Bundle Mental Health and Capacity Compliance Committee 24 September 2021

0 09:30 - MC21/1 Children and Adolescent Mental Health Service (CAMHS) – Patient Experience Update and Patient Story

Chris Stockport
Bethan Jones in attendance
Recommendation:
The Committee is asked to note this Patient Experience Update report and Patient Story

MC21.1a CAMHS Patient Experience report and patient story DCE approved.docx

MC21.1b Appendix 1 Patient Experience project overview DCE approved.docx

MC21.1c Appendix 2 CAMHS Patient story DCE approved.pptx

1.0 GOVERNANCE

1.0.1 09:45 - MC21/2 Terms of Reference for approval

Teresa Owen
Recommendation:
The Committee is asked to note the revised Terms of Reference and recommend their approval to the Board through the Committee Chair's Report

MC21.2a MHCCC ToR DCE approved.docx

MC21.2b MHCCC ToR v1.03 DCE approved.docx

1.0.2 09:55 - MC21/3 Cycle of Business for approval

Teresa Owen
Recommendation:
The Committee is asked to review and approve the Cycle of Business

MC21.3a COB inaugural DCE approved.docx

MC21.3b Cycle of Business MHCCC draft v.01 Sept 2021 DCE approved.docx

1.1 MC21/4 Apologies

Jo Whitehead

Note Mark Polin, BCU Chairman in attendance to enable quoracy

1.2 MC21/5 Declaration of Interest

1.3 10:05 - MC21/6 Draft minutes of the previous MHAC meeting held on 25.6.21 - for approval

MC21.6 Draft MHAC Minutes 25.6.21 v0.2.docx

1.4 10:05 - MC21/7 Matters arising and MHAC summary action

Recommendation:
MHAC summary action is reviewed and any outstanding actions to be transferred to the MHCCC Table of actions

MC21.7 MHAC Summary Action Plan FINAL for closure.doc

1.5 10:10 - MC21/8 Report of the Chair - verbal

Lucy Reid

1.6 10:15 - MC21/9 Report of the Lead Executive - verbal

Teresa Owen

2.0 STRATEGIC ITEMS FOR DECISION - THE FUTURE

2.1 Developing Strategies or plans

2.2 10:17 - MC21/10 Reforming the Mental Health Act White Paper - Update

Teresa Owen
Wendy Lappin in attendance
Recommendation:
The Committee is asked to nore the report

MC21.10 New Mental Health Act v2 DCE approved.docx

2.3 10:22 - MC21/11 Liberty Protection Safeguards (LPS) Update

Michelle Denwood in attendance
Recommendation:
The MHCC Committee is asked to accept the LPS position report in preparation for the implementation of Liberty Protection Safeguards (LPS) on 1st April 2022.

MC21.11 LPS Update Report September 2021 V1 DCE approved.docx

2.4 10:37 - MC21/12 Approval for All Wales Approved Clinicians and Section 12(2) Doctors)

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

MC21.12 ACandS12 report_September 2021 DCE approved.docx

3 QUALITY, SAFETY AND PERFORMANCE - THE PRESENT for assurance

3.1 10:37 - MC21/13 Deprivation of Liberty Safeguards (DoLS) Quarterly Report September 2021

Michelle Denwood in attendance
Recommendation:
The MHCC Committee is asked to note the Deprivation of Liberty Quarterly Report and the identified activity for the period of April 2021 to August 2021.

MC21.13 DoLS Update Report September 2021 V1.00final DCE approved.docx

3.2 10:52 - MC21/14 Associate Hospital Managers Update Report (May 2021 – July 2021)

Teresa Owen
Wendy Lappin in attendance
Recommendation:
The Committee is asked to nore the report

MC21.14 Associate Hospital Managers Update Report DCE approved.docx

3.3 Comfort break

3.4 11:02 - MC21/15 Mental Health Act Performance report

Teresa Owen
Hilary Owen and Wendy Lappin in attendance
Recommendation:
The Committee is asked to discuss and note the report.

MC21.15a MHA Performance Report DCE approved.docx

MC21.15b Appendix 1 Performance Report DCE approved.pdf

MC21.15c Appendix 2 Divisional S136 Report August 2021 DCE approved.pdf

MC21.15d Appendix 3 CAMHS S136 Report August 21 DCE approved.pdf

3.5 11:17 - MC21/16 Mental Health Act CAMHS Com Tier 1 risk register and Committee mapping

Chris Stockport
Bethan Jones in attendance
Recommendation:
The Committee is asked to
note the current structure for governance and risk management arrangements within CAMHS, Regional Children's Services and
consider the mapping undertaken of the meeting structure to support reporting requirements to the Mental Health and Capacity Compliance Committee (MHCCC).

MC21.16a CAMHS Risk and Committee mapping DCE approved.docx

MC21.16b CAMHS Appendix 1 Committee mapping DCE approved.docx

MC21.16c CAMHS report Appendix 2 Risk Register DCE approved.docx

3.6.1 11:27 - MC21/16.1 Mental Health Act Adult risk register : Age appropriate support when children are admitted to an acute adult mental health facility

Teresa Owen
Iain Wilkie in attendance
Recommendation:
The Committee is asked to note the report

MC21.16.1 Risk_Age appropriate support in AMH facility DCE approved.docx

3.6.2 11:32 - MC21/16.2 Mental Health Act Adult risk register : Recruitment and retention of senior doctors, including 12(2) doctors

Teresa Owen
Iain Wilkie in attendance
Recommendation:
The Committee is asked to nore the report

MC21.16.2 Risk_12.2 doctors DCE approved.docx

3.6.3 11:37 - MC21/16.3 Mental Health Act Adult : Committee mapping

Teresa Owen
Iain Wilkie in attendance
Recommendation:
The Committee is asked to note the diagram illustrating the governance structure of the MHLD Division.

MC21.16.3a MHLD Governance mapping DCE approved.docx

MC21.16.3b Governance structure 29.03.2021 with chairs DCE approved.docx

4 LEARNING FROM THE PAST

4.2 11:42 - MC21/17 Healthcare Inspectorate Wales (HIW) Monitoring Report

Teresa Owen
Hilary Owen / Wendy Lappin in attendance
Recommendation:
The Committee is asked to note the report.

MC21.17a HIW Monitoring Report DCE approved.docx

MC21.17b Appendix2 HIW Mesen Fach Report DCE approved.pdf

4.3 11:52 - MC21/18 Compliance with the Mental Health Act in the Forensic, Rehab and Older Persons Units Audit

Teresa Owen
Hilary Owen / Wendy Lappin in attendance
Recommendation:
The Committee is asked to note the audit report.

MC21.18a MHA Audit report DCE approved.docx

MC21.18b MHA Audit September 2021 DCE approved.doc

7 CLOSING BUSINESS

7.1 12:02 - MC21/19 Agree Items for referral to Board / Other Committees

Lucy

7.2 12:04 - MC21/20 Review of risks highlighted in the meeting for referral to Risk Management Group

Lucy

7.3 12:09 - MC21/21 Agree items for Chairs Assurance report

Lucy

7.4 12:14 - MC21/22 Review of meeting effectiveness

Lucy

7.6 12:19 - MC21/23 Date of next meeting 17.12.21

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Children and Adolescent Mental Health Service (CAMHS) – Patient Experience Update and Patient Story**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Louise Bell, Assistant Director, CAMHS
Craffu blaenorol: Prior Scrutiny:	Bethan Jones, Area Director Central
Atodiadau Appendices:	Appendix 1 – CAMHS Patient Experience Project Structure Appendix 2 – Patient Story

Argymhelliad / Recommendation:

The Committee is asked to note this Patient Experience Update report and Patient Story

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**	✓ ☐	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

This report focuses on a structure now in place within CAMHS to use patient feedback we receive, including complaints, which tells us how it feels for our Children and Young People to receive care within CAMHS, and how we will use this feedback to improve patient experience.

It demonstrates work towards embedding a strategy for the engagement and patient experience of children, young people, parents and carers. While the plan is currently in draft, many of the actions have commenced and our work to build on a patient experience strategy continues. A range of examples are shared in the report to show how our patient experience team will be gathering and collating patient feedback to support us to develop and improve our services to Children and Young People.

Cefndir / Background:

There is a vast amount of work being undertaken to improve patient's experiences within CAMHS. It has been recognised that more needs to be done to raise the profile of this and demonstrate a commitment to putting patients' views, experiences and their involvement at the centre of everything we do.

In March 2021 we appointed a CAMHS Patient Experience and Involvement Manager and as part of our commitment to continually improve patients' experiences we have reviewed and secured additional resource to expand the work further. We are in the process of recruiting to support posts with a Patient & Family Liaison Officer to be based at North Wales Adolescent Service (NWAS) and administration support for the Team who will be focusing on the key development areas explained in the body of the report.

Asesu a Dadansoddi / Assessment & Analysis

Within each of the four identified aims detailed in the Structure (Appendix 1), current patient experience work can be demonstrated from the following:

Coproduction

- Embark on 100 Stories Project. The project will look to capture 100 stories from children, young people, families and carers regarding their experiences.
- Leadership and Public Narrative Training: a short leadership-training pilot has now been completed and successfully captured 50 stories from young people. Designed to support young people to gain the confidence to be able to explore what is important to them and the skills to be able to influence and engage others to listen to their view and opinions.
- Children's Charter for BCUHB: standards and principles set out within the charter will support the organisations approaches to working with children, young people, parents and carers. CAMHS have commissioned a Children's Rights Training for Trainers to support the delivery of child's rights based training to all staff and this will be delivered in October 2021.

Communication

- Information Leaflets/Newsletter: Patent Experience Monthly Newsletters for staff Working with the Corporate Communications Team and Corporate Patient Advice and Liaison Service (PALS) to develop our social media and website resources. Plans are in place to pilot 'Ask Me Anything' sessions in the near future.

Structure

- Patient Experience Champions: We have established links with the Corporate Champions initiative and in partnership developed Champions Forums.
- Regional Children, Young People, Parents and Carers Reference Groups: We have worked closely with statutory, voluntary and third sector organisations across each area to establish links with current reference groups. Interacting with existing groups will enable us to ensure young people have access to ongoing support, which is sustainable.
- Complaints/Compliments Group: Following a baseline engagement we have developed a structure to ensure the learning from complaints, compliments and patient experience is embedded into service development and practice.
- Engagement volunteering programme will now be developed which will include links to training and personal development of children, young people, parents and carers wishing to engage with any planning, development, monitoring and evaluation of CAMHS services.

Practice

- Real time feedback: To support the evaluation of our services we are working with the Corporate PALS Team to embed Patient Experience Feedback processes.
- Bespoke feedback: we have developed a number of online SMART surveys relating to specific service areas across BCUHB and these are now reported monthly.

- NWAS are currently in the final draft stages of their bespoke patient engagement and experience implementation plan which will go out for consultation. As part of this work, a steering group of stakeholders will be engaged in implementing the plan moving forward.

A Patient's Story

Following a request for a patient story the Patient Experience Team have made contact with a young person who provided us with their experience of being a patient within our CAMHS services, accessing community services, specialist services within NWAS and out of area Low Secure and Psychiatric Intensive Care Unit (PICU) level services. The story (Appendix 2) has been produced over the last couple of weeks and will be used to inform improvement and as an effective method to ensure learning is responsive and based on real patient experience.

The story will be shared across the relevant professionals at the next CAMHS Clinical Advisory Group Meeting this month and at the CAMHS Patient Experience Champions Forum and a plan for learning will be developed.

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

Not applicable

Dadansoddiad Risk / Risk Analysis

Not applicable

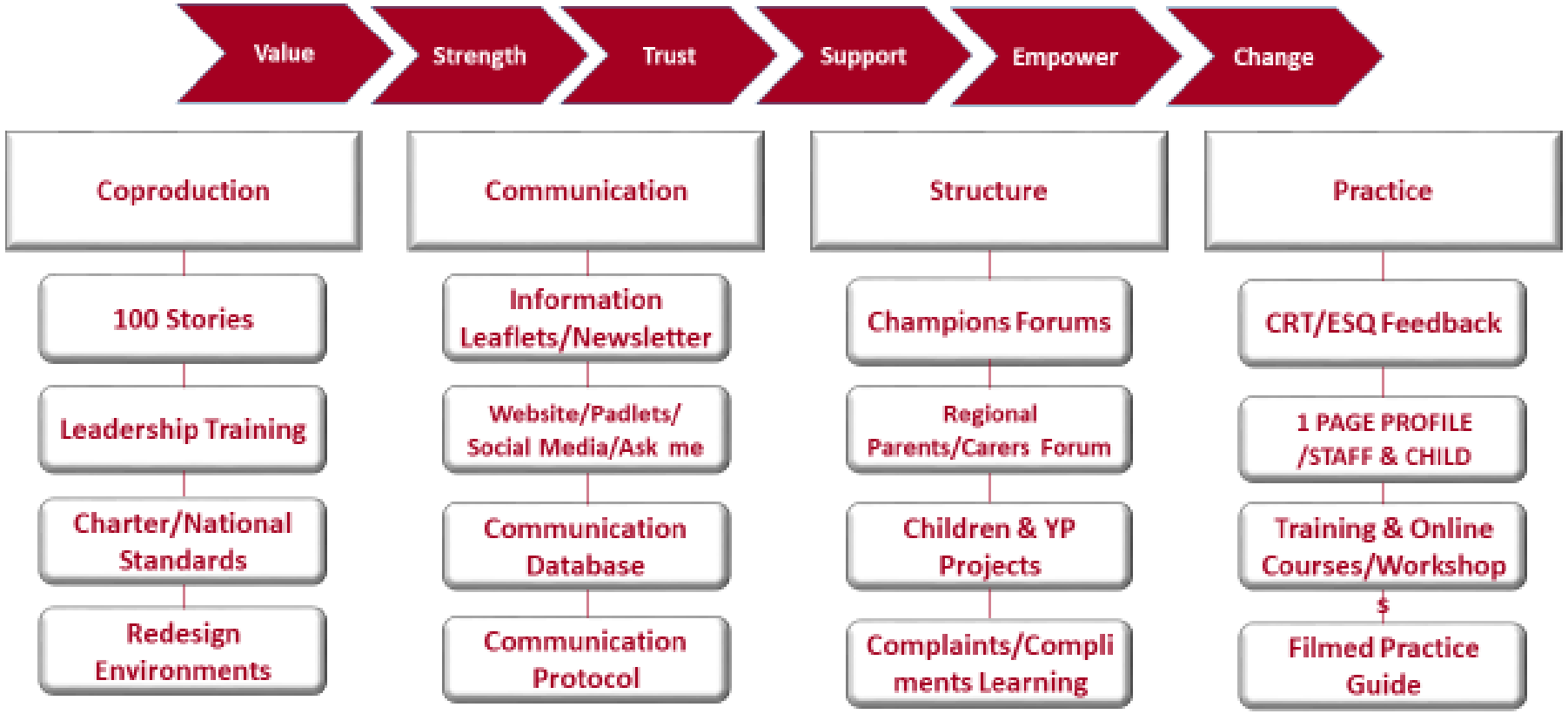
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Not applicable

Asesiad Effaith / Impact Assessment

Not applicable

Patient Experience Project Overview



A Patient Experience Story

from

The North Wales Adolescent Service

September 2021

Produced with support from Tiffany Arnold, HCPC Registered Art Psychotherapist

Background

A young person who was discharged from the North Wales Adolescent Service (NWAS) previously, contacted the service asking if there was something she could do by way of a positive contribution. She wanted very much to give something back because she feels that NWAS has helped her a lot. When we were asked to produce a patient story for the MHCCC we then contacted the young person and invited her to participate.

This young person has a complex trauma history and it was important to work within trauma informed patient experience story guidelines in order to ensure the safety and wellbeing of the participant.

Continued…

Due to the need to work safely and to tight time scales it has only been possible to produce a short, general overview of the young person's treatment journey.

The young person wrote her story and then worked in partnership with the Art Therapist to create the presentation. She then had the final say at editing stage so as to be able to feel in control of the process of telling her own story.

All the words that follow are her own.

The young person hopes that people will learn from her experience and that things will change for the better as a result of the story being told. She has requested feedback about the impact of the work.

Thank you.

Paediatric Admissions

From 2015-2016 I had around 14 admissions to general hospital for mental health reasons (e.g. self-harm, suicidal ideation).

This is where my struggles with mental health became apparent.

CAMHS Assessments

I felt alone, different, and separated from other people, like I had somehow been left out.

During the admissions to hospital and being assessed by CAMHS I tried to tell people about abuse I was suffering at home and how my mood was low and I was struggling with suicidal ideation.

But I was always overlooked and told I was ‘attention seeking’ or ‘making it up’.

First NWAS Admission

I was admitted to general hospital in May of 2016, and was kept on the children's ward for 3 weeks whilst a bed was found for me atNWAS.

I ended up being admitted to NWAS in June 2016 when I was 13 years old. It wasn't safe for me to return home.

Once admitted to NWAS, people started taking me seriously, and listened to how I was feeling. I received lots of different talking therapies and was started on medication to help improve my mood and thoughts.

Being Nursed in Isolation

Around November – December 2016 whilst at NWAS, my mental health deteriorated and I was moved onto a separate ward by myself (Kingfisher Ward).

Two staff were over on the ward with me at all times, and I wasn't allowed to leave the ward or mix with other patients. I was kept with two members of staff at all times. One person was on my 1-1 and the other was there if needed.

Being so young at the time and also mentally unwell, this move was hard for me and I couldn't understand why I was the one who had to be moved. I didn't understand why I was being treated differently to the other patients, as no other patient had been segregated on another ward before. I found the move difficult and I would go as far as to say it may have made my mental health even worse, as I felt trapped and helpless.

It would have been helpful if things had been explained more, or differently to me at the time.

Moving to a PICU: Bury, Manchester

In December 2016 I was placed on a Section 3 whilst on Kingfisher Ward, and I was sent to a PICU in Bury, Manchester. I was kept in the PICU (Mulberry Ward) for around 6 months.

However after an incident where I absconded whilst on leave, I was sent to a low secure hospital called Regis Healthcare in Ebbw Vale.

Regis Healthcare Low Secure Unit, Ebbw Vale

I stayed in Regis Healthcare for a year and a half until the hospital was investigated due to complaints from both patients and staff. The Welsh Children's Commissioner was forced to move all Welsh patients from the hospital.

I was then sent to Elysium Healthcare in Potters Bar, London in October 2018.

Potters Bar, London

Being in London was very different from North Wales and felt very far away. When I was in South Wales the hospital was still three and a half hours away from home by car.

At a time when you need your family and support the most, being so far away was really hard for me for lots of reasons. I was always the youngest, and people were really ill. I felt disconnected and a bit trapped.

But during my time in Potters Bar, my contact with CAMHS increased as plans were made for me to return to NWAS hospital.

Second NWAS Admission

In November 2018 I was moved back to NWAS, where I was re-integrated back into life at home. I was supported on leave to my house and was re-familiarised with life at home.

A tiny crack of light appeared. I couldn't see it at the time, but looking back, I can…

Reintegration

During my second admission to NWAS, I was a lot older and more mature. Spending so much time away from home and in different hospitals across the country, I had a lot of catching up to do.

During my stay and reintegration back into everyday life, I remember being told that I was going to be shown a picture of my abuser. The whole reason I was in hospital and had struggled for so many years was because I have PTSD.

On my return back to North Wales I was very afraid to go out or even sit up straight in a car due to fear of bumping into or seeing my abuser. I hid myself away in fear and all my energy was being channelled into hiding myself away because I was terrified of seeing him.

At NWAS, I remember being told that the staff were going to print out a picture of him and show it to me, because in their words I was 'going to see him anyway'. *This really upset and scared me. I get why they thought it would have been helpful, but maybe there would have been a different approach.*

In the end I never did look at that picture anyway.

Discharge to Community Services

After making lots of progress, in November I was taken off my section, and in April of 2019 I was discharged from NWAS.

After my discharge I was supported by the Kite outreach team, whilst also seeing my therapist in community CAMHS multiple times per week.

‘What Could Have Been Done Differently?’

Looking back, it’s hard to know what would have happened if things were handled differently. *But I feel like most of my experiences could have been prevented had I been listened to when I very first came into contact with CAMHS in 2014.*

I do believe that if I would have been taken seriously and believed at that point, or if I would have received help during my huge number of general hospital admissions during 2015 and 2016, and services had become involved earlier, then possibly my admission to NWAS and following admissions may have been prevented, or my admission times shorter.

‘What Was the Impact of the Treatment?’

I think my experiences of past abuse and then, some professionals’ behaviour made my treatment journey longer.

What happened made me doubt peoples’ motives, and made it harder to finally open up and trust people. I was left feeling that no one believed me and that I was making up my feelings and that things weren’t as bad as I thought after all.

This made me feel invalidated and like I was wasting peoples’ time and that I didn’t deserve any help.

People don’t realise how much I still struggle. But at least I’m not in hospital anymore and I’m still alive.

Negatives… And Positives….

There have been a lot of bad things that have happened during my journey and I had a lot of negative experiences with services. There were some decisions that me and my family have questioned and that may not have been helpful.

But there have also been lots of positive experiences, and the services have saved my life on numerous occasions. I wouldn't be here today without the help that I received.

Being Treated as a Person

The staff at NWAS were amazing. They were very kind and understanding, and helped me through lots of my struggles. Having experienced lots of different hospitals and settings, NWAS was the place where I felt the most safe.

There are so many lovely staff members who genuinely wanted to help and supported me to find ways around my struggles. The staff at NWAS saw me as a person, whereas other hospitals just saw me as a patient. They took time to get to know me and my family, which was so refreshing.

After all my experiences it was so nice to find people who genuinely cared and wanted to make a positive difference. The amazing staff members have inspired me to train and become a mental health nurse, to help people who may experience struggles like me.

NWAS Education Centre: Nant-y-Bryniau

The school attached to NWAS (Nant y Bryniau) was incredible. They helped me stay on track and during my second admission they helped me with re-integrating back to mainstream school, and set up meetings and would come with me so I didn't feel alone.

I wouldn't be where I am today with my studies today without all of the help and support they offered me.

Making Things Better for Other Young People

I’m aware that there are flaws in the system, mainly due to funding and lack of communication.

My family had to beg for the help I was entitled to, and the amount of social workers we have been through is in the double figures.

There needs to be more funding and awareness of children and adolescents with mental health difficulties.

Hopefully my story can highlight both the positive and negative areas in the system.

Professional Postscript

The patient experience story reveals some concerning ‘emotional touch points’ in this young person’s treatment journey.

The common thread through all of them is that regardless of actions that may or may not have been taken by professionals at the time, the service user did not *feel* listened to by staff at certain key times.

Despite the best efforts of staff, if we do not understand the reality of the service user experience then we cannot know about the areas that require improvement and change. Only our service users can tell us about this.

Learning Points

Because the young person did not *feel* her concerns were taken seriously, the anxiety created by the treatment was greater than it may otherwise have been, resulting in long term health implications. This anxiety has led to a significant financial cost with additional treatments potentially then having become necessary.

It is clear that more could be done to improve young people's experience of services by paying more attention to how people are *feeling, and reducing the anxiety* associated with any treatment or actions that may be necessary.

The story presents a great opportunity to review the need for staff training in certain clinical areas that were highlighted by this journey, ie. to create an improved understanding of what a trauma presentation looks like, appropriate responses, and active listening techniques. It is different reading about trauma in a book than seeing what it looks like in a real person.

It would be most useful for these trainings to be co-designed and delivered in partnership with service users, since they are the best experts on their experience.

Diolch am wrando.

Thank you for listening.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Committee Terms of Reference
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Diane Davies, Corporate Governance Manager
Craffu blaenorol: Prior Scrutiny:	Teresa Owen, Executive Director Public Health
Atodiadau Appendices:	1. MHCC Committee Terms of Reference v1.03

Argymhelliad / Recommendation:

The Committee is asked to note the revised Terms of Reference and recommend their approval to the Board through the Committee Chair's Report

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

The Committee's Terms of Reference have been refreshed as part of the wider Integrated Governance Framework led by the Interim Director of Governance.

Cefndir / Background:

The Board approved the Integrated Governance Framework at its meeting of 15th July 2021 which included the replacement of the Mental Health Act Committee with the Mental Health Capacity and Compliance Committee. The Terms of Reference of the previous MHAC were amended as highlighted within V1.03 attached to this paper. This has also been amended to reflect that the Power of Discharge Group is no longer a sub-committee which was omitted in error from the Board submission. It should be noted that the PODG will continue to meet, provide a Chair's assurance report to MHCCC and be chaired at senior MH operational level.

Asesu a Dadansoddi / Assessment & Analysis

The Committee is being presented with this amended version in respect of good governance and version control.

Opsiynau a ystyriwyd / Options considered

Not applicable
Goblygiadau Ariannol / Financial Implications Not applicable
Dadansoddiad Risk / Risk Analysis Not applicable
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance The Committee is required through the Health Board's Standing Orders to operate within its terms of reference
Asesiad Effaith / Impact Assessment Not applicable

Mental Health and Capacity Compliance Committee

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

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Mental Health & Capacity Compliance Committee (MHCC). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

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

3. DELEGATED POWERS

3.1. The Mental Health & Capacity Compliance Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to Mental Health Act compliance.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Mental Health & Capacity Compliance Committee is authorised by the Board to:

3.2.1. 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.

3.2.2. Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated.

3.2.3. Monitor the use of the legislation and consider local trends and benchmarks.

3.2.4. Consider matters arising from the Hospital Managers' Power of Discharge Committee.

3.2.5. Ensure that all other relevant associated legislation is considered in relation to Mental Health and Capacity legislation.

3.2.6. Consider matters arising from visits undertaken by Healthcare Inspectorate Wales (HIW) Review Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports [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.

3.2.7. Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation.

3.2.8. Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;

3.2.9. Consider and approve on behalf of the Board any 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.

3.2.10. Receive and review Depravation of :Liberty reports regarding authorisations and associated reasons;

3.2.11. Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved.

3.2.12. 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.

3.2.13. 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.

3.2.14. Consider any other information, reports, etc. that the Committee deems appropriate.

3.2.15. Approve the appointment of Associate Hospital Managers.

4. AUTHORITY

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

4.1.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

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

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

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning workforce, Partnerships and Population Health matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in

place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

5.2. The Committee will receive regular reports from:

5.2.1. ~~Sub-Committee - In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as~~ The Power of Discharge Group~~, terms of reference for which are attached as Annex 2.~~

5.2.2. Discharge Panel (s) - 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).

5.3. 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 Group.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Public Health (Lead).
- Executive Director of Nursing and Midwifery.
- Executive Director of Primary Care and Community Services.
- Medical Director for Mental Health.
- Nursing Director for Mental Health.
- Mental Health Director.
- Mental Health Act Manager
- Service User Representative.
- Social Services Representative.
- North Wales Police Representative.
- Welsh Ambulance Services.
- IMCA Advocacy provider Representative.
- IMHA Advocacy provider Representative.
- Associate Director of Safeguarding (director lead for MCA team)
- Associate Director of Quality Assurance (director lead for MHA team)

- DoLS representative.
- Two Associate Hospital Managers (as nominated by the Power of Discharge Group) appointed for a period of four years with re-appointment not to exceed a maximum of eight years in total.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. By Invitation

- A patient / Carer representative.
- A staff representative.

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

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board 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.

6.5.2. 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 by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. 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. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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

8.1. 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.

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

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. 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.

8.4. 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.

~~8.5. Receive assurance and exception reports from~~

~~8.5.1.1. The Power of Discharge Group~~

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. 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.

9.1.3. 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.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. 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

11. REVIEW

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

Version number 1.01	
Committee	**Date of approval**
MHCC	
Audit Committee	**10.6.21**
Health Board	

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, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board’s Scheme of Delegation.

Mental Health Measure

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

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

Mental Capacity Act

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

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Committee Cycle of Business
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Diane Davies, Corporate Governance Manager
Craffu blaenorol: Prior Scrutiny:	Teresa Owen, Executive Director Public Health
Atodiadau Appendices:	1. MHCC Committee Cycle of Business v0.01

Argymhelliad / Recommendation:

The Committee is asked to review and approve the Cycle of Business

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The Committee has been inaugurated as part of the wider Integrated Governance Framework led by the Interim Director of Governance.

Cefndir / Background:

The Board approved the Integrated Governance Framework at its meeting of 15th July 2021 which included the replacement of the Mental Health Act Committee with the Mental Health Capacity and Compliance Committee. The Cycle of Business was agreed to be standardised for the Board and all its Committees.

