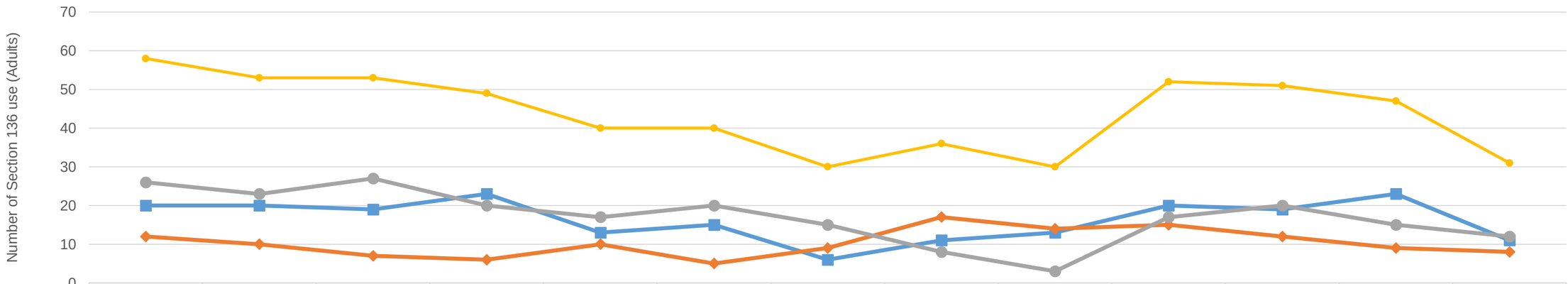
This period there has been a Section 2 and a Section 3 deemed fundamentally defective rendering the sections invalid.

This period there has been 5 lapsed Sections:- 1 x Section 5(4), 1 x Section 2, 2 x Section 136 and 1 x CTO. There were also 2 x Section 5(4)s that were allowed to expire without correct documentation confirming termination times.

Advisory Report - Section 135 and 136

Section 135 - 136	Latest Month	Previous Month	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	31	47	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
129	118	↑	128	1	West	53
				2	East	47
				3	Centre	29



	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	20	20	19	23	13	15	6	11	13	20	19	23	11
Centre	12	10	7	6	10	5	9	17	14	15	12	9	8
East	26	23	27	20	17	20	15	8	3	17	20	15	12
BCU	58	53	53	49	40	40	30	36	30	52	51	47	31

The data above does not include S135 or under 18's.
There has been one S135 this period.
Three Section 136s lapsed this quarter, two have been datixed INC235129 and INC237653.
One instance was due no handover paperwork produced by the police, resulting in confusion around whether a detention had been enacted, information had to be obtained from the police at a later date following investigation.

There were three people noted to be in custody as their first place of safety, two in August and one in July.
Four S136 12 hour extensions were granted due to not being fit for assessment, one resulted in discharge with referral to services, one in a voluntary admission and two admissions under section 2.

Advisory Report - Section 135 and 136

Section 136	Latest Month	Previous Month	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	31	47	↓

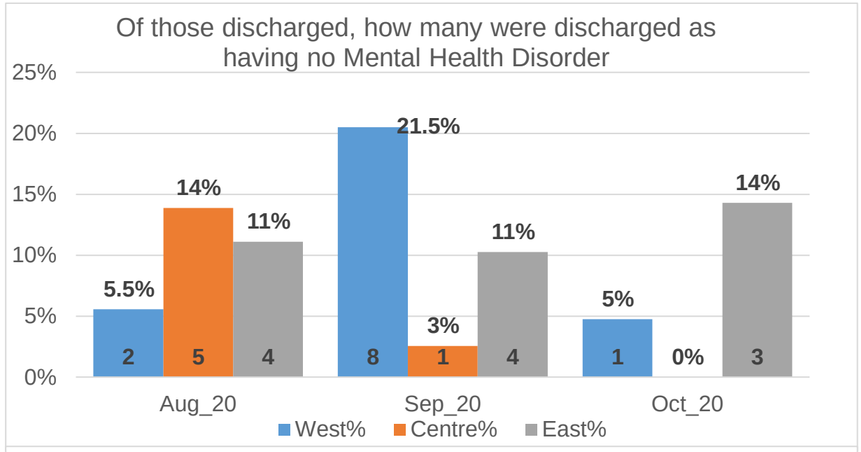
Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
129	118	↑	128	1	West	53
				2	East	47
				3	Centre	29

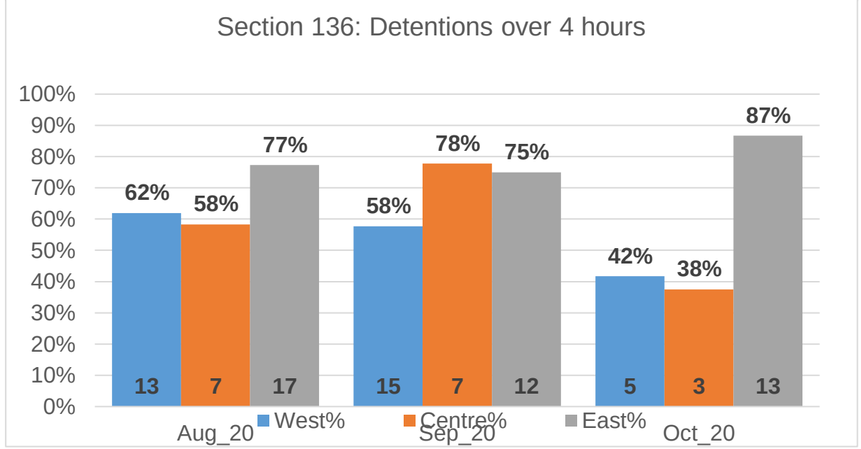
Section 136 Outcomes

	Aug 2020	Sep 2020	Oct 2020
Discharged:	36 67.92%	39 75.00%	21 60.00%
Informal Admission:	10 18.87%	6 11.54%	4 11.43%
Section 2:	6 11.32%	7 13.46%	8 22.86%
Section 3:	1 1.89%	0 0.00%	2 5.71%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Aug 2020	Sep 2020	Oct 2020
Yes	27	23	25
Yes (percentage)	49.09%	45.10%	71.43%





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 continues to be around 20%.

Total percentages for the months for those discharged with no mental disorder are:
August 18%
September 25%
October 11%

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

August 33% discharged with follow up and 36% referred to services.
September 29.5% discharged with follow up and 35% referred to services.
October 57% discharged with follow up and 24% referred to services.

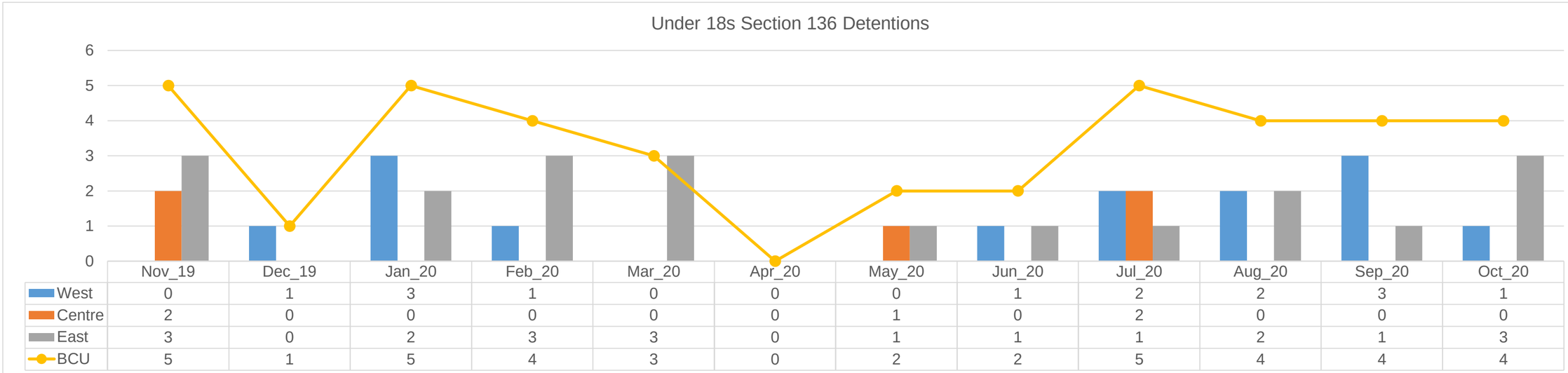
The Criminal Justice Liaison Service has been working out of North Wales Police Headquarters and in the community since January 2020. The service has been actively involved in assisting the police and signposting people in crisis to other avenues rather than the police using the S136 power. Since January this has been recorded and 89 people have not become detained on a S136 due to CJLS intervention. This period accounts for 40 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 13 instances.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	Latest Month	Previous Month	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (<18)	4	4	→

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
12	9	↑	10	1	East	6
				1	West	6
				3	Centre	0



	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20
West	0	1	3	1	0	0	0	1	2	2	3	1
Centre	2	0	0	0	0	0	1	0	2	0	0	0
East	3	0	2	3	3	0	1	1	1	2	1	3
BCU	5	1	5	4	3	0	2	2	5	4	4	4

A total of seventeen under 18's were assessed this period between the ages of 14 and 17 years. Nine assessments resulted in discharge with follow up to services, two resulted in new referrals to CAMHS, one young person was discharged recorded as no mental discorder, four resulted in admissions, two to NWAS under a section 2 and section 3 and two were admitted to the childrens wards without the restriction of a detention.

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	5
17	12

Outcome of Assessments

Outcome	Number
Returned Home	9
Returned to Care Facility	3
Admission to childrens ward	2
Admission to Adult ward / S136 suite	1
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
July	Heddfan	Discharged	CAMHS	13:35	14
July	Ablett	Discharged	CAMHS	05:10	14
July	Ablett	Discharged	CAMHS	11:20	17
July	Hergest	Discharged	CAMHS	13:40	14
July	Hergest	Discharged	CAMHS	11:15	16
August	Heddfan	Admission	CAMHS	04:50	17
August	Heddfan	Discharged	CAMHS	07:17	17
August	Hergest	Discharged	CAMHS	13:05	17
August	Hergest	Discharged	CAMHS	07:12	17
September	Heddfan	Admission	CAMHS	14:20:00	17
September	Hergest	Discharged	CAMHS	16:05	16
September	Hergest	Admission	CAMHS	16:23	15
September	Hergest	Discharged	CAMHS	11:50	16
October	Hergest	Admission	CAMHS	10:35	17
October	Heddfan	Discharged	Adult	07:55	17
October	Heddfan	Discharged	Adult	03:12	17
October	Heddfan	Discharged	CAMHS	10:40	17

Out of the 17 young persons assessed 13 originated from their own home.

14 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: 11:14 hrs this is a decrease on the previous quarter figures of (12:53 hrs). For the four months July to October Average PoS hours: 10:29 hours.

Under 18's admitted to Adult Psychiatric Wards

There were no admissions to Adult Psychiatric Wards 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	5	3	
Denbighshire	1		2
Conwy			2
Gwynedd			3
Ynys Mon			1
Out of Area			

A

Section	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	1	1	1	1	1	1	0	0	0	0	0	0
Section 37/41:	11	12	12	12	12	9	9	9	8	8	9	8
Section 38:	0	0	0	0	0	0	1	1	1	1	0	0
Section 47:	3	3	3	4	4	2	2	2	2	3	3	3
Section 47/49:	4	4	4	4	4	2	2	3	3	2	2	2
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	1	1	1	0	0	0	0	0	0	0	0	0
Section 3:	2	2	2	2	2	2	2	2	3	3	3	3
Section 45A	1	0	0	1	1	1	1	1	1	1	1	1
Total:	23	23	23	24	24	17	17	18	18	18	18	17

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility.

