Bundle Mental Health and Capacity Compliance Committee 4 November 2022

1 OPENING ADMINISTRATION

1.1 MHA22/46 Welcome, introductions and apologies for absence - Chair - Information - Verbal report

1.2 MHA22/47 Declarations of interest on current agenda - Chair - Decision - Verbal Report

1.3 MHA22/48 Minutes of last meeting – 29 July 2022 - Chair - Decision - Paper

MH22.48 - draft MHAC Minutes 29.7.22 v0.3LR.docx

1.4 MHA22/49 Action log - Chair - Decision - Paper

Table of actions - updated 28.10.22.doc

1.5 MHA22/50 Patient Story - Acting Associate Director of Quality, Patient Safety and Experience - Information - Paper

MH22.50 - MHCCC - Nov 2022 - Patient Story.docx

MH22.50a - Patient Story follow up CAMHS - Board Committee Coversheet - Mental Health Capacity and Compliance Committee V0.1 20221025 (003).docx

2 STRATEGY

2.1 MHA22/51 Approval of All Wales Approved Clinicians and Section12 (2) Doctors - Executive Medical Director - Consent Paper

MH22.51 - AC and S12 Report Nov 2022 Mental Health Capacity and Compliance Committee meeting FV.docx

3 QUALITY SAFETY AND PERFORMANCE

3.1 MHA22/53 Deprivation of Liberty Safeguards quarterly report - Director Of Safeguarding and Public Protection - Assurance - Paper

MH22.53 - Final Version MHCC Committee DoLS MCA LPS Report and Action Plan V1.00.docx

3.2 MHA22/54 Associate Hospital Managers' update report - Mental Health Act Manager - Assurance - Paper

MH22.54 - Associate Hospital Managers Update Report V2.docx

3.3 MHA22/55 Mental Health Act Performance Report - Mental Health Act Manager - Assurance - Paper

MH22.55 - Coversheet MHA Performance Report V2.docx

MH22.55a - Appendix 1 MHAct Report September 2022.pdf

MH22.55b - Divisional S136 Report September 2022.pdf

MH22.55c - CAMHS S136 Report September 2022.pdf

3.4 MHA22/56 Mental Health Legislation Risk Register - Assistant Director of Information Governance & Risk - Assurance - Paper

MH22.56 - DRAFT MHCCC Committee Coversheet - Corporate Risk Register v2.0.docx

MH22.56 - Appendix 1 - Mental Health Act Capacity and Compliance Committee Corporate Risk Report.pdf

MH22.56 - Appendix 2 - Newly Escalated Risks.pdf

4 LEARNING FROM THE PAST

4.1 MHA22/57 Quarterly Mental Health Act rolling audit report - Mental Health Act Manager - Assurance - Paper

MH22.57 - Audit Report and coversheet V3.docx

4.2 MHA22/58 Consideration of any HIW/Inspection reports/Audit reports - Acting Associate Director of Quality, Patient Safety and Experience - Assurance - Paper

MH22.58 - HIW Monitory Report V2.docx

4.3 MHA22/59 Report on the use of Restraints Divisional Director for MHLD - Executive Director of Workforce and Organisational Development - Assurance - Paper

MH22.59 - MHACCC report on restraint 27.10.2022 Final Version(2).docx

5 POLICIES AND REPORTS

5.1 MHA22/60 Policies - Assurance - Paper

Policy on Application for admission to hospital under Part II of the Mental Health Act 1983
Section 17 Leave of Absence Policy

MH22.60 - Mental Health Act Policies Coversheet V2.docx

MH22.60 - Appendix 1 Policy on Application for admission to hosptial under Part II of the Mental Health Act 1983.doc

MH22.60 - Appendix 2 BCU EQIA - Application for admission to hospital under Part II of the MHA.docx

MH22.60 - Appendix 3 MHLD 0044 Section 17 Leave of Absence Policy v2 Review.doc

MH22.60 - Appendix 4 BCU EQIA - S17 Leave of Absence Policy.docx

5.2 MHA22/62 Chair's Assurance Reports - Assurance - Paper

Power of Discharge Group Chairs Information

MH22.62- POD Chairs Assurance Report V2.docx

MH22.62 - Appendix 2 Terms of Reference PoD V3 for approval.doc

Expression of interest MHCCC.txt

5.3 MHA22/61 Court of Protection Report - Mental Health Act Manager - Assurance - Paper

MH22.61 - MHCCC - Nov 2022 - Court of Protection.docx

6 CLOSING BUSINESS

6.1 MHA22/63 Issues Discussed in Previous Private Session - Chair - Assurance - Paper

6.2 MHA22/64 Date of Next Meeting - 10 February 2023 – Chair - Information - Verbal

10 February 2022

6.3 MHA22/65 Exclusion of Press and Public - Chair - Information - Verbal

Mental Health Act Committee (MHAC)
DRAFT Minutes of the meeting held on 25.6.21 via Teams

Present:	
Lucy Reid	Health Board Vice Chair (Chair)
Cheryl Carlisle	Independent Member
John Gallanders	Independent Member
In Attendance:	
Teresa Owen	Executive Director of Public Health
Frances Millar	Head of Safeguarding, Adults representing Director Of Safeguarding And Public Protection
Gaynor Thomason	Interim Executive Director of Nursing & Midwifery
Iain Wilkie	Interim Director, MHLD
Louise Bell	Assistant Director Children and Adolescent Mental health Services (CAMHS)
Matthew Joyes	Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience
Marilyn Wells	Head of Nursing – East Area for Child and Adolescent Mental Health Services, Neuro-developmental and Learning Disability Services
Wayne Davies	Locality Manager, Welsh Ambulance Services Trust (part meeting)
Wendy Lappin	Mental Health Act Manager, MHLD
Fiona Lewis	Minute taker

Agenda item	**Action**
MHAC22/27 Welcome and apologies **MHAC22/27.1** The Chair welcomed everyone to the meeting and confirmed that apologies had been received from Gill Harris, Executive Director of Integrated Clinical Services / Deputy Chief Executive Officer; Dr. Alberto Salmoiraghi, Consultant Psychiatrist / Medical Director, MHLD; Michelle Denwood, Director of Safeguarding and Public Prosecution; Helena Thomas, Associate Hospital Manager; Ruth Joyce, Criminal Justice Liaison Service Manager, MHLD, Justine Parry, The Assistant Director for Information Governance & Risk and Helena Thomas, Associate Hospital Manager.	
MHAC22/28 Declarations of Interest **MHAC22/28.1** The Chair declared an interest with relation to the Criminal Justice Report item on the Agenda, as Justice for the Peace for the Central Bench.	

MHAC22/29 Minutes of the last meeting held on 29.4.22 to be approved. **MHAC22/29.1** The minutes were approved as an accurate record of the previous meeting once an amendment to item MC22/15.4 note for accuracy of minutes – Regional Assistant Director CAMHS is Vice Chair of the Children's RPB Sub Group, rather than Director of Safeguarding, as noted in minutes.	
MHAC22/30. Action Log **MHAC22/30.1** The summary action log was reviewed and updated accordingly. **MHAC22/30.2** It was noted that both the minutes of the previous meeting and the action log were not provided in a timely manner which resulted in many actions not being fulfilled. Both the Chair and the Executive Director of Public Health had intentions to discuss this matter with the Office of the Board Secretary.	
MHAC22/32 Approval of All Wales Approved Clinicians and Section 12 (2) Doctors – Executive Medical Director **MHAC22/32.1** The Executive Director of Public Health presented the report. The Chair had been notified of a process issue, whereby there was a GMC sanction for a doctor which had not been flagged as part of the approvals process. The Executive Director of Public Health agreed to enquire what the expectations of the Health Board were as a host. The Medical Director MHLD, The Executive Medical Director, The Board Secretary, The Associate Director of Governance and The All Wales Approval Manager for Clinicians and Section 12(2) Doctors) to provide an update on the host arrangements and assurance to the Committee. **MHAC22/32.2** An Independent Member requested assurance that there was sufficient capacity within the system financially to fulfil the Health Board's contracted obligations to Welsh Government and the other Health Boards as he felt that this left the Health Board open to significant criticism. The Executive Director of Public Health agreed to seek clarification regarding ring-fenced finance provided for the hosting of the service, as opposed to the separate issue the Health Board has had on an ongoing basis on the capacity of its Section 12(2) doctors to speak with the Interim Director of Regional Delivery, whose responsibility it is. **MHAC22/32.3** The Interim Director for MHLD informed the Committee that he was not aware of any incidents relating to capacity in this area, however recognised there were significant challenges within the division and these do feature on the Risk register. **MHAC22/32.4** The Committee received the report for assurance, subject to the queries raised.	TO TO / PM
MHAC22/33 Update on Reforming the Mental Health Act	

MHAC22/33.1 The Mental Health Act Manager presented her report, noting that the report reflected what had been outlined in the Draft Mental Health Bill published 27th June 2022. **MHAC22/33.2** Since writing her report, the Mental Health Act Manager advised that indicative timescales have now been provided and that the Bill is expected to be introduced into Parliament in the spring of 2023. Phased implementation is planned between 2024 and 2031. Welsh Government's response to the draft Bill is still awaited. **MHAC22/33.3** An Independent Member enquired as to the impact on the Health Board of the removal of Police Stations and prisons, as places of safety. The Mental Health Act Manager agreed that this was a concern, however the numbers that this currently relates to is low. **MHAC22/33.4** The Chair wished to see this as an opportunity to bring the Health Board and its partners together but asked if there would be an implementation plan/risk register put together to address the effects on the wider Health Board, not only the Mental Health Division. It was agreed that the Executive Director of Public Health would take the paper to the executive team and the Together for Mental Health Partnership Board, to ensure it can be discussed with partners. **MHAC22/33.5** The Committee accepted the report.	TO / LR
MHAC22/35 Associate Hospital Managers Update Report **MHAC22/35.1** The Mental Health Act Manager presented her report, which covered four months (February to May) rather than the usual three, due to the move of the Committee meeting. She highlighted that fact that although they were still holding virtual hearings, patients were now being offered face to face hearings. Forms have been adjusted to incorporate feedback on whether patients are being offered face-to-face meetings, whether they were happy with this and if they got the service they wanted. This information will be incorporated into subsequent reports. **MHAC22/35.2** Within the four month period, twenty five hearings had taken place with two patients being discharged and with regards to the KPIs, 64% of the hearings took place within the recognised timeframe – a decrease due in part to necessary staff being unavailable, due to covid-related staffing issues. **MHAC22/35.3** Four further people have been appointed to assist with hearings and were due to start their training shadowing, within the next four weeks. **MHAC/35.4** An Independent Member noted that within the report, some hearings were delayed due to administrative errors or lack of legal representations and sought assurance that there were no legal implications for the Board, if hearings were not held within the appropriate time. The Mental Health Act Manager stated there were no consequences and that when a	

patient's section was to be renewed, the Mental Health Act required this to take place within a set timeframe and the Associate Hospital Managers act independently, to ensure that people are not being detained unnecessarily. **MHAC/35.5** The Chair sought assurance regarding reference to the ongoing training and discussions about reinstating the six-monthly training. The Mental Health Act Manager explained that historically this was done by the Office of the Board Secretary but since responsibility for the Associate Managers had moved over to the Quality Directorate, the Mental Health Act Manager felt this might in time move over to them. **MHAC22/35.4** The Committee noted the report.	
MHAC22/34 Deprivation of Liberty (DoIs) Update **MHAC22/34.1** The Head of Adult Safeguarding (representing Director Of Safeguarding And Public Protection) provided a verbal update. She wished to note that the LPS Strategic and Operational Implementation Group held its inaugural meeting in the last quarter and was due to meet again during the Summer. **MHAC/22/34.2** The Head of Adult Safeguarding noted also that there had been a 40% increase in DoLs applications in the 12 month period 2021/22, as opposed to the previous 12 months, which increased the risk of non-compliance and might lead to an unlawful deprivation. This risk has been recorded as part of the Tier 1 Corporate risk. The Committee sought assurance that when comments, as noted in the report, state 'can result in non-compliance', that the organisation will not get into non-compliance. The Executive Director of Public Health agreed to take this forward and discuss the process and risks involved, with the Deputy CEO/Executive Director of Integrated Clinical Services. **MHAC22/34.3** The Head of Adult Safeguarding noted the recent Court Protection case which resulted in a BCUHB patient being detained unlawfully for a significant period of time. The case is ongoing and relates to an individual in the community. **MHAC22/34.4** A new protocol is being developed to help manage complex interfaces between the Mental Health Act and the Mental Capacity Act and to review informal psychiatric patients who are not objecting to their care and treatment, as defined in the Mental Health Act. **MHAC22/34.5** The Head of Adult Safeguarding wished it noted that there were no financial implications from the report, however as part of the wider Corporate Safeguarding team review, it had been placed on the reserve list for the IMTP and is pending an Executive Management Group agreement on the revised Corporate Safeguarding team business case that is being put forward. **MHAC22/34.6** It was noted that there was a written paper which, due to an administrative error, had not been included in the agenda. The Head of Adult	TO / GH

Safeguarding agreed to forward the report to the Executive Director of Public Health, who would circulate it to members after the meeting. **MHAC22/34.7** The Chair noted that she felt that the safeguards being brought in were very good but that she had concerns surrounding the bureaucracy sitting behind the LPS and had raised these concerns with a Welsh Government representative at the recent Together for Mental Health Partnership Board, who in turn raised it with Westminster. **MHAC22/34.8** There was a general discussion around the concerns that time delays caused by the business case approval process, when it was understoof that this should have already been undertaken as part of the IMTP approval process. The impact of the delay could result in the allocated funds no longer being available if it could not be approved within the financial year. The Interim Executive Director of Nursing & Midwifery and The Executive Director of Public Health agreed to take to Execs. **MHAC22/34.9** The Committee noted the report.	FM / TO GT / TO
MHAC221/36 Mental Health Act Performance Reports **MHAC22/36.1** The Mental Health Act Manager presented the report highlighting activity over the last 4 months from February to May, noting that there had been 5 lapsed sections and 5 detentions deemed fundamentally defective or invalid, within that period. She wished it noted that this was due to the different ways England and Wales conduct their paperwork. In England, they are allowed to type all paperwork including signatures, whilst Wales still works on a 'wet' signature' being required. When any direct admission from England takes place at night, the admission has to be declared as invalid due to the lack of a 'wet' signature; a decision then has to be made as to whether an assessment must take place. This is causing severe delays throughout Wales and has been brought to the attention of Welsh Government. With regards to Wales still using 'wet' signatures and not accepting any digitalized forms using electronic signatures (as used in England), WL was to bring to the next Mental Health Managers' Forum and if no progress made there, agreed to advise the Executive Director of Public Health in order to escalate. **MHAC22/36.2** The Committee sought assurance that the causes of the situations surrounding the lack of an AMHP over a weekend in May, would not be repeated. This was reportedly due to a lack of beds which, once it had been investigated by the clinical service, was discovered to be incorrect. The Interim Director, MHLD agreed to clarify the situation with Medical Director for MHLD on his return from annual leave and provide an update to the Chair. **MHAC22/36.3** An Independent Member asked if figures were routinely captured for people who had booked into the Emergency Department and then, before being seen by a doctor in a timely manner, leave the premises and then represent at a later date? The Interim Director of Mental Health agreed that this would be very useful information to have and agreed to discuss with colleagues how best to collect this information; he also agreed to address the situation	WL IW / AS IW

regarding the adults' mental health assessment room being placed within the Paediatric ED area at YGC, and the problems this causes, as highlighted in the recent HIW report. The Interim Executive Director of Nursing & Midwifery agreed to look at the progress as to the possibility of relocating the assessment unit away from the Paediatric ED in YGC. Regarding the positioning of the adult Mental Health Assessment area within the Paediatric waiting area at YGC, The Interim Director of Mental Health was asked to find out what had been done to mitigate the situation where adults in mental distress, waiting to be assessed, are being placed next to children – as witnessed by a Committee member on an unannounced visit recently. The possibility of relocating the room was discussed. **MHAC22/36.4** Within the two reports relating to both Under 18s and Adults, The Mental Health Act Manager reported there were 3 detentions that lapsed under a 136, however all 3 detainees were not fit for assessment. All have been Datixed, investigated and the patients discharged from hospital with follow-ups from services but not re-admitted. **MHAC22/36.5** The Mental Health Act Manager wished to note that the number of patients discharged with an outcome of no mental disorder had reduced dramatically. For a long period it had stood at around 20% and within the timeframe of the report now stood at 8.8%. **MHAC22/36.5** With regards to the Criminal Justice Liaison Service, the Executive Director of Public Health wished to highlight the need for the consultation piece of work that the Criminal Justice Liaison Service Manager had for some time been attempting to get completed, which aimed to increase the level of training to better inform the police as to best practice in these situations. The Executive Director of Public Health agreed to pick this up with the Criminal Justice Liaison Service Manager to get clarification as to the need for reinstating police training to avoid inappropriate placing of patients into the S136 suite and what can be done to avoid this. It was suggested that a small study be carried out to discover what the Health Board knows of the cohort that go through 136, how patients are monitored, tracked, their outcomes, including the number re-presenting. **MHAC22/36.6** The Committee noted the reports.	GT IW TO / RJ
MHAC22/37 Mental Health Legislation Risk Register **MHAC22/37.1** The Executive Director of Public Health presented the report, acknowledging the new, shorter style of report. **MHAC22/37.2** The Committee noted with concern that the report showed 92 live risks under Tier 1 and 88 under Tier 3, all of which had been identified but none of which had been developed. The Executive Director of Public Health agreed to feed the concern back to The Assistant Director for Information Governance and Risk.	TO

MHAC22/37.3 Noting the lengthy time taken for business cases to go through the approvals process, thus raising the possibility that funds already agreed and allocated for projects within the IMTP were running the risk of not being utilised within the financial year. The Committee asked The Executive Director of Public Health to raise this concern with the Executive Team. **MHAC22/37.4** The Committee asked for assurance that certain areas noted as having the potential to become non-compliant, risked the possibility of things going wrong if they had not been followed through. The Executive Director of Public Health agreed to bring this to the attention of The Assistant Director for Information Governance & Risk. **MHAC22/37.5** The Committee noted the report.	TO TO
MHAC22/38 Criminal Justice Liaison Report **MHAC22/38.1** The Executive Director of Public Health presented the report. **MHAC22/38.2** The Committee was concerned for the service provision and what appeared to be an increase in frequency of evening/early morning incidents and whether the service is meeting the demand. The Executive Director of Public Health agreed to take this concern to Ruth Joyce, Criminal Justice Liaison Service Manager. **MHAC22/38.3** The Committee asked for clarification as to whether the figures recording emergency calls involving the police actually pick up those incidents that involved the transport police. The Executive Director of Public Health agreed to take this concern to Ruth Joyce, Criminal Justice Liaison Service Manager. **MHAC22/38.4** Clarification was also sought as to how returns on investment figures were being calculated and reported for this service. The Executive Director of Public Health agreed to ask her Public Health colleagues if there was any literature that might help with this calculation. **MHAC22/38.5** The Committee sought clarification as to why, with regards to the increased numbers of young people requiring the service, there was such a restricted time period of service operation - Monday to Thursday 6.00am to midnight - when Friday to Sunday appeared to be the busiest period. It was noted that this service was originally set up based on figures from the East area, and the current service times covered this and that a piece of work was underway to analyse the figures contained within the report and how best to adapt the service provided. The Assistant Director Children and Adolescent Mental Health Services (CAMHS) confirmed that they were working to extending their Crisis and Unscheduled Care Service to a 24/7 and that they were working with their Adult Mental Health colleagues on the 111+2 project to do likewise with that service, which will link into the local authority EDTs and the Criminal Justice and Liaison Service and the North Wales Police control rooms.	TO TO TO

MHAC22/38.6 The Head of Nursing – East Area for Child and Adolescent Mental Health Services noted that funding for this service was now mainstream and not funded as a project, as had originally been the case. **MHAC22/38.7** The Committee noted the report.	
MHAC22/39 Report on the Use of Restraints **MHAC22/39.1** The Interim Director, MHLD, provided a verbal report. The Chair expressed concern that the Committee was not sighted on the use of restraints across the Health Board and felt that, as it is an area of high risk, it should be. The Interim Director, MHLD agreed that there were very important implications and that there was a large piece of work underway which includes input from CAMHS colleagues, the Director of Governance, the Head of IT along with other health boards. **MHAC22/39.2** The Head of Nursing – East Area for Child and Adolescent Mental Health Services wished to bring to the Committee's attention a recent BBC news article in relation to a young person that had been detained under section in the Hillview Secure Unit, and wished to assure the Committee that learning from this incident was taking place in the Health Board. **MHAC22/39.3** The Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience offered to share some guidance released in England in 2014 on Restraint Reduction, titled 'Positive and Safe Care', which set out certain suggestions about incident that should be reported through to Board. He felt it might be a useful piece of work, which followed the national review in England by the Department of Health, with the support of Minds. **MHAC22/39.4** The Assistant Director of CAMHS noted that on Datix there is currently no way of recording restraint incidents involving children. The Committee sought assurance that this function on Datix would be made available to Emergency Departments also. The Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience agreed to look into the matter and find the timescale involved nationally in enhancing Datix accordingly. **MHAC22/39.5** The Head of Nursing – East Area for Child and Adolescent Mental Health Services wished to note that paediatric colleagues do not restrain and that some situations have resulted in the child's carers often staying with them and it is they who do the restraining. She noted that there is a need for a piece of work to be done, in conjunction with the local authorities, to ensure safe practice and levels of observation to maintain safety. The Executive Director of Public Health and The Interim Director of MHLD agreed to provide a proposal to the Committee in November, providing context and being clear of the scope of what is wanted to be measured under the Mental Health Act, using the code of practice and with reference to the information being provided by The Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety & Experience, what the process is currently and how incidents are recorded and	MJ MJ

monitored. The proposal would, using the information scoped, find where the gaps are and how we intend to address those gaps. This proposal is intended to provide assurance that the use of restraints under the Mental Health Act, are being appropriately used and monitored. **MHAC22/39.3** The Committee accepted the verbal report.	TO / IW
MHAC22/40 Report on Medium Secure Unit **MHAC22/40.1** The Interim Director, MHLD suggested that a meeting be arranged outside the Committee, which would involve himself, the Chair, the Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience and the Executive Director of Public Health to determine exactly what the scope is, to ensure that he can deliver what the Committee required at the next meeting. The Committee felt that as the people detained in medium secure units are there for long periods of time, sometimes years, the Chair felt that the primary concern of the Committee was that it needed assurance that those patients the organisation is responsible for, are being kept safe. **MHAC22/40.2** The Committee accepted the verbal update.	
MHAC22/41 Court of Protection **MHAC22/41.1** The Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience provided a verbal update, noting that there was nothing new to escalate to the Committee. **MHAC22/41.2** He noted that they had been working through restructuring of the Board's clinical and legal function. This meant that going forward they would have responsibility for overseeing compliance with the Court of Protection cases. **MHAC22/41.3** The Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience confirmed that for the next meeting he would bring a clear policy and procedure around the Court of Protection, for approval, as currently this does not exist. He also described the work that is being done in conjunction with Legal and Risk, around creating a database of cases to ensure there is organisational oversight. He also noted the new escalation process which, along with other measures, demonstrated that they were tightening up their governance processes. **MHAC22/41.4** The Committee accepted the verbal update.	MJ
MHAC22/42 Quarterly Mental Health Act Rolling Audit Report **MHAC22/42.1** The Mental Health Act Manager presented her report. Within the report it showed that overall, since the last report, there had been some improvements, however there were still some areas for concern. She also noted that due to administrative shortages some standards had been affected but	

where this had happened, the responsible person had been informed where improvements were necessary. **MHAC22/42.2** The Committee sought assurance that where papers had gone missing, requiring documentation to be produced retrospectively, that the narrative does not get changed and that there is a truly and accurate record and that any such documentation is clearly noted as being created retrospectively. **MHAC22/42.3** The Committee sought assurance regarding two areas within the report which highlighted low compliance – Carig Fawr and Ty Llewellyn. The Mental Health Act Manager responded by noting that the Carig Fawr ward Manager was putting together a paper with regards to the requirement for administrative support not being allowed to work from home, when paper files were involved and she agreed to follow this up to see how this had progressed. With regards to Ty Llewellyn, a comprehensive training package had been put together for the administration staff so that they were clear as to what had to be within the Mental Health Act sections and what needed to be carried forward - the next audit would show if this intervention had worked. The Committee asked why it was necessary for a paper to be written to show that administrative staff must not work from home when paper files are involved and the Interim Director MHLD agreed and said he would urgently look into the matter and report back. **MHAC22/42.4** The Committee wished to acknowledge that, from an assurance perspective, the improvement in the quality of the Audit report, particularly bearing in mind that these had only been introduced very recently, was impressive. **MHAC22/42.5** The Committee sought assurance regarding care and treatment plans, as these continued to be an area of non compliance and has also been raised in inspections undertaken by HIW**.** The Mental Health Act Manager believed that they were to start more in-depth scrutiny with regards to care and treatment plans, and agreed to ascertain the progress in this regard. The Interim Director, MHLD agreed that this recurring theme was unacceptable and that he and the Mental Health Act Manager would discuss the best way forward outside the meeting. **MHAC22/42.6** The Committee noted the report.	WL IW WL / IW
MHAC22/43 Consideration of any HIW/Inspection Reports/Audit reports as appropriate to the Meeting **MHAC22/43.1** The Mental Health Act Manager advised the Committee that there had been two inspections relevant to the Committee. The first inspection specifically focussed on Covid-19 and the risk of infection transmission on the ward. The report noted that in relation to the Mental Health Act and DoLs, they did require assurance on how the Health Board was discharging its duty of care but that no areas of improvement were identified under the governance of the Mental Health Act or DoLs for that ward.	

MHAC22/43.2 The Mental Health Act Manager wished to update the Committee on the Tan Y Coed's actions, as at the last meeting it had been queried as to why the timescale said February 2022 and whether the actions had been closed. She noted that the actions had been updated but initially, when they had responded to HIW, they believed they were too ambitious regarding these timescales. They were continuing to work on the action plan, with students looking at projects around medication and the CT work was aligned to the pathway work. The Mental Health Act Manager will provide updates as and when the situation changes. **MHAC22/43.3** The Committee received the reports.	
MHAC22/44 PoD Chairs Assurance Report **MHAC22/44.1** The Mental Health Act Manager presented her report. She noted that both Huw Jones and Laurence Naggs would both be leaving the PoD Group and the Health Board, and that their expertise would be greatly missed. **MHAC22/44.2** The Mental Health Act Manager advised the Committee that they were progressing with electronic support for hospital managers, which had been approved and work was ongoing with IT. She hoped that by the time of the next meeting, all would be in place and that they would be able to go 'paperless'. **MHAC22/44.3** It was noted that face to face hearings had resumed, dependent on the patients' wishes; that staffing was fully up to complement, along with the Children's Services, Mental Health and that there had been no expressions of interest to join the Mental Health Committee. **MHAC22/44.4** The Committee sought assurance that enough support had been offered by the organisation to the Associate Hospital Managers. The Mental Health Act Manager confirmed that at a recent Associate Hospital Forum Managers' meeting, where they had discussed, with particular attention to the following - support from the organisation and herself, IT, their expenses, ESR, were they receiving enough support when attending difficult hearings, etc, and the general consensus was that they were. **MHAC22/44.5** The Committee raised the question as to why the Associate Hospital Directors were required by ESR to do Manual Handling courses. The Mental Health Act Manager understood that it was mandatory training required by ESR. The Executive Director of Public Health asked the Mental Health Act Manager to write a summary of the inappropriate mandatory training that was currently required by the Associate Hospital Managers and she would link with the Workforce and OD colleagues and have them opted out of these requirements. **MHAC22/44.6** The Chair raised concerns about the operation and attendance at the Committee of key personnel. She asked the Executive Director for Public Health to raise this with the Executive Team, to ensure that the Committee is given the appropriate priority and representation.	WL / TO TO

MHAC22/44.7 The Committee noted the report.	
MHAC22/45 Date of next meeting 4.11.22	

BCUHB Mental Health Capacity and Compliance Committee Table of actions – last updated 28/10/2022 17:07					
	Executive Director	**Minute reference and action agreed**	**Original timescale**	**Latest update position**	**Revised timescale**
17.12.21 meeting					
1	Teresa Owen	**MC21/32 Terms of Reference** The Executive Director of Public Health undertook to verify if staffside groups were included in all the new Committee ToRs following the Integrated Governance Review	19.4.22	This action will be considered at the next HB CBMG meeting – when staff side attendance will be discussed for all committees given need for a consistent and clear approach. 29.7.22 Due to delay in receiving actions prior to meeting, TO to provide update following meeting HB CBMG meeting has not met. The OBS are considering how all TOR and COB should be coordinated. This action will be taken forward as part of this work. Suggest close	
2	Teresa Owen	**MC21/39 Mental Health Act risk register** The Committee acknowledged the next steps to be undertaken in order to assign Tier one risks to the Committee, however the Committee Chair questioned whether Risk "*CRR21-14 There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients"* should be transferred from the Quality, Safety and Experience Committee as this might 'fit' with both Committees. The Executive Director of Public Health agreed	19.4.22	Further work is required on the risk register. Verbal update to be provided alongside the risk paperwork for the Committee. **29.7.2022:** Due to delay in receiving actions prior to meeting, TO to provide update following meeting **05.10.2022:** Justine Parry provided update CRR21-14 – on the 11th January 2022 the QSE Committee approved the transfer of this risk to the MHCC Committee for future oversight. Therefore the first presentation of the risk to MHCC Committee was on the 29th	21/4/22

		to seek further guidance from the Interim Director of Governance on this matter.		April 2022. Suggest close	
3	Teresa Owen	**Patient Story - Paulo** **Follow up on:** ▪ Lack of Treatment plan is a wider thematic issue (not only MH) – provide assurance and how learning will be disseminated across organisation in all services ▪ Variation in quality of patient experience in the MH Services encountered across areas ▪ Provide assurance the action plan has been addressed and learning embedded ▪ Clarify the key responses ▪ Clarify staffing issues ▪ Provide assurance that robust processes are in place to ensure advocacy service is referenced in relation to MH Act and wider services	31.5.22	TO to provide update following meeting **19.10.2022** – Update prepared by Louise Woodfine and will be circulated. Suggest Close	
4	Matt Joyes	**Patient Story - Paulo** • Draft letter for Committee Chair to offer a meeting with senior officer of the Health Board to listen to their experiences, and know their story has been shared with Board members at a Committee meeting.	13.5.22	The letter has been drafted and is with the Chair for sign off.	
5	Michelle Denwood	**CAMHS follow up Patient Story** Share Sammy Woodhouse information with Board members and Louise Bell	13.5.22	The information and findings from the National Enquiry relating to one of the victims, 'Sammy Woodhouse' were shared with both Louise and	

				wider. In addition; BCUHB Safeguarding has two Child Sexual Abuse/Child Sexual Exploitation Leads (CSA/CSE) and we are monitoring our interventions against the National CSA/CSE action plan. Suggest close	
6	Louise Bell	**CAMHS follow up Patient Story** Check risk on register re CAMHS / MHAct Revisit 21/24 Provide ToRs before next meeting	20.5.22	LB to provide update following meeting	
7	Teresa Owen	**CAMHS follow up Patient Story** Provide analysis of repeat S136s linking in with Ruth Joyce/Mike Smith/Michelle Denwood for presentation to the T4MHPB	20.5.22	GH to provide update following meeting	
8	Gill Harris	**MC22/11 MHLD 0026 policy** Discuss with Board Secretary the length of approval process to consider if can be shortened	20.5.22	GH to provide update following meeting	
9	Alberto Salmoiraghi	**MC22/13 S12(2) Doctors** • Continue to update T4MHPB on progress • Escalate the issue that training posts recommended by HEIW had not been funded to the Executive Medical Director on behalf of the Committee	13.5.22	**05.10.2022** - Next update will be at T4MHPB meeting - January 2023 (13.01.2023).	
10	Teresa Owen	**MC22/13 S12(2) Doctors** • Raise the above ** issue externally	13.5.22	29.7.22 Due to delay in receiving actions prior to meeting, TO to provide update following meeting. **05.10.2022** - HEIW Decision is well justified,	

				AS & NL in agreement. Suggest Close	
11	MM	**MC22/14 Corporate Risks** • Consider reduction of the size of paper for next submission	7.6.22	The report is now five pages including the coversheet, which is in line with the guidance. Appendices are being reduced due to new arrangements of the QSE overseeing risk. Suggest Close	
12	Teresa Owen	**MC22/14 Corporate Risks** • Together with Nick Lyons and Iain Wilkie advise how changes to the Mental Health Act risks will be monitored in BCU	13.5.22	This will be taken forward through the risk management group with a new agenda item being added specifically around MHA.	
13	Alberto Salmoiraghi	**MC22/14 Corporate Risks** • Feedback how national forums are dealing with risk in regard to changes to the Mental Health Act	13.5.22	See Above	
14	Louise Bell	**MC22/15 CAMHS Pathway** • Provide the Committee with Child pathway as assurance of journey from ED.	13.5.22	LB to provide update following meeting	
14	Teresa Owen	**MC22/15 CAMHS Pathway** • Discuss how a child's psychological therapy and social care needs are met to ensure no gap, and how risk is monitored within BCU.	20.5.22	TO to provide update following meeting	
15	Gill Harris	**MC22/16 DoLs quarterly report** • Provide assurance on how physical restraint monitoring and risk management is effectively carried out across BCU services and accounted for	20.5.22	GH to provide update following meeting	

		at BCU's Committees			
16	Teresa Owen	**MC22/16 DoLs quarterly report** • Research how other Health Boards monitor physical restraint and associated risk	20.5.22	TO to provide update following meeting	
17	Anna Reid	**MC22/16 DoLs quarterly report** • Link in with team regarding Capacity assessments to support the wider organisation	20.5.22	AR to provide update following meeting	
18	Alberto Salmoiraghi/ Wendy Lappin	**MC22/18 Performance report** Analyse data in respect of East outlier to consider if underlying issue not associated with population density	13.5.22	AS & WL to provide update following meeting	
19	Louise Bell / Teresa Owen	**MC22/18 Performance report** LB to explore data to explore any underlying issue with very unbalanced gender split on Appendix 3 S136 TO to explore same with Public Health Team	20.5.22 20.5.22	05.10.2022 – Search completed. Search findings to be circulated. **Suggest Close**	
20	Teresa Owen	**MC22/19 HIW monitoring** Provide update on Tan Y Coed implementation actions	7.6.22	Tan y Coed, LD Unit, Bryn y Neuadd Hospital HIW Inspection held 19th and 20th October 2021. An action plan developed aligned to improvements identified, including - Quality of patient experience – 3 improvements identified, 3 actions completed Delivery of safe and effective care – 9 improvements identified, 7 actions completed, 2 due for completion February 2023. Quality of management and leadership – 1 improvement identified aligned to transformational work, progress remains ongoing.	

				Improvements made include implementation of a weekly blood sugar monitoring form, MDT review now includes review of personalising patients rooms, appointment of OT for 30 hours for Learning Disability patients, risks assessments reviewed with ongoing review of compliance, creation of easy read documentation for patients aligned to mental health and one-to-one observations audit undertaken with 6 monthly review of compliance. Outstanding actions aligned to CTP audit due to be completed in October 2022, CTP training workshops due to commence in October 2022 and ongoing transformational development of model and ethos of Tan y Coed remains ongoing led by the Inpatients Pathway Groups.	
21	Michele Denwood	**MC22/19 HIW monitoring** Explore with Iain Wilkie how incident training/learning is being taken forward	31.5.22	Incident Training and Learning is being taken within the MHLD by the following; • Full access to Multi-agency and single agency training, engagement in multi-agency case reviews, and full participation in the strategic and operational Safeguarding Agenda. • Corporate Safeguarding attend and contribute to MHLD MIS+ meetings, to support the identification of safeguarding risk and provide independent challenge. • Desk Top Reviews are undertaken in high areas of Adult at Risk activity or where	

				wider safeguarding concerns have been raised. • Additional Safeguarding and MCA training is available to MHLD staff. Bespoke sessions are offered routinely with 'targeted' intervention where training compliance is low or where higher levels of concerns have been raised. • Safeguarding Specialists attend Local and Regional PTR meetings to promote learning from incidents. In addition the MHLD Safeguarding Forum have 'practice reviews' recorded as a standard item agenda. • The Safeguarding Governance and Performance Group Quarterly meetings provide learning from local, regional and national practice reviews to support learning and improved practice within the Health Board. • 7 Minute briefings are completed and shared across a wide variety of safeguarding topics. • Safeguarding Ambassadors - Ambassadors are frontline staff based within MHLD (and wider BCUHB) services. We aim to increase the number of Ambassadors across the Division. Suggest Close	
22	Teresa Owen	**MC22/20 Compliance with MHA Audit** Discuss with IW variation and quality of Care and Treatment plans to make	20.5.22	TO to provide update following meeting	

		improvements			
23	Teresa Owen	**MC22/21 PODG** Seek clarification with Board Secretary whether 2 Associate Hospital Managers are required to be present at each MHCCC meeting or 1 present and another nominated as deputy re ToRs	20.5.22	TO to provide update following meeting. **06.10.2022** – Phil Meakin / Molly Marcu suggested having 1 Associate present and 1 Deputy. TOR to be reviewed. TOR's being reviewed and this will be captured. Suggest Close	
24	Anna Read	**MC22/22 Court of Protection** Ensure future reports include assurance that Judges' directions and any issues highlighted have been dealt with	7.6.22	AR to provide update following meeting	
26	Teresa Owen / Phil Meakin	**MC22/32.2 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales.** Clarification to be sought regarding ring-fenced finance provided for the hosting of the service, as opposed to the separate issue the Health Board has had on an ongoing basis on the capacity of its Section 12(2) doctors.	1.9.22	**06.10.2022** – Phil Meakin met with Heulwen Hughes & Meryl Roberts (06.10.2022) – this is being followed up.	
27	Teresa Owen & Lucy Reid	**MHAC22/33.4 Update on Reforming the Mental Health Act.** It was agreed that The Executive Director of Public Health would take the paper to the Executive team and that with the Chair, to the Together for Mental Health	4.10.22	**05.10.2022 -** Request in place to take paper to ET/HBLT discussion late October/early November 2022 / T4MHPB in January 2023 (13.01.2023).	

