Bundle Mental Health Act Committee 19 October 2020

To be held virtually via Webex from 10:30am - 12:30pm

Agenda attachments

Agenda_Mental_Health_Act_Committee_19_October_2020 (1) V1.0.docx

1 10:30 - MHAC20/1 Welcome and apologies

Apologies received from Alberto Salmoiraghi, Consultant Psychiatrist/Medical Director and Alison Cowell, Assistant Area Director Centre - Childrens, Child & Adolescent Health.

2 10:32 - MHAC20/2 Declaration of Interests

3 10:33 - MHAC20/3 Draft minutes of the meeting held on 20.12.19, matters arising and summary action plan

1\. To confirm as a correct record the minutes of the previous meeting and deal with any matters arising\, not dealt with elsewhere on the agenda
2\. To review the Summary Action Log

MHAC20.03a Draft_Mental Health Act Committee Minutes - Dec 19 V0.3 LR.docx

MHAC20.03b Summary Action Plan live version (002).doc

4 10:39 - MHAC20/4 Items circulated since the previous meeting:

11.03.2020 - Advisory reporting of errors - Action plan.
11.03.2020 - Action plan in relation to forensic and rehabilitation processes.
30.07.2020 - March and June 2020 Performance reports, Associate Hospital Managers updates and HIW Monitoring Report.

5 10:40 - MHAC20/5 Draft minutes of Power of Discharge Sub-Committee meeting held on 20.12.19 and verbal update from the earlier meeting

Wendy Lappin, Mental Health Act Manager to provide the verbal update.

MHAC20.05 Draft Minutes Power of Discharge Sub Committee 20th Dec 2019 v0.3 LR.docx

6 10:45 - MHAC20/6 CANIAD – Patient Story

Mike Smith - Interim Director of Nursing, Mental Health & Learning Disabilities to present.
Recommendation: To be received by the Mental Health Act Committee for information only.

MHAC20.06 CANIAD Patient Story - 2020-09.doc

7 10:56 - MHAC20/7 Analysis of S136 update on the Criminal Justice Liaison Service

Ruth Joyce, Criminal Justice Liaison Service Manager and Neil Coppack, North Wales Police, to present an update on the service.
Recommendation: The Mental Health Act Committee is asked to note the report. This is the first report in relation to progress of CJLS.

MHAC20.07 MHAct report Sept 2020 FINAL.docx

8 11:07 - MHAC20/8 Comfort break

9 11:12 - MHAC20/9 Use of Section 136 for Young People under the age of 18 years

Steven Riley, Consultant Nurse and Marilyn Wells, Head of Nursing - East Area, Child & Adolescent Health to present.
Recommendation: To be received by the Mental Health Act Committee for information and discussion.

MHAC20.09a MHA Committee Report CAMHS s136 detentions.docx

MHAC20.09b Appendix 1 Crisis Care for CYP V3.pdf

10 11:24 - MHAC20/10 Deprivation of Liberty Safeguards

Christopher Pearson, Safeguarding Specialist Practitioner/DOLS Manager to present.
Recommendation: The Mental Health Act Committee is asked to note the range of activity and challenges that arise from the current demand, scrutiny and practice issues relating to DoLS and its application within the Mental Health Division.

MHAC20.10 DoLS MHA 092020.docx

11 11:36 - MHAC20/11 Draft MHAC Committee 2019/20 Annual Report

Matthew Joyes, Acting Associate Director of Quality Assurance to present for approval.
Recommendation: The Committee is asked to approve the Committee Annual Report for 2019/20 (in particular, confirming agreement or amending the proposed RAG scores).
To also review and approve the Terms of Reference and Cycle of Business 2020/21 for submission to the Audit Committee.

MHAC20.11a Draft Committee Annual Report for Approval - Report Front Template (002).docx

MHAC20.11b DRAFT Mental Health Act Committee Annual Report Template V7.0.docx

12 11:47 - MHAC20/12 Associate Hospital Managers 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.

13 11:52 - MHAC20/13 Mental Health Act Performance Report

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

MHAC20.13a Coversheet MHA Performance Report.docx

MHAC20.13b Appendix 1 MHA Committee Performance Report Quarter April - June - MHAct Report.pdf

MHAC20.13c Appendix 2 Divisional S136 Report August 20.pdf

MHAC20.13d Appendix 3 CAMHS S136 Report Aug 2020.pdf

14 12:04 - MHAC20/14 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 to present.
Recommendation: The Mental Health Act Committee is asked to note the arrangements for approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.

MHAC20.14 Approval for All Wales Approved Clinicians and Section 12(2) Doctors) -Updated Clinicians Report..docx

15 12:16 - MHAC20/15 Healthcare Inspectorate Wales (HIW) Monitoring Report

Hilary Owen, Head of Governance & Compliance to present.
Recommendation: The Mental Health Act Committee is asked to note the report.

MHAC20.15a HIW Monitoring Report & Appendix 1 – Inspections.docx

MHAC20.15b Appendix 2 HIW Ty Llywelyn Inspection Report.pdf

16 MHAC20/16 FOR INFORMATION

16.1 12:27 - MHAC20/16.1 NAW - Health, Social Care and Sport Committee: Mental health in policing and police custody report

For information only: The item had previously been communicated to the Mental Health Act Committee Chair and Executive Lead via email on 08/01/2020.
Detail included: The National Assembly for Wales - Health, Social Care and Sport Committee had agreed to hold a short enquiry on the partnership between police, health and social care. (Documents relating to this are attached for information only).

MHAC20.16.1a Report - Mental health in policing and police custody.pdf

MHAC20.16.1b Welsh Government Response - 10 December 2019.pdf

17 12:29 - MHAC20/17 Issues of significance to inform the Chair's assurance report

18 12:30 - MHAC20/18 Date of next meeting

Friday, 11th December 2020.

Agenda Mental Health Act Committee

Date	19/10/2020
Time	10:30 – 12:30
Location	Virtual via Webex
Chair	Lucy Reid

1 10:30	**MHAC20/1 Welcome and apologies** Apologies received from Alberto Salmoiraghi, Consultant Psychiatrist/Medical Director and Alison Cowell, Assistant Area Director Centre – Childrens, Child & Adolescent Health.
2 10:32	**MHAC20/2 Declaration of Interests**
3 10:33	**MHAC20/3 Draft minutes of the meeting held on 20.12.19, matters arising and summary action plan** 1. To confirm as a correct record the minutes of the previous meeting and deal with any matters arising, not dealt with elsewhere on the agenda 2. To review the Summary Action Log
4 10:39	**MHAC20/4 Items circulated since the previous meeting:** 11.03.2020 – Advisory reporting of errors – Action plan. 11.03.2020 – Action plan in relation to forensic and rehabilitation processes. 30.07.2020 – March and June 2020 Performance reports, Associate Hospital Managers updates and HIW Monitoring Report.
5 10:40	**MHAC20/5 Draft minutes of Power of Discharge Sub-Committee meeting held on 20.12.19 and verbal update from the earlier meeting** Wendy Lappin, Mental Health Act Manager to provide the verbal update.
6 10:45	**MHAC20/6 CANIAD – Patient Story** Mike Smith – Interim Director of Nursing, Mental Health & Learning Disabilities to present. Recommendation: To be received by the Mental Health Act Committee for information only.
7 10:56	**MHAC20/7 Analysis of S136 update on the Criminal Justice Liaison Service** Ruth Joyce, Criminal Justice Liaison Service Manager and Neil Coppack, North Wales Police, to present an update on the service.

Recommendation: The Mental Health Act Committee is asked to note the report. This is the first report in relation to progress of CJLS.

8 **MHAC20/8 Comfort break**

11:07

9 **MHAC20/9 Use of Section 136 for Young People under the age of 18 years**

11:12 Steven Riley, Consultant Nurse and Marilyn Wells, Head of Nursing - East Area, Child & Adolescent Health to present.
Recommendation: To be received by the Mental Health Act Committee for information and discussion.

10 **MHAC20/10 Deprivation of Liberty Safeguards**

11:24 Christopher Pearson, Safeguarding Specialist Practitioner/DOLS Manager to present.
Recommendation: The Mental Health Act Committee is asked to note the range of activity and challenges that arise from the current demand, scrutiny and practice issues relating to DoLS and its application within the Mental Health Division.

11 **MHAC20/11 Draft MHAC Committee 2019/20 Annual Report**

11:36 Matthew Joyes, Acting Associate Director of Quality Assurance to present for approval.
Recommendation: The Committee is asked to approve the Committee Annual Report for 2019/20 (in particular, confirming agreement or amending the proposed RAG scores).
To also review and approve the Terms of Reference and Cycle of Business 2020/21 for submission to the Audit Committee.

12 **MHAC20/12 Associate Hospital Managers Update Report**

11:47 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.

13 **MHAC20/13 Mental Health Act Performance Report**

11:52 Wendy Lappin, Mental Health Act Manager to present.
Recommendation: The Mental Health Act Committee is asked to note the report for information.

14 **MHAC20/14 Approval for All Wales Approved Clinicians and Section 12(2) Doctors)**

12:04

Heulwen Hughes, all Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors to present.
Recommendation: The Mental Health Act Committee is asked to note the arrangements for approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.

15 **MHAC20/15 Healthcare Inspectorate Wales (HIW) Monitoring Report**

12:16 Hilary Owen, Head of Governance & Compliance to present.
Recommendation: The Mental Health Act Committee is asked to note the report.

16 **MHAC20/16 FOR INFORMATION**

16.1 **MHAC20/16.1 NAW - Health, Social Care and Sport Committee: Mental health in policing and police custody report**

12:27 For information only: The item had previously been communicated to the Mental Health Act Committee Chair and Executive Lead via email on 08/01/2020.
Detail included: The National Assembly for Wales - Health, Social Care and Sport Committee had agreed to hold a short enquiry on the partnership between police, health and social care. (Documents relating to this are attached for information only).

17 **MHAC20/17 Issues of significance to inform the Chair's assurance report**

12:29

18 **MHAC20/18 Date of next meeting**

12:30 Friday, 11th December 2020.

Mental Health Act Committee

Draft Minutes of the Mental Health Act Committee held at 10:30am Friday 20th December 2019, in the Boardroom, Carlton Court

Present

Lyn Meadows	Independent Member – Chair
Lucy Reid	Independent Member and future Chair
Eifion Jones	Independent Member

In Attendance

Alberto Salmoiraghi	Medical Director, MH&LD (VC)
Alison Cowell	Assistant Area Director – Children's Services
Frank Brown	Associate Hospital Manager
Heulwen Hughes	Approval Manager for Approved Clinicians (VC)
Francine Moore	Risk and Governance Lead, MH&LD
Lynda King	All Wales Project Support Manager (VC)
Wendy Lappin	Mental Health Act Manager
Jody Evans	Corporate Governance Officer – Secretariat

VC - VC facility had been made available for the Committee Meeting, due to prior commitments of those whom required usage of the facility.

It had been noted that the Attendance was Quorate.

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Agenda Item	Action
MHAC19/63 - Apologies, welcome and remarks **MHAC19/63.1** The Chair welcomed everyone to the meeting. The Chair introduced Mrs Lucy Reid, as the newly appointed BCUHB Vice Chair and advised members that LR was to be the future Chair of the Mental Health Act Committee from March 2020. **MHAC19/63.2** The Chair also welcomed Frank Brown, Associate Hospital Manager and Eifion Jones, Independent Member as a new member of the Committee. **MHAC19/63.3** Apologies were received from Andy Roach, Mark Jones, Joan Doyle, Gill Harris, Rachel Turner, Deborah Carter and Cheryl Carlisle. **MHAC19/63.4** The Committee noted the resignation of Christine Robinson and expressions of interest were being sought from the PoD Sub-Committee members in due course. **MHAC19/63.5** A discussion ensued relating to the functions of the PoD Sub-Committee and MHA Committee regarding the duplication of some of the items reported. The need to streamline the Committees was agreed in order to optimise attendance, however it was noted that there had been previous discussions about this and the Health Board would need to ensure that both Committees were operating in accordance with their statutory requirements. The Corporate Governance Officer agreed to contact the Acting Board Secretary to clarify detail and actions which would require attention. **RESOLVED** **The Corporate Governance Officer would liaise with the Acting Board Secretary to establish opportunities to streamline the agendas of the Committees.**	JE
MHAC19.64 – Declarations of Interest **MHAC19.64.1** – There were no declarations of interest made at the meeting.	

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MHAC19/65 - Minutes of last meeting and Matters Arising **MHAC19/65.1** The minutes of the meeting held on 28th June 2019 were ***approved*** as an accurate record subject to one typographical amendment. **MHAC19/65.2** The summary action log was reviewed and updated. In relation to action 19.08 Approved Clinicians and Section 12(2) Doctors Report, the Medical Director for MHLDS provided an update on the Task and Finish Group findings in relation to the availability of Section 12(2) doctors. A number of barriers to increasing numbers/recruitment had been identified by the group including defence costs and vacancy rates for consultant psychiatrists and GPs nationally. The report provided a number of helpful recommendations for the Health Board to consider. The Committee discussed the options presented and were supportive of these in principle. Members noted however that the Committee did not have the delegated authority to approve some of the solutions identified, for example the increase in fees. **Resolved** 1. The paper would be presented to the relevant Committee of the Health Board for further consideration in accordance with the delegated authorities. 2. 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 3. Other options relating to MHA assessments would be explored as a way to manage the geographical challenges faced in North Wales	LS/AS AS WL
MHAC19.66 – Minutes of Power of Discharge Sub Committee **MHAC19.66.1** The Minutes of the meeting held on 28 June 2019 were noted. **MHAC19.66.2** The Mental Health Act Manager summarised an oral update from the Chair on relevant feedback from the Sub-Committee meeting held earlier on the 20 December 2019. The Committee were informed of a question raised by the PoD Sub Committee regarding the turnover of Responsible Clinicians. The Medical Director confirmed that the Health Board continued to experience challenges to recruitment and this was being managed. It was agreed that a briefing would be provided to the PoD Sub Committee on this issue. **Resolved:** That the minutes of the Sub Committee were received and a briefing note on recruitment and medical staffing vacancies would be provided by the Medical Director to the next PoD Sub Committee.	AS

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MHAC19/67 - Approval for All Wales Approved Clinicians and Section 12(2) Doctors) **MHAC19/67.1** The Committee noted the arrangements for approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales. The All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors then presented the report. **MHAC19/67.2** The All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors informed the Committee of the four portfolios submitted. It had been noted that one portfolio had been approved and three portfolios would require further evidence. An influx of applications had been received, including from a nurse. Any applications requiring amendment had been returned. **MHAC19/67.3** It was noted that an induction and refresher training session would take place in February 2020 and that further training had been arranged for the remainder of 2020 in both Cardiff and Wrexham. It was stated that the contract was place until March 2021. A member enquired as to whether there was a charge for attendance for non-employed Section 12(2) doctors. It was reported that there had been communication between the Director of Primary Care and Community Services and the Medical Director for MHLD querying whether independent contractors would be required to pay the cost to attend. It was agreed that this would be clarified outside of the meeting. **MHAC19/67.4** The Approvals team were in the process of arranging the Mental Health Legislation Conference for 2020, to be held in March. **MHAC19/67.5** Appendix 1 had also been referenced within the report concerning additions and removals to the all wales register of approved clinicians as dated from 7th September – 29th November 2019. **RESOLVED** The report was received and noted and the fees for the Induction and Refresher Training for Section 12(2) doctors would be clarified.	HH
MHAC19/68 - Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit. **MHAC19/68.1** The Mental Health Act Manager presented the report detailing full updates in relation to the inspections conducted by Healthcare Inspectorate Wales within the last 12 months. The report covered findings in relation to the Mental Health Act and the Mental Health Performance Measure, as detailed within appendix 1. It was explained that the report highlighted that there had not been any immediate concerns. The inspections included the sites of: • Ty Derbyn CMHT Review	

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• Cefni Hospital • Ablett Unit • Nant Y Glyn CMHT • Hergest Unit. **MHAC19/68.2** The Mental Health Act Manager reported that the inspection of Cefni Hospital had been positive. The Ty Derbyn CMHT review report is due to be published in January 2020. **RESOLVED** The Committee received and noted the report.	

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MHAC19/69 - Hospital Manager's Update Report from Power of Discharge Sub-Committee for info only. **MHAC19/69.1** The Mental Health Act Manager provided the update on the activities of the Associate Hospital Managers [AHMs] activity during the last quarter within the Division. The report provided details in relation to the AHM activity within the Division, which included Hearings, Scrutiny Training, Recruitment, Forums and Key Performance Indicators. **RESOLVED** The Committee noted the report for information only.	
MHAC19/70 - Performance Report **MHAC19/70.1** The Mental Health Act Manager presented the report on performance in relation to the Mental Health Act and Mental Health Performance Measures within the Division. The report detailed compliance against key sections of the legislative requirements of the Mental Health Act 1983, as amended 2007. **MHAC19/70.2** Discussion ensued in relation to rectifiable error reporting as some of these documentation errors can affect the validity of the section. The Mental Health Act Manager advised the Committee that the Division undertakes quality checks against these requirements and action is taken where necessary. She clarified that they type of errors identified include only documenting the patient's first name and surname. It was further noted that inspections had been complimentary of paperwork and completion. **MHAC19/70.3** A member asked if the data reported could include a 12-13 months rolling period in order to provide a trend analysis. The Mental Health Act Manager agreed to liaise with the Performance Directorate. It was also agreed to improve the data in relation to areas of concern and increases for CAMHS and Section 136 data. **MHAC19/70.**4 The Committee were informed that the CJLS (Criminal Justice Liaison Service) nurse recruitment had been completed with the staff starting to work within the Police Control Room. A previous report on the analysis of S136 had been produced by David O'Brien. It was agreed to invite the Criminal Justice Liaison Service Manager to the March meeting to present an update on the service. **MHAC19/70.5** Members highlighted that the dates for the data reported were out of sync with other Committee and Board reports. It was agreed that this would be addressed in the future to ensure that the Committee received the most up to date information available. There was some	WL March Agenda

discussion about the reporting of the Mental Health Performance Measures as members noted that the data was also reviewed by the Quality, Safety and Experience Committee. It was agreed that, subject to confirmation against reporting requirements, the Mental Health Measure would not be reported to this Committee in future. **RESOLVED** The report was received and noted and the amendments requested to be actioned for the next Committee meeting.	WL
MHAC19/71 - Agree CoB for coming year **MHAC19/71.1** The Committee considered the Cycle of Business for the coming year and approved the draft version with the inclusion of the Patient Story/Patient Safety Experience item being included within each committee meeting. **RESOLVED** The cycle of business had been approved.	
MHAC19/72 - Issues of Significance to inform Chair's Report to Board **MHAC19/72.1** The Chair agreed to raise any issues of significance with the Board.	LR
MHAC19.74 – Date of Next Meeting **MHAC19/74.1** - 27th March 2020.	

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BCUHB MENTAL HEALTH ACT COMMITTEE Summary Action Plan – Live Document – last updated 08/10/2020 13:13				
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
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	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 (**Agenda Item at the**

	the Committee.			**PoD**)
AC	**MHAC19.52 – Child and Adolescent Mental Health Services - Update** **MHAC19.52.3** There had been a peek in the number of s136 detentions in the under 18 year olds. AC agreed to further analyse the data. (**Amendment to the above corrected by AC: March 2020** AC removed reference to designated beds, as this is not s136).	December	**December update** AC confirmed that the update would be provided to the March Meeting.	Deferred to October Meeting (**Agenda Item**)
	MHAC19.55 Mental Health Act Committee Performance Report – June 2019			
WL/AR	**MHAC19.55.3** Advisory reporting of errors. It was confirmed that AR and WL had planned to complete the analysis of data from the month of June. Action plan to be developed.	December	**December Update -** Verbal feedback had been received at the December Meeting. Discussion ensued with regards to zero tolerances and it was agreed that analysis would be further reviewed, in order to update upon trends at regular intervals. **March Update** – Action plan distributed to Committee Members on 11.03.2020.	Actions to be closed
WL	**MHAC19.55.5** It was agreed that an action plan in relation to forensic and rehabilitation processes would be brought to next meeting.	December	**December update** - It was agreed for an action plan to be developed and presented to the March meeting. **March Update** – Action plan distributed to Committee Members on 11.03.2020.	
20th December 2019				
JE	**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	Action to be closed.

			Experience Committee.	
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**)
HH	**MHAC19/6** Fees regarding the Induction and Refresher Training for Section 12(2) doctors would be clarified.	March	Update: 10/02/2020 - Update provided by HH to Lesley Singleton and Lucy Reid via email.	Action to be closed.
WL	**MHAC19/70.3 Performance** • The Mental Health Act Manager agreed to contact the Performance Directorate in order to gain 12-13 months rolling data.	March	Complete - within March 2020 report.	Action to be closed.
WL	**MHAC19/70.3 Performance** • Nurse Recruitment Report - it was agreed to Invite the Criminal Justice Liaison Service Manager to the March meeting, in order to present the update on the service.	March	**Agenda Item** – MHAC – March 2020 - Deferred to October Meeting	Deferred to October Meeting (**Agenda item)**
WL	**MHAC19/70.3 Performance** • It was agreed that, subject to confirmation against reporting requirements, the Mental Health Measure would not be reported to this Committee in future.		Update: Confirmed as required.	Action to be closed.
LR	**MHAC19/72.1** The Chair agreed to raise any issues of significance with the Board.	January	Update: Complete as required.	Action to be closed.

Draft Power of Discharge Sub Committee

Draft Minutes of the Power of Discharge Sub Committee held on Friday 20th December 2019 Boardroom, Carlton Court

Lyn Meadows	Independent Member (Chair)
Lucy Reid	Independent Member (Future Chair)
Eifion Jones	Independent Member
Ann Owens	Associate Hospital Manager
Frank Brown	Associate Hospital Manager
Jackie Parry	Associate Hospital Manager
John Williams	Associate Hospital Manager
Satya Schofield	Associate Hospital Manager

In Attendance

Francine Moore	Risk and Governance Lead, Mental Health Services
Wendy Lappin	Mental Health Act Manager
Jody Evans	Corporate Governance Officer, Office of the Board Secretary

Agenda Item	Action
POD19.27 – Apologies, welcome and remarks **POD19.27.1** The Chair welcomed everyone to the meeting. The Chair introduced Mrs Lucy Reid, BCUHB Vice Chair and advised the Sub Committee that LR would be the future Chair of the Sub-Committee from March 2020. **POD19.27.2** The Chair also introduced Mr Eifion Jones, Independent Member to the Committee. **POD19.27.3** Apologies had been received from Gill Harris, Steve Forsyth, Andy Roach, Shirley Ann-Davies, Cheryl Carlisle, Diane Arbabi, Shirley Cox and Delia Fellowes.	
POD19.28 – Declarations of Interest **POD19.28.1** - There were no declarations of interest made at the meeting.	

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POD19.29 – Minutes of Last Meeting & Review of Summary Action Log **POD19.29.1** – Minutes of the meeting held on 27th September were agreed as an accurate record. **POD19.29.2** – Action log was reviewed and updated.	
POD19.30 – Membership updates **POD19.30.1** Members discussed the Expressions of Interest received in relation to the vacant Associate Hospital Manager position upon the sub-committee. **POD19.30.2** There was some discussion about the two expressions received and whether both could be accommodated within the Terms of Reference. It was agreed that the Terms of Reference regarding numbers was clear, however not all members attended regularly. It was agreed that current members with a low attendance record would be contacted to ask whether they wished to remain on the Sub Committee. The Corporate Governance Officer agreed to collate recent attendance and liaise with the Mental Health Act Manager to contact existing members before a decision is taken on the Expressions of Interest. **RESOLVED** **It was agreed that members with low attendance would be contacted before consideration is given to the AHM who had made Expressions of Interest.**	WL/JE

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POD19.31.1 – Hospital Manager's Update to include periodic updates on training and appraisals	
POD19.31.2 The Mental Health Act Manager provided an update on the activities of the Associate Hospital Managers during the quarter, June to September 2019. The update report included details in relation to hearings, training, recruitment, forums and Key Performance Indicators (As referred to within Appendix 1).	
POD19.31.3 A discussion took place in relation to Responsible Clinicians and challenges regarding recruitment and retention. Members were concerned at the turnover of Responsible Clinicians which impact upon the continuity of information presented at hearings. It was agreed that an update regarding the recruitment and retention of psychiatrists would be provided for the meeting in March.	WL
POD19.31.4 A discussion took place regarding awareness of rights and it was agreed that the Mental Health Act Manager would provide further analysis of the data. Elements in relation to hearings being arranged and availability of staff within set dates was also discussed.	WL
POD19.31.5 The Mental Health Act Manager reported that 26 scrutiny sessions had taken place since the month of February and that 144 files had been scrutinised. She confirmed that an annual audit would be produced in January 2020 and will be included as an appendix for the next meeting.	WL
POD19.31.6 Mandatory training had been continuous and at the time of reporting the compliance rate was 40%. A training day provided in August for the Associate Hospital Managers had been well received. Follow up training would take place on the 30th January 2020.	
POD19.31.7 Recent recruitment activity was discussed with 2 recent appointments being made. New appointments would be announced in the Newsletter once checks had been completed. There was discussion about the induction and appraisal system for Associate Hospital Managers and whether there should be a 4 year tenure period considered to keep decision making current. The consensus was that any concerns about decision making could be addressed through regular appraisals.	
POD19.31.8 The Associate Hospital Managers Forums had been held within October and was very well attended.	
RESOLVED: **The sub-committee noted the report and update**.	

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POD19.32 – Performance Report **POD 19/32.1** 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. **POD19/32.2** Members asked some questions for clarification on some of the information including the section 136 and 5 (4) data. **RESOLVED:** **The sub-committee noted the report for information only**.	
POD19.33 To review and agree the Cycle of Business for the coming year **POD19.33.1** The Sub Committee considered the Cycle of Business for the coming year and approved the draft version. It was clarified that the Sub Committee would continue to accept adhoc items within forthcoming agendas. **RESOLVED:** **The Sub Committee approved the Cycle of Business for 2020/2021.**	
POD19.34 - Issues of Significance to inform the Chair's Report to the Mental Health Act Committee **POD19.34.1** The Chair agreed to raise any issues of concern within the Assurance report to the Board.	LM/LR
POD19.35– Date of Next Meeting **POD19.35.1** The date of the next Sub-Committee Meeting is 27th March 2020 – Boardroom, Carlton Court.	

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GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Mental Health & Learning Disabilities Patient Story (Caniad)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mike Smith, Interim Director of Nursing (MHLD)
Awdur yr Adroddiad **Report Author:**	Denise Charles, Caniad
Craffu blaenorol: **Prior Scrutiny:**	NA
Atodiadau **Appendices:**	NA

Argymhelliad / Recommendation:

To be received by the Committee for information.

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:

Below is a story shared by Caniad.

Cefndir / Background:

"When my son was sectioned it was a traumatic day for us all. The Mental Health Team and Police were here, there were many people watching and filming the incident. My son refused to come down from his bedroom and asked to speak to the Doctor at one point, he went upstairs and told my son that he was being sectioned and then came back downstairs. My son went berserk, a member of the public ran into the house and up the stairs. I told the Police I did not want them here but they did nothing. The member of the public made my son worse by shouting and told him to barricade his door. My son finally came down with the Police and the member of the public was still shouting. They went into the kitchen and my son tried to get a knife out of the drawer for his protection. It was at this point the Police pepper-sprayed him, which distressed him further and was very distressing to see. They took him to Bangor Mental Health Unit. He telephoned me the next day crying which upset me again. He wanted to come home. He was there for a week and was released back home".

"A plan has been put in place for him to see the Community Team, but my son refused to attend the appointments. We have had some bad days with him since, Police out looking for him, ambulance service coming out late at night and staying with him for hours. He has an appointment in a couple

of weeks with his Doctor and I hope he goes. He is scared that they will try and section him again".

"When my son was under CAMHS they were great with him, and you could always get in touch with them, but once he turned 18 and transitioned to Adult Mental Health, it was a long time before he was even seen by a Doctor, and that was only a quick appointment and increased medication. There is no support and it is hard to manage to speak to anyone within the Team. When my son was sectioned, it was a relief to know he was safe and being looked after. I feel that he should be seen every couple of weeks, or at least contact made with myself for an update on him, but I do not think they have the funding to do this. I dread him getting up in the morning, as you never know what sort of mood he will be in. His behaviour is so draining on us as a family, I am constantly tired, crying and do not want to go out. I am on anti-depressants myself. My son causes so much conflict between us all. He is not taking his medication again so his behaviour has escalated; he trashes his bedroom on a daily basis, throws food out of the fridge into the garden, has broken all the garden furniture and is abusive to everyone. I do not know what the solution is and how much longer we can put up with him. I do not want him ending up on the streets".

Asesiad / Assessment & Analysis

Strategy Implications

NA

Options considered

This story has been escalated to the Service Manager.

Financial Implications

None

Risk Analysis

NA

Legal and Compliance

NA

Impact Assessment

NA

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Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Criminal Justice Liaison quarterly update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Director of Mental Health and Learning Disabilities
Awdur yr Adroddiad **Report Author:**	Ruth Joyce Service Manager Criminal Justice Liaison Service (CJLS)
Craffu blaenorol: **Prior Scrutiny:**	MHLD QSE Local Criminal Justice Board
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

This is the first report in relation to progress of CJLS.
The Mental Health Act Committee is asked to note the report.

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 Criminal Justice Liaison service is a regional service covering all areas of BCUHB. This quarterly update report provides an update in relation to the activity within the team and will, in future reports include feedback from the S135/136 Monitoring Group and the Criminal Justice Liaison Steering group that has been set up to support and facilitate feedback during early stages of the service being in operation.

Cefndir / Background:

The Criminal Justice Liaison Service has been operational since the 13th January 2020. This is the first report that has been prepared utilising the data collected on bespoke SharePoint system.
The service provision has been affected by Covid-19 and this is reflected in the data.
This service was awarded further funding to increase an existing service. This funding has come via the Welsh Government. The service is based within both police and local magistrates' courts along with police custody and the triage element of the service is based within the regional Force Control Centre (FCC) in St Asaph.

Asesiad / Assessment & Analysis
Strategy Implications The service has recently recommenced S135/136 monitoring group and will be recommencing the Criminal Justice Liaison Service Steering group. Both of these groups are able to feed into the Crisis Care concordat and the Together for Mental Health \board by escalation where needed. **Options considered** Not applicable **Financial Implications** Budget gained after bids put forward to Welsh Government. This funded allowed expanding the team form three practitioners to 6.5 band 6 practitioners and service manager. **Risk Analysis** No major risks identified. **Legal and Compliance** *No legal implications. Standard Operating protocol has an agreed WASPI with North Wales police. This is published on the WASPI website* **Impact Assessment** *Impact assessment has been completed and following being submitted with standard operating protocol this is being discussed with colleagues in EQIA department.*

Criminal Justice Liaison Service update

1. Background

North Wales Criminal Justice Liaison Service (CJLS) is a 9-5 Monday-Friday service providing mental health assessments in North Wales Police (NWP) three custody suites (Llay, Caernarfon and St Asaph) and the three North Wales Magistrates court (Mold, Llandudno and Caernarfon).

The team also cover a 15.5 hour period in Force Communication Centre (FCC) from 10:30-02:00hrs made up of two 7.5hr shifts offering advice to officers and staff dealing with mental health incidents. The CJLS practitioners can access the usual health databases to ascertain if individuals have accessed services along with psych liaison records for West and Central.

The service launched full time from the 13th January 2020 having covered key dates over the festive period in FCC (Dec 2019).

The CJLS pulled back from usual community work on the 29th March 2020 as part of the covid-19 contingency management plan. The service temporarily ceased the community element of the role following discussion with the Head of Operations.

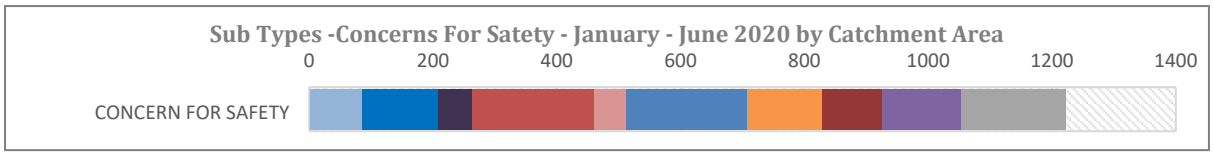
The agreed change to 24/7 cover in FCC was taken through Covid command centre and agreed due to the perceived opinion around increased calls from those experiencing distress and deterioration in mental health. Therefore the data provided here is for 6 months from an FCC perspective and 3 months from community court/custody perspective.

The team covered 24/7 in FCC from 29/03/2020. An SBAR was prepared to evidence a planned/safe return to the community element of CJLS and this commenced from 5th July 2020 and agreed by senior clinical management in negotiation with infection control team.

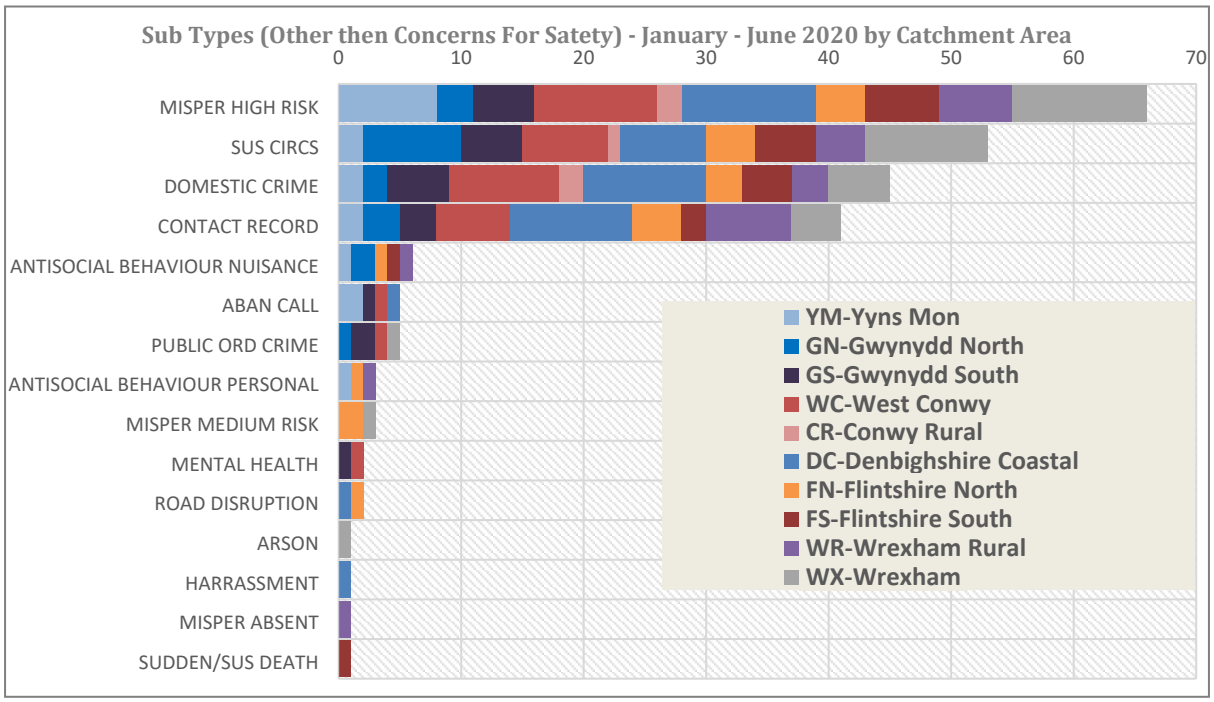
2. Activity

From January 2020 to end of June 2020 the team have been involved with 1711 calls (NW Police classify calls in relation to the incident). The majority of calls with CJLS Involvement are in relation to 'concern for safety'. Just over 1200 of the total calls for that period being related to 'concern for safety'. This is also reflected in NWP data where incident classed and tagged as 'mental health' concern for safety accounted for 48% between periods of 01.12.19-29.02.20.