The nature of the forensic sections does not always generate rapid activity.

There are times when section 3 patients will be detained within the unit.

Total Transfers for the Quarter

	Aug 2020	Sep 2020	Oct 2020
Internal Transfers	18	33	36
External Transfers (Total)	6	10	6
External Transfers (In)	4	7	5
External Transfers (Out)	2	3	1

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.

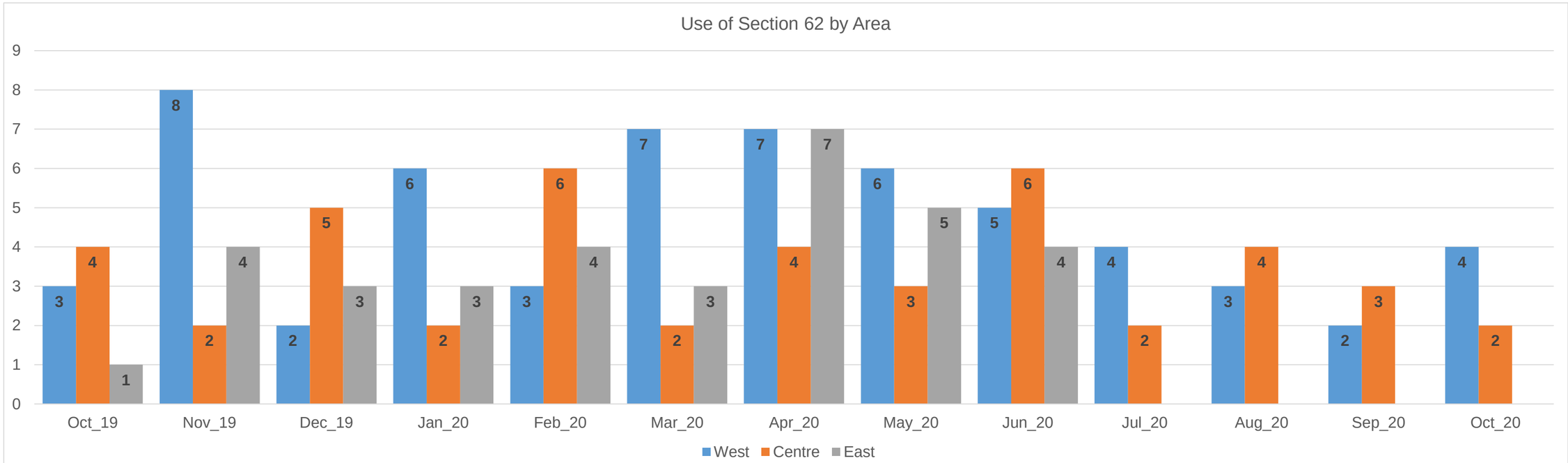
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised 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 97 detained patients within independent hospitals 51 of these are outside of Wales ie out of area placements.

Month	Transfers In
Aug_20	HMP Berwyn (Gwynedd)
Aug_20	New Hall (Denbighshire)
Aug_20	Bowmere (Flintshire)
Aug_20	Priory, Bristol (Ynys Mon)
Sep_20	Cygnet (Flintshire)
Sep_20	St Davids Independent Hospital (Flintshire)
Sep_20	Cygnet Maidstone (Conwy)
Sep_20	Coed Du Hall (Wrexham)
Sep_20	Cygnet (Wrexham)
Sep_20	Ty Grosvenor (Wrexham)
Oct_20	Priory, Ticehurst (Gwynedd)
Oct_20	Aberystwyth (Gwynedd)
Oct_20	Wintson Hospital (Gwynedd)
Oct_20	Cheadle Royal (Wrexham)
Oct_20	The Redwoods Centre (Wrexham)

Month	Transfers Out
Aug_20	HMP Berwyn (Wrexham)
Aug_20	Transferred to The Priory Hospital Nottingham (Repatriated)
Sep_20	Cygnet Mold (Gwynedd)
Sep_20	Transferred to Goodmayes (Repatriated)
Sep_20	Maidstone (Conwy)
Oct_20	Cheadle (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.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

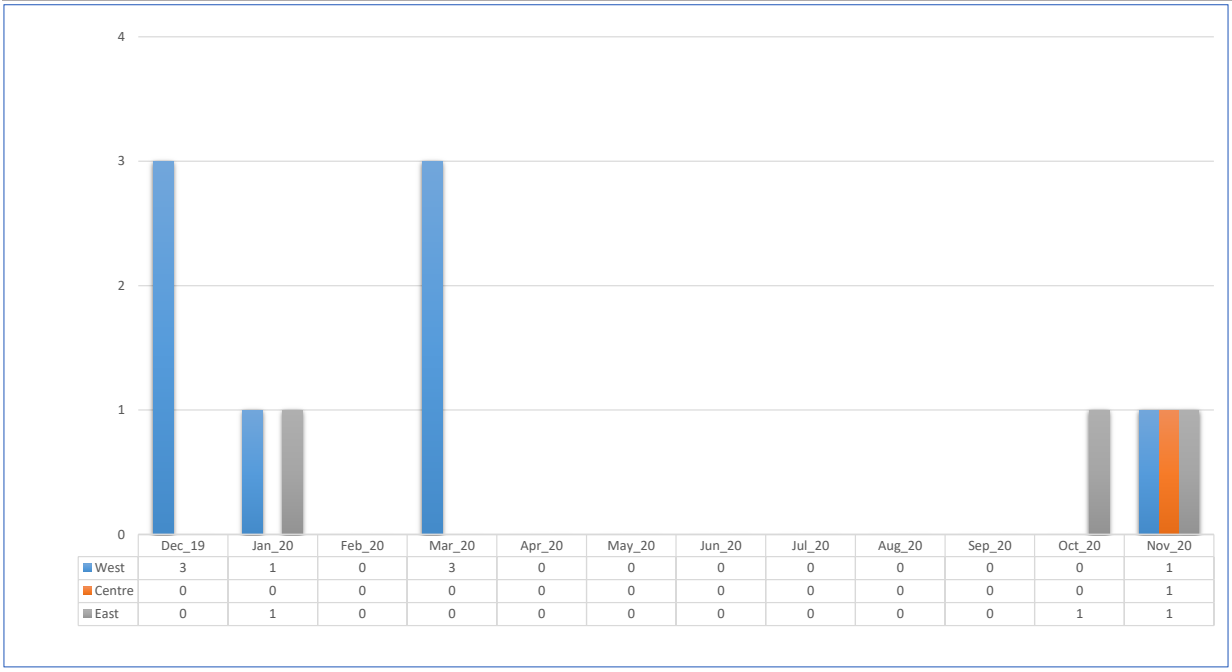
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

S.136/135 use in BCUHB
KPI Report for: November 2020

Data Source:	BCUHB MHA Database
Report Created on:	02/12/2020
Report Created by:	Performance Directorate

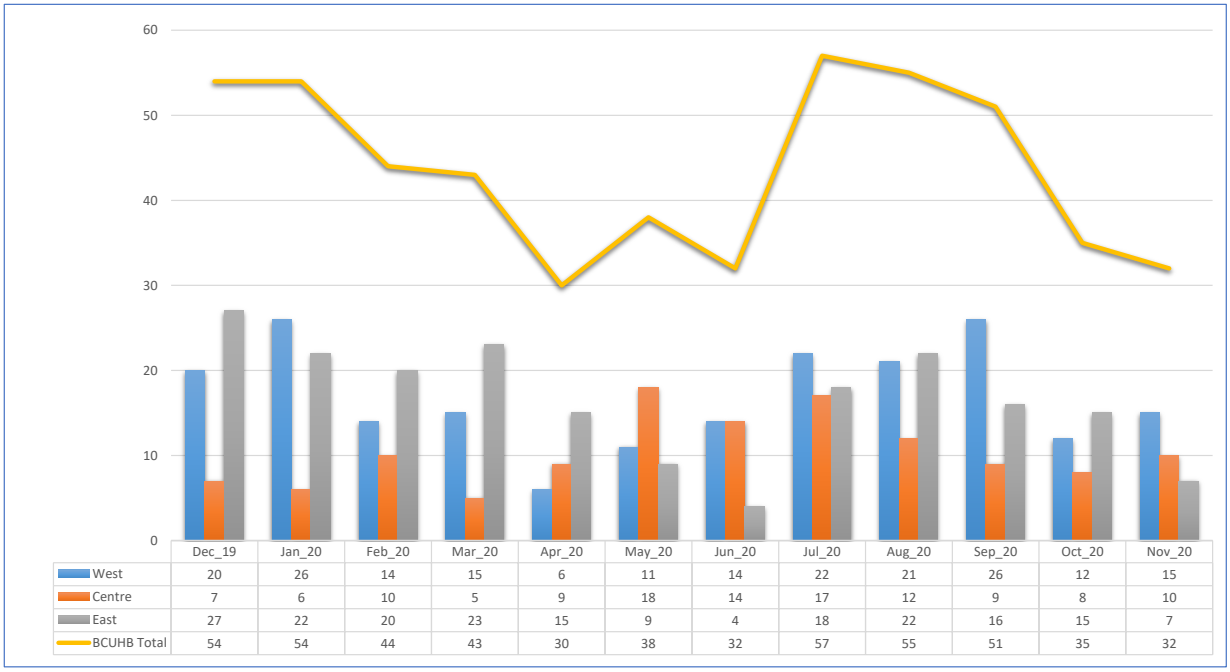
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Nov_20



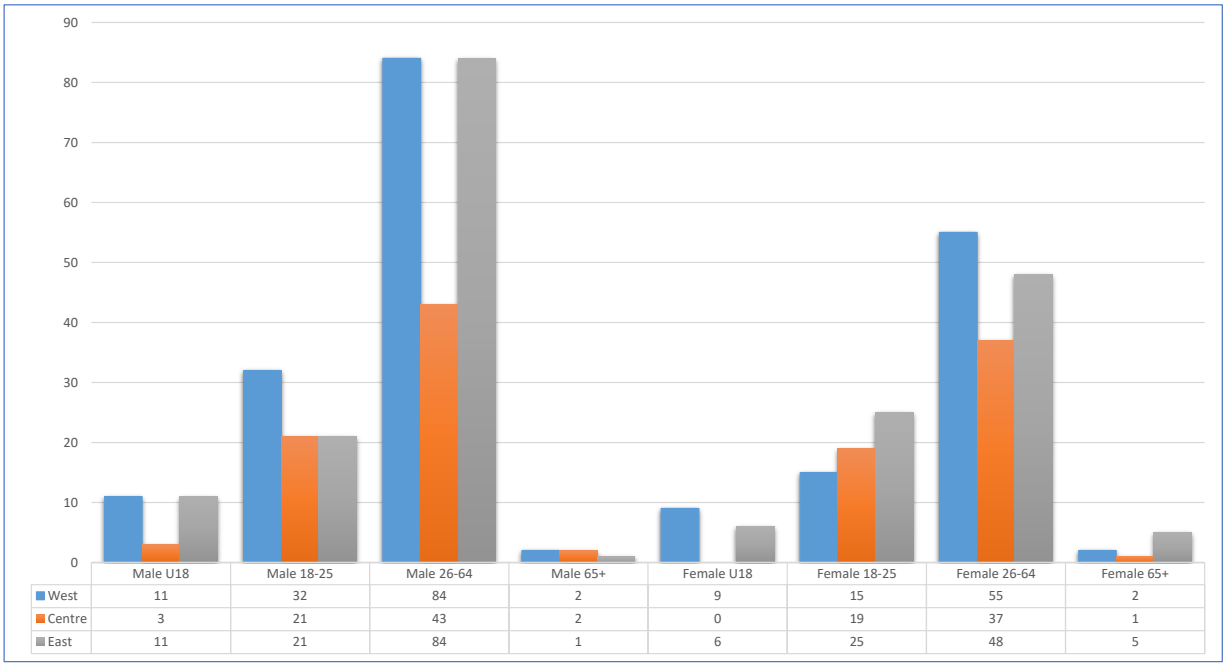
	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	3	1	0	3	0	0	0	0	0	0	0	1
Centre	0	0	0	0	0	0	0	0	0	0	0	1
East	0	1	0	0	0	0	0	0	0	0	1	1