		Partnership Board, to ensure that not only the Local Authority partners but also the Police and Ambulance Services are made aware of the impact.			
28	Teresa Owen / Gill Harris	**MC22/34.2 Deprivation of Liberty Safeguards Quarterly Report.** The Committee sought assurance that when comments, as noted in the report, state 'can result in non-compliance', that the organisation will not get into non-compliance. TO agreed to take this forward and discuss the process and risks involved, with Gill Harris.	4.10.22		
29	Frances Millar / Teresa Owen	**MHAC22/34.6 Deprivation of Liberty (DoIs) Update.** It was noted that there was a written paper which, due to an administrative error, had not been included in the agenda. The Head of Adult Safeguarding agreed to forward the report to The Executive Director of Public Health, who would circulate it to members after the meeting .		**06.10.2022** – Paper was received on 29.07.2022 and distributed to MHCACC members by Emma Hughes (29.07.22) Complete. Suggestion Close.	
30	Gaynor Thomason / Teresa Owen	**MC22/34.8 Deprivation of Liberty Safeguards Quarterly Report.** There was a general discussion around the frustration felt due to time delays caused by what was felt to be excessive bureaucracy involved in getting business cases through for approval, even though the business cases have already been approved, with funding already allocated	4.10.22	This was discussed at Cabinet Committee and LR agreed to share examples of this with the CEO. Suggest close from this action log	

		within the IMTP. It was felt that the impact of the delay and risk of losing the funding needs to be taken into account and that the process needs to be more streamlined and less time consuming. GT & TO to take to Execs.			
31	Wendy Lappin	**MC22/36.1 Mental Health Act Performance Report.** With regards to Wales still using 'wet' signatures and not accepting any digitalized forms using electronic signatures (as used in England), WL was to bring to the next Mental Health Managers' Forum and if no progress made there, agreed to advise TO in order to escalate.	4.10.22		
32	Iain Wilkie / Alberto Salmoiraghi	**MC22/36.2 Mental Health Act Performance Report.** With regards to paragraph at bottom of Pg. 12 of report (the patient required to remain in ED due to AMHP not attending), the Committee requested assurance that the situation had been rectified. The Interim Director, MHLD agreed to clarify the situation with Dr. Alberto Salmoiraghi, on his return from annual leave and provide an update to The Chair.	1.9.22		
33	Iain Wilkie	**MC22/36.3 Mental Health Act Performance Report.** In answer to a query concerning the number of patients who book into ED and leave before	4.10.22		

		support is provided and then re-present with mental health issues which should have been picked up at ED, IW confirmed no such data was currently routinely captured at Triage, however he felt it should be and that he would discuss with colleagues the best way to go about this.			
34	Gaynor Thomas	**MC22/36.3 Mental Health Act Performance Report.** GT agreed to look at the possible progress in relocating the assessment suite away from the Paediatric ED in YGC			
35	Iain Wilkie	**MC22/36.3 Mental Health Act Performance Report.** Regarding the positioning of an adult Mental Health Assessment area within the Paediatric waiting area at YGC, IW was asked to find out what had been done to mitigate the situation where adults in mental distress, waiting to be assessed, are being placed next to children – as witnessed by a Committee member on an unannounced visit recently. The possibility of relocating the room was discussed.	1.9.22		
36	Teresa Owen / Ruth Joyce	**MC22/36.5 Divisional S136 Report June 22** TO agreed to pick up with RJ on her return, the need for police training to avoid inappropriate placing of patients into the S136 suite and what can be done to avoid this. It was suggested that a small study	4.10.22		

		be carried out to discover what the Health Board knows of the cohort that go through 136, how patients are monitored, tracked, their outcomes, including the number re-presenting. TO to discuss with Ruth Joyce.			
37	Teresa Owen	**MHAC22/37.2 Mental Health Legislation Risk Register** The Committee noted with concern that the report showed 92 live risks under Tier 1 and 88 under Tier 3, all of which had been identified but none of which had been developed. TO agreed to feed the concern back to Justine Parry		**11.10.2022** – (Justine Parry no longer responsible for Risk Management, now sits with Phil Meakin). Pravitha Rajendraprasadh provided action update: 94 live risks under tier 2- were risks that were under review or awaiting decision to close- current figure is 54 live risks as at 11/10/22. 88 risks under Tier 3 were risks being developed and the current figure is 33 risks being developed as at 11/10/2022. Suggest close	
38	Teresa Owen	**MHAC22/37.3 Mental Health Legislation Risk Register** Noting the lengthy time taken for business cases to go through the approvals process, thus raising the possibility that funds already agreed and allocated for projects within the IMTP were running the risk of not being utilised within the financial year. The Committee asked The Executive Director of Public Health to raise this		This has been addressed by the Vice Chair through Cabinet Suggest close	

		concern with the Executive Team.			
39	Teresa Owen	**MHAC22/37.4** The Committee asked for assurance that certain areas noted as having the potential to become non-compliant, risked the possibility of things going wrong if they had not been followed through. The Executive Director of Public Health agreed to bring this to the attention of The Assistant Director for Information Governance & Risk.		This has been brought to the attention of Associate Director of Governance and will be taken forward at the Risk Management Group on 4 December.	
40	Teresa Owen	**MHAC22/38.2 Criminal Justice Liaison Report** The Committee was concerned for the service provision and what appeared to be an increase in frequency of evening/early morning incidents and whether to service is meeting when the demand arises. TO agreed to take this concern to Ruth Joyce	4.10.22		
41	Teresa Owen	**MC22/38.3 Criminal Justice Liaison Report** TO agreed to meet with Ruth Joyce to discuss the transport police service provision and to seek assurance that the service is now actually meeting the demand.	4.10.22		

42	Teresa Owen	**MC22/38.4 Criminal Justice Liaison Report** Clarification was sought as to how returns on investment figures were worked out. TO agreed to ask her Public Health colleagues if there was any literature that might help to understand how the calculations were arrived at.	4.10.22		
43	Matt Joyes	**MC22/39.3 Report on the Use of Restraints** MJ to circulate the 'Positive and Safe Care' 2014 English report, which addressed the reduction in the use of restraints.		The new Once for Wales RLDatix system, implemented across BCUHB in April 2022, has more limited restraint recording fields than the previous BCUHB local system and requires restraint to be recorded as a separate incident rather than integral to another incident (such as violence). As such, more limited management information is available. The PICCS Team have complemented this with more locally collated information, and the separate report to the Committee on restraint provides detail on this. The new Once for Wales RLDatix system is undergoing a programme of continual improvement over the next 6 months at all all-Wales level to achieve standardisation, and improving the restraint recording section is part of this. BCUHB has fed its requirements and expectations into this process. Suggest Close	
44	Matt Joyes	**MC22/39.4 Report on the Use of Restraints** Louise Bell noted that on Datix there is		On agenda Suggest Close	

		currently no way of recording restraint incidents involving children. The Committee sought assurance that this function on Datix would be made available to Emergency Departments also. MJ agreed to look into the matter and find the timescale involved nationally in enhancing Datix accordingly.			
45	Teresa Owen / Iain Wilkie	**MC22/39.5 Report on the Use of Restraints** TO & IW agreed to provide a proposal to the Committee in November, providing context and being clear of the scope of what is wanted to be measured under the Mental Health Act, using the code of practice and with reference to the information being provided by MJ, what the process is currently and how incidents are recorded and monitored. The proposal would, using the information scoped, find where the gaps are and how we intend to address those gaps. This proposal is intended to provide assurance that the use of restraints under the Mental Health Act, are being appropriately used and monitored	4.10.22	On agenda Suggest Close	
46	Iain Wilkie / Teresa Owen	**MC22/39.5 Report on The Use of Restraints.** Following a discussion around reporting failings in the Datix system, IW agreed to provide a report, identifying the reporting gaps, stating how the organization intends to address those gaps, with a proposal to	November	On agenda Suggest Close	

		the Committee, laying out how it will provide assurance that the use of restraints, under the MH Act, are being appropriately applied, monitored and reported.			
47	Matt Joyes	**MHAC22/41.3 Court of Protection** MJ confirmed that for the next meeting he would bring a clear policy and procedure around the Court of Protection, for approval, as currently this does not exist.	4.10.22	On agenda Suggest Close	
48	Wendy Lappin	**MHAC22/42.3 Quarterly Mental Health Act Rolling Audit Report** WL, noting that the Carig Fawr ward Manager was putting together a paper with regards to the requirement for administrative support not being allowed to work from home, when paper files were involved, agreed to follow this up to see how this had progressed.			
49	Iain Wilkie	**MHAC/42.3 Quarterly Mental Health Act Rolling Audit Report** The Committee asked why it was necessary for a paper to be written to show that administrative staff must not work from home when paper files are involved and IW agreed and said he would urgently look into the matter and report back.			
50	Wendy Lapin /	**MHAC/42.5 Quarterly Mental Health Act**			

	Iain Wilkie	**Rolling Audit Report** The Committee sought assurance regarding care and treatment plans, as echoed in the concerns raised by HIW. WL believed that the Measure department was to start more in-depth scrutiny with regards to care and treatment plans, and agreed to ascertain the progress in this regard. IW agreed that this recurring theme was unacceptable and that he and WL would discuss the best way forward, outside the meeting.			
51	Wendy Lappin / Teresa Owen	**MC22/44.5 Chair's Assurance Report** With regards to a query from WL, where ESR expects Associate Hospital Directors to do inappropriate courses such as Manual Handling, WL to provide a detailed summary and send to TO, who will pick up with W&OD.	1.9.22		
52	Teresa Owen	**MC22/44.6 Chair's Assurance Report** Following a request from LR, TO agreed to talk with Executive Team, to ensure that the Committee is given the appropriate priority and representation.	4.10.22	This has been done and the Chair has also raised this at the R&TS committee. Suggest close	

RAG Status	
P	Complete
G	On track
A	Slippage on delivery
R	Delivery not on track

Teitl adroddiad: ***Report title:***	Carer Story			
Adrodd i: ***Report to:***	MHCC Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to the Committee to bring the voice of the service user and their loves ones directly into the meeting.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
In line with best practice, the patient/carer story is presented to the Committee; it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board
Denise's Story (Carer Story)

Overview of the Carer Story

My Husband was diagnosed with dementia in November 2015. I supported him for five years until he had to move into residential care. When he was good, he was very good. He was a hard worker and really outgoing he loved keeping busy.

In 2015, my husband knew something was wrong, he felt he was losing it so he went to the Doctor in the summer of 2015. By November, he was diagnosed with dementia. The processes of assessment to diagnosis was very easy. At that time of diagnosis, my husband felt that he didn't need any support.

After his diagnosis in January 2016, we went to visit my daughter in Singapore and then visited Vietnam. It was then my husband suddenly became angry. I think his dementia made it worse. He was really angry and he left me when we were out shopping. He walked off and I was really worried about him. After four hours of searching, I went back to the hotel to find him there. My husband was angry he was shouting, scream and pushing me. He took all of the money, my phone and credit card and walked out of the hotel. I had no way of getting in touch with anyone. I thought he was lost. I eventually found out he had flown back to the UK and went back to our house. I was left on my own in Vietnam trying to get back home to the UK.

My Husband realised what he had done and he tried to commit suicide he took over 150 tablets. An Ambulance was called and he was taken to hospital. Following his attempted suicide he was then assigned a CPN. I continued supporting my husband and living with him even though it was horrendous. It was pretty awful the anger he felt and I did wonder if he had additional mental health problems not just dementia. When I said my thoughts to the Psychologist, she dismissed it – I felt like they were thinking you don't know what you were talking about. My husband was since diagnosed with Bi-Polar. I do wonder if I had been listened to at the start, could he have been treated earlier for Bi-Polar and he may have responded better to the medication.

For over five years, I supported him and within that time he had a lot of anger, violent episodes and threatening behaviour towards me. The CPN was very aware of his irrational behaviour. We had a lot of respect for his CPN, as they were able to talk him down. My husband's dementia had progressed too far for him to receive anger management support. I expressed concern over this as I felt that the Mental Health Team should have provided more timely intervention and support to both my husband and I.

When his behaviour was serious, the Police would be called to the house. He would take car keys, money, slash car tyres and threaten me. In December 2020, the Police were called to the house due to his threatening behaviour they found an axe and knives in our house he was using as weapons. The Police called the Mental Health Team who said they were not able to support us, as it was a marital problem as I was starting divorce proceedings. This was totally untrue.

My husband would tell the Police and the Mental Health Team that I was a cruel wife. I was treated and judged as if was the cause for his violent behaviour. His dementia had progressed and his mental health was unstable he was saying things he didn't mean. Everything he had said wasn't true but I was being made to feel like a criminal.

The Police were worried for my safety living with him and advised me to move out of the family home. After this incident, I was left to feel cut off and excluded from my husband's care. I went to live with my sister and had to move four times until I found a place I could settle in. My husband couldn't cope in the house on his own and he would always go to the neighbours asking for help to use the oven, put the heating on etc. I was still very much supporting him I was paying the house bills and supporting him with shopping but I was described as the 'estranged wife' by the CPN and it was a term used a lot to describe me. I kept saying to them I am not the estranged wife I have been told for my own safety I can't stay with my husband as he has threatened me with knives. I am his wife and his next of kin.

A number of professionals came out to the house to see if he needed to be sectioned under the Mental Health Act but he was extremely persuasive and talked everyone around. He persuaded them that I had made all of the acquisitions up. They believed him and I felt I was not supported and I was treated with hostility. I kept saying my husband does not have capacity.

I kept saying he does not have capacity, it took eventually four months for them to get this. He had no capacity with money, he refused to speak to me he would only speak to his daughter when she rang him – but they always believed his when he said I was being cruel.

My husband was eventually sectioned under the Mental Health Act; he spent time at Bryn Hesketh and then the Ablett Unit. The day before he was admitted into Bryn Hesketh one of his daughters died suddenly. One of his daughters had rang me and said I think he has been taken out of house but I can't cope with phoning up to find out where he has gone. So I agreed to phone up the Mental Health Team only to be told 'I can't tell you where he is' and 'we cannot update you on his care'. I told them the circumstances and they advised me it was Bryn Hesketh. They were not able to tell me any more information and that remained the same until he moved into a residential home six months later. I don't know if it was my husband's choice not to tell me or the service.

He is my husband and I care for him I should have received information on how he is doing. I don't know law but if he did not have capacity, he did not have capacity to say he did not want to speak to me. I had Power of Attorney for my husband and this was also his daughter's wishes for me to have this. I understand the importance of respecting patient wishes but if he did not have capacity, I should have been kept up to date on his care.

I was treated like I had done something wrong it really upset me and it left me feeling suicidal. I will never forget how they treated me. I still have nightmares. I now experience periods of depression and I feel angry how I was shut out from my husband's care. I feel more support is required for partners/carers, caring for people with dementia.

I was living and caring for my husband even when I left the marital home but the Health Board did not recognise this as my husband would refuse to speak to me then ask staff why I wasn't contacting him. He just did not understand fully what he was saying.

One minute he did not want to talk to me then the next he was very apologetic – this shows how unstable he was. He would sometimes say where have you been I would say you have told them not to talk to me and he would say I didn't mean it.

I just couldn't understand why staff were not communicating with me when my husband was in hospital under a mental health section, when he did not have capacity. He may have said to staff he didn't want to speak to me but he did not have capacity. I was his next of kin.

I was fortunate enough to be in a position to get a Solicitor to intervene so I could find out what was happening with my husband's care. I would have never been given updates if I hadn't involved a Solicitor. The Solicitor cost over £3,000. I do think what happens to other families who are not able to speak up or have money to fight for the right updates on their loves ones care.

I was left for 6 months whilst my husband was in hospital with no communication on his care. It was only when he was moved into a residential home I was able to visit him. When I did finally see him in person, he was very upset and crying asking where had I been.

Eventually my husband was moved from the Ablett Unit into 24 care at an EMI residential unit. They are looking after him really well and are able to cope with his anger outbursts. He is still my husband and I still go to see him on a regular basis.

The Mental Health Service should have found a way of communicating with me they should have not refused communication with me when my husband did not have capacity.

I raised a formal complaint to the Health Board about my experience and I received a written apology. A Mental Health Service Manager agreed that they could have found other ways to communicate with me on my husband's care.

Summary of Learning and Improvement

On 13th October 2021, Denise met with Head of Nursing to discuss her experience and to ensure other people do not have the same experience.

- The assessment process was discussed in some detail and it was explained that assessments are not always overt and some questions may have been asked during a normal conversation, may have formed part of a fuller assessment.
- It was explained that an assessment might take a number of weeks to determine an individual's true level of functioning and, at times during the assessment process; a person's mental wellbeing may deteriorate to the point where an assessment under a legal framework, such as the Mental Health Act (MHA) might be required.
- It was outlined that assessments may be longer term in nature and services must assist patients in the least restrictive way as possible, however, also needing to consider risks in parallel. As Denise's husband was not detainable under the MHA, staff would have attempted to maintain him in his own home until this became unsafe and he met the threshold for detention under the MHA, as he may have refused or lacked capacity to accept hospitalisation.
- It was discussed that mental capacity fluctuates and relates to an individual's ability to make considered decisions. It was outlined that the service will always assume an

individual has capacity to make a decision and explained that this also includes unwise decisions. It was explained that usually, a patient who had capacity may well decide they do not want people involved in their care. However, this should have not stopped staff having discussions with family/carers of their needs and any potential risks they may need to be aware of.

- It was explained a section of the Mental Health Measure (MHM) documentation used by all Care Co-ordinators includes an assessment, which explores any potential abuse and in particular, domestic abuse. An apology was given if this had not been completed and examples were provided of measures previously employed and would expect from staff, to address any situations involving potential abuse.
- It was acknowledged that communication with Denise had been poor and it was acknowledged there are ways the team could have maintained good lines of communication without breaching her husband's confidentiality.
- An apology was given with regards to inaccuracies in information in the patients (husband) file stating that divorce proceedings had started. The patients file has been updated to reflect she remains married and supportive of her husband.
- It was agreed that a carer's assessment should have been completed to acknowledge and support her own needs and wellbeing. The requirement to undertake a carers assessment was raised at a Divisional level to agree how this can be monitored for assurance.

To ensure the voice of an un-paid carer is heard the Patient and Carer Experience Team continue to capture carer stories to share with services for learning.

NEWCIS and Carers Outreach are now based in the PALS Hubs across sites weekly, working very closely with PALS to promote their services to both patients and carers.

BCUHB are currently in discussions with Carers Trust about looking to pilot the Triangle of Care model within the Health Board. This model is currently being followed by English NHS Trusts but not in Wales so we would be the first to roll this model of good practise out. The Triangle of Care model is an approach to involve carers in at the earliest stages possible in the patients care. We would look to pilot this within the mental health service initially.

Teitl adroddiad: ***Report title:***	**MC22/2 Patient Story Follow up – Children and Adolescent Mental Health Service (CAMHS)**
Adrodd i: ***Report to:***	**Mental Health Capacity and Compliance Committee (MHCCC)** **(**Action from meeting held on 29.4.22)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides an update on actions further to the presentation of a Patient Story during the Mental Health Capacity and Compliance Committee (MHCCC) meeting held on 29.4.22. The Committee noted the patient story, and agreed the following actions be followed up – ▪ The absence of a Treatment Plan which is a wider thematic issue (not only MH) – provide assurance and ensure learning will be disseminated across the organisation; ▪ Variation in quality of the patient experience within MHLD encountered across areas; ▪ Provide assurance the action plan has been progressed and associated learning shared; ▪ Share the key responses; ▪ Clarify staffing issues; ▪ Provide assurance that robust processes are in place to ensure advocacy services are referenced in relation to the Mental Health Act, wider services and are appropriately communicated. The Board is requested to review the update and consider whether further information is required.
Argymhellion: ***Recommendations:***	The Board is asked to note the update against each acton as follows – **The absence of a Treatment Plan which is a wider thematic issue (not only MH) – provide assurance and ensure learning will be disseminated across organization in all services** Work is in progress to monitor and improve the compliance with Care and Treatment Plans across the division. Planned audits are undertaken across each area with a focus on identifying that they are individualised and outcome focussed. Learning identified from complaints and incident reviews is shared within both local and Divisional Putting Things Right (PTR) meetings and Quality, Safety and Experience (QSE) meetings. Learning bulletins and 7-minute briefings are shared throughout the division. The attachment below is an example of a briefing that was produced by the East locality.

Themes and key messages East 2021.

Variation in the quality of patient experience within MH Services.

The Divisional Patient and Carer Experience (PCE) group monitor themes and trends across the MH&LD Division in respect of patient and carer experience. Learning from complaints and incidents is routinely shared Division wide, to support uniformity of experience and standardised care. These themes and trends are also discussed in Divisional PTR meeting and Divisional QSE meetings.

In addition, Caniad reports are presented and shared at local QSE meetings to evidence patient experience and any actions taken to improve Quality, safety and patient experience issues.

Quality and Safety Audits were undertaken as a baseline in August 2022 highlighting a variance in the completion of Care and Treatment Plans across the Division. The results were presented to the Divisional Senior Leadership Team (SLT) and a rolling programme of monthly audits by the Governance team and peer auditors is due to commence in October 2022. Mental Health Measure leads are undertaking audits in their respective areas in terms of compliance with the measure and feeding back to locality senior leadership team.

A vital piece of work, focussing on primary care transformation, is underway, looking at the various routes into mental health services and the patients' progression through services. This will provide an opportunity to streamline the process, and remove any barriers regarding accessibility, so that patients can access the right service at the right time.

Provide assurance the action plan has been implemented and learning embedded.

The Ty Derbyn action plan continues to be progressed. This locally driven piece of work was developed in response to themes from concerns and staff feedback. The aim is to improve the patient and carer experience.

The following actions are included within the plan:

- Ensuring mental health examinations are recorded consistently;
- Ensuring that SharePoint reflects accurate workloads and is updated within appropriate timeframes;
- Reviewing the legacy issue of consultant caseload ensuring patients are care coordinated appropriately to meet individual needs;
- Process mapping review of Single Point of Access (SPOA) and Duty;
- Strengthening communication between professionals and service users/carers;
- Reviewing the Care and Treatment Plan process.

	The implementation and delivery of the 111+2 service is a key component of the development of the Local Mental Health Primary Support Services (LMHPSS). **Staffing issues** It is recognised that there is a national shortage of nurses, and the staffing shortfalls are representative of the NHS as a whole. There are ongoing plans to facilitate recruitment across the whole division with the Just R Marketing campaign, which is also aligned to development of a talent pool process to streamline the recruitment process. Focus is also being made on staff retention, with the development of a Divisional Workforce plan. **Provide assurance that robust processes are in place to ensure advocacy service is referenced in relation to MH Act and wider services** All individuals who are detained under the Mental Health Act must have their risks explained. The documentation details that a referral to an independent mental health advocate (IMHA) has been offered. Rights are revisited on a regular basis for those who initially declined, and is subject to audit by the MHA team which is reported to Divisional QSE. Information is also clearly displayed on wards and the patient can ask to be referred, or contact the IMHA independently.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Carole Evanson, MH&LD Director of Operations, Interim.

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The strategic implications of the Mental Health Capacity and Compliance relate to the following: ➢ Priorities within "A Healthier Wales: long term plan for health and social care" ➢ Together for Mental Health North Wales Strategy ➢ Alignment with the BCUHB Integrated Medium Long-term Plan ➢ Supports delivery against Targeted Intervention requirements ➢ Alignment with the Divisional Clinical Strategy/Clinical Effectiveness and BCUHB operating model. ➢ Links with delivery of the Digital Strategy ➢ Covid-19 response and recovery ➢ Strengthening our wellbeing focus ➢ Recovering access to timely planned care pathways ➢ Improved unscheduled care pathways ➢ Integration and targeted improvement of mental health services ➢ BCU Estates Strategy ➢ People Stronger Together Strategy ➢ Mental Health Measure Standards ➢ Mental Health Act
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Mental Health Capacity and Compliance is aligned to the Mental Health Act.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol/ If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol/ If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.

	WP68 Procedure for Socio-economic Impact Assessment.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No financial implications identified.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No additional workforce implications as a results of implementing the recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been reviewed internally by the MH&LD Divsional Senior Leadership Team.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** ***Implementation of recommendations*** • To note the update provided	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Cyfarfod a dyddiad: **Meeting and date:**	Mental Health, Capacity and Compliance Committee. 4th November 2022
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 – 09.07.22 - 12.10.2022 Appendix 2 – Additions and Removals to the All Wales register of Section 12(2) Doctors – 09.07.2022 - 12.10.2022 Appendix 3 - Breakdown of Section 12(2) GPs currently approved in Wales as at 12.10.2022.

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 June and September 2022 Induction and Refresher training was held via Webinar. The next induction and refresher training will take place on 15, 16 and 17 November 2022 and will also be facilitated via Webinar. Training dates have been agreed up to November 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

9th July 2022 to 12th October 2022

New Applications Received:	**7**
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	3
Number of ACs already approved in England	4
Number of applications with panel (including portfolios)	1
Number of applications not approved	0
Re-approval Applications Received (5 Yearly):	**15**
Number of applications with panel	1
Number of applications approved	14
Number of applications not approved	0
Number of ACs reinstated	4
Number of re-approvals which have come to an end:	**12**
Expired	4
Retirement	1
No longer working in Wales	4
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	3
Awaiting CCT	0
Suspended	0
RIP	0
Total Number of Approved Clinicians	**370**
Total Number of Approved Clinicians from previous report	**369**

APPENDIX 2

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

9th July 2022 to 12th October 2022

New Applications Received	**9**
Applications from GPs	0
Applications from Psychiatrists	9
Application from Forensic Medical Examiner	0
Number of Applications Approved	7
Number of Applications Not Approved	0
Number of Applications with Panel	0
Incomplete Applications	2
Re-approval Applications (5 years)	**4**
Applications from GPs	1
Applications from Psychiatrists	3
Applications from Forensic Medical Examiners	0
Number of Applications Approved	3
Number of Applications Not Approved	0
Number of Applications with Panel	1
Transferred from AC register	**1**
Transferred from England	**1**
Number of Approvals which have come to an end:	9
Ended	0
Become an Approved Clinician	5
No longer working in Wales	4
No longer registered	0
Registered without a licence to practise	0
Retired	0
Under Police Investigation	0
Suspended from Medical Performers' List	0
Total Number of S12(2) Doctors currently approved	**184**
Total Number of S12(2) Doctors from previous report	**184**

APPENDIX 3

Breakdown of Section 12(2) Doctors currently approved BCUHB

As at 12th October 2022

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	4	0	0	2	3	**12**
Section 12(2) Psychiatrists	1	7	4	3	2	11	**28**
Approved Clinicians *(Includes non-medics)*	3	17	15	11	15	19	**80**

Number of 12(2) GPs per Health Board

As at 12th October 2022

BCUHB	12
ANEURIN BEVAN	5
CARDIFF & VALE	5
CWM TAF MORGANNWG	0
HYWEL DDA	1
POWYS	2
SWANSEA BAY	1

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Capacity and Compliance Committee** 01.11.2022
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA); and the Implementation of the new Liberty Protection Safeguards (LPS) Legislation Q2 Update**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Director of Safeguarding and Public Protection Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Chris Walker, Head of Adult Safeguarding (MHLD) supported by Michelle Denwood, Director of Safeguarding and Public Protection
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 Executive Director of Nursing and Midwifery and this update has been reviewed by; Michelle Denwood, Director of Safeguarding and Public Protection; and Angela Wood, Executive Director of Nursing and Midwifery
Atodiadau **Appendices:**	Appendix 1. Deprivation of Liberty Safeguards/MCA Action Plan

Argymhelliad / Recommendation:

The Committee is asked to:

1. Accept the Deprivation of Liberty Safeguards Quarterly Report and the identified activity for the period of Q2 2022-23.
2. Receive the Deprivation of Liberty Safeguards Action Plan and progress.
3. Accept the position in preparation for the implementation of Liberty Protection Safeguards (LPS).

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 activity recorded provides oversight and organisational assurance in relation to BCUHB's statutory duty under the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005 for the period of Q2 2022-23. The activity includes key actions and activities to ensure that DoLS/MCA, and the future Liberty Protection Safeguards (LPS) 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.

The Safeguarding Reporting Framework is under review to ensure it continues to be in line with organisational reporting as a result of the new BCUHB Operating Model.

Consultation Activity

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) Code of Practice has been amended 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 2022. This revised date is April 2023.

On the 17th of March 2022 the Welsh Government published the consultation on the LPS draft Regulations for Wales. The National (Wales) MCA/LPS 'working' groups were reconvened to address the consultation programme. All key BCUHB stakeholders were invited to attend weekly consultation forums facilitated by the BCUHB MCA and DoLS Team to address and engage in the consultation programme. The National consultation ended on the 14th July 2022 with the responses to this consultation now under review by both UK and Welsh Governments respectively.

We await notification from the Welsh Government on the revised date of the publication of the Code of Practice. The National LPS Task and Finish groups remain on hold.

An LPS implementation Welsh Health Boards and NHS Trusts support group is meeting in December. The group will address current MCA practices, awareness and training across organisations, and review current DoLS challenges facing both Supervisory and Managing Authorities. Feedback will be shared in Q3.

Current BCUHB Position

In partnership with other Health Boards, BCUHB has supported the development of the agenda for The National Workforce Group set up for Q3 2022-23. A further aim of this group is to identify areas where preparatory actions can take place while awaiting the new Code of Practice and Regulations.

BCUHB LPS Strategic and Operational Implementation Group held the inaugural meeting in Quarter 1. The Group will meet during Q4 of 2022-23 unless we receive a UK and Welsh Government announcement.

Monthly Safeguarding MCA/LPS Bulletins providing real time updates on the consultation process and the implementation of LPS is currently suspended. All information and updates will be available via the BCUHB Safeguarding webpage.

As previously reported the implementation of LPS will have an impact across all BCUHBs services. The priority over the next twelve months is to continue to support all clinical staff to improve their MCA application ensuring staff are able to act in accordance with the principles of the Act and evidence operational understanding.

The responsibility for assessment under LPS will be with frontline staff. We continue to await training programmes from the Welsh Government. All public service organisations have been given a clear direction that we must not to develop individual training programmes.

The key activity for this period is to deliver and improve organisational understanding of the MCA and address the DoLS backlog. The DoLS backlog is a legal term recognised by the Welsh Government referring to the number of applications awaiting authorisation. The Health Board has secured additional and time limited funding from Welsh Government to support this work.

Mental Capacity Act (MCA) educational materials are available, such as banner pens, MCA booklets for employees, MCA easy read guides for patients and carers, posters and other useful resources to promote MCA awareness. These products have been received and will be disseminated across BCUHB in Q3 as part of the wider Corporate Safeguarding Team's activity during the National Safeguarding Awareness Week, this is held the week beginning the 14th of November 2022.

Cefndir / Background:

Performance and Activity

It remains evident that the annual trend for DoLS applications is an upward trajectory within BCUHB.

Although Quarter 2 reports a slight decline in applications, we continue to report an increase in activity and complexity, in line with the upward trajectory.

We are currently reporting a five (5) week delay between receipt of a DoLS application and the subsequent authorisation. This position is not unique to BCUHB. Other Health Boards and Local Authorities are in a similar position. WG have responded to organisational challenges and are supporting additional activities by the provision of financial support. We can report this improved position from a six (6) week delay to a five (5) week delay, resulting in applications awaiting authorisation (DoLS Backlog).

The Deprivation of Liberty Safeguards Tier 1 Corporate Risk was reported at the Risk Management Group (RMG) on the 4th October 2022.

The actions to reduce the risk of an unlawful detention are in response to the risks associated with the increase of activity, complexity, demand within the Court of Protection and the awaited implementation of the Liberty Protection Safeguards and the organisations understanding and lawful application of the Mental Capacity Act.

The Safeguarding Reporting Framework ensures all risks are discussed as a mandatory agenda item in all BCUHB Safeguarding and Public Protection forums.

Welsh Government recognises the risks for all organisations resulting in the potential unlawful detention of service users. As noted in this report, non-recurring monies from the Welsh Government has been received to support NHS organisations to support the reduction of any compliance challenges regarding the legal process, which could result in an unlawful detention.

The Safeguarding/DoLS Business Case is included within the IMPT and remains on the reserve list, awaiting formal submission of the detailed funding requirements, which have been determined by the current and future activity and progress made regarding the LPS National Code of Practice. The detailed proposal is undergoing consultation, financial oversight was obtained and it will be submitted with an implementation plan which is cross referenced against the risk register by December 2022 line with the organisations cycle of business.

Welsh Government (WG) Monies
Temporary funding is in place from the Welsh Government (WG) to support key activities during Q3 and Q4. WG have also confirmed that temporary funding will be available during 2023-24 and 2024-25, in line with a bidding process.

To meet WG expectations and due to recruitment challenges, we have developmental opportunities for trained staff within the current team to support the strategic and operational management of the implementation of Liberty Protection Safeguards.

Having undertaken a short scoping exercise in relation to the need for a 24/7 MCA support service, the team is to pilot an 'out of hours' service from November 2022. This will offer an increased level of assurance and provide staff with the necessary support when considering the MCA in practice.

The Phase 2 WG funding bidding process secured monies to support the LPS and MCA programme. This total included £169,000 to support the Independent Mental Capacity Advocate (IMCA) resourcing ahead of the implementation of the LPS.

There will be greater demand for IMCAs under the LPS than the existing Deprivation of Liberty Safeguards system, and it is important to start to build capacity ahead of implementation. This funding is being provided to health boards as they have a responsibility to commission IMCA services on behalf of their geographical area.

Funding has also supported the following activity as per WG guidance:

- Development of Data Capacity for Liberty Protection Safeguards.
- Additional Deprivation of Liberty Safeguards activity to reduce the number of applications awaiting authorisation (Backlog).
- Additional advocacy arrangements.
- Enhanced and bespoke 'needs led' training activities to support the application of the legislation and improve practice. These are monitored through safeguarding reporting and scrutiny and the development of local workforce and training plans.

Asesu a Dadansoddi / Assessment & Analysis

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 obtain assurance against compliance with Safeguarding legislation and statutory guidance.

DoLS Documentation Audit
The latest audit of the 365 (Q2) DoLS applications received and reviewed demonstrated an increase of 74% of the applications having contained some issues that resulted in them having to be, discussed, and support given to the Managing Authority (Ward) before they were able to progress onto the next stage.

The majority of the issues, in most applications, were minor with minimal amendments required.

The MCA and DoLS Team play a leading role in the scrutiny of the documentation and this is included within the Corporate Safeguarding and DoLS Business Case.

Analysis
The submitted applications identify four (4) main themes;

- No inclusion of the Mental Capacity Assessment Form. During the audit it was noted that in almost all cases the Managing Authority had completed the Form but had not sent as part of the initial set of paperwork.
- Mental Capacity Assessments are completed incorrectly. Similar to the omission of Mental Capacity Assessments the forms suffered from minor inaccuracies such as a lack of address, or date of birth. These we resolved immediately by the Managing Authority.
- The DoLS application documentation is not completed correctly, not signed, and not dated correctly. Once again the minor oversight here was the inclusion of a signature on the form.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority should provide current medical information. Some detail was included, however to fully adhere to the legal framework the Managing Authority must provide all necessary information. This issue was addressed immediately by the Managing Authorities.

Training
DoLS training has been/is delivered by the team as well as bespoke MCA awareness raising sessions delivered directly to staff and wards.

Mandatory Training
To mitigate risk and gain assurance monthly training data is produced and shared across services to support the training programmes and positive target specific areas of non-compliance.

Analysis
Although there has been an increase in the number of forms having to be returned to the Managing Authority the respective individuals and services completed the necessary amendments with immediate effect. The audit also identified that 'new' staff had completed some of the applications. As an action to support this the MCA and DoLS Team are offering bespoke training sessions on the completion of paperwork.

Safeguarding training compliance is a key target for Corporate Safeguarding with a targeted approach in place for areas or departments with reduced compliance.

A revised virtual training programme is also available and remains in place to encourage ongoing training. MCA training is also included within the mandatory Adult Level 2 Safeguarding Module to utilise all available opportunities.

The additional MCA materials, funded by WG, will support the promotion of MCA awareness with the key aim of embedding this knowledge into daily clinical practice.

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

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

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

The number and complexity of cases engaged in the Court of Protection arena remains on the increase. Legal challenge has resulted in intensive Court of Protection activity and as a result, external legal services are commissioned in some cases, to support the Court process.

Court of Protection – Deprivation of Liberty (CoP DoL)
A recent case has highlighted the need to strengthen the organisations procedures in relation to CoP DoL cases within community placements. This includes all known and unknown activity specific to the CoP DoL Legal Framework. After undertaking a National scoping exercise, the need to strengthen this activity is not unique to BCUHB.

As part of our ongoing work across BCUHB the MCA and DoLS Team will complete a piece of work to support the development of a Standard Operating Procedure (SoP) to reflect the legislative policy and, to ensure good practice and governance is in place.