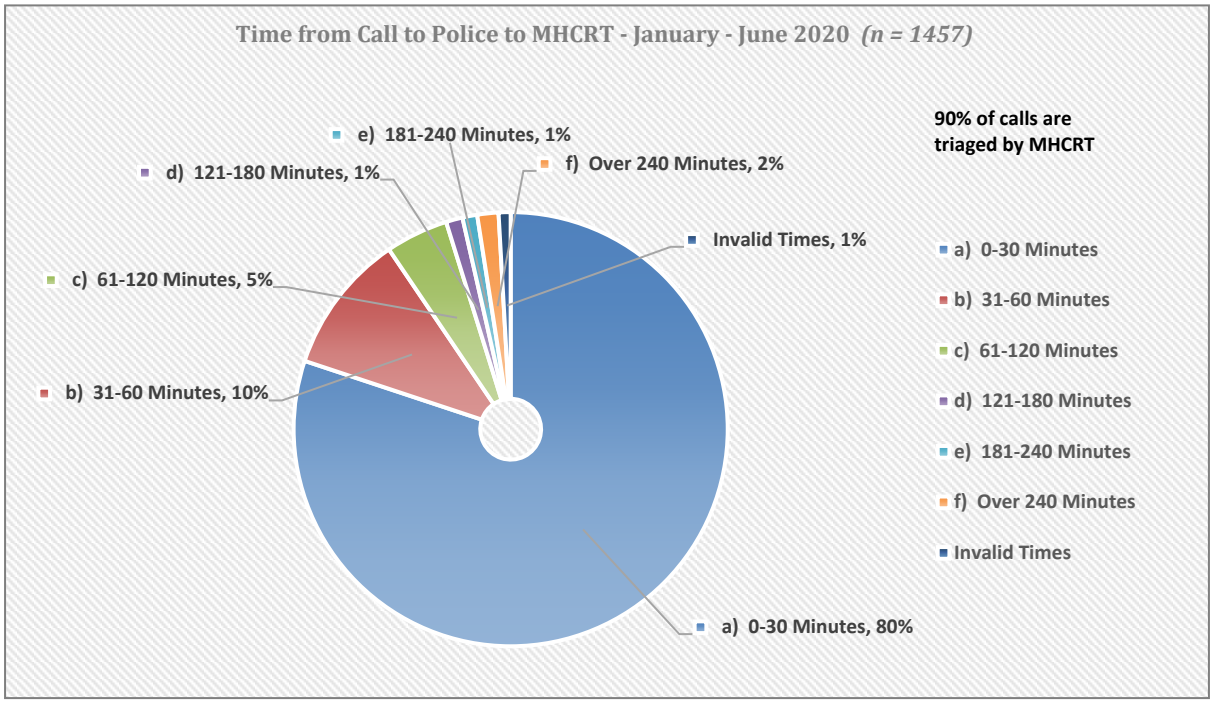
The first graph below highlights concerns for safety calls in relation to graphical areas: (the coloured key is on the graph below).



The second graph gives an example of the other types of calls the team have been involved in during the last six months along with the geographical area the call was generated from:



There are many incident classifications and within each classification a call is graded in order of seriousness from P0 immediate response to P8 slow time enquiries. The team focusses on the P0 and P1 calls to ensure swift sharing of information and intervention where needed.



The above data shows the time response between FCC receiving the call and the CJLS responding with intervention or information. 80% of calls involving the CJLS have had an input within the first 30 minutes of the call being received.

The larger time lapses are usually calls that have commenced as a contact record or other subtype (routine information sharing call) and escalated to require the Force Incident Manager (FIM) or call handlers to request our advice. For example, a call was received in regard to suspicious circumstances at a low grading.

On attendance by officers from Protection of Vulnerable Persons Unit (PVPU), it was evident the female involved was experiencing distress due a deterioration in her mental health and after speaking with the CJLS practitioner liaison was conducted with the CMHT to access support. With the consent of the individual, their G.P was made aware via letter in regard to some of her current difficulties to facilitate access to support. .

3. Consultation

Another of CJLS key roles is to provide and promote the use of consultation prior to the use of Section 136 police powers as per recommendation within the legislation. Consultation data is covered in MH Act report and we continue to work closely with Wendy Lappin and team.

The CJLS are now able to track data or diverted S136 (previously unavailable): i.e. by discussing an alternative intervention or liaising with officers and individuals in regard to accessing services in a voluntary capacity. The CJLS team are actively promoting the services with police colleagues and providing training opportunities. The S136 data will be available in full for the next report.

4 Repeat/frequent callers.

Within the work in the FCC there is always an element of repeat/frequent callers. The team are getting involved in the panels throughout north Wales and are now on the invite list for when meetings recommence.

From police data (covering 01.12.20-29.02.20) there were 41 ‘repeat’ calls that were deemed to have a mental health element. With each of those caller making between two and ten separate calls. This was a fairly equal gender split between male 55% and female 45% with the majority of calls coming from 66+ age range within ‘concern for safety. This data gives an idea of the trends that NWP experience.

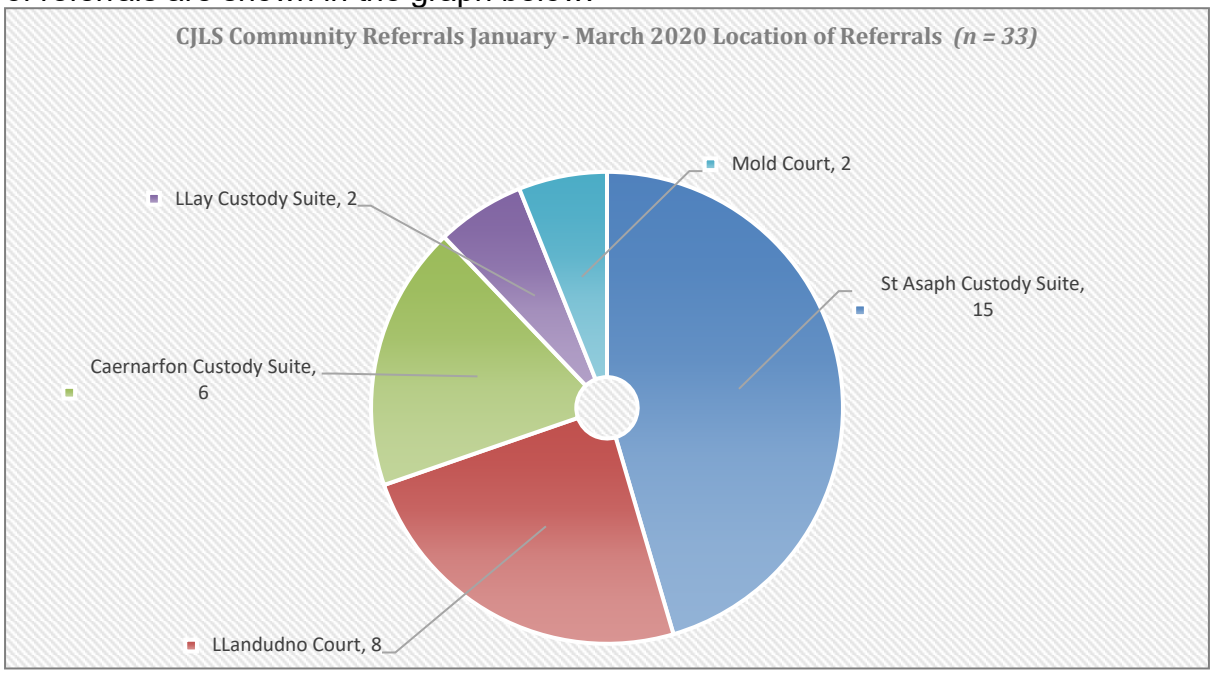
As a team we are noticing some regular callers and have been involved in MDTs around the individual to enable CJLS to share a management plan with NWP this work will grow and enhance once we are also active within frequent attender panels.

5 Community.

The community (court, police custody and probation) element of the service has less data due to the impact of covid on what is still a very new team.

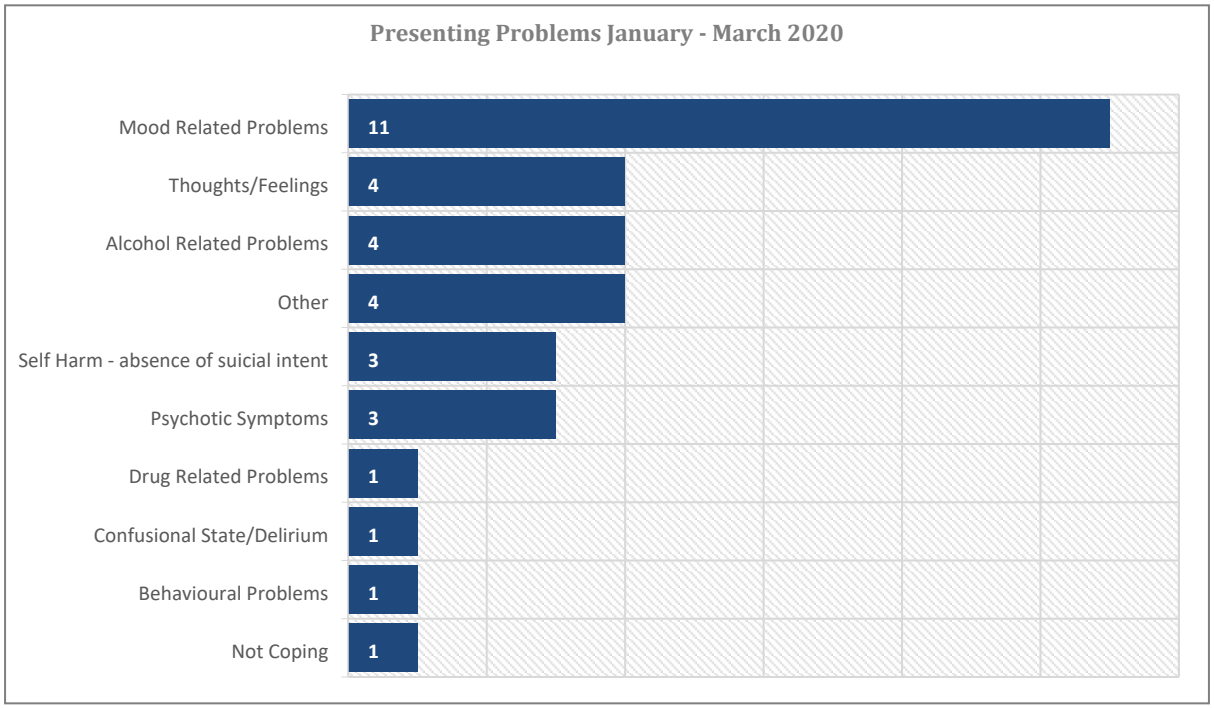
During the period 14.01.2020-27.03.2020 the team have received and conducted 33 assessments. The majority of which have come via police custody or court. The area

of referrals are shown in the graph below.



As a team, a priority moving forward will be to establish clinic type set ups within probation offices in order for the probation teams to directly refer to and for the teams to have a point of access that will benefit both probation, CJLS and the individual as this will hopefully assist in reducing the amount of breached community orders and reduce time in court by having speedy access to assessment appointments.

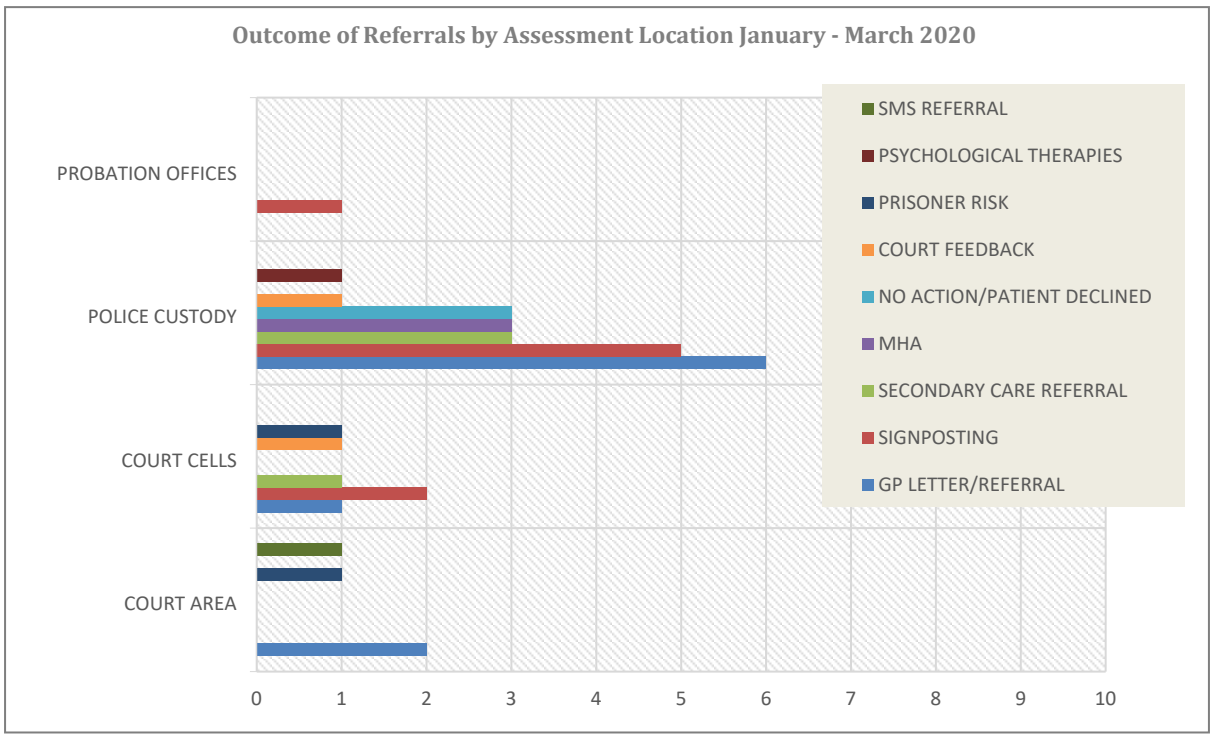
The data below provides a summary of the presenting problem for the individual assessed again this is similar to data captured by police data when profiling the mental health incidents.



A large part of the first three months of recommencement of CJLS was around relationship building with partner agencies and raising awareness of the service. This is a continuing action and area of focus.

As a team, the CJLS are able to provide comprehensive assessments and feedback these outcomes with the criminal justice agencies with the consent of the individual, as well as refer on to the appropriate service so the individual can feel supported and have equal access to healthcare.

The data below show the onward referrals made for the period the service was operational.



The CJLS service has recently recommenced the S125/136 monitoring group which is a bi-monthly group, co-chaired with NWPolice with multi-agency membership that give an opportunity to review S135/136 data and review cases where there may be learning opportunities.

The CJLS also developed a steering group in order to have multi-agency support and perspective on the service in the first 12 months of service.

Both of these groups assist to feed into the wider governance of the Together for Mental Health Board and the Crisis Care Concordat. As expected these meetings have had to be put on hold but to demands around covid but will recommence in the coming weeks

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Use of Section 136 for Young People under the age of 18 years
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Chris Stockport, Executive Director, Primary and Community Care
Awdur yr Adroddiad **Report Author:**	Steven Riley, Child & Adolescent Health Services Consultant Nurse
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	1. Appendix 1 - Crisis Care for C&YP Update 2. Appendix 2 - Annual Data: Section 136 (2010 – 2020) 3. Appendix 3 – Annual Data: Number of Self Harm Assessments in Acute setting

Argymhelliad / Recommendation:

While much work and improvement has been undertaken over the past 2 years in relation to the high prevalence of S136 detentions used by North Wales Police for Children and young People there is still work to be done to reduce these. The work to address this is multi-faceted and requires a whole system approach.

1. There remains high use of the s136 power of detention by North Wales Police and the number of C&YP presenting in crisis. This is a national trend and we are anticipating more presentations with the easing of lockdown. We need to understand the balance between S136 and presentations to ED as they can be interchangeable. We can therefore not look at S136 detentions alone but must also understand the whole.

2. Crisis bid has been developed for submission to WG for extending the unscheduled care offer including the evening provision to support young people presenting in crisis in the DGHs and in the community.

3. Continued work is required with North Wales Police and Local Authority partners to develop a shared approach to risk management for C&YP who appear to be in crisis and understanding if there is a difference in risk management across North Wales which accounts for the differing levels of detention or whether this is due to differing environmental and social circumstances in each Area.

4. Preventative and early intervention services is key to changing the journey that young people take. The initiatives with Primary Care and Schools are developing rapidly, Family Wellbeing practitioners are being recruited to support GP clusters and CAMHS are supporting school clusters, early help hubs and via the WG school in-reach project.

5. New WHSSC Tier 4 specification now includes provision of High Dependency care. This requires a significant increase in workforce to meet the requirements of providing HDU including

junior Doctors. This is to be determined with WHSSC. Important to note that the WHSSC specification clearly states "*The HDU will not constitute a designated 'place of safety' within the terms of the Mental Health Act and therefore will not be able to admit young people detained under Section 136 of the Act*."

6. Designated age appropriate beds are required by all Health Boards - access to these has been challenging due to limited awareness of the requirement to have the bed, compliance with the Transition Policy, adult patient bed pressures, door safety in the Heddfan unit and Safeguarding level 3 training for adult mental health staff.

7. A key principle in Children's Services is to engage with children, young people and their families inform service planning and development. As a consequence the service is recruiting to an engagement post to ensure this is given the capacity required.

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 Mental Health Act Committee has requested an analysis of the detention of Young People under S136 due to the high prevalence of use by North Wales Police. The purpose of this paper is to provide the analysis and update the Committee on the work that supports young people presenting in crisis and are typically detained on S136.

Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

Once detained an Approved Mental Health Practitioner and an approved Doctor have to assess the individual within 24 hours, this can be extended by 12 hrs. The Section 136 power ends once the assessment process has been completed and a decision has been reached by Health and Social Care professionals as to whether the person requires further assessment or treatment or whether they can be discharged.

The Act changed in 2017. Prior to this the duration of the section was 72 hrs and police are also now required to consult a mental health professional before applying a section 136 where possible.

Across North Wales the number of S136 detentions reduced from a high of 50 in 2017/18 to 25 in 2018/19 but rose again to 38 for 2019/20, but still lower than the 2017/18 figures. This year will be very difficult to gauge given the impact of lockdown.

Cefndir / Background:

During 2018/19 a work stream was established in response to concerns raised over the number of under 18 year olds being brought to the S136 suites; and the low number of calls from the Police to a Mental Health Practitioner for advice prior to use of the s136 power to detain, required under the changes to the Police and Crime Act. A Project Team was established including, Police, Adult

Mental Health, CAMHS, Paediatrics, Local Authorities and it reported to the then Children's Transformation Group.

Five priorities for action were identified within a workshop attended by a number of agencies and services (Local Authorities, Police, CAMHS, Adult Mental Health, Paediatrics, and Public Health).

1. **Listening to Children, Young People and their families, advocates and referrers**
2. **Safe and appropriate Management of Children &Young People removed and detained under s136**
3. **Integrated, multi-agency and responsive pathway for children and young people in crisis.**
4. **Residential Schools/Units/Homes**
5. **Transition to adult services**

During the time of this work key external factors occurred which have influenced the service models required to meet the needs of young people and their families and to manage the associated risks, including the implementation of the Police and Crime Act, the WHSSC specification for inpatient units, the Welsh Health Building Note 03-01 – Adult Acute Mental Health Units, Place of Safety (Section 136) and the changes to the workforce model in NWAS.

A progress report was presented to EMG in October 2018 which detailed the key objectives for each of these objectives, work completed and the next steps. Appendix 1 provides the most recent update on this work.

Asesiad / Assessment & Analysis

Strategy Implications

The clinical pathway for S136 saw change in 2017 with the introduction of the Police and Crime Act amendments which required the Police to contact a mental health practitioner prior to using the S136 to discuss alternative solutions and care. In hours, this is via a dedicated CAMHS SPOA telephone number in each county and out of hours via the S136 suite bleep holder.

During the hours of 9am-5pm, S136 assessments for young people are undertaken by the CAMHS Psychiatrist from the Area the young person is from. The figures demonstrate that the overwhelming majority of S136 detentions occur out of hours (including weekends). Out of hours the arrangements are via MHLD.

From the data collated, it suggests that there is a higher incidence of young people detained under S136 in the East (Flintshire and Wrexham) locality.

The data captured monthly via the mental health act administrators, (Appendix 2) also suggests a reduction in the use of S136 in young people since the amendments to the Police and Crime Act. Hopefully this is reflective of the work that has been undertaken, however, it is unclear on monitoring the use of consultation prior to the use of S136 suggests this element of the clinical pathway is not always used by the police, with only 4 of 38 cases analysed in 2019/20, accessing advice.
While the number of C&YP being detained has gradually reduced the number of BCUHB Section 136 detentions of C&YP remains one of the highest in Wales and significantly higher than in England. More interagency work is therefore required to understand the reasons for this.

One of the more concerning statistics illustrated in the analysis demonstrates the increase in the number of C&YP 15 years and under being detained. Furthermore, an analysis for 2019 – 2020

identified that 37 of the 38 incidents of detention are related to C&YP threatening or demonstrating self-harm or suicidal intent. Also of note is the low number of C&YP being converted from Section 136 to another section of MHA – as follows: 4 of 45 in 2017/18; 4 of 50 in 2018/19 and 4 of 38 in 2019/20.

We also cannot view S136 detentions in isolation but must also review the number of mental health crisis presentations via A&E departments. This resulted in 823 assessments being undertaken by CAMHS urgently for 2018/19 and 829 assessments for 2019/20. (Appendix 3).

It can be seen then that there are still significant numbers of children and young people who find themselves in a MH Crisis and work has been undertaken working with partners to support this cohort and also to intervene earlier and prevent a crisis occurring. As set out in Appendix 1. We are committed to halt and reverse this trend and set out in the recommendation section of this report we describe the work which we continue to develop. Of particular concern is the unknown impact and demand that lockdown and COVID will have and we are closely monitoring current activity levels.

Financial Implications
The bid for increasing capacity for unscheduled care and a crisis response has been submitted to Welsh Government for the new Mental Health Improvement funding

Risk Analysis
The risk associated with young people presenting in distress, self-harming or suicidal behaviour is measured as a red risk (16), due to the limited capacity to meet this need.

There is an increasing risk that s136 protocol will be breached due to the lack of assessment provision for children under the age of 16yrs outside of core hours and heightened clinical risk for those awaiting suitable mental health beds, designated age appropriate beds locally, and Psychiatric Intensive Care or Low Secure out of area.

Measures on place to manage the risk include:
- 7 day CAMHS provision on the paediatric wards and Consultant Psychiatry.
- Out of hours: 5pm – 9am 7 days a week On-call telephone consultation Psychiatry rota
- Joint working with adult mental health to access the designated age appropriate bed

Legal and Compliance
The legal and compliance to the changes outlined in the alterations to the Police & Crime Act 2017: *'before exercising a section 136 power police officers must, where practicable, consult a health professional',* have been met by BCUHB. However, the number of consultations by the police prior to detention are very low with only 4 of 38 cases analysed in 2019/20 accessing advice. {N.B – no data is available of cases the police sought prior advice and the C or YP was not detained}.

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

Appendix 1 – Crisis Care for C&YP Update

Appendix 1 Crisis Care for CYP V3.xlsx **(Please see Appendix 1 also separately attached)**

Appendix 2 - Annual Data – Section 136 (2010 – 2021)

Young People under the Age of 18 years Changes to Police & Crime Act – Dec 11th 2017

Annual Data - Section 136 – Area/BCUHB											
Area	2010 - 2011	2011- 2012	2012 – 2013	2013 – 2014	2014 - 2015	2015 – 2016	2016 - 2017	2017 – 2018	2018 – 2019	2019 – 2020	2020 – 2021 (13th Aug)
West	6	No Data Available	1	No Data Available	6	7	10	6	9	9	2
Central	4		2		8	5	8	10	5	7	3
East	1		4		9	7	27	34 (22 incidents = 2 young people)	11	22	3
BCU Total	**11**		**7**		**23**	**19**	**45**	**50**	**25**	**38**	**9**

Annual Data – Section 136 – Time of Day											
Time of Day – Day/OOH	2010 - 2011	2011- 2012	2012 – 2013	2013 – 2014	2014 - 2015	2015 – 2016	2016 - 2017	2017 - 2018	2018 - 2019	2019 - 2020	2020 – 2021 (13th Aug)
Day	No Data Available	No Data Available	No Data Available	No Data Available	No Data Available	No Data Available	8	6	5	11	2
OOH							29	42	20	27	7
BCU Total							**45**	**50**	**25**	**38**	**9**

Annual Data – Section 136 – Outcome of Assessment											
Outcome	2010 - 2011	2011- 2012	2012 - 2013	2013 – 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	2018 - 2019	2019 - 2020	2020 – 2021 (13th Aug)
Care /Home/Foster placement/	7	No Data Available	4	No Data Available	15	10	32	40	19	12	6
Informal Admission	1		0		0	1	7	2	2	0	0
Sectioned	0		1		3	4	4	4	4	3	3
Paediatric Ward	3		1		5	0	0	0	0	1	0
Other	0		1		0	0	2	4	0	19 (referral to CAMHS)	0
BCU Total	**11**		**7**		**23**	**19 (4 unknown)**	**45**	**50**	**25**	**35 (3 unknown)**	**9**

Appendix 3 - Annual Data: Number of Self Harm Assessments in Acute setting

Total	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year To date	Monthly Average	Full Year	Full Year % +/-
2020-21	47	50	63	69									229			
2019-20	59	65	70	50	48	66	87	104	41	80	99	60		69	829	1%
2018-19	72	70	86	56	39	74	61	71	58	67	76	93		69	823	18%
2017-18	62	71	71	51	48	51	71	48	55	49	48	47		56	672	-3%
2016-17	55	64	61	43	49	50	62	67	50	50	55	88		58	694	-3%

Crisis Care for Young People	Last Updated: 04/09/2020		
Priority Area and Objectives	**Overall RAG rating**	**Work completed within priority area**	**Next Steps for priority area**
1. Listening to Children, Young People and families/advocates/referrers			
To design a model for service user and carers involvement in specialist CAMHS services that meets the needs of service users and carers and also meets strategic needs both locally and nationally		Miller Research commissioned to support Specialist CAMHS in developing their approach to engaging children and young people in the planning and delivery of CAMHS services, and gathering a set of young people/family stories to support service change and development within this important area. Report receieved with recommendations	Identifying a specific BCUHB CAMHS system for service user participation and recruit a participation post
To engage with service users and their families and carers from the outset			
To map current involvement of service users in all specialist CAMHS services across North Wales		A desk-based review has been completed of relevant strategic and operational documentation on CAMHs delivery in North Wales and UK best practice.	Finalise the design and write up the proposed bespoke approach for North Wales, including information gathered through stories of lived experience (October 2018).
To identify the gaps, pockets of good practice and existing capacity that can be built upon		There are demonstrable existing pockets of emerging good practice across the teams but not an overall systematic approach	Recruit to engagement post
To identify and develop interested local clinicians in building capacity for ensuring that participation is maintained and developed over time		Initial drop-in surgeries for staff in all community and inpatient/KITE teams.	
2. Safe and Appropriate Management of Children & Young People Removed and Detained Under S136 & Integrated and Multi-Agency and Responsive Pathway for Children and Young People in Crisis			
Engagement with key stakeholders (Police, Social Services, Adult Mental Health) to achieve a multi-agency whole system approach.		The project team has been working collaboratively to address the needs of young people and the risks associated. Good working partnership in particular with the Police and the Local Authorities has developed. Adult Mental Health representation at the Project Team was mainly from the Locality Heads of Operations.	Ensure implementation of all the risk management measures are in place and sustained
Implement the changes to the Police and Crime Act.		Now compliant with Police and Crime Act	Refine the Business Case for the crisis care model.
To fully understand the risks associated with young people being detained under a Section 136 in the BCUHB designated places of safety and address these risks by ensuring that mitigating measures are in place.		Risks associated with young people being detained on a s136 or admitted to a paediatric ward are individually assessed and measures put in place to support the young person	
Ensure that the risks are fully assessed for young people admitted to a paediatric ward and mitigating measures implemented.			Progress the discussions with WHSSC and Contracting regarding the potential for a block contract with Cheshire and Wirral Mental Health Partnership
To assess whether there are alternative environments that could be designated as places of safety		Review of potential alternative designated places of safety completed and concluded that there could not be changes to current arrangements	
To be advised by relevant legislation and guidance to ensure that quality and safety is paramount.		New WHSSC Tier 4 inpatient specification ciculated for consultation, now includes HDU, BCUHB response submitted indentifying gap analyis.	Discussion with WHSSC scheduled around tier 4 inpatient specification. Will require business case.
To explore unscheduled care models across the UK and develop a model that meets the needs of young people in North Wales		Bid for WG funding and business case for crisis pathway developed submitted to execs for 2019/20 funding - unsuccessful.	Bid submitted for 2020/21 funding for crisis pathway
To address the need for emergency beds and be advised by relevant legislation and guidance to ensure that quality and safety is paramount.			
To produce a business case for a crisis care model.		Bid for the Parliamentary Review Transformation fund developed in partnership with the Local Authorities successful. This model will support the crisis pathway in part and focuses on Children who are on the Edge of Care or are Looked After by the Local Authority.	
Ensure that prevention and early intervention is systematically delivered		School in Reach, Whole School Approach well developed. Denbighshire Family wellbeing pilot with Primary Care Cluster successful.	Family well being practitioner posts rolled out across all clusters
3. Residential Schools/Units/Homes			
Review current pathways for Looked After Children		Integrated Care Fund has supported the development of LAC pathways in CAMHS	
Review partnership working with Local Authority partners in regards to quality		Children's Continuing Care Team work with the LAs through the joint commisssioning panels to ensure the quality of care provided in residential care is of a high standard and meets the needs of children and young people	
4. Transition			
Transition between CAMHS and AMH: workstream focusing on quality and workforce required, to understand how CAMHS and AMH pathways operate		Quality and workforce group established and meeting regularly, with passport being put in place. Some challenges around age of transition; needs to be inline with WG policy and BCUHB protocol	Promote the adoption of the Welsh Government's Transition Passport, the passport being reviewed by members and young people.
			Synchronise transition protocol for a varied range of services, whilst embracing the different needs of young people receiving specialist service (e.g. Eating Disorder; Substance Misuse Services; Early Intervention in Psychosis).

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee Meeting** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	To inform and alert the Board of the current position relating to Deprivation of Liberty Safeguards (DoLS) activity, demand, training and challenges.
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:**	This paper has been developed from previous reports to the Safeguarding Governance and Performance Group, the Corporate Safeguarding Leadership Team, Safeguarding Performance and Governance, Quality Safety Group and Quality Safety Executive
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Mental Health Act Committee is asked to note the range of activity and challenges that arise from the current demand, scrutiny and practice issues relating to DoLS and its application within the Mental Health Division.

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 Mental Capacity Act Deprivation of Liberty Safeguards provides protection for vulnerable people in NHS hospitals (including registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment.

A number of reports have been produced and shared at key forums evidencing activity, increased demands and the implementation and identification of strategic activities; QSG, QSE and Final Internal Audit Report Committee, HASCAS Improvement Group and the Safeguarding Governance and Performance Group.

Cefndir / Background:

Governance

The governance of the Deprivation of Liberty Safeguards (DoLS) within the Health Board has been the subject of recommendations in response to the investigation of the Tawel Fan Ward. During the identified period, DoLS was managed within the portfolio of the Office of the Medical Director (OMD) but was transferred into the portfolio of the Executive Director of Nursing and Midwifery and forms part of the Corporate Safeguarding portfolio, during 2017/2018. The reporting arrangements follow

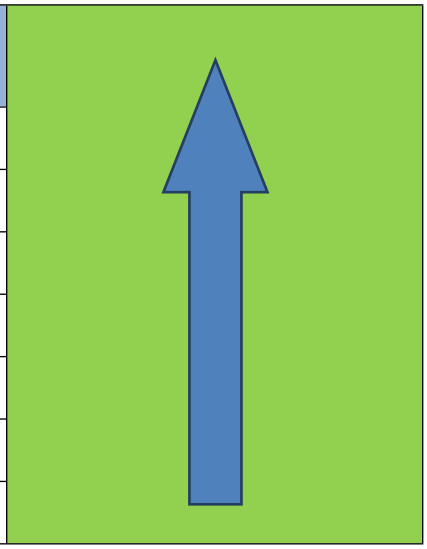
the Safeguarding Reporting Framework and up to the Board, with recognised reporting of the DoLS activity, governance and challenges to the Mental Health Act Committee (MHA Committee).

Both the HASCAS and Donna Ockenden reviews identified the DoLS work plan as a high-risk area, which required a full review. This was supported by the lookback report developed by the Associate Director of Safeguarding in March 2018 and presented at the Board. The internal audit review of DoLS is the first of its kind within BCUHB and was undertaken during Q4 2019-2020. The reported outcomes were considered by the Audit Committee in July 2020 and by QSG in August 2020.

Activity

Since 2014, the number of DoLS applications has increased significantly due to the Supreme Court creating a new case law test (the 'acid test') which has resulted in a higher number of patients being subject to a deprivation of liberty in a registered hospital. The total number of BCUHB DoLS applications have increased annually as evidenced below, this impacts upon service provision but figures alone do not show the level of complexity and demand upon the service.

Year	Total DoLS Applications
2014/15	414
2015/16	787
2016/17	854
2017/18	792
2018/19	744
2019/20	1014
2020/21 Q1	256 (projection 1024)



DoLS has two key frameworks, the Supervisory Body, which is the Corporate Safeguarding Team and the Managing Authority, which is the responsibility of the ward manager, or senior manager who is responsible for the care of patients. The DoLS legislation and Code of Practice set out the standards required for any DoLS application from the Managing Authority. Every application is scrutinised by the DoLS team (Supervisory Body (Corporate Safeguarding) to ensure it meets the required legal standard.

The total number of DoLS applications received from the Mental Health Division during Q1 is 24 of which, 50% had areas of improvement and omissions which resulted in the required standards not been met, these include;

- 9 cases where there is No Care and Treatment Plan to accompany the application.
- 7 applications do not have an identified named Consultant which results in ongoing delays in requesting a s12(2) Mental Health and Eligibility Criteria Assessment under DoLS legislation
- 6 applications had no accompanying Mental Capacity Assessment and 3 other cases did not have the new BCUHB Capacity Assessment documentation.

- 2 applications where the patient was detained under the MHAct 1983 and the ward manager had grated an urgent DoLS application (noting you cannot have two forms of detention at the same time on the same ward.
- 7 cases had a range of issues relating to incomplete documentation.

Court of Protection (CoP)
Additional responsibilities that impact upon the work of the DoLS Corporate Safeguarding Team include attending Court of Protection hearings. Court of Protection cases are referred for two key reasons. Firstly, because the patient's advocate is stating that the individual is objecting to their detention under DoLS and has a right in law to appeal (Article 5(4) ECHR). Secondly, it is referred because there is a need to have a welfare decision relating to the patient's care in hospital or elsewhere, which, is in their best interests. The number of cases referred by the DoLS service through Legal and Risk services has increased significantly from one (1) case in 2018/19 to sixteen (16) cases in 2019/20. Cases may take months for the Court to conclude a case, due to the amount of evidence and complexity, each case resulting in a number of hearings. The experience of clinicians dealing with these cases is of significance as all cases incur legal costs for which there is no indicative Safeguarding/DoLS budget so it not only becomes a cost pressure within the Corporate Safeguarding service, but the impact upon the patient, and the reputation of the organisation has a personal, financial and reputational cost.

Legislative impact
In September 2019, the Supreme Court held that in the case of *D v Birmingham,* where a 16 or 17 year old child cannot (or does not) give their own consent to circumstances satisfying the 'acid test'. This means that whereas previously parents could consent to a deprivation of a young person aged 16 or 17 years old who lacked capacity to agree to circumstances of a deprivation, now lawful authority is required from the Court of Protection to agree to deprive that person. This increases the number of cases referred to the Court of Protection. Several actions have been put in place which include alerting all relevant children's services of the impact of this case law by amending DoLS mandatory training from December 2019 to embrace the impact of this court judgement; direct training offered to Children's Services, Paediatrics and CAMHS from February 2020.