Asesu a Dadansoddi / Assessment & Analysis

The Committee is being presented with this inaugural COB to ensure alignment with the Board's agreed format, that will be reflected in Committee meeting agenda going forward

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications Not applicable
Dadansoddiad Risk / Risk Analysis Not applicable
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance The Committee is required through the Health Board's Standing Orders to operate within its terms of reference
Asesiad Effaith / Impact Assessment Not applicable

Cycle of Business – Mental Health Capacity and Compliance Committee

- for approval September 2021 v.01 draft

Agenda item	June	Sept	Dec	Mar		
Opening Business						
Apologies	✓	✓	✓	✓		
Declaration of Interests	✓	✓	✓	✓		
Minutes from previous meeting	✓	✓	✓	✓		
Matters Arising & Table of Actions	✓	✓	✓	✓		
Report of the Chair • Chair's Action • Feedback from Board	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓		
Report of the Lead Executive	✓	✓	✓	✓		
Notification of matters referred from other Board Committees on this or future agendas	#	#	#	#		
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
New Mental health Act – impact to the Health Board and Plans			✓	✓		
Liberty, Protection and Safeguarding – impact to the Health Board and Plans			✓	✓		
Monitoring Existing Strategies or plans						
Approval of All Wales Approved Clinicians and Section12 (2) Doctors	✓	✓	✓	✓		
Other						
CAMHS - tba						
Quality Safety and Performance – The Present						
Deprivation of Liberty Safeguards quarterly report	✓	✓	✓	✓		
Hospital Managers update report	✓	✓	✓	✓		
Performance report	✓	✓	✓	✓		
Mental Health Act risk register	✓	✓	✓	✓		
Criminal Justice Liaison report	✓		✓			
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Learning from – The Past						
Consideration of any HIW/ Inspection reports / Audit reports as appropriate to meeting remit	✓	✓	✓	✓		

Agenda item	June	Sept	Dec	Mar		
Quarterly rolling audit report – BYN/ Rehab/ Ty Llywelyn	✓	✓	✓	✓		
Chairs Assurance Reports / Lead Executive Triple A Report						
Chairs Assurance Reports (for information) Initial mapping report to Inaugural meeting to ascertain if necessary	✓					
Chair Assurance report: Power of Discharge Group		✓	✓	✓		
Other						
Closing Business						
Agree Items for referral to Board / Other committees	✓	✓	✓	✓		
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓		
Agree items for Chairs Assurance Report	✓	✓	✓	✓		
Review of Meeting Effectiveness	✓	✓	✓	✓		
Date of next meeting	✓	✓	✓	✓		

- if arise

v.01 draft

Mental Health Act Committee (MHAC)
Draft minutes of the meeting held on 25.06.21 via Teams

Present:	
Lucy Reid	Health Board Vice Chair (Chair)
Cheryl Carlisle	Independent Member
Eifion Jones	Independent Member
In Attendance:	
Dr Alberto Salmoiraghi	Consultant Psychiatrist/Medical Director, MHLD
Teresa Owen	Executive Director of Public Health (part meeting)
Frank Brown	Associate Hospital Manager (AHM)
Michelle Denwood	Associate Director of Safeguarding
Iain Wilkie	Interim Director, MHLD
Simon Evans-Evans	Interim Director of Governance
Matthew Joyes	Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience
Liz Jones	Assistant Director, Corporate Governance
Wendy Lappin	Mental Health Act Manager, MHLD
Marilyn Wells	Head of Nursing – East Area for Child and Adolescent Mental Health Services, Neuro-developmental and Learning Disability Services
Rachel Turner	Ward Manager, MHLD
Ruth Joyce	Criminal Justice Liaison Service Manager, MHLD
Tristan Edwards	Performance Officer (Observer)
Laura Jones	Secretariat

Agenda item	**Action**
MHAC21/17 Welcome and apologies **MHAC21/17.1** The Chair welcomed everyone to the meeting and confirmed that apologies had been received from Jo Whitehead, Chief Executive Officer; Gill Harris, Executive Director Nursing and Midwifery / Deputy Chief Executive Officer; Mike Smith, Interim Director of Nursing; Bethan Jones, Area Director for Central and Sue Hamilton, Consultant in Child & Adolescent Psychiatry.	
MHAC21/18 Declarations of Interest **MHAC21/18.1** The Chair and the Independent Member, Eifion Jones declared an interest in relation to the Criminal Justice System as Justices for the Peace for the Central bench and the North West Wales bench.	

MHAC21/19 minutes of the last meeting held on 12.03.21 to be confirmed and review of Summary Action Log **MHAC21/19.1** The minutes were confirmed as an accurate record of the previous meeting. **MHAC21/19.2** The summary action log was reviewed and updated accordingly.	
MHAC21/20 Minutes of the Power of Discharge Sub-Committee **MHAC21/20.1** The Mental Health Act Manager presented a verbal account of relevant feedback from the sub committee meeting, held earlier that day. The minutes were confirmed and ratified.	
MHAC21/21 FOR DISCUSSION	
MHAC21/22 Deprivation of Liberty Safeguards Annual Report (DoLS) **MHAC21/22.1** The Associate Director of Safeguarding presented the report highlighting the key issues and referencing the significant amount of work that has been accomplished within this annual period. The annual report includes activity and data which evidences the improvement made and provides a level of assurance for those areas which have significant challenges. Since 2018-19 there has been a steady increase in applications for consideration of DoLS including applications which do not meet the threshold. The quality of reporting has been analysed and a number of delays have been identified resulting in the need for further work to be completed across the organisation to ensure staff are acting appropriately to mitigate errors and omissions in the process. **MHAC21/22.2** A significant amount of work has taken place in relation to training and there have been changes in case law that will affect practice. Going forward there is a need to focus on case law for 16 and 17 year olds who have an impact on CAMHS and working with services to ensure processes are followed and children are not being unlawfully detained. The Associate Director of Safeguarding highlighted new legislation which has been introduced and will be known as Liberty Protection Safeguards. The Code of Practice is yet to be implemented however a Task and Finish Group has been established to develop the Terms of Reference and scoping of the new legislation. It was suggested that these documents could be brought to the next meeting for agreement and oversight to ensure the implementation is monitored. **MHAC21/22.3** The Associate Director of Safeguarding highlighted the evidence and impact of training and engagement which included learning from clinical case discussions. The learning has allowed for the development and strengthening of pathways which includes confirmation that patients follow the clinical assessment pathway and are appropriately referred in line with the legal framework. A case was highlighted where the capacity was not assessed and the impact that had in terms of unlawful detainment. This area is being reviewed and a process will be implemented to address it. Due to an increase in DoLs applications, additional authorisers have been employed to undertake this	MD

additional legal work. Audit activity has been taking place to scrutinise the completed documentation and there is a requirement for the Health Board to provide clear assurance in terms of the legislation. **MHAC21/22.4** The Chair thanked the Associate Director of Safeguarding for the report and the detail relating to the case studies and learning. The Medical Director of MHLD confirmed there are implications in terms of resources in relation to the new Mental Health Capacity Act. There has also been an increase in section 49 requirements particularly those with short timescales and this activity will increase in the future due to the changes in the legislation. Whilst funding has been provided by Welsh Government, it does not accommodate all of the additional training requirements necessary to ensure compliance. **MHAC21/22.5** A Committee Member queried what the training budget from Welsh Government included and how additional training for staff will impact on the service. The Associate Director of Safeguarding confirmed that the training focused on capturing the right people at the right level within Paediatrics and CAMHS and the service are currently waiting on confirmation from Welsh Government in terms of the funding for the Liberty Protection Safeguards. A Committee Member raised concerns in relation to the increase in cases, the requirement for training at ward level and also queried how the business case is progressing and how quickly the resources will be in place. The Associate Director of Safeguarding confirmed that the business case is imminent, it has had final sign off from Finance and will be going to the Executive Team for approval. The team are hoping to receive additional resources for this year and next to enable implementation. The team have been completing job descriptions and adverts to help move things forward as quickly as possible once the business case has been approved. **MHAc21/22.6** The Chair advised that meetings have taken place with the Minister where concerns about funding and resources were highlighted. The Associate Director of Safeguarding highlighted that it is still unclear when the guidance will be available and this is causing concern as well. **MHAC21/22.7** The Committee accepted the report.	
MHAC21/23 Hospital Manager's Update Report **MHAC21/23.1** The Mental Health Act Manager provided a verbal update on the report presented to the Power of Discharge Sub Committee. 73% of the hearings have taken place within the required timescale. One case had taken 194 days to hold the hearing due to changes in the Responsible Clinician. **MHAC21/23.2** The Committee noted the update.	
MHAC21/24 Performance Report **MHAC21/24.1** The Mental Health Act Manager presented the report highlighting the activity over the last 3 months from February to April noting that there were 4	

sections which lapsed throughout this period which are detailed within the report. There are currently some under 18s on a section 2 and no exceptions in terms of sections 3s. The number of CTOs has decreased although there has been an exception where a CTO expired due to lack of paperwork. There has been small rise in the number of Mental Health Act errors this quarter with the majority being in relation to section 2 paperwork. There is a need to ensure legal documentation is correct therefore any errors need to be rectified. **MHAC21/24.2** In terms of section 135 and 136 there has been one section 136 which lapsed due to the patient being on ICU and not being fit for assessment. Since September 2020 the report has been recording those detained following consultation, in relation to under 18s the figures have been low and there has also been a decrease. During this quarter there have not been any admissions from a section 136 to the adult unit. There are currently 81 patients being detained in independent hospitals, 41 of those are outside of Wales. In relation to forensic figures, the unit is not accepting admission due to medical staffing and capacity. The report also now includes monitoring of section 62s following a request from Health Inspectorate Wales. **MHAC21/24.3** The Medical Director of MHLD highlighted the current staffing issues, which has resulted in some transfers being blocked due to lack of staffing. However, individual risk assessments are taking place and if the relevant staff are available, the admission can go ahead. A meeting is taking place with WHSSC to highlight this issue. A Committee Member requested further information in relation to the CAMHS section 136 report. The Mental Health Act Manager confirmed that the report details all detentions that may have occurred for under 18s over the past 12 months. Section 136s for CAMHS have increased. Every time a child is detained under a section 136, safeguarding are informed and it is recorded as a Datix incident. The Chair queried how the information is being gathered via Datix and also whether an alternative to the use of Excel for the Mental Health Act team to record sections is being reviewed. The Mental Health Act Manager confirmed that the information is currently input into an Excel database and an alternative system was being reviewed however the team are unsure whether the system would work for all staff. The Committee expressed concern in relation to the IT capability in terms of the recording and monitoring system that the Mental Health office currently utilise. The Chair also highlighted the use of the terms “previous month” and “latest month” within the report and requested this information is changed to use the actual month going forwards to avoid confusion. The Performance Officer agreed to make this change for future reports.	TE
MHAC21/24.4 The Chair asked whether an assessment is undertaken when a young person is placed in a 136 suite to determine whether that is the most appropriate place of safety. The Mental Health Act Manager explained that the decision to take someone to a 136 lies with the police. The Medical Director of MHLD added that if a child is brought in on a section 136, the paediatric team are asked to do the initial assessment. The Head of Nursing for CAMHS East confirmed that they do not assess whether there is an alternative place of safety other than the 136 suite. It was suggested this could be discussed at the Adult / CAMHS Forum as it has previously been raised that the environment is too	

clinical and sterile for children. The Chair asked for this to be taken forward for action. *The Executive Director of Public Health joined the meeting* **MHAC21/24.5** The Criminal Justice Liaison Manager highlighted that there has been an increase in joint working between CAMHS and the team in terms of multidisciplinary meetings and focus on the use of 136 suites. The Interim Director of Mental Health confirmed that there is good evidence of collaboration between CAMHS and Adult Mental Health services and discussions are taking place including assessment of the 136 suites from an environmental point of view. The Chair suggested it would be useful to have a wider discussion on this topic at the Quality, Safety and Experience Committee workshop in August. **MHAC21/24.6** The Head of Nursing for CAMHS confirmed that there has been an increase on paediatric wards and highlighted that 70% of crisis placements include some form of social care setting with repeat section 136s being placed into area from the North East without prior conversations taking place with the CAMHS team. These presentations place the team in a difficult situation as Local Authority assistance is then required. The Chair recognised the complexity of these issues and highlighted this is an issue in terms of boundaries between health and social care and suggested this needs to be raised with Welsh Government. The Head of Nursing for CAMHS highlighted the need to focus on a partnership approach for these young people and determine a solution for these patients. The Chair confirmed discussions are required between the two service areas and this issue needs to be discussed at the Quality, Safety and Experience Committee workshop in August to agree a plan on how to address this issue and who needs to be involved in implementing the changes going forward. **MHAC21/24.7** The Committee noted the report.	AS/MW TO/MW
MHAC21/25 Healthcare Inspectorate Wales (HIW) Monitoring Report **MHAC21/25.1** The Mental Health Act Manager presented the report highlighting that no areas for improvement has been identified relevant to this Committee during the most recent visit to Coed Celyn Hospital. There has been one update in relation to the bed escalation policy which went through the Clinical Policy Group and is due to go to the Patient Quality and Safety Group on 13th July for approval. The Chair highlighted that the bed escalation policy has been reviewed and however considered that the document is more of a procedure than a policy. The Mental Health Act Manager confirmed that the document has been queried in terms of whether it is a policy or a procedure and also that there has been a multitude of reasons for the delay with this document. The Chair raised a concern in terms of implementing a draft policy before it has been formally ratified. The Acting Associate Director of Quality Assurance confirmed that the Clinical Policy Group has only recently been put in place and going forward it will be clear that policies need to go to that group in the first instance as this has previously caused confusion. The Executive Director of Public Health	

welcomed a clear process going forward and a need to ensure all divisions now follow this process. **MHAC21/25.2** A Committee Member highlighted the improvement plan in terms of Coed Celyn Hospital included in appendix 2 and queried whether the infection control audit took place in April. The Acting Associate Director of Quality Assurance agreed to track back through the system and also follow up with Coed Celyn Hospital to ensure this was completed. **MHAC21/25.3** The Committee noted the report.	MJ
MHAC21/26 Update on Section 12 (2) Recruitment **MHAC21/26.1** The Medical Director of MHLD presented the report highlighting that the action plan has been divided into 5 themes and going forward, proposed that a meeting will take place in 3 months time to update the actions and a total of 6 months to complete the actions. The report will then come back to the Committee to provide any updates in terms of exceptions and asked for any comments on the action plan to be provided. The Executive Director of Public Health highlighted that the plan has been developed following cross Health Board discussions. The challenge is how this will be delivered, however the team are making progress. A Committee Member queried whether there is a similar plan available in terms of the shortage of nurses. The Medical Director of MHLD confirmed that the Nurse Director of MHLD is putting together a nursing recruitment strategy that will link in with the universities. The Chair confirmed that the nurse staffing query should transfer over to the Quality, Safety and Experience Committee as this is an issue across the Health Board and is within the remit of that Committee. In terms of the action plan presented, the Chair confirmed that a verbal update should be provided to the Committee in September and a written update against the action plan should be presented to the Committee in January 2022. **MHAC21/26.2** The Committee noted the report. *The Head of Nursing left the meeting*	LJ AS
MHAC21/27 Risk Register Review **MHAC21/27.1** The Interim Director of MHLD highlighted the risks confirming these mirror the conversations that have taken place in terms of 136 usage and concerns regarding the availability of psychiatrists in Ty Llewellyn. The nursing leads for CAMHS and MHLDS have been working together to review the risk register. The Chair reminded the Committee that the need for this item was identified when the annual report for the Committee was completed, which highlighted a requirement under the terms of reference for the Committee to review risks relating to the Mental Health Act. She reiterated that the risk register review should be confined to the remit of this Committee and is not a general review of risks relating to mental health services across the Health Board, which should be covered by other governance arrangements. The Interim Director of Governance highlighted that the new terms of reference will state that risks	

associated with compliance in terms of the Mental Health Act will be referred to this Committee as it is important these issues are discussed as part of the Committee. The Chair queried whether the team will be in a position to provide a risk register report to the next Committee, the Interim Director of MHLD agreed. **MHAC21/27.2** The Committee noted the verbal update.	IW
MHAC21/28 Clinical Audit / Audit Activity **MHAC21/28.1** The Mental Health Act Manager presented the report highlighting that a 3 month rolling audit has been introduced for the Bryn y Neuadd, Rehab and Ty Llewellyn. The audit has been registered and will be presented to the Clinical Effectiveness Group. This will also cross reference with the Mental Health Act and the correspondence file to ensure the correct information is being collated. Also to note, the care and treatment plans are in date and patients are being offered treatment in their primary language. The first audit report will be presented to the Committee in September. The Chair thanked the team and as this is an important form of assurance for this Committee. **MHAC21/28.2** The Committee noted the verbal update.	
MHAC21/29 Reforming the Mental Health Act White Paper Consultation Responses from BCUHB **MHAC21/29.1** The report provided the Committee with a summary of the white paper consultation and responses provided by the Health Board. The Chair highlighted the removal of the Associate Hospital Manager role in reviewing patients for discharge and also the additional work required in terms of the process to discharge rather than detain people. The Mental Health Act Manager confirmed a letter has been circulated to the Committee giving people the opportunity to respond individually and a response will also be sent to the Board for approval prior to submission. **MHAC21/29.2** The Committee noted the report.	
MHAC21/30 Criminal Justice Liaison Service Update Report **MHAC21/30.1** The Criminal Justice Liaison Service Manager presented the report highlighting this is the second report to be presented to the Committee. The performance in terms of the work with the Control Centre was highlighted and also referred to in terms of the data from North Wales Police as the team are looking to promote the service for local policing teams to utilise. The highest percentage of calls received by the service relate to calls for safety and the majority of calls are managed within 30 minutes or less. The team have been consulted on 70 potential S136s this quarter with 27 of those patients being diverted to alternative intervention and liaison with appropriate services. The team are working closely with North Wales Police in terms of training including bespoke training for detectives in relation to adult mental health issues.	

MHAC21/30.2 A Committee Member welcomed the report particularly the work in terms of offenders and prevention and highlighted concerns in relation to Colwyn Bay and Gwynedd and the clinics available. The Criminal Justice Liaison Service Manager has flagged Caernarfon as a concern due to the higher rate of DNAs within that area due to the distance people need to travel and is proposing the use of a clinic closer to the area on a monthly basis. The Chair suggested it would be helpful for the service to link in with the magistrates court as they may not be aware of the service and confirmed the team are having a great impact and suggested a focus on outcomes and financial implications for future reports. **MHAC21/30.3** The Committee noted the report.	RJ
POLICY APPROVALS	
MHAC21/31 Mental Health Act Policies **MHAC21/31.1 Policy for Section 5(2) Doctors holding power in psychiatric units MHLD0034** **MHAC21/31.1.2** This policy was approved. **MHAC21/31.2 Policy for the implementation of Section 5(4) Nurses Holding Power MHLD 0033** **MHAC21/31.2.1** The Chair highlighted that the policy reads more like a procedure rather than a policy. The Mental Health Act Manager agreed and confirmed that discussions have taken place with other Health Boards and Mental Health services and the document is deemed as a policy if it follows the code of conduct. The Medical Director of MHLD confirmed the need to comply with the legal requirement and the team agreed to take the comments away and review the documentation requirements. **MHAC21/31.2.2** The policy was approved. **MHAC21/31.3 Policy for Information to Patients (S132/3 Mental Health Act) MHLD0030** **MHAC21/31.3.1** The policy was approved.	
FOR INFORMATION	
MHAC21/34 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales **MHAC21/34.1** The Chair raised concerns, which have been discussed with the Board Secretary, in relation to the robustness of the governance arrangements for this item as it is received for information but assurance is required in terms of the approval process. The Executive Director of Public Health confirmed the report is presented to the Committee for information, in terms of governance, the Health Board are the host organisation therefore the required progress is being	

discussed with the Board Secretary. The Interim Director of Governance confirmed this is an All Wales service therefore there is a need to provide reports for assurance purpose not the process being undertaken. The Chair requested for the wording on the cover page to be amended. **MHAC21/34.2** The Committee noted the report.	
MHAC21/35 Mental Health Act Committee Annual Report : feedback from Audit Committee **MHAC21/35.1** The Committee noted the approval of the report at a recent Audit Committee workshop.	
MHAC21/36 Issues of Significance to inform Chair's Report to the Board	
MHAC21/37 Date of next meeting 24.9.21	

Mental Health Act Committee – Summary action plan (Final September 2021)

BCUHB MENTAL HEALTH ACT COMMITTEE **Summary Action Plan – Live Document – last updated 08/09/2021 12:25**				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
March 2021 meeting action				
MS	**MHAC21/7.4** The Director of Nursing, MHLD (Interim) agreed to produce an action log to track patient stories and he would provide feedback directly to members regarding progress against the actions.	Ongoing	The MHAC has instructed that Patient stories (from MHLD) if presented, will have had prior scrutiny and organisational learning when they then present to the MHAC. MHLD can confirm that MHLD Patient stories are presented to the Patient Carer Experience subgroup of the divisional QSE, now following the BCUHB approach. In the response to the internal audit report on governance, the governance team reviewed support to all tier 1 and tier 2 meetings in the division. A named lead from the BCUHB corporate governance team has been allocated to support the Patient and Carer Experience meeting (a Tier 2 subcommittee of the divisional QSE committee) from May 2020 who will support the governance of the group. The MHLD Director of Nursing proposes to the MHAC that:- -Actions arising from stories presented and discussed (if any) are to be logged in the PCE sub group and presented with the story if it is subsequently presented to the MHAC (or any other governance groups of the board). -The MHAC may properly scrutinize the actions after considering the story and add to them any further	Action to be closed

			learning and the log will facilitate this. -The MHLD Director of Nursing will report progress of completion of any actions in the log to the PCE subgroup, where the actions will be tracked. This log may be submitted where appropriate to the subsequent committees and the MHLD Divisional Director of Nursing may directly provide feedback to MHAC members if required in a timely manner upon progress. This will allow more robust governance and reflect the BCUHB corporate approach around the presentation of patient stories to the MHAC committee and to assure completion and record of any actions that may be generated from the organisational learning from these stories.	
WL	**MHAC21/10.8** The Associate Director of Safeguarding confirmed that she was interested in the identification of key themes and trends. It was confirmed that a listing would be shared at a later date, in order to triangulate ways of working which could be linked together as regards to administration errors.	June 2021	Update as at 14.6.21 WL will do a review of all papers in July to pull together the information and will then link in with Safeguarding. 8.9.21 Update as at 8.9.21 WL has linked in with Safeguarding and it was felt that there are no safeguarding concerns in regards to the errors on the paperwork as we have processes to deal with. It is a governance issue, which we have processes for and the Mental Health Act allows for errors to be rectified. Themes identified are spelling of names, missing details such as county or patients middle names. Errors are made both by medics and the AMHPs (Approved Mental Health Professionals) the fact that they are picked up and do not escalate to invalidity of documents highlights our effective scrutiny. It was confirmed there is no justification to involve safeguarding in relation to errors on mental health	Action to be closed

			act paperwork, if a fundamentally defective error is made safeguarding are involved if this results in any harm or neglect being identified.	
June 2021 meeting actions				
Michelle Denwood	**Deprivation of Liberty Safeguards Annual Report (DoLS)** Provide Liberty Protection Safeguards Task and Finish Group Terms of Reference for agreement and scoping documents of the new legislation to the next meeting.	(10.9.21 for 24.9.21 meeting)	Update 8.9.21 Due to the National delay in the publication of the revised MCA Code of Practice - Liberty Protection Safeguards the remit of the group is under continual review which continues to impact upon finalising this activity. A draft Terms of Reference has been prepared. However, on receipt of the draft Code of Practice this will be further reviewed and consulted upon prior to submission to the MHCC Committee *Action to be transferred to MHCCC Summary action plan following inaugural meeting*	
Tristan Edwards	**MHAC21/24 Performance Report** The Chair also highlighted the use of the terms “previous month” and “latest month” within the report and requested this information is changed to use *the actual month* going forwards to avoid confusion. The Performance Officer agreed to make this change for future reports		Changes have been made and have been implemented for Q2 report.	Action to be closed
Alberto Salmoiraghi/ Marilyn Wells	**MHAC21/24 Performance Report** Ensure discussion takes place at the Adult / CAMHS Forum regarding an alternative place of safety other than the 136 suite as it has previously been raised that the environment is too clinical and sterile for children.		The CAMHS and MHLD teams now have regular meetings. These meetings focus on strategic and operational matters, and the place of safety discussions are under discussion.	Action to be closed

TO/MW	**MHAC21/24 Performance Report** The Chair confirmed discussions are required between the two service areas and issue discussed at the Quality, Safety and Experience Committee workshop in August to agree a plan and who needs to be involved in implementing the changes going forward.		29.8.21 The Committee Chair confirmed that the action had been undertaken	Action to be closed
Matthew Joyes	**MHAC21/25 Healthcare Inspectorate Wales (HIW) Monitoring Report** The Acting Associate Director of Quality Assurance agreed to follow up with Coed Celyn Hospital the completion of actions provided in the improvement plan and whether the infection control audit took place in April.		The actions were added to the new HIW Action Tracker Database and progressed. The IPC Audit of Coed Celyn took place on 06 May 2021.	Action to be closed
Liz Jones	**MHAC21/26 Update on Section 12 (2) Recruitment** A Committee Member queried whether there is a similar plan available in terms of the shortage of nurses. The Medical Director of MHLD confirmed that the Nurse Director of MHLD is putting together a nursing recruitment strategy that will link in with the universities. The Chair confirmed that the nurse staffing query should transfer over to the Quality, Safety and Experience Committee as this is an issue across the Health Board and is within the remit of that Committee.		8.9.21 Transferred to QSE Committee action log	Action to be closed
Alberto Salmoiraghi	**MHAC21/26 Update on Section 12 (2) Recruitment** In terms of the action plan presented, the Chair confirmed that a verbal update should be provided to the Committee in September and a written update against the action plan should be presented to the Committee in January 2022.		Verbal update to be provided in discussion of Summary action plan on 24.9.21 Action plan update to be transferred to MHCCC Cycle of Business / Rolling Programme *(17.12.21 agenda / submission date 7.12.21) following inaugural meeting*	

Iain Wilkie	**MHAC21/27 Risk Register Review** Provide a risk register report to the next Committee, the Interim Director of MHLD agreed.		Agenda item 24.9.21	Action to be closed
Ruth Joyce	**MHAC21/30 Criminal Justice Liaison Service Update Report** • Ensure service links in with the magistrates court as they may not be aware of the service • Provide a focus on outcomes and financial implications for future reports.		• The services are now linked. Training opportunities have also been offered however given the current situation this is not feasible at this point, however this will be kept under review. • The team are working to ensure thee focus as specified It is confirmed that the next quarterly report will include information a financial focus. The work on the outcomes focus is progressing..	Action to be closed

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Reforming the Mental Health Act White Paper - Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities Hilary Owen, Head of Governance and Compliance.
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The committee is asked to note this report

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

This report is intended to update the Committee on the activity underway (nationally) to reform the Mental Health Act.

The Mental Health Act is a prescriptive legislation in law. The decision to change the Mental Health Act legislation will come from Government, to which the Health Board will be required to comply with any changes when these occur.

This report highlights the aspects of the consultation paper which the Government has said will be amended and which is being considered further. Further information on the timescales are awaited.

Sefyllfa / Situation:

The Government response to the consultation was published July 2021.

A number of changes have been identified. As yet, it is unclear when these changes will be introduced and we await further information on the scheduled timeline.

This paper provides an update on the key areas of discussion.

Further updates will be shared with Committee as work progresses.

Cefndir / Background:

The Independent Review of the Mental Health Act was commissioned by Government in October 2017.

The Independent Review was conducted throughout 2018 and involved engagement with service users, carers and professionals facilitated through surveys, meetings and conferences. The academic literature review allowed the latest evidence on themes under the Mental Health Act to be gathered.

An interim report was published in May 2018, with the final report and recommendations published on the 6th of December 2018.

The key themes which emerged are:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- people as individuals – ensuring patients are viewed and treated as rounded individuals

The White Paper: '*Reforming the Mental Health Act*' was published by the UK Government for consultation (following the independent review undertaken in 2018), with a consultation deadline date of the 21st of April 2021.

Asesu a Dadansoddi / Assessment & Analysis

Strategy Implications

The Reforming the Mental Health Act Government Response details:

- The proposals in the White Paper
- How people responded to the consultation questions
- Comments received in response to each consultation question
- Next Steps

Proposed changes:

- The ability for those detained under Section 3 to appeal 3 times in a 12 month period of their detention to the Mental Health Tribunal (MHT). Automatic referrals to be instigated at the 3 month point, 6 month point, month twelve and with annual reviews thereafter.
- The automatic referrals for Community Treatment Order (CTO) patients would be at 6 months, 12 months and then yearly.
- Part 3 patients to move to yearly reviews.
- Part 3 conditionally discharged patients to have automatic reviews 24 months following discharge and then at 4 yearly intervals.
- Removal of automatic referrals when a CTO patient is readmitted to hospital.
- Care and treatment plans to become statute documents, to be in place by day 7 of detention.
- Changes to the nearest relative function with the replacement of a nominated person who would have additional powers under the MHA.

- Independent Mental Health Advocates (IMHA) being able to appeal on behalf of the patients and being available to those waiting prison transfer to hospital.
- Use of the Mental Capacity Act Section 4B and Section 5 of the MHA to 'hold persons' in A&E rather than police powers needing to be used.
- A new designated role to manage the process of transferring people from prison or immigration removal centres.
- A statutory time limit of 28 days for immigration removal centres and prisons to a secure hospital.
- The MHT to be able to grant supervised discharge of restricted patients.

The response notes that these changes will require careful consideration and planning to include working closely with the Mental Health Tribunal (MHT), Her Majesty's Courts and Tribunals Service and phased changes may be required.