Actions will include:

- Supporting services to complete a comprehensive audit of all patients in community placements to identify where there may be a deprivation of liberty that should be authorised.
- Support the introduction and consideration of deprivation of liberty as part of the funding panel process ensuring any new packages of care, or changes to packages of care that would require a review of funding or where there is a question relating to the deprivation of liberty or any changes to authorised deprivations are identified.
- Work with Legal & Risk Services to develop a bespoke training package to deliver issue specific training to identified services.
- Support the development of a risk management tool to enable appropriate prioritisation of cases and assessment of resources and in addition develop a process for renewing authorisations annually or as required.

This activity will be carried out during Q3 and Q4 2022-23.

Analysis
The funding received by the Welsh Government has enabled the Corporate Safeguarding Team to implement an enhanced service provision and implement bespoke activities relating to the Mental Capacity Act, Deprivation of Liberty Safeguards applications and support the preparation and engagement for the Liberty Protection Safeguards Code of Practice. A summary of early activity include:

- Contact with commissioning services to identify individuals within the community who are deprived of their liberty and are unable to consent to this arrangement.
- Commissioning legal and risk services to develop a process to ensure a CoP DoL is in place for existing cases.
- Engagement with the National (Wales) DoLS, MCA and LPS working groups.
- See an improved position regarding the number of DoLS applications awaiting authorisation.
- Increased targeted MCA training.
- Targeted intervention on receipt of applications that have identified omissions in information.

Next Steps include:

- Further engagement with commissioning services.
- Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.
- Support the development of a protocol to help manage the complex interface between the Mental Health Act and the Mental Capacity Act and review service users accessing Mental Health services (individuals who are not objecting to their care and treatment as defined under the Mental Health Act).
- Review the training compliance and provide additional training support to all staff who may have patients' eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Coordinators, Health Visitors and Commissioned Service Providers.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

There are no financial implications for this report

Risk Analysis

The risks associated with the Deprivation of Liberty Safeguards are included within the Tier 1 Corporate Risk Register.

Risk CRR21-14. There is a risk that the increased level of Deprivation of Liberty Safeguards 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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

- The Deprivation of Liberty Safeguards Code of Practice supplements the main Mental Capacity Act 2005 Code of Practice.
- The Supreme Court Judgment, P v Cheshire West Council [2014] and P & Q v Surrey County Council [2014] UKSC 19.
- The Supreme Court Judgment D [A Child] judgement given on 26th September 2019.

Asesiad Effaith / Impact Assessment

n/a

Appendix 1

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

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

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

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	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, **Mental Capacity Act 2005)** and code of practice relating to the LPS.	• Development and Ratification of the LPS ToR. • 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 HL	Update: 21/10/2022 UK and Welsh Government have not provided any LPS updates. National Groups have not reconvened. There is an 'All Wales' meeting planned for December 1st 2022. The BCUHB Liberty Protection Safeguards (LPS) Implementation Group has ToR agreed and has had an inaugural meeting. The Strategic LPS Implementation Task and Finish Groups will meet again in Q4.	**1.08.2022**	**Red**

				The development of the Scope and ToR for Sub Groups has commenced. **Target Date extension request 31.03.2023**		
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.	CW HL	<u>Update 21/10/2022</u> The delay in the draft Code of Practice has had an impact upon the identification of required resource for LPS/MCA. Due to an unprecedented increase in safeguarding activity during Q1 and Q2 the Corporate Safeguarding Business Case requesting agreement for resources to support a 7 day service will be submitted for Executive approval during Q3 2022-23. Temporary WG monies are to support the implementation of a 7 day service as a pilot - November 2022 Financial overview and scrutiny has taken place. **Target Date extension request 31.03.2023**	**1.08.2022**	**Red**

Appendix 1

3.0	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	Update 21/10/2022 MCA training is reported to all BCUHB services on a monthly basis with analysis and scrutiny undertaken during governance meetings and the Safeguarding Forum.	**1.05.2022**	**Green**
5.0	Documentation Audit.	• Planned DoLS Application Audit. • Report findings to be shared.	CW	Update 21/10/2022 Quarterly audits and reporting now in place.	**30.04.2022**	**Green**
6.0	Confirm and engage with the BCUHB Mental Capacity Act Lead.	• New job description to be developed to reflect the changes in the MCA/LPS legislation. • Consultation with workforce. • Ensure changes are in line with Corporate Safeguarding Business Proposal.	CW HL	Update 21/10/2022 As reported to WG, the service were unable to secure a 'single' lead for LPS. However, in agreement with WG we have offered developmental opportunities to current professional staff within the team to support a clinical and social approach to the implementation of LPS and wider MCA legislation awareness. These roles are in line with our Corporate Safeguarding Business Proposal.	**1.08.2022**	**Green**

7.0	Welsh Government funding, actions and objectives.	• Fund additional Best Interest Assessments to reduce the DoLS Backlog. • Embed MCA training across BCUHB. • Prepare for the implementation of LPS.	CW HL	Update 21/10/2022 This action will be ongoing until March 2025 following confirmation from WG that funding is available for 3 years. We continue to undertake additional DoLS assessments, provide additional training and are engaged in preparations for the implementation of LPS. ***Target Date extension request** 31.03.2023 pending further review	**01.08.2022**	**Red**
8.0	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	• Further engagement with commissioning services. • Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients. • Support the development of a protocol to help manage the complex interface between the Mental Health Act and the Mental Capacity Act and review service users accessing Mental Health services (individuals who are not objecting to their care	CW HL	National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services to support the development of a Standard Operating Procedure.	**31.03.2023**	**Amber**

		and treatment as defined under the Mental Health Act). • Review the training compliance and provide additional training support to all staff who may have patients' eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors and Commissioned Service Providers		Training Data is under review relating to key services, with the objective to develop a bespoke training provision and evidence improved identification of service users who require a legal deprivation to be in place.		

Teitl adroddiad: ***Report title:***	Associate Hospital Managers Update Report (June – September 2022)
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	The Associate Hospital Managers update report provides details regarding the Associate Hospital Managers activity within the Health Board for the detailed period. The report describes activities in the following areas: Hearings, Scrutiny, Training, Recruitment, Forums, Meetings, and Key Performance Indicators. This report provides assurance that the individuals who form the Hospital Manager Discharge Panels (namely **Mental Health Act Associate Hospital Managers** (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards. The report details the activity of the Associate Hospital Managers in relation to hearings and activity undertaken, concerns raised and improvements to the division or service to which they have input for the period June 2022 – September 2022.
Argymhellion: ***Recommendations:***	The committee is asked to note the report.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Mental Health Act 1983 (amended 2007) The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A This report does not inform strategic decisions, it relates to the day to day operations of the Associate Hosptial Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level.

	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. 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.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The Associate Hospital Managers are paid a sessional fee for each activity. 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, imminent plans are in place for the Associate Hospital Managers to have reports transferred to them electronically once Health Board devices are received.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience and Iain Wilkie, Interim Director, Mental Health & Learning Disability Division have seen the report prior to submission. The Power of Discharge Group reviewed the activity for June – August 2022 within their meeting. The Mental Health and Learning Disability Senior Leadership Team Quality Safety

	Group have had sight of the report. None of the above have made any changes.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Appendix 1 – Associate Hospital Managers Update Report*	

Appendix 1

Quarterly Activity

1 Hearings

At the time of writing (04.10.2022) hearings are being held both remotely via Microsoft Teams and face to face. The hearing venue is determined by patient capacity and choice. Patients have been asked how they wish their hearing to be held beginning July 2022.

28 hearings were held during the months June – September 2022. The hearings consisted of five Community Treatment Orders (CTO) renewals, 19 section 3 renewals, one section 37 renewal and three patient appeals.

The Hospital Managers discharged no patients during this period.

Seven patients appealed their detentions this period, four hearings were not held due to two withdrawals, one regrade by the Responsible Clinician (RC) and one transfer between units.

A breakdown of the hearing activity is below:

June

- ***Eight hearings arranged (Six held), all via Microsoft Teams.***
  Three hearings were patient appeals and three renewals. One hearings was for a community patient.

  Two hearings were cancelled – The RC regraded one patient to informal and one hearing was postponed due to the patient requesting a different solicitor.

  Outcomes of hearings held
  - Five detentions were upheld.
  - One hearing was adjourned as the care coordinator did not attend, the patient had a subsequent MHRT within the month and remained detained, following the Tribunal they decided to withdraw their appeal.

July

- ***Eight hearings arranged (Six held); three held face to face and three via Microsoft Teams.***
  All hearings were in relation to renewals. One hearing was for a community patient.

  Two hearings were cancelled – The RC discharged one patient and one patient withdrew their appeal.

  Outcomes of hearings held
  - All detentions were upheld.

August

- ***15 hearings arranged (Eight held); four held face to face and four via Microsoft Team.***
  All hearings were in relation to renewals. Three hearings were for community patients.

  Three hearings were cancelled – One patient withdrew their appeal and two patients were discharged by their RC.

  Four hearing were postponed - one patient was transferred to another unit following the transfer a hearing was due to be held in August but the RC was unable to attend this accounts for one of the three hearings that required rescheduling.

  Three hearings required rescheduling due to sickness absence of the RC, two are in process of being rescheduled and one has not been rearranged due to the RC regrading the patient to informal.

  Outcomes of hearings held
  All detentions were upheld

September

- ***14 hearings arranged (Eight held); one held face to face and seven via Microsoft Team.***
  All hearings held were in relation to renewals.

  Four hearings were cancelled – all patients were regraded to informal.

  Two hearing were postponed - one due to the bank holiday, the patient was subsequently recalled so a new hearing will not be arranged.

  One hearings requires rescheduling due a solicitor request, which was not actioned until the day of the hearing.

  Outcomes of hearings held
  All detentions were upheld

Patient's views, venue choice and feedback forms
From July 2022 patients have been provided with a form to choose if they wish to have their hearing via virtual or face to face means. Patients who lack capacity and who will not be attending their hearings will automatically have a virtual hearing.

To date:
- Eight forms have been received noting the patient lacks capacity.
- Ten requests have been received for the renewal to be held face to face.
- Five requests have been received for the renewal to be held via Microsoft teams.
- One appeal against detention requested the hearing be held via Microsoft teams.
- One appeal against detention requested the hearing be held face to face.
- Six feedback forms have been received stating the patient expressed how they wished their hearing to be held and that they attended (three face to face and three virtual).

Hearing KPIs

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

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

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

There were three applications from patients this quarter to measure within the KPI, and there were no 'barring' hearings. 82% of hearings were held within the KPI.

Renewal Date	**Hearing Date**	**KPI (31 days)**
04/05/2022	01/06/2022	28 days
05/05/2022	13/06/2022	39 days
21/05/2022	04/07/2022	44 days
26/05/2022	14/06/2022	19 days
11/06/2022	07/07/2022	26 days
13/06/2022	15/07/2022	32 days
21/06/2022	21/07/2022	30 days
22/06/2022	05/07/2022	13 days
28/06/2022	04/07/2022	6 days
20/07/2022	09/08/2022	20 days
20/07/2022	03/08/2022	14 days
21/07/2022	10/08/2022	20 days
21/07/2022	12/08/2022	22 days
22/07/2022	14/09/2022	54 days *
23/07/2022	16/08/2022	24 days
27/07/2022	17/08/2022	21 days
09/08/2022	09/09/2022	31 days
11/08/2022	02/09/2022	22 days
15/08/2022	25/08/2022	10 days
15/08/2022	12/09/2022	28 days
16/08/2022	09/09/2022	24 days
17/08/2022	09/08/2022	Held before
30/08/2022	07/09/2022	8 days
10/09/2022	21/09/2022	11 days
20/09/2022	30/09/2022	10 days
Appeal by Patient Date	**Hearing Date**	**KPI (31 days)**
07/04/2022	10/06/2022	64 days *
19/05/2022	17/06/2022	29 days
31/05/2022	29/06/2022	29 days

- The extended KPI date for a patients appeal was in relation to RC availability and the patient requesting different solicitors.
- The extended KPI of 54 days for the renewal hearing was due to the patient being transferred shortly after their renewal.

2 Scrutiny

Scrutiny has been reinstated from March 2022 and is conducted on a monthly basis within the three psychiatric units, Heddfan, Ablett and Hergest. A scrutiny report will be produced at the end of the year.

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

3 Training

The mandatory training list that is expected to be completed by the Health Board is under review, discussions are underway between the Executive Director of Public Health and Workforce to reduce the requirements to training that is specifically linked to the Associate Hospital Manager role. The managers have been instructed to only complete relevant training.

Discussions have been held with the Assistant Director of Quality about additional training days for Associate Hospital Managers, the cohort to inform future training have completed training needs analysis forms, a training day will be scheduled for February 2023.

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:
21 persons of which 19 are actively involved in hearings, two of these being new members and undertaking training via shadowing sessions. The active cohort consists of seven male and 12 female members, of which two are Welsh speakers.

Of the active members, there are eight chairpersons, (three male and five female), of which one is a Welsh speaker.

Four persons have recently been appointed to the role, all are able to undertake shadowing.

5 Forums and Meetings

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

The last meeting on the 9th of June involved discussions relating to: the Associate Hospital Managers cohort, mental health act staff changes, Covid plans in relation to hearings, the ‘All Wales Conference’ and feedback, sharing of recent activity and support/debrief provisions. The next meeting is due to be held on the 13th of October.

6 Future developments

It has been agreed that devices will be provided to the Associate Hospital Managers to allow the service to go paperless. A number of IPADs have been received and distributed, laptops are on order.

Associated benefits will be:

- Patient's details and data will be more secure as these will not go through the postal system.
- Managers will have access to an NHS email and information about the Health Board.
- Managers will have more time to read and review reports not having to wait for the postal system to deliver.
- Financial costs associated with posting reports recorded delivery will disappear.
- Managers will have suitable devices to support them when undertaking remote hearings.
- Managers will have suitable devices to complete mandatory training and submission of expenses.
- Mental Health Act Administrators will no longer have to copy multiple documents therefore having a time and financial saving.

Teitl adroddiad: ***Report title:***	Mental Health Act Performance Report			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during June – September 2022. A four month period has been reported on due to a change in meeting dates. The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections. 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'. Any lapses or fundamentally defective sections are datixed and investigated. Up to date S136 reports are submitted to the Committee along with any ad hoc requests for information.			
Argymhellion: ***Recommendations:***	The Committee is asked to discuss and note the report and appendices.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

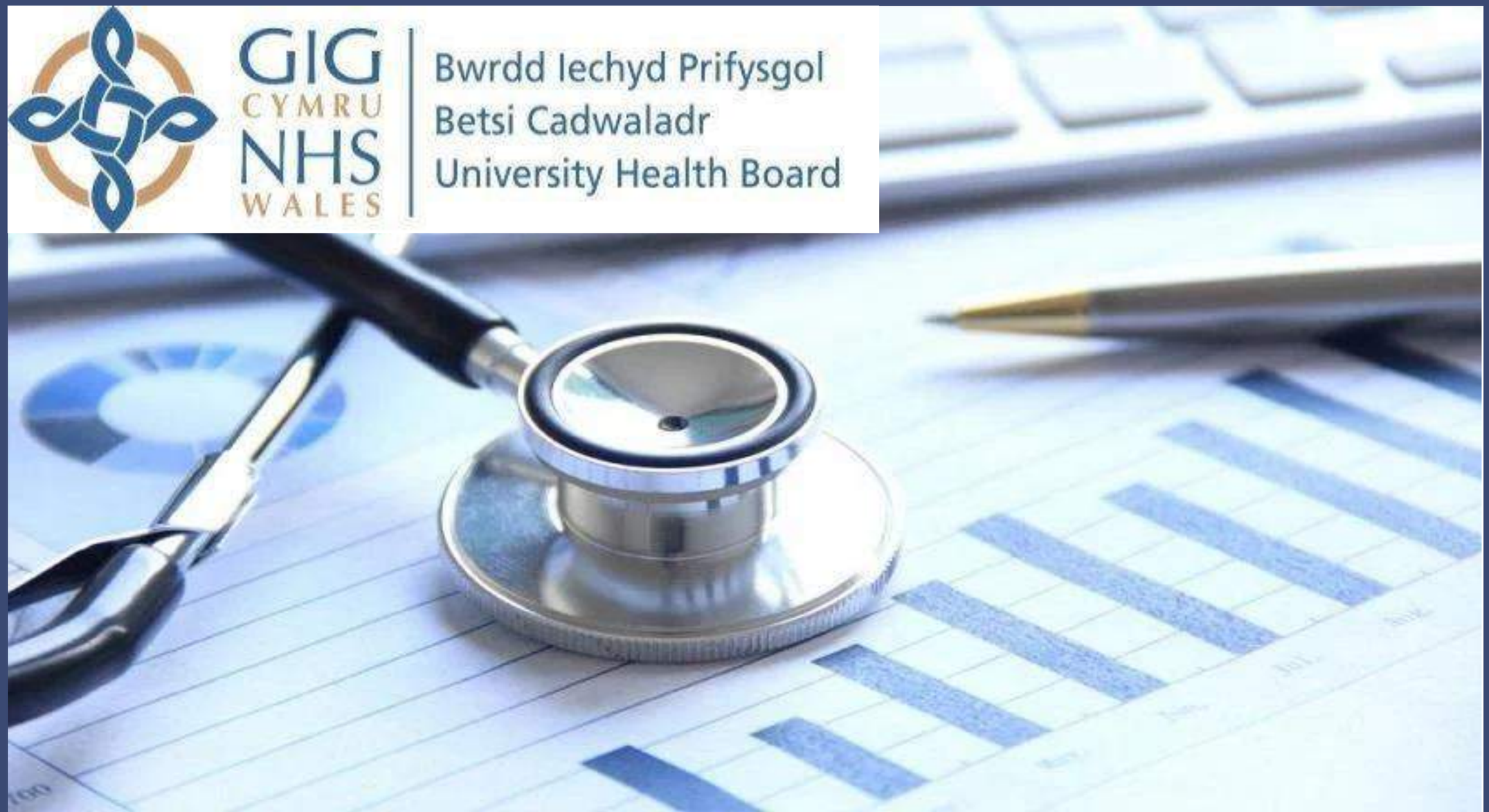
	delivery of existing mechanisms/objectives	*existing mechanisms / objectives*	*existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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 option.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The use of the Mental Health Act Sections apply to all persons All policies in relation to the use of the Mental Health Act have been equality impact assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The patient information recorded to produce the reports required for the Health Board, Welsh Government, and North Wales Police also assists the Health Board in the management of the Mental Health Act functions such as expiry dates, consent to treatment, patient history, movements and deadlines. This data is currently recorded within excel databases which have been identified as unsustainable and difficult to future proof due to the amount of data held and detentions the Health Board experiences. This has been raised as a concern by the Chair of the Mental Health Capacity and Compliance Committee and by the Performance department. Discussions are ongoing as to a more safe and robust way of storing and reporting data between Performance and Information Technology (IT), with a recent demonstration and presentation in regards to WCCIS being provided, this system appears to cover the majority of what is recorded currently but a timescale of potentially 12 months to implementation was

	advised, a meeting is to be held on the 21st of November to explore this system and reporting requirements in detail. 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 was one fundamentally defective section and ten sections which lapsed. The lapsed detentions consisted of two x S2 and eight x S136. These are reported as exceptions within the report.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The increase in Mental Health Act detentions has financial implications.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None required
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report and data has been seen by those listed below and been submitted to the groups detailed. Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience Power of Discharge Group 23/09/2022 Mental Health & Learning Disability Senior Leadership Team Quality and Safety Group 18/10/2022
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:***	

Implementation of recommendations
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 MHA Committee Performance Report June – September 2022 Appendix 2 S136 BCUHB Report – September Appendix 3 S136 CAMHS Report – September

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



Mental Health Capacity and Compliance Committee Performance Report

September 2022

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

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Report to Mental Health Capacity and Compliance Committee Additional Appendices will be included as requested.

This report provides assurance to the Mental Health Capacity and Compliance 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 Capacity and Compliance 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.

T

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 ten sections lapsed: two x S2 lapsed: (INC10524) the Doctor in charge of the patients detention did not complete and return the forms, the office omitted to chase this on the day of expiry due to workload, the patient was reassessed and detained on a S3. Learning has included Responsible Clinicians being included in a weekly reminder email and telephone communication being instigated. (INC9597) lapsed due to the Doctor in charge of the patients detention failing to complete the paperwork prior to taking leave. There was no doctor aviailable to conduct a review, the patient has since been made subject to DOLS (Deprivation fo Liberty Safeguards) learning has included the Responsible Clinician being included in the weekly reminder email.

Eight S136s lapsed: three due to the patients not being fit for assessment at the time of writing none of these people have been subject to any further S136s and all were eventually discharged from the general hospital. (INC9869, 10864 and 10307). Five sections expired whilst the detainees were undergoing an assessment three were made subject to a detention under the Mental Health Act, one was referred to services and one agreed to informal admission.

There is one fundamentally defective section to report: (INC13834) A section 2 was found to be invalid on direct admission from England as the medical recommendations contained the typed name of the medic, the duty nurse did pick this error up on admission but due to the medics not being available to sign prior to admission the detention was therefore not valid. The patient agreed at that time to stay informally at the unit.

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

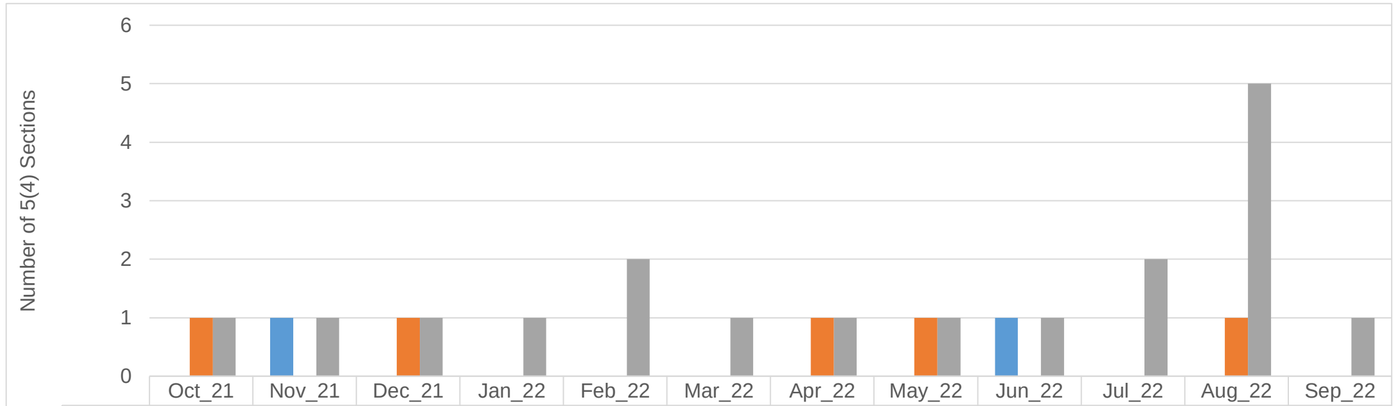
Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

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	September 2022	August 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	1	6	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
9	6	↑	6

Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
1	East	8
2	Centre	1
3	West	0



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	1	0	0	0	0	0	0	1	0	0	0
Centre	1	0	1	0	0	0	1	1	0	0	1	0
East	1	1	1	1	2	1	1	1	1	2	5	1

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

All sections this period met the criteria.

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

LAPSES

There were no section 5(4)s noted to have lapsed within this period.

WEST

The data above does	Duration (hh:mm)	Outcome

d

CENTRE

Month	Duration (hh:mm)	Outcome
Aug_22	03:23	Section 5(2)

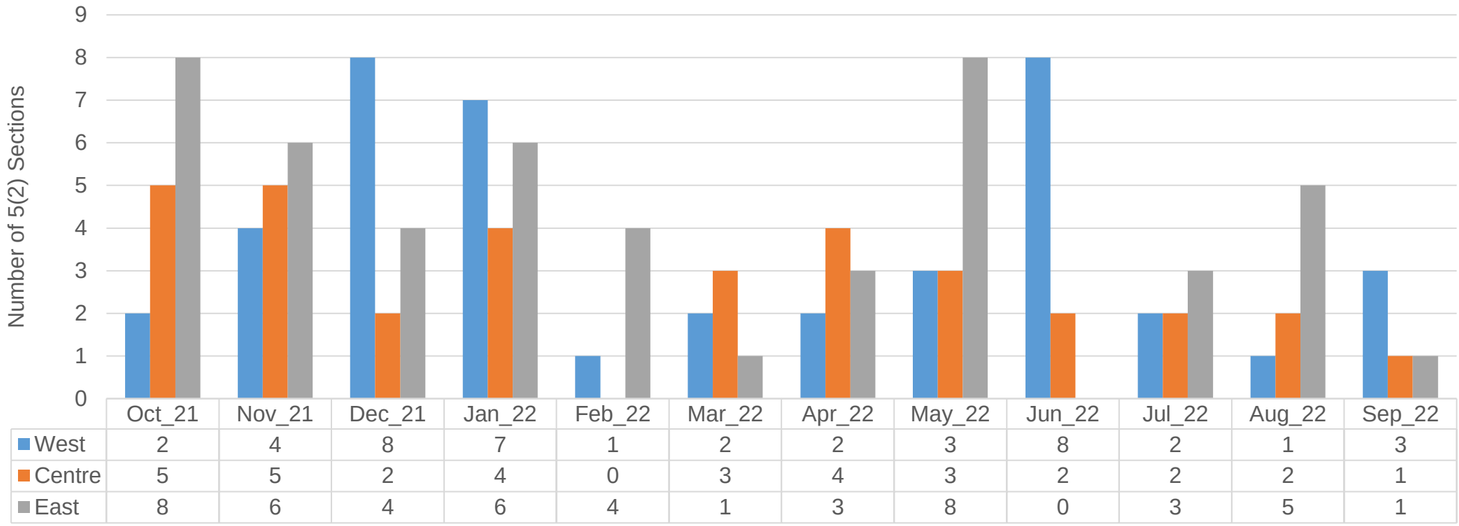
EAST

Month	Duration (hh:mm)	Outcome
Jul_22	00:09	Section 5(2)
Jul_22	01:58	Section 5(2)
Aug_22	01:20	Section 5(2)
Aug_22	05:05	Informal
Aug_22	00:15	Informal
Aug_22	05:55	Informal
Aug_22	03:35	Section 5(2)
Sep_22	03:30	Section 5(2)

Advisory Report - Section 5(2)

Section 5(2) - BCUHB	September 2022	August 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	5	8	↓

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
20	33	↓	31	1	East	9
				2	West	6
				3	Centre	5



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	2	4	8	7	1	2	2	3	8	2	1	3
Centre	5	5	2	4	0	3	4	3	2	2	2	1
East	8	6	4	6	4	1	3	8	0	3	5	1

Section 5(2) Outcomes

	Jul 2022	Aug 2022	Sep 2022
Section 2:	2	2	4
Section 3:	1	4	1
Informal:	2	1	1
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	3	1	0
Other:	0	0	0

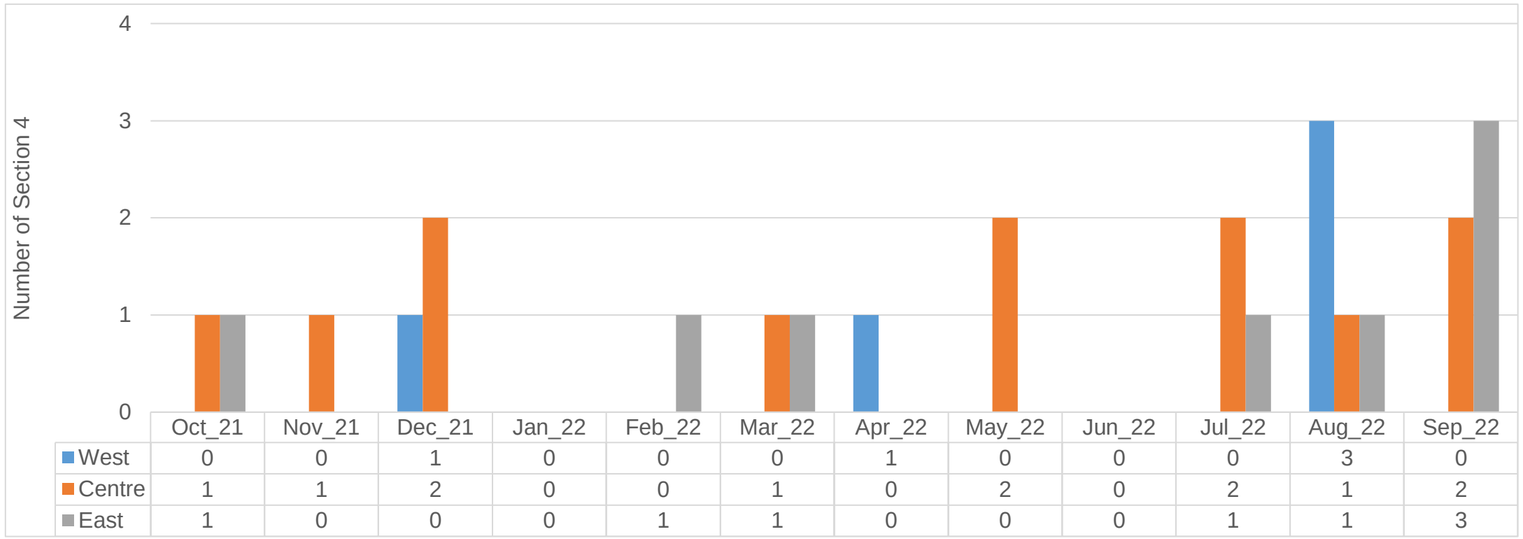
d

A Section 5(2) on occasions will be enacted within the acute hospital wards, during this period there were no detentions in the acute hospitals.

EXCEPTIONS
There are no exceptions to report this period:

Section 4 - BCUHB	September 2022	August 2022	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	5	5	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
13	3	↑	6	1	Centre	5
				1	East	5
				3	West	3



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	0	1	0	0	0	1	0	0	0	3	0
Centre	1	1	2	0	0	1	0	2	0	2	1	2
East	1	0	0	0	1	1	0	0	0	1	1	3

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

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

There are no exceptions to report.

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

Three of the section 4 admissions were noted to be due to risks and safety requiring immediate admission, ten of the detentions noted a risk in waiting for a second doctor who was not immediately available and the need for immediate admission.

WEST

The data above does	Duration (hh:mm)	Outcome
Aug_22	28:34	Section 2
Aug_22	38:45	Section 3
Aug_22	13:00	Informal

d

CENTRE

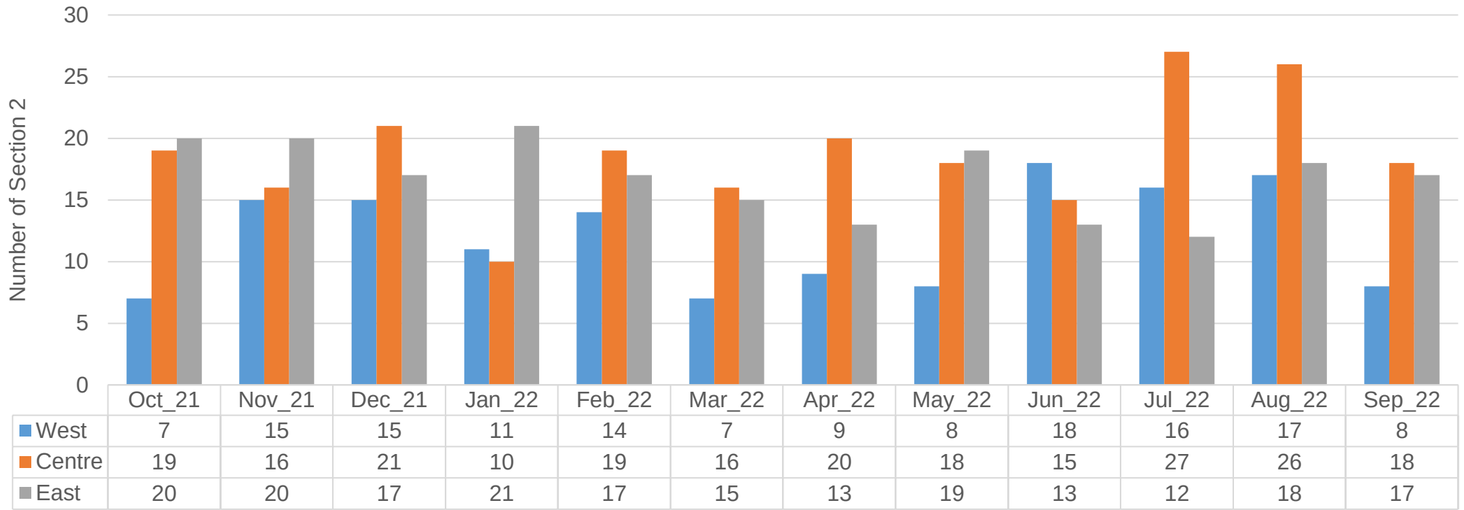
Month	Duration (hh:mm)	Outcome
Jul_22	16:45	Section 2
Jul_22	24:00	Section 2
Aug_22	64:15	Section 2
Sep_22	20:05	Section 2
Sep_22	20:40	Section 2

EAST

Month	Duration (hh:mm)	Outcome
Jul_22	11:00	Section 2
Aug_22	35:28	Section 2
Sep_22	39:55	Informal
Sep_22	12:35	Section 2
Sep_22	26:58	Section 2

Advisory Report - Section 2

Section 2 - BCUHB	September 2022	August 2022	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
Section 5: Admission for assessment	43	61	↓	159	133	↑	143	1	Centre	71
								2	East	47
								3	West	41



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	7	15	15	11	14	7	9	8	18	16	17	8
Centre	19	16	21	10	19	16	20	18	15	27	26	18
East	20	20	17	21	17	15	13	19	13	12	18	17

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

Section 2 Outcomes

	Jul 2022	Aug 2022	Sep 2022
Section 3:	13	13	15
Informal:	15	22	18
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	4	6	6
Transferred:	14	15	10
Invalid and Other:	1	0	0

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

Section 2 is also used as a direct admission detention.

There were nine under 18s placed on a Section 2 this period, five as direct admissions, one regraded from informal and three following S136 assessments.
.