Increased organisational challenges are recognised when new legislative requirements replace DoLS with Liberty Protection Safeguards (LPS), which is now projected to come into full implementation in 2021/2022.

Asesiad / Assessment & Analysis

Strategic Implications

The 2019-2020 audit of the DoLS service provision by BCUHB was the first of its kind. It was recognised that progress had been made during 2019-2020 and the overall outcome was positive; however, the audit recorded an outcome as Limited Assurance and five (5) key findings and recommendations were identified.
Four (4) out of the five (5) findings and recommendations have been implemented with the exception of the appointment of the remaining one (1) Best Interest Assessor/Mental Capacity Act Practitioner post however, this is now in progress with the post having been advertised and the recruitment process underway. It should be recognised that the findings from the review have highlighted no issues that are classified as weakness in the system / control or design for Deprivation of Liberty Safeguards, managed under the direction and authority of the Associate Director of Safeguarding.

The summary of assurance given against the individual objectives are recorded as;
Policies, Procedures and Responsibilities; DoLS Applications and completeness of documentation; DoLS Monitoring; and Issues and actions identified. The audit highlighted key findings and recommendations (5); these have been acknowledged, actioned and implemented into practice by the DoLS Corporate Safeguarding team (Appendix 1).

Finding One (1) recorded that there is no published up-to date operational procedure clarifying expectations of departments/wards in their capacity as Managing Authorities. Staff would also benefit from further guidance on timescales / escalation and reporting breaches to ensure ward staff are taking appropriate action. In response The Corporate Safeguarding DoLS Manager produced a Standard Operating Procedure (SOP) which provides additional guidance for staff across the Health Board.

The SOP includes actions, timescales and a rationale for responding to an actual or potential deprivation of a patient. Ratification of the SOP took place through the Safeguarding Governance and Reporting Framework; which is the, Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group (QSG).

Finding Two (2) highlighted the need for all wards (Managing Authority) to be reminded of the need to complete DoLS paperwork in an accurate and comprehensive manner in accordance with the legislation. This remains an ongoing and demanding activity for the DoLS Corporate Safeguarding Team and audit is built into the safeguarding quality and assurance activities to measure compliance.

In response, the DoLS team have produced a Safeguarding Bulletin specifically assigned to DoLS that has be disseminated across BCUHB. The Safeguarding Ambassadors have also ensured the bulletin has been shared within their areas and teams. The Managing Authority have developed an audit and assurance process by using Datix to ensure all DoLS applications are completed accurately and correctly. The development of the SOP for DoLS further strengthens the process, supports staff by enhancing their awareness of their responsibilities and the actions to be taken to safeguard patients when a deprivation is occurring.

Finding Three (3) stated that whilst there has been significant progress made on the implementation of strategic activities by the DoLS Corporate Safeguarding Team and the significant increase in the number of BCUHB Authorisers (Signatories), it was recognised only a small pool of Authorisers were actively engaged. Bespoke training, within a governance framework was developed to support engagement and provide clarity regarding the role.

The Managing Authority (Wards/Units) ensure that Authorisers (Signatories) are reminded of their role and responsibilities through the PADR and supervision processes available to them. The DoLS Manager has developed guidance, reinforcing their role and responsibilities as authorisers within the Safeguarding Bulletin. A Standard Operational Procedure has been developed identifying the responsibilities for those who have been approved to authorise a DoLS.
This has been ratified by the Corporate Safeguarding Governance and Reporting group.
Furthermore, a bespoke barrister provided training for Authorisers (Signatories) which was completed in 2020 to further enhance and support the role.

Finding Four (4) found that within the reports produced from Datix the auditors were unable to identify any specific reporting of breaches by the, individual wards/departments (Managing Authority), specific to DoLS, within the period under review. In response, the Managing Authority

have undertaken a random sample of Datix incidents within their responsibility to determine if breeches have been reported.

The Managing Authority have developed an audit of DoLS paperwork and DoLS activities within the current Audit of records and developed a process to cross-reference Datix incidents to determine whether breeches have been reported promptly. It should be noted that the management response of developing a SOP identified in findings 1 and 3 demonstrate that the Managing Authority are fully aware of their responsibilities and the consequences of breaches of Article 5 (a deprivation of liberty, Human Rights Act '98) and expectations to have in place Datix reporting and notification to the Corporate Safeguarding DoLS Team.

The use of Datix has been used within Mental Health services when DoLS application are not completed as required under legislation and guidance. Corporate Safeguarding DoLS share trends, findings and omissions at Divisional / Departmental quality meetings to enhance awareness, provide independent challenge and both monitor and support change.

Finding Five (5) states that the lack of BIAs is impacting upon the timescales for DoLS applications. Although an establishment figure of six BIAs was identified with two in each of the three Safeguarding Area Teams across North Wales, the West area still relies on one BIA. With the recognition of the delayed assessments identified from the audit, there was a recognised risk to the Health Board, acknowledging that we could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the financial legal costs currently being saved by having a reduced establishment. The initial challenge to proceed to the full identified establishment was due to a cost pressure as a result of the banding outcome.

In response, the DoLS Manager initiated the recruitment process, and the vacant post is now advertised.

In addition, the submission of a further paper by Corporate Safeguarding to QSG highlighted the increased demands and organisational risks relating to the DoLS service provision, with escalation of the potential impact of LPS across the Health Board. A further business case highlighting the financial requirements to support the service delivery has been developed as a result of the escalation and reporting.

Audit Improvements

Identified trends and themes relating to the templates and documentation of the National DoLS forms determined that they have not undergone a review since 2015. This was recognised by Corporate Safeguarding who initiated a successful bid to Welsh Government for funding to support a review of the National DoLS forms used and adapted by BCUHB. Although the forms do not carry a statutory status like those used for detention under the Mental Health Act 1983, they do form the basis upon which people are detained under the Mental Capacity Act 2005.

The development of a DoLS/MCA Flowchart to support applications during the COVID-19 pandemic has been completed. This provides clear guidelines to support patient and staff safety and offers assurance with regard to the legal process.

During 2019/20 there has been a concerted effort by the Corporate Safeguarding DoLS Team to increase awareness of the rights based approach to depriving individuals lawfully of their liberty. This has been created by increasing the range of training provision across BCUHB to internal and external health and social care professionals. In 2019-2020, 620 BCUHB staff completed the DoLS/MCA training provided by Corporate Safeguarding.

Training and COVID-19 Pandemic

Corporate Safeguarding anticipated that face-to-face training would not be possible for all training during the current lockdown. DoLS and MCA Level 3 mandatory training is being delivered through on-line access and through peer led voice-over and video recordings, specifically in relation to training focused upon 16-17 year olds based upon new legislation. This includes learning assessments, which can be accessed by managers of staff using the e-learning to ensure learning objectives are being met. This option is now being explored through the use of professional staff registering through ESR to attend a Skype classroom so it will result in reporting compliance to mandatory training.

Liberty Protection Safeguards

Work-stream task groups are being put in place during 2020/21 to develop a strategic impact risk assessment and actions to mitigating against the risks for the Health Board for LPS implementation and support the facilitation, understanding and knowledge of the content.

Following the successful bid to Welsh Government for funding we commissioned a barrister to develop an introductory E-learning training package to be used by Betsi Cadwaladr Health Board in preparation for the new Liberty Protection Safeguards ('LPS') in hospital and NHS registered facilities. Corporate Safeguarding have been leading on innovative methods to deliver training to large cohorts of health professionals who will be involved in assessments under LPS. The introductory LPS E-learning training package will enable staff to have a working knowledge and understanding of their role and responsibilities within the assessment for LPS through downloadable content.

In addition to online and video based training documentation for LPS, Corporate Safeguarding are producing text documents, a folding pocket size leaflet, slides, and self-assessment quizzes to improve and retain knowledge of LPS. The folding pocket sized leaflet will support staff by setting out key messages and processes of the new LPS arrangements. This activity is ensuring we have a knowledgeable and prepared workforce.

Financial Implications

The demand upon the Corporate Safeguarding DoLS team extends not just to BIAs but also to all members of the team, and the implication of LPS will mean a substantial change and responsibility for BCUHB. It is estimated that in excess of 55% of residents across North Wales within Nursing Homes are in receipt of CHC Funding. The current responsibility for DoLS assessment or appeal lies with the Local Authority but from April 2022, this will be the responsibility of the health board. The impact of LPS will also mean that all community DoL application will become the responsibility of the health board to approve a DoL but any cases involving an 'objection' will have to be referred to the Court of Protection. As noted earlier, this will substantially increase the number of applications and costs involved in taking cases through the court process.

The overall objective identified by Corporate Safeguarding is to ensure that DoLS applications are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice, Welsh Government guidance and Health Board procedures. Noting the recommendations of the HASCAS and Ockenden reports and the identified recommendations, Corporate Safeguarding have identified progress where this directly relates to those areas, recommendations relating to the structure review and full assurance remain outstanding and are the focus of the business case to the Executive Management Group.

There are current and future financial implications for the health board in relation to the DoLS service provision and with the required implementation of the Liberty Protection Safeguards (LPS) that formulate part of the Mental Capacity (Amendment) Act 2019. The financial impact for LPS is wide ranging with a change of roles and responsibilities across the Health Board. LPS no longer relies upon the current Deprivation of Liberty Safeguards (DoLS), where Best Interest Assessors (BIAs) and S12 (2) Doctors are solely responsible for the assessments. Under LPS clinical staff on wards will have greater responsibility and accountability to assess individuals. Health Boards will retain ownership of LPS for all commissioned patients wherever they reside and this will see a huge increase in assessment requests, with an approximate additional application figure of 1200, recognising that if they are not completed on time this could result in legal and financial implications.

Legal and Compliance

Safeguarding is underpinned by legislation, policy and procedure. The role of Corporate Safeguarding within BCUHB is to ensure that the Health Board execute their responsibilities and comply with the Safeguarding legislation, providing assurance that the strategic measures are implemented, audited and reviewed.

The law has changed with an amended Mental Capacity (Amendment) Act 2019, which received Royal Assent in May 2019.

The Mental Capacity (Amendment) Act 2019 also puts in place new legislation, the publication of a new statutory Code of Practice and statutory Regulations under Liberty Protection Safeguards (LPS), which will replace DoLS legislation and procedures. The expected date of implementation has now been revised from 1st October 2020 to 2021/2022.

Risk

Tier 2 Corporate Risks DoLS - 2548 Current Risk Rating 20 and LPS - 2780 Current Risk Rating 6. The risk register is closely monitored through the safeguarding Reporting Framework and it is hoped the business case developed for consideration at the Executive Management Group will support the required resource to enable the organisation to comply with the required legislation and enable the organisational risk to be reduced.

Conclusion

Corporate Safeguarding have actively progressed and engaged in the DoLS, MCA and LPS national agenda. Work undertaken over the last 18 months to ensure that patients are supported under the right legal framework has been evident but has not been without challenge. Risk has been identified and communicated within BCUHB, with mitigation recorded. Corporate Safeguarding responses to

improvement are limited with recognition that the service provision is more reactive rather than proactive. This is due to demand and reduced capacity within the service to support the Managing Authority to comply with the DoLS process. Progress within this specialist arena is ongoing and further work is needed to strengthen current policy, procedure and process alongside sufficient resources to manage demand and capacity.

Appendix 1: Audit Findings:

Finding / Recommendation	Risk	Mitigation and Action
1	The lack of a local up-to-date procedure for DoLS.	A Standard Operating Process (SOP) has been completed (1/5/20) and approved by QSG (12/06/20).
2	DoLS applications not completed accurately and the Managing Authority should be informed of their responsibilities. Applications re-submitted and still incorrect place more and unnecessary demand on the limited capacity of resources within the DoLS team	Corporate Safeguarding Bulletin has alerted all staff of the need to complete accurate applications. DoLS specific training implemented and ongoing. Managing Authorities made aware of their responsibilities, Safeguarding Ambassador role implemented and supporting DoLS process, DoLS service providing continuous daily advice, support and guidance (30/04/20).
3	Lack of engagement from nominated signatories in attending training and ensure signing authorisations are within timeframe.	Further bespoke training completed for signatories to support process and authorisation now completed on average within 2 days (1/05/20).
4	Any DoLS breeches to be reported to the Managing Authority to include a Datix (CSS code) for any documents that do not meet requirements.	Electronic response devised in relation to the receipt of DoLS applications. Information and request to complete process of DATIX reporting where breech has occurred communicated and in place (15/04/20).
5	Vacant Best Interest Assessor post not released due to financial pressures.	Post has been agreed at QSE (12/06/20). Post now advertised and recruitment process in place (10/08/20).

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Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Draft Committee Annual Report 2019/20
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: **Prior Scrutiny:**	The Committee Annual Report has been scrutinised by the Committee Lead Executive and Chair of the Committee.
Atodiadau **Appendices:**	The Draft Committee Annual Report 2019/20 which also incorporates the Draft Cycle of Business 2020/21 and current Terms of Reference.

Argymhelliad / Recommendation:

The Committee is asked to:

- approve the Committee Annual Report for 2019/20 (in particular, confirming agreement or amending the proposed RAG scores)
- review and approve the Terms of Reference
- approve Cycle of Business 2020/21

for submission to the Audit Committee.

Please tick one as appropriate (

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

Sefyllfa / Situation:

The Committee is asked to approve the Committee Annual Report 2019/20

Cefndir / Background:

The Committee Annual Report 2019/20 has been prepared on a BCU-wide template and will be submitted to the next meeting of the Audit Committee. Due to the Covid-19 pandemic submission of the report was delayed.

Asesiad / Assessment & Analysis

Strategy Implications
Strategies discussed during the period are noted within the report.

Options considered
N/A

Financial Implications
N/A

Risk Analysis
Risks assigned to the Committee were discussed as per the Committee's Cycle of Business.

Legal and Compliance
All Committees are required to produce an annual report which forms part of a composite report to the full Health Board.

Impact Assessment
N/A

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Mental Health Act Committee* Annual Report 2019-20

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

1. Title of Committee

Mental Health Act Committee

2. Name and role of person submitting this report:

Matthew Joyes, Acting Associate Director of Quality Assurance

3. Dates covered by this report:

01/04/2019-31/03/2020

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

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

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

Members of the Mental Health Act Committee	28/06/19	27/09/19	20/12/19	27/03/20
Marian Wyn Jones (Chair)	P	P	◆	Meeting cancelled due to COVID-19 pandemic
Lucy Reid (Chair)	◆	◆	P	
Cheryl Carlisle Independent Member	P	P	A	
Lyn Meadows Independent Member	P	P	P	
Eifion Jones Independent Member	◆	◆	P	

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Formally In Attendance	28/06/19	27/09/19	20/12/19	27/03/20
Alberto Salmoiraghi - Medical Director for Mental Health	P	P	P	Meeting cancelled due to COVID-19 pandemic
Alison Cowell - Assistant Area Director Centre - Childrens	P	P	P	
Andy Roach (Lead Director) - Director of Mental Health & Learning Disabilities Lesley Singleton (Interim) Lead Director of Mental Health & Learning Disabilities	P	P	A	
Steve Forsyth Nursing Director for Mental Health	A	P	A	
Wendy Lappin - Mental Health Act Manager	P	P	P	
Gill Harris - Executive Director of Nursing and Midwifery	A	A	A	
Mark Jones - Social Services	A	A	A	
Satya Schofield Associate Hospital Manager	A	◆	◆	
Christine Robinson Associate Hospital Manager	A	A	◆	
Frank Brown Associate Hospital Manager	P	P	P	
Vacant Associate Hospital Manager	◆	◆	◆	
Joan Doyle – Unillas IMCA Advocacy IMHA Advocacy	A	A	A	
Caniad Service User Representative & Carer Representative	A	X	X	
Neil Coppack North Wales Police	X	X	X	
Chris Pearson MCA representative DoLS representative	P	P	A	

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Heulwen Hughes All Wales Approval Manager For Approved Clinicians And Section 12(2) Doctors	P	P	P	
Hilary Owen Head Of Governance And Compliance	P	P	A	

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

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

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

Members of the Power of Discharge Sub-Committee	28/06/19	27/09/19	20/12/19	27/03/20
Marian Wyn Jones (Chair)	P	P	◆	Meeting cancelled due to COVID-19 pandemic
Lucy Reid (Chair)	◆	◆	P	
Cheryl Carlisle Independent Member	P	P	A	
Lyn Meadows Independent Member	P	P	P	
Eifion Jones Independent Member	◆	◆	P	
Formally In attendance	28/06/19	27/09/19	20/12/19	27/03/20
Frank Brown Associate Hospital Manager	P	P	P	Meeting cancelled due to
Jackie Parry Associate Hospital Manager	P	P	P	

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Satya Schofield Associate Hospital Manager	A	P	P	
Shirley Cox (Resigned as from March 2020) Associate Hospital Manager	P	A	A	
Shirley Davies Associate Hospital Manager	P	P	A	
Delia Fellows Associate Hospital Manager	P	A	A	
Ann Owens Associate Hospital Manager	P	P	P	
Diane Arbabi Associate Hospital Manager	A	P	A	
John Williams Associate Hospital Manager	A	A	P	
Christine Robinson Associate Hospital Manager	A	A	◆	
Hugh E Jones Associate Hospital Manager To be welcomed on the group:	◆	◆	◆	
Helena A Thomas Associate Hospital Manager	◆	◆	◆	COVID-19 pandemic

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

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

5. Assurances the Committee is designed to provide:

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

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

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

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

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

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

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were zero breaches of this nature.

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

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

NOTE: INDICATIVE RATINGS HAVE BEEN PROVIDED FOR THE COMMITTEE TO SCRUTINISE AND CHANGE/CONFIRM (this text will be removed in the final version)

Objective as set out in Terms of Reference	Assurance Status (RAG)*	Supporting narrative
Ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities.		In relation to the Mental Health Act legislation, the Associate Hospital Managers and Responsible Clinicians can discharge patients from their detention. Associate Hospital Managers discharges are monitored and reported at every Mental Health Act Committee meeting and documented within the quarterly report. Training in relation to the Mental Health Act is provided to the Associate Hospital Managers and Health Board staff on a rolling programme. Associate Hospital Managers receive training twice yearly and also receive a PADR format supervision review on an

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		annual basis which identifies any additional training needs. The Committee noted training compliance was below target.
Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;		The quarterly Mental Health Act reports detail any areas of legislation that have been breached this includes lapses and illegal detentions. The Mental Health Act report also considers any errors that are rectifiable and these are benchmarked against other Health Boards in Wales. In order to improve quality and safety the Mental Health Act Manager has instigated KPIs for BCU an example of this is the timescale for hearing a renewal of section. In terms of the Mental Capacity Act this is monitored by the Corporate Safeguarding Team and any issues of concern are reported through local safeguarding forums and reported to the Mental Health Act Committee quarterly. However, the Committee has not received a specific report regarding risk management or risk register and is therefore unable to provide full assurance on mitigating measures.
Monitor the use of the legislation and consider local trends and benchmarks;		Trends, benchmarks and performance is managed by the Mental Health Act Manager and the team and is reported comprehensively on a quarterly basis through the Divisional QSE meeting to the Mental Health Act Committee. Mental Health Act Activity is also benchmarked across Wales and is evident via a quarterly report produced by Cardiff and Vale.

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		In relation to the other health boards throughout Wales BCUHB accounted for 50% of all rectifiable errors for the period of April - June 2019 (latest data reviewed).
Consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;		There is a report produced for the Power of Discharge Sub-Committee on activities undertaken by Associate Hospital Managers. This not only includes hearings activity but also the scrutiny of detentions that is undertaken as a separate part of the role. These reports are received by Divisional QSE, Power of Discharge Sub-Committee and the Mental Health Act Committee. The Mental Health Act Manager has established an Associate Hospital Managers Forum and any issues that require escalation are raised in the Power of Discharge Sub-Committee and escalated to Mental Health Act Committee as necessary.
Ensure that **all** other relevant associated legislation is considered in relation to Mental Health Act and Capacity legislation;		The Committee has received reports in relation to MHA compliance and DoLS however limited assurance has been provided on compliance with the MCA.
Consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports		Any actions arising in relation to Mental Health Act legislation from external inspections e.g. HIW are monitored locally via the QSE sub groups which in turn report to Divisional QSE to corporate QSE and the Mental Health Act Committee.
Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental		There have been no relevant reports during the reporting period.

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Health and Capacity legislation		
Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors		The Committee has received reports in relation to the approval for all Wales Approved Clinicians and Section 12(2) Doctors. The Committee noted concerns in relation to the lack of doctors and was made aware of concerns regarding this from Gwynedd Council. The Committee was informed a task and finish group was to be established.
Consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate		The Committee received assurance that a list of policies was in place that met the requirements of legislation but was not assured that all policies were reviewed and in-date. A number of policies were identified that were out of date. Assurance was offered that the MHLD Policy Group was addressing this.
Receive and review DoLS reports regarding authorisations and associated reasons		The Committee received DoLS information for part of the year, however not for the full year which may be due to meeting scheduling.
Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved		The Committee received information on compliance with the Measure however not for the full year which may be due to meeting scheduling. The Committee noted the MHLD Division continues to work on achieving the target across all teams, however, high referral rates, sickness and recruitment to vacancies continues to impact on delivery.
Receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure		No internal audits were presented to the Committee in the reporting period. No internal audits were presented in the previous reporting period either, which is in itself a risk. The Committee will need to consider how it directs internal audit to provide assurance.
Receive the results of clinical audits and any		No clinical audits were presented to the Committee in the reporting

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other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations		period. No audits were registered in the previous reporting period either, which is in itself a risk. The Committee will need to consider how it directs clinica; audit to provide assurance.
Consider any other information, reports, etc. that the Committee deems appropriate		The Committee has received ad-hoc reports as required.
Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference		The Committee has not needed to commission investigations during the reporting period but is aware of its right to do so.
Obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;		The Committee has not needed to obtain outside independent or legal advice during the reporting period but is aware of its right to do so.

**Key:*

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

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

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

<u>Standing Items:</u>

- Patient story scheduled at each meeting.
- Deprivation of Liberty Safeguards: Quarterly Report
- Hospital Manager's Update Report
- Performance Summary Report
- Report on Approval for All Wales Approved Clinicians and Section 12(2) Doctors)

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- Consideration of HIW inspection reports and audit reports as appropriate to the meeting remit.

Governance Items:

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

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

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

Meeting Date	Key risks including mitigating actions and milestones
28.06.2019	• Recruitment of Section 12[2] doctors remained a concern, discussions were being held with Executive Director of Primary Care & Communities, particular concerns have been raised by Gwynedd County Council. • The Committee remained concerned about the inappropriate DoLs referrals and the timing of such referrals. Discussions were taking place with the Executive Director of Nursing and Midwifery to address matters.
27/09/2019	• Healthcare Inspectorate Wales (HIW) Monitoring Report - the theme of continuous improvement was been noted, along with significant improvements across the Division.
20/12/2019	• A Task and Finish Group chaired by the Medical Director for MHLDs has identified a number of recommendations to increase the number of Section 12(2) doctors for North Wales. The Committee supported the recommendations which will now be referred through the appropriate forums to consider the actions to address the shortage identified.

9. Focus for the year ahead:

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

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

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Appendix 1

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

MENTAL HEALTH ACT COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

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

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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seek assurance that such risks are being mitigated;

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

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

Sub Committees/Panels

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

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

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

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

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

4. MEMBERSHIP

4.1 Members

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

4.2 In attendance

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

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

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

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Committee

4.4 Member Appointments

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

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

4.5 Secretariat

4.5.1 Secretary: as determined by the Board Secretary.

4.6 Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

5.1 Quorum

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

5.2 Frequency of Meetings

5.2.1 Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

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6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

9. REVIEW

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

V4.0 Approved:

Audit Committee 30.5.19

Chair's Report to Board 25.7.19

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Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

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

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

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

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

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

Mental Health Measure

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

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

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Mental Capacity Act

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

The MCA covers three main issues:

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

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

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Annex 2

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

1. INTRODUCTION

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

2. PURPOSE

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

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

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

4. MEMBERSHIP

4.1 Members

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

4.2 Attendees

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

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

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

4.3 Member Appointments

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

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

4.4 Secretariat

4.4.1 Secretary: as determined by the Board Secretary.

4.5 Support to Committee Members

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

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

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

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

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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

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9. REVIEW

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

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Appendix 2

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

DRAFT

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Mental Health Act Committee Performance Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	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 QSE Divisional Directors Meeting
Atodiadau **Appendices:**	Appendix 1 MHA Committee Performance Report Quarter April - June Appendix 2 S136 Divisional Report – August Appendix 3 S136 CAMHS Report - August

Argymhelliad / Recommendation:

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

Please tick one as appropriate

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

Sefyllfa / Situation:

The Mental Health Act Committee Performance Report provides an update in relation to the Mental Health Act Activity within the division for the detailed quarter. 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.

Cefndir / Background:

The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act, this reporting is done 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 least restrictive options. Consideration is made regarding care closer to home. Considering the Health Boards Well-Being Objectives the use of the Mental Health Act is in line with improving physical, emotional and mental health and well-being for all, targeting resources to those with the greatest need this is including putting resources into preventing problems occurring or getting worse for the population of North Wales.

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 to which there is no budget for.

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.

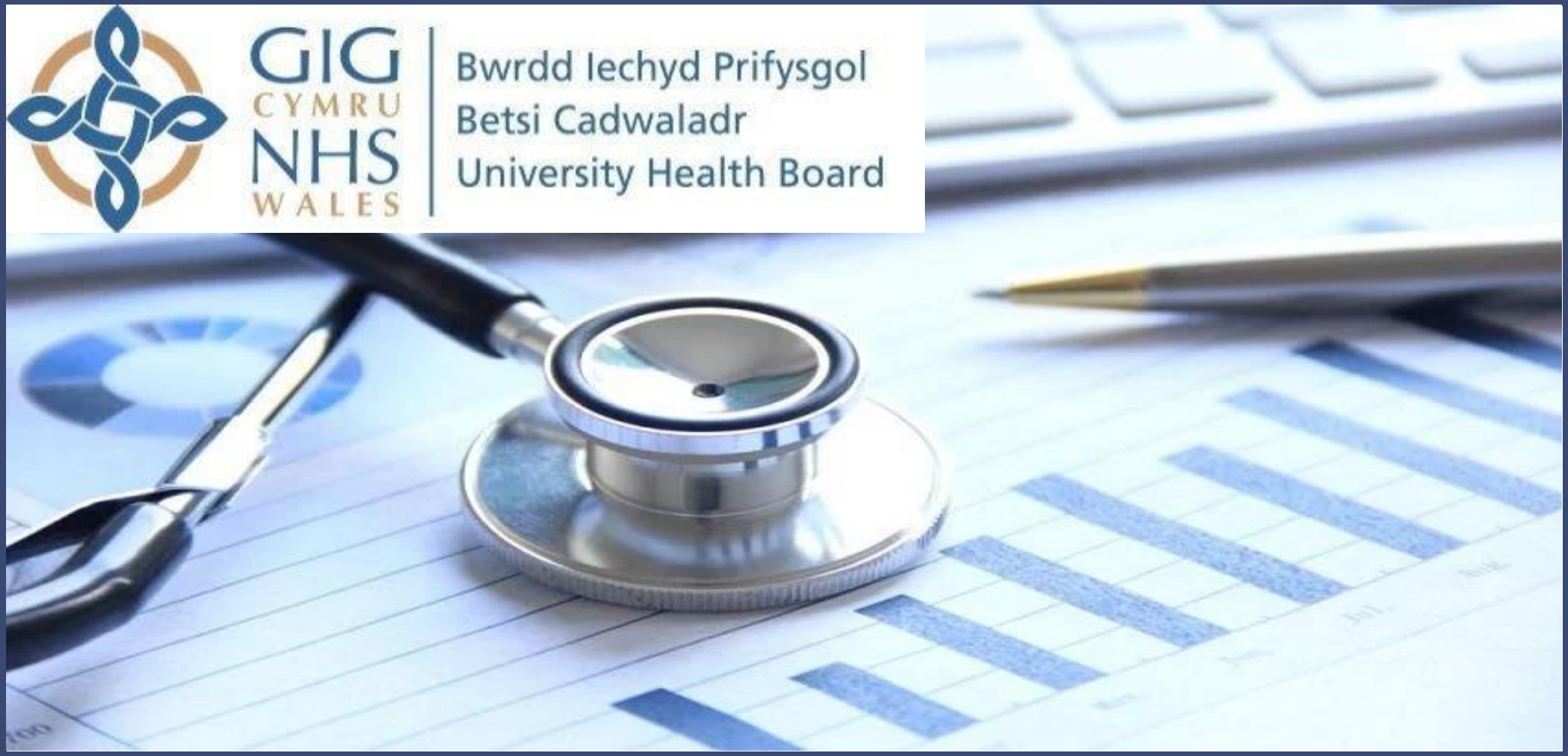
Legal and Compliance

This report is generated quarterly. The Mental Health Act sections are monitored as used 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 who may or may not fall under the protected characteristics. All policies in relation to the use of the Mental Health Act have been equality impact assessed.

Mental Health Act Committee Performance Report



Mental Health Act Committee
Performance Report

June 2020

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Mental Health Act Committee Performance Report - Foreword

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

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

Seven Domains

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

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.

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

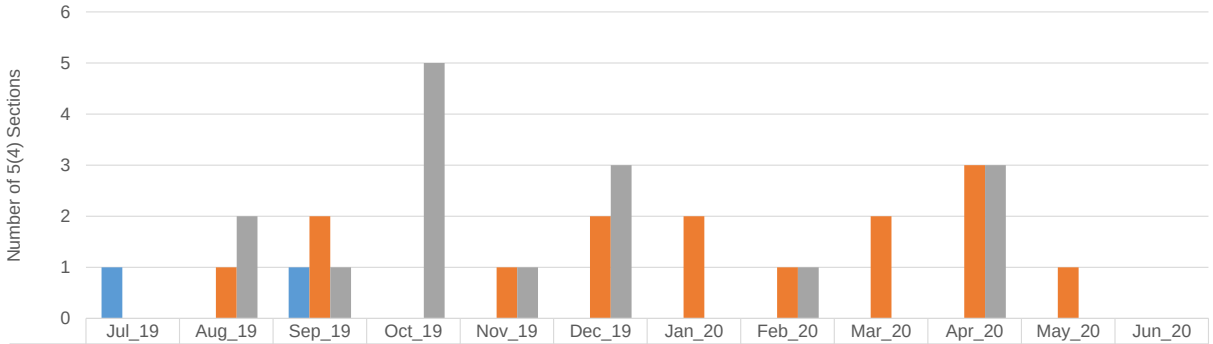
Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

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.

Advisory Report - Section 5(4)

Section 5(4) - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	0	1	↓	7	6	↑	8	1	Centre	4
								2	East	3
								3	West	0



	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	1	0	1	0	0	0	0	0	0	0	0	0
Centre	0	1	2	0	1	2	2	1	2	3	1	0
East	0	2	1	5	1	3	0	1	0	3	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.

All 5(4) sections within this period were appropriate.

The highlighted entries refer to the same person, these were on seperate days and enacted by different staff.

LAPSES

There were no lapses or exceptions to report this quarter

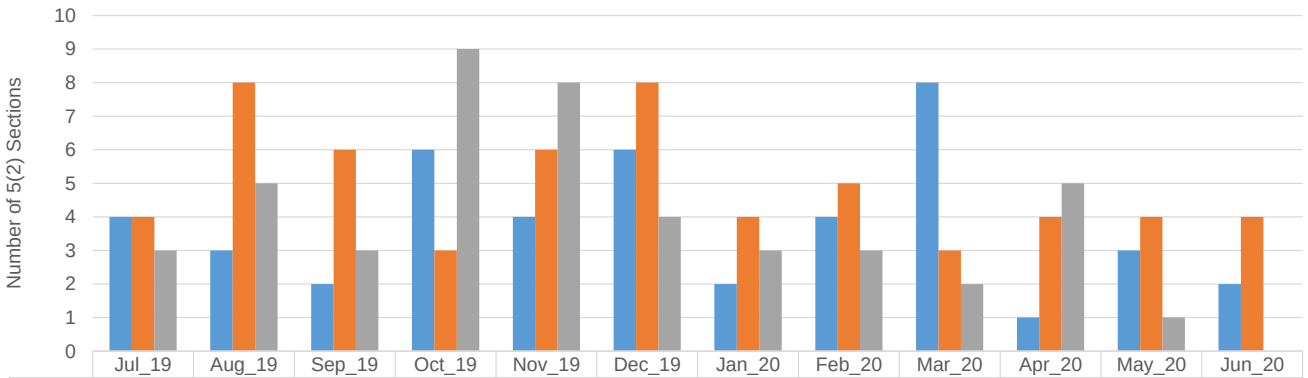
WEST		
Month	**Duration (hh:mm)**	**Outcome**

CENTRE		
Month	**Duration (hh:mm)**	**Outcome**
Apr_20	04:34	Section 5(2)
Apr_20	01:53	Section 3
Apr_20	00:20	Section 5(2)
May_20	03:45	Informal

EAST		
Month	**Duration (hh:mm)**	**Outcome**
Apr_20	05:00	Informal
Apr_20	05:12	Section 2
Apr_20	05:47	Section 5(2)

Advisory Report - Section 5(2)

Section 5(2) - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(2) during Quarter		Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	6	8	↓	24	34	↓	38	1	Centre	12
								2	East	6
								2	West	6



	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	4	3	2	6	4	6	2	4	8	1	3	2
Centre	4	8	6	3	6	8	4	5	3	4	4	4
East	3	5	3	9	8	4	3	3	2	5	1	0

Section 5(2) Outcomes

	Apr 2020	May 2020	Jun 2020
Section 2:	2	2	2
Section 3:	3	3	2
Informal:	3	2	2
Lapsed:	1	0	0
Invalid:	1	1	0
Discharged:	1	0	0
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards, during this quarter there was one instance which resulted in the patient being discharged to informal status.

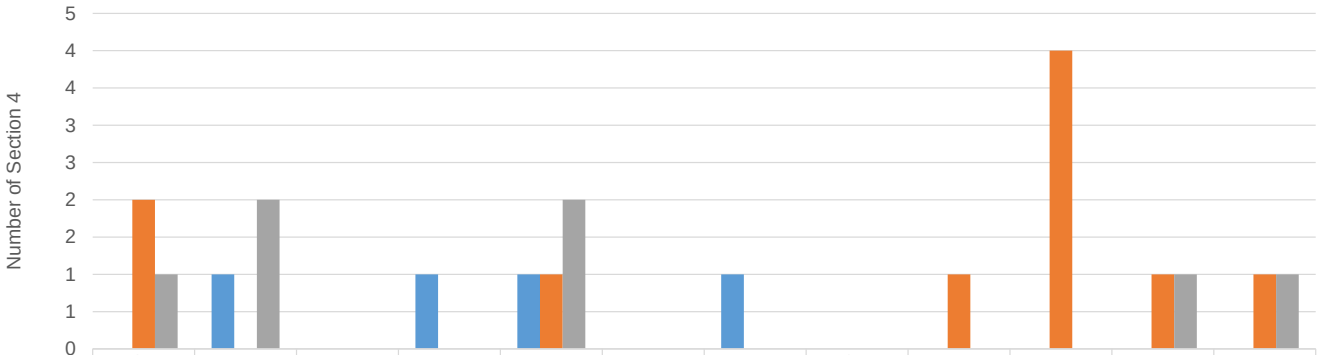
<u>This quarter there are three exceptions to report</u>

East: One S5(2) lapsed as the S2 was not completed on time, this was due to the 5(2) following a 5(4) and the combined timeframe was not taken into account. A S2 was completed.
One was deemed invalid as the patient did not have the capacity to consent to an informal admission prior to the use of section 5(2).

West: One was deemed invalid as the noted reason for use of the S5(2) was so that the patient could be transferred between wards, this is not an adequate reason.

Advisory Report - Section 4

Section 4 - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	2	2	→	8	2	↑	5	1	Centre	6
								2	East	2
								3	West	0



	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	0	1	0	1	1	0	1	0	0	0	0	0
Centre	2	0	0	0	1	0	0	0	1	4	1	1
East	1	2	0	0	2	0	0	0	0	0	1	1

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

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

There was a spike in April which may have been due to the Coronavirus but this did not continue through to May and June.