Proposals that were highlighted for further consideration and discussion by government are as follows:

- Embedding 4 principles into the MHA as well as the MHA Code of Practice.
- Strengthening and clarity of detention criteria to include Community Treatment Orders.
- Greater powers for the MHT to make directions to include the Judge (sitting alone) to give directions regarding treatment.
- Removal of the Associate Hospital Managers role in reviewing patients for discharge.
- Contents of an advanced choice document and processes.
- Patients with capacity having the right to refuse treatment.
- Consideration of previous consent for informal admission rather than formal detention.
- Redefining the role of social supervisor.
- Autism or a learning disability to no longer be considered a mental disorder for the purpose of most powers of the MHA.
- CTOs to be time limited to 24 months if possible.

Proposals not intended to be taken forward at this time are:

- Introduction of a clearer process for deciding if someone should be detained under the MHA or Deprivation of Liberty Safeguards (LPS).

The response paper notes that "*the proposals that require additional funding, continue to be subject to future funding decisions, including at Spending Review 2021. We will continue to work on a Bill to reform the Act, taking into consideration the valuable feedback we have received at consultation. We intend to bring forward a Mental Health Bill, which will give effect to many of the changes we wish to make, when Parliamentary time allows".*

Opsiynau a ystyriwyd / Options considered

Not applicable for this paper.

Goblygiadau Ariannol / Financial Implications

The proposed changes will potentially require additional administrative work for clinicians, nursing staff and the Mental Health Act office. This may result in the need for changes in working patterns and extra staffing.

Additional assessments will potentially increase the use of S12(2) doctors and have financial implications.

Dadansoddiad Risk / Risk Analysis

The proposed changes will potentially:

- Strengthen assurance that patients are detained appropriately, and strengthen assurance that patients have access to an IMHA.
- Require additional administrative tasks for the Mental Health Act office staff.
- Require additional reports and assessments by professionals.
- Require increase data assurance and enable comparisons and benchmarking.
- Enable additional monitoring and checks.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

- The white paper and consultation feedback is concerned with the Mental Health Act 1983 (as amended 2007).
- It is noted that the MHT and Care Quality Commission (CQC), mentioned within the document are organisations for England.
- Duties within Wales fall to the Mental Health Review Tribunal (MHRT) and Healthcare Inspectorate Wales (HIW).
- It is unclear if the MHRT and HIW will adopt the same proposals as the MHT and CQC but in relation to section timescales and reviews becoming prescriptive in law, Wales may be expected to follow suit.

Asesiad Effaith / Impact Assessment

An impact assessment has been completed in relation to the white paper, and this is available on the government website and linked within the summary.

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Liberty Protection Safeguards (LPS) Update**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Associate Director of Safeguarding Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Chris Walker, Head of Adult Safeguarding (MHLD) supported by Michelle Denwood, Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Agreed reporting framework directly into the MHCC Committee Deprivation of Liberty Safeguards (DoLS) is within the portfolio remit of the Executive Director of Nursing and Midwifery and this report has been reviewed by; Michelle Denwood, Associate Director of Safeguarding and Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery.
Atodiadau **Appendices:**	Appendix 1 - LPS Priority Action Plan

Argymhelliad / Recommendation:

The MHCC Committee is asked to accept the LPS position report in preparation for the implementation of Liberty Protection Safeguards (LPS) on 1st April 2022.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	x
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						No	

Sefyllfa / Situation:

Governance

The Mental Capacity Act 2005 was amended in May 2019, this is referred to as the Mental Capacity (Amendment) Act 2019.

This amended Act will change the Mental Capacity Act Code of Practice and DoLS to create new statutory regulations known as Liberty Protection Safeguards (LPS). A new Code of Practice and regulations to accompany the Act were due to be in place by October 2020 this revised legislation has an expected implementation date of April 2022.

UK Government have acknowledged the delay in the publication of the draft Code of Practice, the Code is to be available for consultation during September 2021. With regard to the implementation date of the 1st April 2022, we have been advised this is subject to change and is under continuous review by UK Government.

As a result it is expected that BCUHB will have in excess of 3000 annual applications under LPS, this is an additional 1800 applications based upon the current DoLS data.

A priority action identified for 2021-22 is to create a strategic LPS Implementation Task and Finish Group and supporting Programme Task Groups to support the implementation of the LPS framework across the health board.

The draft Terms of Reference for this group are following the consultation and Governance and Reporting processes for formal ratification. Challenges remain, as we do not have the detail to progress with any proposed implementation activities due to the delay in the publication of the Code of Practice.

Corporate Safeguarding, on behalf of BCUHB, currently attend Local, Regional and National working groups in relation to LPS to ensure that BCUHB remain informed of any developments.

We have received draft LPS assessment forms from Welsh Government and these are now subject to scrutiny via the working group, which is chaired by Welsh Government. In addition, Welsh Government have communicated an update in relation to LPS training.

Welsh Government have advised Statutory Bodies to refrain from undertaking any localised training, to await both the publication of the Code of Practice and an agreed National Training Framework which will be produced and delivered by Social Care Wales. This activity is monitored via the North Wales Safeguarding Board Training Group.

On the 24th September 2021 NWSSP Legal & Risk Complex Patient Team are hosting an afternoon to review some key issues around the transition to LPS of which we are representing BCUHB.

Cefndir / Background:

Performance and Activity (DoLS)

In 2020-21, the DoLS/MCA Team received 1162 applications illustrated in Table 1 below. The table evidences the continued increase in DoLS activity. Between April 2021 and August 2021 639 DoLS applications have been received.

Table 1: Annual DoLS applications

Year	West	Central	East	England	Other	Applications
2018-19	89	257	343	55	0	743
2019-20	177	282	483	72	0	1014
2020-21	208	322	550	82	0	1162

This is a 44% increase when, compared to the same period in 2020-21 when we received 444 applications.

Training

The UK Government have advised that no LPS training should be undertaken prior to the publication of the LPS Code of Practice. Training programmes are yet to be submitted for consultation (UK Government advise a 3 month consultation process will be enacted).

Analysis

BCUHB staff will require a complete understanding and awareness of the MCA to undertake effective Liberty Protection Safeguard assessments. A National training package is being developed to ensure

that all Health and Social Care staff are afforded the correct level of training and education. This is being led by Welsh Government with Social Care Wales having been identified as the training facilitator.

The recognised challenge is there will be a delay in preparation and roll out and due to the large workforce some staff may have a limited understanding when the act comes into force.

Corporate Safeguarding have engaged with Professor Neil Allen to support and facilitate bespoke LPS training to key staff. Professor Allen is awarded the contract in England to provide the Approved Mental Capacity Professional (AMCP) training and currently provides BIA refresher courses to qualified BIA's.

We remain in contact with Professor Allen as this commissioned piece of work was funded in 2020-2021. In addition to the training package, leaflets will be available for front line staff to support clinical practice.

Safeguarding DoLS/MCA/LPS Business Case

A Safeguarding Business Case is under development and will be submitted and presented for consideration by BCUHB's Executive Team in September 2021.

Finalisation of the Business Case has experienced a four (4) week delay due to the requirement of a review following to the identification of additional challenges. Final financial calculations are taking place with the aim if agreed, to introduce additional resource over an eighteen (18) month period.

Analysis

The increase in activity and demand under LPS will result in unprecedented numbers of applications to the Health Board, estimated at in excess of 3000 applications. The strengthening of the current DoLS/MCA team is paramount to ensure that BCUHB staff are supported throughout the transition to LPS. The Safeguarding Business Case has identified the need to expand the service to provide adequate support for staff. This includes the additionally of staff at all levels of the service but in particular, Clinical Expertise, Training and Performance and Governance and Administration.

Strategy Implications

Liberty Protection Safeguards (LPS)

The legislative changes will have significant implications in terms of demand, capacity, training, financial resources and challenges for the Health Board.

The current DoLS arrangements are where practitioners known as Best Interest Assessors (BIA) and Mental Health Assessor (S12 (2) Doctors) undertake the necessary assessments. Under LPS these assessments will be carried out by those already involved in the person's care, such as hospital ward staff, therapists, doctors and possibly GPs.

This will require substantial education and training to ensure the workforce are competent to complete the required assessments. The assessment documents are currently in development and will be shared with all Health Boards and Local Authorities across Wales for consultation during Q3.

The Health Board will also be responsible for authorising LPS within additional care settings for which it is commissioning, such as Continuing Health Care (CHC) funded placements, Domiciliary Care Packages and 16 or 17 year olds in any setting across England and Wales.

BCUHB will also continue to be responsible for authorising LPS for any BCUHB patients in any registered NHS Hospital, Independent Hospital and Hospice across England and Wales. Any patient objecting to an authorised LPS will have the right to be assessed by an Approved Mental Capacity Practitioner (AMCP) this new role will replace the current Best Interest Assessor (BIA) role.

Asesu a Dadansoddi / Assessment & Analysis

Early recommendations taken from the LPS working groups suggest the following All Wales approach to the implementation:

- Mental Capacity Act Training will be considered mandatory for all NHS staff in Wales and contracted services. Training requirements are to be developed on a national footprint and Welsh Government are to be asked to consider what currently exists with the focus on an agreed governance framework to maximise effectiveness and support a competent workforce.

- All Health Boards to have a Mental Capacity Act Lead. This is recorded as a priority action on the Corporate Safeguarding 2021-2022 Action Plan to be completed by April 2022.
- Additional resources will be required for the transition period and the continuation of implementing LPS. Welsh Government state the 5% of agreed UK Government funding for the implementation of LPS is to be signposted to Wales. The figure remains unknown.

In addition the NHS Wales Safeguarding Network MCA, DoLS & LPS Task and Finish group will:

- Provide a collaborative response to the LPS Code of Practice consultation (delayed until September 2021).
- Work with the Welsh Government LPS Implementation Group.
- Provide expert advice to the Once for Wales Concerns Management System in respect of MCA, DoLS & LPS.

Corporate Safeguarding are finalising the Terms of Reference for the LPS Implementation Group, which will include strategic and operational membership to ensure the full implementation of the Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards. The inaugural meeting is proposed to take place in October 2021 to allow for the publication of the Code of Practice as this will inform the group on key issues such as roles and responsibilities.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications
N/A

Dadansoddiad Risk / Risk Analysis

The risks associated with the Deprivation of Liberty Safeguards presented at QSE on the 8th September 2021 resulted in the approval of the Risk to be included within the Tier 1 Corporate Risk Register.

Risk ID 2548. The increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

Risk Calculation. 4 [major/high] x 5 [almost certain, will undoubtedly happen or recur, possibly frequently] = 20

Mitigating activities are in place to reduce the risk and improve service delivery across the Health Board. A targeted approach is required based upon trends, themes, incidents and data and these include;

The DoLS/MCA Standard Operating Procedure, this is in place to provide additional guidance and direction to support the actions required for a DoLS application to be authorised to prevent unlawful deprivation.

We have increased the number of Authorisers across the Health Board. There are 51 registered DoLS Authorisers within BCUHB. This has provided some assurance with regard to improved timescales in the authorisation of a DoLS application, once it has progressed through the scrutiny process. A review of the Authorisation process is underway as further improvements to the governance arrangements are required.

The Corporate Safeguarding DoLS/MCA Team have delivered bespoke MCA/DoLS training to focus upon the key omissions in the DoLS process by the wards.

Implementation and the development of revised DoLS training packages, booklets and events to support the application of learning to support care.

Triangulation of data, the Team cross-reference incidents with Datix to target trends, provide individual supervision, and ensure reporting compliance. Data and incidents are triangulated with the wider Corporate Safeguarding activity, when specific Adult at Risk concerns are raised in relation to individuals who are subject to DoLS. This enables a joint working approach to addressing safeguarding concerns.

The scrutiny of applications is conducted by the DoLS/MCA Team and includes both the DoLS Form 1 and supporting documentation, to ensure evidence is lawful and the individual lacks the capacity to consent to be 'accommodated' in hospital, which is a vital aspect of the patient care pathway.

A 'Sample' Mental Capacity Assessment Form is available and provides enhanced guidance. This best practice guidance is included in all MCA/DoLS training and is routinely disseminated to ward staff.

We have developed and accessed legal DoLS 'Forms' in the Welsh Language and other languages to fully support the use of a patients/families first language to support capacity decisions ensuring the organisation is patient centred.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

BCUHB will adhere to the Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.

Asesiad Effaith / Impact Assessment

The full impact of Liberty Protection Safeguards (LPS) on the organisation is currently unknown as we await the Codes of Practice, WG Training Materials, Assessment Documentation and the AMCP role guidelines. However, early indiciation suggests an increase in demand and activity that requires further action and engagmeent.

The National LPS working groups are supported by the NHS Wales Safeguarding Network, membership includes BCUHB representatives from the Corporate Safeguarding Team.

The National LPS working groups are:

- LPS Workforce and Training Group.
- LPS in relation to 16 and 17 year olds Group.
- LPS Monitoring and Reporting Group.
- LPS Transition Group.
- Welsh Government LPS Strategic Implementation Steering Group.

Key priorities identified by the working groups are as follows:

- Funding for the implementation of LPS, the increase in Independent Mental Capacity Advocates (IMCA)'s, and Training, Welsh Government are in consultation with the UK Government.
- Continuing NHS Health Care planning for LPS.
- DoLS backlogs, Welsh Government have just announced their bid application process for funding.
- 'Once for Wales' materials to support the new LPS forms, national consultation is underway.
- Promoting the MCA ahead of the implementation of LPS and embedding the principles of the MCA across organisations.

Over the next six (6) months further work will take place as guided by the National LPS implementation programme. Co-production and engagement with BCUHB services and divisions will support a smooth transition to LPS and offer assurance that the Health Board are compliant with legislation and process prior to April 1st 2022.

Priority Activities for Q3 and Q4

1. To create a BCUHB LPS Implementation Group, and supporting Programme Task Groups which will include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.
2. Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service.
3. Refreshed bespoke training on MCA/DoLS.
4. Confirm and engage with the BCUHB Mental Capacity Act Lead.
5. LPS update reports are to be included on the agenda of the MHCC Committee as required.

Betsi Cadwaladr University Local Health Board (BCUHB)
Mental Health Act Committee Report Action Plan 2021-2022

Action Plan

Corporate Safeguarding MCA/DoLS Team

	Recommendations	Action Required	Lead(s)	Evidence of completion	Target Date	RAG
1.0	To create a BCUHB Liberty Protection Safeguards (LPS) Implementation Group, which will include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and code of practice relating to the LPS.	• Development and consultation of the LPS Strategic Implementation Group and Programme Groups ToR • Ratification of the ToR • Meeting Convened • Engagement in Local, Regional and National meetings/groups: a) LPS Workforce and Training Group b) LPS in relation to 16 and 17 year olds Group c) LPS Monitoring and Reporting Group d) LPS Transition Group e) LPS Welsh Government Strategic Implementation Steering Group NHS Wales LPS/MCA/DoLS Task and Finish Group	CW FM	Corporate Safeguarding continue to engage in Local, Regional and National Groups. The LPS Implementation Group ToR are being finalised and is to be presented at the Corporate Safeguarding Senior Leads Meeting with wider consultation will progress. For final approval on the 29/10/21 and following receipt of the MCA/LPS Code of Practice.	**1.10.2021**	**AMBER**

2.0	Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service	• Weigh up the benefits and negatives to the costings of providing a seven day service. • Consultation with staff and appropriate services i.e. workforce. • Assessment of staff members, working days, working hours. • Task and Finish Group with agreed reporting framework.	C W	In progress, Safeguarding Business Case to be submitted to the BCUHB Executive Team in September 2021 for approval.	**1.4.2022**	**AMBER**
3.0	Refreshed dissemination to promote the Training MCA/DoLS booklets during 2021-2022	• MCA/DoLS Best Interest Assessors are currently in the process of disseminating the booklets to the wards and appropriately identified services. • In addition bespoke MCA/DoLS training sessions (max 45 minutes) have been developed to promote the MCA.	Best Interest Assessors	Booklets have been disseminated across services. Bespoke training sessions are in progress.	**30.09.2021**	**AMBER**
4.0	Confirm and engage with the BCUHB Mental Capacity Act Lead	• New job description in the process of being developed to reflect the changes in the MCA/LPS legislation • Consultation with workforce • Ensure changes are in line with Corporate Safeguarding Business Proposal	C W FM	This action is inherently linked to action 2.0 above and is in progress.	**1.4.2022**	**AMBER**
5.0	LPS update reports are to be included on the agenda of the MHCC Committee as required	• Provide agreed updates to the Mental Health Act Committee • Report changes as and when required • Ensure the MHCC Committee Chair is fully informed of any key developments or actions	CW	Actioned	**1.4.2022**	**GREEN**

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
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:	Dr Nick Lyons Executive Medical Director
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 Dr Nick Lyons 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 3rd September 2021.

Argymhelliad / Recommendation:

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

Please tick as appropriate

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

Sefyllfa / Situation:

Betsi Cadwaladr University Health Board is responsible for the initial approval, re-approval, suspension and termination of approval of Approved Clinicians and Section 12(2) Doctors for all Health Boards 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 may be mentally disordered.

Options Considered

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

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

Impact Assessment

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

Service Developments

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

The September Induction and Refresher training was held via Webinar. The next induction and refresher training will take place in November 2021 which will also be facilitated via Webinar. Training dates have been agreed up to February 2023.

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

Following discussions with Welsh Government, a letter was sent via email in June 2020 to all ACs and S12 (2) doctors informing of and clarifying details for a temporary variation in the arrangements for re-approval during the Covid19 pandemic. The variation applied to ACs/S12(2) doctors who were due to apply for re-approval during the pandemic advising that the Team were able to continue to offer Webinar-based refresher training compliant with social distancing requirements during Covid-19. This would enable clinicians to meet the extant requirements of re-approval. Welsh Government agreed that it would also be prudent to make a temporary and minor variation in the event that the refresher training could not be delivered or where a clinician had been unable to attend due to Covid-19 related reasons. In that exceptional circumstance, the Approving Board may grant approval, on condition that the clinician attends refresher training within 12 months of the start date of the new approval period.

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

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

28th May 2021 – 3rd September 2021

New Applications Received	**14**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	0
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	14
Number of ACs already approved in England	9
Number of applications with panel (including portfolios)	1
Number of applications not approved	0
Re-approval Applications Received (5 Yearly)	**19**
Number of applications with panel	0
Number of applications approved	19
Number of applications not approved	0
Number of ACs reinstated	0
Number of re-approvals which have come to an end	**9**
Expired	1
Retirement	2
No longer working in Wales	4
No longer registered with professional body	0
AC requested	1
Registered without a licence to practise	0
Awaiting CCT	0
Suspended	0
RIP	1
Total Number of Approved Clinicians	**378**
Total Number of Approved Clinicians from previous report	**377**

APPENDIX 2

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

28th May 2021 – 3rd September 2021

New Applications Received	17
Applications from GPs	0
Applications from Psychiatrists	17
Application from Forensic Medical Examiner	0
Number of Applications Approved	15
Number of Applications Not Approved	0
Number of Applications with Panel	2
Incomplete Applications	0
Re-approval Applications (5 years)	4
Applications from GPs	3
Applications from Psychiatrists	1
Applications from Forensic Medical Examiners	1
Number of Applications Approved	4
Number of Applications Not Approved	0
Number of Applications with Panel	1
Transferred from AC register	0
Number of Approvals which have come to an end:	3
Ended	2
Become an Approved Clinician	0
No longer working in Wales	2
No longer registered	0
Registered without a licence to practise	0
Retired	1
Under Police Investigation	0
Suspended from Medical Practitioners List	0
Total Number of S12(2) Doctors currently approved	**176**
Total Number of S12(2) Doctors from previous report	**164**

APPENDIX 3

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

As at 3rd September 2021

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	5	0	0	2	3	**13**
Section 12(2) Psychiatrists	0	4	5	2	2	5	**18**
Approved Clinicians	4	10	19	11	14	21	**79**

Number of 12(2) GPs per Health Board

BCUHB	13
ANEURIN BEVAN	6
CARDIFF & VALE	5
CWM TAF	0
HYWEL DDA	2
POWYS	2
SWANSEA BAY	1

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Deprivation of Liberty Safeguards (DoLS) Quarterly Report September 2020-2021**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Associate Director of Safeguarding Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Chris Walker, Head of Adult Safeguarding (MHLD) supported by Michelle Denwood, Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Due to the alignment of the cycles of business, this quarterly report is submitted directly to the MHCCC. Deprivation of Liberty Safeguards is within the portfolio of the Deputy CEO/Executive Director of Nursing and Midwifery and this update has been reviewed by; Michelle Denwood, Associate Director of Safeguarding and Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery
Atodiadau **Appendices:**	N/A

Argymhelliad / Recommendation:

The MHCC Committee is asked to note the Deprivation of Liberty Quarterly Report and the identified activity for the period of April 2021 to August 2021.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	x
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						No	

Sefyllfa / Situation:

Governance

This Deprivation of Liberty Safeguards (DoLS) Quarterly Report provides an overview of the DoLS activity undertaken by BCUHB during the period of April 2021 and August 2021 (inclusive).

The activity recorded provides oversight and organisational assurance in relation to BCUHB's statutory duty under DoLS and the Mental Capacity Act (MCA) 2005. The activity includes key actions and activities to ensure that DoLS/MCA, as part of the wider Corporate Safeguarding agenda, remains paramount to service delivery across BCUHB.

Deprivation of Liberty Safeguards reports throughout the organisation in accordance with the Safeguarding Reporting Framework. This framework reinforces organisational engagement, reporting

and escalation, by the Safeguarding Governance and Performance Group, Patient Safety and Quality Group and directly into the Mental Health Capacity and Compliance Committee Meeting.

Cefndir / Background:

Throughout the COVID pandemic the Corporate Safeguarding - DoLS/MCA Team has continued to offer full engagement and support to all services across BCUHB.

The figures alone do not reflect the level of complexity and demand upon the DoLS/MCA service. What is evident is that the trend for DoLS applications is an upward trajectory. An increase in the number of Best Interest Assessor's (BIA's), which is now 6, has had little impact upon the applications waiting list.

A business case is under development, with the objective to strengthen organisational performance and provide assurance that authorisations are completed within the legal timeframe, reducing unlawful detentions and improving patient experience and the reduction of potential harm.

Performance and Activity

In 2020-21, the DoLS/MCA Team received 1162 applications illustrated in Table 1 below. The table evidences the continued increase in DoLS activity. Between April 2021 and August 2021 639 DoLS applications have been received. This is a 44% increase when, compared to the same period in 2020-21 when we received 444 applications.

Table 1: Annual DoLS applications

Year	West	Central	East	England	Other	Applications
2018-19	89	257	343	55	0	743
2019-20	177	282	483	72	0	1014
2020-21	208	322	550	82	0	1162

Figure 1 below represents the cumulative number of DoLS applications received each year.
Not only does this highlight the number of applications is increasing year on year, it also identifies that even during the COVID-19 Pandemic there was a gradual and sustained increase in applications.

Figure 1: BCUHB Cumulative Applications 2018 – 2021

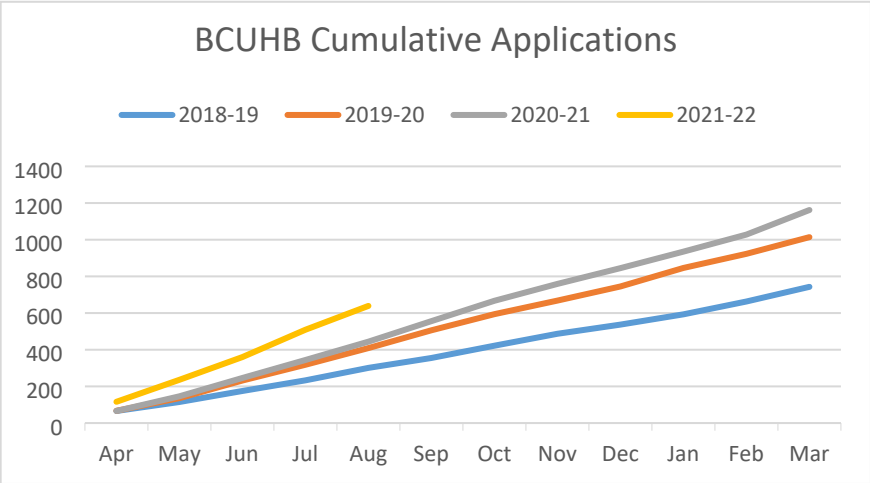


Table 2 represents the exact number of applications received by month between April and August 2021. Comparison figures from 2020 are included, evidencing a substantial increase in DoLS applications each month for this period.

Table 2: DoLS applications by month 2020 and 2021

Month	2020	2021	Increase	%change
April	66	116	+ 50	76%
May	80	120	+ 40	50%
June	100	124	+ 24	24%
July	98	149	+ 51	52%
August	100	130	+ 30	30%
Total	**444**	**639**	**195**	**44%**

Completion of Documentation

Out of the 639 DoLS applications in the identified period 28% of the applications contained some issues or concerns that resulted in them having to be returned to the Managing Authority (Ward). Comparison data for the period 2020-2021 identified 44% of applications evidenced some form of documentation error.

Failure to complete the forms accurately and appropriately causes an unnecessary delay in the authorisation process and can lead to further challenges by the Court of Protection. This in turn can result in financial damages placed upon BCUHB as well as the possibility of reputational damage and importantly the unlawful detention of patients.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategic Implications Assessment and Analysis

The following are aligned to the agreed strategic objectives identified within the Corporate Safeguarding Governance and Reporting activity to support performance and ensure compliance with Safeguarding legislation and statutory guidance.

Audit

DoLS applications are prioritised according to the risks and urgency identified within the application and the accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the DoLS/MCA Team recognising;

- Whether the patient objects to the restrictions in place.
- What level of restrictions are in place including 1:1 nursing, sedating medication, physical restraint or other.
- Whether the patient is in an Acute or Mental Health Unit and the level of supervision needs to be greater.
- Whether the patient is already subject to an existing DoLS authorisation, which is going to expire.
- Whether there is a Court of Protection appeal or an existing Court Order in place.

The Corporate Safeguarding – DOLS/MCA Team, conducted an audit of the DoLS documentation completed by the Managing Authority in Q4 2020-2021.

The audit identified four (4) main themes;

- No inclusion of the Mental Capacity Assessment Form.
- Mental Capacity Assessments are completed incorrectly or relates to the wrong decision.

- Missing details regarding communication (language, format) and medical information.
- The DoLS application documentation was not completed correctly, not signed, not dated, not dated correctly.

The audit will be repeated again in Quarter 3, 2021-2022 to gain assurance or identify risks.

Training

To mitigate risk and obtain assurance, additional and bespoke training programmes are available to facilitate learning for clinical staff, Band 5 and above.

Table 3:

Training Module	August 2020	August 2021	Trajectory
MCA – Level 1	83.6%	80.6%	↓
MCA – Level 2	87.0%	81.8%	↓

Online MCA Level 1 and 2 training is available for all staff. The recent drop in compliance was reviewed with actions taken to remind staff to check their ESR mandatory training requirement in relation to MCA. Reminders are provided by using a variety of resources, for example; respective Safeguarding Forums, PTR meetings and the monthly Safeguarding Bulletin.

The dissemination of MCA booklets is complete, this was a key action for 2021-22. The MCA/DoLS booklets are available to support staff who are unable to access IT equipment or attend online training. The booklets ensure all staff are given the opportunity to complete essential mandatory training to improve awareness and processes compliance.

Analysis

Safeguarding training compliance is a key target for Corporate Safeguarding with a targeted approach in place for areas or departments with reduced compliance. A reduction in compliance was reported during early 2021-22, Table 2. A revised virtual training programme is also available and remains in place to encourage ongoing training during the COVID-19 pandemic

Between April and August 2021 the Team completed 5 (1 each month) DoLS training sessions across BCUHB. In total 301 staff attended. In addition, the team provided bespoke DoLS training at Bangor University (via Teams) for 170 students. We continue to promote and offer sessions on a ward/team basis where there is targeted intervention due to reduced compliance, or when complex cases support reflective learning or where issues are raised due to audit or compliance challenges.

DoLS training is included within the mandatory Adult Level 2 Safeguarding Module. The current competency rate for Level 2 training across BCUHB stands at 79.6%, which is a slightly increased position. Within the MHLD Division compliance stands at 83.5%.

DoLS and MCA training and the recording of compliance is to be included within the October Corporate Safeguarding Bulletin to ensure organisational engagement and compliance.

To ensure accuracy and targeted training data is on ESR, work has commenced to cleanse the data and identify competencies in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff. This activity is completed in the MHLD Division.

Bespoke and issue specific DoLS training, following the methodology of a 30 minute workshop, will target areas of low compliance or where audit activity identifies the need for greater awareness and improvement. This is because the compliance data does not always correlate with evidenced clinical practice.

Deprivation of Liberty Safeguards 16/17 year old

In 2019 the Supreme Court ruling decided where a 16/17 year old lacks capacity to consent themselves to arrangements which meet the 'acid' test for deprivation of liberty, parental consent will not stop that amounting to a deprivation of liberty, unless legally authorised, the deprivation will be unlawful.

This has resulted in an increase in legal engagement, an increase in applications to the Court of Protection and the requirement of bespoke training and supervision for Children and Adolescent Mental Health Services (CAMHS) and paediatric clinical practitioners.

Analysis

To ensure clinical staff have full understanding of this case law, a number of training packages continue to be delivered using a variety of platforms. The Deprivation of Liberty 16/17 year old training package is currently available online.

To support the implementation of this legislation the team support complex cases and provide advice, guidance and constructive challenge.