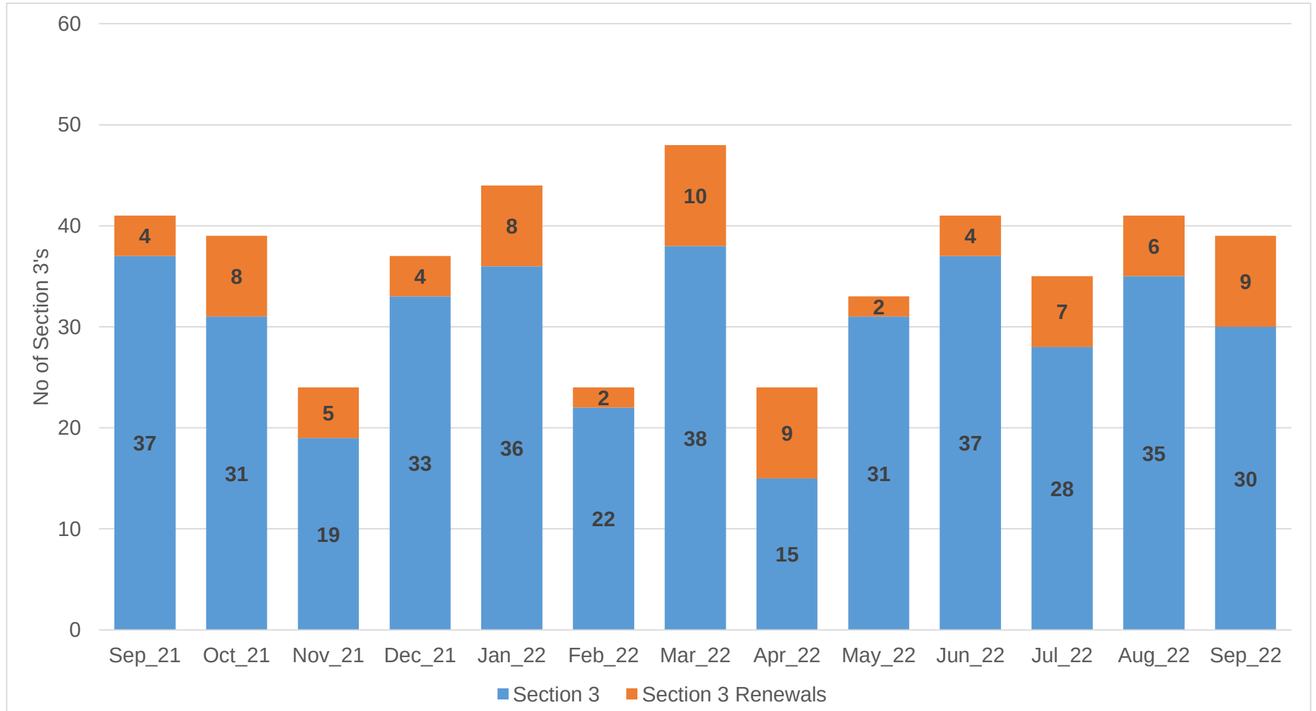
EXCEPTIONS:

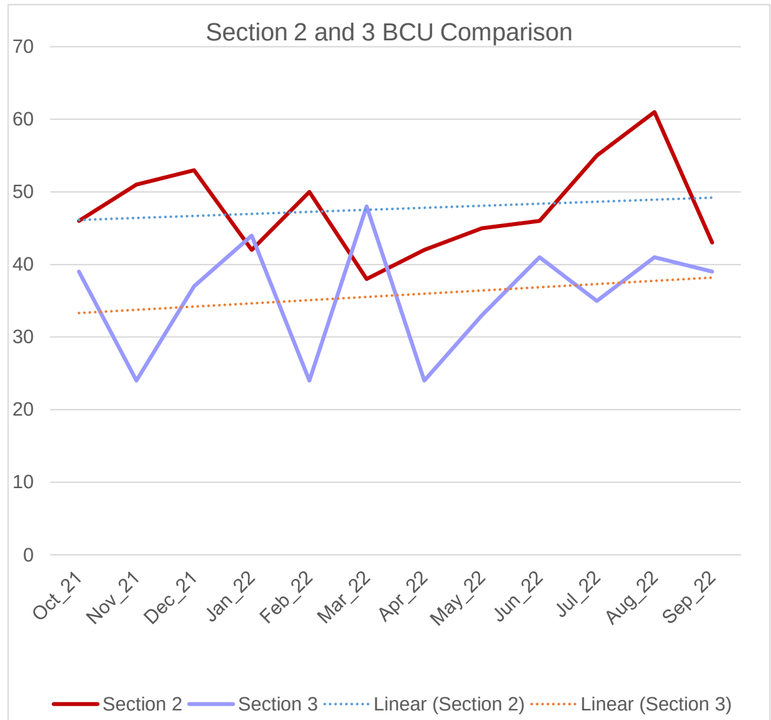
There are three exceptions to report this period. Two lapsed detentions from June.
EAST: A section 2 lapsed due to the RC not completing and no other available doctor to cover, RCs have now been included on the weekly Acute Care Meeting (ACM) reminder email. (INC 9597).
WEST: A section 2 lapsed due to the RC not completing, this was not followed up verbally. As above RCs are now included in the ACM email and staff have been advised to telephone rather than email (INC10524).
CENTRAL: A section 2 was deemed invalid as the signature was electronic on the english medical recommendation, this was picked up by the duty nurse but due to the medics being in England these were not able to be signed immediately. (INC13834)

Section 3 - BCUHB	September 2022	August 2022	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	39	41	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
115	98	↑	107

Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
1	East	40
2	West	38
3	Centre	37





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

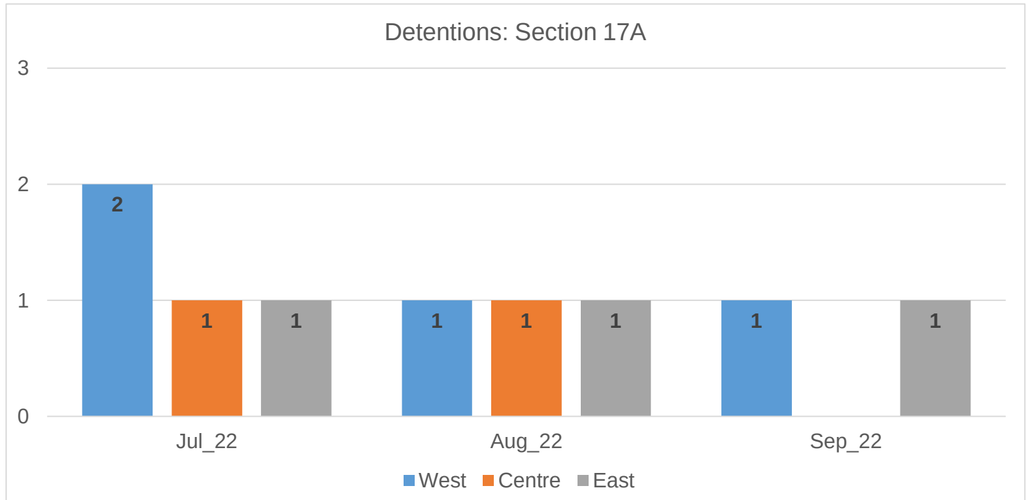
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

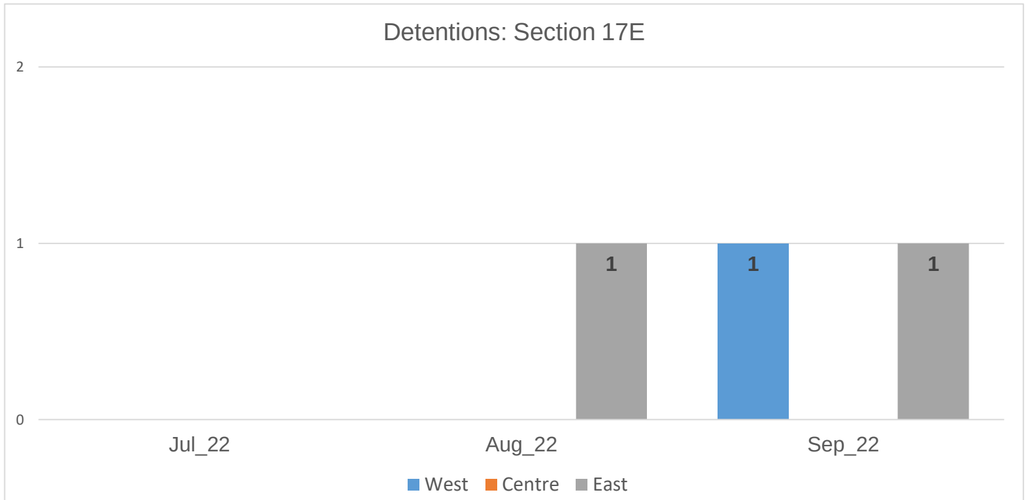
This period there were no under 18s made subject to a section 3. The trend over the 12 months at the end of September has risen for section 2/

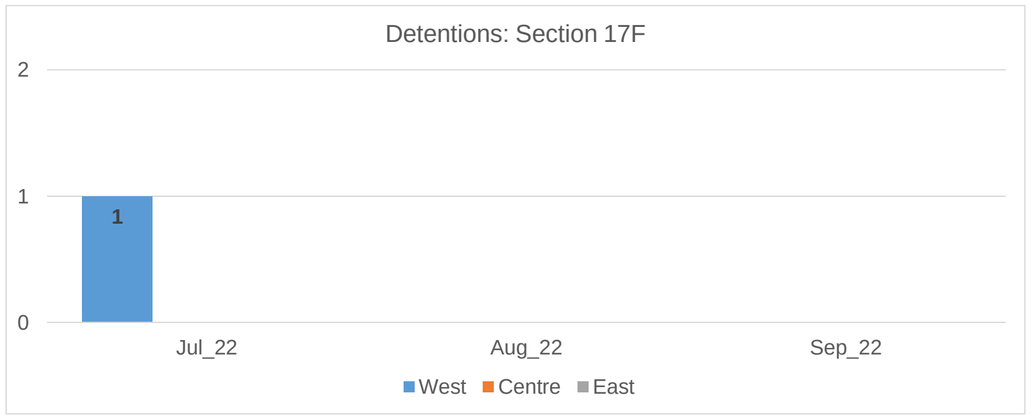
There are no exceptions to report this quarter.

Section 17 A-F - BCUHB	September 2022	August 2022	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	4	4	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
13	18	↓	15	1	West	6
				2	East	5
				3	Centre	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 September West:8, Central: 3 and East: 8.

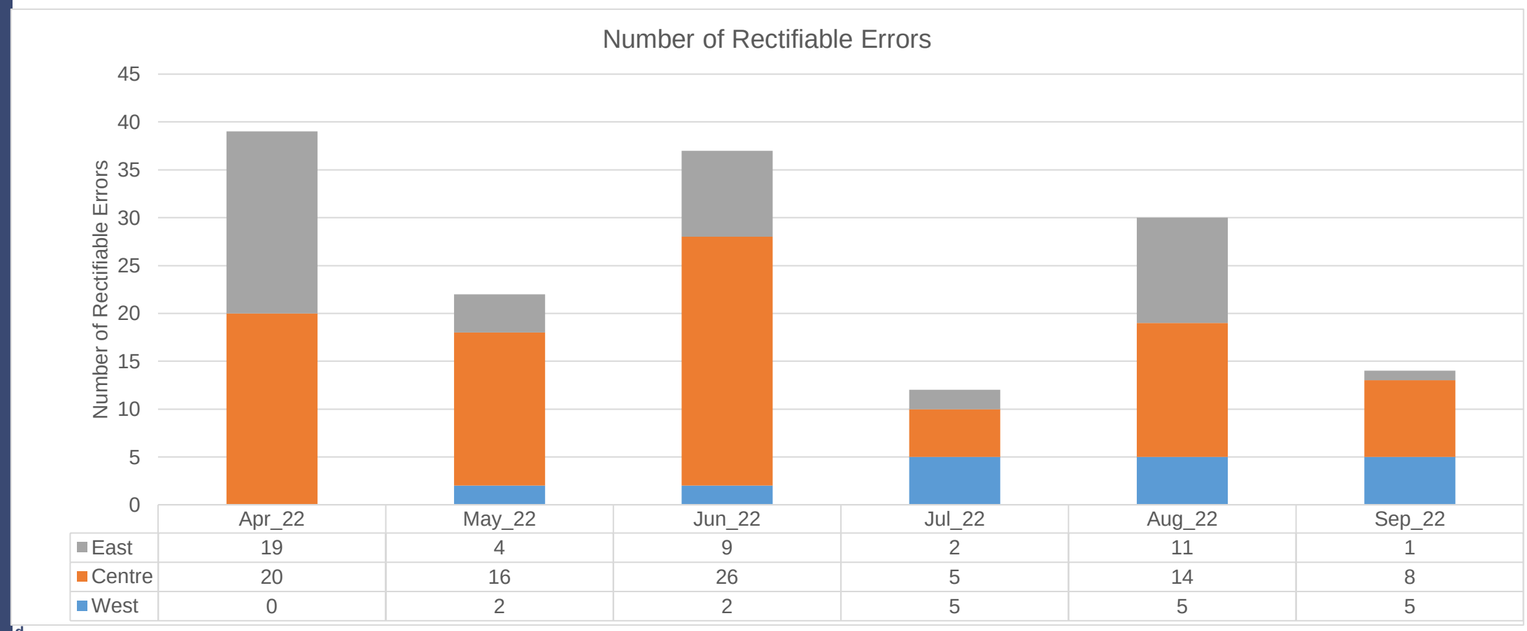
There has been a decrease in the number of patients subject to a CTO for Central and an increase for East.

Exceptions: None to report this period.

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	September 2022	August 2022	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	14	30	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	Centre	28
				2	West	15
				3	East	14



	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
East	19	4	9	2	11	1
Centre	20	16	26	5	14	8
West	0	2	2	5	5	5

Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales.The latest report received covers April - June 2022.

The report confirms BCUHB:
* accounted for the highest number of inpatient detentions.
* was ranked 2nd for inpatient detentions when considering Health Board population.
* is not an outlier for fundamentally defective applications and accounted for 15% with one Health Board accounting for 45%.
* is not an outlier for rectifiable errors and accounted for 36% with one Health Board accounting for 47%.

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

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

This period there has been one fundamentally defective section under section 2.

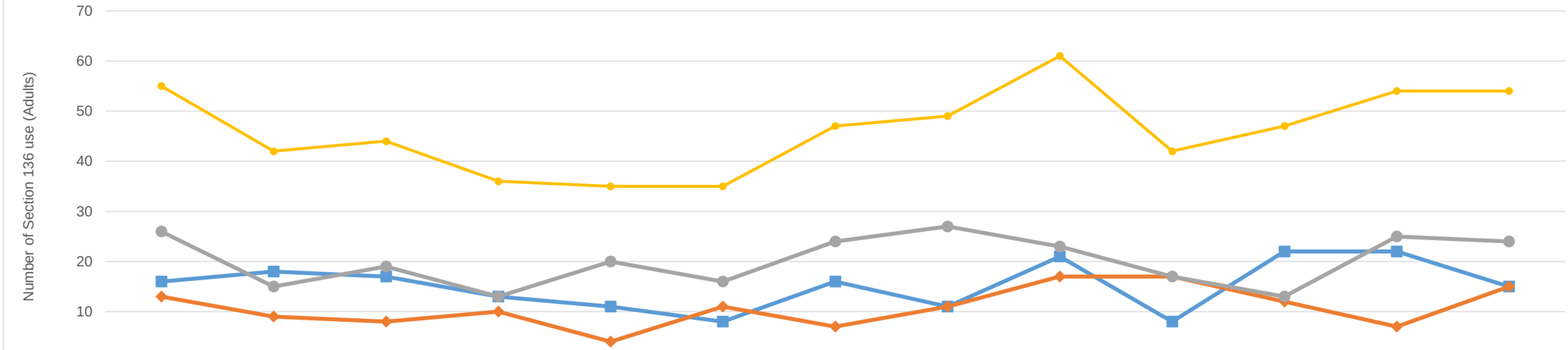
This period there has been ten lapsed Sections - two x section 2 and eight x section 136.

Advisory Report - Section 135 and 136

Section 135 - 136	September 2022	August 2022	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	54	54	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
155	152	↑	137

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	62
2	West	59
3	Centre	34



	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	16	18	17	13	11	8	16	11	21	8	22	22	15
Centre	13	9	8	10	4	11	7	11	17	17	12	7	15
East	26	15	19	13	20	16	24	27	23	17	13	25	24
BCU	55	42	44	36	35	35	47	49	61	42	47	54	54

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

There have been four S135 detentions this period resulting in one detention under S2 and three under S3.
Eight Section 136 lapsed this quarter, INC9869, INC10864 and INC10307 were due to the detainees being unfit for assessment, all were discharged from hospital and have not been subject to any further detentions to date. Five lapsed as the assessments overran the S136 24 hour timeframe three were detained under S2, one was referred to services and one resulted in an informal admission.
During this period there were three custody detentions noted as the first place of safety, all were discharged, two with follow up from services and one referral.
Six requests for extensions were made this period, one resulted in a detention under S2, on informal admission and four were discharged with follow up or referral to services.

Advisory Report - Section 135 and 136

Section 136	September 2022	August 2022	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	54	54	→

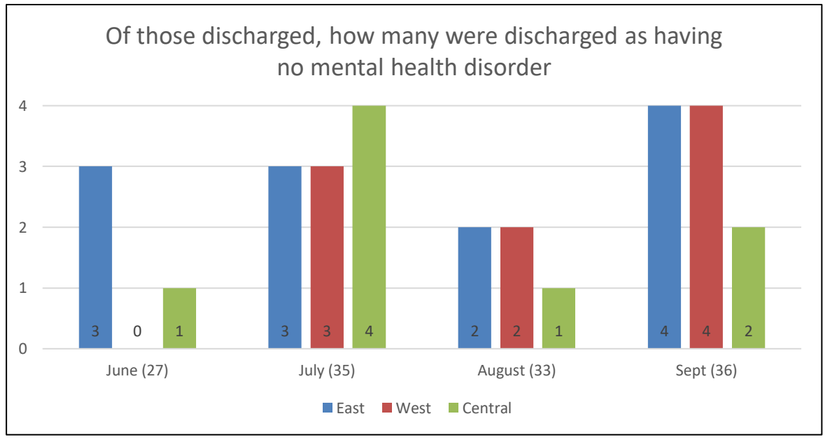
Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
155	152	↑	137	1	East	62
				2	West	59
				3	Centre	34

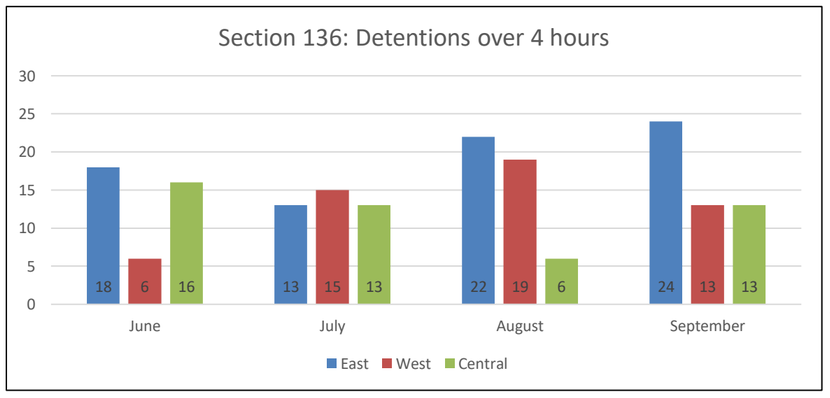
Section 136 Outcomes

	Jul 2022	Aug 2022	Sep 2022
Discharged:	35 70.00%	33 58.92%	36 64.28%
Informal Admission:	5 10.00%	7 12.50%	5 8.92%
Section 2:	9 18.00%	14 25.00%	9 16.07%
Section 3:	1 2.00%	0 0.00%	3 5.36%
Other:	0 0.00%	2 3.57%	3 5.36%

Section 136 - Known to Service

	Jul 2022	Aug 2022	Sep 2022
Yes	27	20	32
Yes (percentage)	54.00%	35.71%	57.14%





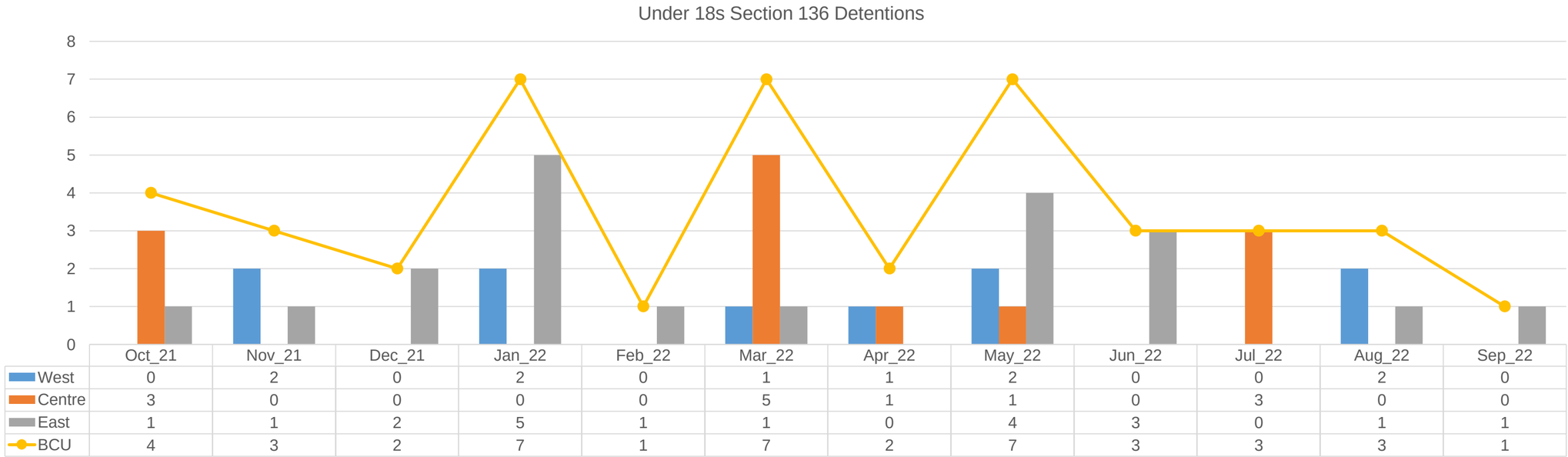
The data shows figures from outcomes recorded and whether a patient is known to service. A large proportion of 136's are discharged those with no mental disorder has historically been around 20%.

Total percentages of all detentions for those discharged with no mental disorder (rounded up) are:
June 9% July 20%
August 9% September 18%

Data below shows the percentage of the detentions discharged that are followed up by services or new referrals into services these figures are rounded up/down as appropriate:
June 48% discharged follow up, 37% referred to services.
July 57% discharged follow up, 14% referred to services.
August 61% discharged follow up, 24% referred to services.
September 36% discharged follow up and 36% were 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 259 people have not become detained on a S136 due to CJLS intervention. This period accounts for 23 of those figures.
Data is now being recorded in relation to those that do progress to being detained on a S136 following consultation, since September 2020 there have been 124 instances.

Section 135 - 136 (Under 18)	September 2022	August 2022	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)	1	3	↓	7	12	↓	11	1	Centre	3
								2	East	2
								2	West	2



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	2	0	2	0	1	1	2	0	0	2	0
Centre	3	0	0	0	0	5	1	1	0	3	0	0
East	1	1	2	5	1	1	0	4	3	0	1	1
BCU	4	3	2	7	1	7	2	7	3	3	3	1

A total of ten under 18's were assessed this period between the ages of 11 and 17 years. Four assessment resulted in admission, three initially to the adult unit prior to transfer to appropriate services. five assessments resulted in discharge with follow up to services and one discharge was noted due to no mental disorder.

d

The tables below shows the ages of young persons assessed and the outcomes for the year period April 22 - March 23.

5

Under 18 Assessments	
AGE	Number of Assessments
11	1
13	2
14	5
15	1
16	1
17	9

Outcome of Assessments	
Outcome	Number
Returned Home	5
Returned to Care Facility	10
Admission to childrens ward	0
Admission to Adult ward / S136 suite	3
Admission NWAS / CAMHS	1
Admission OOA	0
Other (Friends, Hotel, B&B)	0

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
June	Heddfan	Discharged	CAMHS	18:30	14
June	Heddfan	Discharged	CAMHS	14:05	14
June	Heddfan	Discharged	CAMHS	17:20	17
July	Ablett	Discharged	CAMHS	16:40	14
July	Ablett	Discharged	CAMHS	20:10	17
July	Ablett	Admission	CAMHS	21:40	13
August	Hergest	Admission	CAMHS	24:00 hr	13
August	Wrexham Maelor	Admission	CAMHS	22:00	16
August	Hergest	Discharged	CAMHS	17:31	11
September	Heddfan	Admission	CAMHS	24:00 hr	17

Out of the ten young persons assessed four originated from their own home, five from a placement, one was noted as no fixed abode.
Eight 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: 19:49 hrs this is an increase on the previous quarter figures of (14:53 hrs).
Two detentions lapsed whilst the young persons were being assessed, total time from acceptance of S136 to conclusion was 26:15 hours and 24:22 hours.

Under 18's admitted to Adult Psychiatric Wards
There was a direct admission to a unit under section 2 of a young person total duration 2 days and 12 hours hours prior to being discharged.
Three young persons remained in the S136 suite following assessment for 27:38 hours, 23:25 hours and 15:13 hours prior to admission to suitable services.
The table below shows the county that the young persons originated from and where they were assessed for the period April 22 - March 23

County Originated from and where assessed:

	East	Central	West
Wrexham	5	0	2
Flintshire	2	1	0
Denbighshire	1	1	0
Conwy	0	1	1
Gwynedd	0	0	1
Ynys Môn	0	2	1
Out of Area/NFA	1	0	0

Section	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022
Section 35:	0	0	1	1	0	0	0	0	0	0	0	0
Section 37:	1	1	1	1	0	1	1	1	1	1	2	2
Section 37/41:	8	8	8	8	8	8	8	7	5	5	5	5
Section 38:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47:	1	1	1	1	1	1	2	2	2	1	2	2
Section 47/49:	3	3	3	3	3	3	2	3	3	2	2	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	1	1	1	1	2	2	2	2	2	2	2
Section 3:	4	4	5	5	4	3	3	3	4	4	4	4
Section 45A	0	0	0	0	0	0	0	0	0	0	0	0
Total:	17	18	20	20	17	18	18	18	17	15	17	18

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility.
The nature of the forensic sections does not always generate rapid activity. There are times when section 3 patients will be detained within the unit.

There are no exceptions to report.

Advisory Report - Transfers

Total Transfers for the Quarter

	Jul 2022	Aug 2022	Sep 2022
Internal Transfers	13	11	5
External Transfers (Total)	8	6	2
External Transfers (In)	2	3	0
External Transfers (Out)	6	3	2

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

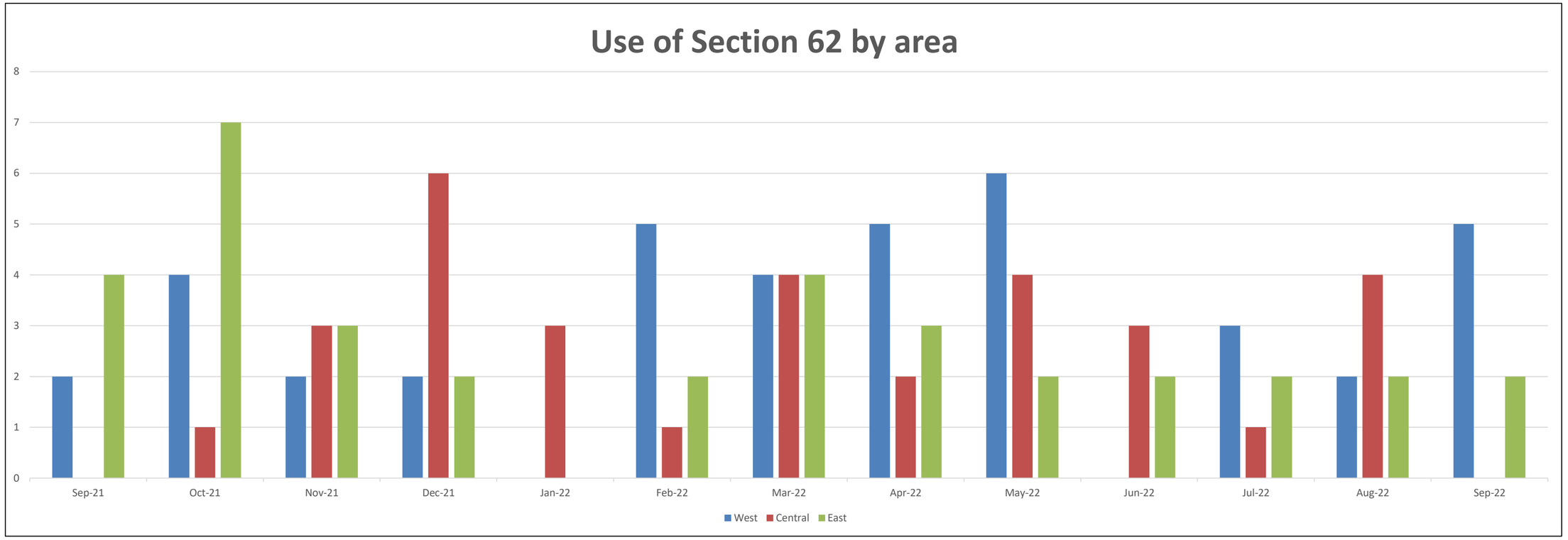
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised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

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

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 69 detained patients within independent hospitals this is three less than last reported. 29 of these are outside of Wales ie out of area placements, this is the same as last reported.

Month	Transfers In
Jun_22	Stafford (Denbighshire)
Jul_22	Priory, Darlington (Conwy)
Jul_22	Cygnet Stevenage (Conwy)
Aug_22	Priory, Hassocks (Conwy)
Aug_22	Godden Green, Cygnet (Denbighshire)
Aug_22	Ty Grosvenor (Wrexham)

Month	Transfers Out
Jul_22	St Mary's Warrington (Gwynedd)
Jul_22	Joyce Parker Hospital, Coventry (Conwy)
Jul_22	Cygnet Hospital Godden Green (Denbighshire)
Jul_22	The Priory Hospital Brent Green (Wrexham)
Jul_22	returned to Berwyn (Conwy)
Jul_22	The Priory Sussex (Gwynedd)
Aug_22	Halton Hospital, Runcorm (Repatriated)
Aug_22	Llandough Hospital (Repatriated)
Aug_22	Cygnet Hospital Bury. PICU (Conwy)
Sep_22	Cygnet Hospital Sheffield (Flintshire)
Sep_22	Nottingham (Conwy)



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

Reason for S62 use:
Medication changes
Patient no longer able to give consent to treatment or refusing consent
ECT
Awaiting a Second Opinion Appointed Doctor (SOAD) to arrive and three month consent to treatment has expired.

APPENDIX 2

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

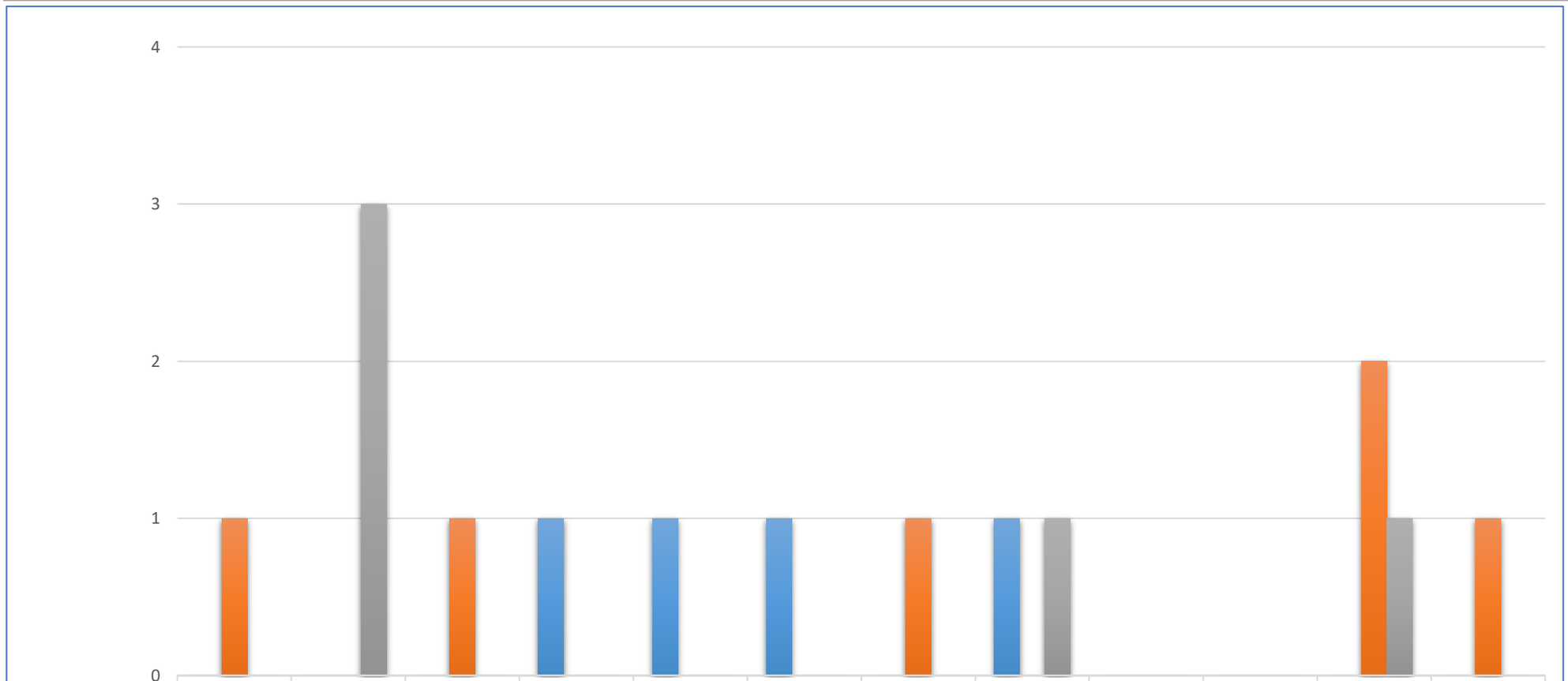
S.136/135 use in BCUHB

KPI Report for: September 2022

Data Source:	BCUHB MHA Database
Report Created on:	04/10/2022
Report Created by:	Performance Directorate

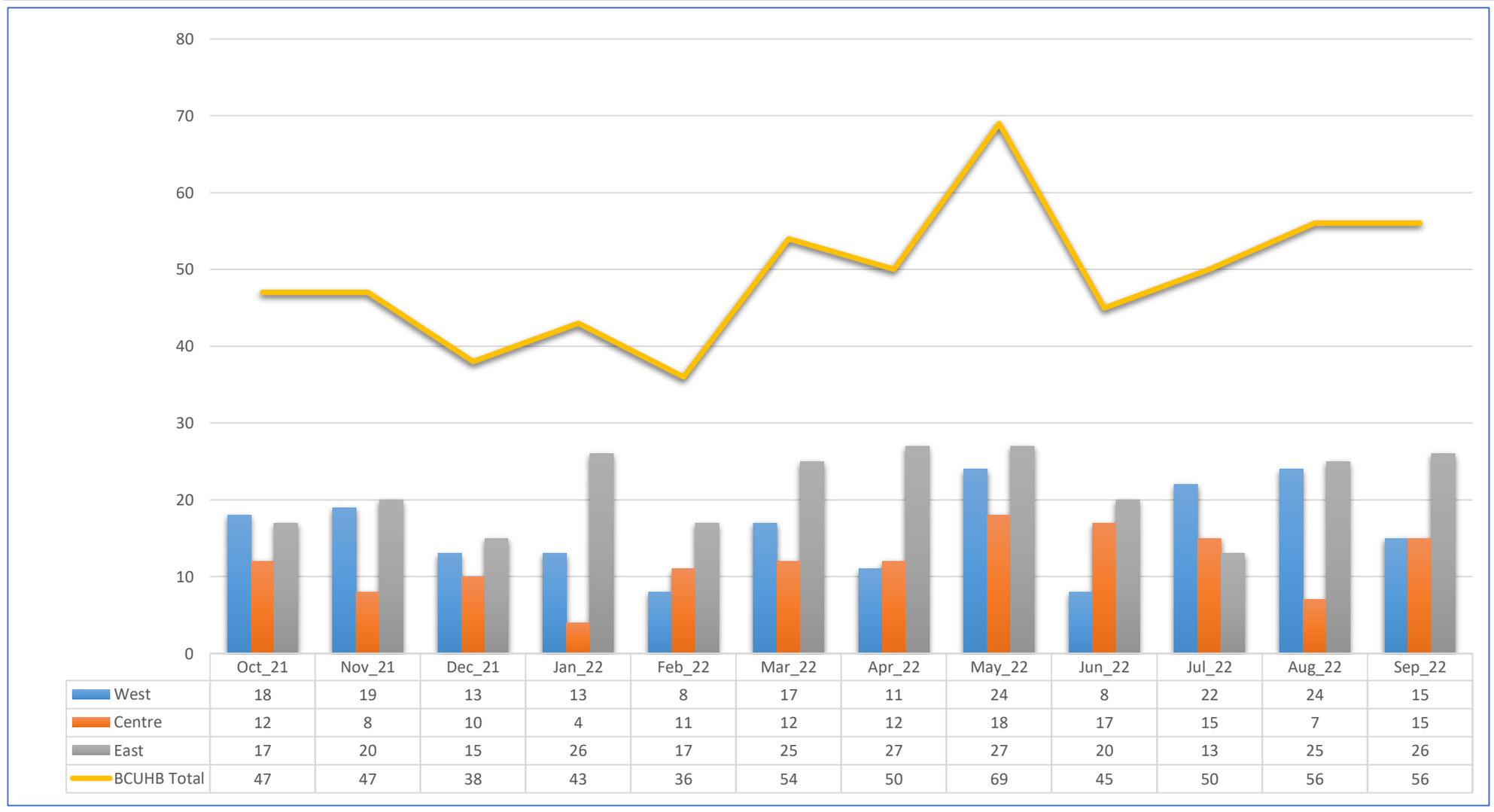
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Sep_22



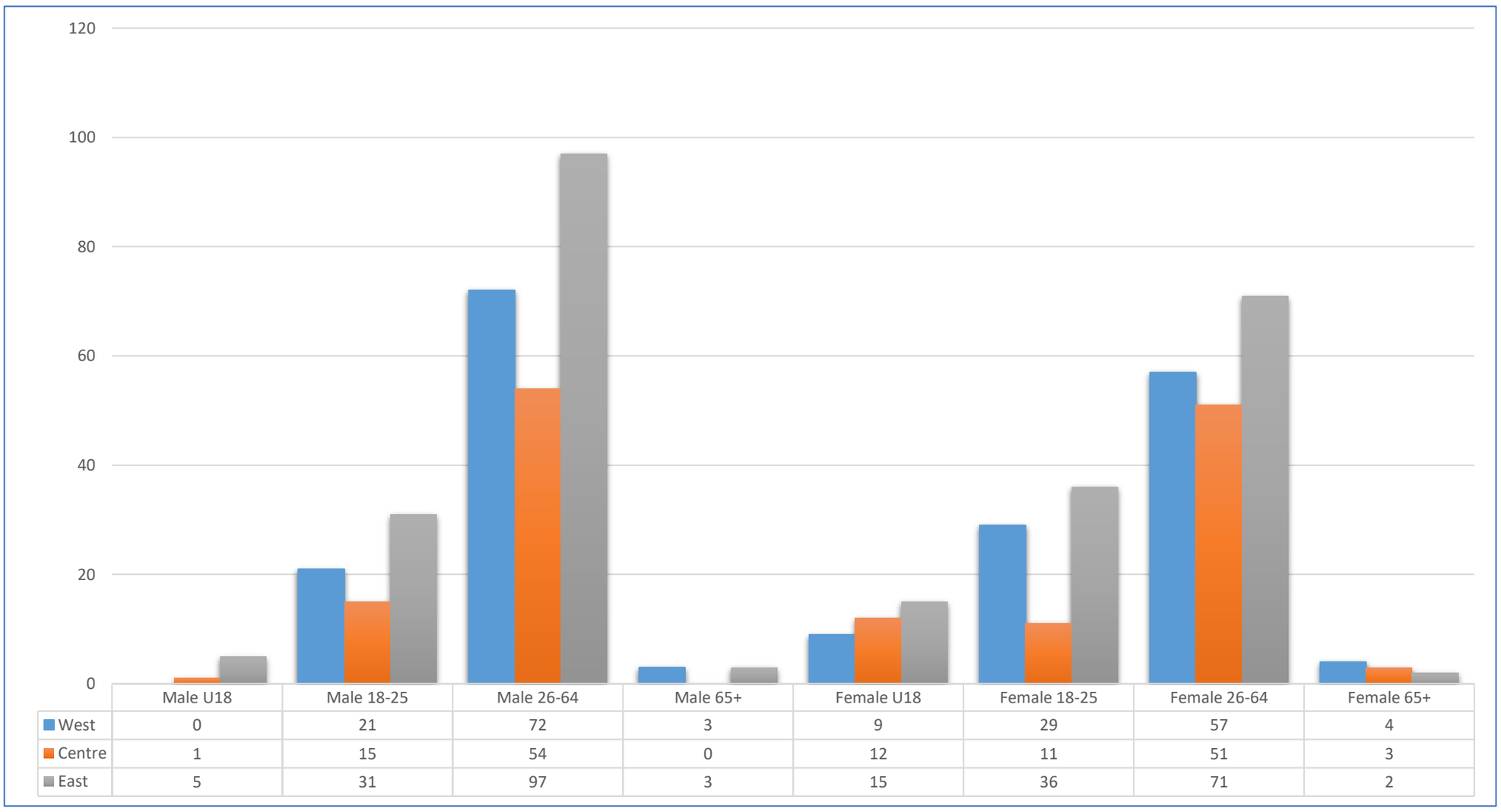
	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	0	0	1	1	1	0	1	0	0	0	0
Centre	1	0	1	0	0	0	1	0	0	0	2	1
East	0	3	0	0	0	0	0	1	0	0	1	0