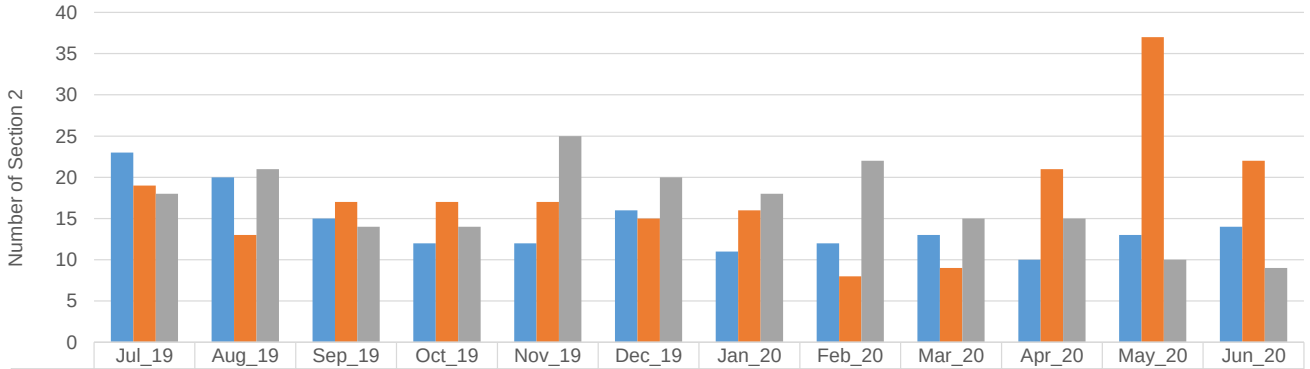
WEST		
Month	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome
Apr_20	21:00	Informal
Apr_20	19:00	Section 2
Apr_20	18:30	Section 2
Apr_20	04:40	Informal
May_20	04:47	Section 2
Jun_20	67:17	Section 3

EAST		
Month	Duration (hh:mm)	Outcome
May_20	18:00	Section 2
Jun_20	02:25	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	45	60	↓	151	124	↑	146	1	Centre	80
								2	West	37
								3	East	34



	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	23	20	15	12	12	16	11	12	13	10	13	14
Centre	19	13	17	17	17	15	16	8	9	21	37	22
East	18	21	14	14	25	20	18	22	15	15	10	9

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

Section 2 Outcomes

	Apr 2020	May 2020	Jun 2020
Section 3:	5	11	5
Informal:	9	22	26
Lapsed:	1	0	2
Pending:	0	0	0
Discharged:	4	5	9
Transferred:	7	14	13
Invalid and Other:	0	0	0

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

There were four under 18s placed on a Section 2 this quarter three were within an age appropriate bed in CAMHS and one within the adult unit folloiwng a S136, this person was moved to an age appropriate bed.

EXCEPTIONS:

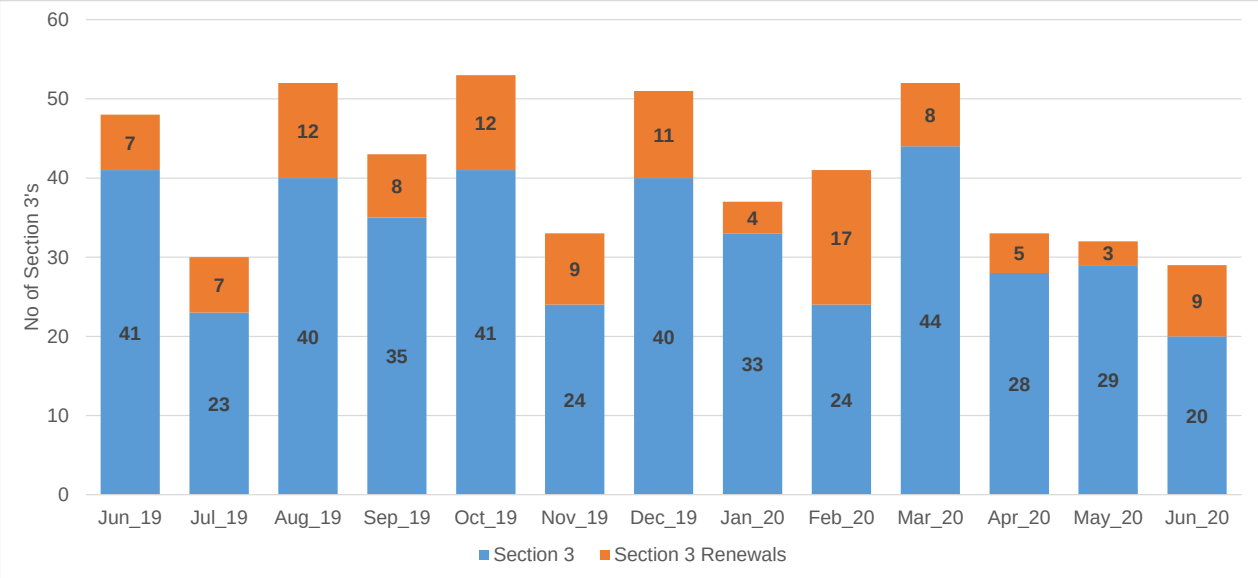
There are three exceptions to report this quarter in relation to lapsed sections.
two of these occurances were in the East and one in the West.

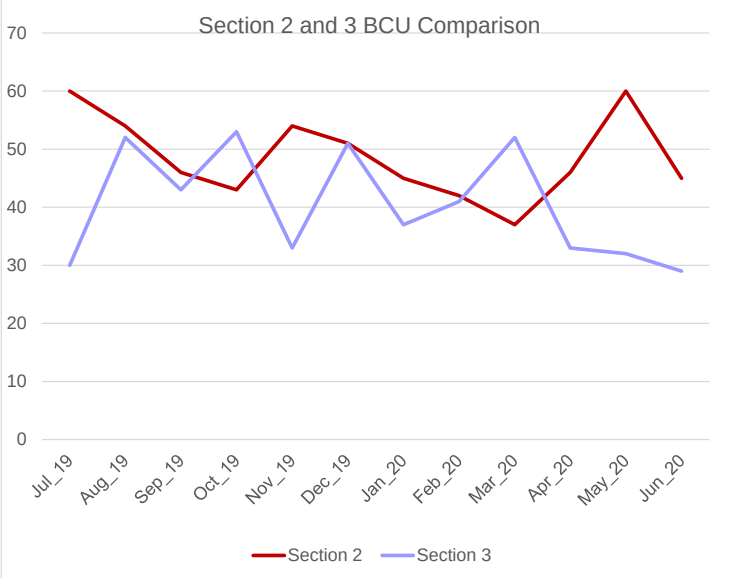
West: The S2 lapsed as no further paperwork was completed. The patient agreed to stay in hospital as an informal patient.

East: Two S2s lapsed due to a 2nd doctor not being available to complete the assessments in time. Lack of experience from the admin contributed to these lapses and aditional safeguards have now been put in place.

Advisory Report - Section 3

Section 3 - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	29	32	↓	94	130	↓	122	1	Centre	35
								2	West	31
								3	East	28





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

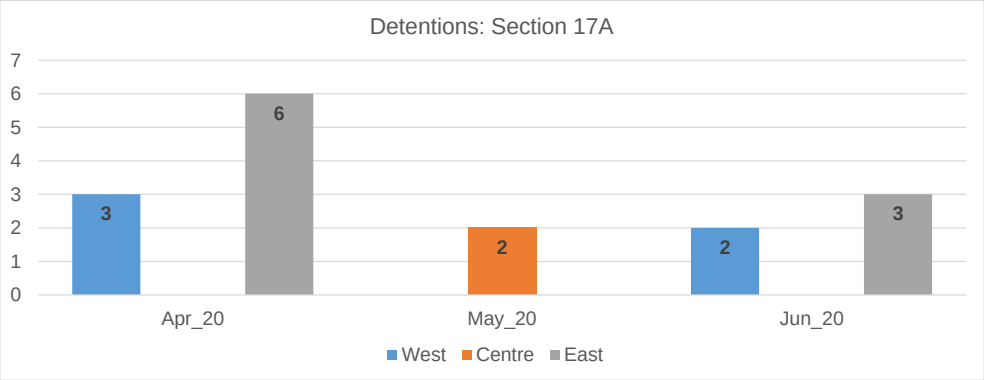
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

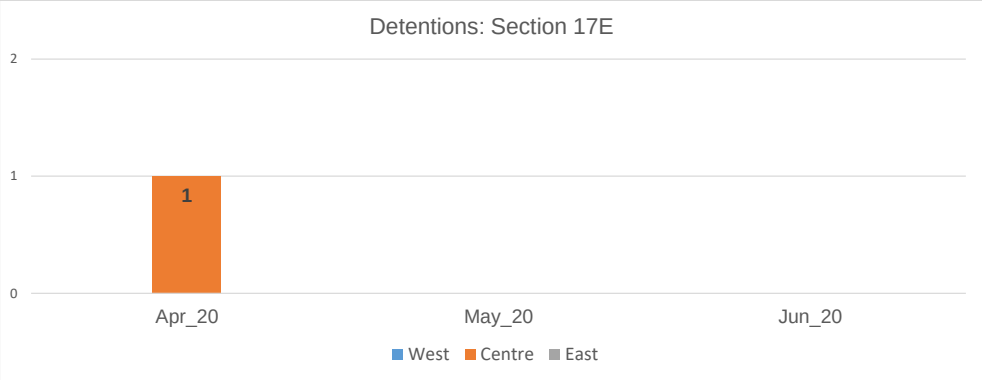
This quarter there was one under 18 made subject to a section 3 in an age appropriate setting. The trend for use of S3 and S2 are both on a downward trend.

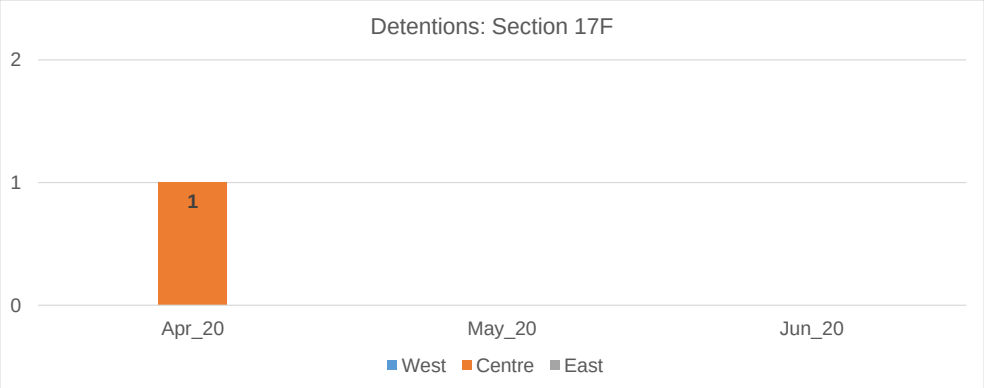
There were no exceptions to report this period.

Advisory Report - Section 17A - F

Section 17 A-F - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	5	2	↑	18	8	↑	19	1	East	9
								2	West	5
								3	Centre	4







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. Within this period there were no 17E or 17F activity.

The number of patients subject to a CTO at the end of June: West:15, Central: 8 and East: 6.

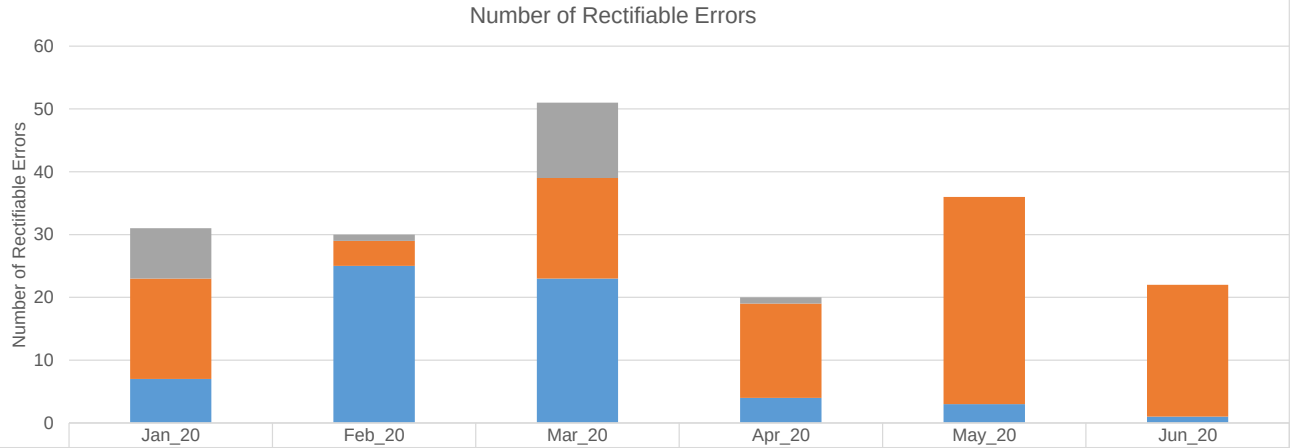
There has been a decrease in the West of patients subject to a CTO whilst the East has begun to increase.

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

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	22	37	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
80	114	↓	124	1	Centre	70
				2	West	9
				3	East	1



	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
East	8	1	12	1	0	0
Centre	16	4	16	15	33	21
West	7	25	23	4	3	1

Rectifiable Errors

The number of rectifiable errors for the last quarter has again decreased.

In relation to the other health boards throughout Wales due to the 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.

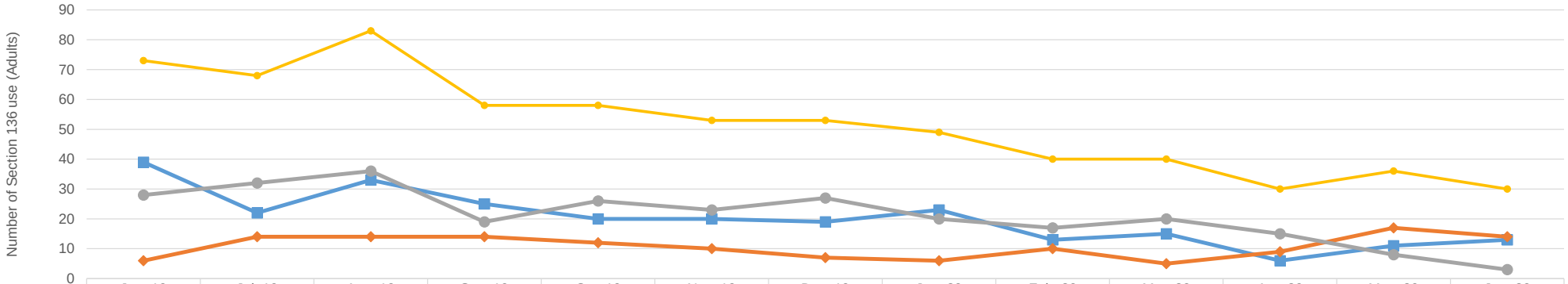
Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report.

This quarter there has been 2 x Section 5(2) deemed fundamentally defective rendering the section applications invalid.

This quarter there has been 5 lapsed Sections:- 1 x Section 5(2), 3 x Section 2 and 1 x CTO.

Advisory Report - Section 135 and 136

Section 135 - 136	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	30	36	↓	96	129	↓	150	1	Centre	40
								2	West	30
								3	East	26



	Jun_19	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	39	22	33	25	20	20	19	23	13	15	6	11	13
Centre	6	14	14	14	12	10	7	6	10	5	9	17	14
East	28	32	36	19	26	23	27	20	17	20	15	8	3
BCU	73	68	83	58	58	53	53	49	40	40	30	36	30

The data above does not include S135 or under 18's. The last quarter has seen a 25% decrease on the previous quarters figures.

There were no S135s this quarter.
There were no lapses of S136 detentions this quarter.
there were no persons noted to be in custody as their first place of safety.

One S136 12 hour extension was granted in June due to not being fit for assessment, resulting in the person being informally admitted to thier home area hospital.

Advisory Report - Section 135 and 136

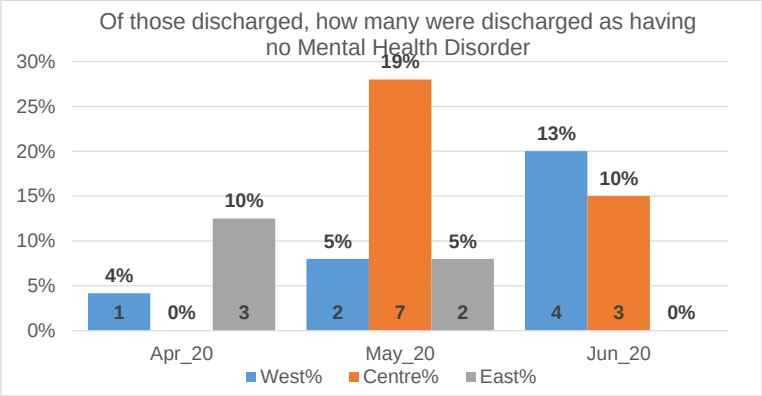
Section 136	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	30	36	↓	96	129	↓	150	1	Centre	40
								2	West	30
								3	East	26

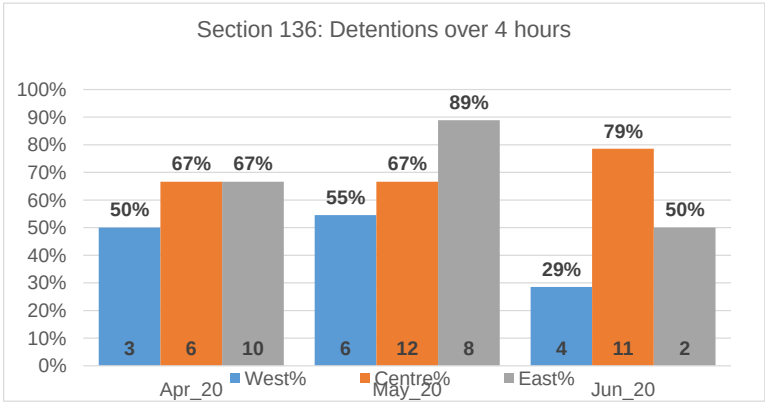
Section 136 Outcomes

	Apr 2020	May 2020	Jun 2020
Discharged:	24 77.42%	25 65.79%	20 62.50%
Informal Admission:	2 6.45%	3 7.89%	5 15.63%
Section 2:	5 16.13%	8 21.05%	7 21.88%
Section 3:	0 0.00%	2 5.26%	0 0.00%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Apr 2020	May 2020	Jun 2020
Yes	14	19	12
Yes (percentage)	66.67%	50.00%	37.50%





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 alone has decreased this quarter although it is regularly above 20%.

Total percentages for the months for those discharged with no mental disorder are:
April 14%
May 29%
June 23%

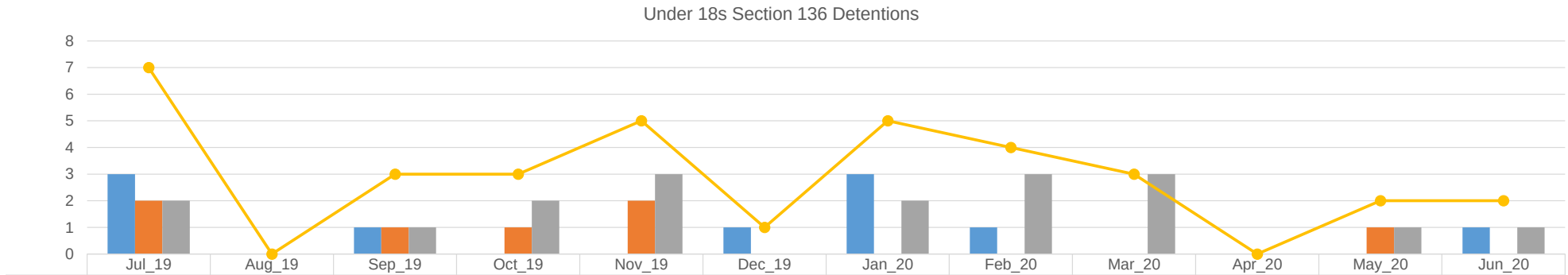
For additional persons discharged these are further broken down as below indicating those followed up by services or new referrals into services:

April 26% discharged with follow up and 38% referred to services.
May 3% discharged with follow up and 33% referred to services.
June 19% discharged with follow up and 21% 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 49 people did not end up on a S136 due to the CJLS intervention. This quarter accounts for 22 of those figures.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter		Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	2	2	→	4	12	↓	9	1	East	2
								2	Centre	1
								2	West	1



	Jul_19	Aug_19	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20
West	3	0	1	0	0	1	3	1	0	0	0	1
Centre	2	0	1	1	2	0	0	0	0	0	1	0
East	2	0	1	2	3	0	2	3	3	0	1	1
BCU	7	0	3	3	5	1	5	4	3	0	2	2

A total of four under 18's were assessed this quarter between the ages of 16 and 17 years. One assessment resulted in discharge with follow up to services, three resulted in admissions, one to NWAS under a section 2, one to an out of area bed under Section 2 and one remained in the S136 suite on a section 2 until an age appropriate bed was obtained in NWAS.

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	0
15	0
16	2
17	2

Outcome of Assessments

Outcome	Number
Returned Home	1
Returned to Care Facility	0
Admission to childrens ward	0
Admission to Adult ward / S136 suite	1
Admission NWAS/CAMHS	1
Admission OOA	1
Other (Friends, Hotel, B&B)	0

Advisory Report - Section 136: Under 18 Admissions

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
May	Ablett	Admission	CAMHS	5:30:00	16
May	Heddfan	Admission	CAMHS	23:00:00	16
June	Hergest	Discharged	CAMHS	01:45	17
June	Heddfan	Admission	CAMHS	21:20:00	17

Out of the 4 young persons assessed 3 originated from their own home.

3 out of the 4 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: 12:53 hrs this is an increase on the previous quarter figures of (10:03 hrs).

Under 18's admitted to Adult Psychiatric Wards

There was one admissions to Adult Psychiatric Wards this quarter from a S136. although the young person remained in the S136 suite whilst an age appropriate bed was sought for transfer.

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			
Flintshire	1	1	
Denbighshire	1		
Conwy			
Gwynedd			1
Ynys Mon			
Out of Area			

Advisory Report - Forensic

Section	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	1	1	1	1	1	1	1	1	1	1	0	0
Section 37/41:	11	11	11	11	11	12	12	12	12	9	9	9
Section 38:	0	0	0	0	0	0	0	0	0	0	1	1
Section 47:	4	3	3	3	3	3	3	4	4	2	2	2
Section 47/49:	5	5	5	4	4	4	4	4	4	2	2	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	0	1	1	1	1	0	0	0	0	0
Section 3:	1	1	2	2	2	2	2	2	2	2	2	2
Section 45A	0	0	0	1	1	0	0	1	1	1	1	1
Total:	22	21	22	23	23	23	23	24	24	17	17	18

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

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

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

Advisory Report - Transfers

Total Transfers for the Quarter

	Apr 2020	May 2020	Jun 2020
Internal Transfers	26	25	25
External Transfers (Total)	13	4	5
External Transfers (In)	0	2	3
External Transfers (Out)	13	2	2

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.

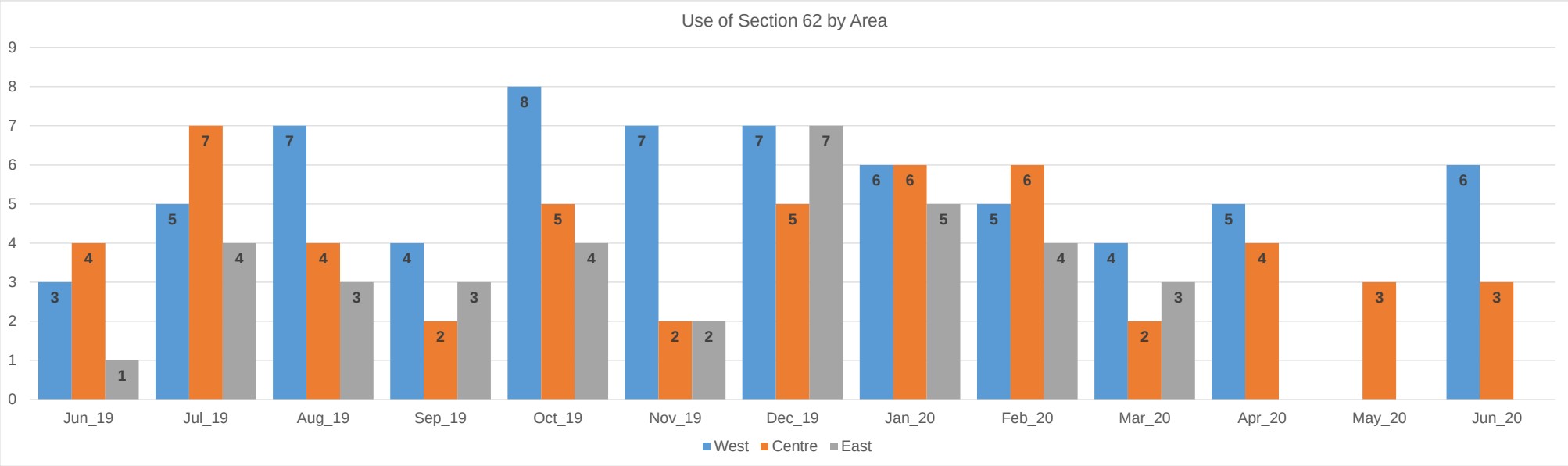
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised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

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

Month	Transfers In
Jun_20	Tegid, Ablett (Wrexham)
Jun_20	Coed Du Hall (Ynys Mon)
Jun_20	HMP Berwyn (Wrexham)
May_20	Millbrook, Nottingham (Gwynedd)
May_20	HMP Swansea (Powys)

Month	Transfers Out
Apr_20	Ty Catrin, Cardiff (Conwy)
Apr_20	HMP Featherstone (Wrexham)
Apr_20	Ty Grosvenor (Flintshire)
Apr_20	Ty Grosvenor (Wrexham)
Apr_20	Ty Catrin, Cardiff (Denbighshire)
Apr_20	Coed Du, Mold (Conwy)
Apr_20	Coed Du, Mold (Denbighshire)
Apr_20	Coed Du, Mold (Wrexham)
Apr_20	Coed Du, Mold (Ynys Mon)
Apr_20	Delfryn House, Mold (Flintshire)
Apr_20	Coed Du Hall Hospital (Wrexham)
Apr_20	John Moore Hospital, Staffordshire (Flintshire)
Apr_20	Delfryn House (Wrexham)
May_20	St Marys Hospital (Gwynedd)
Jun_20	Ty Grosvenor (Wrexham)
Jun_20	Stafford (Flintshire)
May_20	Stafford (Flintshire)

Advisory Report - Section 62



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

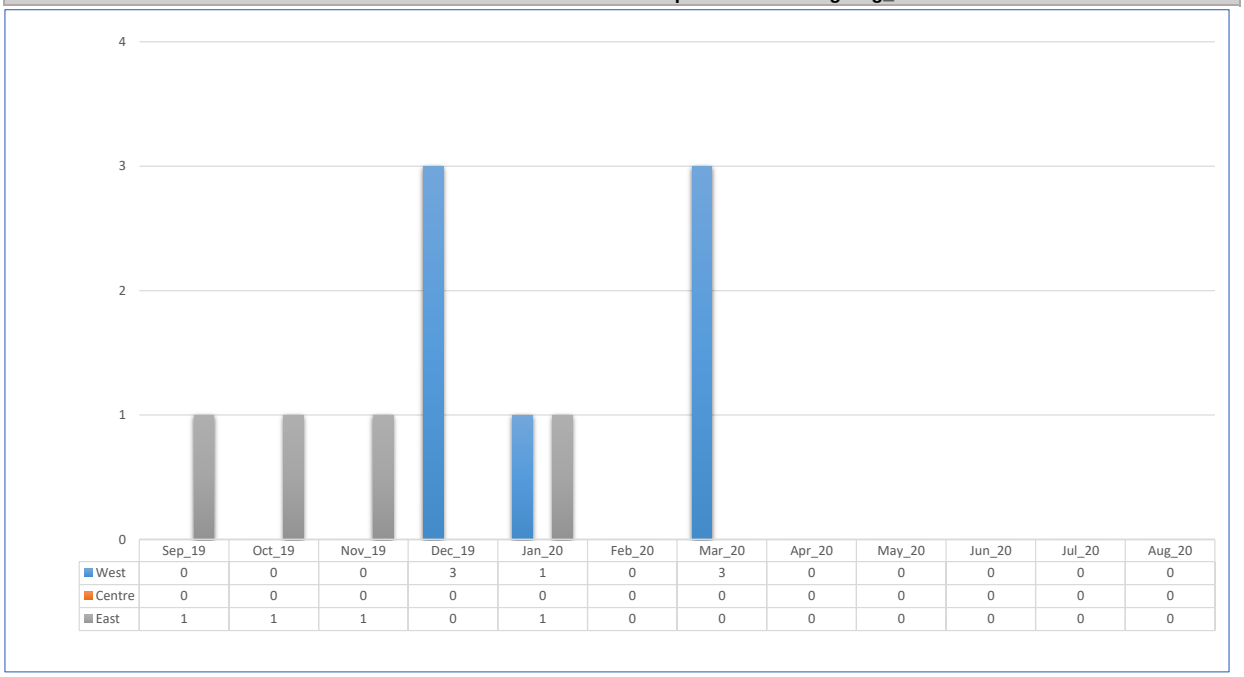
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

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

Data Source:	BCUHB MHA Database
Report Created on:	04/09/2020
Report Created by:	Performance Directorate

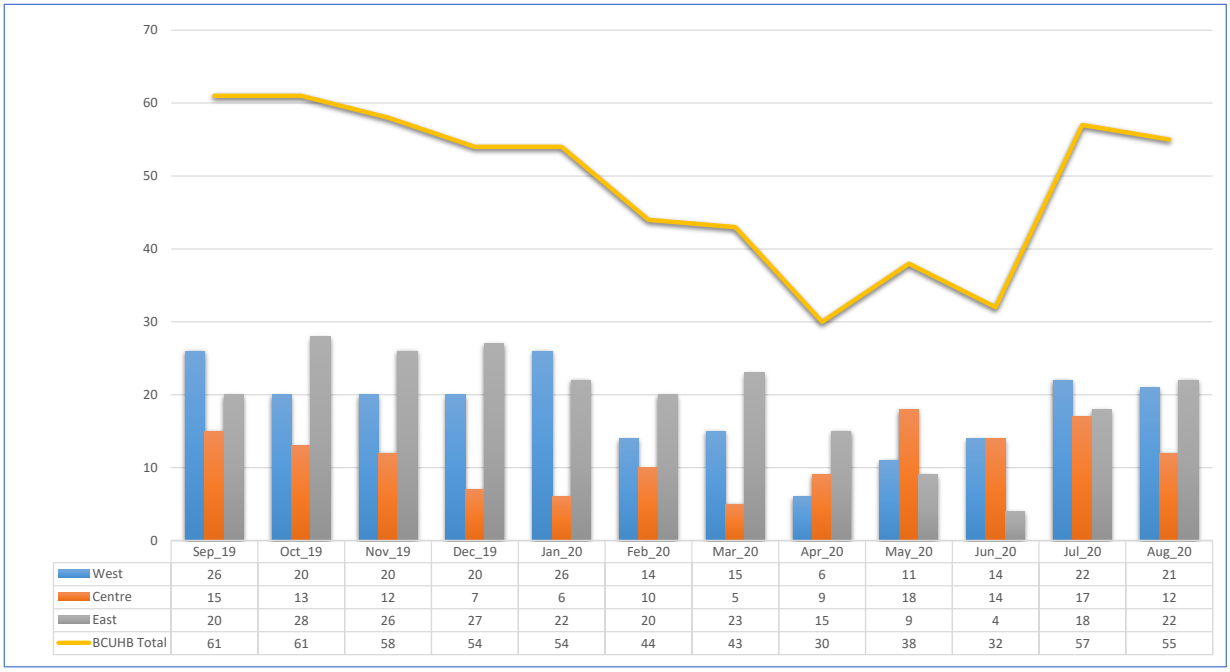
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Aug_20



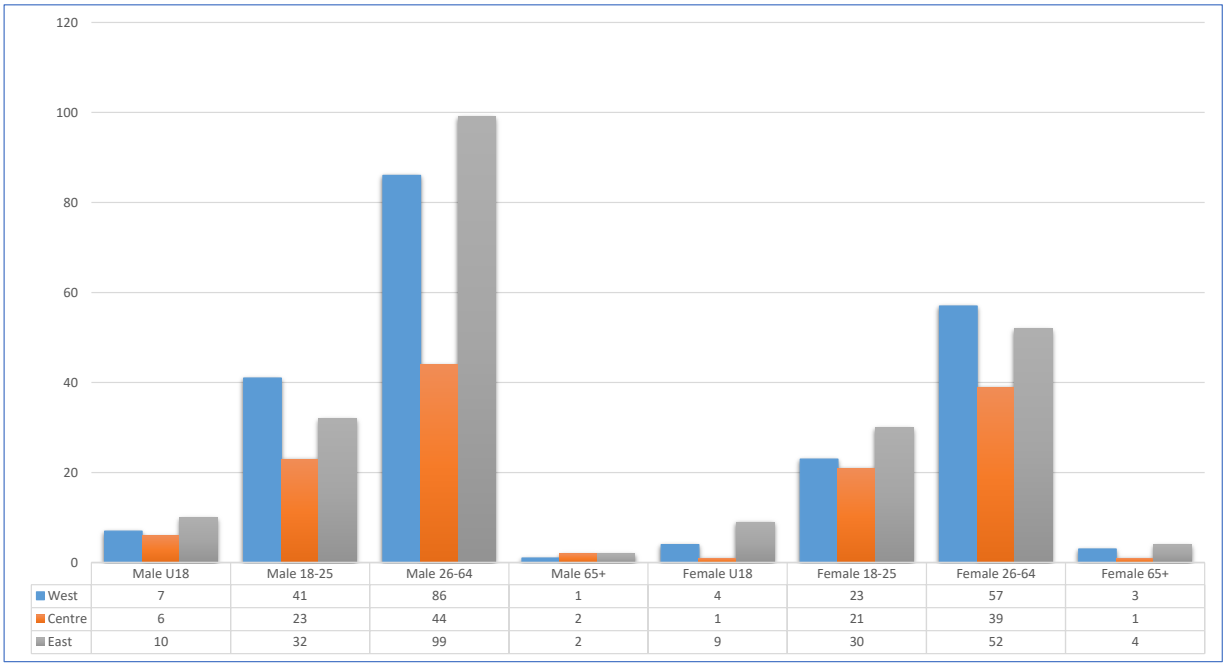
	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	0	0	0	3	1	0	3	0	0	0	0	0
Centre	0	0	0	0	0	0	0	0	0	0	0	0
East	1	1	1	0	1	0	0	0	0	0	0	0

2.1: Section 136 twelve month trend up to and including Aug_20



	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	26	20	20	20	26	14	15	6	11	14	22	21
Centre	15	13	12	7	6	10	5	9	18	14	17	12
East	20	28	26	27	22	20	23	15	9	4	18	22
BCUHB Total	61	61	58	54	54	44	43	30	38	32	57	55

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



4: 1st Place of Safety 12 month trend up to and including Aug_20

Area Split - 1st Place of Safety by category

	Aug_20			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	4	1	1	39	32	38
Ward	0	0	0	1	0	1
PICU	0	0	0	0	0	0
136 Suite	16	11	20	164	106	183
Hospital	0	0	0	3	0	3
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	1	0	1	7	0	5
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	0	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	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	9	3	4	3	5	2	2	0	3	2	2	4
Centre	2	4	2	2	1	1	2	3	4	5	5	1
East	3	3	5	5	6	3	8	0	1	0	3	1

1st Place of Safety: 136 Suite Split	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	17	14	14	15	20	12	13	6	7	12	18	16
Centre	13	9	10	5	5	9	3	6	14	9	12	11
East	16	23	17	22	15	16	13	14	8	4	15	20