Safeguarding DoLS/MCA/LPS Business Case

A Safeguarding Business Case is under development and will be submitted and presented for considered by BCUHB's Executive Team in Sept 2021.

Finalisation of the Business Case has experienced a four (4) week delay due to the requirement of a review following to the identification of additional challenges. Final financial calculations are taking place with the aim if agreed, to introduce additional resource over an eighteen (18) month period.

Court of Protection (CoP)

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

- **Section 21A Appeal:** Patients have a right in law to challenge the detention if the patient feels it is unlawful. (Article 5(4) ECHR).

- **Section 16 MCA (2005):** Relating to welfare decisions.

The number of cases engaged in Court of Protection activity has increased significantly. Cases may take months for the Court to conclude due to the amount of evidence and complexity with each case resulting in a number of hearings.

During this period, we have seen a significant escalation of complexity in a number of Court of Protection cases. This has resulted in intensive Court of Protection activity and has required Senior BCUHB Board member attendance. One case is to be heard at the High Court in London where the direction of the court has again required the Chief Executive's attendance.

There have been three (3) new CoP applications received since April 2021. There are four (4) ongoing cases from 2020-2021, 3 of the 4 cases have been ongoing for over 12 months.

There are three (3) new cases, relating to a Section 21a Appeal, where we are waiting for a Court date and draft Order to enable us to proceed.

The increase in complex CoP cases has resulted in additional costs to the Health Board. This includes the number of staff engaged in the process, legal challenge as a result of the recognised delay on behalf of BCUHB, to address the concerns and the directions of the Court Order. Engagement with

Legal and Risk which includes, Barrister fees, Court costs, Official Solicitor costs (on behalf of P), external expert costs, and where applicable compensation to P.

A further exploration of the costs incurred by the Health Board is to be actioned, with future reporting to the Committee.

Analysis

After reviewing a number of cases, activities within the process are causing organisational challenge. To respond to this the Team have developed a Memorandum of Understanding and Section 21a Appeal Process to facilitate cooperation, escalation and coordination within the Health Board. This describes the role, responsibility and accountability when the need arises to respond to directions of the Court.

The provision of additional support and guidance in relation to Court of Protection applications and compliance with Court Order directions will reduce additional costs awarded against the Health Board.

The draft Memorandum of Understanding is following the Safeguarding Governance and Reporting Framework to ensure consultation and ratification.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications

There are no financial implications for this report.

Dadansoddiad Risk / Risk Analysis

The risks associated with the Deprivation of Liberty Safeguards presented at QSE on the 8th September 2021 resulted in the approval of the Risk to be included within the Tier 1 Corporate Risk Register.

Risk ID 2548. The increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

Risk Calculation. 4 [major/high] x 5 [almost certain, will undoubtedly happen or recur, possibly frequently] = 20

Mitigating activities are in place to reduce the risk and improve service delivery across the Health Board. A targeted approach is required based upon trends, themes, incidents and data and these include;

The DoLS/MCA Standard Operating Procedure, this is in place to provide additional guidance and direction to support the actions required for a DoLS application to be authorised to prevent unlawful deprivation.

We have increased the number of Authorisers across the Health Board. There are 51 registered DoLS Authorisers within BCUHB. This has provided some assurance with regard to improved timescales in the authorisation of a DoLS application, once it has progressed through the scrutiny process.

A review of the Authorisation process is underway as further improvements to the governance arrangements are required.

The Corporate Safeguarding DoLS/MCA Team have delivered bespoke MCA/DoLS training to focus upon the key omissions in the DoLS process by the wards.

Implementation and the development of revised DoLS training packages, booklets and events to support the application of learning to support care.

Triangulation of data, the Team cross-reference incidents with Datix to target trends, provide individual supervision, and ensure reporting compliance. Data and incidents are triangulated with the wider Corporate Safeguarding activity, when specific Adult at Risk concerns are raised in relation to individuals who are subject to DoLS. This enables a joint working approach to addressing safeguarding concerns.

The scrutiny of applications is conducted by the DoLS/MCA Team and includes both the DoLS Form 1 and supporting documentation, to ensure evidence is lawful and the individual lacks the capacity to consent to be 'accommodated' in hospital, which is a vital aspect of the patient care pathway.

A 'Sample' Mental Capacity Assessment Form is available and provides enhanced guidance. This best practice guidance is included in all MCA/DoLS training and is routinely disseminated to ward staff.

We have developed and accessed legal DoLS 'Forms' in the Welsh Language and other languages to fully support the use of a patients/families first language to support capacity decisions ensuring the organisation is patient centred.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

DoLS came into force as an amendment of the Mental Capacity Act (MCA) 2005 and provided a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. The Deprivation of Liberty Safeguards Code of Practice supplements the main Mental Capacity Act 2005 Code of Practice.

The Supreme Court Judgement, P v Cheshire West Council [2014] and *P & Q v Surrey County Council [2014] UKSC 19* looked at the 'threshold' concerning the criteria known as the 'Acid Test' for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty.

The Supreme Court Judgement D [A Child] judgement given on 26th September 2019. This case considered the European Convention on Human Rights and looked at the decision making when a 16/17 year old is assessed not to have capacity and the lawful detention of that person.

Asesiad Effaith / Impact Assessment

The increase in applications and complexity of cases continues to be a recognised risk for the Health Board.

The service delivery of Deprivation of Liberty Safeguards has a number of stages, all of must be lawfully actioned. The mitigating activities and the ongoing implementation of improvements driven by data and activity will require resource.

Welsh Government have announced a bidding process to secure funds to support the Health Board in their efforts to reduce what is referred to as; the 'DoLS backlog'. Welsh Government acknowledge that all Health Boards and Local Authorities in Wales hold a number of DoLS applications that are awaiting BIA's, Section 12(2) Doctor assessments, scrutiny, and authorisation.
This is limited and must be used prior to the introduction of Liberty Protection Safeguards (LPS) on 1st April 2022. Activities are taking place to fully engage and include other key Divisions to bid and utilise this resource.

Over the next six (6) months further work will be actioned as part of an LPS implementation programme. Co-production and engagement with BCUHB services and divisions will support a smooth transition to support the implementation of Liberty Protection Safeguards and offer assurance that the Health Board is compliant with legislation and process in response to the proposed implementation date which commences on April 1st 2022.

Priority Activities for Q3 and Q4

1. To ratify the ToR and implement the BCUHB LPS Strategic Implementation Group, which will include the development of Programme Task Groups to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.
2. Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service.
3. Refreshed bespoke training on MCA/DoLS.
4. Review training compliance to ensure accuracy and target training data is on ESR.
5. Ratify and Monitor the implementation of the strengthened CoP and S21a appeal process.
6. Q3 Documentation Audit
7. Confirm and engage with the BCUHB Mental Capacity Act Lead to comply with MCA guidance.
8. Review of the Governance arrangements for DoLS Authorisation.
9. Reporting of the Liberty Protection Safeguards to the MHCC Committee as required

Betsi Cadwaladr University Local Health Board (BCUHB)
Mental Health Act Committee Report Action Plan 2021-2022

Action Plan

Corporate Safeguarding MCA/DoLS Team

	Recommendations	Action Required	Lead(s)	Evidence of completion	Target Date	RAG
1.0	To create a BCUHB Liberty Protection Safeguards (LPS) Implementation Group, which will include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and code of practice relating to the LPS.	• Chris Walker, Head of Adult Safeguarding (MHLD), and Frances Millar, Head of Adult Safeguarding are currently in the process of completing an LPS ToR to share with the BCUHB Senior Team. • Engagement in Local, Regional and National meetings/groups: a) LPS Workforce and Training Group b) LPS in relation to 16 and 17 year olds Group c) LPS Monitoring and Reporting Group d) LPS Transition Group e) LPS Welsh Government Strategic Implementation Steering Group NHS Wales LPS/MCA/DoLS Task and Finish Group	CW FM	Corporate Safeguarding continue to engage in Local, Regional and National Groups. The LPS Implementation Group ToR are being finalised and will be presented at the Corporate Safeguarding Senior Leads Meeting for approval and ratification on the 29/10/21 and following receipt of the MCA/LPS Code of Practice.	**1.10.2021**	**AMBER**

2.0	Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service	• Weigh up the benefits and negatives to the costings of providing a seven day service. • Consultation with staff and appropriate services i.e. workforce. • Assessment of staff members, working days, working hours. • Task and Finish Group with agreed reporting framework.	ADS	In progress, Safeguarding Business Case to be submitted to the BCUHB Executive Team in September 2021 for approval.	**1.4.2022**	**AMBER**
3.0	Refreshed dissemination to promote the Training MCA/DoLS booklets during 2021-2022,	• MCA/DoLS Best Interest Assessors are currently in the process of disseminating the booklets to the wards and appropriately identified services. • In addition bespoke MCA/DoLS training sessions (max 45 minutes) have been developed to promote the MCA.	Best Interest Assessors	Booklets have been disseminated across services. Bespoke training sessions are in progress. These will be completed during September 2021.	**1.10.2021**	**AMBER**
4.0	Review training compliance to ensure accuracy and target training data is on ESR.	• Work has commenced to cleanse the data and identify competencies in line with the Adult Safeguarding. • This activity is completed in the MHLD Division	CW	Work has commenced to cleanse the data and identify competencies in line with the Adult Safeguarding. This activity is completed in the MHLD Division	**1.12.2021**	**AMBER**
5.0	Ratify and Monitor the implementation of the strengthened CoP and S21A appeal process	• Documents have been written and shared with the Corporate Safeguarding Senior Team for comments and amendments. • To be shared for ratification at SGPG on 13/10/21.	MD CW	Documents have been written and shared with the Corporate Safeguarding Senior Team. Requires wider consultation	**1.11.2021**	**AMBER**

				To be shared for ratification at SGPG on 13/10/21.		
6.0	Documentation Audit	• Planned DoLS Application Audit during Q3. • Report to be completed and shared.	CW	Audit application under development	**1.2.2022**	**AMBER**
7.0	Confirm and engage with the BCUHB Mental Capacity Act Lead	• New job description in the process of being developed to reflect the changes in the MCA/LPS legislation • Consultation with workforce • Ensure changes are in line with Corporate Safeguarding Business Proposal	CW FM	This action is inherently linked to action 2.0 above and is in progress.	**1.4.2022**	**AMBER**
8.0	Review of the Governance arrangements for DoLS Authorisation	• Review to be completed during Q3 to identify current arrangements and highlighted issues/concerns • Actions to ensure authorisations are processed and addressed within an agreed timescale. • Development of guidance for authorisers, to include step by step instructions and statutory/organisational responsibility and accountability.	CW	Memo disseminated to DNS and Governance leads Request for updated list of Authorisers. Interim arrangements agreed.	**1.11.2021**	**AMBER**
9.0	LPS update reports are to be included on the agenda of the MHCC Committee as required	• Provide agreed updates to the Mental Health Act Committee • Report changes as and when required • Ensure the MHCC Committee Chair is fully informed of any key developments or actions	CW	Actioned	**1.4.2022**	**GREEN**

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Associate Hospital Managers Update Report (May 2021 – July 2021)**
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Mental Health and Learning Disabilities, Senior Leadership Team Quality Safety and Experience Group 17/08/2021 Mr Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**	√	**Er gwybodaeth For Information**	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

This report does not inform strategic decisions. It relates to the day to day operations of the Associate Hosptial Managers who are delegated functions under legal obligations of the Mental Health Act. Stategic changes would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.

Sefyllfa / Situation:

The Associate Hospital Managers Update Report provides details regarding the Associate Hospital Managers Activity within the division for the period May – July 2021. The report details activity in the areas of: Hearings, Scrutiny, Training, Recruitment, Forums and Meetings and the key performance indicators (KPIs).

Cefndir / Background:

Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'. In Wales, NHS hospitals are managed by local health boards. The local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.

Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (Code of Practice Wales (CoPW) 37.4)

In practice, most of the decisions of the Hospital Managers are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)

In particular, decisions about discharge from detention and CTOs are taken by Hospital Managers' Discharge Panels, specifically selected for the role. They are directly accountable to the Board in the execution of their delegated functions. (CoPW 37.6).

This report provides assurance that the individuals who form the Hospital Managers' Discharge Panels (namely **Mental Health Act Associate Hospital Managers** (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards.

The report below details the activity of the Associate Hospital Managers in relation to Hearings and activity undertaken, concerns raised and improvements to the Division or service to which they have input for the period May 2021 – July 2021.

Quarterly Activity

1 Hearings

At the time of writing (9.8.21) hearings continue to be held remotely via Microsoft Teams.

Four Associate Hospital Managers are secured for a hearing in case of technological difficulties. Within this period there has been one instance where the fourth member was required to join due to connection difficulties being experienced by another panel member.

The relaxation of some Covid restrictions does not currently impact on the way the hearings are being held. Healthcare settings are required to adhere to face coverings and the Health Board has requested that social distancing is still a consideration. It is imperative that the patients, panel members and staff are safe when a hearing is being facilitated. This will be reviewed when the 'working from home if possible' guidance is amended.

A total of 18 hearings were held during the months May – July 2021. The hearings consisted of one Section 2 appeal, five Community Treatment Orders (CTO) renewals and 12 Section 3 renewals. One person was discharged from their section 3.

A breakdown of the hearing activity is detailed below:

May

- ***Thirteen hearings arranged (Six held)***
  All hearings were in relation to renewals. One hearing was for a community patient, and five were for inpatients.
  - ***Seven hearings were cancelled*** – Two patients were discharged, (one on a CTO), and one patient was transferred to guardianship.

- Three hearings were rearranged. One due to unavailability of the video conferencing room. One due to staff sickness and, one due to unavailability of the Responsible Clinician (RC) at short notice. All patients have since had a hearing within this period and continue to remain detained.

Outcomes of hearings held
- All detentions were upheld.

June
- ***Four hearings arranged (Two held)***
  One hearing was for a community patient renewal, and one for a Section 2 inpatient appeal.

  Two hearings were cancelled – One patient was regraded to informal and one patient was transferred to another unit within BCUHB. This patients hearing was rescheduled to July to allow the new RC to review.

  Outcomes of hearings held
  All detentions were upheld.

July
- ***Fourteen hearings arranged (Ten held)***
  All hearings were in relation to renewals. Three hearings were for community patients, and seven were for inpatients.

- ***Four hearings were cancelled*** – Two patients were regraded to informal.

  One hearing was postponed following a request from the legal representative to allow time for the Court of Protection to grant sharing of information, as it was felt this would be of benefit to the Managers Panel. Once permission is received the hearing is to be rearranged.

  One hearing was cancelled following the discovery that the detention was unlawful as the initial Section 3 had been implemented following a virtual assessment. The patient agreed to stay informally.

  Outcomes of hearings held
  Nine detentions were upheld
  One patient was discharged.

Hearing KPIs

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

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

In instances where the patient appeals their detention, the hearing should be held as close as possible to the appeal date. The KPI for appeals focused on working days to allow for reports to be produced and distributed.

There was one application from a patient under a section 2 during this period, and there were no 'barring' hearings. 72% of hearings were held within the KPI.

Renewal Date	**Hearing Date**	**KPI (31 days)**
25/02/2021	14/05/2021	78 * see note 1
09/05/2021	07/05/2021	Held before
13/05/2021	27/05/2021	Held before
16/04/2021	11/05/2021	25
26/04/2021	04/05/2021	8
09/05/2021	20/05/2021	11
12/12/2020 (29/04/2021)	02/07/2021	64 * see note 2
05/06/2021	23/07/2021	48
30/05/2021	05/07/2021	36
10/06/2021	07/07/2021	27
18/07/2021	16/07/2021	Held before
11/06/2021	01/07/2021	20
21/06/2021	06/07/2021	15
29/06/2021	13/07/2021	14
22/06/2021	14/07/2021	22
20/04/2021	08/07/2021	79 * see note 3
10/05/2021	03/06/2021	24
Appeal by Patient Date	**Hearing Date**	**KPI (31 days)**
10/06/2021	18/06/2021	6 working days

Issues which extended the KPI dates are:

Note 1. 78 days – the patient wished to attend but due to commitments and coordination with the solicitor and Responsible Clinician this extended the timeframe.

Note 2. 64 days - the initial renewal date was in December 2020 at that time hearings were not being held if a Mental Health Review Tribunal (MHRT) was arranged within a specific timeframe. The initial MHRT due to be held in February was adjourned to March 2021. In April (29.4.21) the solicitor requested that a Managers Hearing be arranged because the MHRT had not actually held the hearing within the timeframes to discount a renewal hearing. Initially the Managers Hearing was arranged for May but reports were not produced in time, it was therefore delayed until July.

Note 3. 79 days - the initial review date had to be rearranged due to an urgent meeting taking priority in the video conferencing room. The second date arranged the RC was on unplanned leave which delayed the hearing till July 2021.

2 Scrutiny

'Scrutiny' by the Associate Hospital Managers has been reinstated from June within Hergest, Ablett and Heddfan psychiatric units as the 3 units have rooms large enough to facilitate social distancing for the amount of people required. The audit report on scrutiny findings will be completed at the end of the year.

3 Training

All managers who are undertaking hearings are receiving 1:1 reviews, and training is discussed to ensure that they can access the ESR system and receive help if required. To date three managers are not participating:- one has returned to assist the local authority as an Approved Mental Health Professional (AMHP), and two prefer not to undertake remote hearings, (both these managers are happy to return once face to face hearings resume).

Managers have been informed that they are able to arrange to contact the Health Board for assistance from the Mental Health Act Manager if there are problems accessing ESR or passwords require resetting.

A number of managers are now completing their training via ESR.

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:
23 persons of which 20 are actively involved in hearings or shadowing. The active cohort consists of nine male and 11 female members, of which four are Welsh speakers.
Of the active members, there are nine chairpersons, (four male and five female), of which three are Welsh speakers.

Contact has been made with the other Health Boards in Wales to ascertain their numbers of Welsh speakers and the processes they have regarding Welsh patients and Welsh hearings. From the responses received two of the Health Boards do not have any Welsh speaking Associate Hospital Managers and one has a total of five persons to which they ensure there is one welsh speaker if possible for a Welsh hearing.

5 Forums and Meetings

The Associate Hospital Managers Forum Meeting is held on a quarterly basis. This is linked in with training to allow the Associate Hospital Managers to get together and discuss any relevant information and receive updates about changes within the Health Board that is relevant to their role. The next meeting is to be held on the 16th September 2021, via Microsoft Teams.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The use of the Mental Health Act is determined by patient needs, and the least restrictive options are at the forefront of all professionals practice. The Associate Hospital Managers have a duty as independent persons to ensure that the Health Board only detains patients who meet the criteria for detention.

Opsiynau a ystyriwyd / Options considered

Not applicable for this report the functions of the Associate Hospital Managers are governed by legislation, the Associate Hospital Manager Panels are a requirement of the law.

Goblygiadau Ariannol / Financial Implications

The Associate Hospital Managers are paid a sessional fee for each activity. The closure of local post offices and the need to collect documents from a main depot has meant an increase in travel claims. Additional safeguards in relation to Information Governance, has an impact on financial costings due to security requirements for posting reports. Hearings held via virtual means has reduced the claims for travel, but has incurred additional costs given 'back up' arrangements. Since the last quarterly report there have been no changes to these arrangements.

Dadansoddiad Risk / Risk Analysis

The number of Associate Hospital Managers must be kept at reasonable levels to ensure the availability of persons for this activity. The Health Board addresses this by having an open direct hire advert to ensure that the cohort is kept at an adequate level.

Hearings for patients should be conducted as close to the renewal date as possible. If a patient requests a hearing this should be given priority. The risks associated with not conducting a hearing as close as possible to the relevant date, would be:

- Transfers impacting on hearings with the potential for a hearing to be missed or rearranged.
- The Associate Hospital Managers Discharge Panel may not agree with the professionals and feel that patient should be discharged. Any delay in the hearing may result in the patient being detained for longer than necessary.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention.

Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.

Asesiad Effaith / Impact Assessment

All policies in relation to the Associate Hospital Managers have been equality impact assessed.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Mental Health Act Performance Report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Mental Health and Learning Disabilities, Senior Leadership Team Quality Safety and Experience Group 17/08/2021 Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau Appendices:	Appendix 1 MHA Committee Performance Report May – July 2021 Appendix 2 S136 Divisional Report – August Appendix 3 S136 CAMHS Report – August

Argymhelliad / Recommendation:

The Committee is asked to discuss and note the report.

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

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

Sefyllfa / Situation:

The Mental Health Act Performance Report provides an update in relation to the Mental Health Act Activity within the Mental Health and Learning Disability (MHLD) Division and the Child and Adolescent Mental Health Services (CAMHS) during May – July 2021. Additional appendices are included, (as determined by the Committee) when additional assurance is required.

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 completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections.

Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation.

Lapsed sections are reported as ‘Exceptions’ throughout the report, and invalid detentions recorded as ‘Fundamentally Defective’.

Up to date S136 reports are submitted to the Committee.

Asesiad / Assessment & Analysis

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

Options considered
Not Applicable

Financial Implications
The increase in Mental Health Act Detentions has a financial implications.

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

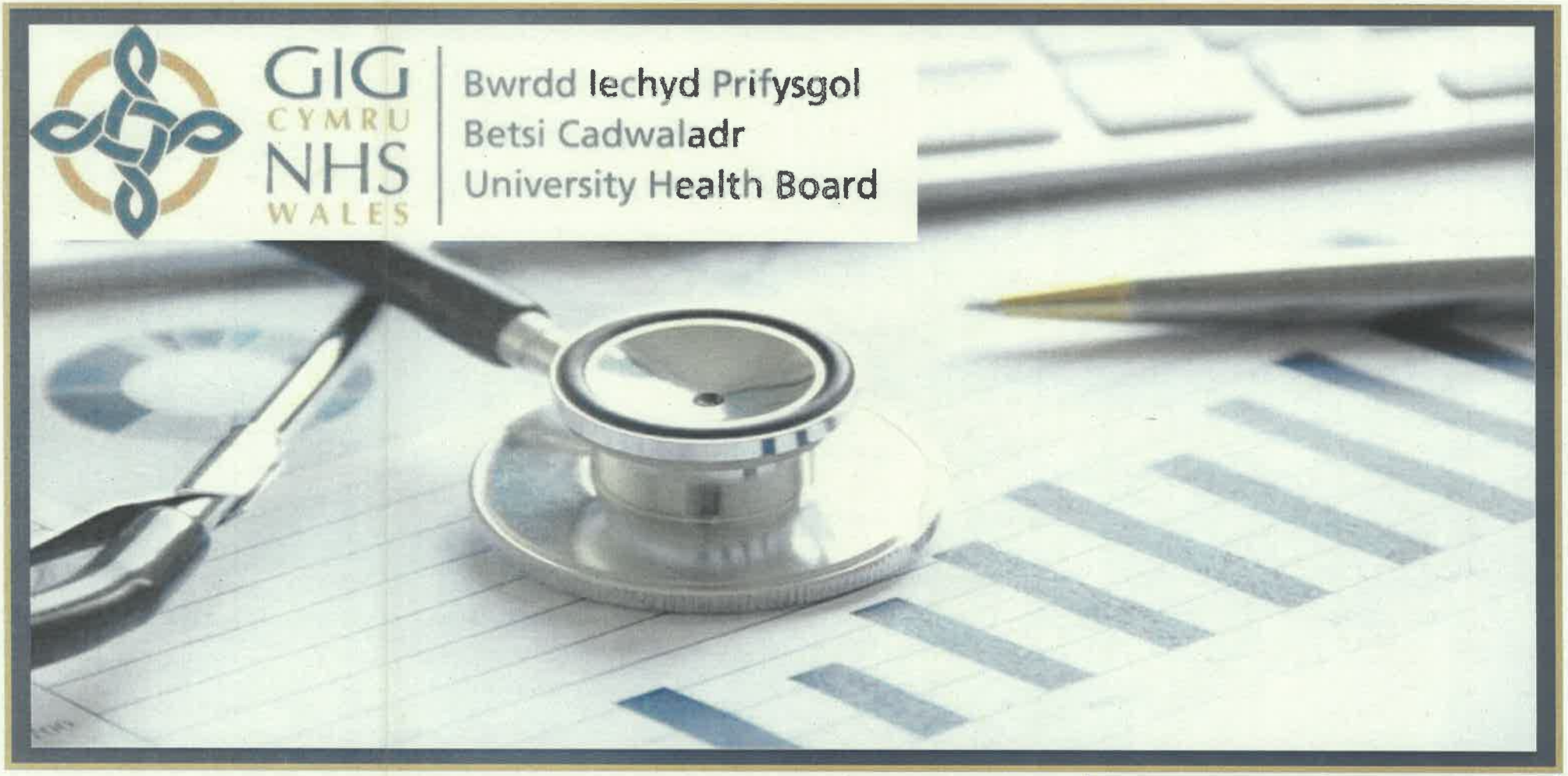
Within this reporting period there were three fundamentally defective sections. Three sections had lapsed, and these are reported as exceptions within the report. All have been datixed and investigated.

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

Impact Assessment
The use of the Mental Health Act Sections apply to all persons All policies in relation to the use of the Mental Health Act have been equality impact assessed.

APPENDIX 1.

Mental Health Act Committee Performance Report



Mental Health Act Committee
Performance Report

July 2021

CONTENTS:

Mental Health Act Committee Performance Report - Foreword

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

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

Seven Domains

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

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

Advisory Reports & Exception reports

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

Exceptions are noted throughout the report within this period three sections lapsed: 1 x S5(4) - due to a belief the timescales had been extended (INC263624), 1 x S5(2) (INC263629) - the RC was off sick assessment was arranged to complete following the weekend, 1 x S2 (INC264591) the medical recommendation was left in an unstaffed office, the section expired at midnight that night.

There are three fundamentally defective sections to report: 1 x S2 (INC264263) one medic failed to sign and date their recommendation. 1 x S3 (INC265333) the nearest relative had been identified incorrectly, due to the person not being elligible this rendered the section invalid and 1 x S3 it was discovered a remote assessment had been conducted for the initial detention following a court ruling in January 2021 this was now classed as illegal.

Advisory Report Definitions

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

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

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

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

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

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

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

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

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

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

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

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

Section 37: Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter
Section 37/41: Hospital Order with Restrictions – made with no time limit

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

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

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

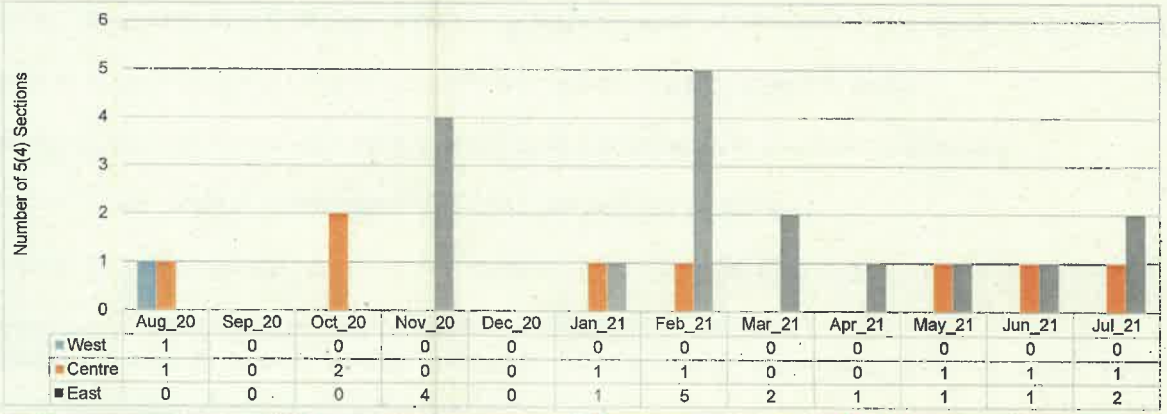
Section 62: Emergency Treatment of a detained patient regardless of section status

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

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

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

Section 5(4) - BCUHB	July 2021	June 2021	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	3	2	↑	7	9	↓	7	1	East	4
								2	Centre	3
								3	West	0



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	1	0	0	0	0	0	0	0	0	0	0	0
Centre	1	0	2	0	0	1	1	0	0	1	1	1
East	0	0	0	4	0	1	5	2	1	1	1	2

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 sections this period met the criteria.

There were no instances of multiple detentions under a 5(4).

LAPSES

The lapsed section occurred due to staff believing this lasted for 12 hours rather than 6 due to the Coronavirus Act 2020. Whilst this was a recommendation within the Act, the Act was not implimented and made law and was created as a provision in case the pandemic escalated.