2.1: Section 136 twelve month trend up to and including Nov_20



	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	20	26	14	15	6	11	14	22	21	26	12	15
Centre	7	6	10	5	9	18	14	17	12	9	8	10
East	27	22	20	23	15	9	4	18	22	16	15	7
BCUHB Total	54	54	44	43	30	38	32	57	55	51	35	32

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	11	32	84	2	9	15	55	2
Centre	3	21	43	2	0	19	37	1
East	11	21	84	1	6	25	48	5

4: 1st Place of Safety 12 month trend up to and including Nov_20

Area Split - 1st Place of Safety by category

	Nov_20			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	2	0	1	29	28	32
Ward	0	0	0	0	0	0
PICU	0	0	0	0	0	0
136 Suite	11	10	4	163	94	155
Hospital	1	0	0	3	2	5
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	0	0	0	6	0	2
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	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	3	5	2	2	0	3	2	2	4	2	2	2
Centre	2	1	1	2	3	4	5	5	1	2	2	0
East	5	6	3	8	0	1	0	3	1	1	3	1

1st Place of Safety: 136 Suite Split	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	15	20	12	13	6	7	12	18	16	23	10	11
Centre	5	5	9	3	6	14	9	12	11	5	5	10
East	22	15	16	13	14	8	4	15	20	12	12	4

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

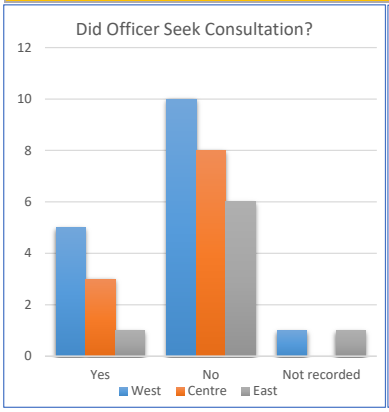
5.1: Area split 3 month table up to and including Nov_20 and latest 12 month total

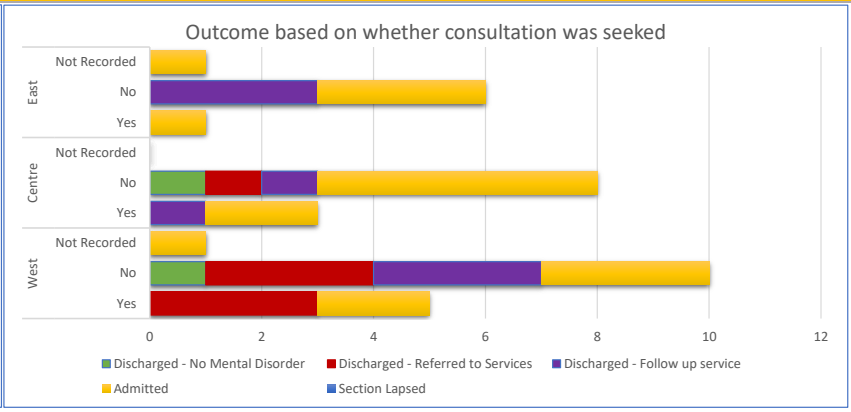
West	Sep_20	Oct_20	Nov_20	**12 Month Total**	**Centre**	Sep_20	Oct_20	Nov_20	**12 Month Total**	**East**	Sep_20	Oct_20	Nov_20	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	2	3	4	**28**	Ynys Mon	1	0	0	**4**	Ynys Mon	0	0	0	**2**	Ynys Mon	**4.85**
Gwynedd	12	6	5	**79**	Gwynedd	1	1	1	**8**	Gwynedd	0	0	0	**2**	Gwynedd	**7.20**
Flintshire	3	1	1	**23**	Flintshire	1	2	0	**15**	Flintshire	7	6	0	**59**	Flintshire	**6.26**
Wrexham	0	1	0	**10**	Wrexham	1	0	0	**28**	Wrexham	6	8	4	**119**	Wrexham	**11.28**
Conwy	6	0	3	**35**	Conwy	2	2	2	**26**	Conwy	1	0	1	**6**	Conwy	**5.73**
Denbighshire	3	1	0	**14**	Denbighshire	3	2	5	**39**	Denbighshire	2	1	0	**7**	Denbighshire	**6.28**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	0	**4**	OOA	0	0	0	**0**	OOA	0	0	0	**0**	OOA	**#N/A**
Incident Rate per 10,000 population	1.34	0.62	0.67	**9.96**	Incident Rate per 10,000 population	0.42	0.33	0.38	**5.65**	Incident Rate per 10,000 population	0.54	0.51	0.17	**6.63**	BCUHB	**7.25**

***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

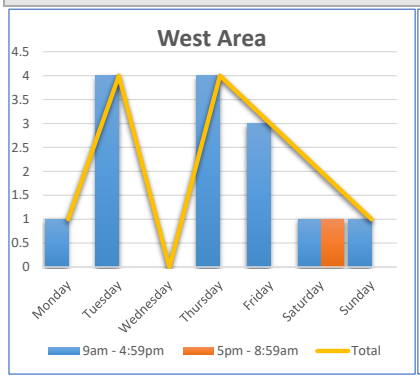
Section B: 12 Month Data for Nov_20

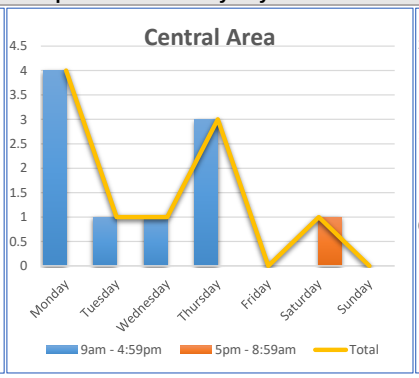
6.1: Consultations and Outcomes all areas during Nov_20

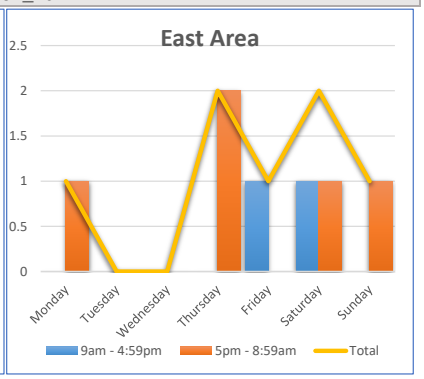




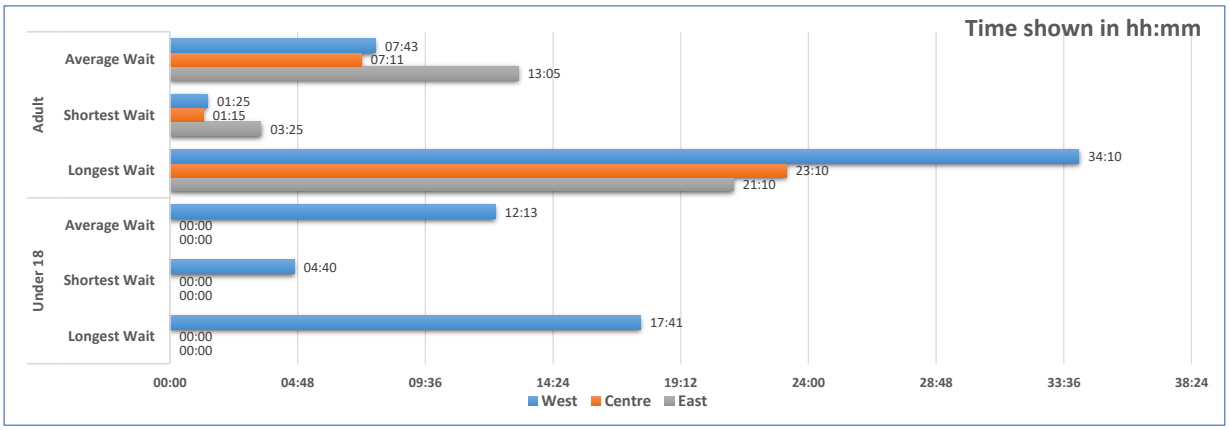
7.1: Area split of S.136 use by Day and Time for Nov_20



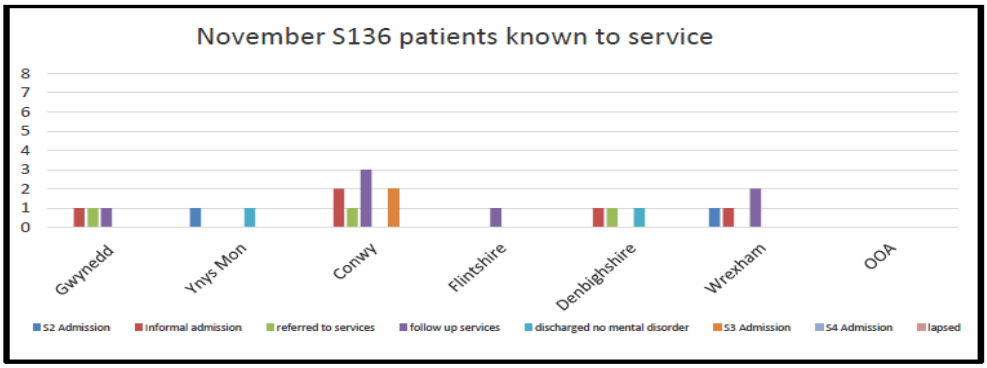




8.1: Duration in S.136 Suite for Nov_20



Within this month there was one S136 extension, the person was not fit for assessment within the initial 24 hours.



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 32 S136 detentions 4 people were not seen within the closest S136 suite.

3 were due to no capacity, and 1 did not have the reason recorded.