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

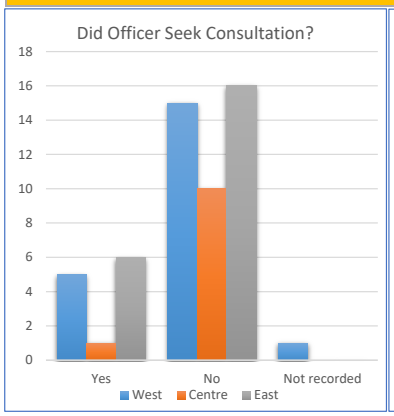
5.1: Area split 3 month table up to and including Aug_20 and latest 12 month total

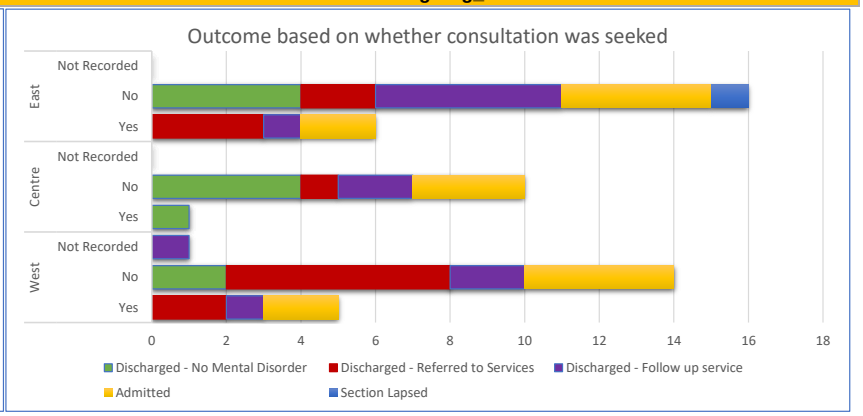
West	Jun_20	Jul_20	Aug_20	**12 Month Total**	**Centre**	Jun_20	Jul_20	Aug_20	**12 Month Total**	**East**	Jun_20	Jul_20	Aug_20	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	2	5	3	**26**	Ynys Mon	1	0	1	**3**	Ynys Mon	0	0	1	**4**	Ynys Mon	**4.70**
Gwynedd	6	6	5	**79**	Gwynedd	0	0	0	**7**	Gwynedd	0	0	0	**5**	Gwynedd	**7.36**
Flintshire	2	2	4	**25**	Flintshire	4	2	1	**17**	Flintshire	2	8	9	**63**	Flintshire	**6.78**
Wrexham	1	3	0	**15**	Wrexham	5	5	4	**35**	Wrexham	2	9	9	**148**	Wrexham	**14.23**
Conwy	1	2	6	**46**	Conwy	2	2	2	**30**	Conwy	0	1	1	**6**	Conwy	**7.02**
Denbighshire	1	2	2	**13**	Denbighshire	2	8	2	**44**	Denbighshire	0	0	2	**7**	Denbighshire	**6.70**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	1	**4**	OOA	0	0	0	**0**	OOA	0	0	0	**0**	OOA	**#N/A**
Incident Rate per 10,000 population	0.67	1.03	1.08	**10.73**	Incident Rate per 10,000 population	0.66	0.80	0.47	**6.40**	Incident Rate per 10,000 population	0.14	0.61	0.75	**7.92**	BCUHB	**8.24**

***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

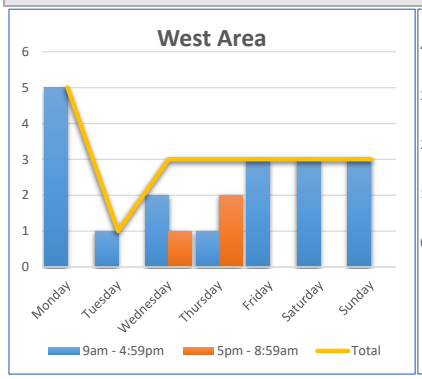
Section B: 12 Month Data for Aug_20

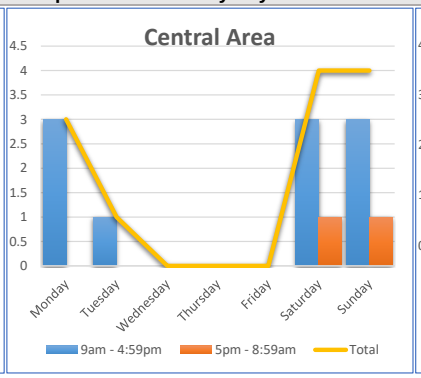
6.1: Consultations and Outcomes all areas during Aug_20

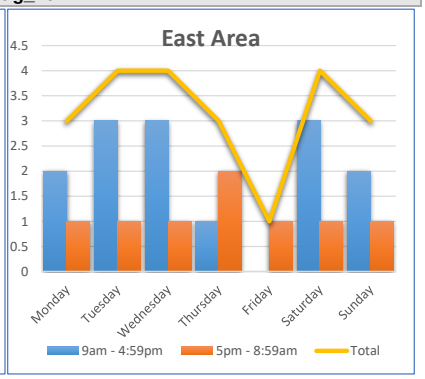




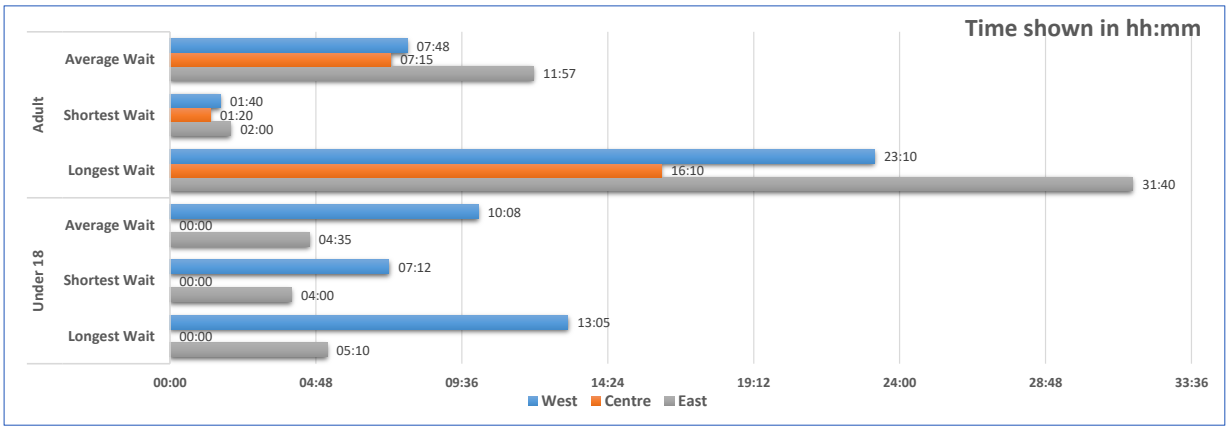
7.1: Area split of S.136 use by Day and Time for Aug_20



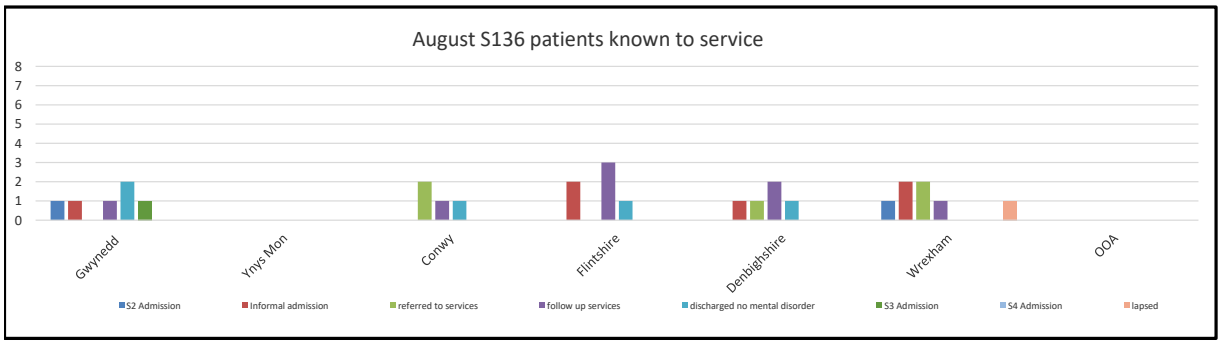




8.1: Duration in S.136 Suite for Aug_20



Within this month there was one S136 detention that required an extension due to the person not being fit for assessment this resulted in a discharge with referral to services. One person also left the S136 suite and was not returned by the Police Datix Ref INC235129



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 55 S136 detentions 17 people were not seen within the closest S136 suite.

9 were due to no capacity 8 did not have the reasons recorded.

Local Authority Originates from	Detained in	S136 Suite assessed at
OOA	Flintshire	Hergest
Conwy	Denbighshire	Hergest
Denbighshire x 2	Denbighshire x 2	Hergest x 1 Heddfan x 1
Wrexham	Flintshire	Hergest
Flintshire x 3	Flintshire x 3	Hergest x 2 Ablett x 1
Denbighshire	Conwy	Hergest
OOA	Wrexham	Ablett
Ynys Mon x 2	Ynys Mon x 2	Ablett x 1 Heddfan x 1
Wrexham x 3	Wrexham x 3	Ablett
Gwynedd	Denbighshire	Heddfan
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 August the Mental Health Act Office has received notification that there have been seven instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

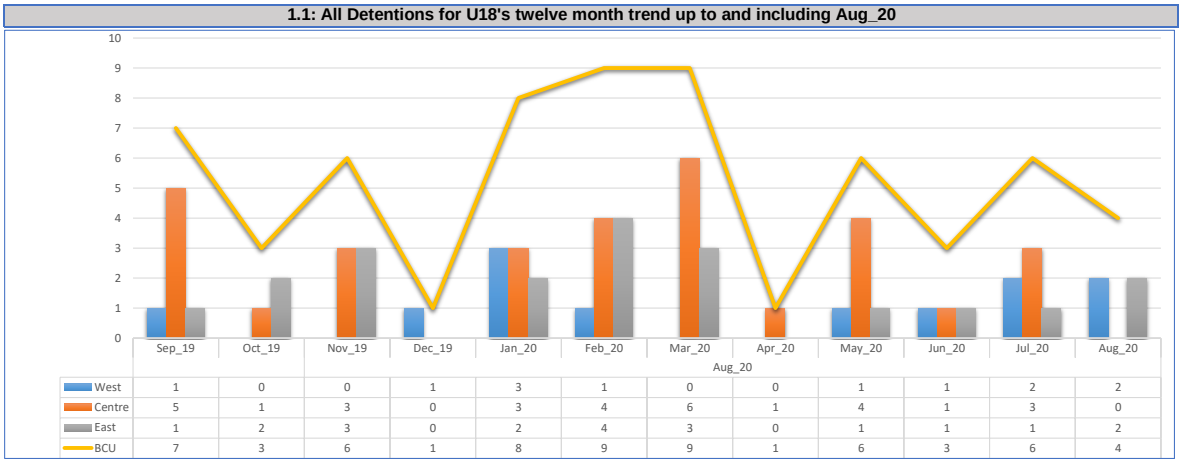
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

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

Data Source:	BCUHB MHA Database
Report Created on:	03/09/2020
Report Created by:	Performance Directorate

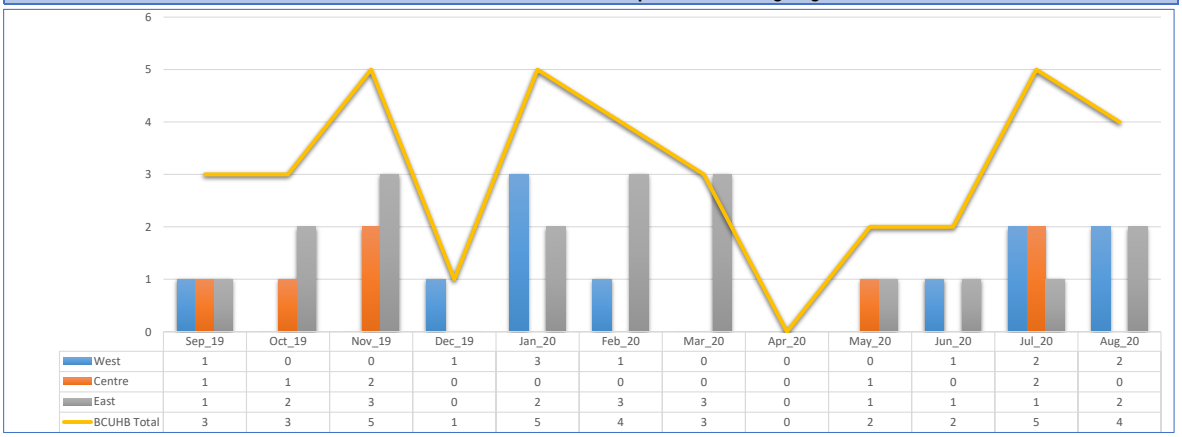
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Aug_20



	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	1	0	0	1	3	1	0	0	1	1	2	2
Centre	5	1	3	0	3	4	6	1	4	1	3	0
East	1	2	3	0	2	4	3	0	1	1	1	2
BCU	7	3	6	1	8	9	9	1	6	3	6	4

2.1: Section 136 twelve month trend up to and including Aug_20

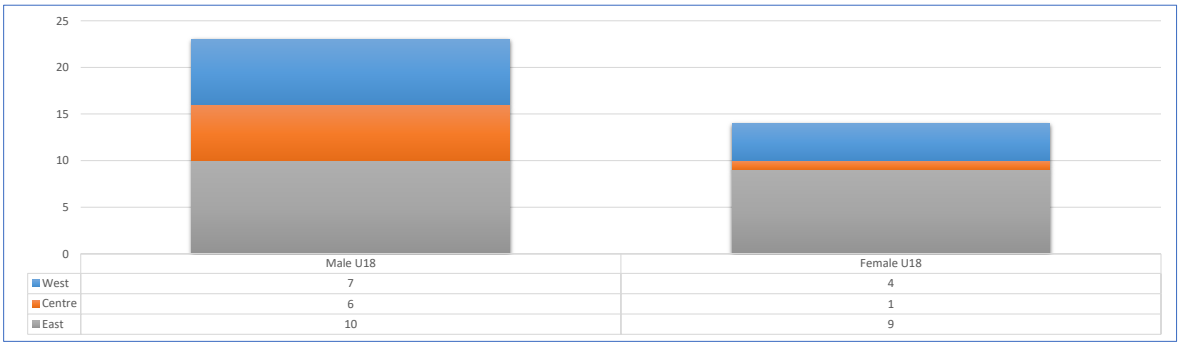


	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	1	0	0	1	3	1	0	0	0	1	2	2
Centre	1	1	2	0	0	0	0	0	1	0	2	0
East	1	2	3	0	2	3	3	0	1	1	1	2
BCUHB Total	3	3	5	1	5	4	3	0	2	2	5	4

2.2: Section 136 Outcomes twelve month trend up to and including Aug_20

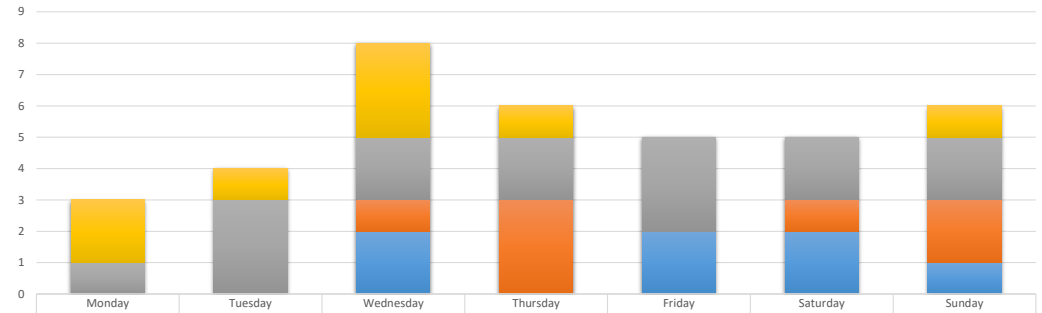
Outcome of 136 detention	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
Discharged - No Mental Disorder	0	0	2	0	1	0	1	0	0	0	0	0
Discharged - Referred to Services	0	2	0	0	0	0	0	0	0	0	3	1
Discharged - Follow up service	3	0	1	1	3	3	1	0	0	1	2	2
Admitted	0	1	2	0	1	1	1	0	2	1	0	1
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	7	4
Centre	6	1
East	10	9

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

4: 1st Place of Safety 12 month trend up to and including Aug_20

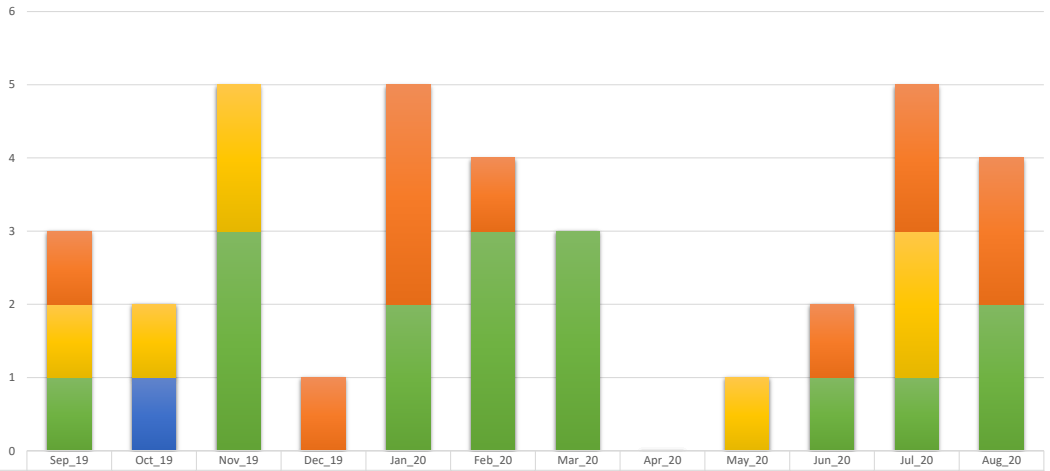
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
A&E	1	0	1	1	1	0	0	0	1	0	0	2
Ward	0	1	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	2	2	3	0	4	4	3	0	1	2	5	2
Hospital	0	0	1	0	0	0	0	0	0	0	0	0
Independent Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0	0	0	0	0	0	0
Police Station (Custod)	0	0	0	0	0	0	0	0	0	0	0	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0	0	0	0	0	0	0
Any other place	0	0	0	0	0	0	0	0	0	0	0	0

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

1st Place of Safety: A&E Split	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West	1	0	0	1	0	0	0	0	0	0	0	2
Centre	0	0	1	0	0	0	0	0	1	0	0	0
East	0	0	0	0	1	0	0	0	0	0	0	0

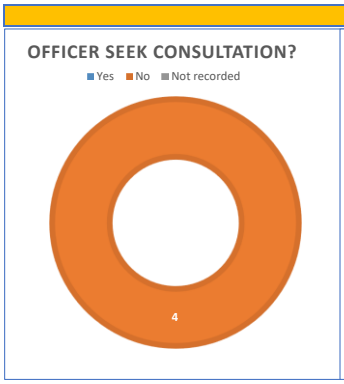
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Aug_20

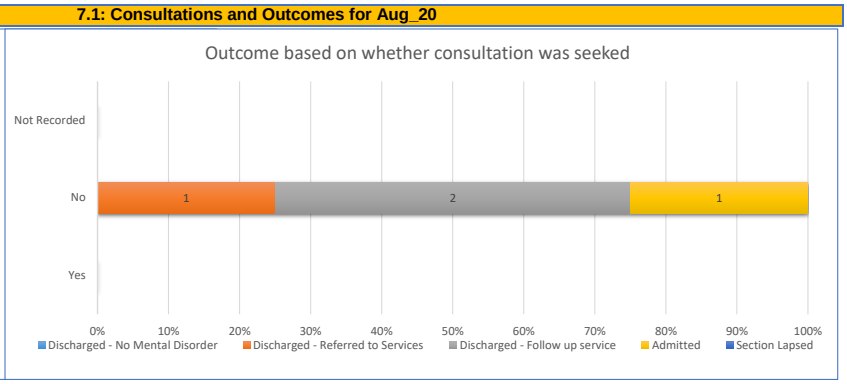


	Sep_19	Oct_19	Nov_19	Dec_19	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20
West Police	1	0	0	1	3	1	0	0	0	1	2	2
Centre Police	1	1	2	0	0	0	0	0	1	0	2	0
East Police	1	0	3	0	2	3	3	0	0	1	1	2
West Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	1	0	0	0	0	0	0	0	0	0	0

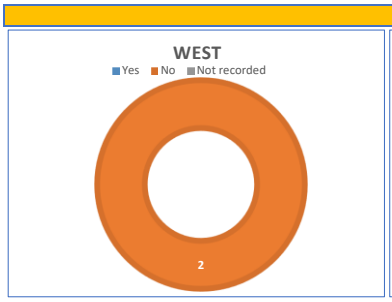
Section B: Data for Aug_20

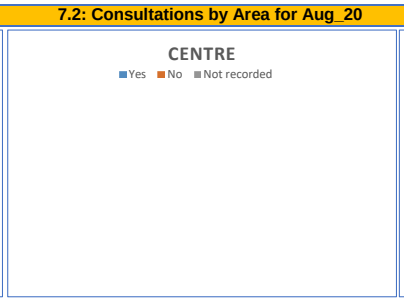
7.1: Consultations and Outcomes for Aug_20

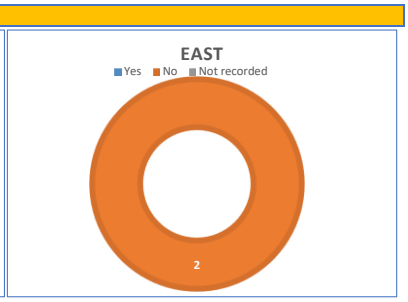




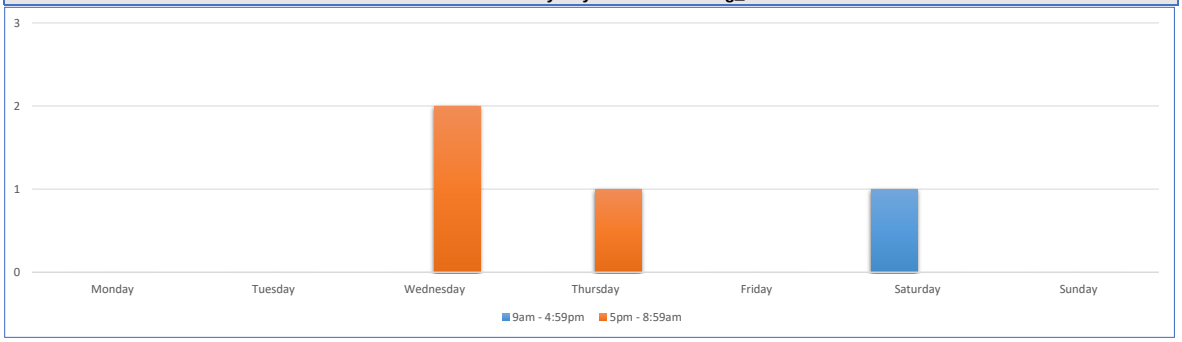
7.2: Consultations by Area for Aug_20



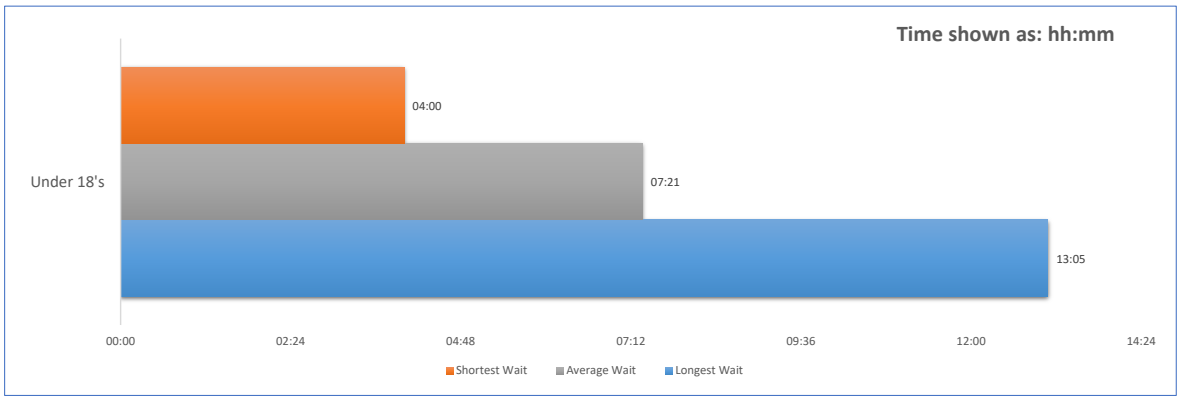




8.1: S.136 use by Day and Time for Aug_20

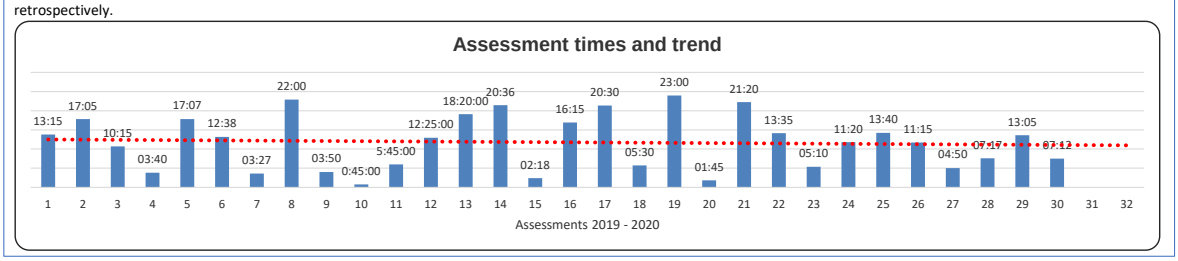


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Aug_20



10.1: Narrative for Aug_20

Following the S136 assessments there were no admissions under a section this month, one young person was admitted to a childrens ward.
All assessments were conducted by a CAMHS Consultant.
The chart below details the length of time that the young person was detained under a S136 and a trend line for the last 30 detentions.
The S136 clinical pathway has been updated to ensure that Safeguarding are made aware of a young person under a S136 detention at the time rather than this being reported retrospectively.



GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 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 5 October 2020.

Argymhelliad / Recommendation:

To note the arrangements for 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. Arrangements for Approval of Approved Clinicians in Wales

Since the inception of the new Approved Clinician approval process in July 2018, nine portfolios have been received by the Approvals Team. Three portfolio applications have been approved, two portfolios are currently with the Panel for scrutiny. Panel assessment meetings took place on 28th August 2020 and 1st September 2020. Both applicants have been requested to submit additional evidence. Two portfolios have been returned to the applicants for further information prior to being submitted to the Panel. Two portfolios are being scrutinised by the Approval Team to consider whether they are complete prior to submission to the Panel for assessment.

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

The June Induction and Refresher training took place via Webinar and received excellent feedback. The next induction and refresher training will take place in September 2020 via Webinar also. Training is arranged for November 2020 and February 2021. 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.

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

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

In that exceptional circumstance, the Approving Board may draw on a temporary variation to the re-approval requirement for refresher training to have been undertaken in the two years prior to an application for re-approval, during the pandemic period.

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

30 November 2019 – 5 October 2020

New Applications Received	**27**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	2
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	24
Number of ACs already approved in England	12
12	
Number of applications with panel (including portfolios)	3
Number of applications not approved	0
Re-approval Applications Received (5 Yearly)	**54**
Number of applications with panel	5
Number of applications pending awaiting further evidence	2
Number of applications approved	49
Number of applications not approved	0
Number of ACs reinstated	7
Number of re-approvals which have come to an end	**19**
Expired	8
Retirement	3
No longer working in Wales	7
No longer registered with professional body	0
AC requested	1
Registered without a licence to practise	0
Awaiting CCT	0
Total Number of Approved Clinicians	**379**
Total Number of Approved Clinicians from previous report	**367**

APPENDIX 2

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

30 November 2019 – 5th October 2020

New Applications Received	**25**
Applications from GPs	3
Applications from Psychiatrists	22
Application from Forensic Medical Examiner	0
Number of Applications Approved	24
Number of Applications Not Approved	0
Number of Applications with Panel	1
Re-approval Applications (5 years)	**16**
Applications from GPs	5
Applications from Psychiatrists	11
Applications from Forensic Medical Examiners	0
Number of Applications Approved	16
Number of Applications Not Approved	0
Number of Applications with Panel	0
Transferred from AC register	**0**
Number of Approvals which have come to an end:	**26**
Expired	4
Become an Approved Clinician	11
No longer working in Wales	4
No longer registered	1
Registered without a licence to practise	0
Retired	2
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	**159**

APPENDIX 3

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

As at 5th October 2020

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	5	0	0	2	3	**13 (+2 increase from previous report)**
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

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **19th October 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Healthcare Inspectorate Wales (HIW) Monitoring Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	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 QSE Divisional Directors Meeting
Atodiadau **Appendices:**	Appendix 1 – Inspections Appendix 2 – Ty Llywelyn HIW report

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick one as appropriate

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

Sefyllfa / Situation:

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.

Cefndir / Background:

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

- 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.

This report provides assurance that following inspections and recommendations that these actions are followed up.

Asesiad / Assessment & Analysis
Strategy Implications The Health Boards Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is will be around Quality of patient experience, delivery of safe and effective care and quality of management and leadership. **Financial Implications** Issues highlighted by HIW may have financial implications in regards to the environment. 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 within the area QSE meetings on a monthly basis. Policies –Policies are an ongoing project that requires 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 personal, this is reported on monthly to the MHLD QSE meeting and reported up to the Health Board QSG and 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 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 Heddfan Unit Wrexham Maelor NEW

Inspection Date: 7th & 8th July 2020

Publication of report due: TBC

The visit to Heddfan was not to focus on specifics of the Mental Health Act although the informal feedback has not raised any issues in regards to the use of legislation. Once the report is published if there is any reference to the Mental Health Act and the Mental Health Measure this will be detailed within this report.

2 Ty Llywelyn Medium Secure Unit UPDATE

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 assurance 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	All Complete February 2020

	is located in the patient's notes.	
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 are submitted in a timely manner.	MHA administrator attends the weekly planning meeting and 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.	Complete 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

2 Ty Derbyn CMHT Review

Inspection Date: 15th & 16th October 2019

Publication of report: 7th February 2020

Initial verbal feedback received from the inspection was positive. No immediate concerns were identified and no immediate assurance required.

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

During the visit a longstanding CTO was found to be invalid due to the initial S3 being completed incorrectly. The documents had progressed through a number of scrutiny avenues. Staff have been informed and actions have already been completed to ensure no repetition.

Improvement Needed	Service Action	Timescale
The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed.	Ensure that the process in place to scrutinise and check Mental Health Act papers is followed.	Complete
	Ensure that all staff are up to date with their Mental Health Act mandatory training.	March 2020
	Ensure that staff utilise the expertise of the Approved Mental Health Practitioner Team that is co-located in the CMHT and also that of the Mental Health Act Team.	Complete

3 Cefni Hospital

Inspection Date: 16-18 September 2019

Publication of report due: 19th December 2019

The summary of the report found that Cefni Hospital provided safe and effective care. Upholding patients' rights and supported them to be as independent as possible. Good team working was noted and it was found that staff were committed to providing patient care to high standards.

It was noted within the report that the service did well in staff engagement, patient and family involvement, person centred and holistic approaches to planning and provision of care, Mental Health Act compliance, multidisciplinary team working and management overview, governance, auditing and reporting.

Service improvements were aligned to staff recruitment, use of bed bays, mandatory training and formalising management structure which was underway.

In relation to the Mental Health Act and Mental Health Wales Measure the inspection found that records were generally well maintained and care planning was comprehensive with good risk management in evidence all statutory detention documentation was complaint with the requirements of the Mental

Health Act. The quality of the care plans and clinical records were noted to be of a high standard.

There were no actions cited in relation to the Mental Health Act or the Mental Health Wales Measure.

Appendix 2

Ty Llywelyn HIW full report.

Ty LLywelyn Inspection Report.p **(Please see Appendix 2 also separately attached).**

Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Ty Llywelyn

Branwen, Gwion & Pwyll

Betsi Cadwaladr University Health Board

Inspection date: 27 – 29 January 2020

Publication date: 16 June 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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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 mental health inspection of Ty Llywelyn within Betsi Cadwaladr University Health Board on the evening of 27 January 2020 and following days of 28 and 29 January 2020. The following sites and wards were visited during this inspection:

- Gwion – Medium Secure Psychiatric Intensive Care Unit
- Pwyll – Medium Secure Acute Ward
- Branwen – Medium Secure Rehabilitation Ward

Our team, for the inspection comprised of two HIW inspectors and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by one of the HIW Inspectors.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

HIW previously inspected Ty Llywelyn in December 2016.

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. We observed that staff interacted with patients respectfully throughout the inspection.

There was clear leadership for the service and evidence of service development plans.

Patients had good access to a range of occupational therapy activities within the hospital and community.

We identified some improvements required in relation to medicines management.

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients were provided with a good range of therapies and activities
- Care plans were individualised and focused on patient rehabilitation
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Provision of information for patients
- Safe and effective medicines management
- Recordkeeping arrangements.

3. What we found

Background of the service

Ty Llewelyn provides NHS medium secure mental health services at Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, Conwy LL33 0HH within Betsi Cadwaladr University Health Board.

The service has three male wards:

- Gwion, a five bed Medium Secure Psychiatric Intensive Care Unit
- Pwyll, a ten bed Medium Secure Acute Ward
- Branwen, a ten bed Medium Secure Rehabilitation Ward

At the time of inspection, there were 23 patients at the hospital.

The service employees a staff team which includes a service manager, three ward managers who are supported by deputy ward managers and a team of registered nurses and healthcare assistants.

The multidisciplinary team included three psychiatrists, an occupational therapy team and a psychology team of two psychologists and a psychology assistant as well as long term student placements. The Forensic Community Team was also located at Ty Llywelyn who worked collaboratively with the wards, this included two social workers, a registered nurse and two healthcare assistants. The service can refer to other health board services as required.

The operation of the hospital is supported by a team of administration staff. The hospital employs a team of domestic and catering staff. The hospital is supported by the management and organisational structures of Betsi Cadwaladr University Health Board.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed that staff interacted and engaged with patients appropriately and treated patients with dignity and respect.

There were a range of suitable activities and therapies available at Ty Llywelyn and accessed within the community. These provided patients with recovery and rehabilitation opportunities.

A range of information was available for patients, however this needs to be displayed consistently across the hospital.

Staying healthy

There was strong emphasis at the hospital to provide patients with a wide range of activities to help support their independence and aid recovery.

Each patient had a plan of therapies and activities. Input from the occupational therapy team provided an appropriate range of assessments and activities, within the hospital and the community. We observed patients to be regularly engaged in activities and therapies, on the wards, around the hospital and accessing the community.

The hospital exercise facilities included a gym with cardo-exercise machines and free-weights, a sports hall that was used for sports such as football and badminton. In additional, the hospital was set within large grounds that enabled patients to use these for exercise, which included the twice weekly morning mile, a positive initiative where patients and staff would work a mile around the

grounds. There were also some patients participating in the couch to 5k well-being initiative[1].

From each ward patients had direct access to an enclosed garden area so that they could regularly access fresh air. However, Gwion and Pwyll shared the same garden area and therefore there were set times when each ward had access to the area. During the inspection senior managers shared service development plans that included extension of hospital facilities that would not only provide further on-ward therapeutic spaces but also enable each ward to have its own garden area. These developments sounded positive and would provide additional therapeutic facilities to aid rehabilitative care for patients at the hospital.

There was arts and craft facilities at the hospital and a woodwork room. Each ward had an Activities of Daily Living[2] (ADL) kitchen which enables patients to learn and maintain cookery skills whilst in hospital. However, at the time of the inspection staff and patients informed us that the use of these had reduced,as there was no policy in place to support staff with the use of the ADL kitchens. Adraft policy is now in place, which the health board must ensure ratified to enable patients to access these valuable facilities as part of their rehabilitative care. The freezer on Gwion was out of order and awaiting replacement, we were informed that this was due imminently.