WEST

Duration (hh:mm)	Outcome

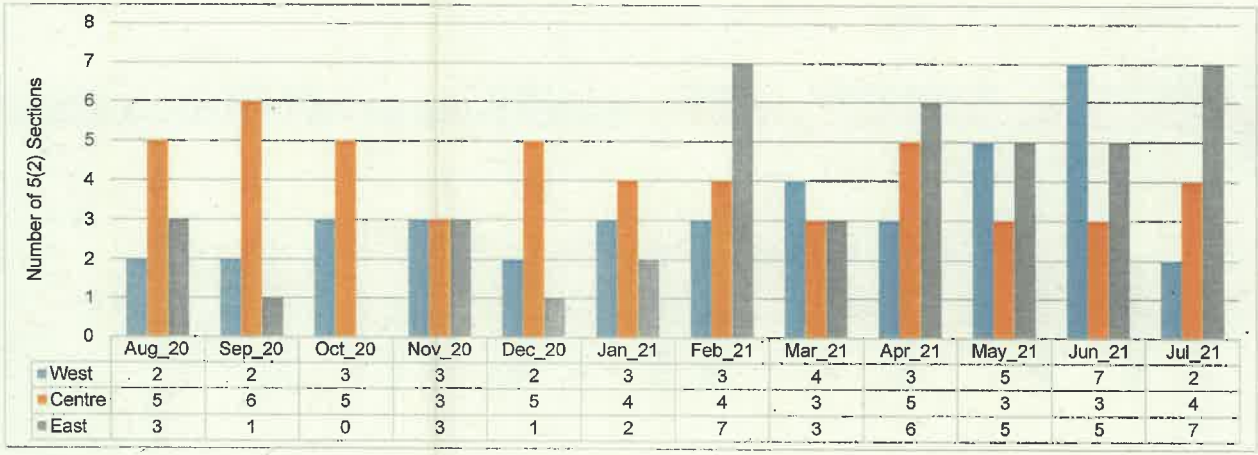
CENTRE

Month	Duration (hh:mm)	Outcome
May_21	06:00	Lapsed
Jun_21	04:00	Informal
Jul_21	01:14	Section 5(2)

EAST

Month	Duration (hh:mm)	Outcome
May_21	16:00	Informal
Jun_21	03:28	Section 5(2)
Jul_21	02:30	Informal
Jul_21	00:55	Section 5(2)

Section 5(2) - BCUHB	July 2021	June 2021	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	13	15	↓	41	38	↑	33	1	East	17
								2	West	14
								3	Centre	10



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	2	2	3	3	2	3	3	4	3	5	7	2
Centre	5	6	5	3	5	4	4	3	5	3	3	4
East	3	1	0	3	1	2	7	3	6	5	5	7

Section 5(2) Outcomes

	May 2021	Jun 2021	Jul 2021
Section 2:	2	7	3
Section 3:	3	4	4
Informal:	5	3	6
Lapsed:	1	0	0
Invalid:	0	0	0
Discharged:	1	1	0
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards, during May - July there was one instance which progressed to a Section 2.

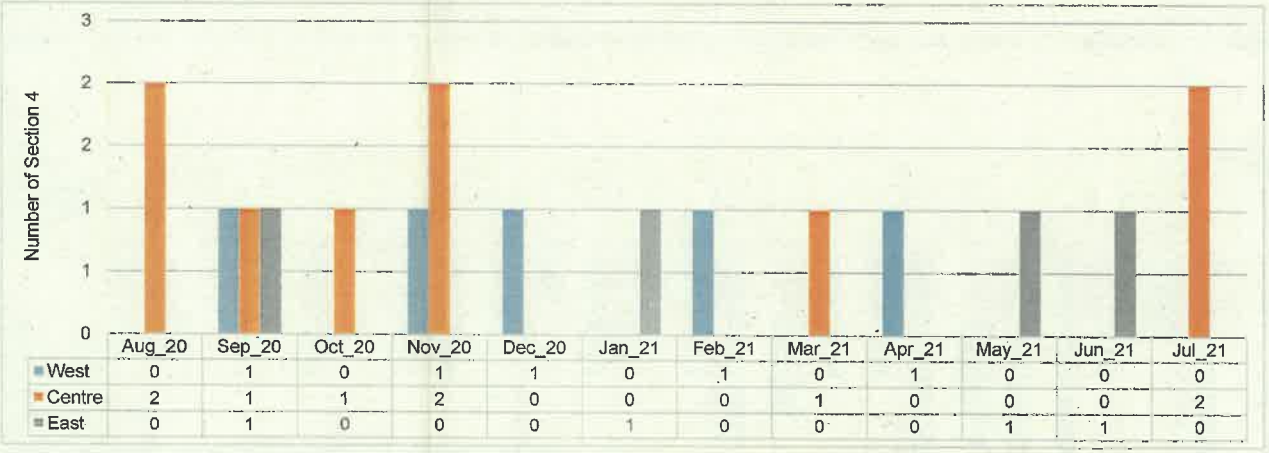
EXCEPTIONS

There is one exception to report this period:

Central: The 5(2) lapsed due to RC being off sick, no available doctors to see over the weekend, the assessment was arranged and completed 1hr 20mins following the expiry of the section.

Advisory Report - Section 4

Section 4 - BCUHB	July 2021	June 2021	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	1	↑	4	3	↑	5	1	Centre	2
								1	East	2
								3	West	0



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	0	1	0	1	1	0	1	0	1	0	0	0
Centre	2	1	1	2	0	0	0	1	0	0	0	2
East	0	1	0	0	0	1	0	0	0	1	1	0

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

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

There are no exceptions to report.

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

WEST

Duration (hh:mm)	Outcome

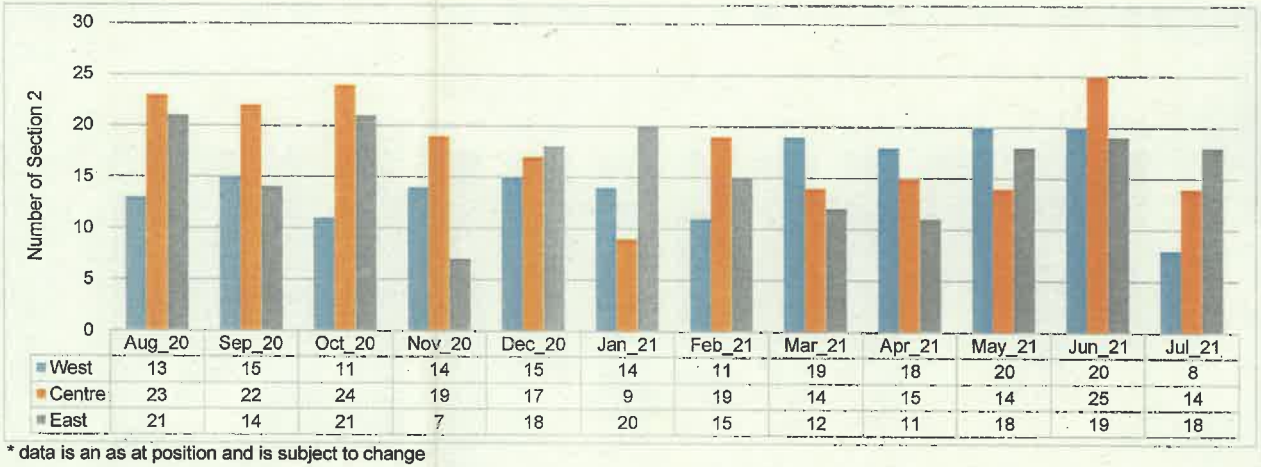
CENTRE

Month	Duration (hh:mm)	Outcome
Jul_21	21:20	Section 2
Jul_21	19:04	Section 2

EAST

Month	Duration (hh:mm)	Outcome
May_21	01:47	Section 2
Jun_21	14:56	Section 3

Section 2 - BCUHB	July 2021	June 2021	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	40	64	↓	156	134	↑	147	1	East	55
								2	Centre	53
								3	West	48



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	13	15	11	14	15	14	11	19	18	20	20	8
Centre	23	22	24	19	17	9	19	14	15	14	25	14
East	21	14	21	7	18	20	15	12	11	18	19	18

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

Section 2 Outcomes

	May 2021	Jun 2021	Jul 2021
Section 3:	6	11	7
Informal:	20	28	22
Lapsed:	0	1	0
Pending:	0	0	0
Discharged:	5	12	9
Transferred:	10	15	6
Invalid and Other:	0	2	0

It is hard to interpret these figures in isolation. It must be noted from April 2020 to January 2021 the Ablett Unit was used as the admissions unit for adults and Heddfan for older persons.

There were eight under 18s placed on a Section 2 this period.
Three young persons were initially in the general hospital when detained.
Two were transfers in from out of area placements.
None of the detentions were following a S136.

One patient (Adult) passed away whilst on a detention.

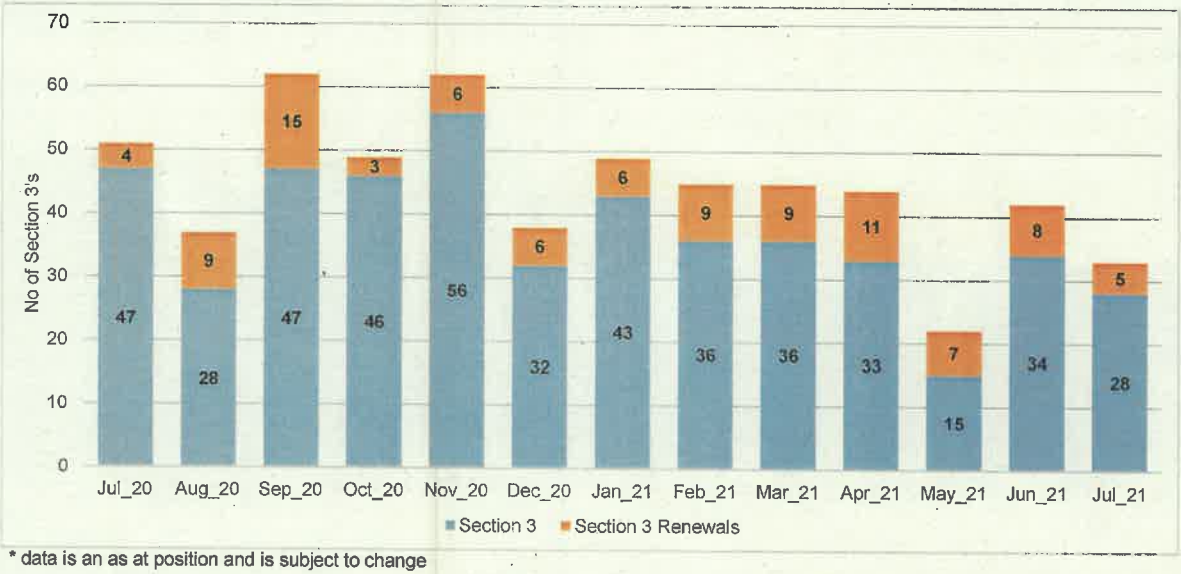
EXCEPTIONS:

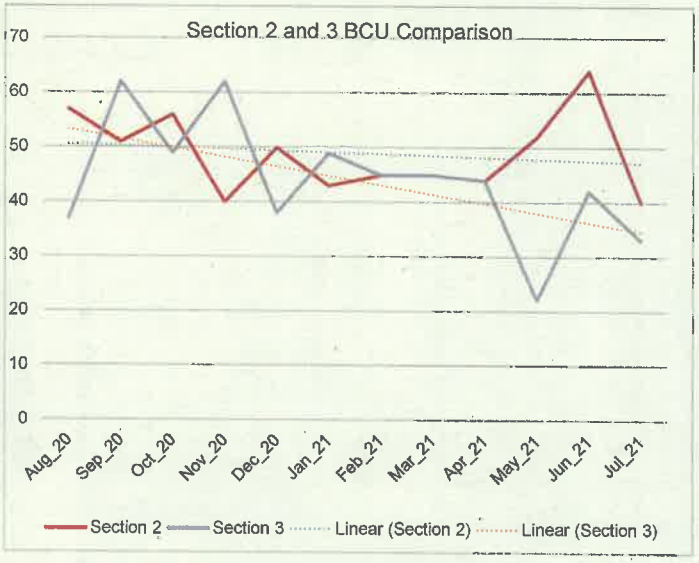
There are two exceptions to report this period.

EAST: (June) A Section 2 expired the first medical recommendation for converstion to a Section 3 was left on the MHA office desk after the staff had gone home the section expired at midnight that day.

WEST: (June) A Section 2 was deemed invalid due to one of the medics failing to sign and date the medical recommendation.

Section 3 - BCUHB	July 2021	June 2021	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	33	42	↓	97	134	↓	132	1	Centre	34
								2	West	32
								3	East	31





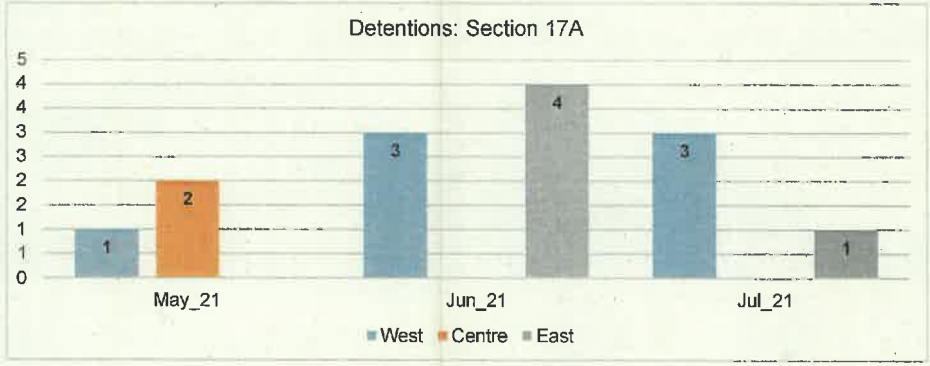
* data is an as at position and is subject to change

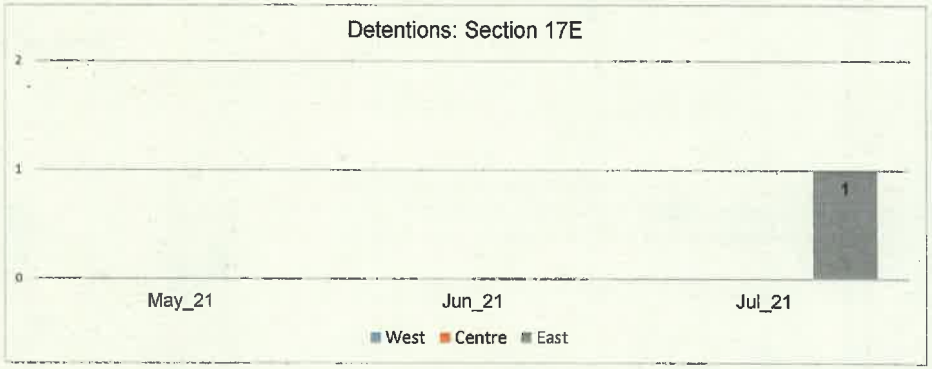
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

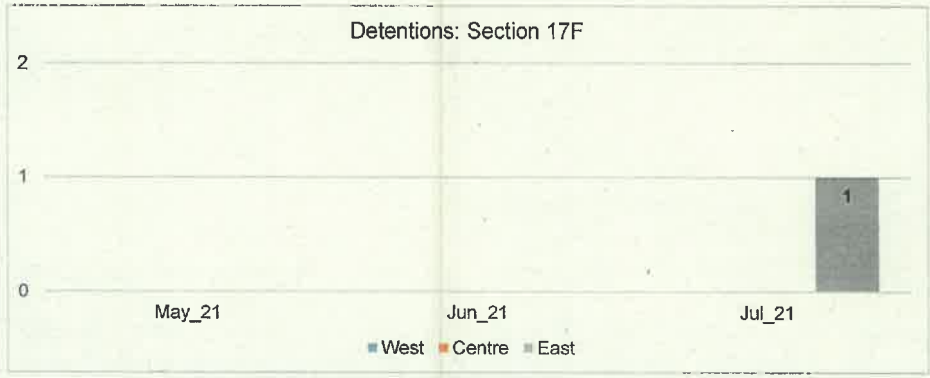
This period there were two under 18s made subject to a section 3, one was a conversion from a Section 2. The trend for use of S2 and S3 over the 12 months at the end of July shows downwards for both.

There are two exceptions to report: (WEST) It was discovered that the nearest relative had been incorrectly identified, therefore rendering the section invalid. This was not an error that could be rectified under Section 15 and (CENTRAL): following discovery that a remote assessment had been conducted the section 3 and proceeding renewal were deemed to be invalid.

Section 17 A-F - BCUHB	July 2021	June 2021	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	6	7	↓	16	21	↓	21	1 1 3	East West Centre	7 7 2







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

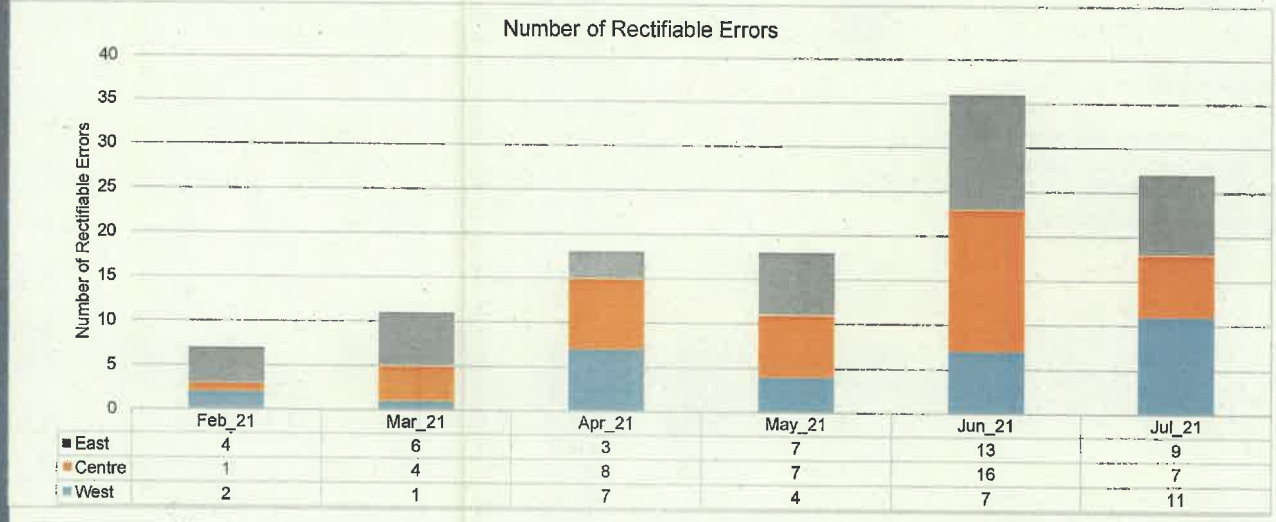
The number of patients subject to a CTO at the end of July West:10, Central: 8 and East: 6.

There has been a decrease in the number of patients subject to a CTO for Central and East this quarter with an increase in the West.

Exceptions: none to report.

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	July 2021	June 2021	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	27	36	↓	76	80	↓	107	1	Centre	30
								2	East	29
								3	West	23



Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales. Due to coronavirus we have not received any benchmarking reports for the year 2020 onwards so are not aware of our current position in relation to the other healthboards. Data from BCUHB has been submitted at the required times. Cardiff and Vale have confirmed they will begin republishing from June 2021, data has been submitted, we are waiting the report.

A deep dive has been conducted in relation to July errors.

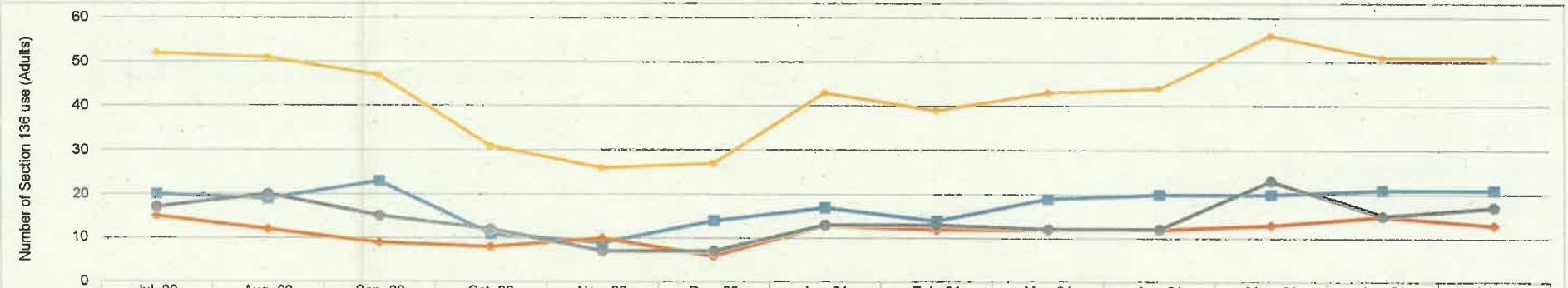
It is important to note that these are rectifiable errors which can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

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

This period there have been three fundamentally defective sections, a Section 2 and 2 x Section 3.

This period there have been three lapsed Sections:- 1 x Section 5(4), 1 x Section 5(2) and 1 x Section 2.

Section 135 - 136	July 2021	June 2021	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)	51	51	→	158	126	↑	127	1	West	62
								2	East	55
								3	Centre	41



	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	20	19	23	11	9	14	17	14	19	20	20	21	21
Centre	15	12	9	8	10	6	13	12	12	12	13	15	13
East	17	20	15	12	7	7	13	13	12	12	23	15	17
BCU	52	51	47	31	26	27	43	39	43	44	56	51	51

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

There have been five S135 detentions this period resulting in detention under an informal admission, S2 and S3.
One Section 136 lapsed this quarter, INC268641 the person was initially unfit for assessment, the detention was extended by 12 hours but lapsed during the assessment period.
During this period there were no custody detentions.
One S136 12 hour extension was granted due to the person not being fit for assessment, on assessment they were discharged with no mental disorder.

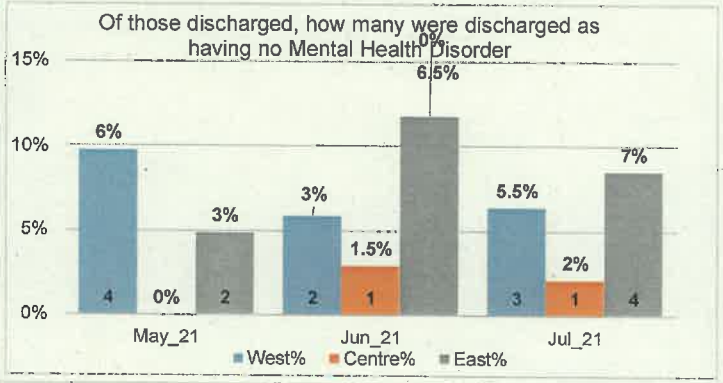
Section 136	July 2021	June 2021	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	51	51	→	158	126	↑	127	1	West	62
								2	East	55
								3	Centre	41

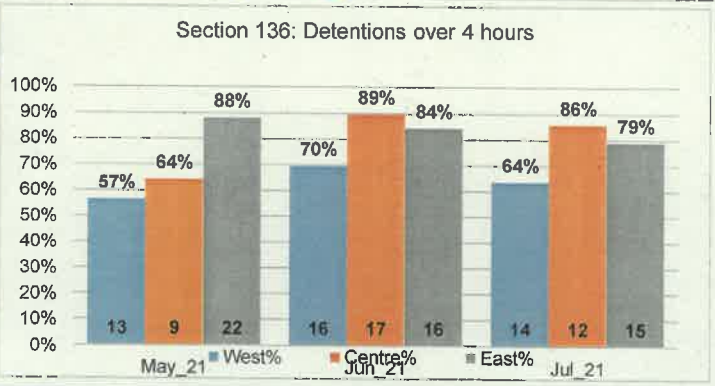
Section 136 Outcomes

	May 2021	Jun 2021	Jul 2021
Discharged:	41 65.08%	34 57.63%	47 83.93%
Informal Admission:	12 19.05%	9 15.25%	4 7.14%
Section 2:	10 15.87%	14 23.73%	5 8.93%
Section 3:	0 0.00%	2 3.39%	0 0.00%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	May 2021	Jun 2021	Jul 2021
Yes	34	45	37
Yes (percentage)	55.74%	75.00%	69.81%





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

Total percentages of all detentions for those discharged with no mental disorder are:
May 9%
June 11%
July 14.5%

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

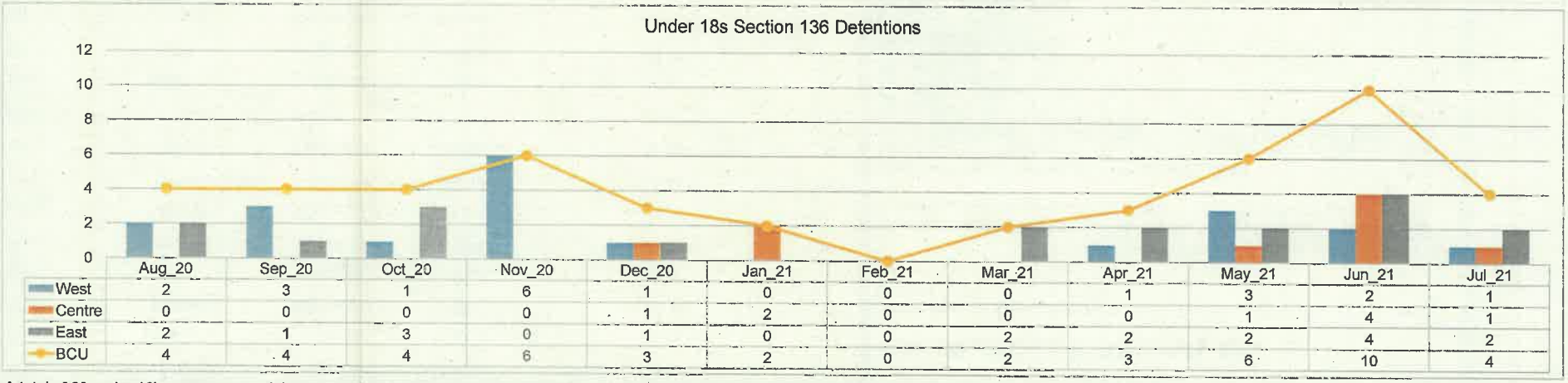
May 26% discharged with follow up and 30% referred to services.
June 34% discharged with follow up and 13% referred to services.
July 46% discharged with follow up and 23% referred to services.

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 165 people have not become detained on a S136 due to CJLS intervention. This period accounts for 27 of those figures.

Data is now being recorded in relation to those that do progress to being detained on a S136 following consultation.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	July 2021	June 2021	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)	4	10	↓	20	5	↑	12	1 2 2	East Centre West	8 6 6



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21
West	2	3	1	6	1	0	0	0	1	3	2	1
Centre	0	0	0	0	1	2	0	0	0	1	4	1
East	2	1	3	0	1	0	0	2	2	2	4	2
BCU	4	4	4	6	3	2	0	2	3	6	10	4

A total of 20 under 18's were assessed this period between the ages of 12 and 17 years. Six assessments resulted in admissions to adolescent services or the paediatric ward, two under section 2, the remainder were voluntary admissions. 11 assessments resulted in discharge with follow up to services, one referral to services and two with no mental disorder.

The tables below shows the ages of young persons assessed and the outcomes for the year period April 21 - March 22.

Under 18 Assessments	
AGE	**Number of Assessments**
12	1
13	4
14	2
15	4
16	5
17	7

Outcome of Assessments	
Outcome	**Number**
Returned Home	13
Returned to Care Facility	2
Admission to childrens ward	6
Admission to Adult ward / S136 suite	0
Admission NWAS / CAMHS	2
Admission OOA	0
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	Hergest	Discharged	CAMHS	16:47	17
May	Heddfan	Admission	CAMHS	05:55	16
May	Heddfan	Discharged	CAMHS	18:20	13
May	Ablett	Admission	CAMHS	03:57	12
May	Hergest	Discharged	CAMHS	11:44	17
May	Hergest	Discharged	CAMHS	13:10	14
June	Ablett	Admission	CAMHS	18:25	13
June	Ablett	Admission	CAMHS	15:45	15
June	Hergest	Discharged	CAMHS	20:15	15
June	Ablett	Discharged	CAMHS	10:55	15
June	Heddfan	Admission	CAMHS	10:40	16
June	Hergest	Discharged	CAMHS	21:30	17
June	Wrexham Maelor	Discharged	CAMHS	15:02	15
June	Heddfan	Discharged	CAMHS	09:30	16
June	Heddfan	Admission	CAMHS	11:45	16
June	Ablett	Discharged	CAMHS	11:12	13
July	Ablett	Discharged	CAMHS	15:10	13
July	Hergest	Discharged	CAMHS	15:30	17
July	Heddfan	Discharged	CAMHS	09:50	16
July	Heddfan	Discharged	CAMHS	06:24	17

Out of the 20 young persons assessed 18 originated from their own home and 2 from a care facility.

19 of the detentions were initiated out of hours.

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

Average PoS hours: 13:05 hrs this is an increase on the previous quarter figures of (12:57 hrs).

Under 18's admitted to Adult Psychiatric Wards

There were no admissions to an Adult Psychiatric Ward this quarter from a S136.

The table below shows the county that the young persons originated from and where they were assessed for the period April 21 - March 22

County Originated from and where assessed:

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

Advisory Report - Forensic

Section	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	0	0	0	0	0	0	0	0	0	0	1	1
Section 37/41:	8	9	8	9	9	9	9	9	9	9	9	9
Section 38:	1	0	0	0	0	1	1	1	0	0	0	0
Section 47:	3	3	3	3	3	3	2	2	2	1	0	2
Section 47/49:	2	2	2	3	3	4	4	4	4	3	2	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	0	0	1	0	0	0	1	0	0	0
Section 3:	3	3	3	3	3	3	3	3	3	4	4	4
Section 45A	1	1	1	1	1	1	1	1	0	0	0	0
Total:	18	18	17	19	20	21	20	20	19	17	16	19

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

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

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

Total Transfers for the Quarter

	May 2021	Jun 2021	Jul 2021
Internal Transfers	11	12	9
External Transfers (Total)	1	10	5
External Transfers (In)	0	6	2
External Transfers (Out)	1	4	3

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.