Local Authority Originates from	Detained in	S136 Suite assessed at
Flintshire	Flintshire	Hergest
Wrexham	Wrexham	Hergest
Gwynedd	Gwynedd	Ablett
Conwy	Conwy	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 November the Mental Health Act Office has received notification that there have been nine 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 monitoredfor the month of November there have been four of these instances.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

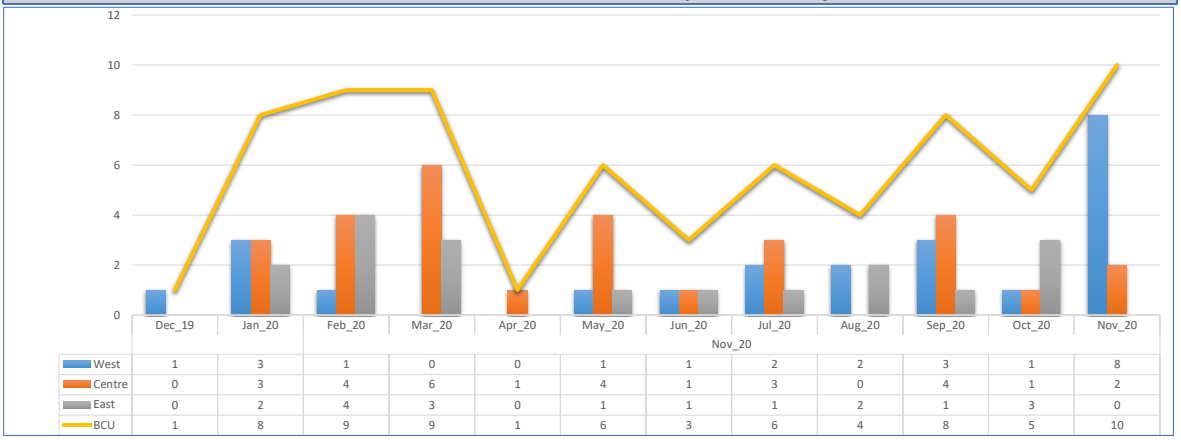
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

Under 18's detentions in North Wales
KPI Report for: November 2020

Data Source:	BCUHB MHA Database
Report Created on:	02/12/2020
Report Created by:	Performance Directorate

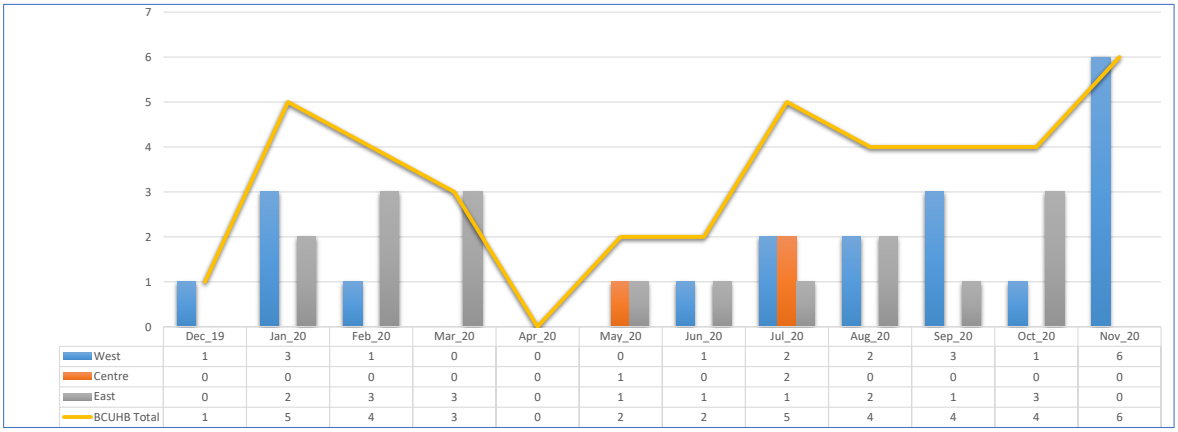
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Nov_20



	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	1	3	1	0	0	1	1	2	2	3	1	8
Centre	0	3	4	6	1	4	1	3	0	4	1	2
East	0	2	4	3	0	1	1	1	2	1	3	0
BCU	1	8	9	9	1	6	3	6	4	8	5	10

2.1: Section 136 twelve month trend up to and including Nov_20

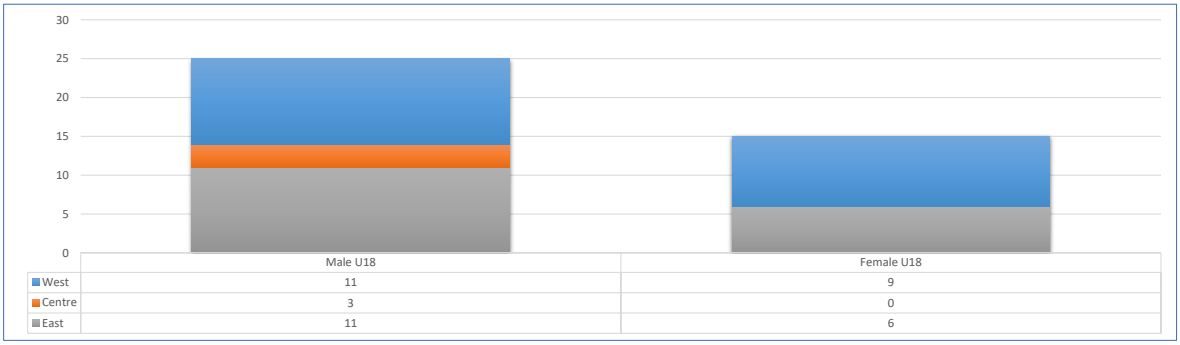


	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	1	3	1	0	0	0	1	2	2	3	1	6
Centre	0	0	0	0	0	1	0	2	0	0	0	0
East	0	2	3	3	0	1	1	1	2	1	3	0
BCUHB Total	1	5	4	3	0	2	2	5	4	4	4	6

2.2: Section 136 Outcomes twelve month trend up to and including Nov_20

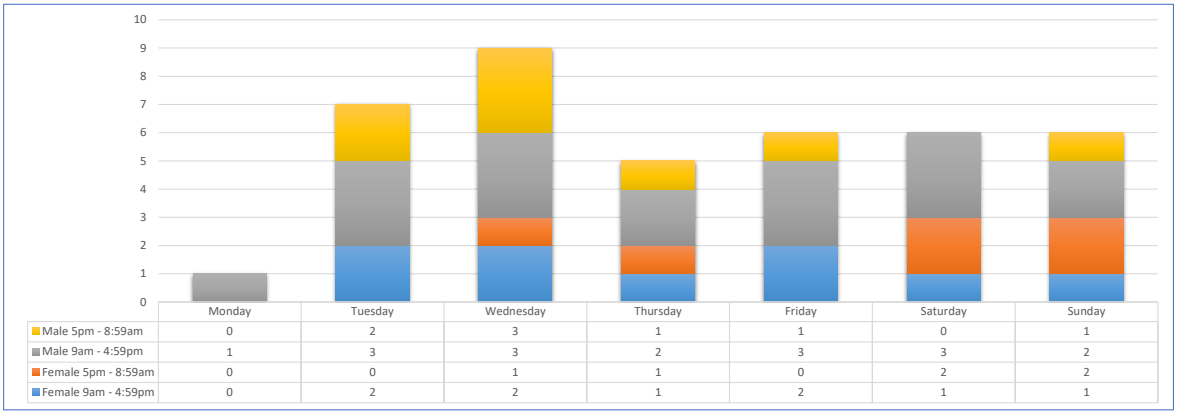
Outcome of 136 detention	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
Discharged - No Mental Disorder	0	1	0	1	0	0	0	0	0	1	0	1
Discharged - Referred to Services	0	0	0	0	0	0	0	3	1	0	0	1
Discharged - Follow up service	1	3	3	1	0	0	1	2	2	1	3	0
Admitted	0	1	1	1	0	2	1	0	1	2	1	4
Section Lapsed	0	0	0	0	0	0	0	0	0	0	0	0

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



	Male U18	Female U18
West	11	9
Centre	3	0
East	11	6

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	3	1	1	0	1
Male 9am - 4:59pm	1	3	3	2	3	3	2
Female 5pm - 8:59am	0	0	1	1	0	2	2
Female 9am - 4:59pm	0	2	2	1	2	1	1

4: 1st Place of Safety 12 month trend up to and including Nov_20

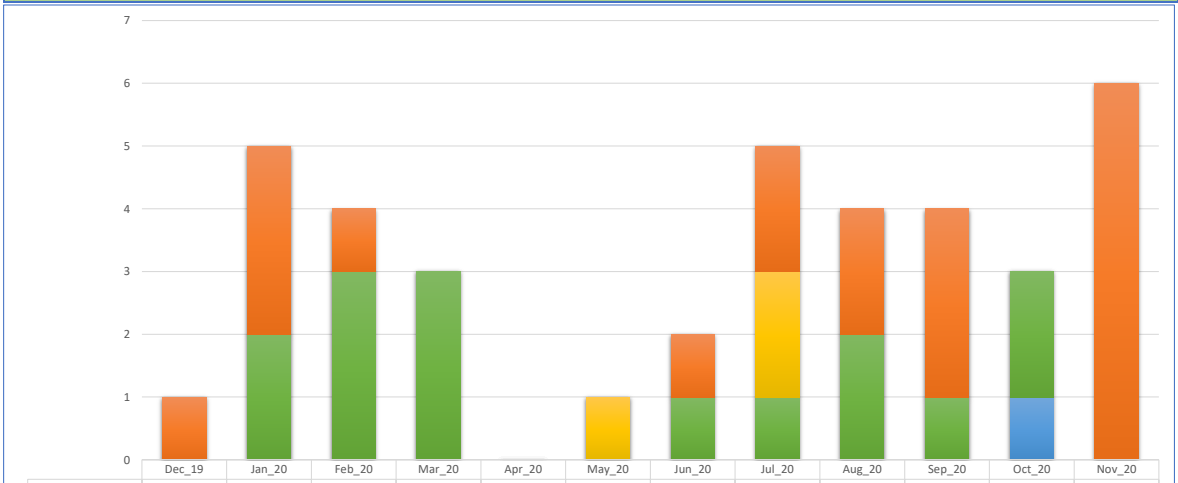
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
A&E	1	1	0	0	0	1	0	0	2	0	1	1
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	0	4	4	3	0	1	2	5	2	4	3	3
Hospital	0	0	0	0	0	0	0	0	0	0	0	1
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	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West	1	0	0	0	0	0	0	0	2	0	1	1
Centre	0	0	0	0	0	1	0	0	0	0	0	0
East	0	1	0	0	0	0	0	0	0	0	0	0

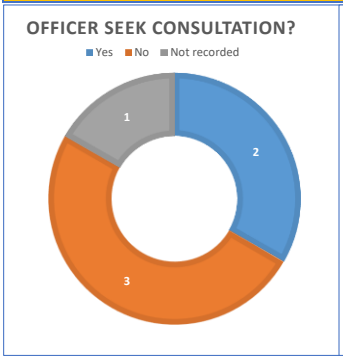
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Nov_20