Each ward also had laundry facilities which could be used by patients to learn and maintain skills as part of ADL activities. However, at the time of the inspection the tumble drier on Gwion was out of order as was the washing machine on Pwyll. We were informed that both these appliances had only recently become unavailable and that a work request was being processed to repair or replace these appliances. There were appropriate arrangements in place to ensure that patients could still use laundry facilities whilst minimising inconvenience.

---

[1] A programme of exercise of increasing increments of activity with the aim for the person to be able to complete 5km run/walk https://www.nhs.uk/LiveWell/c25k/Pages/couch-to-5k.aspx

[2] These activities can include everyday tasks such as dressing, self-feeding, bathing, laundry, and meal preparation

Improvement needed

The health board must:

- Update HIW on the additional therapeutic space
- Ensure a ratified policy is in place to support the use of the ADL kitchens
- Ensure that all non-working appliances are repaired or replaced in a timely manner.

Dignified care

We noted that all employees; ward staff, senior management and administration 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.

We observed staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients. The patients we spoke with were complimentary about the staff engagement and the care that was provided at the hospital.

Each patient had their own bedroom that provided patients with a good standard of privacy. There was one bedroom on each ward that had en-suite facilities, however at the time of the inspection the en-suites were out of use to support the safety of patients whilst awaiting the completion of anti-ligature work. It was explained that work was due to be completed but unfortunately there had been delays with the external contractors which was out of the control of the health board. We were informed that this work would be completed within the coming months.

We observed a number of patient bedrooms, it was evident that patients were able to personalise their rooms and that there was sufficient storage for their possessions. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and orderly on each of the wards and patients could request access to them when needed.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There were visiting arrangements in place for

patients to meet visitors at the hospital, this included facilities to support child-visiting arrangements.

There was no internet/Wi-Fi access at Ty Llywelyn. It is acknowledged that there can be risks to the protection of patients and other persons with unrestricted access to the internet and associated communication technologies. However, risk should be based on individual patient basis and the use of the internet and communication technologies can be used to support patients with appropriate contact with family and friends. The health board can also use access to the internet to educate patients in staying safe whilst online and building skills to use the internet as part of their rehabilitative care.

Improvement needed

The health board must:

- Ensure that the anti-ligature works are completed to reinstate the en-suite facilities.
- Consider how to provide appropriate access to Wi-Fi at Ty Llywelyn.

Patient information

There was a range of information for patients displayed at the hospital.

Information was displayed on how patients and their families can provide feedback about their experiences of the care provided on the wards; this included how to raise a concern through the NHS Wales Putting Things Right[3] arrangements. There was also information displayed regarding advocacy arrangements.

Information was also displayed in some ward areas to promote well-being and healthy lifestyles, such as healthy eating and smoking cessation.

[3] Putting Things Right is the process for managing concerns in NHS Wales. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

However, the range of information was not consistently displayed across all ward areas, and therefore not visible for all patients. There was also no information available on the role of HIW and how patients can contact us.

Improvement needed

The health board must ensure that each ward area displays information about:

- NHS Wales Putting Things Right
- Advocacy arrangements
- Well-being and healthy lifestyles
- The role of HIW and how patients can contact us.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

There was a daily morning meeting on each ward where staff arranged the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals and medical appointments.

The hospital had a regular patient forum where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns.

There was a positive initiative “Together for Recovery” which included the advocacy service, patients and their families, to discuss the service and future developments with members of the hospital and health board.

Individual care

Planning care to promote independence

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

Each patient had their own individual weekly activity planner, this included individual and group sessions, based within the hospital and the community.

As detailed above, the activities were varied and focused on recovery, either at the hospital or in the community. Individual patient activity participation was monitored and audited. Where patients declined, we observed staff offering alternatives; this was recorded in the patient record.

People's rights

Staff practices aligned to established hospital policies and systems ensured that the patients' equality, diversity and rights were maintained.

Legal documentation to detain patients under the Mental Health Act (the Act) was compliant with the legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code).

As detailed earlier, there were suitable rooms where patients could meet with visitors. Patients were also able to use telephone to contact family, friends and professionals. As also stated, improvements could be made to support patients, based on individualised risk assessments, in the use of internet technology to support external contact whilst at the hospital.

The hospital had submitted a capital funding bid to develop the reception area to meet national medium secure standards and therefore enhance patient and visitor experience. The proposed improvements would aid the hospital safety arrangements for patients, staff and visitors. In addition providing disabled toilet facilities that were not present within the reception area.

Improvement needed

The health board must provide an update on the redevelopment of the Ty Llywelyn reception area.

Listening and learning from feedback

As detailed earlier, the health board had arrangements in place for patients and their families to provide feedback about their experiences and to raise a concern.

Governance documentation evidenced how this information was monitored and reviewed, in addition how learning from feedback could be shared across the health board's services.

Delivery of safe and effective care

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

The hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk and health and safety. This enabled staff to provided safe and clinically effective care for patients. However, improvements are required with the storage of medication at the hospital.

Safe care

Managing risk and promoting health and safety

Ty Llywelyn had established processes in place to manage and review risks and to maintain health and safety at the hospital. These supported staff to provide safe and clinically effective care.

Access to the hospital was direct from the hospital car park and street, this provided suitable access for people who may have mobility difficulties. Visitors were required to enter the hospital via a reception area and intercom system. This helps to deter unauthorised persons from entering the building. Access through the hospital was restricted to maintain the safety of patients, staff and visitors, this included the controlled egress from each ward. As stated earlier, there were plans in place to improve the reception facilities for the benefit of patients, staff and visitors.

Staff wore personal alarms which they could use to call for assistance when necessary. We observed on a number of occasions that when alarms were activated staff attended promptly. There were also nurse call points around the hospital and within patient bedrooms that were within reach of the beds, this ensure patients can summon assistance if required, an improvement since our previous inspection.

On the whole the hospital was well maintained and suitably furnished. However, apart from the non-working appliances detailed earlier, there were also some torn seating on Pwyll; this poses potential infection control and safety risks.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There was a ligature point risk assessment in place, this identified potential ligature points and what action had been taken to remove or manage these. At the time of the inspection there were some ligature points remaining that had been identified to be removed, in the meantime, these risks were managed by monitoring the areas with staff. This however does impact upon the freedom of movement of patients on the ward, who are reliant on staff to be able to observe these areas. Addressing these ligature points would be a benefit to the patient experience on the wards.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

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 hospital and the wider organisation.

Improvement needed

The health board must ensure that the damaged seating on Pwyll is repaired or replaced.

Infection prevention and control

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. A system of regular audits in respect of infection control was in place. Cleaning equipment was generally stored and organised appropriately. However during the first evening of the inspection we observed mops being inappropriately stored within the ADL kitchen on Gwion; this issue was resolved during the inspection.

There were hand hygiene products available in relevant areas around the hospital; these were accompanied by signage and pictograms. Staff also had access to infection prevention and control and decontamination personal protective equipment (PPE) when required. Designated plastic bins were used for the safe storage and disposal of medical sharps, for example, hypodermic needles; these were assembled correctly and stored safely.

Nutrition and hydration

We found that patients were provided with a choice of meals on a four-week menu. We saw that the menu varied and patients told us that they had a choice of what to eat.

However, some staff and patients we spoke with stated that meals could become repetitive when patients are typically at the hospital for long periods; this was compounded by the restricted use of the ADL kitchens.

Improvement needed

The health board must look at providing a more diverse menu for patients at Ty Llywelyn.

Medicines management

Improvements required were identified with the storage of medication at the hospital.

Whilst there was evidence that there were regular temperature checks of the medication fridge, there were no measuements of clinic room temperatures being completed to ensure that non-refrigerated medication was stored at the manufacturer's advised temperature. There was also no means apparent to reduce the temperature of the clinic room if required. This was an issue during our previous inspection and remains unaddressed.

Medication was stored securely within cupboards that were locked, however medication fridges on each of the wards were unlocked during the inspection.

Ward clinic rooms were small but reasonably well organised. There was another clinic room with an examination bed within the hospital. This area was not well kept and we observed areas of high level dust in the room; the health board need to ensure that this area is maintained.

Medication Admission Record (MAR) charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. It was positive to note that each MAR chart was accompanied by an up-to-date photograph of the relevant patient to aid staff with identification. However, MAR charts were not always complete with important patient details being omitted from the MAR charts, such as weight, height, date of birth and legal status under the Act.

Improvement needed

The health board must ensure that:

- The ambient temperature of clinic rooms is monitored and arrangements are in place to alter the temperature of the room as required
- Medication fridges remain locked when not being accessed
- All clinic rooms are organised and free from dust and clutter
- MAR charts contain all required patient information.

Safeguarding children and adults at risk

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken which documented that all resuscitation equipment was present and in date. Each ward had ligature cutters that were stored in designated places so that staff could access these if required.

Effective care

Safe and clinically effective care

We found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance arrangements for the hospital fed through to health board's governance arrangements, which facilitated a two way process of monitoring and learning.

Record keeping

Patient records were a combination of electronic and paper records. Electronic records these were password protected and paper documentation were stored securely within locked offices to prevent unauthorised access and breaches in confidentiality. We observed staff storing the records appropriately during our inspection.

During our review of patient records we found that some documentation being stored in the paper records were not the most up-to-date versions, with the current version being stored electronically. This meant that there was a risk that staff could refer to out-of-date care documentation in error.

Improvement needed

The health board must review the record keeping arrangements at Ty Llywelyn to minimise the number of systems in place.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across the three wards.

The records reviewed evidenced that the patients were legally detained. However one set of patient detention records were incomplete, not all documents were received by the health board when the patient was transferred to the hospital from another setting. It is essential that all detention papers are available to be scrutinised to ease the validation of detentions.

It was documented within patient records that they had been informed of their rights in line with Section 132 of the Act. However, it was not evident how frequently this was being undertaken to remind patients of their rights on a regular basis.

Records evidenced that appeals against the detentions were held within the required timescales. However, it was reported that on regular occasions there have been delays in receiving required reports from varying disciplines involved with the care of the relevant patient. Timely reports are required to ensure that these are available for review and scrutiny in the reviews that are essential in safeguarding patients' rights of the review of their detention in hospital under the Act.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment; with consent to treatment certificates always kept with the corresponding MAR chart. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of Section 58 of the Act.

All patient leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. Section 17 Leave clearly stated the conditions of leave, i.e. escorted or unescorted, location and duration. However, expired leave

authorisation forms were not always marked as no longer valid, therefore there is a risk that staff may refer to these in error.

We also reviewed the governance arrangements for monitoring the application of the Act across the hospital. It was positive to note that a Mental Health Act Action Plan had been devised to aid the internal monitoring process. It was also reported that the Mental Health Act department met regularly with the ward teams and provided training and updates at the hospital.

Improvement needed

The health Board must ensure:

- A full set of detention papers is present for each patient
- That there is a clear record of patients being offered the provision of their rights on a regular basis
- That professional reports for appeals against detentions are submitted in a timely manner.

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

We reviewed the care plans of a total of four patients. For three of the patients their Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. However one patient's Care and Treatment Plan was brief and did not reflect the in-patient care plans held within the electronic records.

To support in-patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, for one patient there was not a fully completed violence risk assessment in place despite the clinical records indicating this was required.

Individual care plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and utilised evidence based practice. There was evidence of discharge planning where appropriate for patients on that pathway.

There were regular individual care reviews completed. It was encouraging that the hospital had recently reviewed the format of these care reviews to actively

encourage patient attendance so that they are able to voice their views alongside members of the multi-disciplinary team.

It was positive to note that since our previous inspection the health board have been able to establish the weekly attendance of a community General Practitioner (GP) at the hospital to aid with the physical health care of the patients.

Improvement needed

The health board must ensure that:

- All patients have up to date Care and Treatment Plans
- Required patient risk assessments are completed in a timely manner.

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.

There were defined health board structures and systems that provided clinical and corporate governance to direct the operation of the hospital.

There was clear focus on reviewing service provision and ongoing service development of both the hospital and the wider health board mental health services.

There was dedicated and passionate leadership from managers who were supported by committed ward teams and multi-disciplinary team members.

Governance, leadership and accountability

We found that there were defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Identified senior managers had specific responsibilities for ensuring that the programme of governance remained at the forefront of service delivery. Those arrangements were recorded so that they could be reviewed both within the hospital and the wider organisational structure.

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

There was dedicated and passionate leadership from the ward managers and deputy ward managers who were supported by committed a ward team and support from senior managers. Staff commented that team-working and staff

morale on the wards was good and we found that staff were committed to providing patient care to high standards.

Through conversations with senior managers there was clear focus on service development and improvement. These discussions not only focused on Ty Llywelyn service but also the development of other health board services to help support patients, when ready, in less secure environments.

There were a number of potential developments that would benefit the care provided at the hospital and wider health board services, these were positive to hear and we would encourage the health board to pursue these developments.

The hospital was also part of a national peer review programme, which included external review of the hospital and enabled staff to partake in reviews of other services and share best practice and learning.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain the safety of patients across the three wards at the time of our inspection. Staff explained that they worked flexibly across each ward to support each other when required.

During the inspection there were two registered nurse vacancies and three healthcare assistant vacancies; these vacncies were in the process of being filled. However, there had also been a number of absences due to sickness which had caused some difficulty in fulfilling the staff rota. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to fill these shortfalls. This helped with the consistency of care at the hosptial.

The training information we reviewed, showed that staff were expected to complete mandatory training on a range of topics relevant to their roles. Training compliance was regularly monitored to ensure compliance was maintained; at the time of the inspection this was at 87%. Staff also attended additional training and conferences relevant to their roles.

Staff completed annual performance appraisals and these were documented to evidence that these had been completed. 84% of staff had received their annual appraisal and there was plans to ensure all staff had theirs completed.

Improvement needed

The health board must ensure that all staff complete their mandatory training and annual appraisals.

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
During the first evening of the inspection we observed mops being inappropriately stored within the ADL kitchen on Gwion.	Infection control risk	Escalated to ward manager	Relocated to appropriate storage area.

Appendix B – Immediate improvement plan

Service: Ty Llywelyn

Date of inspection: 27 – 29 January 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 identified during the inspection	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: Ty Llywelyn

Date of inspection: 27 – 29 January 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 must update HIW on the additional therapeutic space	1.1 Health promotion, protection and improvement	Business Case has been developed to enhance the therapeutic space. Plan is currently within BCU governance processes for approval. Once approved HIW will be notified. In the interim all clinical areas have been reviewed in order to optimise clinical space available for patients to use.	Head of Operations Head of Planning	September 2020
The health board must ensure a ratified policy is in place to support the use of the ADL kitchens	1.1 Health promotion, protection and improvement	Draft policy has been developed and is in use whilst the policy goes through Health Board processes for final ratification. The draft policy was recently presented at the Policy Group on 12th March 2020	Clinical Services Manager	June 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		further amendments were required. The policy was due to be presented at next Policy Group on 30th April 2020 for final ratification however this meeting has been stood down due to Covid-19.		
The health board must ensure that all non-working appliances are repaired or replaced in a timely manner.	1.1 Health promotion, protection and improvement	The required works have been completed	Clinical Services Manager	February 2020 Completed
The health board must ensure that each ward area displays information about: • NHS Wales Putting Things Right • Advocacy arrangements • Well-being and healthy lifestyles • The role of HIW and how patients can contact us.	4.1 Dignified Care 4.2 Patient Information 3.2 Communicating effectively	All required information has been put in place. This is monitored and reviewed on a monthly basis within the Matron Walkabout audit	Clinical Site Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide an update on the redevelopment of the Ty Llywelyn reception area.	6.2 Peoples rights	Planning is in progress with several potential proposals being explored Once approved by Senior Leadership team, an option appraisal will be presented to the Board.	Clinical Services Manager	June 2020
Delivery of safe and effective care				
The health board must ensure that the damaged seating on Pwyll is repaired or replaced.	2.1 Managing risk and promoting health and safety 2.4 Infection Prevention and Control (IPC) and Decontamination	Couches have been ordered and are awaiting delivery	Clinical Site Manager	May 2020
The health board must look at providing a more diverse menu for patients at Ty LLywelyn.	2.5 Nutrition and Hydration	The kitchen are now providing a 3 week cycle of menu's rather that a 2 week cycle Clinical Site Manager has arranged to meet with the Kitchen manager regularly to discuss the menu and food quality	Clinical Site Manager Clinical Site Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the ambient temperature of clinic rooms is monitored and arrangements are in place to alter the temperature of the room as required.	2.6 Medicines Management	Thermometers were ordered and are now in place. The temperature is recorded on a daily basis. This is audited as part of the Matron's monthly walkabout	Clinical Site Manager	February 2020 - completed
The health board must ensure that medication fridges remain locked when not being accessed.	2.6 Medicines Management	The fridges are checked daily to ensure that they are locked.	Clinical Site Manager	February 2020 - completed
The health board must ensure that all clinic rooms are organised and free from dust and clutter.	2.6 Medicines Management	The clinic rooms are checked for cleanliness on a daily basis	Clinical Site Manager	February 2020 - completed
The health board must ensure that MAR charts contain all required patient information.	2.6 Medicines Management	The charts are reviewed and rectified as required on a weekly basis during the ward rounds	Clinical Site Manager	February 2020 - completed
The health board must review the record keeping arrangements at Ty Llywelyn to minimise the number of systems in place.	3.5 Record keeping	Patient record systems to be reviewed in line with best practice guidance to include review of IT systems to support	Head of Operations Head of Nursing Clinical Services Manager IT manager	June 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health Board must ensure a full set of detention papers is present for each patient.	Application of the Mental Health Act	The admitting Doctor and nurse in charge 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 patients notes	Medical and Nursing team MHA Manager Ward Manager	February 2020 - completed
The health Board must ensure that there is a clear record of patients being offered the provision of their rights on a regular basis.	Application of the Mental Health Act	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.	MHA Manager and Ward Managers	February 2020 - completed
That professional reports for appeals against detentions are submitted in a timely manner	Application of the Mental Health Act	MHA administrator attends the weekly planning meeting and all upcoming reports are identified for completion MDT Reports not received in time will be highlighted to the Matron and service	MHA Manager and Ward Managers	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		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.		
The health board must ensure that all patients have up to date Care and Treatment Plans.	Monitoring the Mental Health Measure	Care and Treatment plans are audited on a monthly basis	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed
The health board must ensure that required patient risk assessments are completed in a timely manner	Monitoring the Mental Health Measure	The CTP's and Risk assessments on the unit have been reviewed and we are 100% compliant Risk assessments are audited on a monthly basis	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that all staff complete their mandatory training and annual appraisals.	7.1 Workforce	Mandatory training and annual appraisals are reviewed monthly in the ward manager's supervision and the monthly service operational meeting. Mandatory training is currently 84% and PADR are 85.71% this is within BCUHB targets.	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed

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): Hilary Owen

Job role: Head of Governance and Compliance, Mental Health & Learning

Date: 23 March 2020

National Assembly for Wales
Health, Social Care and Sport Committee

Mental health in policing and police custody

October 2019

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales, agrees Welsh taxes and holds the Welsh Government to account.

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National Assembly for Wales
Health, Social Care and Sport Committee

Mental health in policing and police custody

October 2019

About the Committee

The Committee was established on 28 June 2016. Its remit can be found at: www.assembly.wales/SeneddHealth

Committee Chair:

Dai Lloyd AM
Plaid Cymru

Current Committee membership:

Jayne Bryant AM
Welsh Labour

Angela Burns AM
Welsh Conservatives

Helen Mary Jones AM
Plaid Cymru

Lynne Neagle AM
Welsh Labour

David Rees AM
Welsh Labour

The following Members attended as substitutes during this inquiry.

Vicki Howells AM
Welsh Labour

Darren Millar AM
Conservative Party

The following Members were also members of the Committee during this inquiry.

Dawn Bowden AM
Welsh Labour

Neil Hamilton AM
UKIP Wales

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Recommendations

Recommendation 1. We recommend that the Welsh Government works with the police to seek evidence about why the number of detentions under the Mental Health Act is increasing, and to provide some analysis of national and local data to explain the regional variations. ..... Page 16

Recommendation 2. We recommend that the Welsh Government works in partnership with the police to review the emerging evidence on the effectiveness of the different triage schemes in Wales. Better understanding is needed on which model of joint working between the police and health staff is helping to provide people in crisis with the right help and support, and which can contribute to reducing the use of section 136 overall. ..... Page 17

Recommendation 3. We recommend that the Welsh Government should work with its partners to ensure all services are playing a key role in intervening early to prevent a mental health crisis escalating in the first place. Greater accountability for the implementation of Local Health Board improvement plans for crisis and out of hours services is needed, ensuring that funding is being targeted at actions that will help individuals to access support before crisis point..... Page 17

Recommendation 4. The Welsh Government should work with Healthcare Inspectorate Wales to ensure its thematic review of crisis and out of hours care includes a review of the care pathway for people detained under section 136, looking at the quality, safety and responsiveness of the care provided to people detained under section 136. ..... Page 25

Recommendation 5. The Welsh Government should work with its partners to develop additional health-based places of safety if required. It should also explore the benefits of adopting regional models to address the concerns raised about staff being drawn from other wards, and to ensure section 136 facilities are staffed appropriately to deal with those who may be intoxicated. ..... Page 26

Recommendation 6. The Welsh Government should work with Regional Partnership Boards and the third sector to develop sanctuary provision in local areas for people experiencing mental health crisis. ..... Page 26

Recommendation 7. We recognise that data collection is improving, and that the Welsh Government intend to publish a new section 135/136 data set, but there are still difficulties in getting a full picture of the use of section 136sbecause of the availability and quality of data. We recommend that the Welsh Government works with its partners to ensure the data set it publishes on the use of section 136

includes the type of place of safety people are taken to, and the outcomes for people subject to it. ..... Page 26

Recommendation 8. The Welsh Government should publish the NHS Delivery Unit's recommendations for improving care and treatment planning following its review (a) to help ensure there is greater transparency in holding Health Boards to account for the quality of these plans, and (b) to give assurances to the Committee that individuals who are already known to mental health services have a care and treatment plan in place in line with the Mental Health Wales Measure. ..... Page 30

Recommendation 9. The Welsh Government should implement, as a matter of urgency, its conveyance review and state how it will ensure that alternative patient transport will be provided for individuals experiencing mental health crises, thereby limiting the use of police vehicles in the conveyance of individuals detained under the Mental Health Act 1983 to hospital. ..... Page 33

Recommendation 10. As an immediate action, the Welsh Government should publish the six-monthly assurance reports provided to Welsh Government by the Mental Health Crisis Concordat Assurance Group to help increase transparency and drive service improvement. ..... Page 37

Recommendation 11. The Welsh Government should, in consultation with members of the Mental Health Crisis Care Concordat Assurance Group, review the role, purpose and governance arrangements of the Mental Health Crisis Care Concordat Assurance Group, in order to satisfy itself that there is sufficient focus on implementation; increased accountability in terms of ensuring that learning from pilots and projects is shared and good practice is scaled up so that there is a more consistent approach to mental health crisis care provision and services across Wales. ..... Page 37

1. Background

1. During two recent Assembly Committee inquiries (the Emotional and Mental Health of Children and Young People, and Suicide Prevention), Assembly Members heard from police representatives that an increasing amount of police resource is being used on managing mental health crises. This was also raised in a thematic review[1] by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) in November 2018.

2. The Committee therefore agreed to hold a short inquiry with a focus on partnership working between the police, health and social care services and others to consider how effectively services are working together in Wales to prevent people with mental health problems being taken into police custody, and to help ensure vulnerable people in mental health crisis get the care and support they need.

Terms of reference

3. The terms of reference for the inquiry were to consider:

- Whether there are sufficient services (i.e. health and social care services) available to support police officers in Wales to divert people with mental health problems away from police custody;
- The number of people arrested under section 136 of the Mental Health Act 1983, and the extent to which police custody is being used as a place of safety for people in mental health crisis;
- Whether local authorities and health services are meeting their duties and complying fully with legislative requirements to provide appropriate places of safety to which the police may take people detained under section 136 of the Mental Health Act 1983;
- Adherence to the Code of Practice to the Mental Health Act 1983 which requires that people detained under that Act should always be conveyed to hospital in the manner most likely to protect their dignity and privacy, taking account of any risks (i.e. by ambulance which should be made available in a timely way, as opposed to police transport);

[1] Policing and Mental Health: Picking Up the Pieces, November 2018

- How effectively police forces in Wales work with partners (such as health or social care services) to safeguard vulnerable people in police custody, and how well the police themselves identify and respond to vulnerable people detained in custody, specifically those arrested under section 136 of the Mental Health Act 1983;
- The effectiveness of multi-agency care planning for people with mental health problems when leaving custody, specifically for those detained in police custody under section 136 of the Mental Health Act 1983 to help to prevent repeat detentions;
- Whether effective joint working arrangements are in place, with a specific focus on implementation of the Mental Health Crisis Care Concordat, including whether the Welsh Government is providing sufficient oversight and leadership.

4. Between 13 February and 15 March 2019, the Committee conducted a public consultation to inform its work, based on the agreed terms of reference. The Committee received 28 responses, which are published on the Committee's website.[2] In addition, the Committee heard oral evidence from a number of witnesses on 4 April. Details of those who gave evidence are also available on the Committee's website.[3]

[2] Evidence submitted in response to the consultation

[3] Witnesses to the inquiry

2. Mental health and police custody

5. The Policing and Crime Act 2017 made some significant changes to section 135 and section 136 of the Mental Health Act 1983. The legal changes introduced by the 2017 Act were intended to improve responses to people in mental health crises who need urgent help with their mental health in cases where police officers are the first to respond.

6. Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear to be, mentally disordered.

7. Police officers may use powers of entry under Section 135 of the Mental Health Act to gain access to a mentally disordered individual who is not in a public place. If required, the police officer can remove that person to a place of safety.

8. Section 136 of the Act enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an Approved Mental Health Professional (for example a specially trained social worker or nurse), and for the making of any necessary arrangements for treatment or care.

9. Previously, section 136 of the Mental Health Act explicitly applied to people encountered in a public place, with section 135 requiring a magistrate-issued warrant for a police officer to enter private premises to remove a person to a place of safety for assessment. The 2017 Act introduced changes to allow an assessment to take place in the premises/home under certain circumstances (s135) and removing the need to be in a place to which the public has access (s136).

10. Other changes include:

- Police must consult mental health professionals, if practicable, before using section 136;
- police stations cannot be used as a place of safety for people under the age of 18;

- police stations can only be used as a place of safety in specific "exceptional" circumstances for adults;
- the period of detention for people held under S135/136 is reduced from 72hrs to 24hrs with the possibility of a 12hr extension under certain defined circumstances.

11. The purpose of the Committee's short inquiry was, in part, to satisfy ourselves that police custody is no longer being used as a place of safety for those detained under section 136 of the Mental Health Act except in exceptional circumstances. Whilst the Committee recognises that the police frequently respond to people with mental health problems, we have focused on the use of section 136s in particular, because these powers are usually exercised when people are at their most vulnerable.

12. Witnesses to our inquiry were clear, and in agreement, that it is unacceptable to hold mentally ill individuals in police custody, and that the practice of detaining people under section 136 of the Mental Health Act should only occur in exceptional circumstances. The Royal College of Nursing (RCN) Wales made the point that "people in mental health crisis are amongst the most vulnerable in our society, and sufficient investment must be made in services to meet their needs".[4]

13. The use of police custody as places of safety has fallen significantly over the past four years. The publication of the Crisis Care Concordat in 2015 and subsequently the passage of the Policing and Crime Act in 2017 marked significant reductions in the use of police stations as places of safety, despite the general trend of rising section 136 detentions.

14. In written evidence, Dr Gaynor Jones, Consultant Forensic Psychiatrist and Chair of South Wales Police Partnership Group, provided assurance that police custody being used as a place of safety for people in mental health crisis, "is now a rare event and when it happens is discussed at senior levels".[5]

15. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Assurance Group (MHCCCAG) told us that there has been a 90 per cent reduction in the number of individuals detained in police cells who are in mental health crisis since the introduction of the Concordat.[6]

[4] Written evidence, MHP02

[5] Written evidence, MHP01

[6] RoP, 4 April 2019, paragraph 352

16. Written evidence submitted by the National Police Chief Council also confirmed that "the number of people detained under section 136 of the Mental Health Act 1983 being conveyed to police custody as a place of safety has reduced year on year".[7]

17. Assistant Chief Constable (ACC) Jonathan Drake told us:

> "… one of the significant things that has progressed is the detention of people in police custody with mental health issues. Even for as large a force as ourselves, that's into single figures for the year—you know, under 1 per cent of people would end up in police custody, and normally it's because of extreme violence or it could be that they present with something slightly different than mental health to begin with. So, it's very, very rare."[8]

18. In a joint written submission, Cais, Hafal and Morgan Academy welcomed the progress that had been made in reducing the use of police custody for those arrested under section 136, but stated that "a challenge remains to ensure this practice is fully implemented and maintained".[9]

19. Specifically in relation to children and young people under the age of 18, the Minister told us that although the law changed in 2017 to prevent a police station being used as a place of safety for anyone under the age of 18:

> "… in Wales, this policy intention was realised much sooner and no child or young person has been taken to a police station as a place of safety since 2015."[10]

Our view

20. Too often and for too long vulnerable people experiencing mental health crisis, who have committed no crime, have found themselves in a police cell because there is nowhere else to go.

21. We therefore welcome the assurances we have received from senior police officers, inspectors and Welsh Government officials that police custody is no

[7] Written evidence, MHP03

[8] RoP, 4 April 2019, paragraph 99

[9] Written evidence, MHP11

[10] HSCS Committee, 4 April 2019, Paper 7

longer being used as a place of safety for those detained under section 136 of the Mental Health Act, apart from in exceptional circumstances.

22. Further, we were reassured to hear that there have been no cases of a police cell being used as a place of safety for a person aged under 18 in Wales since 2015.

23. We were pleased to hear from Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Healthcare Inspectorate Wales (HIW) that their joint inspections of police custody in Wales have generally found that where adults are detained in police custody for exceptional circumstances, the provision of mental health care is good.

3. Use of section 136 of the Mental Health Act 1983

25. While the number of people in mental health crisis being held in police custody has decreased, the number of detentions under section 136 of the Mental Health Act 1983 appears to be increasing. According to data published by the Home Office[11], there were 2,256 detentions in Wales under section 136 in 2018/19, compared to 1,955 in 2017/18. The police also report an increase in demand from people in mental health crisis.

26. According to the National Police Chiefs Council:

> "Policing is currently experiencing unprecedented levels of mental health related demand, which continues on an upward trajectory. The police service has become the 'de facto' agency and the first point of contact for many persons suffering with mental ill health. This is unsustainable with finite police resources and diminishing budgets; whilst dealing with the proliferation of new emerging crime types and other increased demand."[12]

27. ACC Jonathan Drake on behalf of the National Police Chiefs Council told us:

> "… most of the cases we deal with—up to 98 per cent—don't actually result in section 136 detentions. They're much more around health and welfare concerns, but the police—we're an agency that are there 24/7, and often the first people to be phoned about issues or come across issues in the street. [ ] … in summation, I'd say that the police, at present, are involved in too many issues that are purely health concerns, or may be linked to social care, as opposed to fitting that definition of an immediate risk to themselves or others."[13]

28. Dr Gaynor Jones, Consultant Forensic Psychiatrist and Chair of the South Wales Police Partnership Group agreed that "many hours of police time is taken up with mental health issues and those in crises".[14] Written evidence from the RCN Wales points to data collected across all Welsh police forces as part of Mental

[11] Detentions under the Mental Health Act (1983) - Police powers and procedures, year ending March 2019

[12] Written evidence, MHP03

[13] RoP, 4 April 2019, paragraph 89

[14] Written evidence, MHP01

Health Demand Day in 2018, where 200 mental health incidents requiring police involvement were recorded, representing 9.5% of all police incidents that day.[15]

29. However, the Minister for Health and Social Services told us:

> "I don't think it's as simple as drawing a line and saying, 'Police on this side, health on the other.' It's actually about, when someone presents with a potential crisis, depending on where they present as well, what the role and responsibility is."
>
> "... we are reviewing current provision, so I'd say it's an open question, but one for partners to address together, rather than pointing the finger at each other and saying, 'It's you, not me,' because that's actually the wrong approach to take for the agencies, and crucially the wrong approach to take for the person in the middle of it."[16]

30. Figures show the use of section 136 varies by police force in Wales. Data compiled by Mind Cymru from the National Police Chiefs' Council (2014-15 and 2015-16) and published by the Home Office (2016-17 to 2018-19) shows the number of section 136 detentions by police force area from 2014-15 to 2018-19:

Number of section 136 detentions by police force area: 2014-15 to 2018-19

	2014-15	2015-16	2016-17	2017-18	2018-19
Dyfed-Powys	197	226	270	239	270
Gwent	310	266	287	237	278
North Wales	466	323	589	680	795
South Wales	749	710	679	799	913
Total	1,722	1,525	1,825	1,955	2,256

(Sources: 2014-15 National Police Chiefs' Council, 2015-16 National Police Chiefs' Council, 2016-17 Home Office statistics, 2017-18 Homes Office statistics, 2018-19 Home Office statistics)

31. Mind Cymru stated that when taking into account population estimates for each police force area, it is clear that some forces account for a disproportionate number of detentions in relation to others. It also suggests that further evidence and analysis is required to identify the reasons behind the significant geographical variations.

[15] Written evidence, MHP02

[16] RoP, 4 April 2019, paragraph 435

32. In response to questions regarding the ratio of detentions in some force areas versus their populations, ACC Jonathan Drake told us:

> "... clearly, there are issues around density and sparsity of population, (...) around the services that are available in individual areas. (...) I couldn't explain why one area would have a disproportionate rate of 136 detentions to anywhere else."[17]

Mental health triage

33. Mental health triage schemes are intended to bring police and mental health practitioners together to jointly assess a mental health incident in order to reduce use of Section 136, and/or use of police cells, and hospitalisation via the emergency department or acute mental health services. There is wide diversity in these models and little evidence of what works in what circumstances.

34. There are different models of mental health triage in place across the four police force areas in Wales. Generally, triage involves a Community Psychiatric Nurse (CPN) or Approved Mental Health Professional (AMHP) based in the police control room, or sometimes out on the street, providing advice to police officers about support services. Independent evaluations are being carried out to assess the benefits of the different models but there is currently no common approach across Wales.

35. The National Police Chiefs' Council believe that the police benefit from more consistent advice as a result of having access to a triage team. However, in their written evidence, Cardiff and Vale University Health Board questioned whether this model actually helps the police more than the health services.

36. The National Police Chiefs' Council also said that triage services are variable and not consistently funded across Wales. At the time of the Committee's inquiry, the South Wales police triage model, for example, was funded entirely by the police, which led the National Police Chiefs' Council to question its sustainability. It believed that the Welsh Government should fund a national triage model for Wales[18], which it estimated would cost under £2.5m.[19]

[17] RoP, 4 April 2019, paragraph 125

[18] RoP, 4 April 2019, paragraph 110

[19] RoP, 4 April 2019, paragraph 199

37. In response, the Minister for Health and Social Services told us that the Welsh Government was not in a position to direct the police to act in a certain way because it is not a devolved service. In respect of funding, he said:

> "... it isn't just money, although, of course, how services are funded is, of course, a consideration that everyone will want to know about, but it is still about how does that work and what's the appropriate model for that particular part of the country? Because I can understand there could be some variance, but I hope we'll get to a point where there are some principles of how people should behave and how partners would want to work together that would help us to deliver the right sort of service."[20]

Our view

38. We have heard that the police are challenged by the number of people with serious mental illness who have crises. The data suggests that the use of section 136 is increasing, with many people being taken to a place of safety to protect themselves or others around them. We are pleased to hear that it is now rare for these vulnerable people to end up in police custody, which can be a frightening experience. However, we are concerned about the increase in detentions, which suggests that services are not acting early enough to prevent crisis.

39. We are also concerned that there is significant geographical variation in the use of section 136 detentions across the Welsh police forces, and that the National Police Chiefs' Council was not able to fully explain the reasons behind this.