2.1: Section 136 twelve month trend up to and including Sep_22



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	18	19	13	13	8	17	11	24	8	22	24	15
Centre	12	8	10	4	11	12	12	18	17	15	7	15
East	17	20	15	26	17	25	27	27	20	13	25	26
BCUHB Total	47	47	38	43	36	54	50	69	45	50	56	56

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	0	21	72	3	9	29	57	4
Centre	1	15	54	0	12	11	51	3
East	5	31	97	3	15	36	71	2

4: 1st Place of Safety 12 month trend up to and including Sep_22

Area Split - 1st Place of Safety by category

	Sep_22			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	7	8	9	62	51	77
Ward	0	0	0	0	0	1
PICU	0	0	0	0	0	0
136 Suite	8	7	20	127	84	180
Hospital	0	0	1	2	0	1
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	0	5	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	0	0

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

1st Place of Safety: A&E Split	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	4	4	2	4	3	5	3	11	2	7	10	7
Centre	4	0	2	1	2	7	3	6	9	6	3	8
East	2	7	6	7	4	6	8	6	9	3	10	9

1st Place of Safety: 136 Suite Split	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	14	15	11	9	5	12	9	11	5	14	14	8
Centre	8	8	8	3	9	5	7	11	7	7	4	7
East	14	12	9	18	13	18	19	20	11	10	16	14

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

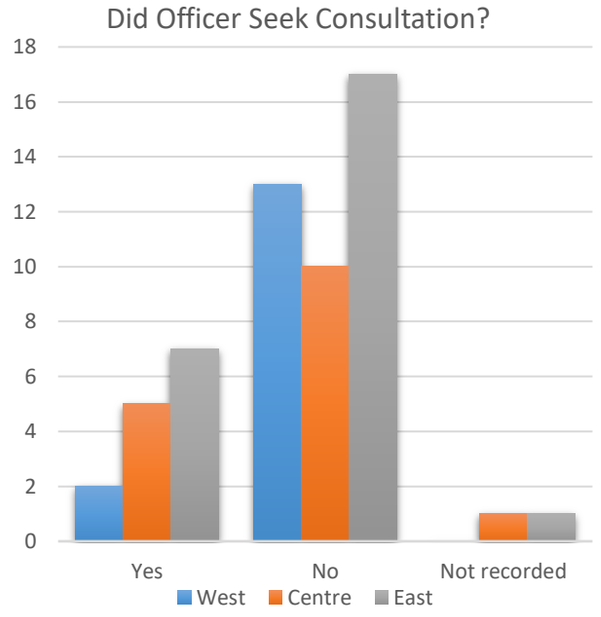
5.1: Area split 3 month table up to and including Sep_22 and latest 12 month total

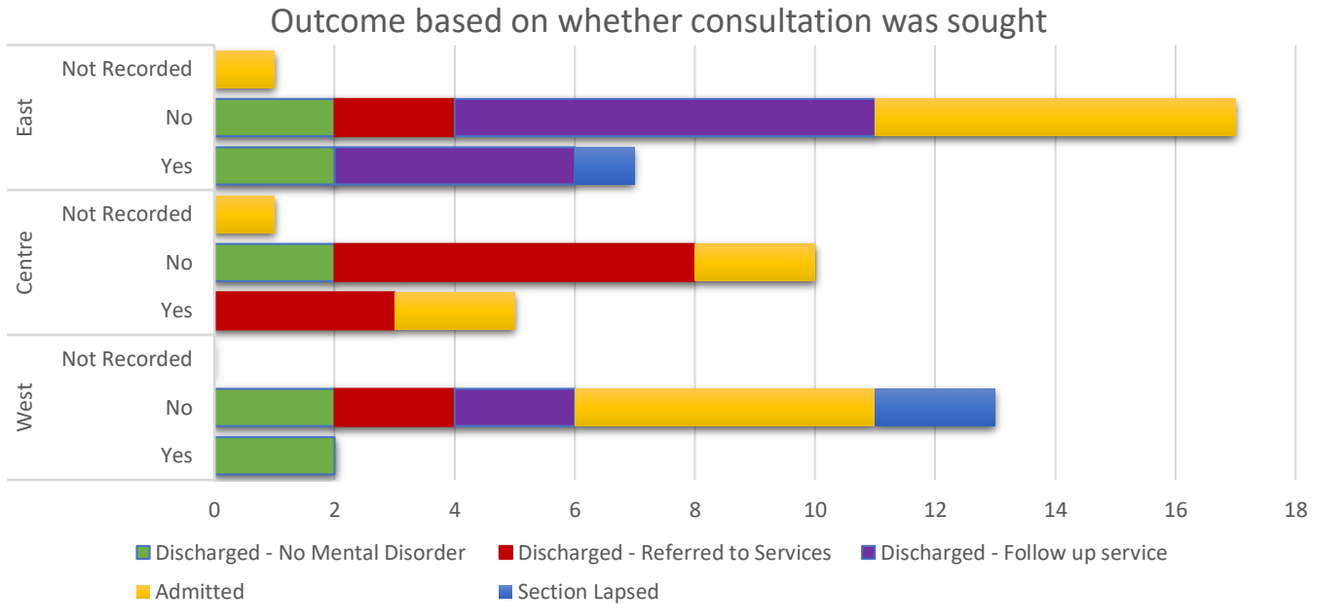
West	Jul_22	Aug_22	Sep_22	**12 Month Total**	**Centre**	Jul_22	Aug_22	Sep_22	**12 Month Total**	**East**	Jul_22	Aug_22	Sep_22	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	2	3	2	**32**	Ynys Mon	3	2	0	**10**	Ynys Mon	0	0	0	**4**	Ynys Mon	**6.56**
Gwynedd	15	7	8	**82**	Gwynedd	2	0	1	**17**	Gwynedd	0	1	2	**14**	Gwynedd	**9.14**
Flintshire	2	1	0	**9**	Flintshire	1	0	0	**16**	Flintshire	7	3	7	**76**	Flintshire	**6.52**
Wrexham	0	0	1	**12**	Wrexham	4	0	1	**12**	Wrexham	4	17	14	**124**	Wrexham	**10.64**
Conwy	1	2	2	**27**	Conwy	2	2	6	**29**	Conwy	2	2	2	**15**	Conwy	**6.07**
Denbighshire	2	6	1	**23**	Denbighshire	3	3	6	**55**	Denbighshire	0	3	0	**23**	Denbighshire	**10.57**
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	**0**	OOA	0	0	0	**0**	OOA	**#N/A**
Incident Rate per 10,000 population	1.13	0.98	0.72	**9.54**	Incident Rate per 10,000 population	0.71	0.33	0.66	**6.54**	Incident Rate per 10,000 population	0.44	0.88	0.85	**8.71**	BCUHB	**8.28**

***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

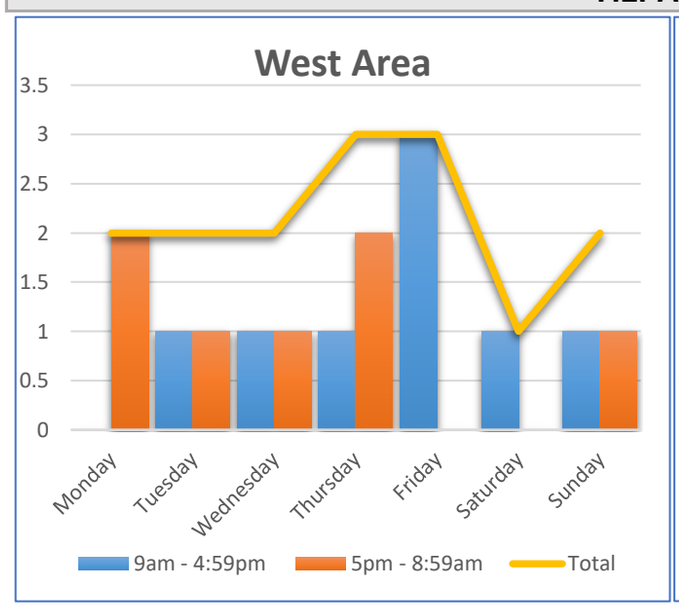
Section B: 12 Month Data for Sep_22

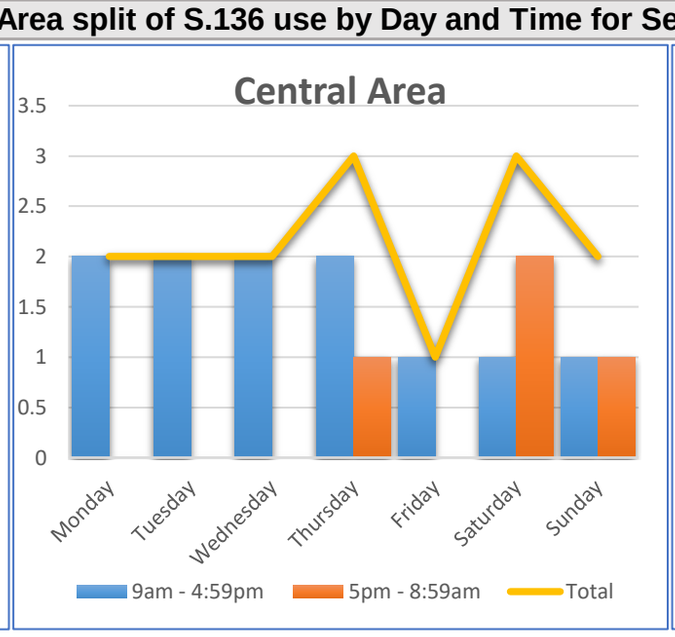
6.1: Consultations and Outcomes all areas during Sep_22

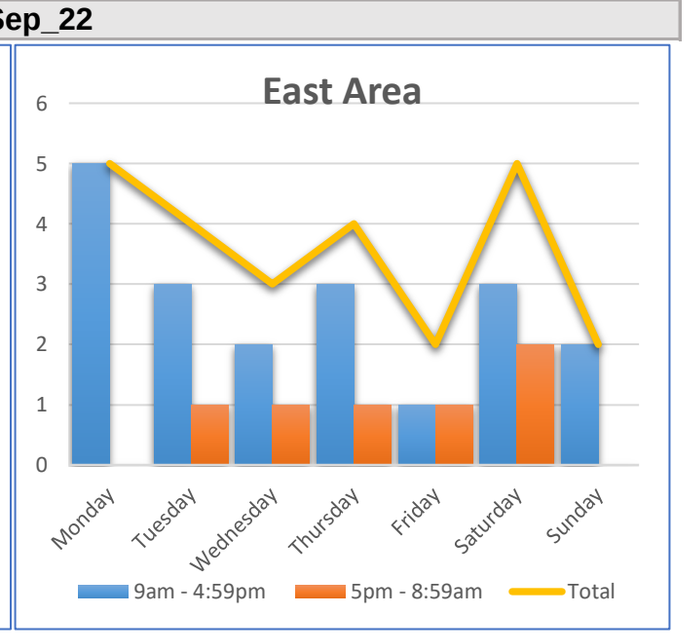




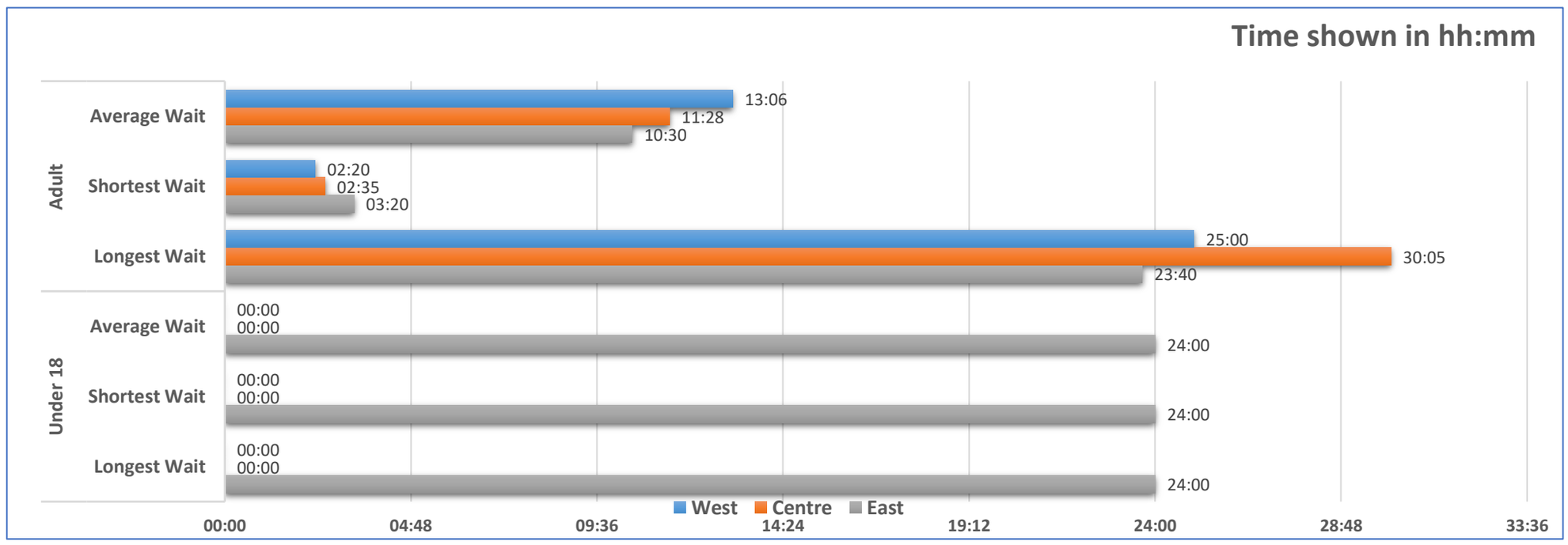
7.1: Area split of S.136 use by Day and Time for Sep_22



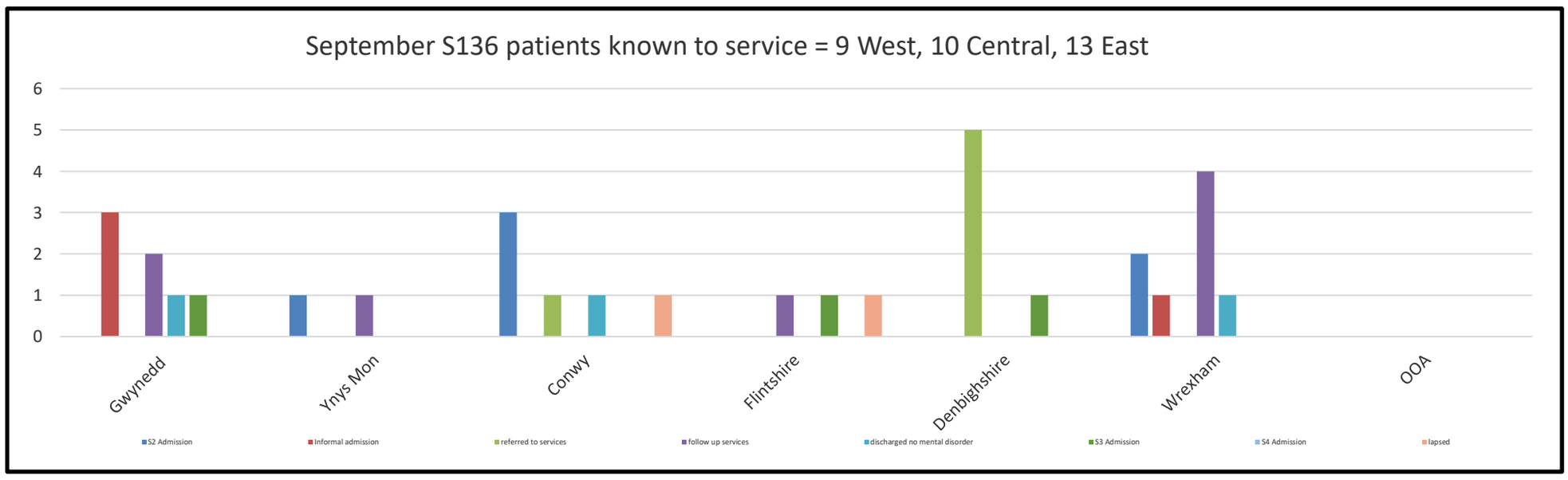




8.1: Duration in S.136 Suite for Sep_22



There were three S136s which lapsed this month, all detentions the assessments had been initiated and were being undertaken at the expiry time.
There was one requests for an extension.
48 assessments were noted to be over four hours, 15 due to the detainees not being fit for assessment, 28 had no reason noted, three due to AMHP availability, one due to a bed being sought and one due to both the AMHP and doctor availability.



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 56 S136 detentions nine people were not seen within the closest S136 suite.

Three were noted to be due to no capacity within the closest suite and six had no reason recorded.

Local Authority Originates from	Detained in	S136 Suite assessed at
Conwy x 2	Conwy x 2	Heddfan
Gwynedd x 2	Gwynedd x 2	Heddfan
Flintshire	Not noted	Hergest
Denbighshire	Denbighshire	Hergest
Wrexham	Wrexham	Hergest
Gwynedd	Gwynedd	Ablett
Wrexham	Wrexham	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 September the Mental Health Act Office has received notification that there have been six instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.
There were six consultations with the service which lead to a S136 detention.

There were 40 instances where the police did not consult.
These resulted in the outcomes as below:

S2 admission x 7
S3 admission x 2
Informal admissions x 5
Discharged no mental disorder x 6 (total for the month = 10)
Discharged referred to services x 9
Discharged with follow up x 9
Lapsed detention x 2 resulting in 1 referred to services and 1 informal admission

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 3

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

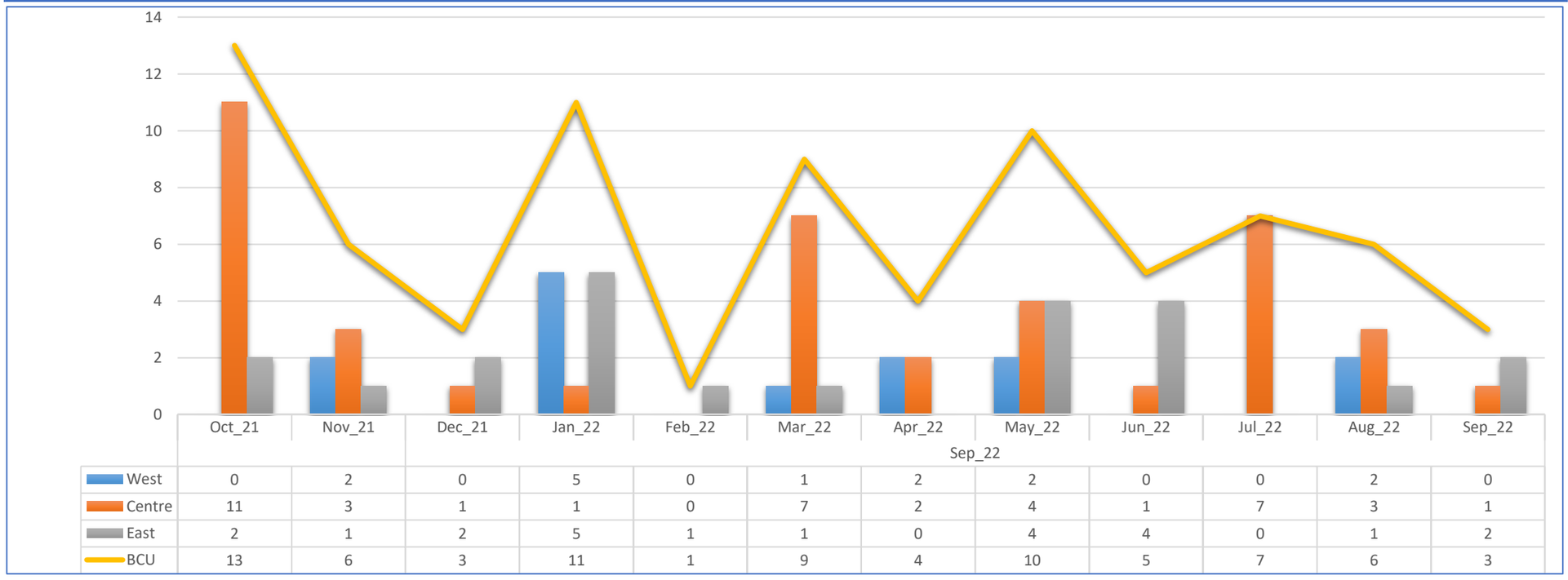
Under 18's detentions in North Wales

KPI Report for: September 2022

Data Source:	BCUHB MHA Database
Report Created on:	04/10/2022
Report Created by:	Performance Directorate

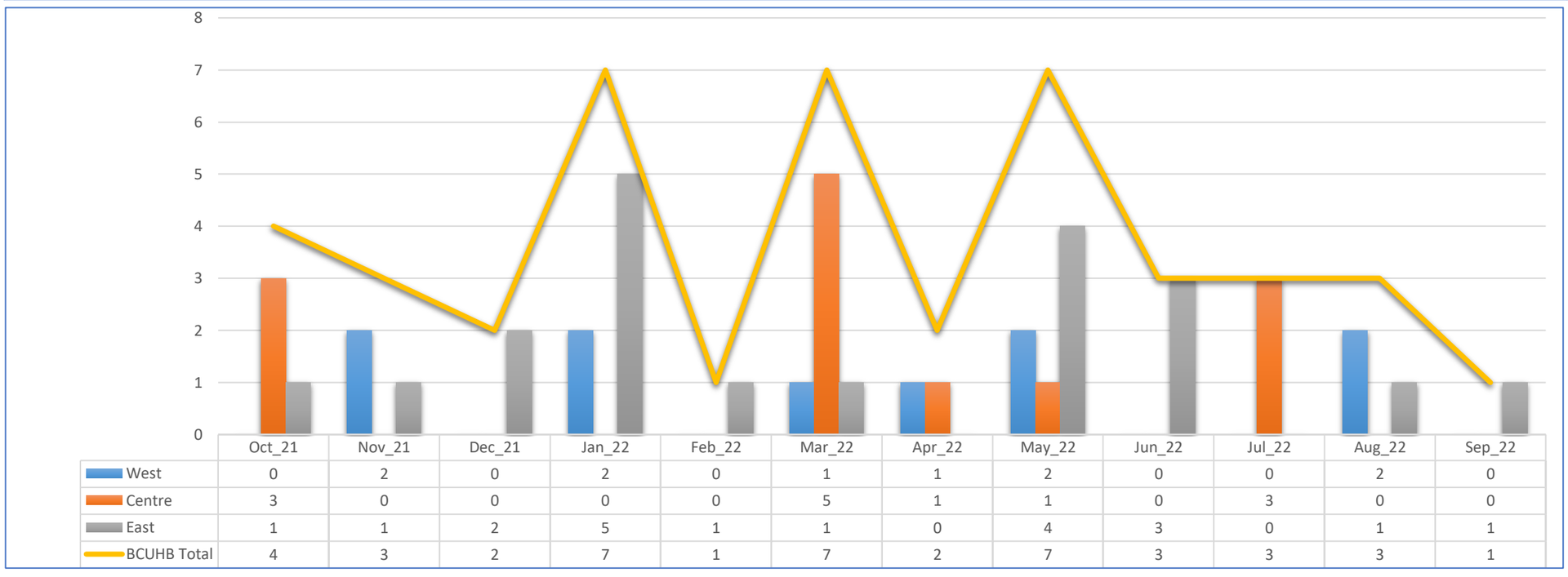
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Sep_22



	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
	Sep_22											
West	0	2	0	5	0	1	2	2	0	0	2	0
Centre	11	3	1	1	0	7	2	4	1	7	3	1
East	2	1	2	5	1	1	0	4	4	0	1	2
BCU	13	6	3	11	1	9	4	10	5	7	6	3

2.1: Section 136 twelve month trend up to and including Sep_22

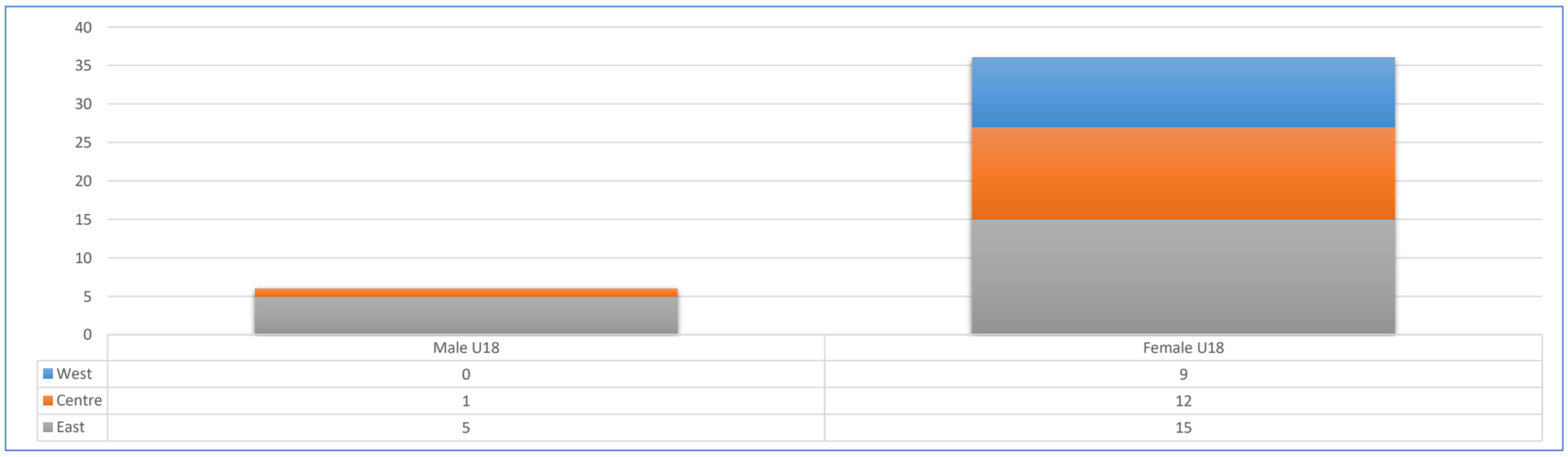


	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	2	0	2	0	1	1	2	0	0	2	0
Centre	3	0	0	0	0	5	1	1	0	3	0	0
East	1	1	2	5	1	1	0	4	3	0	1	1
BCUHB Total	4	3	2	7	1	7	2	7	3	3	3	1

2.2: Section 136 Outcomes twelve month trend up to and including Sep_22

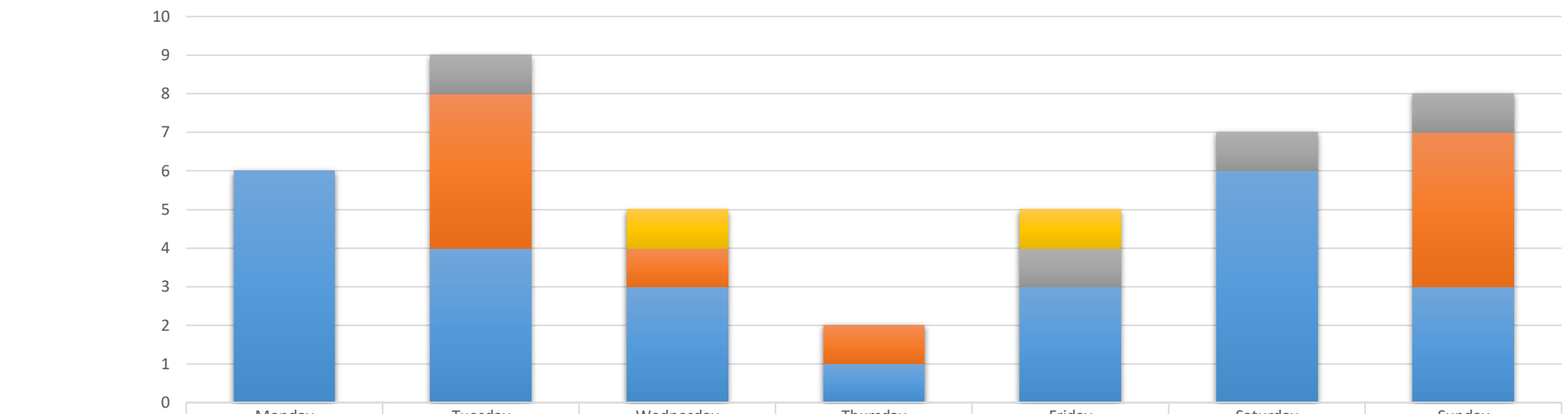
Outcome of 136 detention	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
Discharged - No Mental Disorder	0	0	0	1	1	0	0	0	1	0	0	0
Discharged - Referred to Services	1	0	1	0	0	0	0	0	0	0	0	0
Discharged - Follow up service	2	3	1	5	0	6	2	7	2	2	1	0
Admitted	1	0	0	1	0	1	0	0	0	1	1	0
Section Lapsed	0	0	0	0	0	0	0	0	0	0	1	1

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



	Male U18	Female U18
West	0	9
Centre	1	12
East	5	15

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



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Male 5pm - 8:59am	0	0	1	0	1	0	0
Male 9am - 4:59pm	0	1	0	0	1	1	1
Female 5pm - 8:59am	0	4	1	1	0	0	4
Female 9am - 4:59pm	6	4	3	1	3	6	3

4: 1st Place of Safety 12 month trend up to and including Sep_22

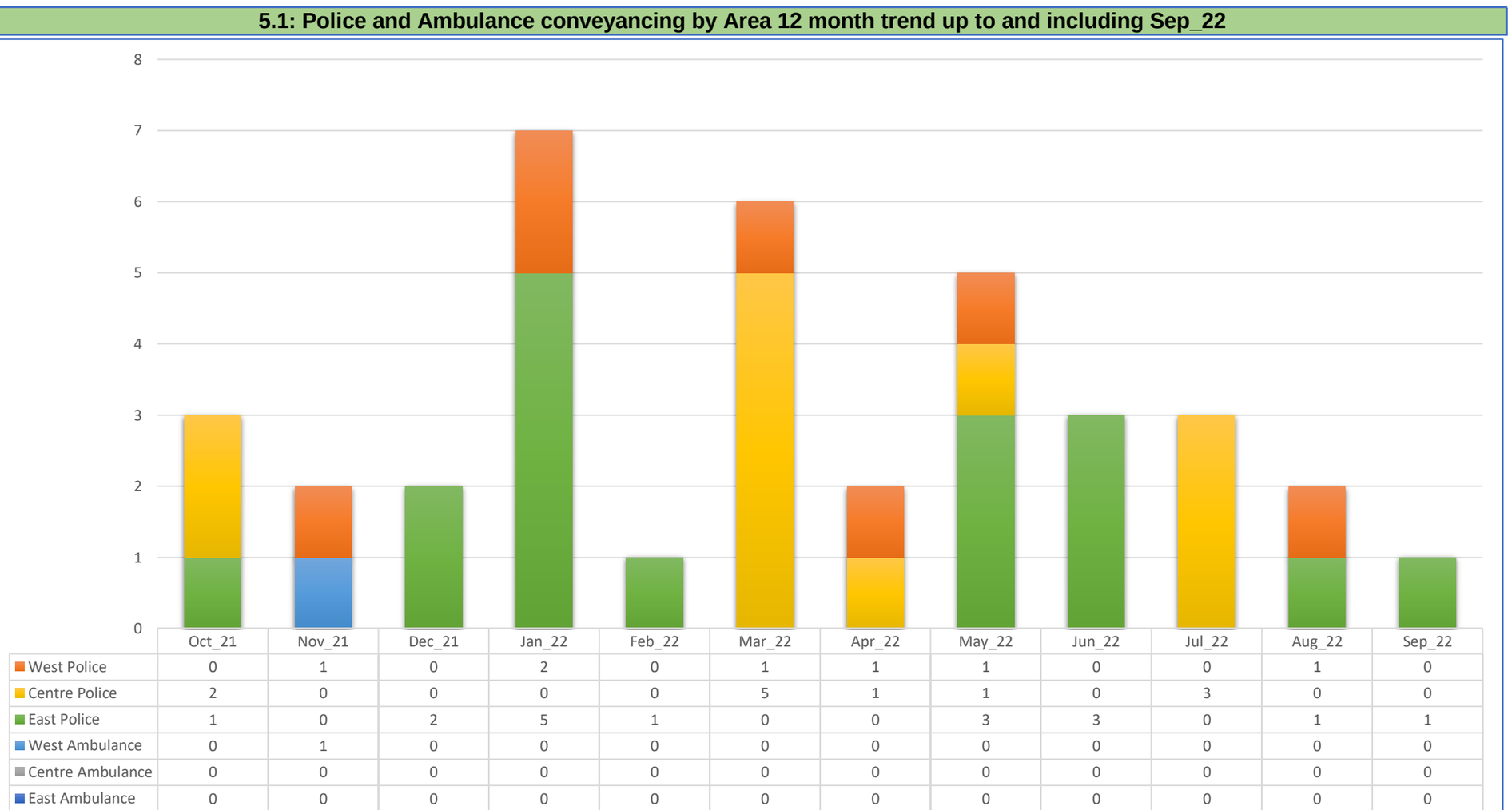
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
A&E	3	2	1	4	0	5	1	2	0	0	2	0
Ward	0	0	0	0	0	0	0	1	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	1	1	1	3	1	2	1	4	3	3	1	1
Hospital	0	0	0	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	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West	0	2	0	1	0	1	0	1	0	0	1	0
Centre	2	0	0	0	0	3	1	0	0	0	0	0
East	1	0	1	3	0	1	0	1	0	0	1	0

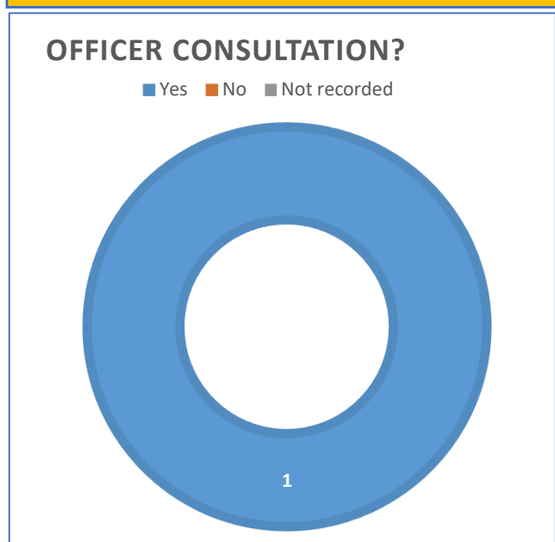
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Sep_22

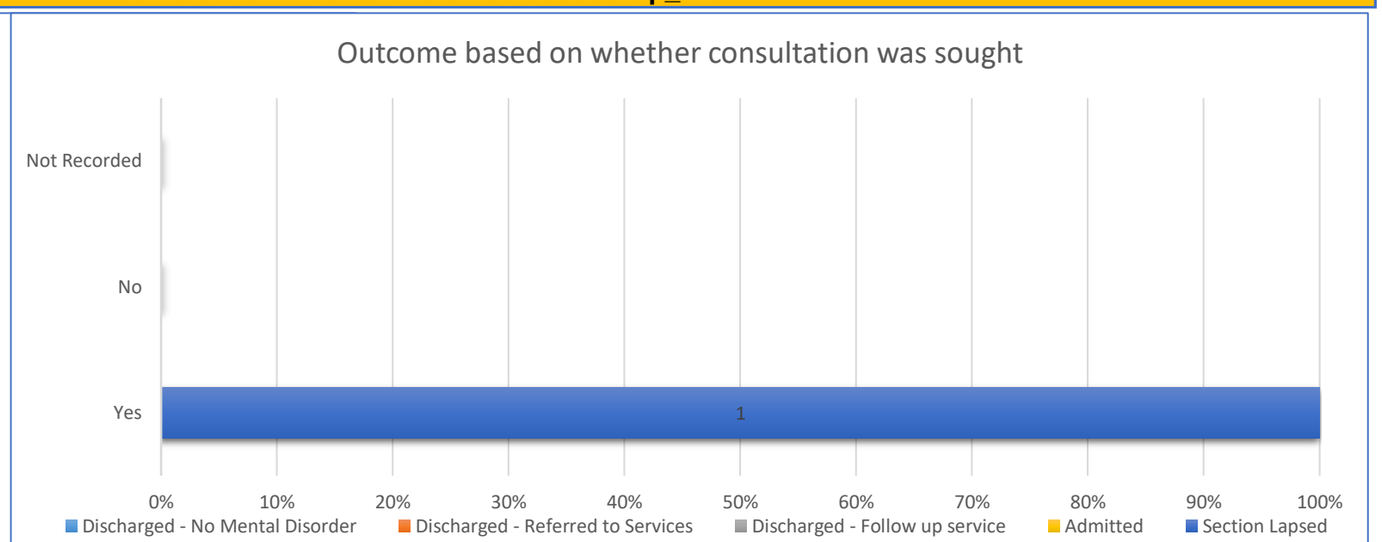


	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22
West Police	0	1	0	2	0	1	1	1	0	0	1	0
Centre Police	2	0	0	0	0	5	1	1	0	3	0	0
East Police	1	0	2	5	1	0	0	3	3	0	1	1
West Ambulance	0	1	0	0	0	0	0	0	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	0	0	0	0	0	0	0	0	0	0