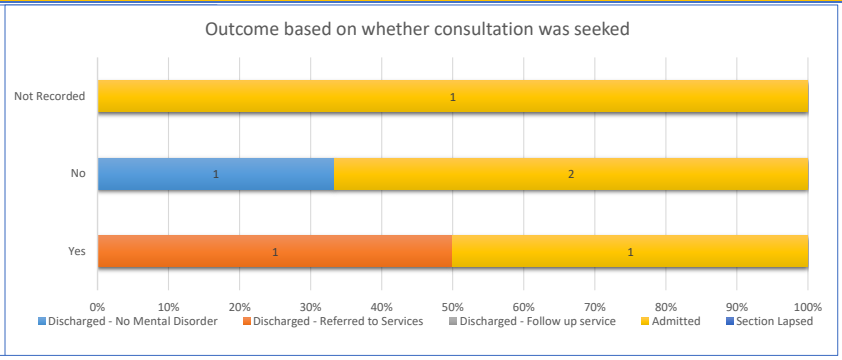


	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20
West Police	1	3	1	0	0	0	1	2	2	3	0	6
Centre Police	0	0	0	0	0	1	0	2	0	0	0	0
East Police	0	2	3	3	0	0	1	1	2	1	2	0
West Ambulance	0	0	0	0	0	0	0	0	0	0	1	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	0	0	0	0	0	0	0	0	0	0

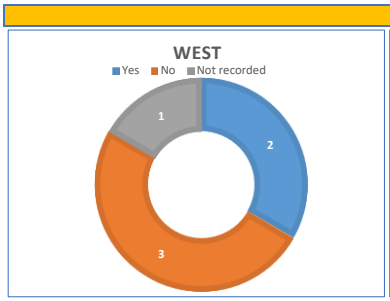
Section B: Data for Nov_20

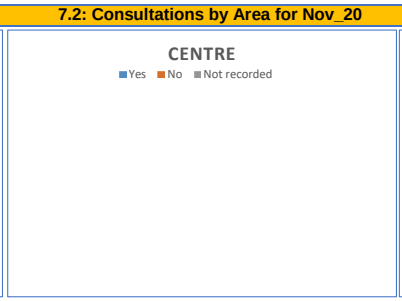
7.1: Consultations and Outcomes for Nov_20

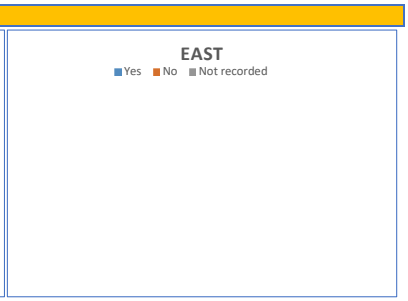




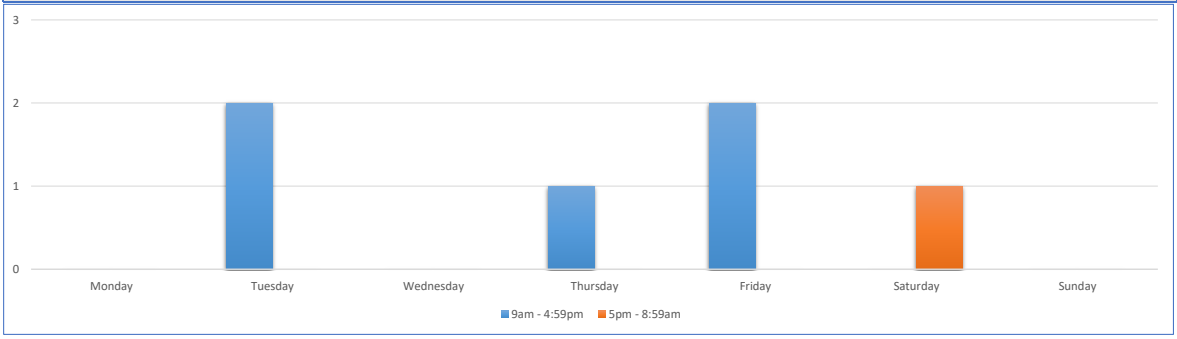
7.2: Consultations by Area for Nov_20



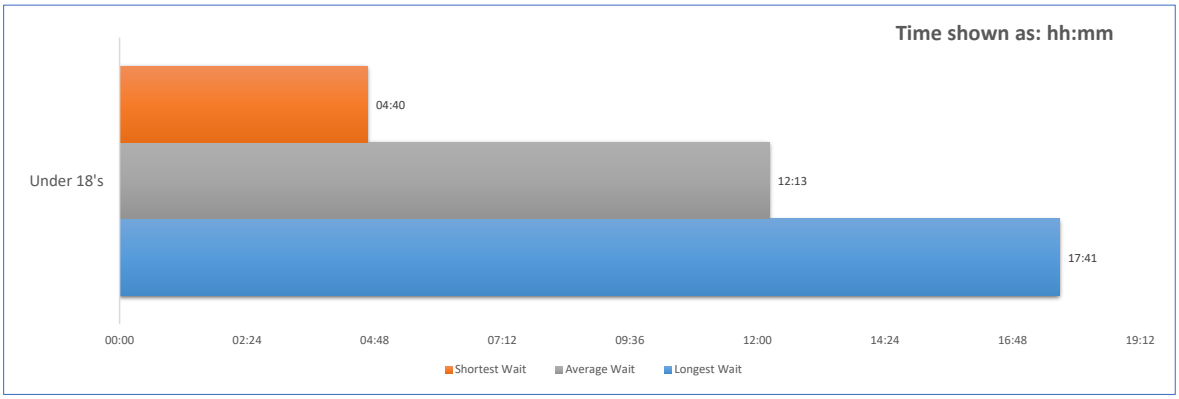




8.1: S.136 use by Day and Time for Nov_20

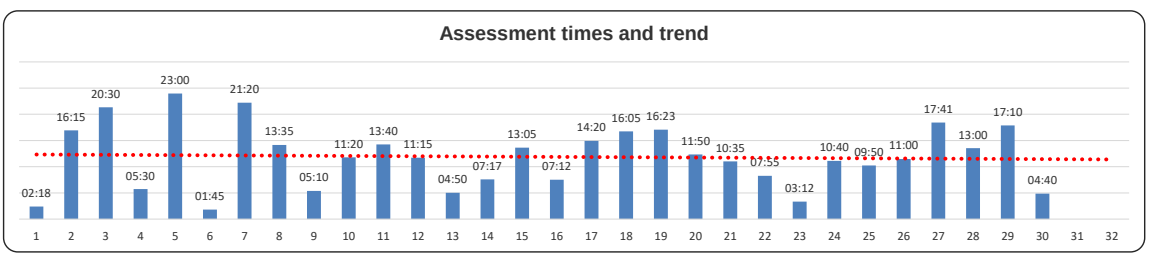


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Nov_20



10.1: Narrative for Nov_20

Three under 18s account for the S136 assessments in November. There were two admissions under a section this month, one initially to the adult unit prior to transfer to an age appropriate bed. Time spent on a S136 was 17:41 hours followed by 18:10 hours under the S2 prior to transfer. One S2 was to a paediatric ward within the general hospital. The chart below details the length of time that the young people have been detained under a S136 and a trend line for the last 30 detentions.



Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **08.12.2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Healthcare Inspectorate Wales (HIW) Monitoring Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr 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:**	MHLD Senior Leadership Team Quality Safety and Experience Group
Atodiadau **Appendices:**	Appendix 1 – Inspections Appendix 2 – Quality Check Summary Bryn Y Neuadd Hospital – Carreg Fawr Unit Appendix 3 – HIW Inspection Report Heddfan Psychiatric 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:

The report provides an update in relation to the inspections conducted by Healthcare Inspectorate Wales. The findings in relation to the Mental Health Act and the Mental Health Wales Measure are the focus of the document and are detailed within the appendix covering a period of 12 months.

New and updated inspections are highlighted as such, any which have been dealt with and are still within the 12 month period are noted as for information.

Cefndir / Background:

Healthcare Inspectorate Wales (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 detail that following inspections, and the recommendations made, that all actions are followed up.

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 Quality of patient experience, delivery of safe and effective care, and the quality of management and leadership.

Financial Implications

Issues highlighted by HIW may have financial implications. Aspects covered by this document namely Mental Health Act and Mental Health Measure require no financial additions at present.

Risk Analysis

- Outstanding HIW Actions are reviewed at the '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 on inspections and therefore no EQIA 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: Bryn Y Neuadd Hospital – Carreg Fawr Unit NEW

Inspection Date: 29th September 2020

Publication of report due: 5th November 2020

From a governance perspective, 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 IMHA access was being maintained by telephone rather than face to face.

The MHLD Bed Escalation Policy was highlighted as a concern following the expiry of the review date. The Health Board was asked to ensure that policies are consistently being 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.

(To Note: The policy meeting will be held on the 26.11.2020 to which the Bed Escalation Policy will be presented for ratification).

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.	Complete

	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 20920 for ratification.	17.12.2020

2 Heddfan Unit Wrexham Maelor UPDATE

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 under the Mental Health Act.

The purpose of the visit 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 that there is a wide range of relevant information leaflets for patients, families and other visitors to include information on mental health issues and guidance around legislation.

Under the Mental Health Measure, care plans viewed were noted to be to a good standard and clear evidence of multidisciplinary involvement in production. The Covid 19 care plans were noted to be individualised, detailed and well developed. The issue of 'unmet needs' was raised by HIW and the actions are detailed below.

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.	Complete Memo dated 19 August 2020 and distributed The unmet needs are now part of the template for the meetings and are discussed.

	A weekly audit will include a monitoring question on unmet needs captured in the Mental Health measure documentation and gaps immediately rectified.	Audits have begun feedback is that these will be completed November.

3 Ty Llywelyn Medium Secure Unit FOR INFORMATION

Inspection Date: 27th & 28th January 2020

Publication of report due: 16th June 2020

The initial verbal feedback received from the inspection was positive. No immediate concerns were identified and no immediate assurances required.

Information contained within the report in relation to the Mental Health Act and the Mental Health Measure is detailed below

Improvement Needed	Service Action	Timescale
The health board must ensure a full set of detention papers is present for each patient	The admitting doctor and nurse in charge to check the MHA paperwork on admission/transfer. MHA manager to ensure that previous information in relation to detentions is obtained and correct on arrival of patients to the unit. Ward management teams to ensure all relevant paperwork is located in the patient's notes.	All Complete February 2020
The health board must ensure that there is a clear record of patients being offered the provision of their rights on a regular basis.	Patients are given their rights on admission to the unit and based on capacity to receive the information following any Tribunal, managers hearing, change of ward and every three months if no movement. To be highlighted in weekly planning meeting	Complete February 2020
That professional reports for appeals against detentions	MHA administrator attends the weekly planning meeting and	Complete

are submitted in a timely manner.	all upcoming reports are identified for completion. MHT reports not received in time will be highlighted to the Matron and Service Manager as part of the action plan. These are also highlighted in the planning meeting. Compliance with reports being provided in a timely manner is reported and monitored through QSE and MHAC.	February 2020
The health board must ensure that all patients have up to date Care and Treatment Plans	Care and Treatment plans are audited on a monthly basis	Complete February 2020
The health board must ensure that required patient risk assessments are completed in a timely manner.	The CTP's and Risk assessments on the unit to be reviewed (100% compliant). Risk assessments to be audited on a monthly basis.	Complete February 2020

Appendix 2

Quality Check Summary Bryn Y Neuadd Hospital – Carreg Fawr Unit

HIW Carreg Fawr Quality Check Summ

Appendix 3

Heddfan Inspection Report

Heddfan HIW Inspection report.pc

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Bryn Y Neuadd Hospital – Carreg Fawr Unit

Activity date: 29 September 2020

Publication date: 05 November 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.