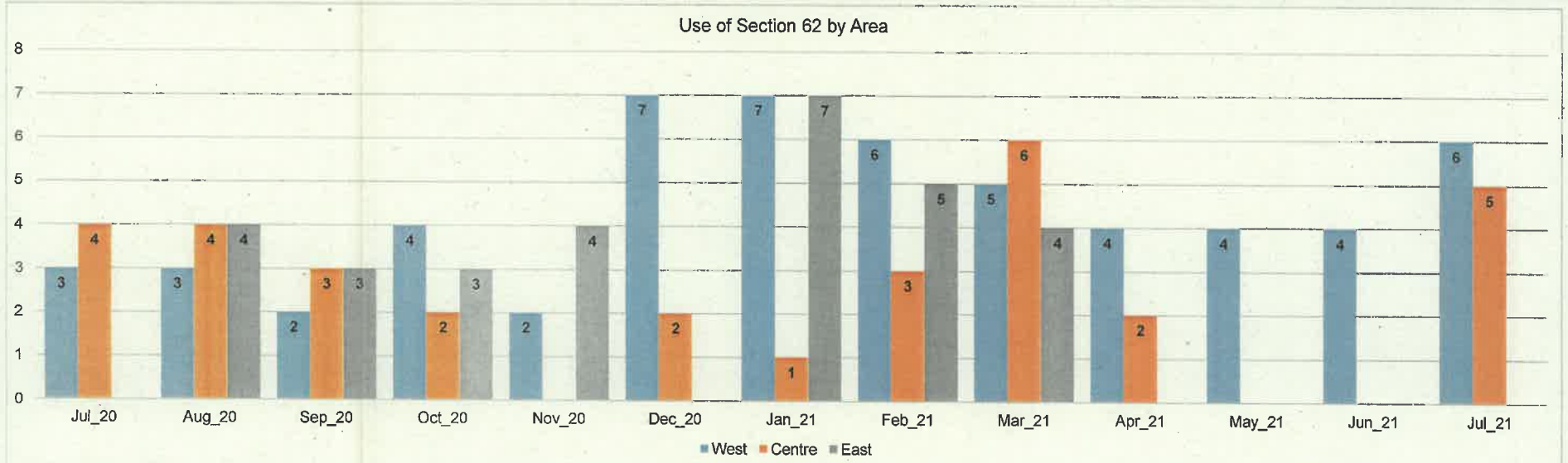
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised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

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

Patients detained in Independent Hopsitals (in Wales and outside of Wales) There are a number of persons who will be detained in independent hospitals that are offering services required. Currently there are 73 detained patients within independent hospitals 46 of these are outside of Wales ie out of area placements, the total number of persons detained in independent hospitals has decreased on the last figures reported whilst the outside of Wales has increased.

Month	Transfers In
Jun_21	Priory, Bristol (Conwy)
Jun_21	Ty Grosvenor (Conwy)
Jun_21	Bristol Priory (Conwy)
Jun_21	St Andrews Healthcare, Nottingham (Denbighshire)
Jun_21	Priory Darlington (Gwynedd)
Jun_21	Camarthenshire (OOA)
Jul_21	Arrowe Park Hospital, Wirral (Denbighshire)
Jul_21	Cygnet, Coventry (Ynys Mon)

Month	Transfers Out
May_21	Elysium Healthcare, Aberbeeg Hospital (Wrexham)
Jun_21	Cygnet Coventry (Ynys Mon)
Jun_21	Priory, Bristol (Conwy)
Jun_21	Bolton MH Unit (Repatriated)
Jun_21	Central and North West London NHS Foundation Trust,St. Charles Mental
Jul_21	To Lakeside (Conwy)
Jul_21	Delfryn Lodge (Wrexham)
Jul_21	Prestwich Hospital (Flintshire)



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.

APPENDIX 2

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

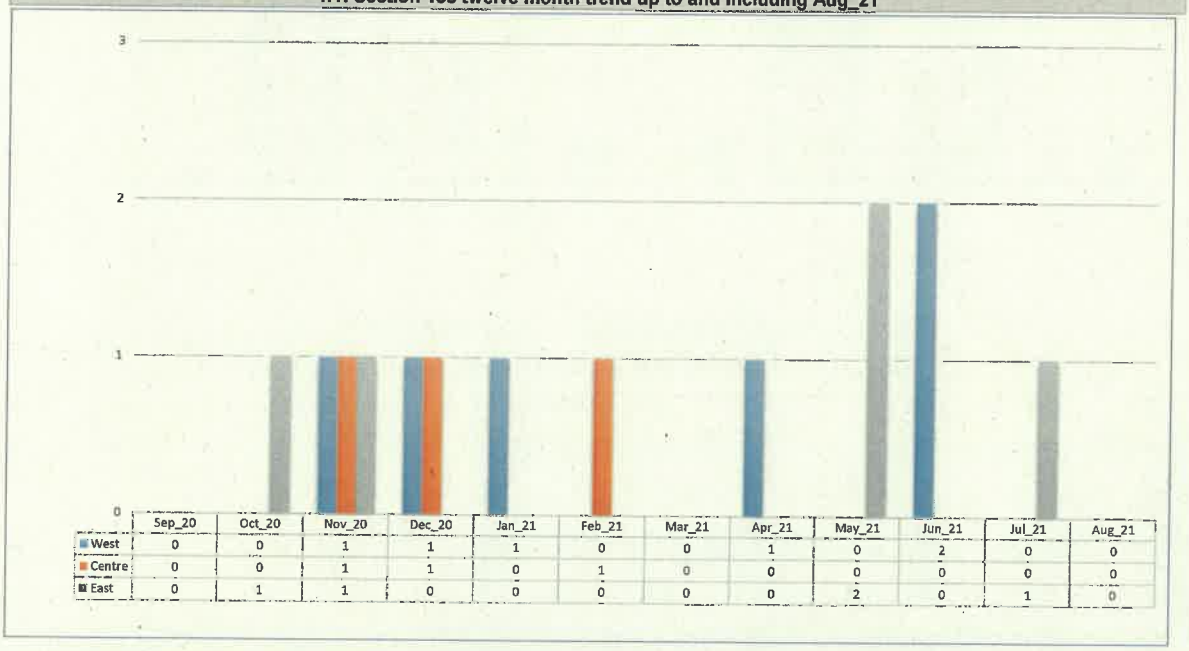
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

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

Data Source:	BCUHB MHA Database
Report Created on:	06/09/2021
Report Created by:	Performance Directorate

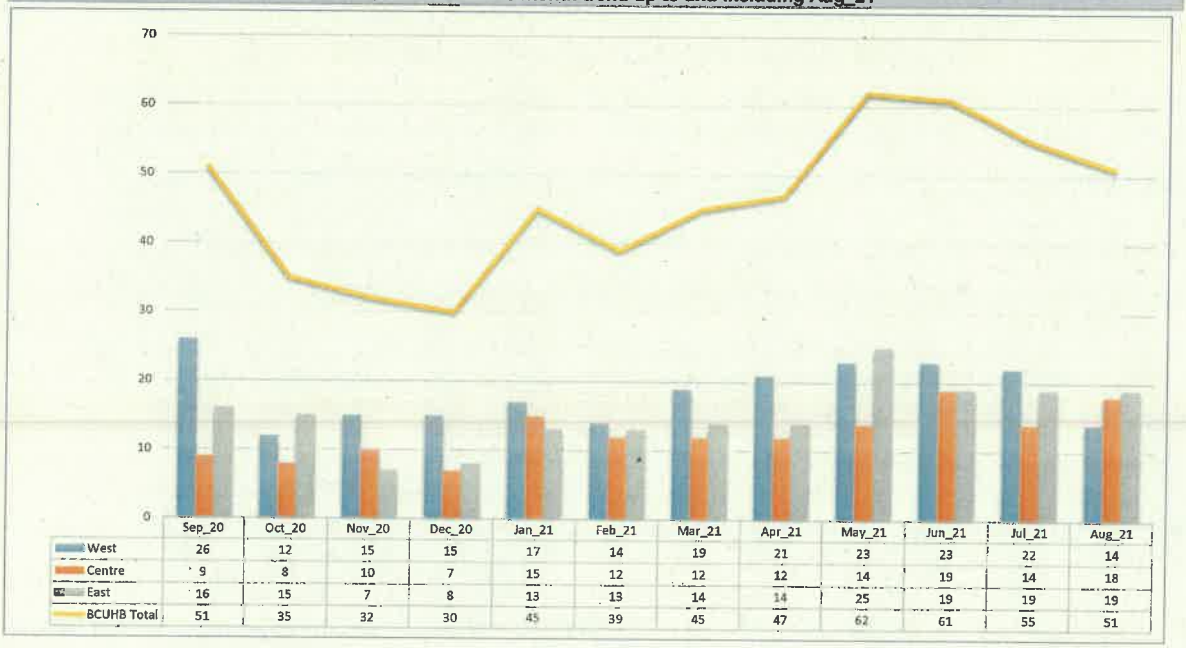
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Aug_21



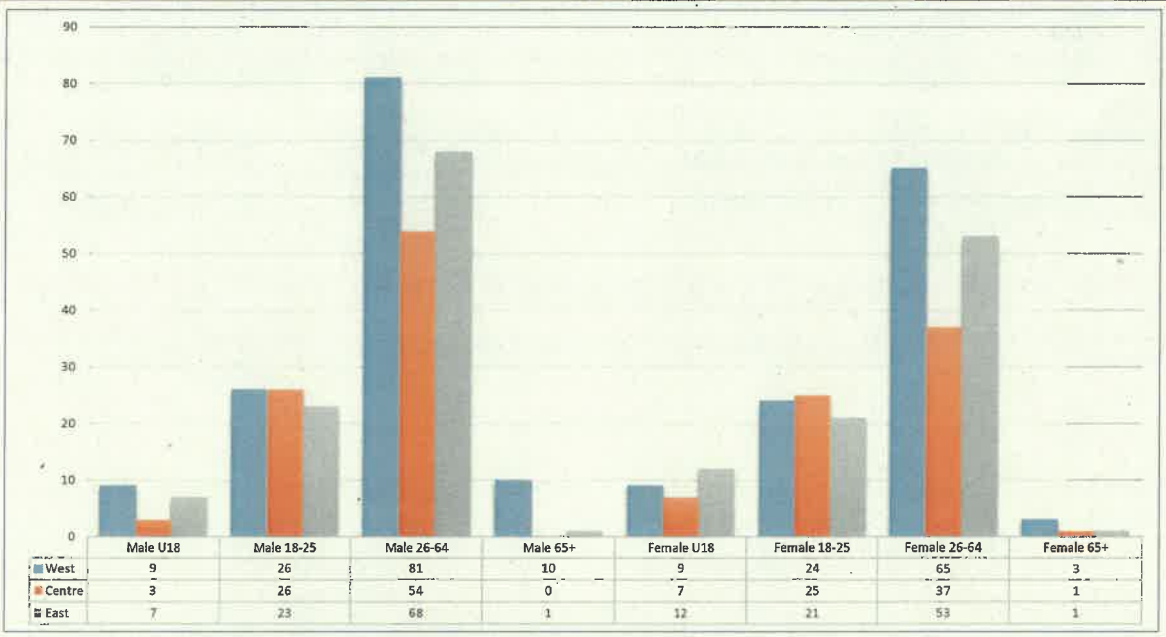
	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	0	0	1	1	1	0	0	1	0	2	0	0
Centre	0	0	1	1	0	1	0	0	0	0	0	0
East	0	1	1	0	0	0	0	0	2	0	1	0

2.1: Section 136 twelve month trend up to and including Aug_21



	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	26	12	15	15	17	14	19	21	23	23	22	14
Centre	9	8	10	7	15	12	12	12	14	19	14	18
East	16	15	7	8	13	13	14	14	25	19	19	19
BCUHB Total	51	35	32	30	45	39	45	47	62	61	55	51

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



	Male U18	Male 18-25	Male 26-64	Male 65+	Female U18	Female 18-25	Female 26-64	Female 65+
West	9	26	81	10	9	24	65	3
Centre	3	26	54	0	7	25	37	1
East	7	23	68	1	12	21	53	1

4: 1st Place of Safety 12 month trend up to and including Aug_21

Area Split - 1st Place of Safety by category

	Aug_21			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	1	5	6	45	27	38
Ward	0	0	0	0	0	0
PICU	0	0	0	0	0	0
136 Suite	13	13	13	170	119	139
Hospital	0	0	0	3	2	3
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	0	0	0	2	0	1
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	1	0

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

1st Place of Safety: A&E Split	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	2	2	2	3	4	1	5	5	9	5	6	1
Centre	2	2	0	0	3	3	3	1	3	4	1	5
East	1	3	1	2	5	3	1	3	6	5	2	6

1st Place of Safety: 136 Suite Split	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	23	10	11	11	13	12	14	16	13	18	16	13
Centre	5	5	10	7	12	9	9	11	10	15	13	13
East	12	12	5	6	7	10	13	11	19	14	17	13

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

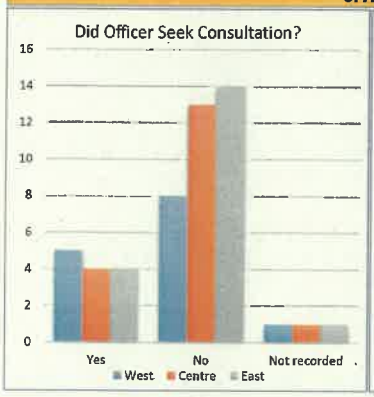
5.1: Area split 3 month table up to and including Aug_21 and latest 12 month total

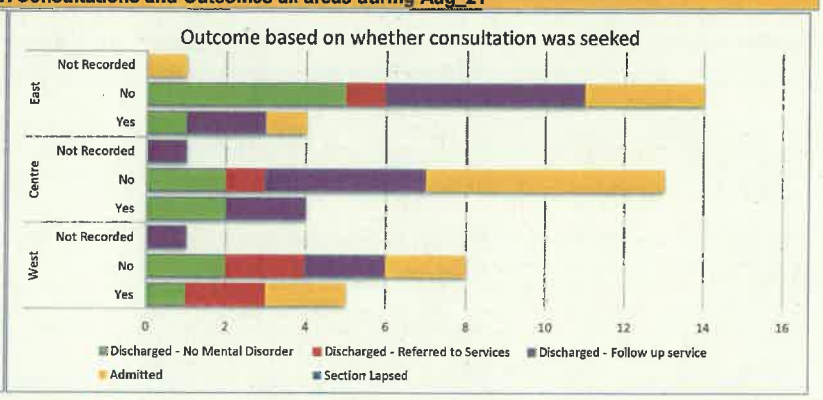
West	Jun_21	Jul_21	Aug_21	12 Month Total	Centre	Jun_21	Jul_21	Aug_21	12 Month Total	East	Jun_21	Jul_21	Aug_21	12 Month Total	Incident rate by county (12 mth total)	
Ynys Mon	7	10	3	47	Ynys Mon	4	0	1	7	Ynys Mon	0	1	0	2	Ynys Mon	7.98
Gwynedd	9	9	5	93	Gwynedd	1	1	4	15	Gwynedd	4	0	2	10	Gwynedd	9.64
Flintshire	1	0	0	8	Flintshire	1	0	1	13	Flintshire	5	10	4	62	Flintshire	6.36
Wrexham	2	0	0	8	Wrexham	4	1	2	15	Wrexham	8	5	8	81	Wrexham	7.47
Conwy	0	0	3	42	Conwy	2	4	5	30	Conwy	0	1	4	9	Conwy	6.93
Denbighshire	0	3	0	15	Denbighshire	5	8	5	64	Denbighshire	1	1	1	13	Denbighshire	9.63
Powys	0	0	0	0	Powys	0	0	0	0	Powys	0	0	0	0	Powys	#N/A
OOA	0	0	0	0	OOA	0	0	0	1	OOA	1	0	0	4	OOA	#N/A
Incident Rate per 10,000 population	0.98	1.13	0.57	10.89	Incident Rate per 10,000 population	0.80	0.66	0.85	6.83	Incident Rate per 10,000 population	0.65	0.61	0.65	6.16	BCUHB	7.70

***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

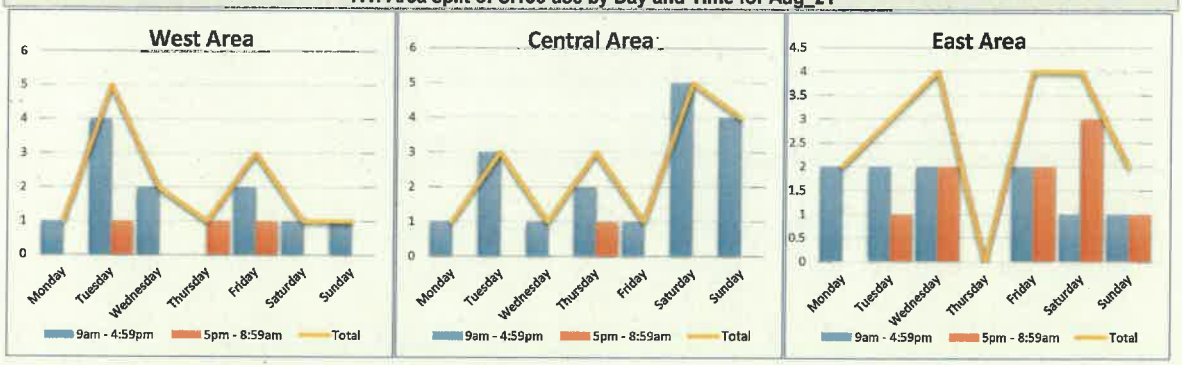
Section B: 12 Month Data for Aug_21

6.1: Consultations and Outcomes all areas during Aug_21

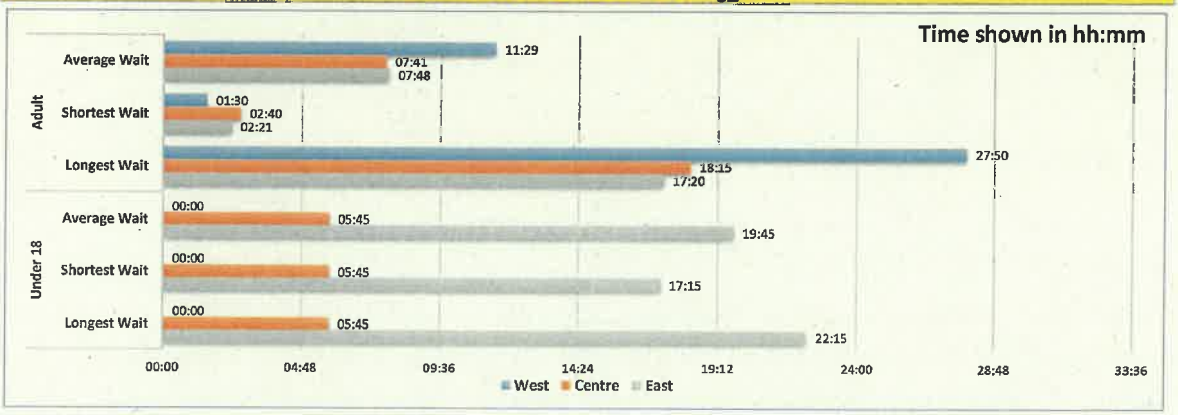




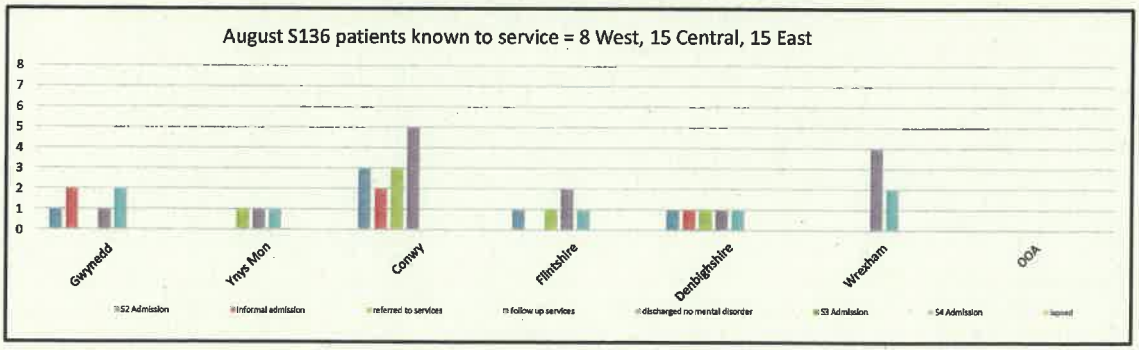
7.1: Area split of S.136 use by Day and Time for Aug_21



8.1: Duration in S.136 Suite for Aug_21



Within this month there were three requests for extensions, all resulted in discharge, two deemed to have no mental disorder and one with follow up.
38 assessments were noted to be delayed, 20 due to the detainee not being fit for assessment, three due to a delay with the doctor and one due to a delay with the AMHP.
13 had no reason noted for the delay and one was due to no bed being available immediately.



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 51 S136 detentions 16 people were not seen within the closest S136 suite.

9 were due to no capacity, 4 the reason was not recorded and 2 due to the closure of the local suite.

Local Authority Originates from	Detained in	S136 Suite assessed at
Denbighshire	Denbighshire	Heddfan
Flintshire	Conwy	Heddfan
Gwynedd	Gwynedd	Heddfan
Conwy x 2	Conwy x 2	Heddfan
Conwy	Gwynedd	Heddfan
Ynys Mon	Ynys Mon	Ablett
Flintshire	Flintshire	Ablett
Gwynedd x 2	Gwynedd x 2	Ablett
Wrexham x 2	Wrexham x 2	Ablett
Conwy	Conwy	Ablett

The Criminal Justice Liaison Service have been 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.

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 are monitored along with consultations which have lead to a S136.

Within the month of August the Mental Health Act Office has received notification that there have been Five instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.

There were two consultations with the service which lead to a S136 for the month of August

APPENDIX 3.

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

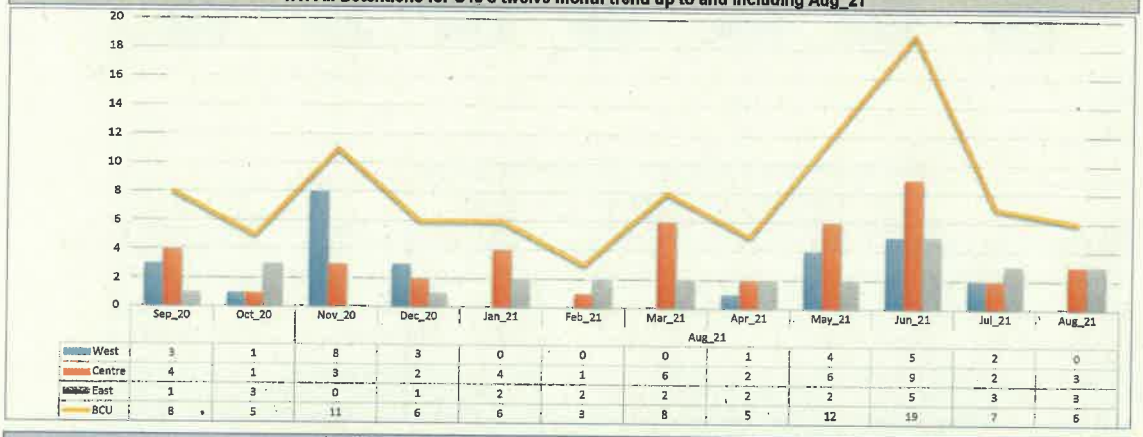
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

Under 18's detentions in North Wales	
KPI Report for:	August 2021

Data Source:	BCUHB MHA Database
Report Created on:	03/09/2021
Report Created by:	Performance Directorate

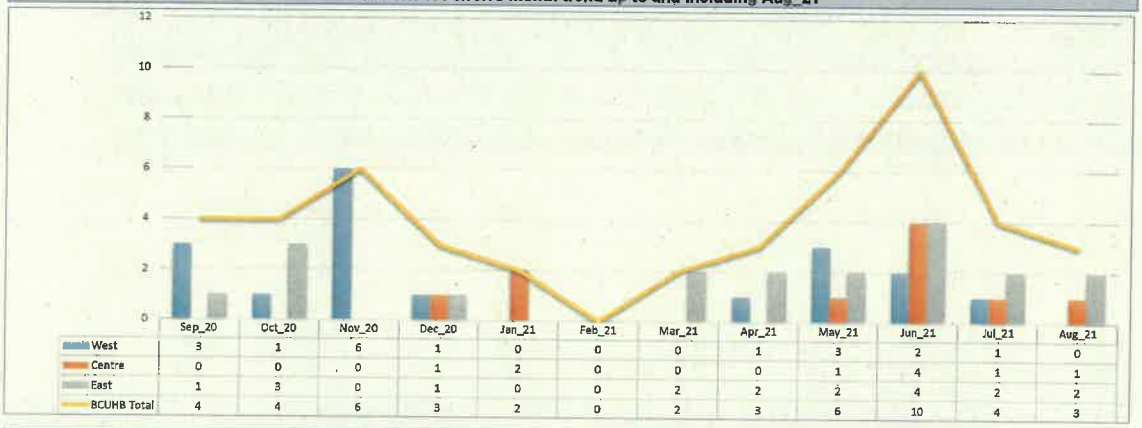
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Aug_21



	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	3	1	8	3	0	0	0	1	4	5	2	0
Centre	4	1	3	2	4	1	6	2	6	9	2	3
East	1	3	0	1	2	2	2	2	2	5	3	3
BCU	8	5	11	6	6	3	8	5	12	19	7	6

2.1: Section 136 twelve month trend up to and including Aug_21

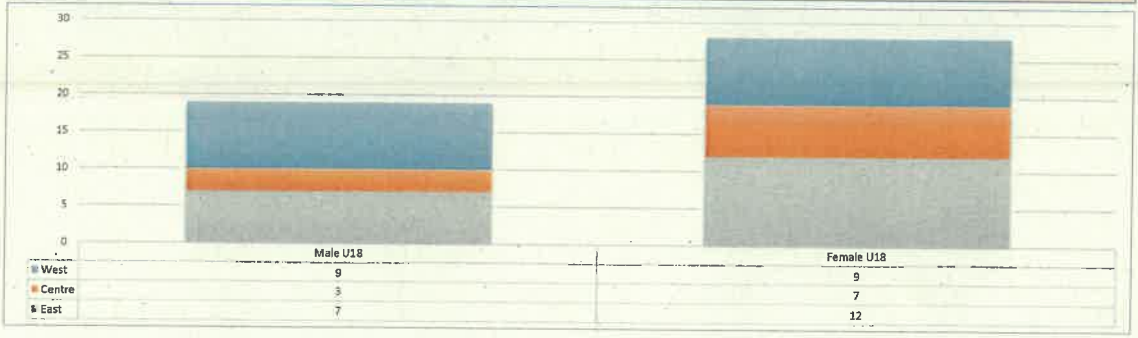


	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	3	1	6	1	0	0	0	1	3	2	1	0
Centre	0	0	0	1	2	0	0	0	1	4	1	1
East	1	3	0	1	0	0	2	2	2	4	2	2
BCUHB Total	4	4	6	3	2	0	2	3	6	10	4	3

2.2: Section 136 Outcomes twelve month trend up to and including Aug_21

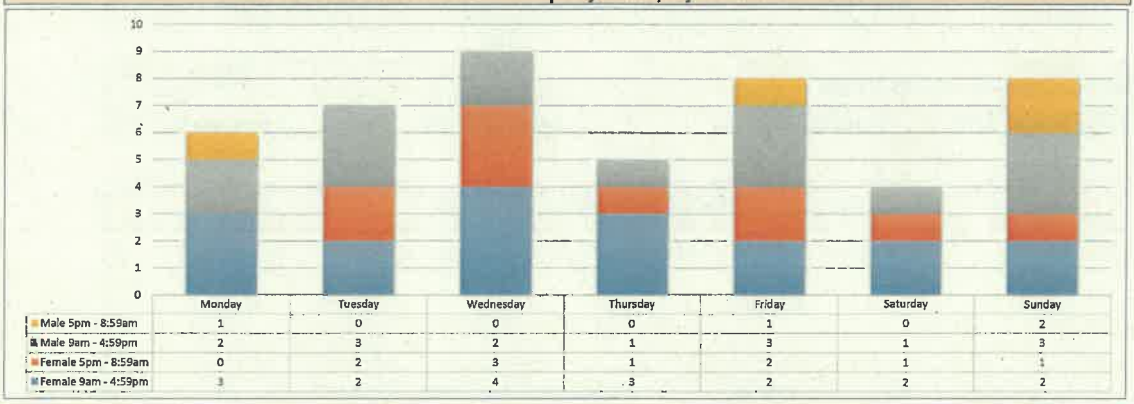
Outcome of 136 detention	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
Discharged - No Mental Disorder	1	0	1	0	0	0	0	0	0	1	1	0
Discharged - Referred to Services	0	0	1	1	0	0	0	1	0	1	2	0
Discharged - Follow up service	1	3	0	1	2	0	0	1	4	4	1	1
Admitted	2	1	4	0	0	0	2	1	2	4	0	2
Section Lapsed	0	0	0	1	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	9	9
Centre	3	7
East	7	12