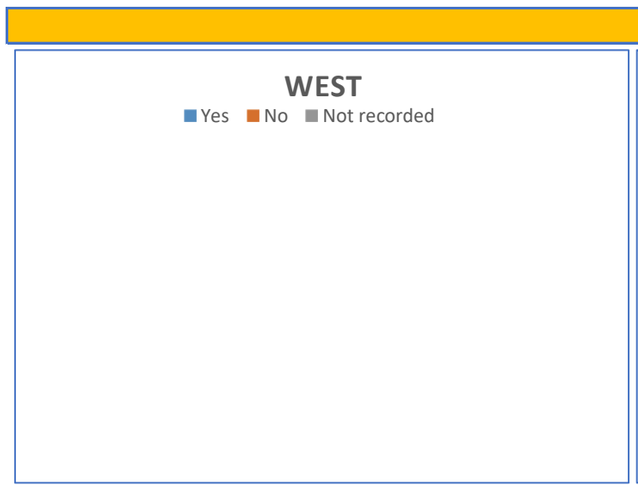
Section B: Data for Sep_22

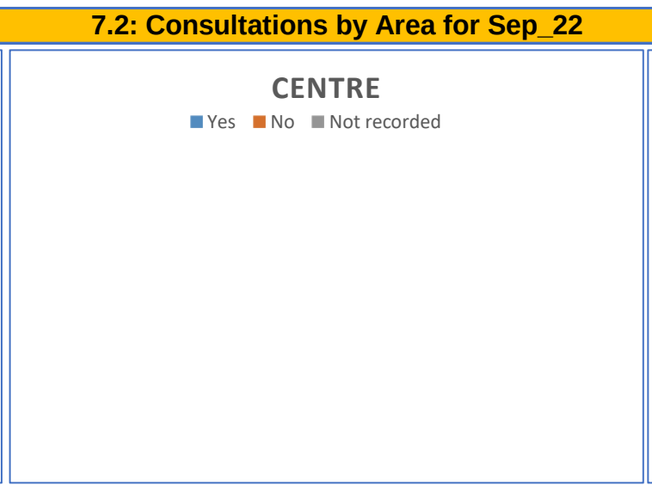
7.1: Consultations and Outcomes for Sep_22

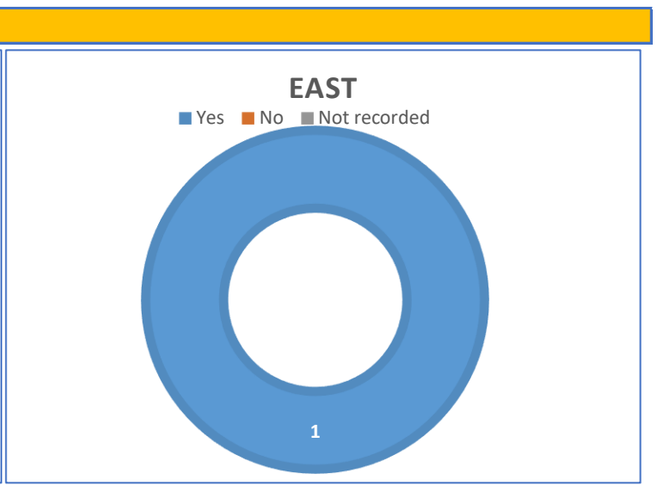




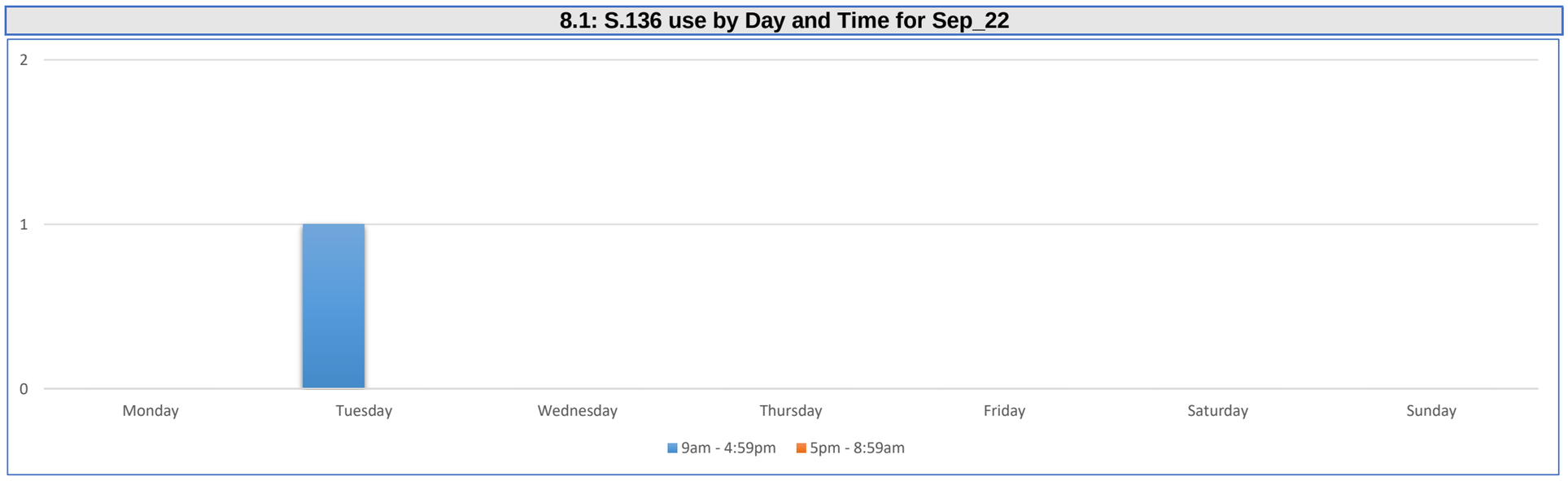
7.2: Consultations by Area for Sep_22



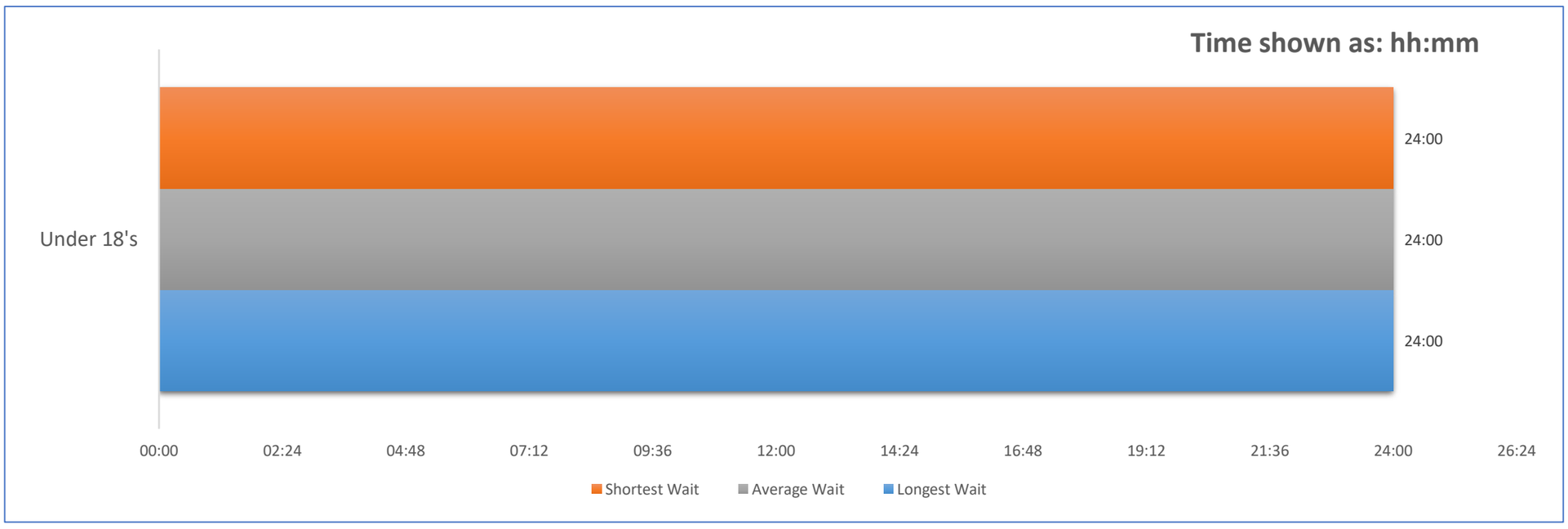




8.1: S.136 use by Day and Time for Sep_22

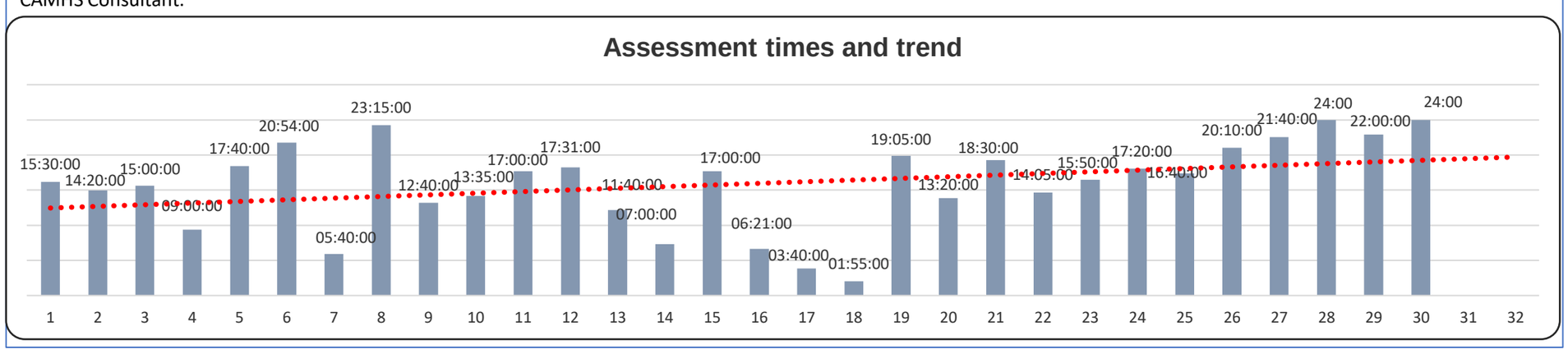


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Sep_22



10.1: Narrative for Sep_22

There were three detentions recorded this month. Two under section 2 one direct admission and one following the S136 which went over the 24 hour timeframe. One young person accounts for two of these detention records. The S136 lapsed due to the assessment still being conducted and a bed being sought, the inaccurate recording on the clinical pathway of the actual start time of the detention meant that the S136 lapsed and the S2 began 22 minutes following.
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. All assessments were conducted by a CAMHS Consultant.



The below information details the S136 detentions in September
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	OOH/Within hours
30 - 24:00	12:50	13:00	Within hours

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Mental Health Act Capacity and Compliance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to highlight the discussions which took place during the Risk Management Group meeting on the 4th October 2022 and to note the progress on the management of the Corporate Risk Register and the new escalated risks aligned to the Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review and discuss the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin, Associate Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Individual risks detail the related links to Strategic Objectives.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	No
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Individual risks detail the related links to the Board Assurance Framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group met on the 4th October 2022 and scrutinised each risk requiring appropriate updates to be undertaken before future submission to each Committee.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Individual risks detail the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: ***Next Steps:*** The Risk Management Group will be meeting on the 6th December 2022, therefore any escalated risk will be presented during the Mental Health Act Capacity and Compliance Committee on the 10th February 2023.	
Rhestr o Atodiadau:	

List of Appendices:
Appendix 1 - Mental Health Act Capacity and Compliance Committee Corporate Risk Register Report.
Appendix 2 – Newly Escalated Risks.

Mental Health Act Capacity and Compliance Committee
4th November 2022
Corporate Risk Register Report

1. Introduction/Background

1.1 The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

(NB Work is underway to redesign Committee Risk and Board Assurance Framework reports as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments)

2. Body of report

2.1 The Risk Management Group met on the 4th October 2022 to review the Corporate Risk Register which included a "deep dive" into the below risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint.

- CRR21-16 – Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.
- CRR22-23 – Inability to deliver safe, timely and effective care
- CRR22-24 - Potential gap in senior leadership capacity/capability during transition to the new Operating Model.

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting scheduled for the 6th December 2022.

2.2 Following discussion and support at the Risk Management Group during August 2022, risk CRR20-06 is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' has been developed, whilst work remains ongoing to develop a further 2 new risks for 'Timely and consistent patient care' and 'Digitisation, Workforce and Transition', which will include the transfer over of open actions from the current CRR20-06 and result in the archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'

2.3 The following risks have been incorporated onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group have been included onto the Corporate Risk Register (Appendix 2).

- CRR22-25 – Risk of failure to provide full vascular services due to lack of available consultant workforce.
- CRR22-26 – Risk of significant patient harm as a consequence of sustainability of the acute vascular service
- CRR22-27 - Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.

2.4 The following risks have been incorporated onto the Health Board's risk register and following Executive approval work is ongoing to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model.

It is not anticipated that any of the risks will fall under the remit of the Mental Health Act Capacity and Compliance Committee.

2.5 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	27	0	5	1
Tier 2 (9-12)	400	68	54	84
Tier 3 (1-8)	231	33	31	107

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the details of individual risks in Appendix 1.

5. Equality and Diversity Implications

5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

5.2 Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 – Mental Health Act Capacity and Compliance Committee Corporate Risk Register Report.

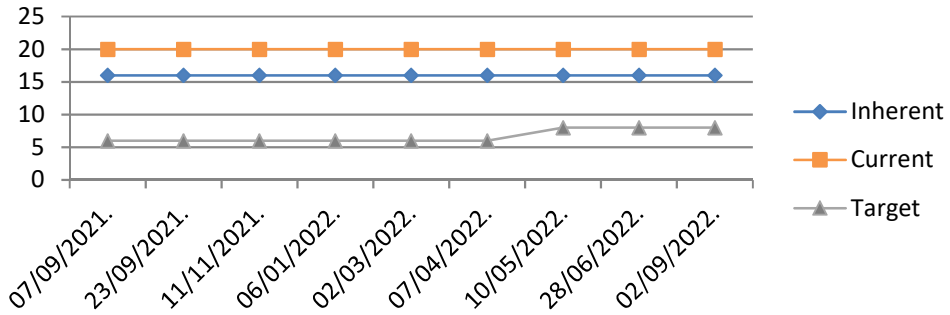
CRR21-14	**Director Lead:** Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 02 September 2022
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 29 July 2022
		Target Risk Date: 31 October 2023

There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.

This may be caused by the increased number of patients who are refusing admission or who have mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

This due to the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and increase in financial cost, poor patient experience and reputational damage for BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory adult at risk training levels 2 and 3 is in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 7. Welsh Government interim monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients. 8. LPS Implementation Group in place to inform the organisation of LPS and to commence the preparation for the receipt of COP and future implementation of LPS across the organisation reporting to the MHCCC Committee.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the Safeguarding Governance and Performance Group reported into Welsh Government. 7. Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the safeguarding team, which is reported to the MHCCC (Mental Health Capacity Compliance Committee).

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised code of practice. A business case has been approved as part of the Integrated Medium Term Plan 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. 3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention. 4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies. 5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator to wards noting the timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training. 6. New Liberty Protection Safeguards code is proposing that the commissioning arrangements of Independent Mental Capacity Act advocates will be the responsibility of Health Boards on behalf of both Health and Local Authorities, confirmed with Welsh Government and meeting arranged with the 6 Local Authorities. At present there is a lack of commissioned service in place and new arrangements require establishments in terms of governance arrangements and quality monitoring. 7. Sudden rise in the number of DoLS assessment resulting in a backlog, currently using Welsh Government monies to support current post holders to work additional hours, weekends and evenings.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position with the identification of a sudden rise in the number of DOLS assessments resulting in a backlog, currently using Welsh Government monies to support current post holders to work additional hours, weekends and evenings. 3. Action ID 18117 – Action delayed, currently working with Finance to identify anomalies which influences the business case. 4. Action ID 20957 – Action delayed due to the UK and Welsh Government for the release of the Liberty Protection Safeguards Code of Practice. Continue to await the Code of Practice.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

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	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	Additional resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. August 2022 progress update - working with Finance to identify anomalies which influences the business case.	Delay

	20957	Development of implementation plan in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. August 2022 progress update - Delay due to UK and Welsh Government for release of the Liberty Protection Safeguards Code of Practice. Continue to await the Code of Practice.	Delay
	21213	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. August 2022 progress update - working with Finance to identify anomalies which influences the Business Case.	On track
	23066	Improve Mental Capacity Act awareness, training	Michelle Denwood, Director of	30/11/2022	Welsh Government monies will support additional resource and educational tools to inform	On track

		and reduction in DoLS 'backlog'.	Safeguarding and Public Protection		the workforce regarding capacity and harm which will reduce risk and improve patient care. August 2022 progress update - Sudden rise in the number of DoLS assessment resulting in a backlog, currently using Welsh Government monies to support current post holders to work additional hours weekends and evenings.	
	23505	Establish commissions and governance arrangements for IMCAS as directed by the LPS Code of Practice	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	The appointment of Independent Mental Capacity Act Advocates and delegated resource will ensure patients voice and choice will be heard and will be part of the legal considerations given to deprivation.	On track
	23506	Establishment of operational groups to support the implementation of LPS within clinical and operational service delivery.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	To ensure that the service and function is embedded in front line practice. This will reduce unlawful detention and comply with the Code of Practice.	On track

Appendix 2 – Newly Escalated Risks

CRR22-25	**Director Lead:** Executive Medical Director	**Date Opened:** 20 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of failure to provide full vascular services due to lack of available consultant workforce	**Date of Committee Review:** New Risk
		Target Risk Date: 31 October 2022
There is a risk that there will be delays in the delivery of emergency, urgent and routine care for vascular patients. This is caused by to lack of consultant workforce which has impacted on services recently and meant only emergency and urgent services can be provided for a short period of time. Business Continuity plans are not adequate to mitigate and patients may need to be transferred NHS England for the the provision of urgent and emergnecy services.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	5	4	20
	Current Risk Rating	5	4	20
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. There are business continuity meetings occurring (between 3 and 5 times weekly) with all relevant operational teams 2. Action plans and decision logs are being maintained and reported to Exec Team daily.	1. Regular review through the 3-5 times weekly vascular operational planning meetings (which feed directly to the Executive Medical

3. Consultant Workforce Rotas are monitored on a daily basis forecasting risks and mitigations put in place 4 records of cancelled procedures are being kept and the risk of patient harm due to those cancellation being monitored. 5. External communication to Community and Primary Care outlining management and referral of routine, urgent and emergent patients 6. Further contingencies are being planned for potential additional complications which may lead to diversion of services to NHSE, including the number of emergency and urgent patients 7 Daily Monitoring of gaps in rota. (Consultant rota as normal from 01/08/2022) from 01/08/2022 Agency Locum commencing to support 1 x long term sickness, restricted practice and dual operating. 8. Further contingency to be agreed with Executive Medical Director in relation to diversion of potential aortic emergency to another Organisation.	Director and be reviewed via Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
1. There is diminished resource across operational, governance, network and clinical teams in order to maintain any traction on day to day service running, planned improvements, action plans, and transformational change in addition to this work.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

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	23819	Develop local business continuity plans with Hub and Spoke Site Directorate Managers	Mrs Elaine Hodgson, Directorate General Manager	26/07/2022	Provide appropriate escalation and plans to mitigate risks Work is in progress, all three General Managers across each site are currently working on the business continuity plan. August 2022 progress update - Business Continuity Planning Session arranged with Clinical and operational teams for the 15th September 2022.	Delay
	23998	Identify critical vascular conditions that may present via the ED or GP/ community referrals. Identify co-dependencies such as Renal and Diabetic Foot Services time critical illnesses	Ms Jenny Farley, Vascular Network Director	31/08/2022	Will ensure patients are not at risk as there is a plan to either treat and stabilise before transfer to NHS England	Completed
	23999	Daily review of all overdue patients to ensure urgent patients are recognised and discussed with clinicians to ensure no	Ms Jenny Farley, Vascular Network Director	31/08/2022	Ongoing daily reviews to ensure no harm due to delay in treatment August 2022 progress update - this continues as part of the	Ongoing

		harm due to delay in treatment	Directorate Manager Surgery East, Centre and West. Elaine Hodgson Dafydd Pleming Keely Twigg		Vascular Operational Group Processes in place	
	24000	Chief Medical Officers Meetings with HB Executive Medical Director to discuss where support can be offered from in the event of inability to provide emergency and time critical care.	Dr Nick Lyons, Executive Medical Director	31/08/2022	Agreement with Liverpool (LiVES) Vascular services to support MDT decision making to ensure patients are prioritised Work in progress with Stoke Hospital to receive Urgent and Emergency Patients if required. August 2022 progress update - Discussions on going with Stoke.	Delay
	24001	Identifying all vascular patients on the waiting lists and prioritising in the event of all day-case and outpatient services need to be transferred out to England	Directorate Manager Surgery East, Centre and West.	31/08/2022	3 x weekly meetings Directorates on each site report any urgent or time critical patients that require escalation for clinical intervention	Ongoing

	24071	Identify clinical workforce establishment and vacancies	Ms Jenny Farley, Vascular Network Director	31/08/2022	Will enable appreciation of workforce required to deliver vascular services	Completed

CRR22-26	**Director Lead:** Executive Medical Director	**Date Opened:** 29 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of significant patient harm as a consequence of sustainability of the acute vascular service	**Date of Committee Review:** New Risk
		Target Risk Date: 31 December 2022
This is a risk that the acute vascular service could not be sustained Potentially caused by a reduction in the consultant workforce (sickness/vacancies) and the need for dual operating which requires two consultants to be available on call 24/7.This could impact on the safety of care for time critical patients.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	5	20
	Target Risk Score	4	2	8
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1.Reintroduction of dual consultant operating (for aortic patients only) 2.Implementation of a focussed recruitment plan 3. Enhanced MDT oversight by a specialist centre. 4.Implementation of the vascular improvement plan (following Royal College of Surgeons review) 5.Contingency planning should the staffing levels fall below acceptable levels (maximising non consultant roles to support patient care and the use of agency)	1. Additional support during the AAA operation to limit risk of complications 2. Reduces the reliance agency locums and doctors without a consultant level qualification 3. Ensures that expert skills are agreeing on the most effective

6.Ongoing risk assessment of the waiting list in line with clinical priority 7. Work in progress to out-source time critical patients including renal.	procedures for patients and timely decision making, and record keeping 4. Evidences the RCS recommendations are being actioned 5. Ensures Operational Team are fully aware of the patients to prioritise for emergency or time critical transfers to other hospitals and which patient conditions can be managed safely by other vascular/renal/diabetic teams internally. 6. Ensures that patients are prioritised on their clinical need and the most urgent patients waiting time deadlines are adhered to for timely treatment 7. Prevents delays to time critical treatments.

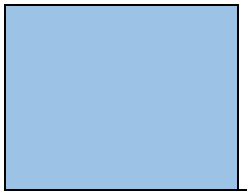
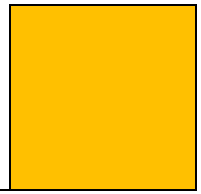
Gaps in Controls/mitigations
1. High sickness and annual leave reduces the ability for dual operating and potentially short notice 2. Poor reputation of service makes recruiting to consultant posts challenging, plus geography of the Health Board 3. Delays in patient decision making when insufficient MDT members attend the MDT 4. 100 + actions, plus actions from the Vascular Quality Panel review, insufficient workforce to support the delivery of the actions in a timely manner 5. May happen at such short notice that immediate transfer of emergency and urgent patient is required with limited notice for NHS England providers 6. Waiting List size significant post Covid, with little capacity to manage anything other than emergency and time critical urgent patients

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

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	24003	Commencement of dual operating.	Ms Jenny Farley, Vascular Network Director	11/07/2022	Reduces the risk of harm to patients Dual operating commenced 11th July 2022.	Completed
	24004	Additional funding requested to ensure effective medical and therapy workforce model. Recruitment campaign ongoing within current establishments	Ms Jenny Farley, Vascular Network Director	31/12/2022	All consultant vacancies recruited to (with the exception of the CD post interviews August 2022) Ensures consistently safe patient care across all three sites. Reduces the reliance on agency workforce	On track
	24005	Invite extended to Stoke as well as Liverpool to attend and contribute to the MDT	Ms Jenny Farley, Vascular	25/07/2022	Action closed 25/07/2022 Support decision making in the absence of sufficient vascular	Completed

			Network Director		surgeons and support prioritisation of patients for intervention	
	24006	Vascular Improvement Plan lead in post and Vascular Network Director in post for wider transformation	Ms Jenny Farley, Vascular Network Director	31/12/2022	Supports the co-ordination of actions needed to deliver against the recommendations. Ensures regular updating of the improvement plan Longer term transformation of the services for stability	On track
	24007	Business Continuity planning in place	Directorate Managers Elaine Hodgson, Dafydd Pleming,	31/09/2022	Ensures all risks are identified and mitigated to support patient safety, enables immediate response to crisis Away Day agreed for the 16th September to complete business continuity plan.	On track
	24008	Risk Assessment of Waiting lists	Directorate Managers Elaine Hodgson, Dafydd Pleming,	31/08/2022	Identifies the upcoming risks/ issues as well as patient demand and capacity to manage time critical patient care	Completed
	24009	Working with NHSE to support the potential transfer of time critical patients to other service providers	Ms Jenny Farley, Vascular Network Director, Dr Andrew Foulkes Medical	30/09/2022	Ensures treatment of time critical patients Will help to develop a future service model to include service provision in England. Discussions are ensuing with Royal Stoke Hospital and Shrewsbury Hospital	On Track

			Director, Mrs Sally Baxter Associate Director of Strategy			

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** New Risk
		Target Risk Date: 28 April 2023

There is a risk that following the RCS stage 2 review of 47 sets of case notes, Vascular medical workfroce documenation is non-compliant with regulatory standards for recording keeping.

This may be caused by the use of software infrastructure across the three sites which doesn't communicate with each other; the lack of digital health records, human factors and staff being used to working without sufficient resource. This could also be caused by lack of communication, human error and the lack of good processes and adequate resources.

This could impact on patient outcomes, patient safety, reputation of the service, poor patient experience and clinical staff fitness to practice.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Weekly case note audits in YGC are undertaken to monitor standards of record keeping actions are taken when poor documentation is identified 2. Medical consultant and trainee grade champions have been identified to support improvement in documentation 3. Refresher training on consent has been between March and May 2022 from HIW and the GMC. 4. Introduction of a pilot scheme for “CITO” electronic MDT proforma to be easily viewed by all relevant MDT members due to complete in October 2022. 5. MDT forms process of being filed by MDT co-ordinator in the notes on the same day put in place. 6. IMTP bids for additional administrative and MDT support have been created.	1. All actions relating to this risk are included on the RCS Vascular improvement plan reviewed monthly at the Vascular Steering Group which feeds into Quality, Safety, and Experience Committee, and then Board

Gaps in Controls/mitigations
1. The infrastructure supporting the vascular service is inadequate. Whilst this doesn't directly affect clinician’s documentation, it does prohibit clear and robust processes to support the efforts. Weekly audits identifying areas for improvement on a regular basis showing need for further input are undertaken. Until August 2022, the lack of permanent Clinical Leadership of vascular medical teams to drive and embed improved practice and ensure compliance and sustainability has been a risk 2. In sufficient MDT co-ordinators across all three sites

Progress since last submission
1. Notes audits continue with signs of some improvement and reported into the VSG meeting monthly 2. Advised by Executive Medical Director that a score of 12 was insufficient in light of the RCS stage 2 report - increased to 15.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-02

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	22282	Reference to RCS vascular improvement plan	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/12/2022	The actions aim to further identify issues, complete weekly audit for assurance of improvement, provide standardised documentation such as clerking and ward round documentation to prompt quality, involvement of regulatory bodies for training, 1:1 meetings with clinicians to review audits results and improvement requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues. There is a large number of actions assigned to improvement for documentation / consent processes which is kept up to date and reported on monthly. This is an ongoing activity. There are objective signs that the Consent process and note keeping standards have gone up.	On track

	24075	Involve regulatory bodies in training medical staffing in record keeping and consent	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/05/2022	Action closed 31/05/2022 This will ensure that all relevant staff area fully conversant with the need for accurate record keeping and the consequences of failure to do so	Completed
	24076	Pilot CITO as part of MDT	Ms Jenny Farley, Vascular Network Director	31/10/2022	To ensure legible documentation. Enhancing security and patient data storage	On track
	24077	Appoint a Clinical Director to lead the service	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/08/2022	Action closed 26/08/2022 Will provide strong leadership, delivery of all key recommendations within the vascular improvement plan.	Completed
	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Ms Jenny Farley, Vascular Network Director	31/10/2022	Will ensure holistic approach to patient care, will improve communication	On track
	24079	Administrative and governance workforce analysis undertaken, identify gaps to support governance processes	Ms Jenny Farley, Vascular Network Director	31/10/2022	Identify the investment required to support effective documentation governance infrastructure	On track

	24080	Case note filing training to be given to Ward Teams	Ms Jenny Farley, Vascular Network Director	30/11/2022	Will ensure correct filing processes for all patient records reducing the risks associated with poor documentation	On track

Teitl adroddiad: ***Report title:***	Compliance with the Mental Health Act 1983 (as amended 2007) Quarterly Audit
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	The scrutiny of the units is completed on a quarterly basis by the MHA administrators, it was agreed with the audit department that to produce a quarterly audit report is not practicable and an annual audit should be registered and produced. This report therefore details the comparisons of the previous audit to show if improvements have been made and actions undertaken as necessary. The annual audit will be produced at the end of 2022. All 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 the audit and form the basis of the scrutiny and checks. Appendix 1 details the comparisons for the units from previous records and actions undertaken as necessary.
Argymhellion: ***Recommendations:***	The committee is asked to note the report.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health.
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	delivery of existing mechanisms/objectives	*existing mechanisms / objectives*	*existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
A number of measures have been taken to assist some units, Cefni has had additional checking and assistance with filing and will be audited again in a months' time, Ty Llywelyn are holding an action plan meeting with their ward managers to address their failed compliance.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board must adhere to the statutory duties as set out in the Mental Health Act.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is a retrospective report on finding from quarterly audits undertaken, no EQIA is required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	An SEIA is not applicable for the audit.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no financial implications associated with undertaking the audit. Financial implications potentially would occur if a detention was invalid.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	The report has been reviewed by Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience. As noted within the report each area has

Feedback, response, and follow up summary following consultation	been contacted to highlight changes required and assurance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** *Appendix 1 – Compliance with the Mental Health Act Quarterly Audit – September 2022*	

APPENDIX 1

Quality Directorate / Legal Services Department

Compliance with the Mental Health Act Quarterly Audit – September 2022

SUMMARY

Seven units were audited, six of these units show an improvement or a maintained position in regards to standard 1 and 8. Standard 7 showed a decline in compliance for five out of the seven units.

When considering the combined resulted Standards 1, 4 and 5 have improved. All other standards have seen a reduction in compliance, a number of these are in relation to the content of the integrated files and issues with administrative staffing within the units along with ensuring that the MHA office receive documents such as S17s and Explanation of rights.

A number of measures have been taken to assist some units, Cefni has had additional checking and assistance with filing and will be audited again in a months' time, Ty Llywelyn are holding an action plan meeting with their ward managers to address their failed compliance.

Carreg Fawr has made steady improvements following the assistance of the MHA office and it is clear they are now maintaining the files and their detention paperwork and responsibilities without this additional assistance.

Feedback has been given to each unit and assurance received that documents have been placed in files and new explanation of rights have been produced.

The audit results will be shared with the managers following the submission to the Mental Health Capacity and Compliance Committee.

The next audit will be completed in December and a yearly audit report produced.

Each unit is detailed within the audit in relation to the nine standards.

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.

The tables detail comparison to the previous audits showing an upward, downward or no change result.

In September seven of the 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. The units not audited were due to no patients being subject to the Mental Health Act at the time.

55 files were scrutinised:

Specialism and Unit	Number of files scrutinised
Older Persons	
Cefni Hospital	13
Bryn Hesketh	10
Rehabilitation	
Tan Y Castell	5
Coed Celyn	0
Carreg Fawr	6

Specialism and Unit	Number of files scrutinised
Learning Disability Villas	
Tan Y Coed	0
Foelas	0
Mesen Fach	3
CAMHS	

Forensic Ty Llywelyn	16	North Wales Adolescent Service	2

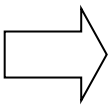
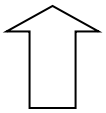
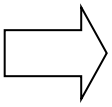
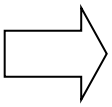
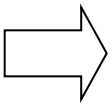
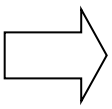
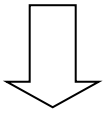
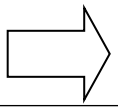
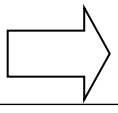
1 Cefni

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**23%**	**76%**	⇩
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**30.8%**	**69.2%**	⇩
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**15.4%**	**84.6%**	⇩
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**7.7%**	**92.3%**	⇩
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**30.8%**	**69.2%**	⇩
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**84.6%**	**15.4%**	⇩
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**53.8%**	**46.2%**	⇩
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**30.8%**	**69.2%**	⇩
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**7.7%**	**92.3%**	⇩

NOTES

There has been a decline in all areas for Cefni, this was raised as a matter of urgency to the Head of Operations and Head of Nursing for the West. There is currently no ward clerk within the unit and additional admin staff have been assisting. The MHA manager has visited Cefni to ensure that all files contain the correct legal detention paperwork and to correct points 6, 8 and 9. A further audit will be conducted in a months' time to ensure compliance is maintained.

2 Bryn Hesketh

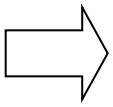
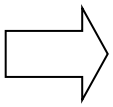
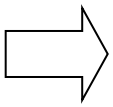
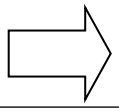
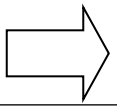
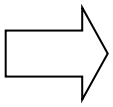
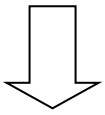
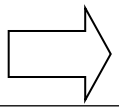
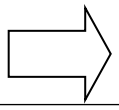
No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**90%**	**10%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**0%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**90%**	**10%**	
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

Bryn Hesketh continues to maintain a high standard of case notes. The file that was missing a CTP was due to the detained person being recently admitted and not known. Whilst the Part 2 Regulations of the measure do not specify a timeframe for production of a CTP it is recommended one should be produced within 6 weeks of admission.

The missing S17 was due to the patient not having any leave it has been communicated that good practice suggests a S17 should be written for emergency purposes regardless of additional leave granted.

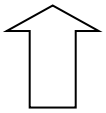
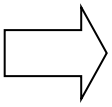
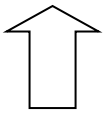
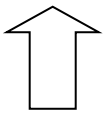
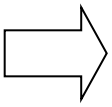
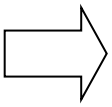
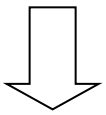
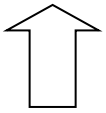
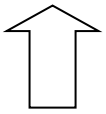
3 Tan Y Castell

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**0%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
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%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES

Tan Y Castell continue to maintain a high standard of functions and documents under the Mental Health Act. The missing CTPs are being addressed.

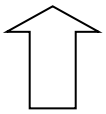
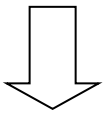
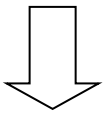
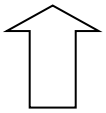
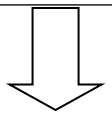
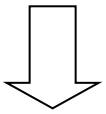
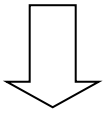
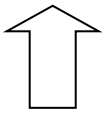
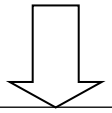
4 Carreg Fawr

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**83.3%**	**16.7%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**83.3%**	**16.7%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**33.3%**	**66.7%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES

Carreg Fawr has improved in a number of areas. There are still issues in regards to Care and Treatment plans being available in the patient's files the unit has assured the office that this has been rectified.

5 Ty Llywelyn

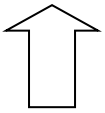
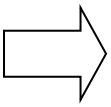
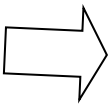
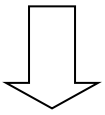
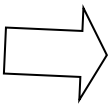
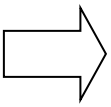
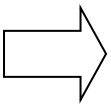
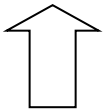
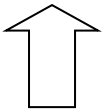
No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**87.5%**	**12.5%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**87.5%**	**12.5%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**81.25%**	**18.75%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**93.75%**	**6.25%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**93.75%**	**6.25%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**56.25%**	**43.75%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**93.75%**	**6.25%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**37.5%**	**62.5%**	

NOTES

The Mental Health Measure Department confirmed the unit is 93.75% compliant with their CTPs with only one CTP not being in date. The unit has been informed that these should be within the patient's files.

Filing still appears to be having a significant impact in relation to standard 9, this has been raised with the Administrative Manager.