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Digital ISBN 978-1-80082-438-6

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Carreg Fawr Unit within Bryn Y Neuadd Hospital, as part of its programme of assurance work. Carreg Fawr is an eight bedded Mental Health Rehabilitation Unit, part of 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 capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the ward manager on 29 September 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?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

A unit specific COVID-19 plan was developed setting out the main challenges and action taken by the service, to support staff to maintain a safe environment for themselves and the patients during the pandemic.

The ward manager confirmed that the unit has a good supply of PPE equipment available and local stock is available on the main hospital site. Additionally, a daily stock check for the unit is completed by the ward manager, to monitor the available equipment.

To allow staff to safely put on the required PPE equipment, the ward manager told us that a 'don and doffing' room has been set up within the unit. Additionally a designated PPE station has been set up at the main entrance. On entering the unit, we were informed that staff must immediately put on a surgical face mask and proceed directly to the staff room to change in to clean uniform prior to entering the ward area.

We were informed that all staff have received training in regards to PPE and there are also posters displayed in relevant areas of the unit. At the entrance to the unit there is also a visitors sign-in book which is can be used as part of 'Track and Trace' if necessary.

The ward manager confirmed that daily safety huddles are held to ensure staff are routinely kept up to date with the relevant guidance and to discuss required changes to care provision. Daily update discussions are also held with patients to ensure that they are provided with relevant information relating to the latest guidance and restrictions. These discussions provide staff and patients with the opportunity to raise any queries, concerns and suggestions with the arrangements in place.

No improvements were identified.

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 following positive evidence was received:

The ward manager outlined some of the changes that have been implemented on the unit due to the onset of COVID-19. These changes have included the reorganisation of some of the key areas of the unit, including the room used for patient ward round meetings and the area of the unit used for patients to eat their meals. The reorganisation of these rooms has meant that there is more space available, which has allowed for social distancing between individuals.

A social distancing risk assessment and a unit specific COVID-19 management plan has been developed. Within the plan it details that corridor traffic in the unit should be reduced as much as possible for staff and patients. Impromptu corridor conversations must cease, to mitigate the risk of the spread of infection.

The Covid-19 management plan details that any access to the unit, including from clinical staff, must be prearranged. Visitors must wear face masks, available on the PPE station at the main entrance, and also sign in on entry. Access to the unit is controlled by a latch on the inside of the main entrance door. This prevents any unscheduled individuals entering the unit.

The ward manager confirmed that initially all visits were suspended following the introduction of the lockdown in March. Patients were able to maintain contact with friends and family either via phone or virtually, using equipment within the unit. Patient visits have subsequently been reintroduced under restrictions. A room within the unit is available for prearranged patient visits to take place. We were informed that prior to any visit which take place, a risk assessment must be completed. Also, face masks must be worn and the room is cleaned following each visit.

Additionally, we were informed a seating area in the unit garden was utilised over the summer period to allow visits to take place. The ward manager confirmed that this was the preferred patient choice for visits. We were told that health board approval has been granted for a gazebo to be installed in garden to allow for these visits to continue regardless of the weather, which will mean that visits can still take place without individuals having to enter the unit.

Patient leave from the unit was also suspended in the initial lockdown. The ward manager

confirmed that during this initial period, patients were able to have escorted walks around the main hospital grounds for fresh air. We were informed that escorted and unescorted leave arrangements have now been reintroduced for patients following relevant risk assessments.

The ward manager explained that a new Occupational Therapist (OT) had recently started working on the unit and that activities available to patients has improved. However, given the restrictions in place, activities were mainly ward based aimed at helping patients develop relevant skills as part of the rehabilitation, for example cooking sessions. We were informed that some outdoor activities were available to patients, which have included walking groups.

Evidence provided by the service outlined that every patient on the unit has an individualised rehabilitation programme, based on the specific needs. We were informed by the ward manager that patients are routinely monitored by staff and efforts have been made to ensure that patients are kept up to date with the latest guidance and restrictions in place throughout the pandemic period. The ward manager confirmed daily discussions take place with patients, which also allow them to raise any concerns or queries around the arrangements in place.

The ward manager informed us that one of the main challenges for staff throughout the pandemic period has been the effect that the restrictions has had on patient motivation. We were informed that plans are in place to provide staff with training in this area in the near future. It is hoped that this training, as well as the additional input from the unit OT, will enable the service to improve the patient motivational issues, to help patients progress in their future care pathways by better engaging in their rehabilitation programmes.

Incident data provided details that in the last three months there were six incidents relating to patient abusive / disruptive behaviour. The ward manager outlined the incident reporting process which will involve the relevant staff member completing and submitting an incident report via Datix. A copy of this report is subsequently sent to the ward manager and any other relevant senior managers. It is then the ward manager's responsibility to investigate and ensure an action plan is agreed and implemented.

The ward manager confirmed that ligature checklists for the unit are in place which are reviewed every week. There is also a ligature risk assessment available.

No improvements were identified.

Infection prevention and control

During the quality check, 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.

The following positive evidence was received:

As previously detailed, we saw evidence of a unit specific COVID-19 management plan which has been developed. The purpose of this document is to support staff in maintaining a safe environment for themselves and the patient group during the pandemic. A COVID-19 risk assessment was also provided, which documented what the service deemed to be the key risks and existing control measures in place on the unit.

The ward manager informed us that throughout the pandemic there have been regular health board updates provided to all staff via email in relation to guidance and required changes to service provision. We were informed that daily safety huddle discussions take place with staff to ensure they are aware of the changes, and to provide them with the opportunity to raise any queries or suggestions.

The ward manager confirmed that daily discussions also take place with patients in regards to the guidance to restrictions in place. Additionally we were informed that relevant infection prevention and control posters were displayed throughout the unit to remind individuals of the importance of following the guidance in place, for example with regards to hand washing. We were informed that three new wall hand sanitisers had also been installed within the unit, to allow staff and patients to regularly clean their hands.

Evidence provided confirmed that all patients have an individual risk assessment agreed by the Multi-Disciplinary Team (MDT) which is aligned to their understanding of COVID-19 and the associated risks and required restrictions.

All staff were required to complete mandatory infection prevention and control training as part of their roles. Evidence provided by the service detailed that at the time of our review staff compliance levels for this training was 87 percent. Also, the ward manager told us that all staff were required to complete a specific COVID-19 e-learning module.

We were informed that a system was in place to respond should any patient develop COVID-19 symptoms. There are two en-suite bedrooms available on the unit which have been designated as ‘Red’ rooms. These rooms are to be used to treat any symptomatic or positive patients as and when required. The ward manager confirmed that this arrangement aims to ensure that the relevant patient can be treated in isolation. Staff only enter the bedroom for essential reasons, such medications and meals, wearing the required PPE equipment.

Evidence provided by the service detailed that a unit specific cleaning schedule has been

developed, in conjunction with domestic staff, to ensure that the areas of the ward which experience 'heavy traffic' are appropriately cleaned on a daily basis. Additionally, we were informed that arrangements were in place to ensure that on the occasions one of the 'Red' bedrooms was used to treat a symptomatic patient, the room would require a deep clean before the bedroom can be used again.

The following areas for improvement were identified:

On review of the evidence submitted by the service, it was highlighted that the review dates of three health board policies, relating to infection prevention and control, had elapsed by significant periods. During discussion with the ward manager, no additional information was available in relation to the status of the policy reviews. As a result, following on from the discussion with the ward manager, HIW requested additional assurance from the health board in regards to the issues identified. Subsequently, the health board confirmed that the content contained in the policy documents was fit for purpose and supports the national guidance in relation to the COVID-19 pandemic. The initial health board response also confirmed that the policies in question have been reviewed and are pending approval at the Infection Prevention Sub Group scheduled for 13 October 2020. An additional update from the health board on the status of these policies can be found in the improvement plan response on page 11.

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.

The following positive evidence was received:

Evidence provided outlined that arrangements were in place to routinely monitor staffing levels, to ensure that there are appropriate numbers to deal with the current risks and the required patient observation levels on the unit. The ward manager confirmed that he felt that staffing levels on the ward were sufficient and safe. We were also informed that contingency plans were in place to respond to any staffing shortfalls which occur on the unit. We were told that previously staffing levels had been affected due to five members of staff needing to shield. During this period the unit was able to borrow staff from other wards and also had access to bank staff to ensure there were adequate staffing levels.

The ward manager confirmed that weekly MDT ward round meetings have continued throughout the pandemic period, with each patient being reviewed every other week. We

were informed that consultant input has not been affected throughout the pandemic and additional to the input provided as part of the MDT meetings, we were told that ad-hoc clinical advice is available where required.

Evidence provided detailed that during the pandemic a service review of the health board rehabilitation model took place. This subsequently resulted in the availability of more psychological input to support both staff and patients on the unit. As a result the unit now has a full MDT consisting of Mental Health Nurses, Healthcare Support Workers, an Occupational Therapist, Psychologist, Consultant Psychiatrist and Community Mental Health Nurses. As part of the MDT discussions, patient rehabilitation programmes are regularly reviewed, as patient leave has been now been reintroduced.

We were informed that that the frequency of Mental Health Review Tribunals has not been affected during the pandemic. However, meetings now take place via telephone conference. Additionally, we were informed that patients on the unit have been able to access advocacy support and to speak to their solicitors as and when required. However, contact is again is by phone.

Staff mandatory training compliance data was provided which detailed that the overall compliance level was 94 percent. The ward manager felt that training available to staff was good. However, as previously outlined, given the issues experienced in relation to patient motivation, as a result of the restrictions, we were informed that staff training in this area is a priority for the service.

Evidence provided outlined that staff were still able to access additional support where required, via the health board employee assistance support structures, which included Occupational Health. We were informed available support services and contact information is regularly circulated to staff. Additionally, as previously mentioned staff on the unit were also now able to access psychological support, which could be accessed either through their line manager or by contacting the Psychologist directly.

The following areas for improvement were identified:

The health board Mental Health Bed Escalation policy was submitted by the service as evidence. Following review of this document it was highlighted that the scheduled review date was January 2020. In light of the concerns already highlighted around missed policy reviews dates, we will be recommending that the health board should undertake a review of the governance arrangements in place, to ensure that policies are consistently being reviewed and updated, as and when scheduled.

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: Carreg Fawr Unit - Bryn Y Neuadd Hospital

Date of activity: 29 September 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 should review the governance arrangements in place to ensure policies are consistently being reviewed and updated when required.	Health and Care Standards Standard 3.4 – Information Governance and Communications Technology	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. Policies 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	Hilary Owen / Francine Moore	Complete

			tracked and reviewed with a monthly report produced for the MHLD Leadership Team Quality, Safety and Experience Meeting. A new corporate task and finish group will be established to take forward a review the current "policy on policies," develop a plan for a new policy tracking IT system and ensure plans are in place for professional each area to maintain current policies.	Matthew Joyes/Bethan Wassell	30/11/2020
2	The health board should ensure that the four policies highlighted as requiring review, are reviewed and updated as soon as possible.	Health and Care Standards Standard 3.4 – Information Governance and Communications Technology	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 of December 2020 for Ratification. The IPC policies are currently being reviewed with additional resource secured to complete this, and will be approved by the IPC Group.	Wendy Lappin / Paul Hanna Amanda Miskell	17/12/2020 30/11/2020

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: Matthew Joyes – Acting Associate Director of Quality Assurance

Date: 27/10/2020

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Focussed Inspection (Unannounced)

Heddfan Psychiatric Unit

Betsi Cadwaladr University Health Board

Inspection date: 7-9 July 2020

Publication date: 7 October 2020

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Digital ISBN 978-1-80082-298-6

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced focussed inspection of Heddfan Psychiatric Unit within Betsi Cadwaladr University Health Board on the evening of 7 July and the following days of 8 and 9 July 2020. The following sites and wards were visited during this inspection:

- Gwanwyn - Older Persons Mental Health
- Hydref - Older Persons Mental Health

Our team, for the inspection comprised of two HIW inspectors and one clinical peer reviewer. The inspection was led by a HIW inspection manager.