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

4: 1st Place of Safety 12 month trend up to and including Aug_21

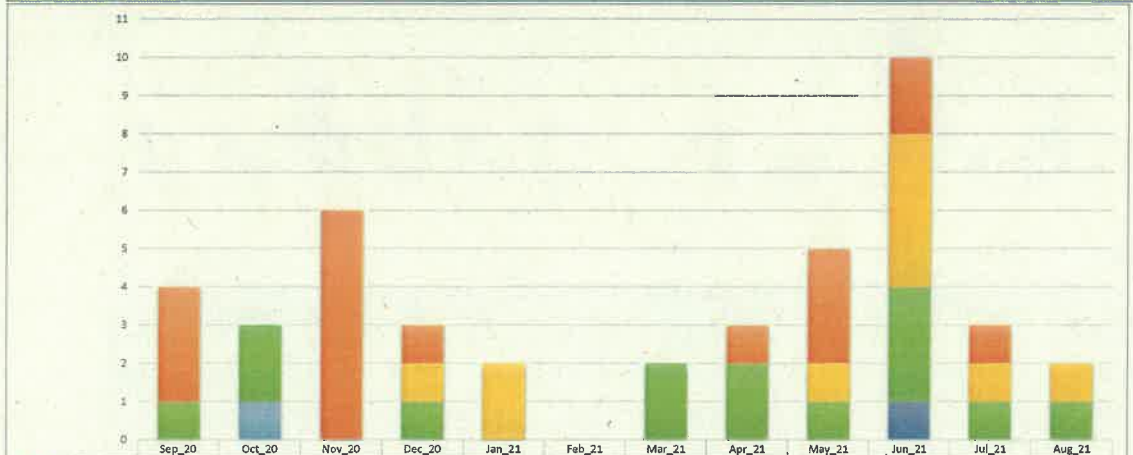
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
A&E	0	1	1	1	0	0	0	1	2	2	1	2
Ward	0	0	0	0	0	0	0	0	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	4	3	3	2	2	0	2	2	4	6	3	1
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_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West	0	1	1	1	0	0	0	1	2	0	0	0
Centre	0	0	0	0	0	0	0	0	0	0	0	1
East	0	0	0	0	0	0	0	0	0	2	1	1

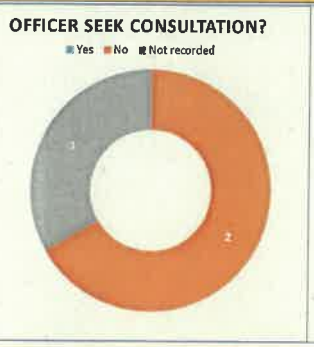
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Aug_21

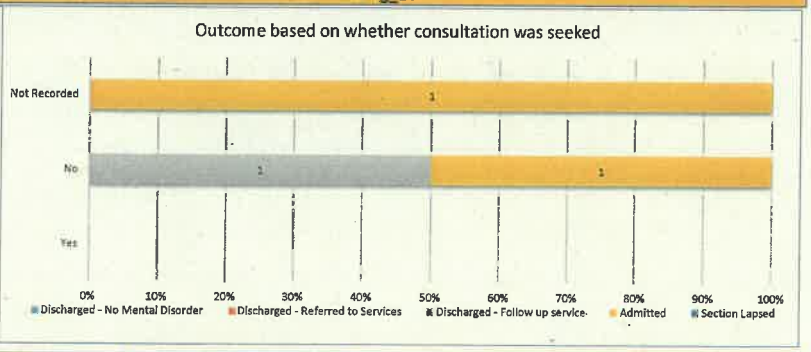


	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21
West Police	3	0	6	1	0	0	0	1	3	2	1	0
Centre Police	0	0	0	1	2	0	0	0	1	4	1	1
East Police	1	2	0	1	0	0	2	2	1	3	1	1
West Ambulance	0	1	0	0	0	0	0	0	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	0	0	0	0	0	0	0	1	0	0

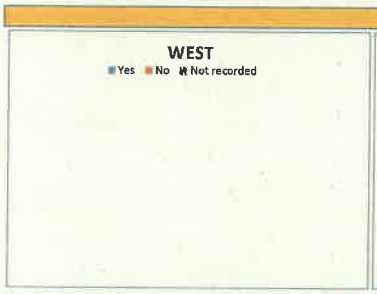
Section B: Data for Aug_21

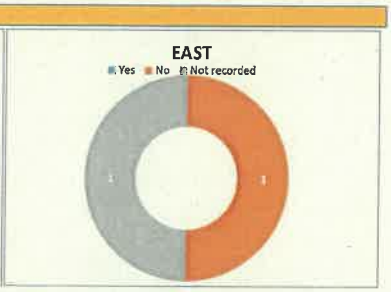
7.1: Consultations and Outcomes for Aug_21



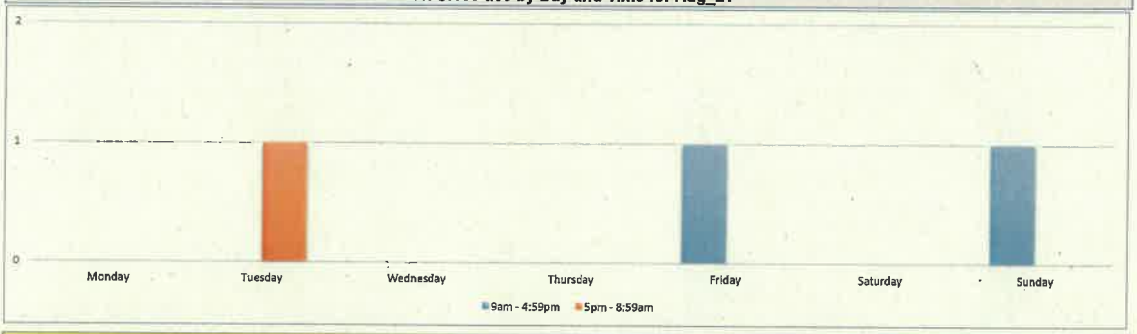


7.2: Consultations by Area for Aug_21

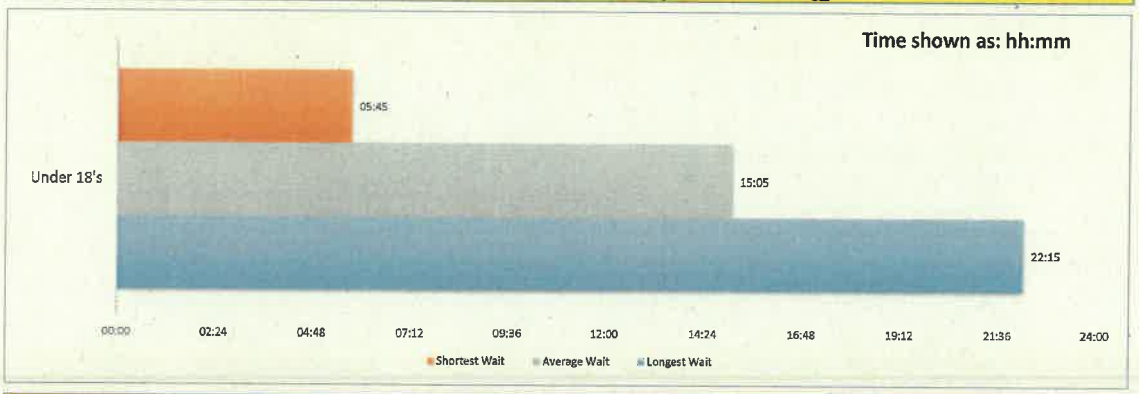




8.1: S.136 use by Day and Time for Aug_21

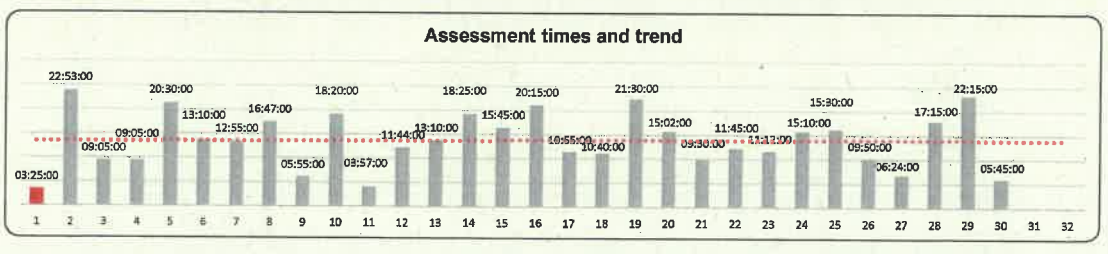


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Aug_21



10.1: Narrative for Aug_21

There were six detentions recorded this month involving four young persons. Three under S136 and three under S2. (One young person accounted for two detentions due to an initial S136 and then admission to NWAS under a S2 and one young person accounted for two S2 records due to a transfer between areas).
The chart below details the length of time that young people have been detained under a S136 and a trend line for the last 30 detentions. The columns have been defined by colour: Blue are in reference to CAMHS assessments, Red for Adult and Green for Joint. The assessment undertaken by an Adult consultant was in relation to a 17 year old.



The below information details the detentions in August
The time the S136's were applied by the police and the transfer time to being accepted into a place of safety when the clock then commences.

Reference	S136 applied	S136 Accepted /clock started
28 - 17:15	22:10	23:15
29 - 22:15	16:03	16:30
30 - 05:45	22:57	09:00

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	CAMHS services – Committee mapping and Tier 1 Risk update
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Fiona Wright, Interim CAMHS TI Business Lead
Craffu blaenorol: Prior Scrutiny:	Bethan Jones, Area Director Central
Atodiadau Appendices:	Appendix 1 – Mapping of CAMHS services meeting structure Appendix 2 – Regional Corporate risk re Crisis services

Argymhelliad / Recommendation:

The Committee is asked to
note the current structure for governance and risk management arrangements within CAMHS, Regional Children's Services and
consider the mapping undertaken of the meeting structure to support reporting requirements to the Mental Health and Capacity Compliance Committee (MHCCC).

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

This report will provide clarification of the current governance arrangements and structure for CAMHS to provide assurance and reporting of compliance with the Mental Health Act, Mental Health Capacity Act, DoLS and the Mental Health Measure to the MHCCC.

Cefndir / Background:

This Committee has been established as a replacement to the Mental Health Act Committee, terms of reference have been agreed, governance and reporting arrangements to be discussed and finalised at the inaugural meeting of the Committee.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The Mental Health and Capacity Compliance Committee will consider and monitor the use of the Mental Health Act 1983, Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards and the Mental Health (Wales) Measure 2010.

To inform the Committee with regard to potential sub-groups of the Committee a mapping of the current governance and meeting structure within CAMHS Services is included in Appendix 1. To note that governance assurance is provided through an Area Structure for CAMHS with Childrens Services Central Area hosting under the Executive Lead for Childrens Services.

In each of the Areas for CAMHS Services a monthly Programme meeting is held, risk and urgent patient safety issues are discussed as a priority in these meetings and escalated as necessary to the Area Children's Service Management team meeting and to the Area Quality and Safety Meeting structure. Any further escalation required is in line with the Area Team governance structure.

On a regional basis, the CAMHS Clinical Advisory Group (CAG) attended by Senior Clinicians, Managers and staff group representatives meet on a monthly basis. The terms of reference of this meeting is currently under review and a Governance & Assurance Sub Group will be formed to meet bi-monthly as part of the CAMHS CAG .

Chaired by the regional CAMHS Clinical Lead, the CAMHS CAG is accountable for continuously improving the quality of mental health services for children and young people, clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning. The Chair of the meeting attends and reports to the regional Children's Services group, chaired by the Area Director (Central).

Goblygiadau Ariannol / Financial Implications

Not applicable

Dadansoddiad Risk / Risk Analysis

This report will advise the Committee on the risk management structure within CAMHS services. Relevant risks on the Tier 1 Corporate Risk Register will be assigned to the Committee as appropriate for review.

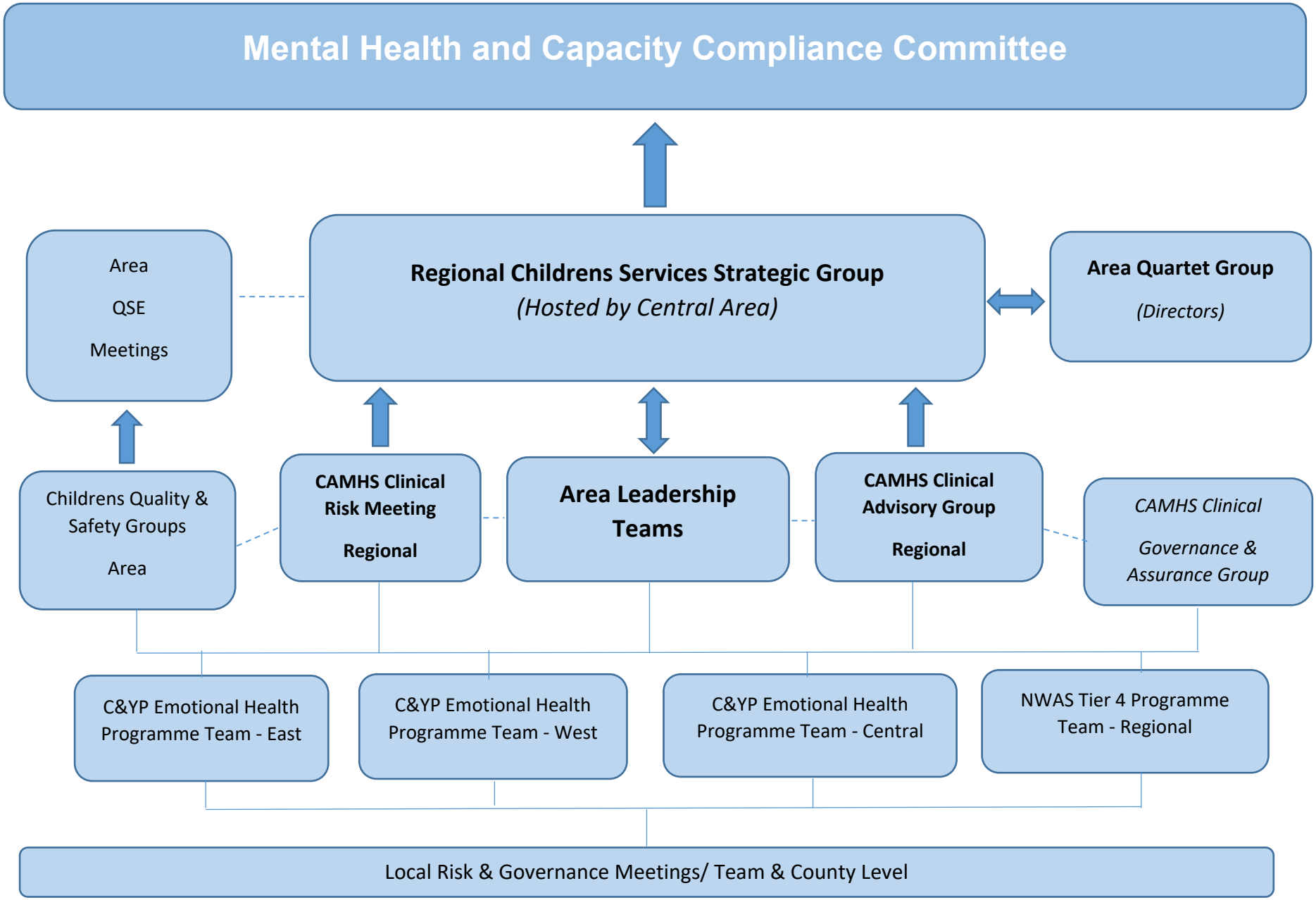
Risks identified for CAMHS services are included on the Children's Services risk registers in the three Areas in line with the management and governance structure. Escalation of risks are aligned to the Area structure and as per the BCUHB risk escalation process.

A regional approach to support the risk management process for those risks that are relevant to all Areas has recently been discussed with the Head of Risk Management, a further meeting is being held on September 28th with a view to streamlining the process. A regional risk in relation to Crisis services has been identified and escalated to the Corporate risk register, details of this risk can be found in Appendix 2. In mitigation of this risk colleagues within both CAMHS services and Acute Paediatrics will be attending Mental Health Act awareness training.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Not applicable
Asesiad Effaith / Impact Assessment Not applicable

CAMHS Mapping for reporting to MCCC



4024	**Director Lead:** Chris Stockport/Teresa Owen	**Date Opened:** 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 18 August 2021
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours	**Date of Committee Review:** New Risk
		Target Risk Date: 31 March 2022

There is a risk that young people in crisis presenting out of hours with suicidal behaviour/ideation and actual self-harm to our Emergency Departments and Paediatric wards and those detained under a s136 may not always receive timely access to CAMHS assessment and treatment to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:

- Current operational hours of CAMHS is 9am-5pm over 7days a week.
- CAMHS psychiatrists are limited in how they can respond out of hours to complete a s136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section which is not available out of hours
- increase in demand which may be linked to the restictions of lockdown and Covid-19 pandemic
- crisis presentations to ED with associated social care placement breakdowns leading to young people who are deemed medically fit for discharge, remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority
- awaiting a CAMHS Tier 4 bed following a mental health assessment

The environment within Emergency Deparments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paedriatic wards.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Low Level		1-8
Movement in Current Risk Rating Since last presented to the Board in - *To be populated following approval*	New Risk		

Controls in place	Assurances
1. Local individual risk assessment which includes environmental factors undertaken by nursing staff as part of the Paediatric admission process. 2. CAMHS practitioners provide a 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 3. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 4. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5 pm for young people up to their 18th birthday and out of hours telephone on-call rota. 5. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 6 Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 7. Safeguarding discharge SOP for young people in place. 8. Daily SITREP reporting and regular safety meetings (3 x weekly) held between Paediatrics and CAMHS. 9. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements. 10. 1:1 care provided on wards/s136 suite to ensure enhanced provision and safety of the young person.	1. A scoping exercise or SBAR of CAMHS Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed and managed Regionally within a Pan-BCU approach. 3. Risk also regularly discussed at the Area - Quality and safety groups. 4. Risk controls, mitigation and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police.

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations fully which has been exacerbated by the lockdown arising from Covid-19. 2. Lack of suitable LA placements or shared safe environments within which young people can be assessed or discharged to 3. Lack of agreed critieria, threshold and standardisation for reporting related incidents.

Progress since last

New risk as it hasn`t been submitted before.

Links to	
Strategic Priorities	**Principal Risks**
Links to Health Board proirities:- Effetive Use of our resources. Safe integration and improvement of Mental Health Services.	BAF21-01 BAF21-07 BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways.	On Track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to meet the needs of young people before a crisis occurs as most of their needs are pyscho-social and not just MH.	On Track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Martin McSpadden, Head of Nursing	29/10/2021	Ensure a safe environment by identifying all ligature points on the ward.	On Track
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will	On Track

					enable us to provide more out-of-hour response.	
	17963	Task and Finish Group to review SCH03 policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On Track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ A&E staff, Local Authority and North Wales Police	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On Track
		Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	On Track

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Statutory compliance risk report - age appropriate support when children are admitted to an acute adult mental health facility**
Cyfarwyddwr Cyfrifol: Responsible Director:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (MHLD)
Awdur yr Adroddiad Report Author:	Mike Smith, Director of Nursing MHLD Hilary Owen, Head of Governance MHLD
Craffu blaenorol: Prior Scrutiny:	Divisional Directors
Atodiadau Appendices:	No appendices

Argymhelliad / Recommendation:

The Committee is asked to note the report

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✔	**Ar gyfer sicrwydd For Assurance**	✔	**Er gwybodaeth For Information**	✔
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

There is a risk that young people will not receive the age appropriate support when admitted to an acute adult mental health facility

Cefndir / Background:

CAMHS are unable to provide a robust 24/7 cover to the age appropriate placement, nor have they been able to control the 72 hour recommended length of stay. CAMHS are not commissioned to undertake unscheduled inpatient care.

The consequence of this may be that tensions remain between adult and CAMHS services in service delivery and young people may not get the most appropriate care.

There are a number of contributory factors, the list below is not exhaustive:

- shortage of CAMHS psychiatrists to respond out of hours to complete a S136 assessment
- increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic
- lack of suitable accommodation and young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority
- awaiting a CAMHS Tier 4 bed following a mental health assessment

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

MH02 - Procedure for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit has been embedded into practice.

Opsiynau a ystyriwyd / Options considered

Multi-agency plan and policy for underpinning needs development. This will enable services to divert young people at the front door and support their needs in different ways. A robust Multi-agency Crisis Intervention pathway to be developed.

To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS. This will enable BCUHB to meet the needs of young people before crises occur as most of the needs are pyscho-social, rather than solely mental health.

Goblygiadau Ariannol / Financial Implications

Issues highlighted potentially have financial implications. However, the aspects covered in this report require no financial consideration at present.

Dadansoddiad Risk / Risk Analysis

This matter is currently logged on the Tier 3 Divisional Risk Register with a score of 6. Mitigating actions currently in place include:

The purpose of MH02 procedure is to ensure that the health and wellbeing of children and young people is promoted and safeguarded when they are being cared for within an Adult Mental Health (AMH) ward. It also provides guidance to staff working in AMH wards regarding the admission and care of children under 18.

A designated bed has been identified on the Heddfan Unit in Wrexham. However, there may be occasions when a young person may need admission to an alternative Betsi Cadwaladr University Health Board (BCUHB) Adult Mental Health (AMH) Unit. In these circumstances, the respective inpatient operations manager for either the Ablett Unit or the Hergest Unit will need to ensure all governance arrangements outlined in the procedure are followed. In the event that there is no designated bed available in the Heddfan Unit, the unit closest to the young person's domicile address becomes the admitting unit. If Ablett and Hergest are used, the young person must be admitted to a single room (not multi-occupancy).

Local individual risk assessments are undertaken by nursing staff as part of the admission process.

CAMHS practitioners provide 7 day service and support to the AMH wards for a limited number of hours (i.e. 9-5pm, 7day a week).

CAMHS Psychiatry provide a 7 day service and out of hours telephone on-call rota.

CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible.

Cyfreithiol a Chydymffurfiaeth / 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 practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.

Asesiad Effaith / Impact Assessment

No EQIA is required. All policies relevant to the Mental Health Act are Equality Impact Assessed.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Statutory compliance risk report – Recruitment and retention of senior doctors, including 12(2) doctors**
Cyfarwyddwr Cyfrifol: Responsible Director:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (MHLD)
Awdur yr Adroddiad Report Author:	Mike Smith, Director of Nursing MHLD Hilary Owen, Head of Governance MHLD
Craffu blaenorol: Prior Scrutiny:	Divisional Directors
Atodiadau Appendices:	No appendices

Argymhelliad / Recommendation:

The Committee is asked to note the report

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✔	**Ar gyfer sicrwydd For Assurance**	✔	**Er gwybodaeth For Information**	✔
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

There is a risk in relation to the recruitment and supply of senior doctors throughout Wales. This includes Section 12(2) doctors.

Cefndir / Background:

According to the Mental Health Act Code of Practice Wales 2016, under paragraph 14.104, the Welsh Ministers have delegated to Betsi Cadwaladr University Health Board the function of approving the Medical Practitioner under Section 12(2) of the Act across Wales, and Welsh Government has delivered guidelines for approval of those doctors.

Section 12(2) Doctors are an essential component for the implementation of the Mental Health Act and in particular, to give medical recommendations in a number of sections such as 2, 3, 37. It is also preferable to have Section 12(2) Doctors for the medical recommendation on Section 4 and medical examination of people detained Section 136 of the MHA.

Section 12(2) approved doctors are those approved by the Secretary of State under section 12(2) Mental Health Act 1983 (MHA), where they are described 'as having special experience in the diagnosis or treatment of mental disorder'. At least one Section 12(2) approved doctor is required to provide a medical recommendation in order to detain a patient under the Mental Health Act. These doctors are known as Approved Clinicians in Wales.

There is the role of a Responsible clinician which can be undertaken by a Psychologist or Nurse Consultant. These individuals can be responsible for the patients care, renew a detention, but cannot provide a medical recommendation for the initial detention.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Current numbers for BCUHB 12(2) approved doctors are 13 GPs and 19 Psychiatrists. Additionally there are 81 Approved Clinicians, 3 of which are non-medics. There may also be Section 12(2) psychiatrists working in BCUHB who have been approved in England who are not recorded on the All Wales database, and cannot legally detain unless approved in Wales.

The sourcing and supply of Section 12(2) doctors can present delays in the detention process, and therefore, a longer term, sustainable solution is required.

Medical Director is in regular discussion with Medical Staffing Business Support team who are in constant liaison with MEDACS regarding sourcing of appropriately qualified locum cover.

BCUHB Board are aware of the recruitment challenges via the Health Professionals Forum.

An Advanced Nursing Practitioner task and finish group has been established to identify where extending the scope of nursing practice can properly support the medical workforce.

Opsiynau a ystyriwyd / Options considered

For the adult South Gwynedd post there are two paid sessions provided by a NHS locum. This Consultant already has a full time locum position and the two sessions are in addition to the full time post. The impact of this is a risk of burnout to the Consultant. This is only providing emergency cover and the waiting list during this time is increasing.

The OPMH service in Anglesey is not covered by any substantive consultant and locums are difficult to procure. The inpatients of the area are currently covered by the substantive Consultant.

Medical Director is in regular discussion with Medical Staffing Business Support team who are in constant liaison with MEDACS regarding sourcing of appropriately qualified locum cover.

BCUHB Board are aware of the recruitment challenges via the Health Professionals Forum.

An Advanced Nursing Practitioner task and finish group has been established to identify where extending the scope of nursing practice can properly support the medical workforce.

Goblygiadau Ariannol / Financial Implications

Issues highlighted potentially have financial implications. However, the aspects covered in this report require no financial consideration at present.

Dadansoddiad Risk / Risk Analysis

Recruitment to senior medical posts pan-division on a substantive basis, but particularly in the West area has been challenging. There is a national recruitment problem, however, it is more difficult to attract interest to the West locality, and more particularly the more remote South Gwynedd area. Posts have been filled intermittently by locums, but this is becoming problematic also.

The impact of this is there are localities in the West that do not have substantive or locum consultant cover (ie emergency only cover) and this impacts negatively on patient care and safety with lack of consistency in provision.

This matter is currently logged on the MHLD Tier 2 Risk Register with a score of 9.

Mitigating actions currently in place include:

Ongoing discussions between Medical Director and MEDACS to fill vacant posts.

Recruit to the vacant posts (which are funded) on a substantive basis.

Continuously advertising posts on NHS jobs and other appropriate means.

Continue to explore where nursing practice can appropriately support medical colleagues.

Cyfreithiol a Chydymffurfiaeth / 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 practices. There are obligations under the Mental Health Act that require Medical Recommendations undertaken by Section 12(2) doctors.

Asesiad Effaith / Impact Assessment

No EQIA is required. All policies relevant to the Mental Health Act are Equality Impact Assessed.

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health and Capacity Compliance Committee** **24.9.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**MHLD Division – Governance structure mapping**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad **Report Author:**	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: **Prior Scrutiny:**	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau **Appendices:**	Appendix 1 MHLD Governance structure

Argymhelliad / Recommendation:

The Committee is asked to note the diagram illustrating the governance structure of the MHLD Division.

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

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

Sefyllfa / Situation:

As the Mental Health and Capacity Compliance Committee convenes for its inaugural meeting – the mapping of key meetings and groups within the Mental Health and Learning Disabilities Division will support the broader work of the Mental Health and capacity Compliance Committee.

Cefndir / Background:

The Mental Health and Learning Disabilities governance structure is attached for information.

Asesiad / Assessment & Analysis

Strategy Implications
Not applicable – the diagram is shared for information to aid the Committee's understanding of MHLD governance structures.