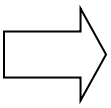
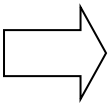
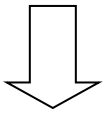
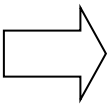
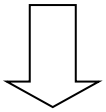
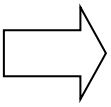
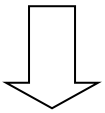
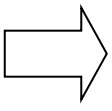
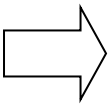
6 Mesen Fach

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**66.7%**	**33.3%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**66.7%**	**33.3%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**0%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES

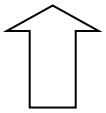
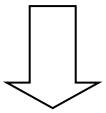
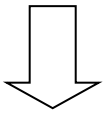
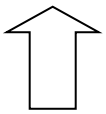
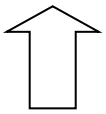
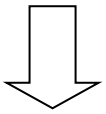
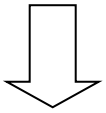
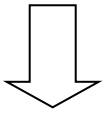
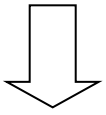
Mesen Fach has improved on many aspects or maintained a high standard this quarter. The use of an old form affected standard 4 and previous renewal documents were not within one patients file this has been rectified.

7 CAMHS – North Wales Adolescent Service

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**50%**	**50%**	
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	**50%**	**50%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**50%**	**50%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES
NWAS continues to maintain high standards with MHA documentation. One explanation of rights form was not completed correctly this was asked to be redone, the care coordinator has been asked to forward the updated CTP.

Combined Results

No.	Standard	% achieved	% not achieved	Comparison to previous audit
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.	**76.4%**	**25.6%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**74.5%**	**25.5%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**67.3%**	**32.7%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**78.2%**	**21.8%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**94.5%**	**5.5%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**63.6%**	**36.4%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**81.8%**	**8.2%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**60%**	**40%**	

Teitl adroddiad: ***Report title:***	Healthcare Inspectorate Wales (HIW) Monitory Report			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	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, considering how the services are meeting the Health and care Standards 2015. This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act and relevant issues highlighted under 3.1 Safe and Clinically Effective Care are followed up appropriately.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health.			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal 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, the effective care and, the quality of management and leadership. 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.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been shared with those listed below none of which have made any changes. Mental Health & Learning Disability Senior Leadership Team Quality and Safety Group Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim **List of Appendices:** Appendix 1 - Inspections	

Inspections within the last 12 months

New inspections, publications and updates.

1 Unannounced Visit: Tan Y Coed Villa, Bryn Y Neuadd UPDATE

Inspection Date: 19 – 20 October 2021
Publication Date: 21 January 2022
The unannounced visit was confirmed to be routine and not in response to any concerns, there were no immediate improvements required.

The report details a positive patient experience was evident with good levels of safe and effective care delivered to the patients, recommendations for improvement were suggested to strengthen existing practice in line with the Health and Care Standards. It is noted there was evidence of a well-established management team, a committed workforce and sound local governance arrangements.

There was no reference to the Mental Health Act within the report but in regards to patients' rights it was noted all patients had access to advocacy services and patient and family involvement was encouraged.

An area of improvement was noted regarding care and treatment plans and the sharing with patients and relatives.

The below actions have been updated within the last quarter.

Improvement needed	Service Action	Responsible Officer	Timescale
The health Board must undertake an audit of the care and treatment plans on the unit, with a view to: • Ensuring that plans and objective are goal and person centred. • Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times.	Each patient on the ward will have a CTP review led by their Care Coordinator and MDT to ensure that plans and objectives demonstrate positive goal planning and are person centred. CTPs will be reviewed monthly by the Care Coordinator to ensure evidence is provided against outcomes identified. 24/05/2022 This has been reviewed by inpatients, work is required to look at how the acre coordinator reviewed these, from the community teams. Tan Y Coed are due to conduct individual care planning meetings, where care coordinators can review the CTP together with the MDT including the individual. 20/06/2022 Cycle of Review of C&T plans has been agreed and is in place. Care Coordinators are supporting individuals in ensuring	Ward Manager. Matron. Head of Nursing.	February 2022

	the Care and Treatment plans are reflective of their needs and delivered in a timely manner. Senior Leadership Team are ensuring CC are confident in delivering on this Action. A further audit of C&T plans will be undertaken By 22/07/2022 to ensure compliance with agreed action. 03/08/2022 External CTP audit undertaken across site, but TYC not audited, due to be audited in September. 14/09/2022 Meetings arranged with community teams to ensure this work is progressed jointly, to ensure clarity of recording the outcomes of these agreed goals.		
The Health Board must ensure that care and treatment plans have been made accessible and communicated appropriately to patients (and relatives where applicable).	Care Coordinators will ensure that patients or their representatives are part of the development of their CTP, and that accessibility and understanding are key to the implementation of care. Utilising inpatient forums, patients will support services to develop a more inclusive approach, to make care planning documentation accessible to patients across site. Update 24/05/2022 an expression of interest has been communicated to staff in TYC to look at how we develop PCP documentation within all areas, to ensure that we move forward in this area Care and Treatment Plans will be routinely shared with patients where effective and with relatives or representatives where appropriate. Ongoing work required to ensure Patients who do not engage in their own C&TPs are supported to understand how we are providing support to them. Update 03/08/2022 Bespoke training with CLDT staff focussing on the formulation of CT's which are person centred, holistic and include recovery focused actions, measurable and person centred with a greater focus on output to formulate a detailed achievable	Head of Nursing	February 2022

	plan specifically outlining outcome based goals and treatment. Update 14/09/2022 Training dates to be confirmed for October 2022 for commencement of workshops and training aligned to formulation of CTPs.		
The health Board must explore how one-to-one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement.	A programme of work is being undertaken across the Division to enhance positive engagement as outlined in the Therapeutic Observation Policy. Therapeutic observation documentation will be audited monthly aligned to the policy and will feed into MDT meetings to inform CTP planning and effectiveness of one-to-one support, engaging patients as part of their treatment journey. Best practice around activity scheduling and therapeutic engagement to be used to inform CTPs. 24/05/2022 update. Early outcomes from the audit are that the documentation meets the required standards however, there is further required to ensure that therapeutic engagement is utilised to inform CTPs. Now that the Therapeutic Support Service is again fully functional and with the reduction in Covid alert levels in the local communities, patients are again able to access community based activities and opportunities. We have recently introduced the monthly audit of therapeutic observation plans, recommended is 6 monthly. To further improve in this area, and to ensure that we continually improve quality. Update 03/08/2022 Audit continues with excellent compliance.	Ward Manager. Matron. Head of Nursing LD.	February 2022 Completed September 2022

Teitl adroddiad: ***Report title:***	Report on Physical Restrictive Intervention February 2022-September 2022 MHLD Division			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee (MHACCC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	Beth yw pwrpas y papur, a yw'n eitem sefydlog/untro? Pa gamau sydd angen i'r Bwrdd eu cymryd gyda'r adroddiad hwn? *What is the purpose of this paper, is it a standing/one off item?* *What is required from the Board as a result of this report?* This paper updates the MHACCC on monitoring arrangements for restraint. The paper sets out themes and trends in restraint practice, how restraint is recorded and reported and associated assurance. The paper also sets out a proposal to set up a Mental Health and Learning Disability Division (MHLD) scrutiny group on restraint. The MHACCC is requested to note the activity on restraint across mental health wards since February 2022 to September 20222. Also to accept the recommendation to establish a MHLD Restraint Reduction Group.			
Argymhellion: ***Recommendations:***	*The Board is asked to:* Note the the activity on restraint across mental health wards since February 2022 to September 2022. Recommend the establishment of a MHLD Restraint Reduction Group			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen			
Awdur yr Adroddiad: ***Report Author:***	Bethan Young, Positive Intervention Clinical Support Service Lead			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch Health and Safety Executive Mental Health Act Mental Capacity Act Deprivation of Liberty Safeguards Mental Health Act 1983 Code of Practice for Wales 2016 Welsh Government Reducing Restrictive Practices Framework 2021
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments* EQIA has not been undertaken for this paper and not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*

	SEIA has not been undertaken for this paper, not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) (summarise risks here and provide further detail) There are no new risks associated with this paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable at this time
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable at this time
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) (summarise where the paper has been reviewed, the response and what changes have made due to feedback) The reporting of restraints has been reported via the MHLD Division Quality Safety Experience group, received monthly
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not identified at this time
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Implementation of recommendations will begin forthwith with the standing up of a Restraint Reduction Group guided by a Terms of Reference and membership from across the Division	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Guidance:

CYFARFOD CYHOEDDUS BWRDD Y CYFARWYDDWYR
RHOWCH Y DYDDIAD
TEITL YR ADRODDIAD

MHACC MEETING IN PUBLIC
INSERT DATE: **4th November 2022**
REPORT TITLE: **Report on Physical Restrictive Intevention February 2022 – September 2022 MHLD Division**

1. **Cyflwyniad / Cefndir**
2.

Y cyd-destun sy'n esbonio pam fod yr adroddiad yn cael ei gyflwyno i'r Bwrdd/Pwyllgor, unrhyw gamau ymgynghori blaenorol, a'r pwrpas o'i gyflwyno i'r Bwrdd

Introduction/Background
Set the scene on why the report is submitted to the Board/committee, where it has been previously in terms of consultation, and the aim for its submission to Board

This report on the themes, trends and reporting of restraint practice within the MHLD has been at the request of the MHACCC. Reporting of restraint has previously been reported through to the Divisional Quality Safety Experience group. The MHACCC has also requested a proposal and this paper sets out the next steps in governance arrangements for the monitoring, reporting and assurance over restraint practices in the MHLD Division.

3. **Corff yr adroddiad /** ***Body of report***

This report sets out the range of activity relating to Restrictive Physical Intervention in Mental Health Units and wards across the Division. This report does not include learning disability wards.

The report also sets out a proposal to establish a MHLD restraint reduction scrutiny group.

NICE guidelines describe restraint as "A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user, to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken and or to end or reduce significantly the danger to the person or others (NG10- Violence and Aggression: short term management in mental health, health and community settings). NICE guidelines are evidence-based recommendations for health and care in England.

They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.
the guidelines help health and social care professionals to:

- prevent ill health
- promote and protect good health

- improve the quality of care and services
- adapt and provide health and social care services.
- Welsh Government are working with the National Institute for Health and Care Excellence (NICE) to improve quality in health and social care. The Welsh Government also have an agreement that all NICE guidelines and quality standards are available to use in Wales.

The information and data within this report has been gathered through the following sources-

- Datix- From 2018 and post April 2022
- Positive Interventions Clinical Support Service database from April 2022 (Data for restrictive physical interventions (RPIs) prior to April 2022 was captured on Datix. Since the implementation of a new Datix system in April 2022 it is no longer possible to record Restrictive Physical Interventions where the primary incident is recorded as something else, e.g. self-harm. Therefore the data for RPIs from April 2022 has been recorded by the PICCS team but is not all available on Datix)
- Training data
- Restraint surveillance
- Support provided to individual areas
- Communication with individual areas

Background

Since February 2022 there has been an increase in restraints within the MHLD Division. The average number for restraints prior to February 2022 would be around 15 restraints per each of the localities, this is based on the data gathered by the data analyst since 2018; this number could fluctuate depending on acuity and individual patient admissions. This is seen as a low number in comparison with the national benchmark throughout the UK

In July 2022 the West area of the Division reported 85 restraints (in one month) which is their highest number of restraints since the department started recording the frequency of restraints following the Health and Social Care Advisory Service (HASCAS) 13 recommendation. When PICSS analysed data it was multi factorial- there was high acuity in the West area due to patients engaging in deliberate self harm. The PICSS team invested a lot of time in this area, supporting staff and patients in working towards reducing restrictive practices through Co- production. The PICSS team and West's SLT hold weekly meetings to discuss restraints and look at any learning from these incidents. Since these interventions have been put in place the restraint numbers have reduced.

HASCAS recommendation 13 informed the Health board that there needs to be an assurance that all older adults and dementia care treatment settings within BCUHB (Emergency Departments, medical wards etc.), are working to the same policies and procedures, and that all staff involved with restrictive practice incidents are trained to the appropriate standard and that all incidents are recorded and form part of the BCUHB organisational learning cycle.

Data

The data shows the amount of restraints recorded February 2022 to September 2022. All staff were asked to complete a Control and Restraint (CR) 1 form whenever a restraint was carried out. The CR1 captures data which the new Datix system does not, including:

- Patients legal status
- Name of staff involved in the restraint
- Length of restraint
- Position of the restraint
- Which staff were carrying out which roles i.e arm holds, leg holds, monitoring of the airway.
- Does the patient have a Positive behavioural Support plan in place
- National Early Warning Score score
- Has the patient received a physical review post restraint
- Have the patients physical observations been taken

There are gaps in the data and therefore numbers are not able to be 'tallied' up due to the number of CR1 forms not being attached to the incidents. The implications of this data recording issue is we are unable to monitor certain elements of a restraint like position, length of restraint, staff involved, whether the patient has a Positive Behavioural Support plan in place, were the patient vital signs monitored and the patients legal status (without the CR1 form). The following information is based on the data we had available to review.

West area

February 2022 - 5 restraints recorded. 3 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, and 2 due to patient assault. In the absence of some CR1 forms the data available shows - restraint positions were 2 prone (face down) positions, 2 where patient was on their side.
March - 24 restraints recorded. 17 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 for patient distress, 3 for aggression, 3 for treatment. In the absence of some CR1 forms the data available shows - restraint positions were 7 prone positions, 4 where patient was on their side, 7 standing and 6 sitting.
April - 71 restraints recorded. 66 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 for patient assault, 1 for agitation. In the absence of some CR1 forms the data available shows - restraint positions were 7 prone positions, 8 where patient was sitting, 9 where patient arms were being held and 4 supine (patient lying on back).
May - 41 restraints recorded. 35 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 3 for patient absconding, 1 for aggression, 2 for treatment. In the absence of some CR1 forms the data available shows - restraint positions were 4 prone positions, 2 standing, 12 supine positions and 3 where staff were restraining the patient's arms.
June - 39 restraints recorded. 19 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 9 for patient absconding, 4 for assault, 1 for treatment and 1 for threatening behaviour. In the absence of some CR1 forms the data available shows- restraint positions were 3 prone positions, 8 standing, 7 supine positions and 8 in the sitting position.
July - 85 restraints recorded. 59 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 2 for patient absconding, 12 for assault, 2 for treatment, 1 for threatening behaviour, 1 due to patient having a weapon, 11 for aggression, 4 to maintain the patients dignity, 1 as the patient was distressed, 2 for agitation and 1 for an escalation of a patients behaviour. In the

absence of some CR1 forms the data available shows - restraint positions were 10 prone positions, 17 standing, 23 supine positions and 8 in the sitting position and 3 where the patient was on their side.
August - 48 restraints recorded. 24 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 7 for patient absconding, 8 for assault, 2 for threatening behaviour, 3 for aggression, 1 as a patient was a risk to themselves, 1 to prevent a patient from setting a fire and 1 due to the patient being intoxicated and aggressive. In the absence of some CR1 forms the data available shows - restraint positions were 12 prone positions, 7 standing positions, 17 in the supine position, 5 in sitting position and 5 standing.
September- 24 restraints recorded. 10 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 2 to prevent a patient from absconding, 5 for treatment, 1 for a patient requiring seclusion, 1 for assault and 1 for a patient attempting to grab a phone from staff. In the absence of some CR1 forms the data available shows - restraint positions were 8 prone positions, 5 standing positions, 7 in the supine position and 3 in the sitting position. It may be worth noting that whilst reviewing the data on Datix it is apparent that a high number of restraints occur whilst patients are on increased levels of observation.

Central area

February- 8 restraints recorded. 2 due to patient assault, 2 for agitation, 1 for a patient search, 1 as the patient was up a tree, 1 for distress. In the absence of some CR1 forms the data available shows - restraint positions were 2 patient was on their side, 1 where patient was sitting, 2 where the patient was on their side and 1 in the supine position. All restraints were for different patients.
March- 17 restraints recorded. 3 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 6 for patient absconding, 2 for aggression and 2 for assault. In the absence of some CR1 forms the data available shows - restraint positions were 2 prone positions, 4 where patient was on their side, 8 standing and 3 in the supine position. There were 1 patient with 1 recorded as being restrained more than once. Patient A - 6 restraints.
April - 3 restraints recorded. 1 restraint was due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 to take the patients' blood and 1 for a patient who was refusing to come back into the building. The restraints were all for different patients.
May - 5 restraints recorded. 3 for patient aggression, 1 for assault and 1 where the patient was reported as being abusive. 2 of the restraints were all for different patients.
June- 4 restraints recorded. 2 for patient absconding, 1 for assault and 1 for an aggressive patent. In the absence of some CR1 forms the data available shows - restraint positions were 1 in the standing position. The restraints were all for different patients.
July- 3 restraints recorded. 1 restraint was due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 for a patient presenting as agitated and 1 where the patient was distressed. In the absence of some CR1 forms the data available shows - restraint positions were 1 in the standing position. The restraints were all for different patients.
August- 9 restraints recorded. 3 of the restraints were due to physical aggression, 2 for assault, 2 to prevent patients from absconding, 1 due to patient distress, and 1 where a patient was confused. In the absence of some CR1 forms the data available shows - restraint positions were 2 in the prone position and 5 in the standing position.

September- 2 restraints recorded. Both of these restraints were due to patient aggression. In the absence of some CR1 forms the data available shows - restraint positions were 1 in standing position.

East area

February- 8 restraints recorded. 5 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 due to patient assault, 1 for aggression and 1 for treatment. In the absence of some CR1 forms the data available shows - restraint positions were 1 where patient was in the prone position, 2 where patient was sitting, 3 standing and 2 in the supine position. All restraints were for different patients.
March- 9 restraints recorded. 3 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 1 for patient absconding, 3 for aggression and 2 for assault. In the absence of some CR1 forms the data available shows - restraint positions were 4 where patient was on their side, 3 standing and 2 in the sitting position. All restraints were on different patients
April- 10 restraints recorded. 3 restraints were due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 6 for aggression and 1 due to threatening behaviour. The restraints were all for different patients
May- 3 restraints recorded. 1 due to patient engaging in deliberate self-harm requiring physical intervention to minimise further harm for patient aggression, 1 to administer treatment and 1 for aggression. The restraints were all for different patients
June- 4 restraints recorded. 2 for patient absconding, 1 for assault and 1 for an aggressive patent. In the absence of some CR1 forms the data available shows - restraint positions were 1 in the standing position. The restraints were all for different patients.
July- 6 restraints recorded. 1 restraint was due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 4 for a patient aggression and 1 for assault. In the absence of some CR1 forms the data available shows - restraint positions were 2 in the prone position.
August- 6 restraints recorded. 1 restraint was due to patients engaging in deliberate self-harm requiring physical intervention to minimise further harm, 2 for patient aggression, 1 to prevent a patient from absconding and 1 due to agitation.
September- 9 restraints recorded. 7 were recorded as the patient being aggressive, 1 for agitation and 1 as the patient was reported as been increasingly paranoid. In the absence of some CR1 forms the data available shows - restraint positions were 2 in the supine position and 1 in the standing position.

It is important to note that all Physical Restraints are potentially harmful and there is a requirement that staff need to evidence on the Datix system that any form of restraint was used as an absolute last resort. The prone position is identified as a high risk position and should only be used for the minimal duration.

Environmental factors in the 3 Acute Mental Health Units-

It is important to consider that each Unit is very different in terms of the Physical environment and the way in which patients are managed.

East nurse their patients in a mixed sex environment that would include the acute wards and the Psychiatric Intensive Care Unit (PICU). Their wards are large and spacious with single rooms available for patients. There are 9 beds on this ward.

Central have single sex wards with no PICU facility, the wards are less spacious and each ward has a double room at the end of the corridor.

West have single sex wards apart from the PICU which is mixed sex. The PICU ward has 6 single rooms and a Seclusion facility. Open wards have 5 designated single rooms and the rest of the ward is made up of 4 beds per patient bay.

Each Unit has its own Section 136 Suite, there are 3 in total- being Heddfan Unit, Ablett Unit and Hergest Unit.

Training to date:

The Positive Intervention Clinical Support Service (PICSS) Team recommenced the face to face training on the 31st January 2022, numbers of staff trained for each area:

East :
- 5 day training- 52 staff completed
- 2 day update- 25 staff completed

Central:
- 5 day training- 16 staff completed
- 2 day update- 28 staff completed

West:
- 5 day training- 54 staff completed
- 2 day update- 22 staff completed

This data comes from the PICSS team database- this training is in the process of being embedded into the ESR system which will provide more accurate monitoring. This action will be completed by next year.

PICSS interventions

The PICSS team structure consists of three substantive staff-
PICSS lead- Band 8a
PICSS training manager- Band 7
PICSS senior trainer- Band 5

In addition to non recurrent staff we have four Band 4 trainers who are seconded until March 2023- this was agreed due to the back log of training as a direct result of Covid-19 pandemic.

The PICCS team offer support in relation to any patient who presents with behaviours which challenge throughout the MHLD Division. Since April 2022 the PICCS team have supported the West area more than East and Central due to their acuity.

The PICCS team provide ongoing surveillance of all incidents of a restrictive nature, which includes restraint, Court of Protection cases, seclusion reviews and advice, guidance and training.

In response to the higher themed reporting of restraint reported in the Hergest Unit, the PICCS team have attended the Hergest Unit regularly and have offered support in co-producing Positive Behavioural Support (PBS) plans with patients who are being restrained on a daily basis. The PICCS team have spent time with patients to look at ways

of reducing incidents and providing support with regards to developing a PBS plan which is meaningful for them. The PICCS team also attend Multi-Disciplinary Team meetings for the more complex cases within the MHLD Division. The PICCS team have also spent time with the staff to offer support. Feedback is then provided to the management team.

The PICCS team inform the respective MHLD Senior Leadership Teams (SLT) when there is a high incidence of restraints and have recently advised that a focus on restraint reduction strategies may be a way to start reducing restrictive practice. The MHLD Division is planning to formalise scrutiny of restraint practice through a Restraint Reduction Scrutiny Group.

Whilst monitoring Datix, PICCS team liaise with the Datix handlers if there has been a restraint and no CR1 form to review, regularly request additional details about incidents where the narrative may not be very clear. When reviewing restrictive practices they ensure that all acts of restrictive practice must be lawful, proportionate and the least restrictive option available. Finally this includes a check to ensure that staff who are involved in a restraint are trained in the use of these techniques.

Interventions in moving forward for Reducing Restrictive Practices

Mental Health Units (Use of Force) Act 2018 **(England only)** relates to every patient having the right to be treated with dignity and respect in a caring and therapeutic environment where their rights are upheld, their needs are met, and they feel supported and listened to. The use of force must always be used proportionately, in accordance with the law, and only ever as a last resort. It must never be used with the intention of causing pain, suffering or humiliation to a patient.

It is important to recognise that staff often have a difficult job to do in challenging circumstances, excellent care and support to patients. Good practice resulting in the reduction in the use or the need to use restraint needs to be acknowledged and shared. Staff are held accountable for their actions, but they should also be equipped and supported to work safely in the least restrictive way and contribute to positive ward cultures.

In **Wales** we have the Reducing Restrictive Practices Framework (2021) which almost mirrors the information detailed in the Use of Force Act 2018.

This framework is intended to promote measures that lead to the reduction of restrictive practices. The framework also seeks to ensure that where restrictive practices are used, as a last resort , to prevent harm to the individual or others, that this is informed by person centred planning, within the context of the service setting and in a way which safeguards the individual, those whom they interact with, and those who provide services to them. In order to achieve these aims a threefold of focus is required:

- Preventing the necessity for restrictive practice through the development of reduction strategies and through the promotion of a human rights approach.
- Working with individuals through person centred planning to meet individual needs in a way that actively reduces the likelihood of situations arising where restrictive practices are used as a last resort.
- Having measures in place so that when situations arise where restrictive practices are used as a last resort, to prevent harm to the individual or others, there is prior planning and training in place to secure the safety of all concerned.

The Reducing Restrictive Practices framework (2021) is working to reduce restrictive practices. The Welsh Government (2021) states that evidence from research and practice suggests a number of key components to reducing restrictive practices within organisations:

- leadership; recording and data collection;
- workforce development; stakeholder involvement;
- post incident support and review; and specific restraint reduction strategies.

Organisations should review their current progress in each area and use this to inform their organisational restrictive practice reduction strategies.

The MHLD Division has recently commenced the process for accreditation with the Restraint Reduction Network for our restraint training. This will provide a form of assurance for the MHLD Division and BCUHB that we are meeting standards set within the Restraint Reduction Training Standards.

This report has made reference to the establishment of a Restraint Reduction Scrutiny Group exception reports from this group will be to the MHLD Division Quality Safety Executive group, MHACCC.

This new governance group will support assurance on

1. Monitoring on all restraints across MHLD
2. Reporting on themes and trends
3. Staff Training compliance
4. Collection of data on patients and protected characteristics subject to the Mental Health Act, Mental Capacity Act and informal patients
5. Limitation of the current DATIX system and scrutiny of CR1 as the additional monitoring mechanism
6. Adherence to current procedural guidelines

4. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications #*

4.1 Nid oes goblygiadau cyllidebol yn deillio o'r papur hwn. Mae'r adnoddau ar gyfer cynnal cydymffurfiaeth yn cael eu goruchwylio gan ...

There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Director of Nursing.

4.2 NEU Mae'r goblygiadau cyllidebol yn cael eu lliniaru'n llawn/rhannol drwy ...
OR Budgetary implications are and fully/partially mitigated via….

5. Rheoli Risg / Risk Management

Mae un risg ar Datix sy'n gysylltiedig â'r maes hwn, sef risg ID xxxx. Mae hon yn risg rannol

Restrictive practices are subject to DATIX and review by the MHLD Division.

6. Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications*

6.1 Os yw'r adroddiad hwn yn ymwneud â 'phenderfyniad strategol', h.y. bydd y canlyniad yn effeithio ar sut mae'r Bwrdd Iechyd yn cyflawni ei bwrpas statudol dros gyfnod sylweddol o amser ac ni ystyrir iddo fod yn benderfyniad 'o ddydd i ddydd', mae'n rhaid i chi gynnwys Dyletswydd Economaidd-gymdeithasol (SED), Asesiad o Effaith Cydraddoldeb (SEIA) yn ogystal ag asesiad Effaith Cydraddoldeb (EqIA) fel atodiad.

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include a Socio-economic Duty (SED) Impact Assessment (SEIA) as well as a completed Equality Impact (EqIA) as an appendix.

6.2 Mae angen cydymffurfiaeth EqIA yn unol â Gweithdrefn WP7 er mwyn sicrhau bod cydraddoldeb a hawliau dynol yn cael eu hymgorffori i brosesau penderfynu a datblygu polisi'r sefydliad.

EqIA compliance is required in accordance to Procedure WP7 to ensure equality and human rights are embedded into organisational decision-making and policy development processes.

Not applicable

Teitl adroddiad: ***Report title:***	Mental Health Act Policies			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	Extant policies are required to be reviewed at regular periods. The attached MHLD 0044 Section 17 Leave of Absence Policy has been in situ for a number of years. It has been reviewed and updated and requires approval to be uploaded to the Health Boards policy page to ensure staff are working to an up to date document. The MHLD 0046 Policy on; Application to Hospital under Part II of the Mental Health Act 1983 has been produced to supersede the MHLD 0046 BCUHB Policy for Section 5(2) for use in general and community hospitals. This document has been extended to include all applications to Hospital under Part II following identified needs for information on the Act to be shared widely within the Health Board and not solely subject to the MHLD division. As the functions within the Mental Health Act are prescriptive by law these documents are policies to ensure that staff adhere to their legal responsibilities.			
Argymhellion: ***Recommendations:***	The committee is asked to approve the policies.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	All policies relating to patient care should be written with the Code of Practice for Wales in mind and take into consideration the Mental Health Act, Human Rights Act and the Mental Capacity Act. Within the Code of Practice for Wales 2016 it states: "It is essential that compliance with the legal requirements of the Mental Health Act 1983 (the Act) and the Mental Health Act Code of Practice for Wales (the Code) are monitored. Local health boards (LHB) and local authorities (LA) should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed" (CoPW A1.1).
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The two policies have undergone an Impact Assessment attached as appendix 2 and 4.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	*Following discussion with MH&LD Senior Management Team, the Office of the Board Secretary and the Equality Team, the assessment is that a SEIA in not required. The Policies submitted to the Committee for approval involve the application by the Health Board of UK legislation. The legislation is highly prescriptive and not open to interpretation. The strategic or 'policy' decisions as to the content and application of the legislation are made at a national level by the UK Government (the Mental Health Act is not devolved). Therefore, the request for the Committee to approve the policies has been assessed as 'not strategic'. The Mental Health Act is currently under review following the final report of the Independent Review of the Mental Health Act 1983 (December 2018) and a consultation 'reforming the Mental Health Act', ran from the 13/01/20 to the 21/04/21. A collective response was submitted by the Health Board 21/04/2021. The Impact assessment for the review is available for information here: Reforming the Mental Health Act: impact assessment (publishing.service.gov.uk).*

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The policies have been reviewed and approved via the relevant policies groups as indicated on the documentation. All relevant feedback and comments from consultation and from within the groups have been addressed and recorded for audit purposes.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 - MHLD 0046 – Policy on: Application to Hospital under Part II of the Mental Health Act 1983 Appendix 2 – EQIA MHLD 0046 Appendix 3 – MHLD 0044 Section 17 Leave of Absence Policy Appendix 4 – EQIA MHLD 0044	

Version: 3.2 Review

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

MHLD 0046

Policy on: Application for admission to hospital under Part II of the Mental Health Act 1983

Author & Title	Wendy Lappin Mental Health Act Manager Catherine Baker, Liaison Consultant Psychiatrist Working Group including CAMHS, Paediatrics and Local Authority Professionals				
Responsible Dept / Director:	Matthew Joyes, Associate Director of Quality / Quality Directorate				
Type of Document	Policy				
Approved by:	MHLD Policy/Procedure Group – 02/08/2022 MHLD Divisional Senior Leadership Team Quality Safety and Experience Group – 16/08/2022 Patient Safety and Quality Group – 12/09/2022 Mental Health Capacity and Compliance Committee -				
Date approved:					
Date activated (live):					
Documents to be read alongside this document:	Mental Health Act 1983 (as amended 2007) Mental Health Act Code of Practice for Wales (Revised 2016) Mental Capacity Act Code of Practice (2020) County Court Act 1984 Mental Health Act Scheme of Delegation MHLD AC008 Missing absconding Patient Policy MPO1 – Procedure for missing persons from BCUHB premises – Emergency Department and General Wards MHLD 0047 Physical Restraint Policy MHLD 0057 North wales Section 135 and 136 MHA Protocol MHLD 0030 Policy for information to patients (s132/3 MHA) MHLD 0026 Policy for admission, receipt and scrutiny of statutory documentation MHLD 0044 Section 17 Leave of Absence Policy				
Date of next review:	Maximum 3 years				
Date EqIA completed / reviewed:	June 2018 Reviewed June 2022				
First operational:	3rd November 2008				
Previously reviewed:	31st March 2009				
Changes made yes/no:	Yes				
Details of changes since last review	The initial S5(2) policy for general and community hospitals has been amended to support the application for admission to hospital under Part II of the Mental Health Act 1983 (as				

	amended 2007). The document provides guidance for all staff and paediatrics and medical wards when detentions occur in the general and community hospital.

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1. Glossary of Terms

AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an appropriate clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers.
AMHP	Approved Mental Health Professional – A mental health professional who has been approved by a local social services authority to carry out certain duties under the Mental Health Act. An AMHP may be a social worker; nurse; occupational therapist; or psychologist. The AMHP holds the responsibility for making an application to the hospital for admission this responsibility includes ensuring the least restrictive option is considered and the views of the patient and their nearest relative are taken into account.
RC	Responsible Clinician, the approved clinician with overall responsibility for the patient's case.
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
Form HO13	Statutory Welsh Form to be completed by a nurse in initiate detention under Section 5(4) of the Mental Health Act.
Forms HO3, HO4, HO7, HO8, HO11 and HO12	Statutory Welsh Forms to be completed by a Doctor detention under the Mental Health Act (S2, S3, S4 and S5(2)).
Forms HO2, HO6, HO10	Statutory Welsh Forms to be completed by an Approved Mental Health Professional to make an application for admission under a detention of the Mental Health Act.
Hospital Managers	The Health Board is defined as the 'Hospital Managers' for the purposes of the Mental Health Act. This role is delegated to staff, who are named within the Mental Health Scheme of Delegation, who receive Mental Health Act paperwork on their behalf. **For the purpose of this document these are Mental Health Senior Managers or Duty Nurse for out of hours and interim periods**.
Mental Capacity Act 2005	An Act of Parliament that governs decision making on behalf of people who lack capacity, both where they lose capacity t some point in their lives and where the incapacitating condition has been present since birth.
DOLS	The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become,

	deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983 (although a patient can be on Section 17 leave ie in a care home and also be subject to a DoLS). The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interest.
Responsible Doctor/ Registered Medical Practitioners	A medical professional who is in charge of a patient's treatment. For the purpose of parts of this document this **cannot** be a Specialty Registrar or an FY1/FY2 doctor. If nominated as a deputy this will be a Consultant, Physician/Surgeon.
Section 5(2)	Enables a medical professional (in charge of a patients treatment) to detain an inpatient for a maximum of up to 72 hours to prevent the patient from discharging himself before there is time to arrange an application under S2 or S3 under the Mental Health Act. The terms "holding power" and "detention" are often deployed as interchangeable and informal terms as a substitute for the correct legal term "detention". No harm or criticism will arise from using the terminology "holding power" in general language.
Section 2	Compulsory admission of a patient to hospital for assessment and for detention up to 28 days
Section 3	Compulsory admission of a patient to hospital for treatment and detention for up to six months.
Section 4	An application for detention for assessment of mental disorder made with only one supporting medical recommendation in cases of urgent necessity. Also known as a section 4 application.
Section 136	A detention under the Mental Health Act which is available to the police when they are the first point of contact with a person who appears in distress and they feel requires a Mental Health Assessment in a place of safety.
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge.
Part 4, Mental Health Act	The part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including

	conditionally discharged and community treatment order patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for the mental disorder without their consent.
Section 17 Leave	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time, patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others.
Section 18 AWOL	Provides for actions that can be taken when a detained patient, a community patient or a patient subject to guardianship absents himself without leave.
Out of Hours	Any time between 17:00 hours and 09:00 hours. Any timer period between 17:00 Friday to 09:00 Monday
Within Hours	Office working hours 09:00 to 17:00 Monday to Friday are classed as within hours.

2. Introduction and Policy Statement

The use of the Mental Health Act must be in line with consideration of that patient's capacity, services should be provided with the presumption of capacity unless demonstrated otherwise, be the least restrictive option, serve the person's best interests and maximise independence. Retaining independence and promoting the patient's recovery should be central to all interventions under the Act. The least restrictive options should always be considered and alternatives to avoid the use of compulsory powers should be explored before making an application for admission.

Admission to hospital can be under a formal (the Act) or informal (voluntary) status. In some instances the use of the Act and detention under the powers may be in the best interests of the patient. Regular reviews are required to ensure that the person still meets the criteria and this need during their hospital admission.

Common Law powers can be used to prevent someone from leaving an acute hospital if there is imminent risk of harm, however that person then needs to be managed under an established piece of legislation as soon as possible. Any form of restraint to prevent the person from leaving MUST be proportionate and reasonable to the need. When working with patients who exhibit challenging behaviour, staff should support patients in a therapeutic manner, and in ways that ensure patients' safety and optimise their privacy and dignity. Interventions to manage the risks associated with challenging behaviour should always be carried out in a way that minimises patient distress and discomfort, promotes dignity, and never in a way that intentionally subjects patients to physical pain. The Act allows for interventions which may include preventing patients from leaving, observations, restraint and/or seclusion. Any restraint used to prevent a detained patient from leaving the hospital / unit must be proportionate and reasonable. For further clarification the Physical Restraint Policy (MHLD 0047) should be referred to.

Part II of the Act deals with patients who are detained in hospital but have no criminal proceedings against them. These are referred to as civil sections.

This policy provides relevant professionals with guidance, to facilitate compliance with the requirements in respect of admission to hospital under Part II of the Act 1983.

Part II of the Act relates to the following:

- Section 2 – Admission for assessment
- Section 3 – Admission for treatment
- Section 4 – Admission for assessment in cases of emergency
- Section 5 - Application in respect of a patient already in hospital
- Section 6 – Effect of application for admission

2.1 Section 2

Detention under section 2 allows for assessment of people who have, or are believed to have a mental disorder for a maximum period of up to 28 days.

Criteria:

- The person is suffering from mental disorder **and**
- It is of a nature or degree to warrant detention in hospital for assessment or assessment followed by treatment for at least a limited period **and**
- The person ought to be detained in the interests of their own health **or** safety **or** with a view to the protection of others.

This section is not renewable following the 28 days but reassessment to detain under a section 3 may occur prior to or on the day of expiry.

2.2 Section 3

Detention under section 3 allows for detention and treatment of a person in hospital for up to six months initially. The detention can be renewed at regular intervals by the Responsible Clinician.

Criteria:

- The person is suffering from mental disorder **and**
- It is of a nature or degree which makes it appropriate for them to receive medical treatment in hospital **and**
- It is necessary for the health **or** safety of the person **or** for the protection of others that they receive that treatment **and**
- Treatment cannot be provided unless they are detained **and**
- Appropriate medical treatment is available for them.