The purpose of this inspection was to gain assurance on whether sufficient attention is being given by the health board to address issues that have been raised through concerns reported to HIW.

The inspection focussed specifically on

- Patient Care
- Governance and leadership
- Safeguarding
- Staffing
- Infection prevention and control.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients.

There was evidence of strong and supportive leadership on both wards.

We found the service provided safe and effective care. However the health board must ensure staff are suitably skilled and trained to care for the ward's specific patient group.

This is what we found the service did well:

- Established and effective clinical processes in place to maintain patient safety
- Care and Treatment plans were completed in line with the Welsh Measure
- Established and effective governance arrangements that provided safe and clinically effective care
- Strong leadership on both wards.

This is what we recommend the service could improve:

- Areas of the environment to help maintain patient safety
- Communication and involvement with staff around potential strategic changes in the unit
- Recruitment into vacant posts.

3. What we found

Background of the service

Heddfan Psychiatric Unit provides NHS mental health services at Heddfan Unit, Wrexham Maelor Hospital, Croesnewydd Rd, Wrexham LL13 7TD, within Betsi Cadwaladr University Health Board.

In response to the COVID – 19 pandemic, the Heddfan Unit became designated as a regional admission unit for older persons care. Clywedog and Dyfrdwy wards transferred from Adult Mental Health wards into Older Persons Mental Health Wards. At the time of our inspection the Psychiatric Intensive Care Unit[1] (PICU) was closed.

Heddfan currently has four mixed gender Older Persons Mental Health wards:

- Clywedog ward, a 13 bed organic[2] mental health assessment ward
- Dyfrdwy ward, a 19 bed functional[3] mental health assessment ward
- Gwanwyn, a 13 bed organic mental health ward

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[1] A Psychiatric Intensive Care Unit is an in-patient mental health ward that provides greater support and lower risk for patients with a more restrictive environment and increased staffing levels than an acute ward. PICUs are designed to look after patients who cannot be managed on acute psychiatric wards due to the level of risk the patient poses to themselves or others. The aim is for the patient's length of stay to be as short as possible to manage the increased challenging behaviours and then returned to an acute ward as soon as their mental state has stabilised to what can be safely managed there.

[2] An organic mental disorder is a dysfunction of the brain that may be permanent or temporary. It describes reduced brain function due to illnesses that are not psychiatric in nature. Organic mental disorders are disturbances that may be caused by injury or disease affecting brain tissues as well as by chemical or hormonal abnormalities. Exposure to toxic materials, neurological impairment, or abnormal changes associated with aging can also cause these disorders.

[3] Functional mental illness applies to mental disorders other than dementia, and includes severe mental illness such as schizophrenia and bipolar mood disorder.

- Hydref, a 16 bed functional ward.

This inspection focussed on Gwanwyn and Hydref ward. Each ward employs a staff team which includes a ward manager and deputy ward manager, and a team of registered nurses and health care support workers. The multidisciplinary team includes professionals from psychiatry, psychology, and occupational therapy.

The unit is supported by the health board's clinical and administrative structures.

Quality of patient experience

We found a dedicated staff team that were committed to providing a high standard of care to patients.

The ward environment on Gwanwyn and Hydref was well maintained, clean, tidy and free from obvious health and safety hazards.

Staying healthy

There was a wide range of relevant information leaflets for patients, families and other visitors available in the reception areas of the unit and on the individual wards. These areas contained information on mental health issues, guidance around mental health legislation and physical wellbeing such as healthy eating. There was also information on organisations that can support patients, their families and carers.

Heddfan had a team of occupational therapists that provided a wide range of activities for patients within the unit. Both wards had their own designated garden area, both of which provided a pleasant outdoor space. Both ward environments were well maintained, clean, tidy and free from any health and safety hazards.

Dignified care

On first night of the inspection we noted that staff interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. Most staff we spoke to also demonstrated a good level of understanding of patients they were caring for.

On both wards there were communal areas which provided sufficient space for patients to have personal quiet time away from their rooms. Each patient had their own en-suite bedroom which included a toilet, sink and shower. The bedrooms provided patients with a high standard of privacy and dignity.

Bedroom doors had observation panels so that staff could undertake observation on patients without opening the door and potentially disturbing the

patient. Patients were able to close the observation panels from inside their bedroom.

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required.

There was a patient status at a glance board[4] in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Due to the Coronavirus (COVID – 19) pandemic no visitors or family members were allowed at Heddfan. There were ward mobile phones available for patients to contact friends and families, however these facilities were poor. It was positive to hear that the health board were looking to reintroduce visitors and were putting together plans for visits to take place safely. However in the meantime, the health board needs to make improvements for patients to receive virtual communications with family members.

There was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[5] process. Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately.

Improvement needed

The health board needs to make sure that patients have access to technology to see and speak to family members.

[4] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

[5] Putting Things Right is the integrated processes for the raising, investigation of and learning from concerns regarding treatment within the NHS

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

There were established processes and audits in place to manage risk, health and safety, and infection control. This enabled staff to provide safe and clinically effective care.

We found that staff were completing clinical processes and documentation as required. However, the skill mix should to be reviewed and the development of staff working with new patient group requires investment to help meet the needs of the patients at the unit.

A review of the environment on Clywedog and Dyfrdwy must take place to ensure the environment is made suitable for older persons care.

Safe care

Managing risk and promoting health and safety

Access to the mental health unit and wards was secure to prevent unauthorised access. Staff could enter the wards with their health board identification cards, and visitors rang the buzzer at the ward entrances.

There were processes in place to manage risk and maintain health and safety on both wards. Gwanwyn was located on the ground floor with Hydref on the first floor of the unit. There was a lift available to the first floor which ensured accessible entry to Hydref ward.

There were nurse call points around the ward and within patient bedrooms so that patients could summon assistance if required. Both Gwanwyn and Hydref had bedroom sensors that would alert staff to patients rising from their beds so that staff could provide the required level of support for patients. On the first night of the inspection we observed staff responding in a timely manner to alarms that activated.

There were up-to-date ligature point risk assessments in place for both wards. These identified potential ligature points and what action had been taken to remove or manage these.

The furniture, fixtures and fittings on both wards were, on the whole, appropriate to the respective patient groups. On Hydref ward we noted an arm rest missing from a semi-circular seat. The health board must make sure this arm rest is fixed or replaced to ensure it does not present a risk to patient safety.

During the inspection we did not visit Clywedog or Dyfrdwy wards, however staff we spoke to told us that these wards were not suitable for older adult care, as they had not been repurposed from adult acute wards into older adult care wards. Examples provided by staff were that the bathroom floors had raised levels which placed older patients at greater risk of falls and the bedrooms did not have appropriate beds and fixtures for older adult care. We were also told that patients could not alert staff when they require assistance from their bedrooms. This was brought to the attention of senior management during the inspection, who assured us that a review of the environment in both these wards was being undertaken. Additional high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility had been ordered for both wards. The health board must ensure this review is completed and relevant actions taken in a timely way.

Some staff told us they did not feel adequately trained to care and support a new patient group with differing risks and needs to previous patient groups they had worked with. Senior management informed us that additional training and support was being developed for staff, and a shadowing programme was being implemented.

Staff also told us that they would benefit from training on subjects such as restraint and manual handling techniques when dealing with older person's care, due to staff having limited experience in dealing with a different type of patient group where different techniques may be required. The health board must make sure that all staff are suitably trained to deal with older person's care to ensure the safety of patients and staff is maintained.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX) that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the unit and the wider organisation.

We reviewed records and confirmed there was evidence of incidents being recorded. These included issues raised by staff regarding the environment of care on Clywedog and Dyfrdwy, and staff shortages. It was reassuring to see that staff felt confident in reporting and raising these issues, which demonstrated professional integrity. This culture of reporting should be encouraged and supported by the health board so that staff feel valued in contributing to change and are confident in reporting issues that affect staff and patient safety.

Improvement needed

The health board must ensure that:

- The arm rest is fixed or replaced on Hydref Ward
- A review of the environment on Clywedog and Dyfrdwy is completed to ensure patient safety
- Patients have access to appropriate beds and fixtures to aid patient independence and safety
- Patients can alert staff that they require assistance from their bedrooms
- Staff, including bank staff, receive training and support to feel confident in caring for the current patient group.

Infection prevention and control

There were hand hygiene products available in relevant areas on both wards and these were accompanied by appropriate signage. Staff also had access to Personal Protective Equipment (PPE) when required.

There were laundry facilities for the wards which were well maintained and we found that laundry rooms and linen cupboards were well organised.

There were cleaning schedules undertaken by health board housekeeping staff across both wards. Ward staff stated that they undertook additional cleaning in clinical areas and we observed staff cleaning clinical areas on the first night of our inspection. Staff were also observed washing hands frequently.

We spoke with the infection, prevention and control staff to determine how the health board had responded to the COVID – 19 pandemic. They told us that at the start of the pandemic a number of deficiencies were identified within Heddfan unit and as a result a plan was put in place to go back to basics, where hand hygiene and environmental hygiene adjustments were implemented.

Some difficulties were initially experienced with the use of PPE. Issues highlighted included identifying single use versus sessional use of PPE, however this has since been resolved. Internal audits demonstrated that learning and improvements had been made following a difficult period at the start of the pandemic and we observed good practice being undertaken by staff during the inspection. We also noted that there was a good supply of PPE on both Gwanwyn and Hydref wards.

Staff we spoke to were aware of infection control obligations and clear on isolation processes. Each ward had areas set aside where if a patient became symptomatic they could be isolated and barrier nursed on the ward within a protected area. None of these areas were in use at the time of inspection.

Infection prevention and control staff also visited the wards on a daily basis. Throughout the inspection we observed the unit to be visibly clean and free from clutter.

Nutrition and hydration

We reviewed care records and confirmed that assessments of patients' eating and drinking needs had been completed. Patient records documented specific individual dietary needs to maintain sufficient nutrition and fluid consumption, and monitoring documentation we reviewed was appropriately completed.

Medicines management

Medication was stored securely in cupboards and medication fridges which were locked and secure. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. The temperatures of

medication fridges and clinic rooms were being monitored and recorded, to check that medication was stored within the appropriate temperature range.

The Medication Administration Records (MAR Charts)[6] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status, or physical health measurements, such as body mass index, weight or height. Staff were consistently recording the administration of medication, or the reason why it had not occurred.

Safeguarding children and adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Both wards provided care to adults only. Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff they were able to demonstrate the process of making a safeguarding referral.

There was good corporate safeguarding oversight by the health board within Heddfan. When the patient group changed to all older persons the health board situated one of its corporate safeguarding team members on-site as it expected an increase in referrals and incidents. The increase did not happen, however the team member remains there to provide advice and guidance and to quality assure all referrals.