40. It is unclear from the evidence we heard whether the increase in detentions reflects more individuals being detained, or whether the same people are being detained more often. It is important that both the police and Welsh Government demonstrate a better understanding of the cause for the rise in rates in detentions and the possible explanations.

41. Further, we would like to see the different mental health triage schemes properly evaluated so that their impact in reducing use of section 136, and hospitalisation via the emergency department or acute mental health services can be evidenced, helping to inform future decisions about what model might work best for Wales.

Recommendation 1. We recommend that the Welsh Government works with the police to seek evidence about why the number of detentions under the

[20] RoP, 4 April 2019, paragraph 466

Mental Health Act is increasing, and to provide some analysis of national and local data to explain the regional variations.

Recommendation 2. We recommend that the Welsh Government works in partnership with the police to review the emerging evidence on the effectiveness of the different triage schemes in Wales. Better understanding is needed on which model of joint working between the police and health staff is helping to provide people in crisis with the right help and support, and which can contribute to reducing the use of section 136 overall.

Recommendation 3. We recommend that the Welsh Government should work with its partners to ensure all services are playing a key role in intervening early to prevent a mental health crisis escalating in the first place. Greater accountability for the implementation of Local Health Board improvement plans for crisis and out of hours services is needed, ensuring that funding is being targeted at actions that will help individuals to access support before crisis point.

4. Police response to people experiencing crisis

42. A number of stakeholders who submitted written evidence were very positive about the contact people had with the police when experiencing a mental health crisis. According to Mind Cymru, many individuals and their families who have been in mental health crisis and called the police have been grateful for the support they received. This, it said, "challenges the general assumption that people experiencing a mental health crisis have negative views of being detained by police".[21]

43. Written evidence from the Wallich states:

> "In my experience the police have always been very helpful when a resident is in crisis, but they are obviously frustrated with the way mental health issues are handled. The police are far more helpful and responsive when a client is in crisis than the Crisis Team. Police help staff to look for solutions so that a person in crisis can access treatment. The Crisis Team just seem to put up barriers preventing people in need from accessing their services."[22]

44. West Wales Action for Mental Health, however, told us that while they had received good feedback about the kindness and compassion shown by the police, there had been occasions where service users had been told that "mental health is not a police matter, and it is taking important police time".[23]

45. Written evidence submitted by a retired police officer, outlining his "frontline" perspective states:

> "There will always be a role for the police to play in dealing with people who are in crisis [...]. However, once the immediate emergency has passed the police are often left abandoned by others agencies caring for a person without the relevant training, skills or resources. This does not mean the police should be given more training or resources; the gaps need to be filled by the correct and proper agencies."[24]

[21] Written evidence, MHP14

[22] Written evidence, MHP16

[23] Written evidence, MHP08

[24] Written evidence, MHP20

Health-based places of safety

46. To adhere to the Mental Health Act Code of Practice for Wales guidance in relation to the use of powers of detention under section 135 and 136, health and local authority partners must ensure adequate provision of facilities for both adults and young people.

47. According to Mind Cymru, "in the majority of cases, people detained under section 136 are brought to a health-based place of safety". However, it does raise concerns about evidence gaps for 2017-18, namely the significant number of "not known" locations.[25]

48. Data published by the Home Office (2016-17 to 2018-19) shows the type of place of safety used following a section 136 from 2016-17 to 2018-19.

Place of safety used following a section 136 detention, Wales; 2016-17 to 2018-19

	Health-based place of safety	Police Station	A&E	Private Home	Other	Not known	Total
2016-17	1536	117	41	29	6	96	1825
2017-18	1333	53	96	0	2	471	1955
2018-19	1,428	20	7	-	5	796	2,256

(Sources: 2016-17 Home Office statistics, 2017-18 Home Office statistics, 2018-19 Home Office statistics)

49. Local Health Boards confirmed that health-based places of safety are provided in their local areas, though the arrangements are different in each Health Board area. Evidence from the National Police Chiefs' Council suggests that provision of health-based facilities is patchy and varies across the country. It is difficult to assess whether the provision available is sufficient to meet the needs of local populations because there are significant gaps in the data.

50. The data for 2018-19 shows that there was a significant reduction in the number of detentions where people were taken to an emergency department. However, in 2018-19 the "place of safety used" was recorded as "Not known" in 796 cases.

[25] Written evidence, MHP14

51. Evidence from ACC Drake highlighted the important role of police service Mental Health Liaison Officers who know their local areas, and can advise police officers on where to access local health-based places of safety:

> "We employ mental health liaison officers as well so that they really know how to access places of safety and build up trust and relationships with the health staff who are there. But it is very variable, particularly in rural areas and out-of-hours as well. That's a real challenge for some of my colleagues across Wales."[26]

52. It is unclear from the evidence we heard why provision other than health-based places of safety are being used. While this may be completely appropriate, it is difficult to understand how often health-based places of safety turned people away, and the reasons for this.

Sufficiency of provision

53. Whilst we were told by Health Boards that there is sufficient provision of health-based places of safety to meet demand, concerns were raised about inadequate staffing, the place of safety environment, and the lack of provision for people who were intoxicated, or where there was a risk of violence. Details of the health-based places of safety in each health board can be found at Annex A.

54. Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site. Hywel Dda UHB suggested that support for those experiencing mental health crisis could be improved if Health Boards developed community based places of safety and not just ward-based section 136 options. Richard Jones, Head of Clinical Innovation and Strategy at Hywel Dda, told us that plans were being considered for a dedicated section 136 facility, staffed adequately to manage people with more acute needs, with a further three community mental health centres that have a non-health-based place of safety to manage lesser needs.

55. The appropriateness and environment of the health-based places of safety is something that has been highlighted by HIW in their inspection reports. The Chief Executive of HIW, Kate Chamberlain, told us section 136 facilities in some Health Boards may not be ideal "in terms of geographical location, but also sometimes in terms of where they're located alongside mental health facilities or otherwise".[27]

[26] RoP, 4 April 2019, paragraph 148

[27] RoP, 4 April 2019, paragraph 18

56. Kate Chamberlain went on to tell us:

> "The other challenge that comes about in terms of the use of these suites is that, very often, because they're not in continuous use, their staffing may require the drawing of staff from the wards, and it may impact upon staffing levels on the wards. That, obviously, would be a concern to us."[28]

57. While acknowledging the point made by HIW about staffing section 136 suites, Phil Lewis, Cwm Taf UHB, made the point that there was a need to balance capacity with demand. He told us that the number of people needing high levels of intervention in Cwm Taf was not high therefore it was difficult to justify the provision of a fully staffed crisis suite. However, he recognised the potential for a regional approach, for example, for the South Wales police force where a regional facility could work across the different Health Boards. He said that discussions had taken place on what a regional approach of that kind might look like.[29]

Complexity of care

58. Concern was also raised about the complex range of issues presented by people being detained under section 136.

59. Phil Lewis, representing Cwm Taf UHB told us:

> "... what we are seeing more and more is a complex mixture of people who are in emotional mental health distress, unfortunately often with alcohol involvement, drug involvement. So, the complexity of their care prior to undertaking an assessment has changed somewhat in the sense that we might have facilities, but we haven't necessarily staffed those areas to deal with a complex mixture of intoxication, potential violence and aggression. And that has a huge impact on our interface with our police colleagues, because they're often better equipped to deal with that level of violence and aggression."[30]

60. Dr Chris O'Connor confirmed a similar situation in Aneurin Bevan UHB. He noted a change in the presentation of individuals to the place of safety, with significantly more individuals engaging in aggressive behaviour and intoxication,

[28] RoP, 4 April 2019, paragraph 19

[29] RoP, 4 April 2019, paragraph 320

[30] RoP, 4 April 2019, paragraph 307

and said that the UHB was looking at changing the skill mix of staff to ensure they are safely supported in providing this service.[31]

61. ACC Jonathan Drake echoed these concerns, stating that there are occasions when the police have to stay with people for longer because they are intoxicated and so they cannot have an assessment. He said the health service is not staffed to deal with people who are intoxicated, particularly if dealing with violence and aggression.

Crisis care and out of hours provision

62. The Mental Health Crisis Care Concordat states that health-based places of safety should be provided at a level that allows for around the clock availability.

63. Access to support was highlighted by the Chair of the Mental Health Crisis Care Concordat Advisory Group and Health Board representatives, who told us "whether it's the individual who's trying to access support or the people around them, it's absolutely vital that people are able to access that support".[32]

64. Mind Cymru's evidence states that access to crisis care services in Wales is limited and geographically varied. It also says that in recent years the number of people referred for support from mental health crisis teams has risen sharply, with a 17 per cent increase in referrals over the four years to 2018.[33]

65. Dr Chris O'Connor, Aneurin Bevan UHB, outlined work being undertaken in Gwent to develop "a single point of contact that would be accessible for individuals themselves, family members or professionals to be able to access support 24 hours a day, seven days a week, to be able to have a meaningful conversation with somebody who can help think about the best way to support that person at that point in time".[34]

66. In their evidence, HIW stated that their Joint Thematic Review of Community Mental Health Teams[35] published in February 2019 by themselves and Care Inspectorate Wales (CIW) highlighted inconsistencies and variability in crisis care provision, particularly where people are experiencing mental health crisis or in urgent need.

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[31] RoP, 4 April 2019, paragraph 310

[32] RoP, 4 April 2019, paragraph 261

[33] Written evidence, MHP14

[34] RoP, 4 April 2019, paragraph 262

[35] Joint Thematic Review of Community Mental Health Teams – February 2019

67. It found that some service users receive immediate intervention and support but others experience a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours. A significant number of people did not know who to contact out of hours and were not satisfied with the help offered. Rhys Jones, Head of Escalation and Enforcement, HIW, told us:

> "… there are some startling numbers, certainly in the report, in terms of the surveys that we undertook and that nearly half of people didn't know who to contact during crisis, and the fact that these MHT services tend to operate to a fixed time schedule and, clearly, crises can happen any time of the day."[36]

68. He went on to say that this variability in provision across Wales was particularly concerning and had led HIW to commit to undertake a thematic review of crisis care during 2019/20. Work is due to start early in 2020and an overarching stakeholder group will be convened to inform the study.

Alternative places of safety

69. In terms of demand and capacity planning, HIW said that the answer to pressure on services does not necessarily mean that more health-based places of safety are needed. It said that pressure could be diverted from those services if there were more alternative places of safety available.[37]

70. Dr Chris O'Connor of Aneurin Bevan UHB told us that some of the evaluations of sanctuary provision elsewhere in the UK show that they have a real impact on the demand and individuals presenting to emergency services such as the police and A&E.[38]

71. Under the changes to the legislation, anywhere can be a place of safety and so there is scope to develop non health-based places of safety.

72. We heard that there are pockets of good practice in terms of provision of crisis cafes and sanctuary houses. ACC Jonathan Drake told us:

> "So, in various areas, those already exist. Parts of Dyfed-Powys, for instance, already have that. We're looking to develop a sanctuary at Swansea at the moment, again, working with third sector partners in

[36] RoP, 4 April 2019, paragraph 42

[37] RoP, 4 April 2019, paragraph 17

[38] RoP, 4 April 2019, paragraph 298

> doing that. Sometimes, there's opportunities there such as buildings that aren't used—public buildings but they're not used out of hours. So, in an evening they could be used to convert into a sanctuary or crisis cafe."[39]

73. Written evidence from Aneurin Bevan UHB stated that a work stream, led by third sector organisations, has been established to review the need for sanctuary provision within Gwent and is currently developing a proposal to seek funding to support a pilot of sanctuary provision in three different areas across the county.[40] Plans are also in place to develop a sanctuary in Swansea, working with third sector partners.[41]

74. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, believed this was an area that would benefit from some targeted resourcing. She said:

> "… if we had an understanding that that was the kind of community-based support that we wanted everywhere, and it's very much in line, (…) with 'A Healthier Wales' and the general direction of travel of the Government in terms of more preventative community-based closer to home services. And I think it's quite a good idea to take it out of statutory services and normalise it and make it much more of a place where people feel safe, rather than a place of safety."[42]

75. The Minister for Health and Social Services, however, told us that it should not be the default position that the Welsh Government would be in a position to provide funding and in the first instance it would be for local partners to determine how they would fund the provision of sanctuary/places of safety to meet the needs of their local population.[43]

Our view

76. We understand why people turn to the emergency services during an episode of crisis and we believe that the police will always have a role to play in dealing with people in such situations. However, once the immediate emergency has passed, responsibility must pass to the appropriate healthcare professional.

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[39] RoP, 4 April 2019, paragraph 152

[40] Written evidence, MHP06

[41] RoP, 4 April 2019, paragraph 152

[42] RoP, 4 April 2019, paragraph 402

[43] RoP, 4 April 2019, paragraph 462

77. We welcome the assurance that all Health Boards have designated health-based places of safety, and that some places of safety are working effectively, with examples of good practice. However, we are concerned at suggestions that provision is patchy and varies across the country. We are further concerned that differences in access to places of safety can make it difficult for people to know who to contact for support and where to go to access help. It is particularly important that frontline staff such as police officers have access to services at any time.

78. Providing sufficient health-based places of safety is not the only answer. We heard that there is a wide range of services that can respond to people experiencing a mental health crisis, such as crisis houses and crisis helplines, which can all help to provide an effective response. We believe that effective partnership working can help to reduce the use of section 136 and, as a result, the demand for places of safety.

79. We recognise the difficulties associated with staffing a crisis suite that is not in continuous use. However, we are concerned that the drawing of staff from other wards during times of need is having an adverse impact upon staffing levels on those wards. We think there is potential in exploring the provision of regional options.

80. We believe that the care pathway for people detained under section 136 needs to be reviewed from the individuals' perspective; from the point the person is detained by police under section 136, through being conveyed to hospital, transferred into the care of place- of- safety staff, and waiting to be assessed under the Mental Health Act and beyond. For most, this is likely to be a distressing experience. This can only be made worse when a place of safety cannot be accessed, when a person has a long wait in the back of a police car, or when they have a long wait to be assessed.

81. The development of crisis houses/ sanctuary provision to offer safe, short-term accommodation and support to people experiencing a mental health crisis is something we believe needs further exploration. We believe the potential of crisis houses to provide a short-term alternative to hospital admission, and/or to provide support, particularly for people at risk of suicide should be examined. There is currently no mention of alternative places of safety in the Welsh Government's consultation document, Together for Mental Health Delivery Plan 2019-22.

Recommendation 4. The Welsh Government should work with Healthcare Inspectorate Wales to ensure its thematic review of crisis and out of hours care

includes a review of the care pathway for people detained under section 136, looking at the quality, safety and responsiveness of the care provided to people detained under section 136.

Recommendation 5. The Welsh Government should work with its partners to develop additional health-based places of safety if required. It should also explore the benefits of adopting regional models to address the concerns raised about staff being drawn from other wards, and to ensure section 136 facilities are staffed appropriately to deal with those who may be intoxicated.

Recommendation 6. The Welsh Government should work with Regional Partnership Boards and the third sector to develop sanctuary provision in local areas for people experiencing mental health crisis.

Recommendation 7. We recognise that data collection is improving, and that the Welsh Government intend to publish a new section 135/136 data set, but there are still difficulties in getting a full picture of the use of section 136sbecause of the availability and quality of data. We recommend that the Welsh Government works with its partners to ensure the data set it publishes on the use of section 136 includes the type of place of safety people are taken to, and the outcomes for people subject to it.

5. Care planning

82. In addition to enabling a police officer to remove a person to a place of safety if they believe they are suffering from a mental disorder and in need of immediate care and control, section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specially trained social worker or nurse), and for the making of any necessary arrangements for treatment or care.

83. According to Mind Cymru, the majority of people detained under section 136 are discharged following assessment. In figures provided as part of their written evidence, 68 per cent of those assessed in 2016-17 were not admitted to hospital for treatment. This accounted for two thirds of the overall number of section 136 detentions that year. Mind Cymru suggested that there could be a number of reasons for this., including people experiencing high levels of distress or being under the influence of alcohol or other substances(see table below).[44]

Outcomes of completed Mental Health Act assessment in hospital under section 136, 2014-15 to 2016-17

	2014-15	2015-16	2016-17
Discharged from Section 136	861	976	1,211
Informally admitted to hospital	292	271	245
Detained under Section 2	209	207	296
Detained under Section 3	16	14	16
Other	20	11	11
All outcomes	1,398	1,479	1,779

(Source: Welsh Government)

84. Richard Jones, Hywel Dda UHB, told us that an exercise undertaken in the Hywel Dda area had shown that, even where people were not being directly admitted to hospital care, many of those people had needs and went on to receive other forms of support that they needed. He went on to say that more

[44] Written evidence, MHP14

needed to be done to prevent people getting into crisis in the first place, particularly in terms of future investment in services.[45]

85. According to the Police Federation of England and Wales:

> "NHS and Social Services as public services use the police as its backstop, often releasing people back into the public domain, having been given advice to seek medical care from say a GP, only for them to once again – and often shortly thereafter – be rearrested under s136."[46]

86. ACC Jonathan Drake made a similar point, raising concerns about "a revolving door". He said that while he couldn't say whether the services put in place for people once they have been released were sufficient or consistent, it was of some concern that 50 per cent of the people dealt with were already patients in some form.[47]

87. Mind Cymru suggested that better data collection could allow services to identify individuals repeatedly detained under section 136, which would provide an opportunity for learning and to ensure adequate preventative support is put in place for the individual.[48]

88. The joint submission from Cais, Hafal and the Morgan Academy stated that "we have observed particular problems with 'revolving door' repeat detentions of individuals which requires special attention on a multi-agency basis".[49]

89. RCN Cymru's written evidence suggested that further work is needed in terms of care planning to better protect vulnerable people. It stated:

> "… there is no built-in mechanism in the existing system whereby multi-agency reviews are automatically triggered for individuals who are repeatedly referred by the police to mental health teams. This means that agencies are not always routinely working together with individuals to achieve the best outcomes for those with mental health problems, and that repeat detentions are not always avoided."[50]

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[45] RoP, 4 April 2019, paragraph 297

[46] Written evidence, MHP25

[47] RoP, 4 April 2019, paragraph 131

[48] Written evidence, MHP14

[49] Written evidence, MHP11

[50] Written evidence, MHP02

90. Evidence from Cardiff & Vale UHB, however, stated that people arrested under section 136 who are known to local mental health services should have a care and treatment plan which reflects the action to be taken in a crisis relapse by the individual and the agencies involved in their care and treatment.

91. Similarly, Richard Jones, Hywel Dda UHB, told us:

> "Anyone in receipt of care from statutory mental health services will have a care and treatment plan, and that will include a crisis and contingency plan that will identify, in collaboration with that individual and their carer, exactly what steps would help them alleviate a crisis and what they could do about it rather than finding themselves in positions where they do end up with the police."[51]

92. He did, however, acknowledge a need to improve the quality of those care and treatment plans to make them more meaningful for service users and carers.[52]

93. HIW's Joint Thematic Review of Community Mental Health Teams (CMHTs) also found that whilst care planning and legislative documentation were, in most CMHTs, being completed in a timely manner, there were concerns that service users and their families / carers were not always as involved in developing the care and treatment plan as they would like to be.

94. Further, it raised concerns that not all CMHTs routinely offer advocacy services on assessment or at significant points during a service user's care, and carers' assessments are not undertaken routinely to identify if and what information, advice, assistance or support they may need to care for the service user.

95. The Minister for Health and Social Services told us that, where a care and treatment plan was in place, he wanted to establish the adequacy of it, how well people are being engaged in it, and whether it was making a difference. He had therefore commissioned the NHS Delivery Unit to undertake a review of the quality of care and treatment planning, the findings of which would help inform the consultation on the next stage of the "Together for Mental Health" delivery plan.[53]

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[51] RoP, 4 April 2019, paragraph 254

[52] RoP, 4 April 2019, paragraph 301

[53] RoP, 4 April 2019, paragraph 451

Our view

96. It is worrying that the majority of people detained under section 136 are discharged following assessment because they do not need urgent mental health inpatient treatment. Clearly, this raises questions as to whether section 136 is being used because of an absence of other, more appropriate support services for someone who is experiencing a mental health crisis.

97. Of further concern are the numbers of repeat detentions, under section 136, following release – described to us as the "revolving door". Whether this is as a result of people being discharged too early or poor discharge planning, it suggests a lack of adequate care and support in the community. To help avoid repeat detentions, individuals and their families need to know where to go for help and support as a crisis is approaching.

98. Improving access to crisis care services, particularly out-of-hours services, is key to both reducing the overall use of section 136 and ensuring those discharged from section 136 following assessment go on to receive adequate care and support in the community. We therefore believe there should be greater monitoring of readmissions and repeat detentions to better inform crisis planning.

Recommendation 8. The Welsh Government should publish the NHS Delivery Unit's recommendations for improving care and treatment planning following its review (a) to help ensure there is greater transparency in holding Health Boards to account for the quality of these plans, and (b) to give assurances to the Committee that individuals who are already known to mental health services have a care and treatment plan in place in line with the Mental Health Wales Measure.

6. Conveyance to a place of safety

99. The Code of Practice to the Mental Health Act 1983 requires that people detained under the Act should always be conveyed to hospital in the manner most likely to protect their dignity and privacy, taking account of any risks (i.e. by ambulance which should be made available in a timely way, as opposed to police transport).

100. However, evidence received by the Committee suggested this is not happening. The South Wales Police Partnership Group told us that "the vast majority of S.136's are still being brought to place of safety by the Police".[54]

101. Evidence from the National Police Chiefs' Council stated that, across Wales, partner agencies appear to be failing to meet the needs of persons that require conveyance to a mental health establishment. It goes on to say that operational pressures on the Welsh Ambulance Services NHS Trust (WAST) and mental health services mean that policing is filling the vacuum that is left and police vehicles are consistently being used to transport persons to mental health establishments.[55]

102. ACC Jonathan Drake told us:

> "... the reason why we primarily take people in police cars, and it's unusual that people detained don't travel in police cars, in truth, is simply because of delays in waiting for WAST. It would be a significant delay, and there's a delay because of how busy they are, and, in truth, if you were to triage a call, if someone was suffering a medical emergency versus a case of transport, I can see why there's a real challenge there and a wait."[56]

103. WAST response times were cited as the reason for over-reliance on the police by all the health board representatives we spoke to. Health boards are exploring alternative options of patient transport but there is no consistent approach.[57] Richard Jones, Hywel Dda UHB, described it as "an enormous challenge" because:

[54] Written evidence, MHP01

[55] Written evidence, MHP03

[56] RoP, 4 April 2019, paragraph 182

[57] RoP, 4 April 2019, paragraph 183

> "... part of the problem we have is we haven't accurately mapped our transport need. We simply don't know what the real demand is out of hours, and that's been very difficult to gather."[58]

104. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Assurance Group told us: "this has been on the agenda as one of the long-standing, intractable issues". She went on to say that what is needed is:

> "something that's responsive, quick, not necessarily fully equipped as an ambulance is, and you need it to be more discreet and less stigmatising than being picked up by a police car in your community."[59]

105. ACC Drake told us that there are examples of good practice and initiatives being piloted across Wales but these are not being rolled out everywhere so there is no consistency. He was, however, very clear that police funding should not be used to invest in alternative transport arrangements.[60]

106. The Minister for Health and Social Services confirmed that the Mental Health Crisis Care Concordat Assurance Group had been looking at this issue and had asked the NHS Collaborative Commissioning Unit to undertake a mental health urgent access and conveyance review to look at how and where access is provided. He also said that, in addition to the review, there are pilots underway in Aneurin Bevan and Hywel Dda health board areas to look at non-emergency conveyance:

> "I recognise from the Welsh ambulance service's point of view, as a national organisation they're dealing with a variance in how that is organised between different police force areas, different health board areas, and also 22 local authorities as well. So, actually, it's in everyone's interest, not just the ambulance service's but everyone's interest, to have some more consistency around that. So, whether that is a single, once-for-Wales model or whether it's something with more flexibility is something that we'll be looking at, following that review."[61]

Our view

107. The Code of Practice to the Mental Health Act 1983 requires that people detained under the Act should always be conveyed to hospital in the manner

[58] RoP, 4 April 2019, paragraph 329

[59] RoP, 4 April 2019, paragraph 408

[60] RoP, 4 April 2019, paragraph 183

[61] RoP, 4 April 2019, paragraph 440

most likely to protect their dignity and privacy. However, it is clear that this is not happening and in the vast majority of cases people are still being transported to a place of safety by the police.

108. While we recognise the need for the prioritisation of ambulance calls, it is extremely distressing for the person experiencing a mental health crisis and their family for them to be taken away in a police car.

109. We are aware of examples of good practice and initiatives being piloted across Wales but are concerned that these are not being rolled out everywhere so there is no consistency of practice. We believe this needs to be addressed as a matter of urgency.

Recommendation 9. The Welsh Government should implement, as a matter of urgency, its conveyance review and state how it will ensure that alternative patient transport will be provided for individuals experiencing mental health crises, thereby limiting the use of police vehicles in the conveyance of individuals detained under the Mental Health Act 1983 to hospital.

7. Mental Health Crisis Care Concordat

110. Published in 2015, the Mental Health Crisis Care Concordat[62] is a national agreement between health, criminal justice and social care agencies that sets out how services and agencies involved in the care and support of people in a mental health crisis will work together to provide the necessary support. It includes arrangements for more joint work and better information sharing between agencies.

Progress in implementation

111. The Crisis Care Concordat is generally seen as a positive step. Evidence from Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFS) says that:

> "... the concordat is an excellent first step and an early evaluation indicates that it has made some improvements. The most significant is the reduction in the use of police cells as a place of safety. This is undoubtedly positive."[63]

112. However, it went on it say that while the concordat is a step in the right direction, there is still further work to be done.

113. Mind Cymru told us:

> "Whilst progress has been made, a focused approach and greater urgency is needed if we are to truly deliver the Concordat in full and transform the way in which we help those experiencing a mental health crisis."[64]

114. We also heard there is a need to scale up good practice to ensure a consistent approach across Wales. According to Kate Chamberlain, Healthcare Inspectorate Wales:

> "... one of the things we're very good at in Wales is innovative projects and pilots and trying new things. What I don't think we are as strong at

[62] Mental Health Crisis Care Concordat

[63] Written evidence, MHP26

[64] Written evidence, MHP14

> is taking the learning from those pilots and projects and spreading them so that we have a consistent approach across Wales."[65]

115. While ACC Jonathan Drake told us "there are examples of good practice and initiatives that are piloted [...] but they don't seem to then roll out everywhere. They seem to be in individual areas, and, to me, that's such a shame".[66]

Leadership / governance

116. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, stated that stronger central leadership is needed from the Welsh Government to accelerate implementation of the concordat, as well as to increase accountability and transparency.[67]

117. A joint written submission from Cais, Hafal and Morgan Academy questioned whether the Mental Health Crisis Care Concordat Advisory Group has the authority and capacity to drive improvement and hold organisations to account . It suggested that the concordat does not have "high status" in mainstream targets for health and social care agencies or for the police and goes on to say:

> "In our experience effective joint working has depended on local relationships and on local initiative and good will more than on national leadership. The result is great inconsistency and in many instances police and health staff still effectively work in isolation."[68]

118. The Office of the Police and Crime Commissioner for Gwent and Public Health Wales also suggested that increased and robust leadership by the Welsh Government and increased accountability by agencies is needed to achieve the objectives and aims of the Concordat. Evidence from the Office of the Police and Crime Commissioner for Gwent states:

> "Gwent has a robust partnership working group that oversees the Mental Health Crisis Care Concordat. This is a very proactive group with excellent working relationships. However, its ability to influence across all agencies at the levels required is limited due to a lack of consistent and cohesive partnership outcomes."[69]

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[65] RoP, 4 April 2019, paragraph 30

[66] RoP, 4 April 2019, paragraph 185

[67] RoP, 4 April 2019, paragraph 374

[68] Written evidence, MHP11

[69] Written evidence, MHP13

119. Public Health Wales told us:

> "... mental health as an ACE [Adverse Childhood Experience] is so prevalent within communities that it is worthy of this having relevant staffing within Welsh Government to oversee the implementation of the concordat rather than this being a small add-on part of a wider portfolio of responsibilities on an operational level."[70]

120. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, told us that there are clear assurance mechanisms in place. However, she suggests that transparency could be improved if the Welsh Government published the six-monthly assurance reports the Group provides to it, as well as the regional action plans for each area.[71]

121. Matt Downton, Head of Mental Health and Vulnerable Groups at the Welsh Government advised that the Advisory Group had moved from a task and finish group into an assurance group, in recognition of the need to strengthen governance arrangements, because, as a task and finish group, it did not have a formal reporting mechanism into Welsh Government.

122. The Minister for Health and Social Services told us:

> "I think the governance and oversight for the concordat is appropriate. We have an assurance group and regional partnerships report directly into that. The important thing is making sure that it works so people can understand where the governance lies."[72]

123. He also confirmed that the chairing of the advisory group would shortly move to the national health service, which would "reinforce the role of the health service as a key partner to make sure it is not seen as just a health issue or just a police issue, but, actually, the NHS are there to work with other partners and to make sure that they are always present".[73]

Our view

124. We welcome the publication of the Mental Health Crisis Care Concordat, particularly in terms of its contribution in successfully implementing the legislative changes in relation to the use of police custody as a place of safety. We

[70] Written evidence, MHP04

[71] RoP, 4 April 2019, paragraph 354

[72] RoP, 4 April 2019, paragraph 475

[73] RoP, 4 April 2019, paragraph 475

do not believe that further legislation is necessary in this area but do think that more focus and urgency is needed to drive forward full delivery of the Concordat.

125. The Concordat was established to promote local multi-agency arrangements to improve the quality of care for people experiencing a mental health crisis and ensure that they are diverted to health rather than police settings. It is our view that a greater focus on early intervention is needed to ensure people are getting the help they need for their mental health problems early enough so that they do not reach crisis point. We believe that the chairing of the Mental Health Crisis Care Concordat Advisory Group should reflect that ambition.

Recommendation 10. As an immediate action, the Welsh Government should publish the six-monthly assurance reports provided to Welsh Government by the Mental Health Crisis Concordat Assurance Group to help increase transparency and drive service improvement.

Recommendation 11. The Welsh Government should, in consultation with members of the Mental Health Crisis Care Concordat Assurance Group, review the role, purpose and governance arrangements of the Mental Health Crisis Care Concordat Assurance Group, in order to satisfy itself that there is sufficient focus on implementation; increased accountability in terms of ensuring that learning from pilots and projects is shared and good practice is scaled up so that there is a more consistent approach to mental health crisis care provision and services across Wales.

ANNEX A – Health based places of safety

Health Board Name	Name of Hospital where S136 Locally Designated Place of Safety is Located	Name of Ward/Unit used as the S136 place of safety within the hospital site
Abertawe Bro Morgannwg	**Cefn Coed Hospital**	Fendrod Ward
	Neath Port Talbot Hospital	Ward F
	Princess of Wales Hospital, Coity Clinic	Ward 14, Coity Clinic
Aneurin Bevan	**St Cadocs Hospital Caerleon NP18 3XQ**	Adferiad Ward
Powys	**Bronllys Hospital**	Felindre Ward
Betsi Cadwaladr	**Ysbyty Gwynedd**	Hergest Unit
	Ysbyty Glan Clwyd	Ablett Unit
	Wrexham Maelor Hospital	Heddfan Adult Mental Health Unit
Cwm Taff	**Royal Glamorgan Hospital Llantrisant**	Crisis Team Mental Health Unit A&E
	Prince Charles Hospital Merthyr Tydfil	Crisis Resolution Home Treatment Team A&E
Cardiff and Vale	**Hafan Y Coed University Hospital Llandough**	Emergency Assessment Suite
Hywel DDa	**Hafan Derwen, Carmarthen**	Cwm Seren PICU
	Prince Philip, Llanelli	Bryngofal Ward
	Bro Cerwyn, Haverfordwest	St Caradog Ward
	Glangwili Hospital Carmardden	Morlais Ward (under 18 only)

Mental Health in Policing and Police Custody Health, Social Care & Sport Committee Report (October 2019)

Recommendation 1. We recommend that the Welsh Government works with the police to seek evidence about why the number of detentions under the Mental Health Act is increasing, and to provide some analysis of national and local data to explain the regional variations.

Welsh Government response –

Accept in principle.

We agree in principle on the basis that the recommendation needs to be owned across all agencies who have a collective responsibility for the use and outcomes of section 135 and section 136 detentions in Wales – including the NHS, Local Authorities and the police.

In order to achieve the outcome of providing effective support to people experiencing mental health crisis, the Mental Health Crisis Care Concordat (MHCCC) has sought to secure better quality data to inform, engage further enquiry and better understand whether people's needs are being met in a timely and effective manner. As part of this work, the Welsh Government has led the development of a new, strengthened data set for the use of police powers under the Mental Health Act 1983. The data set was developed collaboratively with partners, including the police. It will be published on a quarterly basis, with the first statistical release on 5 December 2019, capturing the position from April 2019 onwards. Ongoing quarterly publication within the year will enable the MHCCC Assurance Group to engage and analyse national and local data on section 135 and section 136 detentions.

We consider that the *number* of section 135 and section 136 events alone (whether they be going up or down) should be a starting point of enquiry and understanding. The key question is what difference and improvements are being made across the system to effectively support people experiencing mental health crisis.

All partners will need to understand and learn from the reasons where the number of detentions are either increasing or decreasing. Whilst any increase in the number of detentions would demand further analysis, there are a range of factors that may have contributed to this. For instance, changes to police powers and places of safety provision under the Mental Health Act 1983, made by the Policing and Crime Act 2017, expanded the circumstances where police officers can exercise these powers (e.g. to include railways, rooftops and offices). At the same time, while officers are able to use these police powers in an expanded range of situations, the changes to the law also require officers (where practicable) to consult with specific

professionals to secure an alternative response to using section 136 where possible, on a case by case basis.

The revised data set takes account of these changes and will include more information than has been published previously, such as ethnicity, age and methods of conveyance. Further work is needed to secure more reliable recording and transfer of information from policing to health services on the consultation process, before this aspect of the data set can be published.

Welsh Government will propose to the MHCCC Assurance Group that the Data Task and Finish Group is reconvened to agree a multiagency framework of questions to investigate the data further and to identify factors that are contributing to any variation in the use of police powers and outcomes.

Financial Implications

None. Seeking and analysing evidence about the number of detentions under the Mental Health Act 1983 and providing analysis of national and local data to explain the regional variations, is a core role for the MHCCC Assurance Group.

Recommendation 2. We recommend that the Welsh Government works in partnership with the police to review the emerging evidence on the effectiveness of the different triage schemes in Wales. Better understanding is needed on which model of joint working between the police and health staff is helping to provide people in crisis with the right help and support, and which can contribute to reducing the use of section 136 overall.

Welsh Government response –

Accept.

A key aim for the MHCCC Assurance Group is to collectively understand which approaches are most effective – and all partners need to ensure that approaches include robust evaluation to inform this understanding. Police powers under the Mental Health Act 1983 have an important place in safeguarding the safety of people experiencing acute mental health crisis and these powers were retained and expanded by the change in law in December 2017. The well-being and safety of citizens is paramount, and the collective aspiration of the MHCCC Assurance Group is to see a reduction in the use of police powers where a less restrictive response is more appropriate and practicable.

At a national level, the Welsh Government has commissioned the NHS National Collaborative Commissioning Unit to conduct a Mental Health Urgent Access and Conveyance Review. The review is being overseen by a multiagency steering group and will analyse data across a range of partners – including the police, local authorities, 111, the NHS and WAST – to help us to better understand the current demand which is currently recorded by partners as ‘mental health demand’.

Partners on the MHCCC Assurance Group agree that this work is fundamental to improving the crisis pathway. We expect to receive the findings from the review by April next year.

We are also working to identify which approaches could be scaled up at a national level. In particular, we are working with mental health clinicians, Local Health Boards and 111 to identify opportunities to develop a mental health crisis pathway.