Options considered
None for this report

Financial Implications
None for this report

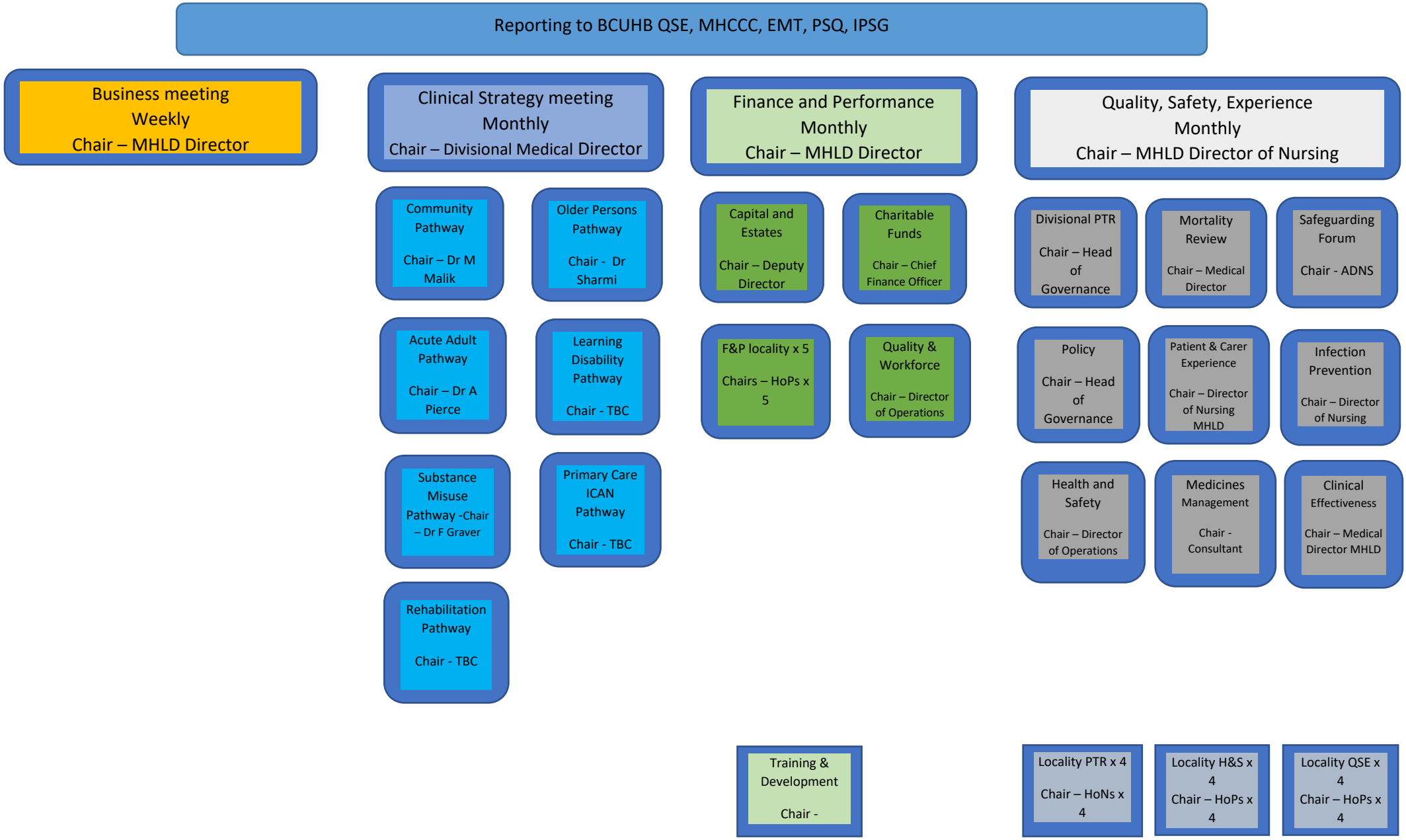
Risk Analysis
None for this report

Legal and Compliance
None for this report

Impact Assessment
Not applicable for this report

APPENDIX 1: DIVISION OF MENTAL HEALTH AND LEARNING DISABILITIES

GOVERNANCE MEETING STRUCTURE FROM 01.04.2021



Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Monitoring Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Mental Health and Learning Disabilities, Senior Leadership Team Quality Safety and Experience Group 17/08/2021 Mr Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau Appendices:	Appendix 1 – Inspections Appendix 2 – Quality Check Summary Mesen Fach, Bryn Y Neuadd

Argymhelliad / Recommendation:

The Committee is asked to note the report.

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

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

Sefyllfa / Situation:

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

The HIW quality check summary on Mesen Fach, Bryn Y Neuadd is included at Appendix 2.

Cefndir / Background:

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

The primary focus for visits are:

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

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

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

The focus for the quality checks is three key areas:

- Environment
- Infection prevention and control
- Governance

A key line of enquiry is: 'considering COVID-19 how is the area discharging their duty of care against the Mental Health Act and how are patients' rights being safeguarded?'

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

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

Options Considered
Not applicable for this report.

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

Risk Analysis

- Outstanding HIW Actions are reviewed within the MHLD division area Quality Safety and Experience (QSE) meetings on a monthly basis.

- The MHLD Policy Implementation Group ensures policies are kept up to date and are reviewed by appropriate personnel. This is reported monthly to the MHLD Senior Leadership Team QSE meeting, and reported up to the Health Board QSE committee meetings.

Legal and Compliance
The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.

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

Appendix 1

Inspections within the last 12 months

New Inspections and updates are provided below.

1 Quality check Summary: Mesen Fach, Bryn Y Neuadd NEW
Inspection Date: 27 May 2021
Publication of report due: 2 July 2021

The report details the detention paperwork for patients subject to the Mental Health Act and notes '*that the five patients who were detained under the Mental Health Act had access to virtual tribunal hearings and were able to access advocacy services if required ensuring that the rights of the patients are protected'.*

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

2 Quality check Summary: Coed Celyn Hospital FOR INFORMATION
Inspection Date: 17 March 2021
Publication of report due: 7 May 2021

The report details that multi-disciplinary team meetings involving external professionals have continued and reviews scheduled under the Mental Health Act have been undertaken within prescribed timeframes. Patients have continued to have access to advocacy and external professional services via telephone during times of restrictions for face to face meetings. Patients leave is managed in accordance with government guidelines and subject to individual risk assessments.

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

3 Quality check Summary: Glan Clwyd Hospital – Ablett Unit FOR INFORMATION
Inspection Date: 20 November 2020
Publication of report due: 16 December 2020

The report shows outcomes in relation to:

- staffing
- the needs of patients being met by involvement of families
- continued improvement of communication with Community Mental Health Teams (CMHT).

- the support of the MHA administration team in providing guidance to ensure patients are aware of their rights and the continued facilitation of tribunals and access to advocacy.

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

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

Inspection Date: 29th September 2020
Publication of report due: 5th November 2020

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

The MHLD Bed Escalation Policy was highlighted as a concern following the review date expiring. The Health Board was asked to ensure that policies are consistently being reviewed and updated as and when scheduled and that governance arrangements are clear. The response and actions are detailed below, and have been submitted to HIW for assurance.

Improvement needed	Service Action	Timescale
The health board should review the governance arrangements in place to ensure policies are consistently being reviewed and updated when required.	The MHLD Division policy group terms of reference were agreed on the 27.08.2020. It meets on a monthly basis. All documents which are nearing the review date are highlighted in advance to ensure allocation of a professional to review, and monthly updates are required as to process and any obstacles which may need escalation. Polices are also considered in relation to risk and the effect of removal from the intranet and circulation if they have not been reviewed and updated prior to the review date. During March to September 2020 the Policy group was stood down due to Covid 19; since resuming documents are now being tracked and reviewed with a monthly report produced for the MHLD Leadership Team, Quality Safety and Experience Meeting. The MHLD 0045 Bed Escalation Policy has been reviewed and this has been sent for consultation until the 12 November 2020 to then be presented at the MHLD Policy Group meeting on the 17 December 2020 for ratification.	Complete Complete Approved 13/07/2021

Appendix 2 - Quality Check Summary Mesen Fach, Bryn Y Neuadd

APPENDIX 2

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Mesen Fach, Bryn Y Neuadd

27 May 2021

Publication date: 2 July 2021

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

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

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Website: www.hiw.org.uk

Digital ISBN 978-1-80195-635-2

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Mesen Fach ward, Bryn y Neuadd Hospital as part of its programme of assurance work. The ward is one of three inpatient wards situated in Bryn y Neuadd Hospital. It provides assessment and treatment, and therapeutic support services for up to nine patients with learning disabilities.

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

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

We spoke to the Ward Manager on 26 May 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made as a result of COVID-19 to the following:
    - Physical environment
    - Routines, visiting arrangements and contact with loved ones
    - Behaviour management
    - Patient access to community/leave, activities and social networks (including formal leave where the Mental Health Act applies)?

- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?

- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health and care professionals where needed?

Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and DOLS legislation, and how are patients' rights being safeguarded?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environmental risk assessments / audits
- Patient voice data
- Hospital passport / profiles
- Details of incidents; specifically incidents of challenging behaviour, restraint and seclusion

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The ward has single en-suite patient bedrooms and two lounge areas, which we were told supports effective self-isolation and social distancing. Staff added that patients are also able to benefit from access to well-presented and spacious outdoor areas.

We were told that visiting and access to community based activities had been restricted to prevent the transmission of COVID-19. Staff told us that this initially led to a drop in motivation and a slight increase in challenging behaviours. However, it was positive to note that staff had continued to provide a nurse-led therapeutic service in an effort to replicate activities that were usually accessed within the community. This included frequent use of the outdoor space, risk-assessed use of a vehicle and making pizzas to replicate the take-away experience.

Staff told us that ward routines, such as meal times, had remained consistent throughout the pandemic. Staff added that all patients have their own routines and that each patient has an individualised plan based on the activities that they prefer to undertake. Staff added that this plan is created with the input of families wherever possible and that behaviour is monitored to assess how patients are responding to certain activities.

We found that MDT meetings had continued throughout the pandemic on a virtual basis. Staff commented that this had worked well and that there had been positive input from all specialisms. Staff confirmed that MDT meetings would be increased if required and that specialist teams are encouraged to attend weekly ward rounds to support patient needs.

We were told that the patient feedback group had been stopped during the pandemic due to infection control reasons. However, it was positive to note that the ward had used an alternative method to capture the patient voice. We saw an example of a brief questionnaire that is completed weekly by each patient. This asks the patient to write what makes them happy, sad and what things they wish to tell their doctor. Staff confirmed that this feeds into each patient's MDT meeting, which helps to provide individualised care.

We confirmed that all patients had received a physical health check upon admission to the ward. This ensures that the overall health and well-being needs of patients are being met. Staff told us that this service is provided by a local GP practice and that the input from the practice had been very beneficial. It was positive to note that the GP has an active role, attending the ward weekly and MDT meetings as required.

We confirmed that each patient had a hospital passport[1] in place. We saw an example of this and found it to be comprehensive and individualised to the patient. This helps to ensure that the needs of the patients are fully described should they require admission to another ward.

The unit provides assessment and treatment for adults who are admitted with acute needs and, as such, patients can sometimes display challenging behaviours. Staff told us that a positive behaviour support (PBS) model is followed and confirmed that the methods used to manage these behaviours are part of each patient's individual care or PBS plan.

We reviewed restraint data and found that restraint had been used on an infrequent basis. Where restraint had been used, we found that this had been done for minimal durations. We reviewed one incident with the ward manager who was knowledgeable of the incident and provided details of the debriefing and learning that had taken place. We confirmed that relatives and the MDT had been involved throughout.

Staff confirmed that a ligature risk assessment had been recently undertaken and told us that this is reviewed twice each year. Staff added that individual risk assessments are completed for patients who are considered to be at risk of self-harm.

We found that a health and safety risk assessment and self-assessment audit had been completed in response to the pandemic. These had been recently reviewed and contained updated actions. However, we found that there had been a significant length of time between the reporting of some historical maintenance issues and their completion. Whilst the maintenance issues had since been completed, the health board is advised to review and monitor timescales on other wards to assure itself that similar delays are not being experienced at this site.

No areas for improvements were identified.

1

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Generic infection control policies and Covid-19 specific policies
- Current data on infection rates
- Most recent infection control risk assessments / audits

The following positive evidence was received:

The ward manager described how staff are kept up-to-date with the latest infection prevention and control (IPC) information, which included attendance at a daily safety meeting and through a staff bulletin.

The ward manager confirmed that training in how to correctly apply and remove PPE had been provided to staff and that there were donning and doffing champions on the ward whose role is to encourage good practice. It was positive to note that additional training and support from the IPC team had been provided, which were told had promoted a good awareness of IPC procedures amongst staff.

We were told that PPE usage had been difficult for some patients. However, it was positive to note that clear face masks were being trialled on the ward. It is hoped that this trial will help to promote clear communication between staff and patients.

Staff confirmed that visiting to the ward had been managed on a cautious basis. We were told that all professional visitors are pre-planned and that staff are expected to wear an appropriate uniform and PPE. For family visitors, we were told that a checklist is used to risk assess each visit and that designated spaces are used to maintain social distancing.

We found that IPC considerations had been assessed as part of the health and safety risk assessment and self-assessment audit. This had been supplemented by a recent positively scored audit from the health board IPC team. Staff told us that there had been regular input from the IPC team throughout the pandemic.

We were told that one COVID-19 positive patient had been cared for on the ward. Staff confirmed that this patient was successfully isolated in a designated en-suite room on the ward and that a separate staff team was allocated to provide care. Staff told us that a review by the IPC team had been undertaken and we confirmed that relatives were involved in the care and treatment of this patient.

We confirmed that regular COVID-19 testing of staff was being undertaken and that all staff had received their vaccination. We confirmed that patients who had been on the ward for a period of time had also received their vaccination. Staff described how patients were supported to understand COVID-19 and the need for the vaccine, which included use of stories and picture books.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health professionals where needed.

The key documents we reviewed included:

- Escalation policies
- The most recent audit/review of the detention paperwork for patients subject to the Mental Health Act 1983, along with an action plan of how any areas identified will be addressed
- Corporate policies/processes to ensure preparedness for future pandemic emergency
- Mandatory training records for all staff
- The current percentage completion rates for mandatory training
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- The number of safeguarding referrals

The following positive evidence was received:

The ward manager demonstrated a clear knowledge of the ward, its patients and they were complimentary about the way in which staff had responded to meeting the needs of patients during the pandemic.

We found that there were agreed staffing levels across the ward and that staff were aware of the procedure to follow should any staffing concerns need to be escalated. The ward manager noted that there was good engagement from senior management when reviewing staffing needs.

We were provided with the mandatory training statistics and found an overall good level of compliance. The ward manager described what plans were in place to source additional training to meet the needs of learning disability staff. It was positive to be told that disciplines, such as speech and language therapy and psychology, were working closely with the directorate to meet this need.

We confirmed that the five patients who were detained under the Mental Health Act had access to virtual tribunal hearings and were able to access advocacy services if required. This helps to ensure that the rights of patients are protected.

The following area for improvement was identified:

The aim of an assessment and treatment service is to provide treatment on a short term basis for patients with a learning disability. We found that there had been four discharges within the last three months and it was positive to hear that staff placed emphasis on ensuring the lasting success of these. We were provided with examples in which ward staff had temporarily moved with new staff teams to help integrate the patient into their new environment. We also heard positive examples of close working with community and complex needs teams to further support the patient.

However, we found that one patient had been admitted to the ward for a significant period of time and another patient who had been admitted in September 2020. Staff explained that there had been previous attempts to discharge the first patient into suitable placement and that the on-going delay is due to the lack of a suitable therapeutic and social provision within the locality.

Whilst we were assured that safe care is being provided, the health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

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

- Ensure that the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: Bryn y Neaudd Hospital

Ward: Mesen Fach

Date of activity: 27 May 2021

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

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

Reference Number	Improvement needed	Standard/	Service Action	Responsible Officer	Timescale
1	The health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.	Health and Care Standards, 5.1	<u>Operational A&T Pathway.</u> On admission, the inpatient team will be working closely with the external community LD teams to identify suitable, person centred placements. Early planning for discharge will form part of the A&T pathway. MDT meetings will be held fortnightly including care coordinator, advocacy and external MDT & family to ensure that	Head of Operations Head of Nursing Community Ops Manager Ward Manager	1 Month

			planning for discharge is a continuous process aligned with the A&T pathway. Monthly clinical commissioning groups have been established. Membership includes Head of Nursing, Clinical operational Managers and Operational lead for CHC. All complex cases are discussed at this forum and provide a platform for escalation and mitigation of any potential barriers for discharge. This forum will be opened up to LA partners to promote collaborative planning for discharge.		

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

Name: William Haydn Williams - Head of Operations and Service Delivery
Date: 23.06.2021

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 24.9.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Compliance with the Mental Health Act in the Forensic, Rehab and Older Persons Units Audit**
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director Public Health
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau Appendices:	Appendix 1 – Audit report September 2021

Argymhelliad / Recommendation:

The Committee is asked to note the audit report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

The Mental Health Act 1983 (as amended 2007) enables those who meet the criteria for detention, to become subject to a detention within suitable premises to receive assessment and treatment of their mental health for the protection of themselves and others.

Whilst subject to detention patients have a number of rights under the Mental Health Act.

The Health Board has a duty to ensure that detention paperwork is legal, and administrative timescales met, to fulfil all aspects of the Mental Health Act. This includes patients being aware of their rights to appeal, to have access to an Independent Mental Health Advocate (IMHA), and to have an up to date care and treatment plan.

"Hospital managers and local authorities should also ensure arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis". (CoPW 35.20[1])

The aim of the audit is to ensure the Health Board is upholding it's duties under the Mental Health Act in regards to documentation.

[1] Mental Health Act 1983 Code of Practice for Wales 2016

Cefndir / Background:

The forensic, rehab and older persons units do not have an onsite Mental Health Act Administrator. The area Mental Health Act office, situated in the closest adult psychiatric unit (Heddfan, Hergest and Ablett) will receive and hold original Mental Health Act documentation.

The forensic, rehab and older persons units hold an integrated file for each patient; these files are required to contain copies of the Mental Health Act documentation. In some units there is no provision of a ward clerk, this responsibility then falls to the nursing staff to ensure documentation is filed correctly.

Nine standards have been identified for audit as below

Number	Standard
1	**Section papers** The correspondence file and case notes should contain the same detention paperwork.
2	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.
3	**Explanation of Rights** The correspondence file and case notes should contain the same document.
4	**Explanation of Rights** The patient should be made aware of their rights in their primary language
5	**Explanation of Rights** The patient should be offered a referral to IMHA services
6	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.
7	**Care and Treatment Plan** The integrated file should contain an up to date Care and Treatment Plan.
8	**Mental Health Act Divider** The integrated file should contain a mental health act divider.
9	**Paperwork** The documentation should confirm that the Mental Health Act documentation is filed correctly.

Goblygiadau Strategol / Strategy Implications

Detentions under the Mental Health Act require ongoing monitoring. All documents and pathways to give consideration of the appropriateness, and aligned with a least restrictive pathway for our patients.

The Mental Health Act specifies the statutory duties that the Health Board must adhere to when depriving people of their liberty by detention.

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

There are no financial implications associated with undertaking the audit. Financial implications potentially would occur if a detention was invalid.

Dadansoddiad Risk / Risk Analysis

Risks are associated with sections not being enacted correctly and patients detentions deemed invalid. Patients have the right to be aware of their detention and the processes available to them to appeal their detentions.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Health Board must adhere to the statutory duties as set out in the Mental Health Act.

Mental Health and Learning Disabilities Division

Compliance with the Mental Health Act

In the Forensic, Rehab and Older Persons Units

September 2021

Conducted by:

Wendy Lappin

Mental Health Act Manager

CONTENTS

INTRODUCTION AND AIMS

The Mental Health Act 1983 (as amended 2007) enables those who meet the criteria for detention, to become subject to a detention within suitable premises to receive assessment and treatment of their mental health for the protection of themselves and others.

Whilst subject to detention patients have a number of rights under the Mental Health Act.

The Health Board has a duty to ensure that detention paperwork is legal, and administrative timescales met, to fulfil all aspects of the Mental Health Act. This includes patients being aware of their rights to appeal, to have access to an Independent Mental Health Advocate (IMHA) and to have an up to date care and treatment plan.

Documentation is required to be correct and stored in the correct manner to provide evidence of sharing information with the patient.

The forensic, rehab and older persons units do not have an onsite Mental Health Act Administrator. The area Mental Health Act office, situated in the closest adult psychiatric unit (Heddfan, Hergest and Ablett) will receive and hold original Mental Health Act documentation. .

The forensic, rehab and older persons units hold an integrated file for each patient; these files are required to contain copies of the Mental Health Act documentation. In some units there is no provision of a ward clerk, this responsibility then falls to the nursing staff to ensure documentation is correct.

The aim of the audit is to ensure the Health Board is upholding it's duties under the Mental Health Act in regards to documentation.

STANDARDS

The standards used for the purpose of this audit are:

- The Mental Health Act 1983 as amended 2007
- The Mental Health Act Code of Practice for Wales revised 2016 (CoPW)
- The Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

"Hospital managers and local authorities should also ensure arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis". (CoPW 35.20)

Standard 1 - Section Papers
"The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms, those set out in schedule 2 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008. The forms must also be scrutinised to ensure all information contained is accurate and meeting the requirements". (CoPW 35.2)

Patients detained under Part III of the Mental Health Act will be detained in hospital or received into guardianship on the order of a court, or may be transferred to hospital or guardianship from penal institutions on the directions of the Secretary of State for Justice". (MHA 1983)

Standard 2 - Section 17 Leave documentation
Section 17 Leave allows for a detained patient to leave hospital if this is granted by the Responsible Clinician or Ministry of Justice for restricted patients.

"The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. It is good practice for hospital managers to adopt a local recording form for the responsible clinician to authorise leave and specify any conditions including a time-lint or review date. All expired section 17 leave authorisation forms should be clearly marked as no longer valid. (CoPW 27.17)

Standard 3 – 5 - Explanation of Rights
"Sections 132 and 132A of the Act require hospital managers to take such steps as are practicable to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order (CTO), understand important information about how the Act applies to them." (CoPW 4.2)

"Information should be given to the patient both verbally and in writing, in accessible formats, appropriate to the patient's needs, e.g Braille, Moon, easy read, and in a language the patient understands. (CoPW 4.3)

There is a statutory duty to inform patients detained under specific sections of their right of access to an independent Mental Health Advocate (IMHA).

"Independent mental health advocates (IMHAs) can be valuable in helping patient to understand the questions and information that is being presented to them and in helping patients to communicate their views to staff. (CoPW 4.10)

Standard 6 – Medication Certificates and Consent
For treatment of a mental disorder capacity and consent is required after an initial three month period of detention. The medication certificates are required to be completed correctly and appropriate, patients must be given the opportunity to discuss and consider the effects of the treatment.

"*In every case sufficient information must be given to ensure the patient understand in broad terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. A record should be kept of information given to patients". (CoPW 24.34)*

Standard 7 – Care and Treatment Plans
The Mental Health Measure details relevant patients should have a Care and Treatment plan in writing as soon as it is reasonably practicable. The code notes that Part 2 Regulations do not specify a time limit for the production of a care and treatment plan but it is recommended that in most cases it should be produced within 6 weeks of the appointment of a care coordinator. The Care and Treatment Plan should be regularly reviewed, the template document includes a review date.

Standard 8 and 9 – Paperwork
All paperwork held in relation to the Mental Health Act must be easily accessible and filed correctly to identify a patients journey and care. A Mental Health Act divider was introduced into the integrated files a number of years ago to assist staff in the organisation and clear documentation in relation to the Mental Health Act.

METHODOLOGY

In August 2021, six units were audited. All detained patients' files were scrutinised and cross-referenced with the Mental Health Act correspondence files held by the Mental Health Act area office.

51 files were scrutinised:

Older Persons: Cefni = 8 files and Bryn Hesketh = 11 files.
Rehabilitation Units: Tan Y Castell = 4 files, Coed Celyn = 4 files and Carreg Fawr = 5 files.
Forensic: Ty Llywelyn = 19 files.

To comply with the standards, documents considered for accuracy and cross referencing were:

- Section papers
- Section 17 Leave documentation
- Explanation of Rights documentation
- Medication certificates

Additional information considered:

- Is there an up to date Care and Treatment Plan?
- Was the patient made aware of their rights in their primary language?
- Was the patient offered a referral to the IMHA services?
- Is there a Mental Health Act divider in the case notes?
- Are the documents filed correctly?

RESULTS

Each unit is detailed below in relation to the nine standards.

1 Cefni (eight files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	**25%**
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**12.5%**	**87.5%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**25%**	**75%**
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**50%**	**50%**
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**37.5%**	**62.5%**

NOTES
The lack of an explanation of right document will affect the outcome for standards 4 and 5 if no evidence is available to confirm patients have received their rights.

Missing documents have been forwarded following the audit, staff have been informed of the importance of IMHAs and rights forms.

2 Bryn Hesketh (11 files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**82%**	**18%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**82%**	**18%**
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**82%**	**18%**
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**64%**	**36%**
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	

NOTES
The lack of an explanation of right document will affect the outcome for standards 4 and 5 if no evidence is available to confirm patients have received their rights.

Following the audit process confirmation was received from the ward manager that of the patients missing Care and Treatment Plans, two were completed and required filing, and one was due for completion due to the patient being a recent admission.

3 Tan Y Castell (four files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	

NOTES
Good practice was noted:- the language of the patient was recorded on the explanation of rights document and the lack of admin support does not appear to impact on the ability to organise the files sufficiently.

4 Coed Celyn (four files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	**25%**
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**50%**	**50%**
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	

NOTES
Documentation which did not match between the ward and the office has subsequently been rectified.

Staff have been informed of the importance of fully completing the explanation of rights document to evidence the patients have received their rights in the correct manner.

5 Carreg Fawr (five files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**80%**	**20%**
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**80%**	**20%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**80%**	**20%**
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**60%**	**40%**
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**60%**	**40%**

NOTES
Documentation which did not match between the ward and the office has subsequently been rectified.

There is a current ongoing action plan in relation to the Mental Health Act and Carreg Fawr paperwork underway. Training has also been completed with the unit team to ensure improved compliance.

6 Ty Llywelyn (19 files scrutinised)

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**58%**	**42%**
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**89%**	**11%**
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**84%**	**16%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**89%**	**11%**
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**95%**	**5%**
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**63%**	**37%**
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**84%**	**16%**
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**58%**	**42%**

NOTES
Documentation which did not match between the wards and the office has subsequently been rectified.

There is a current ongoing action plan in relation to the Mental Health Act and Ty Llywelyn. The team believe this has assisted in standard 4 result.

The lack of a ward clerk appears to be having an impact on the filing. This has been raised with the Admin Manager.

CONCLUSIONS & DISCUSSION

Combined Results

No.	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**82%**	**18%**
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**90%**	**10%**
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**74%**	**26%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**78%**	**22%**
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**82%**	**18%**
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**96%**	**4%**
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**76%**	**24%**
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**94%**	**6%**
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**70.5%**	**29.5%**

The ward files should reflect the same detention information that is contained within the Mental Health Act correspondence files held in the MHA office. The file dividers have assisted in ensuring that the correct paperwork is carried forward when new files are generated, however more work is still required to ensure that all documents are carried forward including any previous detentions as these form part of the patients care pathway.

Whilst some areas have required reminding of the importance of forwarding documents to the Mental Health Act office, the S17 leave documentation was correct and all patients were adequately authorised. Good practice was evident as old documents had been cancelled and crossed through.

The lack of 'explanation of rights' documentation has an impact on additional standards, it is a requirement of the Mental Health Act that patients have received their rights in appropriate formats and made fully aware. Noted within the Code of Practice for Wales handing over a leaflet is not an adequate provision and documentation should be recorded to confirm patients have understood.

Referral to an IMHA is especially important if the patient lacks capacity, and there is also a requirement to document this. It is concerning that the use of the rights forms is lacking in the older persons units despite the confirmation that records are made in the clinical notes. The Health Board Policy on Information to Patients (S132/3 Mental Health Act) is available to assist staff.

A low number of medication certificates did not match and this has been rectified with the assurance that the previous certificates contained the same medication. A process of scrutiny is involved with medication certificates and pharmacy to ensure medication errors are not made, it is therefore expected that this standard should always be on target at 100%.

Capacity forms were evident for patients on a CO2[1] certificate, providing confirmation that the patient was made aware of, and agreed to the medication.

Care and Treatment Plans are a requirement of the Mental Health Measure (2010). The achievement percentage would have been greater if all documents had been available at the time of the audit. The importance of filing has been communicated.

Mental Health Act dividers are now available in all units, and staff have confirmed that these assist in filing documentation and organisation.

The lack of a ward clerk does appear to be having a negative effect in some units. This has been highlighted to the appropriate Admin Managers.

ACTIONS TAKEN

Following each scrutiny session:

- The areas have been informed of their results and the areas of concern highlighted.
- All issues raised have been looked into.
- Assurance has been provided to the Mental Health Act Manager that everything is in order/or amendments and corrects have been made immediately.

[1] A certificate written by the Responsible Clinician, A CO2 certificate can only be used if the patient consents and understands the proposed treatment and medication.

RECOMMENDATIONS

A three monthly rolling programme of audit will be instigated to include the Bryn Y Neuadd Learning Disability Villa's and the North Wales Adolescent Service.

The report will be shared with the Mental Health Act Capacity and Compliance Committee, the Head of Nursing, Clinical Operational Managers and Head of Operations for each area.

It is recommended that Heads of Nursing disseminate the information contained within the report to appropriate staff.

The Information to Patients Policy is to be highlighted to staff by the Heads of Nursing in relation to Explanation of Rights and the process. Work still needs to be undertaken to ensure that the forms are fully completed.

The importance of updating care and treatment plans and filing to be highlighted to staff by the Heads of Nursing.

MHA Audit form

Unit: _____ Date undertaken: _____ Next due date:_____

Patient Name & ID	MHA office file				Unit / patient file (documents should correspond with the MHA file)			
	Section papers detail and dates AMHP report Y/N	S17 Y/N & date	EOR Y/N & date	CTT CO2/CO3 & Date	Section papers same as corri file Y/N	S17 Y/N & date	EOR Y/N & date	CTT CO2/CO3 & Date
	Additional info: Explanation of Rights – has this been offered in the patients primary language YES / NO Has the patient been referred to an IMHA YES / NO Is there an up to date Care and Treatment Plan YES / NO In the unit file – is there a Mental Health divider for the section papers, S17s etc YES / NO In the unit file – are the papers filed in the correct place YES / NO ANY OTHER COMMENTS / CONCERNS							