There is also a best interest assessor based at Heddfan, this assessor carries out all the DoLS assessments at the unit.

All safeguarding training is delivered within the health board, however some of the training figures were quite low, and this is detailed further in the next section of the report.

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[6] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

Safe and clinically effective care

Within the sample of patients' care records viewed, we saw a number of completed patient assessment tools based upon best practice guidelines and national initiatives. This was with a view to helping staff provide safe and effective care. Examples we saw included those in relation to preventing pressure sores and nutrition.

Record keeping

Patient records were mainly paper files that were stored within the locked nursing office. We observed staff storing the records appropriately during our inspection.

Staff completed entries that were factual, and entries regarding patient daily routine was documented in detail, which provided clear information regarding each patient's care.

We reviewed a sample of patient records for both wards. It was evident that staff from across the multidisciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw evidence to show that extensive efforts were being made to seek the best possible outcomes for patients. Physical health assessment as well as mental health assessments were robust and had been carried out to a high standard. However we did note that the unmet needs were not documented in one set of care plans we viewed. It is important that unmet needs are documented so that these can be regularly reviewed by the multidisciplinary team to look at options for meeting those needs.

Improvement needed

The health board must ensure that unmet needs are documented within patient care plans.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of two patients.

We reviewed a sample of care files and found that they were generally maintained to a good standard. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health. The patient

records we viewed were well organised and easy to navigate. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health (Wales) Measure 2010.

The majority of patient records we examined contained comprehensive needs and risk assessments throughout the patient admission which directly linked to the plan of care and risk management strategies implemented on the wards.

COVID – 19 patient care plans were in place, these plans were individualised, detailed and well developed. These plans demonstrated that both wards had processes in place that maintained the safety of staff and patients. As highlighted in the earlier part of this report, due to the layout of the wards there was opportunities to place symptomatic patients into segregated areas to prevent and protect others from becoming infected with COVID - 19.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

The ward had effective processes and audit arrangements to support staff in maintaining safe and effective care.

There was passionate leadership, strong team working and motivated staff who provided dedicated care for patients.

We found that staff were committed to providing patient care to high standards. Throughout the inspection staff were receptive to our views, findings and recommendations.

The health board should consider how staff are kept informed of the future strategy of Heddfan and what implications there may be for staff and their roles.

Improvements are required in the completion of mandatory training, along with IT systems which can support the completion of training.

Governance, leadership and accountability

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. These arrangements were defined during the day, with senior management and on-call arrangements in place for the night shift.

There was dedicated and passionate leadership from the ward managers who were supported by committed ward multidisciplinary teams and senior health board managers. We found a friendly, professional staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Senior managers of the health board engaged openly during the inspection, and acknowledged that some processes had been implemented since being notified of the concerns raised with HIW. The health board openly provided details of improvements that had been made. Each morning there was a meeting to review the immediate operation of the hospital and any emerging risks or issues that required attention. Staffing resources were reviewed daily and were planned in advance to help ensure sufficient staff numbers were on shift to meet the care needs of the patients at the hospital.

During our discussions with staff it was clear that staff had been affected by the changes made to the wards in response to the COVID 19 pandemic. Staff we spoke with raised concerns around the quality of communication during this time and also in relation to the phase 2 plan which sets out the health board’s intentions of transitioning into a new service model of care. Staff stated that there had been no consultation with them over the proposed plans. Some staff we spoke to indicated that experienced staff were intending on leaving the health board due to the uncertainty and lack of communication around the changes taking place in the next phase.

Staff would benefit from clarity of the health board's future strategy and what implications there are for staff and their roles. It is important that the health board have ongoing transparent communication with staff about the changes they are planning.

The health board must encourage staff to feel confident in sharing ideas, demonstrating that staff are valued and are supported to contribute to any proposed changes.

Improvement needed

The health board must make sure that staff feel consulted and involved in decisions that affect them, and that staff feel confident in sharing ideas and contributing to change.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain patient safety within the unit at the time of our inspection.

Staff told us that the unit management team were approachable and visible. During interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns.

Staff evidenced strong team working and appeared motivated to provide dedicated care for patients.

We noted a number of registered nurse vacancies, which the health board was attempting to recruit into. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to temporarily fill these shortfalls. Daily meetings on staffing levels and patient flow and demand took place to immediately resolve any shortfalls. The health board must continue to ensure it has sustainable and sufficient capacity to provide safe and effective care to patients.

Staff told us that the current system of recruitment was very resource intensive on ward managers, and due to the competing demands of the wards there were delays in submissions of paperwork for vacancies on the wards. The health board should look at alternative ways of supporting staff in the administration recruitment to ensure there are no unnessecary delays in the recruitment and appointment of new staff.

The unit had a clear policy in place for staff to raise any concerns and staff we interviewed had knowledge of the policy.

There was a programme of training so that staff would receive timely updates on what training required completion. The electronic records provided the

senior managers with details of the course completion rates and individual staff compliance details.

We reviewed the mandatory training and clinical supervision statistics for staff at the unit and found that completion rates were generally high. Whilst reviewing records we identified that safeguarding training completion rates were low. It was acknowledged that due to the difficulties surrounding the pandemic with staff shortages, this had impacted upon the ability to release staff for training. It was reassuring to see that the completion rates for training had already been identified and the health board were in the process of arranging this training. The health board also needs to make sure that staff have access and availability to additional IT systems which can support the completion of their training.

There were good systems in place to support staff welfare. The unit's clinical psychologist was providing ongoing support to staff, the psychologist had met and spoken with all staff and it was reassuring to see that support had also been considered for the clinical psychologist. The health board must continue to monitor, promote, and invest in staff welfare and wellbeing.

Improvement needed

The health board must ensure that:

- Staff vacancies are filled and future initiatives are explored to encourage recruitment into the unit.
- Staff are supported to avoid preventable delays incurred during recruitment and pre-employment checks.
- Safeguarding mandatory training rates are improved, along with IT systems which can support the completion of training.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- 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.

As a result of the findings from this inspection 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.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Heddfan Psychiatric Unit

Ward/unit(s): Gwanwyn and Hydref Wards

Date of inspection: 7 – 9 July 2020

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurance issues				

Appendix C – Improvement plan

Service: Heddfan Psychiatric Unit

Ward/unit(s): Gwanwyn and Hydref Wards

Date of inspection: 7 – 9 July 2020

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board needs to make sure that patients have access to technology which allows patients to see and speak to family members	1.1 Health promotion, protection and improvement	The health board have purchased an additional 4 IPADS, making 6 in total, which are solely to facilitate contact between patients and families. 'How to use' Guides will be made available for patients, staff and relatives to enable them to use the apps to access different forms of social media.	Head of Nursing Business Manager	30 August 2020 30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ward managers will monitor the use of I PADS for patients to have contact with family members. The audit will be completed on a weekly basis The Health Board is undertaking an evaluation of the use of technology and MHLD services will be part of this evaluation.		
Delivery of safe and effective care				
The health board must ensure that the arm rest is fixed or replaced on Hydref ward.	2.1 Managing risk and promoting health and safety	The fault for this specialist seating equipment has been reported to estates and awaiting repair.	Clinical Operations Manager	30 August 2020
The health board must ensure that a review of the environment on Clywedog and Dyfrdwy is	2.1 Managing risk and promoting	The Health Board will undertake a full environmental review for all OPMH wards	Clinical Operations	30 September

Improvement needed	Standard	Service action	Responsible officer	Timescale
undertaken to ensure patient safety.	health and safety	at the Heddfan Unit this will include: Shower area and bedrooms and accessibility. The environmental review team will include estates, IPC and Health and Safety.	Manager	2020
The health board must ensure that patients can alert staff that they require assistance from their bedrooms	2.1 Managing risk and promoting health and safety	There is currently a patient call system in each bathroom which is not fit for purpose. However, an additional and appropriate wireless patient call system is required for those patients with mobility issue. This system has been ordered and awaiting delivery.	Inpatient Operations Manager	30 September 2020
The health board must ensure patients have access to appropriate beds and fixtures to aid patient independence and their safety.	2.1 Managing risk and promoting health and safety	All patients have access to an appropriate bed and any specialist bed requirements raised at the daily Older Adult Acute Care Meeting for action to ensure the patient is in an appropriate bed. Specialist fixtures to ensure independence and safety in relation to the appropriate bed is currently being reviewed as part of the equipment review.	Clinical Operations Manager	30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Specialist fixtures will then be procured for use in the bedrooms.		
The health board must ensure staff, including bank staff, receive training and support to feel confident in caring for a different patient group.	2.1 Managing risk and promoting health and safety	A refreshed training needs analysis will be undertaken to review the gap in skill set in caring for a different patient group	Training and Development Lead	31 October 2020
		A training plan will be put in place to address gaps in Restrictive Physical Interventions, Manual Handling specifically directed towards caring for older people		
		An Advanced Nurse Practitioner will be recruited to support the physical health care and training in older persons nursing	Head of Nursing	30 August 2020
		Each ward manager will have opportunity to shadow a ward manager in Care of the Elderly to increase confidence and skill	Head of Nursing	30 August 2020
		Additional support package from Practice Development Nurse to support the wards in caring for a different patient group	Assistant Director of Nursing	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		A plan to be in place for one of the former adult wards in Heddfan Unit to return to its adult function. Thus reducing the gap in caring for a different patient group to one ward in Heddfan.	Head of Nursing	30 August 2020
The health board must ensure that unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	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.	Head of Nursing Inpatient Clinical Operations Manager Inpatient Clinical Operations Manager	Complete Complete 30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must make sure that staff feel consulted and involved in decisions that affect them, and that staff feel confident in sharing ideas and contributing to change.	Governance, Leadership and Accountability	Engagement event with senior leaders to gather views on the way forward	Deputy Director Strategy	30 September 2020
		Staff suggestion boxes have been insitu across the Heddfan Unit for staff to provide feedback	Inpatient Operations Manager	Ongoing
		Implement 'You said, we did' Notice Boards.	Business Manager	30 September 2020
		Implementation of Safety Culture Survey to collect views from front line staff on the Heddfan Unit	Head of Nursing	September 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that staff are supported to avoid preventable delays incurred during recruitment and pre-employment checks	7.1 Workforce	A dedicated Business Support Manager has been aligned to the recruitment process to support ward managers and reduce avoidable delays with recruitment. Delays in recruitment will be monitored through the operational group	Business Support Manager Head of Operations	Completed Ongoing
The health board must ensure that staff vacancies are filled and future initiatives are explored to encourage recruitment into the hospital.	7.1 Workforce	All current vacancies have been identified and progressing through recruitment exercise Early identification of leavers and support with TRAC recruitment	Head of Nursing Business Manager	30 October 2020 30 September 2020 Ongoing
The health board must ensure safeguarding mandatory training rates are improved, along with IT systems which can support the completion of training.	7.1 Workforce	A training plan will be put in place to address areas of low compliance (less than 85% completed compliance) with safeguarding training for each ward A review of IT equipment and accessibility will be undertaken to support easier	Inpatient Operations Manager Business Manger	30 September 2020 30 September

Improvement needed	Standard	Service action	Responsible officer	Timescale
		access to E-Learning		2020

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.

Service representative

Name (print): **Mike Smith**

Job role: **Interim Director of Nursing MHLD**

Date: 18 August 2020