As one partner in the multiagency crisis pathway, we have made crisis and out-of-hours care a priority area, both for the NHS and in the new 2019-22 Together for Mental Health Delivery Plan, which will be published shortly. We invested an additional £1million in 2018/19 and £1.4million in 2019/20 to support a range of interventions – including extending crisis care, liaison services and street triage. These new approaches and interventions are overseen by the Regional Mental Health and Criminal Justice Partnerships who report on progress to the MHCCC Assurance Group meetings to enable partners to identify areas of good practice and advocate for wider adoption. For example, Swansea University will present the findings from the evaluation of the triage pilot in South Wales to the MHCCC Assurance Group meeting in December.

Financial Implications

Unknown at present. Working in partnership with members of the MHCCC Assurance Group to review the emerging evidence on the effectiveness of the different triage schemes in Wales will be absorbed from within existing programme budgets and NHS allocations. However, potential costs associated with implementing recommendations from the forthcoming Urgent Access Review are not yet known.

Recommendation 3. We recommend that the Welsh Government should work with its partners to ensure all services are playing a key role in intervening early to prevent a mental health crisis escalating in the first place. Greater accountability for the implementation of Local Health Board improvement plans for crisis and out of hours services is needed, ensuring that funding is being targeted at actions that will help individuals to access support before crisis point.

Welsh Government response –

Accept.

The MHCCC is designed to support policy making, investment in services, anticipating and preventing crisis, and making sure effective emergency response systems operate in localities when a serious crisis occurs. The Concordat is structured around a number of core principles, one of which is “people have effective access to support before crisis point”. Other core principles include people having urgent and emergency access to crisis care when they need it; people receiving

improved quality of treatment and gain therapeutic benefits of care when in crisis; a focus on recovery and staying well and receiving support after crisis; securing better quality and more meaningful data, with effective analysis to better understand whether people's needs are being met in a timely and effective manner; and maintaining and improving communications and partnerships between all agencies/organisations, encouraging ownership, and ensuring people receive seamless and coordinated care, support and treatment.

The National Mental Health Crisis Care Delivery Plan reflects this focus on prevention and all Regional Mental Health and Criminal Justice Partnerships have plans in place to deliver on this, locally.

More broadly, we are taking forward a range of programmes and activity which aim to prevent poor mental health and to intervene earlier. This include the Joint Ministerial Whole School approach to emotional health and well-being, funding for Regional Partnership Boards to improve lower tier support in the community, and our mental health social prescribing pilots. We are also working across Government to strengthen the protective factors for good mental health including housing, employment and education. The actions we are taking will be set out in the third and final Together for Mental Health Delivery Plan which will be published soon.

Financial Implications

None. Working with partners to ensure all services are playing a key role in intervening early to prevent a mental health crisis escalating in the first place is a key focus of the Together for Mental Health Delivery Plan and any costs will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 4. The Welsh Government should work with Healthcare Inspectorate Wales to ensure its thematic review of crisis and out of hours care includes a review of the care pathway for people detained under section 136, looking at the quality, safety and responsiveness of the care provided to people detained under section 136.

Welsh Government response –

Accept in principle.

Welsh Government will work with Healthcare Inspectorate Wales, who are currently planning the scope and associated timings for the thematic review. A further update to the HSC+S Committee will be provided once these plans are in place.

Financial Implications

None. Any costs will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 5. The Welsh Government should work with its partners to develop additional health-based places of safety if required. It should also explore the benefits of adopting regional models to address the concerns raised about staff being drawn from other wards, and to ensure section 136 facilities are staffed appropriately to deal with those who may be intoxicated.

Welsh Government response –

Accept.

All Health Boards provide health-based places of safety for the purpose of an assessment of a person's mental health when they are subject to section 135 or section 136. We will request assurance from the Health Boards that current capacity is meeting demand.

The Urgent Mental Health Access and Conveyance Review will help us and partners understand which elements of the crisis pathway need to be strengthened, including alternative places of safety.

Financial Implications

Unknown at present. In the first instance, Welsh Government will work with partners to establish the need for additional health-based places of safety. Costs associated with this initial work will be absorbed from within existing programme budgets and NHS allocations. Should additional health-based places of safety be required, the extent to which associated costs could be met from existing programme budgets and NHS allocations will be considered and addressed in discussions with Health Boards.

Recommendation 6. The Welsh Government should work with Regional Partnership Boards and the third sector to develop sanctuary provision in local areas for people experiencing mental health crisis.

Welsh Government response –

Accept in principle.

Regional Mental Health and Criminal Justice Partnerships are responsible for leading the delivery of regional MHCCC Delivery Plans, and this includes access to sanctuary or alternative models of support. Working with the MHCCC Assurance Group, we will request the five Regional Partnerships to map local provision and to consider this alongside the findings from the Mental Health Urgent Access and Conveyance Review, once they are reported.

There are examples across Wales that we are looking to learn from – for example, the Twilight Sanctuary in Llanelli. This service is one of the first projects from the Transforming Mental Health Programme to launch and has been supported by specific Welsh Government aimed at improving crisis and out of hours provision in mental health services.

Financial Implications

Unknown at present. In the first instance, Welsh Government will work with partners to assess current sanctuary based provision. Costs associated with this initial work will be absorbed from within existing programme budgets and NHS allocations. Should additional sanctuary based provision be required, the extent to which associated costs could be met from existing programme budgets and NHS allocations will be considered and addressed in discussions with Health Boards.

Recommendation 7. We recognise that data collection is improving, and that the Welsh Government intend to publish a new section 135/136 data set, but there are still difficulties in getting a full picture of the use of section 136 because of the availability and quality of data. We recommend that the Welsh Government works with its partners to ensure the data set it publishes on the use of section 136 includes the type of place of safety people are taken to, and the outcomes for people subject to it.

Welsh Government response –

Accept.

On 6 November I wrote to the Committee about the publication of the revised section 135 and section 136 data. The Welsh Government has led the development of a new, strengthened data set for the use of police powers under the Mental Health Act 1983. The data set was developed collaboratively with partners, including the police, and will be published on a quarterly basis, with the first statistical release on 5 December 2019 capturing the position from April 2019 onwards.

Whilst the data published on 5 December includes more information than previously published, such as ethnicity, age and method of conveyance, it reflects only part of the revised data set. We are continuing to work with partners in policing, NHS and

local authorities to improve consistency of all data to enable us to publish a fuller profile in the future.

Financial Implications

None. Costs associated with improving the consistency and quality of data will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 8. The Welsh Government should publish the NHS Delivery Unit's recommendations for improving care and treatment planning following its review:

(a) to help ensure there is greater transparency in holding Health Boards to account for the quality of these plans, and

(b) to give assurances to the Committee that individuals who are already known to mental health services have a care and treatment plan in place in line with the Mental Health Wales Measure.

Welsh Government response –

Accept.

The NHS Wales Delivery Unit was commissioned by Welsh Government to undertake an assurance review, working with Health Boards to gain a clearer understanding of the progress made in the delivery of effective care and treatment planning since the commencement of the Mental Health Wales (Wales) Measure 2010 ("the Measure"). As part of the process of the review, all Health Boards received individual reports with recommendations from the NHS Delivery Unit. The national thematic report was published on the NHS Planning Delivery and Performance webpage which enables all NHS organisations to access the information to support improvements, alongside their individual reports.

The improvements recommended in the review have also informed the development of the Together for Mental Health Delivery Plan (2019/22) which will be published soon. Progress against these actions will be monitored as part of the monitoring arrangements for the Delivery Plan.

The NHS Wales Delivery Framework[1] includes performance standards and measures for the delivery of mental health services in line with the Measure. This includes the standard that 90% of all relevant patients under Part 2 of the Measure will have a valid Care and Treatment Plan (CTP). A valid CTP is one that has been reviewed at least once in a 12 month period. The reason that the target is not set at 100% is to allow for the time period to appoint a Care Co-ordinator for a relevant

[1] https://gov.wales/sites/default/files/publications/2019-05/nhs-wales-delivery-framework-and-reporting-guidance-2019-2020-march-2019.pdf

patient and to develop and write a CTP. A 100% target would require a CTP to be immediately in place as soon as a decision is made that the person is accepted into secondary mental health services and is a "Relevant Patient".[2] This would, in most cases, be impracticable and counter the guidance set out in the Code of Practice for Parts 2 and 3 of the Measure about fully involving the person in preparing their CTP and in consultation with other parties.

Under Part 3 of the Measure, a former 'relevant patient' over the age of 18 who has been discharged from secondary services is able to ask for a re-assessment of their mental health within three years of their date of discharge. This means that a person does not have to go back to their GP to request a referral back into mental health services (although they are not prevented from going back to their GP if that is their preference).

Performance data is published on a quarterly basis on Stats Wales. The latest published data, relating to the quarter ending September 2019, showed that on an All-Wales all-ages basis there were 22,661 patients in receipt of secondary Mental Health services at the end of September 2019. Of these, 20,034 (88.4%) had a valid Care and Treatment Plan. There is an ongoing commitment in the Together for Mental Health Delivery Plan (2019-22) to act on the findings of the NHS Delivery Unit's Review of the Quality of Care and Treatment Planning to improve compliance with statutory requirements and the quality of care and treatment plans.

It is important to understand that not all individuals who are currently or previously "known" to mental health services will be receiving (or be former users of) secondary mental health services in line with the Measure. In this case, it would not be a requirement that they have a statutory Care and Treatment Plan.

Financial Implications

None. The assurance review undertaken by the NHS Wales Delivery Unit has been published.

Recommendation 9. The Welsh Government should implement, as a matter of urgency, its conveyance review and state how it will ensure that alternative patient transport will be provided for individuals experiencing mental health crises, thereby limiting the use of police vehicles in the conveyance of individuals detained under the Mental Health Act 1983 to hospital.

Welsh Government response –

Accept.

[2] "Relevant Patient" means someone who the Local Health Board is responsible for providing a secondary mental health service or someone who is under guardianship of a local authority in Wales.

We expect to receive the findings from the Mental Health Urgent Access and Conveyance Review in April and the findings will be presented to partners on the MHCCC Assurance Group to inform next steps. I will update the Committee when we have considered the findings from the review.

In addition to the review, through our additional investment in mental health crisis care, both Aneurin Bevan and Hywel Dda Health Boards are piloting approaches using non-emergency vehicles for mental health conveyance. The outcomes of these pilots will inform our actions in this area.

Financial Implications

Unknown at present – and dependent on the findings from the Mental Health Urgent Access and Conveyance Review, due to report in April and the outcomes of existing pilots. The extent to which any future costs could be met from existing programme budgets and NHS allocations will be considered and addressed in discussions with Health Boards.

Recommendation 10. As an immediate action, the Welsh Government should publish the six-monthly assurance reports provided to Welsh Government by the Mental Health Crisis Concordat Assurance Group to help increase transparency and drive service improvement.

Welsh Government response –

Accept.

I expect to receive the first 6 month assurance report from the MHCCC Assurance Group in early 2020 and will share this with the Committee. We will publish the 6 monthly reports once we have web pages developed to host these, along with other information from the MHCCC Assurance Group.

Financial Implications

None. Costs associated with publishing six monthly assurance reports will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 11. The Welsh Government should, in consultation with members of the MHCCC Assurance Group, review the role, purpose and governance arrangements of the Mental Health Crisis Care Concordat Assurance Group, in order to satisfy itself that there is sufficient focus on implementation; increased accountability in terms of ensuring that learning from pilots and projects is shared and good practice is scaled up so that there is a more consistent approach to mental health crisis care provision and services across Wales.

Welsh Government response –

Reject.

A review of the role and functions of the MHCCC Assurance Group has recently been carried out with members. It has now moved from a Task and Finish Group as originally convened, to an Assurance Group which will report formally to Welsh Government and other partners. The work of the Assurance Group is now moving to a new phase, focussing on implementation – with the new programme of work being overseen by a new Chair. A new National Delivery Plan has been developed and agreed by all partners and is being implemented by the Regional Groups. I have included the revised Terms of Reference, membership and National Delivery Plan at Annex A for the Committee's information.

Financial Implications

None (rejecting recommendation).

Wales
Crisis Care Concordat
National Action Plan

2019 - 2022

Wales Crisis Care Concordat National Action Plan 2019 to 2022

Introduction

The Mental Health Crisis Care Concordat (the 'Concordat') was published by the Welsh Government and partners in 2015. It is a shared statement of commitment that is endorsed by senior leaders from organisations that are most involved in responding to and supporting people of any age who experience a mental health crisis or who experience a significant deterioration in their mental health that could lead to crisis. The Concordat set out the ways in which partner agencies should work together to deliver a high-quality response to this group of people who require assessment and/or intervention, and who may be in contact with the police, and potentially detained under section 135 or section 136 of the Mental Health Act 1983 (MHA).

Across Wales there is a continuing focus on reducing the need for the police to use their powers under the MHA unless as an absolute last resort, and for people in crisis or at risk of crisis to be effectively supported by health, social care and third sector services. These services should be co-ordinated, delivered in partnership, and ensure that help, advice, support and information are easily accessible and available as early as possible, and by so doing help prevent people from reaching crisis point.

This National Action Plan lists the actions that should be implemented in support of each of the Concordat's four core principles plus two additional ones (see below). It is consistent with current Welsh policies, strategies and legislation, and specifically cross references the 'Together for Mental Health' (T4MH) all Wales strategy to assist facilitation and monitoring of its delivery. We expect to see delivery of the actions set out in this document measured and accounted for through implementation of the T4MH Delivery Plan, and although the outcomes set out here are not specific performance targets and do not need to be directly measured as part of this plan, we would expect to see evidence of improved outcomes for people using services. This plan should be regarded as a live/working document and used in conjunction with the original Concordat which provides further comprehensive details of the core principles, governance arrangements, purpose aim and scope, as well as the partners who have committed and signed up to it. Regional plans should be updated to reflect the actions and outcomes set out in this document.

Overarching aims of National Action Plan

- Services should be centred and focused around the safety and the needs of the person in need of support
- Services should demonstrate that people are being kept safe and that their needs are being met
- Increased availability and use of alternative health and non-health-based places of safety including community-based settings
- Safe and appropriate conveyance of people across and between services
- Continuing development, learning and sharing of new ideas and innovation across agencies/organisations
- To provide links with and draw from existing strategies and plans, and be open and transparent in reporting progress

Core principles

The Concordat is structured around the following four core principles:

- People have effective access to support before crisis point
- People have urgent and emergency access to crisis care when they need it
- People receive improved quality of treatment and gain therapeutic benefits of care when in crisis
- Recovery and staying well and receiving support after crisis

A further two core principles have been added to this action plan:

- Securing better quality and more meaningful data, with effective analysis to better understand whether people's needs are being met in a timely and effective manner
- Maintaining and improving communications and partnerships between all agencies/organisations, encouraging ownership, and ensuring people receive seamless and coordinated care, support and treatment

Policy and Legislation

In Wales mental health policy and legislation stress the importance of preventing and supporting people in crisis or who are at risk of crisis. 'Together for Mental Health' was published in 2012 and is Wales' overarching mental health strategy. The strategy highlights the need for people to be involved in their own care, support and treatment, and at the centre of service planning and delivery. It also emphasises the importance of ensuring that effective partnerships are established and maintained. Since its publication numerous supporting pieces of policy guidance have been issued relating to; criminal justice liaison services, mental health services for veterans in prison, children and young people involved with the Youth Justice system, the care and treatment of people with co-occurring mental health and substance misuse problems, etc. Other national initiatives and programmes have also been developed such as the 'Unscheduled Care Programme' and the 'Early Action Together Programme'.

There are four key pieces of legislation that impact on the delivery of the Concordat and this accompanying action plan:

- Mental Health Act 1983 (the 83 Act) *(see also specific changes to s135 and s136 of the MH Act in the Policing and Crime Act 2017 (Part 4, Chapter 4))* and the MHA 1983 Code of Practice for Wales which provides detailed guidance on required responses to people in mental health crisis
- Mental Health (Wales) Measure 2010 (The Measure) (and its supporting regulations, guidance and the Code of Practice to Parts 2 and 3 of the Measure) The Measure places statutory duties on care co-ordination and the production of care and treatment plans (CTPs) for people using secondary care mental health services. The Measure also places a statutory duty on LHBs and Local Authorities to assess a person who requests such an assessment when they have been discharged from mental health services in the last 3 years without the necessity for a referral from their G.P.

- The Social Services and Well-being (Wales) Act 2014 which provides the legal framework for improving the well-being of people and a duty to produce care and support plans. It also includes a major focus on partnership working across agencies/organisations
- The Well-being of Future Generations (Wales) Act 2015 which puts an onus on organisations to think longer term, prevent problems from occurring, and take a more joined up and collaborative approach. This legislation also provides the legal framework for establishing Public Services Boards across Wales

It is important to ensure that this action plan is not regarded as separate or different to these policies, programmes and legislation but is seen as integral to them.

Governance and assurance

Multi agency 'Mental Health and Criminal Justice Partnership Boards' (MHCJPB) (or equivalent) have been established across each of the four Police force areas in Wales. These Boards provide a mechanism to deliver change and improvement. They are responsible for overseeing and monitoring regional action plans developed to address the core principles of the Concordat. MHCJPBs should receive assurance on a quarterly basis that the actions set out in this delivery plan are being locally implemented. They should also receive assurance that people whose mental health has deteriorated rendering them in crisis, or who were at risk of reaching a crisis, received timely help, support, advice, treatment and care. MHCJPBs should provide assurance to the national Concordat Assurance Group on a quarterly basis that the requirements set out in this plan are being achieved. The national Concordat Assurance Group will provide written assurance to the Cabinet Secretary for Health and Social Services every six months that the Concordat is being effectively implemented and, if not, the reasons why and what remedial action is being taken.

Core principle 1: Access to support before crisis point			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
1.1 Ensure that people currently receiving secondary mental health services: • Have a comprehensive Crisis Plan that includes Contingency Planning and who to contact when in need of help or support, and appropriate detail of planned support to mitigate crisis • Have easy and fast access to a crisis prevention service *(this could either be a statutory service such as a Crisis Team or a community service such as a crisis café, etc.)* • Are appropriately supported or sign-posted to alternative sources of support when contacting statutory health/social care services or community/third sector services, and know where to get information	*The Measure and the MHA 1983 (revised 2007)* *T4MH Delivery Plan: People with a mental health problem have access to appropriate and timely services* *T4MH Delivery Plan: To ensure people with an identified mental health problem have timely access to a range of evidence based psychological therapies* *T4MH Delivery Plan: To ensure timely and appropriate services for people with first episode psychosis*	CTP local audits including the quality of crisis and contingency plans Early intervention services records First episode psychosis records GP data Hospital admissions rates	Fewer re-admissions Earlier access to services Reduction in rate of use of s136 Alternatives to hospital admission Reduced rates of self-harm & suicide
1.2 Ensure that people not currently receiving secondary mental health services: • Have timely access to primary care services • Have timely access to a crisis prevention service within the community, e.g. crisis café or other local community service • Are appropriately supported or sign-posted when contacting statutory health/social care services or community/third sector services and know how and where to receive information	*T4MH Delivery Plan: People to have access to appropriate information & advice to promote mental wellbeing & to help understand/manage their condition* *T4MH Delivery Plan: To promote mental well-being and where possible prevent mental health problems developing* *T4MH Delivery Plan: To ensure there are robust links between primary care and mental health services*	GP records Local Primary MH Support Services (LPMHSS) records Third sector records CALL helpline records	Fewer unnecessary referrals from primary to secondary care Reduced rates of self-harm & suicide Better mean mental wellbeing score More support, care & treatment within primary care with fewer inappropriate referrals to secondary care GMS contract – Directed Enhanced Service

Core principle 2: Urgent and emergency access to crisis care			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
2.1 Ensure that people experiencing a mental health crisis: • Have access to a local service available 24/7 • Receive safe support - treated with dignity & respect • If detained under s136 taken to a place of safety that is appropriate to needs, including alternative places of safety such as crisis café, crisis house, sanctuary • Receive a timely assessment of needs in accordance with current CMHT guidance • Receive timely help, support, care and treatment • Have an urgent referral route available from primary care	*T4MH Delivery Plan: - timely and appropriate Mental Health services for people with mental health problems who are in contact with the criminal justice system* *T4MH Delivery Plan: - ensure people with co-occurring mental health and substance misuse problems are managed effectively* ***'Talk to me 2'** Objective 2: To deliver appropriate responses to personal crisis, early intervention and management of suicide and self-harm*	s135 and s136 data ED unscheduled care Core data work Patient/service user feedback data Suicide and self-harm prevention action plans	More use of local/community resources (reduced use of s136) Improved patient experience in ED Quicker assessment and faster access to treatment Reduced rate of self-harm Reduced rate of suicide Fewer 'serious incidents' or 'never events'
2.2 Police, Health Boards and local authorities have an agreed protocol in place to help ensure: • Less need for police to use powers under s136 • Appropriate and safe means of conveyance is used that best meet people's needs • Swift and easy diversion from criminal justice services to health and social care service, including direct links into crisis teams for both s136 and voluntary assessments • People with mental illness affected by alcohol or drugs receive a timely and appropriate service • Children & young people are never detained in police custody suites under s136 • Availability of real time advice/clinical support from Police control rooms, and MH professional advice always available to the Police	*T4MH Delivery Plan: ensure that all people in crisis and in contact with police are treated with dignity and respect* *SSWBA (14); MH (W) M (10) & MHA* *'Service framework for the treatment of people with a co-occurring mental health and substance misuse problem'* *Mental Health Act 1983* *Policing and Crime Act 2017 Part 4 Chapter 4*	Feedback from people who have used services and their families Audits regarding outcomes from referrals and assessments Data on the use of s135 and s136 and the conversion rate to informal or Ss2 or3 Police & Ambulance data on conveyancing & local authority data regarding detention under MHA	Early detection of MH needs when within police custody and/or fast signposting to appropriate support service More people diverted from criminal justice services to health and social care services People receive appropriate and safe means of transport to services that meet their needs Fewer people being 'bounced' between services

Core principle 3: Quality of treatment and therapeutic care when in crisis			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
3.1 Ensure that people experiencing a mental health crisis are continuously treated with dignity and respect and receive a safe service that meets their needs 3.2 Ensure that the use of restraint is minimised, and all relevant staff are trained in de-escalation techniques and processes 3.3 Ensure seamless transfer of care between and across services, and that effective liaison services are in place 3.4 Ensure people have accurate, timely and up to date information and are aware of their rights 3.5 Ensure that planning for appropriate discharge from hospital takes place as early as possible, and that following discharge appropriate follow up support is provided within targeted timescales 3.6 Ensure there are a wide range of therapeutic activities for people to do whilst in hospital 3.7 Services demonstrate they meet national guidelines and standards relating to inpatient care	*T4MH Delivery Plan: - ensure that all services are planned and delivered based on safety and respect* *T4MH Delivery Plan: - ensure that service users/carers feel listened to and are fully involved in decisions about their own care/family member's care* *T4MH Delivery Plan: Welsh Government to review the provision and the availability of more structured interventions for individuals within the community that have a personality disorder, mental health issues and substance misuse concerns*	Feedback from people who use services HIW inspection/audit reports Reporting of 'serious incidents' and 'Never events' NICE guidelines Accreditation for Inpatient Mental Health Services (AIMS) T4MH delivery plan reports	More people have a positive experience of care, support and treatment provided when in a crisis People spend less inappropriate time in hospital People receive appropriate support to meet their needs once they are discharged from hospital More people with mental health problems are supported by health and social care services rather than by criminal justice agencies

Core principle 4: Recovery and staying well			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
4.1 Care and Treatment Plans (CTPs) for people receiving secondary mental health services should include: • Early warning signs of crisis or relapse – recording the thoughts, feelings and/or behaviours that may indicate when a person is becoming more unwell • Actions that need to be taken should a person become more unwell ('crisis plan') • Details and contacts of local support that is available to help prevent a person's circumstances escalating into a crisis • Who person is most responsive to and who person wishes services to contact when becoming unwell • Identifying factors that are significant to a person being able to remain as independent as possible • With consent CTPs should be accessible to services that people call at points of crisis	*T4MH Delivery Plan: People with mental health problems to have fair access to housing and related support and promote access to mental health services amongst people who are homeless or vulnerably housed* *T4MH Delivery Plan: support people with mental health problems to sustain work and to improve access to employment and training opportunities for those out of work and have access to advice & support on financial matters* *T4MH Delivery Plan: increase the availability of recovery oriented mental health services*	Audit of CTPs Service user and carer feedback Housing support services Out of work services Money advice services CALL helpline Peer mentoring services Quality of life indicators	People discharged from secondary mental health services stay well for longer More people living with a mental health condition live independently Fewer readmissions to hospital More people living with a mental health condition to be in employment, training or education More people living with a mental health condition to have secure good quality housing
4.2 People discharged from secondary mental health services or otherwise not in receipt of secondary mental health services are able to access help, advice, information, support and treatment when they need it	*T4MH Delivery Plan: People to have access to appropriate information & advice* *T4MH Delivery Plan: Promote mental well-being and where possible prevent mental health problems developing* *MH Measure Part 3*	LPMHSS records Third sector records and/or feedback Part 3 data	More people living with a mental health condition to know where to receive help, advice and information

Core principle 5: Data and analysis			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
5.1 Ensure both meaningful and accurate qualitative and quantitative data is gathered and held to demonstrate that the needs of people in crisis, or at risk of crisis, are being met 5.2 Ensure data and information is appropriately shared across and within agencies and organisations in accordance with data protection legislation 5.3 Ensure service provision is evidence based or, if not, part of a pilot/trial programme	*T4MH Delivery Plan: To progress the development and implementation of a national mental health core data set capturing service user outcomes* *T4MH Delivery Plan: To continue to support an evidence-based approach and ensure active research and evaluation is at the heart of service development*	Assurance reports provided to MHCJPBs Quarterly assurance provided by MHCJPBs to national CAG National core data set	Evidence available that shows how services are helping people recover and are meeting their needs Increased knowledge and learning across and within organisations and agencies Assurance of increased focus on delivering what matters to people who use health & social care services

Core principle 6: Communication and partnerships			
Actions to support addressing this principle	**Link to existing plans/legislation**	**Data/Information sources**	**Outcomes to be aiming for**
6.1 Ensure effective partnership working across all organisations involved in supporting people in crisis 6.2 Ensure that people can access and receive services through the Welsh language when they wish to do so 6.3 Ensure effective communication processes across and within agencies/organisations involved in supporting people in crisis 6.4 Ensure a Regional communication strategy is in place that informs stakeholders and partners about the Concordat and its impact	*T4MH Delivery Plan: ensure service users, families and carers are fully involved in service development* *T4MH Delivery Plan: ensure Welsh speakers access services through the medium of Welsh when needed and increase welsh language capacity in the workforce* *T4MH Delivery Plan: ensure public services & third sector work to provide an integrated approach*	Assurance reports provided to MHCJPBs Quarterly assurance provided by MHCJPBs to national CAG	People experience a seamless and joined up service during a crisis Increased knowledge and learning across and within organisations and agencies Reduced waste and duplication, and minimised bureaucracy

Wales

Crisis Care Concordat

Concordat Assurance Group

Terms of Reference

November 2019

Purpose

The Mental Health Crisis Care Concordat is a shared statement of commitment by organisations to work together to provide better support to people who experience, or are at risk of experiencing, a mental health crisis, and improve outcomes. The Concordat Assurance Group (CAG) will provide strategic direction, leadership, oversight and assurance relating to the ongoing implementation of the Wales Mental Health Crisis Care Concordat National Action Plan.

Functions

The CAG will carry out the following functions:

- Receive written and verbal assurance from regional groups and partners every three months that their Crisis Care Concordat regional action plans are being implemented
- Provide assurance to Welsh Government every 6 months that the Crisis Care Concordat National Action Plan is being implemented
- Facilitate improved collaboration, communication and co-ordination between and across all partners working to implement the Concordat and the National Action Plan
- Provide a mechanism, or forum, for escalating any issues that impact on the delivery of the National Action Plan or regional action plans
- Provide a forum for learning and sharing of good practice across Wales
- Receive regular updates from the National Collaborative Commissioning Unit on its review of access and conveyance relating to crisis care and to consider and provide advice on how best to implement its recommendations
- Provide any support needed to help implement regional crisis care action plans
- Be informed by and respond to a broad and diverse range of people across Wales who have used crisis care services

Membership

See Annex 1 for details of organisations that are represented on the National Concordat Assurance Group

Meetings

CAG meetings will be held quarterly on these dates; 11 December 2019, 18 March 2020, 23 June 2020, 22 September 2020.

Chair and Secretariat

The CAG is chaired by Emrys Elias (Vice Chair Aneurin Bevan UHB)
emrys.elias@wales.nhs.uk

The national Crisis Care Concordat co-ordinator is Peter Martin (Mind Cymru)
p.martin@mind.org.uk

Welsh Government secretariat support is provided by Lisa McInch
lisa.mcinch@gov.wales

Governance arrangements

The original Crisis Care Concordat for Wales described how multi-disciplinary 'Mental Health and Criminal Justice Partnership Boards' '*will provide the driver to deliver local and regional change and improvement'*, and should *'act as the prime arena for accountability'.* These Boards no longer exist and have been superseded by other regional multi agency groups or forums.

These regional groups/forums, through either the Chair or through a nominated person, will provide assurance to the CAG on a quarterly basis that the actions set out in the National Action Plan are being implemented through regional action plans, and that successful outcomes are being achieved. Regional groups/forums will also provide assurance and that any transformation or service improvement funding received to deliver improved crisis care services is having a positive impact.

Reporting arrangements

Each of the 5 regional groups/forums should submit a quarterly assurance report (see Annex 2) to the Chair of the CAG (through the national co-ordinator) at least 2 weeks before its next meeting. These assurance reports will be included with the papers circulated for the national meeting.

As well as giving overall assurance that regional action plans are being implemented and making a positive difference, assurance reports should also specifically:

- Detail key outputs and outcomes relating to regional Crisis Care Concordat plan for the last 3 months
- Highlight key achievements over the last 3 months including how transformation or service improvement funding is being used to improve services
- Highlight any current challenges or barriers to implementing regional plans and what remedial action is proposed or is being taken
- Set out any priority areas for action that are planned for next 3 months

The Chair of the CAG will provide a written assurance report every 6 months which will be sent to all partners. This assurance report will be mainly informed by the assurance reports provided by the regional groups/forums. The written assurance report will include:

- An all Wales overview of progress in delivering the Crisis Care Concordat National Action Plan
- What learning and good practice has been shared across Wales and the benefits this has made
- Key achievements on a regional basis, including how any additional transformation or service improvement funding has been used to deliver better services
- Any challenges or barriers to implementing the National Action Plan and what remedial action is being taken

Accountability

The CAG does not have a specific performance management role. Its prime role is receiving assurance that the purpose set out in the original Crisis Care Concordat is being met and its principles are being applied through delivery of regional crisis care action plans. Each partner organisation will have its own internal governance, accountability and performance management arrangements. Multi agency regional groups (relating to crisis care) should have arrangements in place for overseeing and monitoring their regional action plans. The Chair of each regional group is responsible for ensuring that assurance is provided to the national CAG through the reporting arrangements described above.

Escalating concerns

Each partner organisation should have its own processes for escalating any barriers or challenges to implementing any part of the Crisis Care Concordat it is responsible for delivering. Any barriers and/or challenges should be discussed and addressed at regional multi agency group meetings. Where there are any issues or problems identified that cannot be resolved either at an organisational level or through regional partnerships, they can be escalated to the national CAG for further consideration on how to resolve and the best way to take forward.

Being informed by people's lived experience

There are two main networks that will ensure that the CAG is informed, influenced and driven by people who have experience of using mental health crisis service:

Wales Alliance for Mental Health

The mental health third Sector is represented on the CAG by the Chair of the Wales Alliance for Mental Health (WAMH). WAMH is an alliance of national charities which support people with mental health problems and mental illness, and current membership comprises Diverse Cymru, Hafal, Mental Health Foundation, Mental Health Matters, Mind Cymru, Platform and Samaritans. Collectively they bring a wealth of knowledge and reflect a wide and diverse range of 'service user' experiences. All organisations involved in WAMH are committed to ensuring people experiencing mental ill health in Wales have their voices heard.

National Mental Health Forum (Wales)

CAG will also seek views from and be informed by the National Mental Health Forum in taking forward its work. The Forum provides a strong and diverse voice for people with experience of mental health services, and carers, across Wales. It brings together the local and national partnership board members, their deputies, and a further ten members recruited nationally to ensure that it reflects the diversity of the people of Wales and the range of their mental health needs. It is increasingly becoming a powerful voice for service users and carers. The Forum is supported and facilitated by Practice Solutions Ltd - www.practicesolutions-ltd.co.uk – and the co-ordinator for the CAG will ensure it is regularly kept up to date and that there is regular contact and liaison.

Annex 1

Mental Health Crisis Care Concordat Assurance Group: Membership	
Chairs of Regional Partnerships	
Lead: Richard Jones Deputy: Vikki Evans	Dyfed
Lead: Chris O'Connor Deputy: Sarah Paxton	Gwent
Lead: Lesley Singleton Deputy:	North Wales
Lead: Gaynor Jones Deputy: James Thomas	South Wales
Lead: Louisa Kerr Deputy:	Powys
Chair of Assurance Group	
Emrys Elias	Vice Chair: Aneurin Bevan UHB
Crisis Care Concordat Co-ordinator	
Peter Martin	Mind Cymru
Social Services Representatives	
Sarah Paxton	ADSS Cymru
Third Sector	
Sara Moseley	Wales Alliance for Mental Health
Andrew Misell	Alcohol Concern Cymru
NHS Collaborative	
Shane Mills	
NHS Delivery Unit	
Phill Chick	
HM Prison and Probation Service	
Ian Barrow	

Mental Health Act Admin Rep	
Sarah Roberts	
Police Liaison Unit	
Paul Morris	
Police Mental Health Lead	
Mark Collins	
Police and Crime Commissioners	
Alun Michael	
Public Health Wales	
Welsh Ambulance Service Trust	
Stephen Clarke	
Healthcare Inspectorate Wales	
Scott Howe	
Royal College of Psychiatry	
Oliver John	
Welsh Government	
Matt Downton Elin Jones Lisa McInch	

Annex 2

Crisis Care Concordat National Action Plan for Wales

Assurance Reporting

1. The all Wales Crisis Care Concordat Action Plan sets out 20 actions to be implemented to support the following six core aims:

    - People have effective access to support before crisis point
    - People have urgent and emergency access to crisis care when they need it
    - People receive improved quality of treatment and gain therapeutic benefits of care when in crisis
    - People are supported in their recovery, stay well, and receive effective support after crisis
    - Better quality and more meaningful data and effective analysis is secured
    - Effective communications and partnerships are maintained and improved

2. An assurance report template is attached that should be completed and sent to the Chair of the national Concordat Assurance Group, via the national co-ordinator, each quarter. Assurance reports provide a level of confidence that the actions set out in the National Action Plan are being implemented at a regional level through regional action plans. They should include any output and outcomes data that is available to demonstrate progress, highlight any key achievements and show how additional funding is helping achieve results. Assurance reports should also identify any challenges or barriers to implementing action plans, and detail immediate priorities for the next 3 months

3. The Chair of each regional forum should email the completed assurance form to the national co-ordinator each quarter at least 2 weeks prior to the national Concordat Assurance Group meeting. This will then be included in the agenda for the national group's meeting. The Concordat Assurance Group will in turn provide an assurance report to Welsh Government every 6 months that the National Action Plan is being delivered, what learning has taken place, any barriers or challenges, and any remedial action that is being taken.

4. Multi agency crisis care forums have been established across each of the 4 police force areas in Wales to oversee and monitor their own regional action plans. These regional forums should have their own arrangements in place for receiving assurance from each partner agency that the actions set out in regional plans are being implemented.

5. If you have any queries regarding completion of the template, or require any further help or support please contact: p.martin@mind.org.uk

Mental Health Crisis Care Concordat - Assurance Report			
Partnership area:		**Reporting period:**	
Actions set out in the Crisis Care Concordat National Action Plan are being implemented through regional action plans and monitored at a regional level		**Assurance provided by:**	**Date completed:**
Output and outcomes data for this period		**Challenges and remedial action**	
Key achievements in this reporting period - include details of how any transformation or service improvement funding is helping achieve results		**Priorities for next 3 months**	