2.3 Section 4

Detention under section 4 allows for admission to hospital in an emergency for a maximum period of up to 72 hours. It may be applied when section 2 would be appropriate but the team are unable to obtain the two medical recommendations required and the patient needs urgent hospital admission.

An emergency arises when those involved cannot safely manage the mental state or behaviour or the patient.

Criteria:

- The criteria for detention for assessment under section 2 are met
- The patients detention is required as a matter of urgent necessity; **and**
- Obtaining a second medical recommendation would cause undesirable delay

A person with Learning Disability may be detained under section 4 without the criteria of abnormally aggressive behaviour or seriously irresponsible conduct being met.

2.4 Section 5

2.4.1 Section 5(4)

Section 5(4) allows a registered mental health or learning disability nurse to detain an inpatient for a maximum period of up to 6 hours in order for their assessment under the Act.

Under section 5(4) nurses of the prescribed class may detain a hospital inpatient who is already receiving treatment for the mental disorder for up to six hours. The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else. This power may only be used where the nurse considers:

- The patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital, either for the patient's health or safety or the protection of other people.
- The patient is not an informal patient who is also subject to a community treatment order.
- It is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

A nurse of the prescribed class is defined in the Mental Health (Nurses) (Wales) Order 2008 as a nurse registered in sub-part 1 or 2 of the nurses part of the Register of the Nursing and Midwifery Council, with a recordable qualification in mental health or learning disability nursing as follows:

A nurse registered in	**Sub-part 1** of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing
	Sub-part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing
	Sub-part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing
	Sub-part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing

As a section 5(4) criteria is that the patient is already an inpatient and receiving mental health treatment it is unlikely that this section would be used on a general ward unless

the informal patient had been transferred from the psychiatric unit for medical treatment.

A person with Learning Disability may be detained under section 5(4) without the criteria of abnormally aggressive behaviour or seriously irresponsible conduct being met.

2.4.2 Section 5(2)

Section 5(2) is the power under the Act that authorises the detention of an informal patient by the Registered Medical Practitioner or nominated person in the case of absence. The nominated person must be the person in charge of the patient treatment, (within the general hospital out of hours this must be the consultant on call and cannot be the junior doctor).

The Registered Medical Practitioner will use a section 5(2) to detain an in-patient who is expressing a wish to and/or trying to leave hospital and is suspected to be suffering from a mental disorder. The power enables detention for a maximum period of up to 72 hours in order to make arrangements for an assessment for detention under Section 2 or Section 3 of the MHA. **It is not good practice to allow a 5(2) section to lapse once enacted.**

This power can only be used to detain patients who have already been admitted to a hospital as an inpatient (informal admission), it cannot be used for patients physically present but not yet admitted to hospital e.g. outpatients, visitors, Emergency Department (ED).

Section 5(2) should only be used if; at the time it is not practicable or safe to take the steps necessary to make an application for Section 2 or 3 detention under the Act. It should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

2.5 Section 6

Section 6 of the Act gives authority for the AMHP or anyone authorised by the AMHP to take a patient and convey them to the hospital following a duly completed application. Authority given by an AMHP to another does not need to be in writing. However it may be requested.

For an application other than an emergency application; this means within 14 days beginning with the date the patient was last examined by a registered medical practitioner before giving a medical recommendation for the purposes of the application. For the purposes of a section 4 of the Act (emergency application) this means within 24 hours of the time the registered medical practitioner giving the medical recommendation examined the patient or at the time the application is made, whichever is earlier.

The duly completed application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of the Act. No further proof of signature or qualification of the professionals involved is required.

When a patient is admitted to hospital for treatment under the Act, any previous application under this Part shall cease to have effect. E.g. section 2, section 4 or section 7 MHA Guardianship.

2.6 Section 135/136

A section 135(1) warrant provides police officers with a power of entry to private premises, in order to remove a person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care. The warrant will be applied for by an AMHP to the magistrates' court.

A section 135(2) warrant provides officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital, or any other place, or into custody under the Act. The warrant can be applied for by a police officer, any officer on the staff or the hospital or any person authorised by the hospital managers, an AMHP or in the case of a patient subject to guardianship any officer on the staff of the local social services authority, any person authorised by the guardian or the local social services authority.

Following arrival at a place of safety under 135(1) or 135(2) an assessment will be undertaken following the same timeframes as a section 136.

Section 136 is a detention power for the Police to allow them to detain and remove a person appearing to be suffering from a mental disorder to a place of safety to allow for a mental health act assessment.

A section 136 is for a 24 hours period, although can be extended for a maximum of an additional 12 hours (total 36 hours) if a person is deemed not fit for assessment. This may be due to requiring medical treatment or due to inebriation whereby an assessment could not be conducted unless the patient is able to fully participate.

2.7 Mental Capacity Act and Deprivation of Liberty Safeguards

An understanding and application of the principles and provisions of the MCA and DoLS and of the common law relating to consent is essential to enable decision makers to fulfil their legal responsibilities and to safeguard their patients' rights under the Human Rights Act 1998.

The MCA empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and treatment. There is no such thing as "overall capacity".

The MCA, in general, applies to individuals aged 16 years and over. However a DoLS authorisation can only be made in respect of an individual aged 18 years or over. The criteria for DoLS (also referred to as the Acid Test) the patient has to be over 18 years of age, have a disorder or disability of the mind (ie confusion, delirium, dementia, brain injury, stroke etc), lacks capacity to agree to be accommodated in hospital for the purposes of care and/or treatment, are subject to continuous supervision and control and are not free to leave.

The use by staff of common law powers to detain and control patients in emergency situations whilst awaiting the presence of a doctor who has the power to act is also allowable under the European Convention of Human Rights. However such power

should only be used as a “safety net” to cover situations were it not possible to immediately invoke the statutory powers. To be consistent with ECHR, common law powers should not be used an alternative to the powers contained in the Act. (1-089 Mental Health Act Manual).

Consideration should be given as to which Act is appropriate for admission the Code of Practice for Wales Chapter 13.33 – 13.38) details which Act is available based on capacity and whether the patient is objecting to their detention. Illustrated in the table.

	Individual **has the capacity** to consent to being accommodated in a hospital for care and treatment	Individual **lacks the capacity** to consent to being accommodated in a hospital for care and treatment
Individual **objects** to the proposed accommodation in a hospital for care and/or treatment or to any of the treatment they will receive there for mental disorder	**Only the Act** is available	**Only the Act** is available
Individual **does not object** to the proposed accommodation in a hospital for care and/or treatment or to any of the treatment they will receive there for mental disorder	**The Act is available** Informal admission will usually be the appropriate course of action. **Neithe**r DoLS **nor** Court of Protection order is available	**The Act is available.** **DoLS authorisation is available, or potentially a Court of Protection Order**

TO NOTE: DOLS has been under review and will be superseded by Liberty Protection Safeguards in the near future.

3. Purpose of the Document

This policy has been developed to guide all employees/workers on the implementation and management of patients who are detained under a section of the Act. This policy has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice), DOLS and the Code of Practice for Mental Capacity Act.

The purpose is to ensure that all employees/workers are aware of their responsibilities and avenues to follow to obtain assistance and ensure the needs of the patient are met and are safeguarded.

The document is applicable to all areas of the Health Board (General and Psychiatric setting) and covers all ages. The Act is applicable to all and does not have a minimum age for detentions.

4. Scope

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health Capacity and Compliance Committee is specifically for this purpose.

This policy is applicable to all professionals within all Mental Health inpatient settings and general hospital settings.

Within the general hospitals the Psychiatric Liaison Service must be the first point of contact for any concerns staff may have whether this be on a general ward or for a patient in ED (Ysbyty Gwynedd, Glan Clwyd or Wrexham Maelor).

For children and young people the unscheduled care crisis team and the regional on call child and adolescent psychiatrist will be the point of contact out of hours, the duty nurse within the local psychiatric unit can also be contacted.

Within hours the unscheduled care crisis team and the Mental Health Act office can be contacted.

5. Aims and Objectives

The aims of the policy are to:

- Ensure all employees/workers are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Act
- Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended 2007.
- Ensure that statutory requirements under the Mental Health Act 1983 are met.
- To facilitate the development of good practice.

The policy describes:

- The purpose of admission to hospital under Part II of the Act.
- The process for assessing the suitability for admission to hospital under Part II of the Act.
- The duties of the practitioners and agencies involved in the management of patients subject to admission to hospital under Part II of the Act.

Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the guiding principles when they are considering the use of detention. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

6. Mental Disorder

Mental disorder is defined in section 1 of the Act as any disorder or disability of mind.

It is up to the relevant professionals involved to determine whether a person has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken. Compulsory measures are only permitted where specific grounds about the potential consequences of the person's mental disorder are met. There are many forms of mental disorder which are unlikely ever to call for compulsory measures.

6.1 Dependence on alcohol or drugs

There are no grounds under the Act for detaining a person in hospital on the basis of alcohol or drug dependence alone. However, alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. Individuals with a dual diagnosis should receive equitable care and treatment and support. If the criteria for detention are met, it is appropriate to detain people who are diagnosed with a mental disorder, even though they are also dependent on alcohol or drugs and/or if the mental disorder in question results from the person's alcohol or drug dependence.

Disorders or disabilities of the mind which are related to the use of alcohol or drugs e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, or organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act.

6.2 Learning disabilities

Learning disabilities are forms of mental disorder as defined in the Act. However someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or a Community Treatment Order under the Act unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. They can however be detained for assessment under section 2 of the Act, be subject to the holding powers under section 5 and admission under section 4.

6.3 Autistic spectrum disorders

The Act's definition of Mental Disorder includes the full range of autistic spectrum disorders, including those existing alongside a learning disability or any other kind of mental condition. It is possible for someone with an ASD to meet the criteria in the Act for detention without having any other form of mental disorder, even if the ASD is not associated with abnormally aggressive behaviour or seriously irresponsible conduct.

If people with ASD do need to be detained under the Act, they should be treated in a setting appropriate to their social and communication needs as well as being able to treat their mental condition.

6.4 Personality disorders

The Act does not distinguish between different forms of mental disorder and therefore applies to all types of personality disorders in exactly the same way as it applies to

other mental disorders. Personality disorder must never be viewed as a diagnosis of exclusion.

7. Nature or Degree

Nature refers to the particular disorder from which the patient is suffering, its chronicity, its prognosis and the patient's previous response to receiving treatment for the disorder.

Degree refers to the current manifestation of the person's mental disorder.

8. Appropriate Medical Treatment

When a patient has been detained under a treatment section of the Act, there must be appropriate medical treatment available for their mental disorder. This is to ensure that nobody is detained unless they are actually to be offered treatment for their mental disorder.

Medical treatment for mental disorder means medical treatment for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.

Appropriate medical treatment does not have to involve medication or individual or group psychological therapy. In particular cases appropriate treatment consists solely of nursing and specialist day to day care under the clinical supervision of an approved clinician.

8.1 Appropriate Medical Treatment Test

The appropriate medical treatment test requires a clinical judgment about whether an appropriate package of treatment for the mental disorder is available and accessible for the individual within the setting in which they are receiving that treatment. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for the mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for CTO, it refers to the treatment for mental disorder that the person will be offered while on CTO.

9. Nature of the Powers

All employees/workers are required to be aware of the importance of paperwork related to the Act. These are legal documents which allow for the detention of a person which deprives them of their liberty to leave the hospital.

It is important that the patient is aware of their rights under the specific detention, to include access to assistance such as an IMHA and appeal avenues.

It is important information is given in a language and a format that the patient understands and this is documented on the appropriate form.

9.1 Section 2

Detention requires two medical recommendations and an AMHP application which are required to be accepted prior to the person being classed as detained under section 2

of the Act. Detention is for a maximum of 28 days. If the section 2 follows a section 4 any time spent on the section 4 will count towards the 28 day period.

Renewal: **The section cannot be renewed**. If the patient is required to stay in hospital at the expiry of the section this would be either as an informal patient or detained for treatment under section 3. It can only be extended when an AMHP wishes to make an application to further detain a patient under section 3 but the nearest relative objects to the making of the application. The AMHP would consider displacing the nearest relative under section 29 of the Act by making an application to the County Court. If the application is lodged with the court, the section 2 can be extended under section 38 of the County Court Act 1984 whilst consideration is being given to displacing the nearest relative.

Medication: The person can be given treatment for mental disorder with or without their consent.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff, the AMHP or by the police.

S17 Leave: Patients can be granted S17 leave by their Responsible Clinician

Discharge: The Responsible Clinician, Mental Health Review Tribunal for Wales, Hospital Managers Hearing Panel or the Nearest Relative can discharge a patient from section 2.

9.2 Section 3

Detention requires two medical recommendations and an AMHP application which are required to be accepted prior to the person being classed as detained under section 3 of the Act. Initial detention is for a maximum period of up to six months.

Renewal: The section can be renewed for a further six months and annually thereafter. The Responsible Clinician must decide prior to the detention expiry if a renewal is necessary.

Medication: The person can be given treatment for mental disorder with or without their consent up to a maximum of three months, this includes any time spent on a section 2 previously.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff, the AMHP or by the police.

S17 Leave: Patients can be granted S17 leave by the Responsible Clinician

Learning disability: Under the provisions of section 3 of the Act, learning disability is only considered to be a mental disorder if it is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned (this does **not** apply to section 2).

Discharge: The Responsible Clinician, Mental Health Review Tribunal for Wales, Hospital Managers Hearing Panel or the Nearest Relative can discharge a patient

from section 3. Discharge may also occur by the patient becoming subject to a Community Treatment Order.

9.3 Section 4

Detention requires one medical recommendation and an AMHP application which are required to be accepted prior to the person being classed as detained under section 4 of the Act.

The AMHP making the application must have personally seen the patient within the previous 24 hours and the patient must be admitted within 24 hours of either the medical recommendation or the application being made.

The acceptance form will be used in conjunction with a second medical recommendation to convert to a section 2.

Section 4 should only be used where the patient's urgent need for assessment outweighs the alternative of waiting for a medical examination by a second doctor. The section should never be used for medical or administrative convenience, for example because it is more convenient for the second doctor to examine the patient as an inpatient rather than in the community.

Renewal: A section 4 is not renewable. The section may be converted to a section 2 within the 72 hour period by the addition of one other medical recommendation. Upon conversion, the 28 day period begins from the date of the section 4.

If the Approved Clinician in change of the patient's treatment considers that section 3 is more appropriate, two fresh recommendations and a new application must be made within the 72 hour period. The treatment order would begin from the date of the application for section 3.

Medication: Patients cannot be treated without their consent.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff, the AMHP or by the police. If the section expires they cannot be forcibly returned.

S17 Leave: Not applicable for this section.

Discharge: The responsible clinician can discharge the section.

9.4 Section 5

9.4.1 Section 5(4)

Under section 5(4) nurses of the **prescribed class** may detain a hospital inpatient who is already receiving treatment for the mental disorder for up to six hours. The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else.

A nurse of prescribed class is a nurse who is Mental Health and Learning Disability trained. A general nurse is not a nurse of a prescribed class.

Renewal: The section cannot be renewed and may not necessarily be followed by a further detention if the patient is de-escalated and agrees to remain in hospital. informally.

Medication: Patients cannot be treated without their consent.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff or by the police. **If the section expires they cannot be forcibly returned.**

S17 Leave: Not applicable for this section.

Discharge: The assessing Registered Medical Practitioner can conclude that no further detention is required this ends the detention.

9.4.2 Section 5(2)

A section 5(2) on inpatients authorises the detention of an informal patient for up to 72 hours by the Registered Medical Practitioner or nominated person in the case of absence. The nominated person must be the person in charge of the patient treatment, within the general hospital out of hours this must be the consultant on call and cannot be the junior doctor. The period of detention begins once the form is completed and received by Hospital Managers or an authorised person on their behalf who will complete the Receipt of Mental Health Act Documents form. In practice this will usually be the Nurse–In-Charge of the local psychiatric inpatient unit.

Efforts should be made by the Registered Medical Practitioner and nursing staff to persuade and encourage those patients who are at risk of harm to self or others and attempting to leave, to return to, or remain on the ward area. In many cases this will often be the best way to resolve the situation in accordance with the MP01 – Procedure for missing persons from BCUHB premises-Emergency Department and general wards.

Section 5(2) cannot be used for patients who are currently under any other section of the Act ie sections 2, 3, 4, 37, 38, 37/41, 48/49 and 47/49. Section 5(2) may only be used for patients under an informal status.

Patients who are transferred from the prison for medical attention are not under the Act but would be classed as a prisoner under restraint receiving hospital care. Prison Officer Escorts will be in situ at all times therefore alleviating the need to place the prisoner on a section to stop them from leaving the hospital.

Prisoners detained under the Act on Hospital Transfers 48/49 or 47/49 or under the restrictions of the Ministry of Justice 37/41 would not be subject to section 5(2) any admissions would be managed under S17 leave arrangements and escorts would be in place.

The policy does not apply to patients seen in the Emergency Department (ED) and Outpatient Departments (OPD) or those subject to a Community Treatment Order (CTO).

Renewal: Section 5(2) **cannot** be renewed, it ends at the expiry of the 72 hour period. **It is not good practice for a Section 5(2) to lapse**, any lapses will be monitored and followed up.

If a section 5(2) follows a section 5(4) any time spent on the 5(4) will count towards the 72 hour period.

Though section 5(2) cannot be renewed its subsequent reuse can be considered upon the patients reversion to informal status should circumstances arise; however repeated use of section 5(2) would tend to indicate that the patient has been inadequately assessed or managed and should not arise.

Medication: Treatment in relation to the individual's mental health cannot be given against the patient's consent.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff or by the police. **If the section expires they cannot be forcibly returned.**

S17 Leave: Not applicable for this section.

Discharge: The Responsible Clinician can conclude that no further detention is required this ends the detention.

9.5 Section 136

Section 135 detention is initiated by the magistrates Courts and enacted by the police. Section 136 detention is initiated by the police both last for 24 hours to allow for a mental health assessment. The clock starts when the police officer hands over the patient to health staff in a place of safety as identified, regardless as to whether the office remains with the patient. This currently is any hospital or designated place of safety. On acceptance at the place of safety, in ED or on a general ward this begins the detention timeframe.

Renewal: The detentions cannot be renewed but can be extended by 12 hours (maximum 36 hours) if the person is not fit for assessment.

Medication: Treatment in relation to the individual's mental health cannot be given against the patient's consent.

Absconsion: If the person absconds, they can be forcibly returned to hospital by an authorised member of hospital staff or by the police. **If the section expires they cannot be forcibly returned.**

S17 Leave: not applicable for this section.

Discharge: The section 135 and section 136 is discharged by the application and acceptance of a section under the Act or following assessment and a conclusion that no further detention is required.

10. Roles and Responsibilities

10.1 Registered Medical Practitioner

Where the patient was admitted for physical disorder with no previous psychiatric history or treatment, **only the Registered Medical Practitioner in charge of the patient's care may authorise the detention of a Section 5(2)**. They cannot nominate Specialist Registrars or FY1/FY2 doctors as a deputy. Therefore, in all circumstance this will be undertaken by the nominated person**.**

In the case of absence the nominated person will be in charge of the patient's care, for the purposes of BCUHB this will be the Consultant on Call or Surgeon in charge of the Patient's care.

The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances. However, a professional who is treating the patient under the direction of another professional should not be considered to be in charge (CoPW 18.5)

Where a patient is receiving treatment for both a physical and a mental disorder, the Psychiatrist or Approved Clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in Section 5(2) (CoPW 18.6). In the case of Children and young people requiring detention out of hours, the regional On Call CAMHS Psychiatrist can provide advice and guidance to the Registered Medical Practitioner and is contactable out of hours via the switchboard at YGC.

The Registered Medical Practitioner must be fully aware of the diverse needs of the patient when considering detention and must take them into account at all times. They must ensure that every effort is made to ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Within General/Acute Hospitals for adults the Registered Medical Practitioner should consult with the Mental Health Liaison Department for their area. Advice should always be sought from the Liaison Service who will attend as soon as possible and give advice.

The Psychiatric Liaison Team are contactable via:

East: 01978 291100 – bleep 5545
Central: 01745 585484 – bleep 6636
West: 01248 384384 – long range bleep Psychiatric Liaison

Within hours the Registered Medical Practitioner should consult with the Liaison Psychiatrist prior to the use of section 5(2).

Out of hours if the above is not practicable, then a Senior Psychiatrist should be consulted with.

Within Community Hospitals within hours the local CMHT should be contacted for contact details of Approved Mental Health Professionals (AMHPs) and

medics to complete an assessment under section 2 or 3 following a section 5(2) or the local Mental Health Act Office.

Out of hours contact details for AMHPs and Medics can be obtained from the local duty nurse of the area psychiatric unit.

The Mental Health Act Offices and the duty Nurses can be contacted on the numbers below:

Area	MHA Office	Duty Nurse (request the duty nurse for psychiatric unit is bleeped)
East	03000 585136	01978 291100 Bleep 5339
Central	01745 445645	01745 585484
West	01248 384630	01248 384091

The Registered Medical Practitioner must complete a written record of the assessment (Statutory Form HO12). As well as the completion of the statutory documentation, doctors must make a record of the assessment including the start time of the section in the patient's clinical notes.

A full Mental Health Act Assessment must be requested after the use of section 5(2).

10.2 Liaison

The Liaison Psychiatric Team **where practicable** will make the on call Psychiatrist aware of the situation and along with the nurse in charge of the local psychiatric unit assist in arranging further Mental Health Act Assessments out of hours.

The Liaison Psychiatric Team will attend the ward **as practicable** and provide advice and guidance to staff. They will also take the statutory papers from the ward and deliver them to the MHA Office (in hours) or the Duty Nurse (out of hours). The Liaison Team will ensure that the patient understands their rights under the MHA.

The Psychiatric Liaison Team will become involved with patients over 18 years old, within the District General Hospital. For advice regarding use of the Act in paediatric areas, please refer to the relevant section below.

(Community hospitals are covered by the local CMHT for the area). Contact should be made with the local CMHT who will assist in locating the appropriate psychiatrist for an assessment to be made, communication with the Mental Health Act Office for the area will also be instigated, out of hours the local psychiatric unit duty nurse can be contacted for information.

10.3 Adult Psychiatrists

On Call Psychiatrists must provide advice, out of hours, to the Registered Medical Practitioner and the Liaison Team for those over the age of 18 years. Within hours, the Consultant Liaison Psychiatrist will provide this advice for adults.

If a Section 5(2) is applied out of hours the on call Psychiatrist will advise the instigation of a Mental Health Act Assessment.

10.4 Responsible Clinicians

The Responsible Clinician is the Approved Clinician (usually a Consultant Psychiatrist) who is in charge of the patient's care and treatment under the MHA. They will review the patient regularly while they are detained, at least on a weekly basis but more frequently if this is clinically indicated. The Responsible Clinician is able to grant leave under Section 17 of the Act, and to discharge the Section when it is appropriate to do so.

10.5 Nursing staff

The ward nursing staff are responsible for day to day nursing care and to seek advice from other professionals if they have concerns about a patient's mental health.

10.6 CAMHS

The on call psychiatric provision for children and young persons under the age of 18 will be facilitated by the on call Child and Adolescent Psychiatrist who is contactable via switchboard at Glan Clwyd Hospital after 5pm on weekdays and at any time at weekends and must provide advice to the Registered Medical Practitioner.

Within hours the Consultant Child and Adolescent Psychiatrist for the area the patient is from should be contacted. This consultant can be located by contacting the local CAMHS team.

10.7 AMHP

It is the responsibility of the AMHP to ensure that the Mental Health Act office is aware of the detention and the papers are received this can be a delegated task to ward staff if appropriate.

10.8 Ward Manager community hospitals

If a patient is detained under a section the Ward Manager is responsible for linking in with the local CMHT and local Mental Health Act Office to inform of the detention.

10.9 Mental Health Act Office

Within normal working hours the Mental Health Act Administrator will ensure the section paperwork is completed sufficiently and arrange for acceptance by the Hospital Managers.

The Mental Health Act Administrator will contact Clinicians and an Approved Mental Health Professional (AMHP) for further assessment under the Act.

10.10 Nurse-In-Charge of Local Psychiatric Unit

Out of hours, the nurse in charge of the local psychiatric unit (referred to as the Duty Nurse) must accept a section 5(2) for the section to be in place on the form (Appendix 6).

The Duty Nurse will contact a Psychiatrist and an Approved Mental Health Professional (AMHP) to instigate a Mental Health Act Assessment for detention under section 2 or 3 of the Act if this has not already been started by Liaison (see 10.2).

The Duty Nurse will ensure that all section paperwork is delivered to the Mental Health Act Office.

11. Procedure

The flowcharts should be consulted (Appendices 1a & 1b) and The Procedure Summary (Appendix 2) guide the completion of a Section 5(2).

11.1 Section 5(2)

If it is felt a patient who is asking to leave has a mental disorder and will be a risk to self or others the Registered Medical Practitioner can invoke the power to detain the patient for a period of 72 hours, however consideration should also be given to whether the use of the Mental Capacity Act 2005 (MCA) would be more appropriate. Chapter 13 of the Code of Practice and paragraph 13.38 summaries the availability of the Act and of DOLS for treatment of a mental disorder.

The power can also be used if it is felt that the patient needs assessing for a section 2 or section 3 and is stating that they are going to leave and are a risk to self or others.

Patients who are in hospital by virtue of a Deprivation of Liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition (CoPW 18.10).

Contact must be made with the Liaison Psychiatry Service for advice and access to the Liaison Psychiatrist or a Psychiatrist on call.

Nurse in charge of the psychiatric unit to be informed out of hours.

Information to be provided to the patient regarding the actions and completion of form HO12.

The completed paperwork to be delivered via secure means by handing to the liaison nurse who will accept the paperwork and transport to the Mental Health Act Office (not via the hospital post). Within hours the Mental Health Act office should be contacted. Community Hospitals will need to link with the Local CMHT the Ward Manager will be responsible for informing the Mental Health Act Office.

Although section 5(2) can last up to a maximum of 72 hours, the assessment process must be put in place once the HO12 is completed.

The liaison nurse or the Mental Health Act Administrator will contact clinicians and an AMHP to further assess for detention under section 2 or 3.

All documentation to be delivered to the Mental Health Act Office by the liaison Nurse.

IMPORTANT: The patient must be made aware of their rights to include access to assistance such as an IMHA.

It is important information is given in a language and format that the patient understand and this is documented on the appropriate forms.

11.2 Section 2

If it is felt an inpatient is experiencing mental disorder and not expressing a wish to leave but it is felt that for their own health and safety or the safety of others an assessment should be undertaken, staff should contact the liaison team, the local CMHT depending on location or the Child and Adolescent Mental Health Services.

For assessment to detain under section 2 two medics (one must be Section 12(2) approved) will assess either jointly or separately and complete medical recommendations. The AMHP will assess and make an application if they feel it is necessary.

- A judgement is required on whether the patient will accept treatment on a voluntary/informal basis after admission.
- A judgement has to be made on whether a proposed treatment which can only be administered to the patient under Part 4 of the Act, is likely to be effective.
- The condition of a patient who has already been assessed and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and further assessment is required.
- The diagnosis and / or prognosis of a patient's condition is unclear.

The detention requires the completion of forms:

HO1 or HO2	Application by nearest relative or approved mental health professional (AMHP) And
HO3 or HO4	Joint (x1) or single medical recommendations (x2)
HO14	Record of detention in hospital

IMPORTANT: The patient must be made aware of their rights to include access to assistance such as an IMHA and appeal avenues.

It is important information is given in a language and format that the patient understand and this is documented on the appropriate forms.

11.3 Section 3

If it is felt an inpatient is experiencing mental disorder and not expressing a wish to leave but it is felt that for their own health and safety or the safety of others an assessment should be undertaken, staff should contact the liaison team or the local CMHT depending on location or the Child and Adolescent Mental Health Services.

Patients will also be assessed for a section 3 following a section 2 detention if the Responsible Clinician completes the first medical recommendation and does not discharge.

For assessment to detain under section 3 two medics (one must be Section 12(2) approved) will assess either jointly or separately and complete medical recommendations. The AMHP will assess and make an application if they feel it is necessary.

- The patient will be considered to need compulsory admission for the treatment of mental disorder, which is already known to his or her clinical team.

- Appropriate medical treatment must be available in all cases; the recommending doctors are required to state on the form that 'appropriate treatment' is available, including the name of one or more hospitals who can provide the treatment.

The detention requires the completion of forms:

HO5 or HO6	Application by nearest relative or approved mental health professional (AMHP) And
HO7 or HO8	Joint (x1) or single medical recommendations (x2)
HO14	Record of detention in hospital

IMPORTANT: The patient must be made aware of their rights to include access to assistance such as an IMHA and appeal avenues.

It is important information is given in a language and format that the patient understand and this is documented on the appropriate forms.

11.4 Section 136

A person detained on a section 136 may be brought to ED (Appendix 7) or a medical ward rather than the psychiatric unit place of safety.

On arrival the local psychiatric unit should be contacted to inform them of the admission. Liaison should be contacted to confirm whether the person is fit for assessment.

If the S136 relates to a child or young person under 16 years old presenting out of hours the paediatrician must be contacted to provide assessment to confirm that the child has no need of medical attention and that they are medically fit for a mental health assessment under the S136. If the young person presenting is 16 or 17 years old the junior doctor for the unit will provide a physical assessment.

If a child or young person is detained within working hours, the community CAMHS service from where the child is resident should be informed and the relevant Consultant Child and Adolescent Psychiatrist made aware so that a Mental Health Act assessment can be coordinated with an AMHP from the corresponding local authority area. If this occurs outside of working hours, the regional on call Child and Adolescent Psychiatrist should be informed and is contactable via the switchboard at YGC. The following day the relevant local community Child and Adolescent Psychiatrist will be available to provide assessment.

The duty nurse has a responsibility to ensure the section 135/136 paperwork is accepted and the clinical pathway is commenced and is delivered to the Mental Health Act Office on completion.

The on call or local psychiatrist will assess to see if they require detention under the Act and if required a second doctor and AMHP will be arranged to review.

If the local section 136 suite becomes available the person would be moved there if the assessment has not begun and it was felt a more suitable place for the person.

The staffing and environment should be adequate for the situation considering the risks posed to the patient and others whilst awaiting an assessment.

Once assessed if no further detention is required the section 136 ends and the person is no longer detained.

12. Information for patients

All persons detained on a section of the Act should be given a MHA Patient Information Leaflet by the CAMHS staff / Liaison Nurse which explains their legal rights. Information must be given to the patient verbally and in writing (As soon as possible / within 24 hours).

Leaflets can be found via the link:
Patient Leaflets - National Collaborative Commissioning Unit (nhs.wales)

Leaflet 4 (Section 5(2)
Leaflet 1 (Section 2)
Leaflet 2 (Section 3)
Leaflet 22 (Section 136)

The leaflets explain the right of appeal under each detention, this information should also be given verbally by the nurse.

13. Section 18 Absent without Leave (AWOL)

Patients who absent themselves without leave from hospitals who are under a detention of the Act can be returned by specific persons, ie hospital staff, police, AMHPs.

Please see nature of powers section for specific details.

14. Medical Treatment of Patients

The rules in Part 4 of the Act do not apply to patients detained under section 136, 5(4) 5(2) and section 4 and as such there is no power under the Act to treat a patient without their consent for their mental disorder.

Treatment on a CO2 statutory certificate can be authorised by the Responsible Clinician or the Clinician in charge in their absence, ie Consultant on Call or Consultant covering leave these cannot be written by anyone other than the person is the nominated Responsible Clinician and suitably qualified.

Medical treatment always implies that it is given with consent. MCA 2005 can only be used if it is deemed that a patient lacks capacity to consent to their care and treatment. The professional responsible for giving that specific treatment will need to assess to prove that the patient lacks capacity in relation to the material decision, at a specific time, to make the decision for themselves. It is important for the decision maker to determine if the patient has an attorney (donee) for a Lasting Power of Attorney for Health and Welfare as that person is the decision maker in place of the

patient. It is also important to determine if the patient has in place an Advanced Decision ("Living Will" that might be contrary to the proposed treatment.

For children and young people, dependant on the patient's age consideration may be given to Gillick competence or the MCA. A Medical Practitioner may determine that the child or young person lacks the mental capacity to refuse the treatment. Under these circumstances, consideration needs to be given regarding whether the treatment indicated is life saving and therefore treatment may be given under common law and within best interests. In some circumstances where a child under the age of 16 years has made a competent refusal of a treatment, a person with parental responsibility, or the courts, may nevertheless authorise the treatment where it is in the child's best interests. The MHA CoPW 19.25 – 19.31 details clear guidance for practitioners when considering to rely upon parental consent.

15. Transfer to other hospitals

Patients detained under section 5(2) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the Mental Capacity Act.

If following transfer the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

Patients detained under section 2 and 3 can be transferred between hospitals under section 19.

If a patient is to be moved the Mental Health Act office within hours or the duty nurse of the local psychiatric unit out of hours **MUST** be contacted to ensure the transfer is conducted within legal requirements.

16. Monitoring

All sections are monitored. The Mental Health Act Manager provides a quarterly report covering the use of detentions, for some this includes appropriateness of use, speed of assessments and outcomes to the Mental Health Capacity and Compliance Committee.

All lapsed sections are monitored and investigated to ascertain the reasons for the lapse and reported through the Mental Health Capacity and Compliance Committee. Any areas of concern will be escalated to the appropriate manager to address with the relevant staff member.

17. Training

Mental Health Act Awareness and Intermediate Training is available for all staff who have contact with patients.

Levels and competencies are detailed below:

Level	Method	Update	For whom	Comments
Level 1 – Awareness	Workbook	Once only	Registered staff should complete the workbook.	See below
Level 1 – Awareness	Session	Every 3 years	Unregistered staff	
Level 2 – Intermediate	Session	Every 3 years	Band 7 level Ward sisters. Consultant and senior medical staff.	To attend Level 2 staff must already have current competency at Level 1 via completion of the workbook.

18. Reference to Legislation

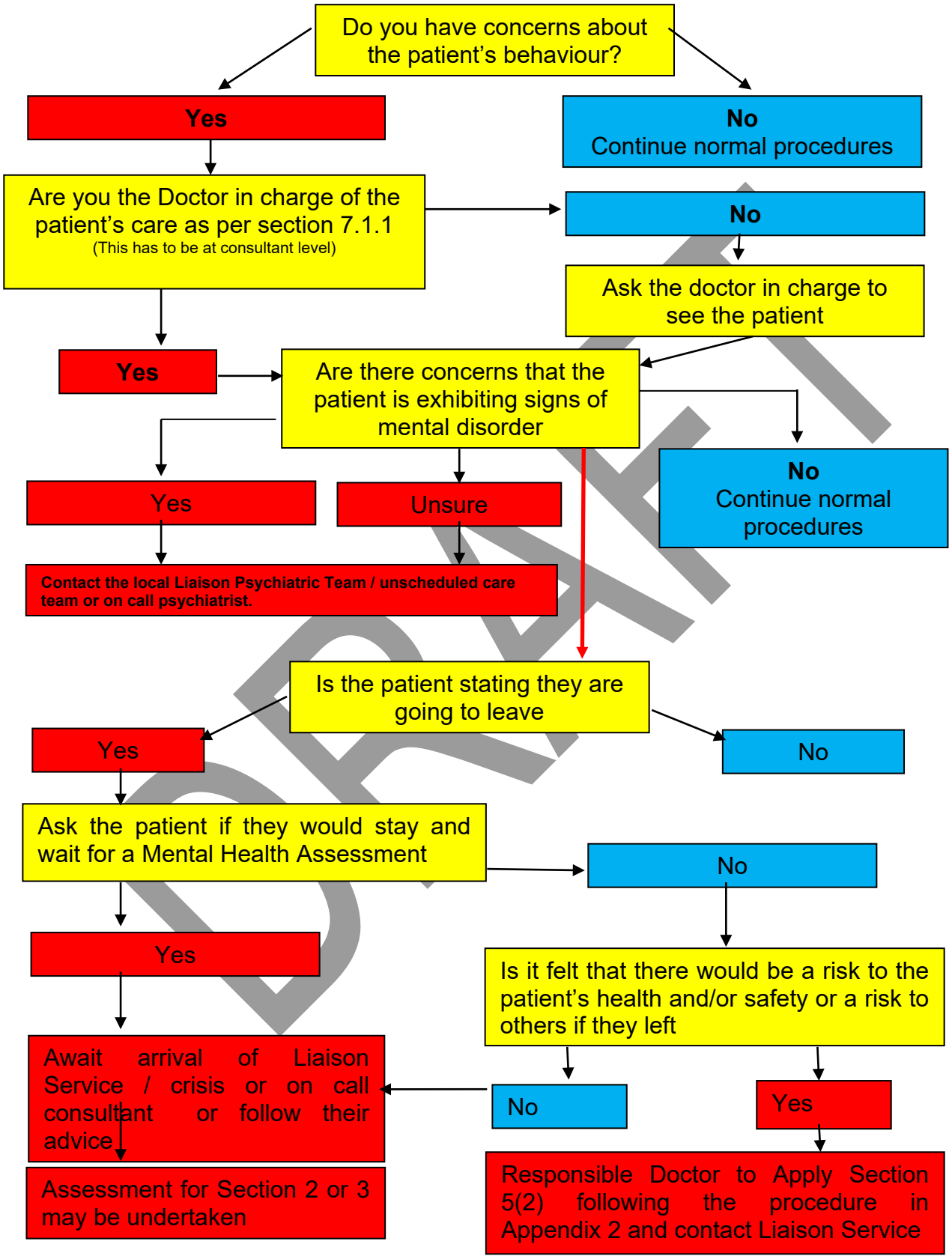
All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2016, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Deprivation of Liberty Safeguards

19. Appendices

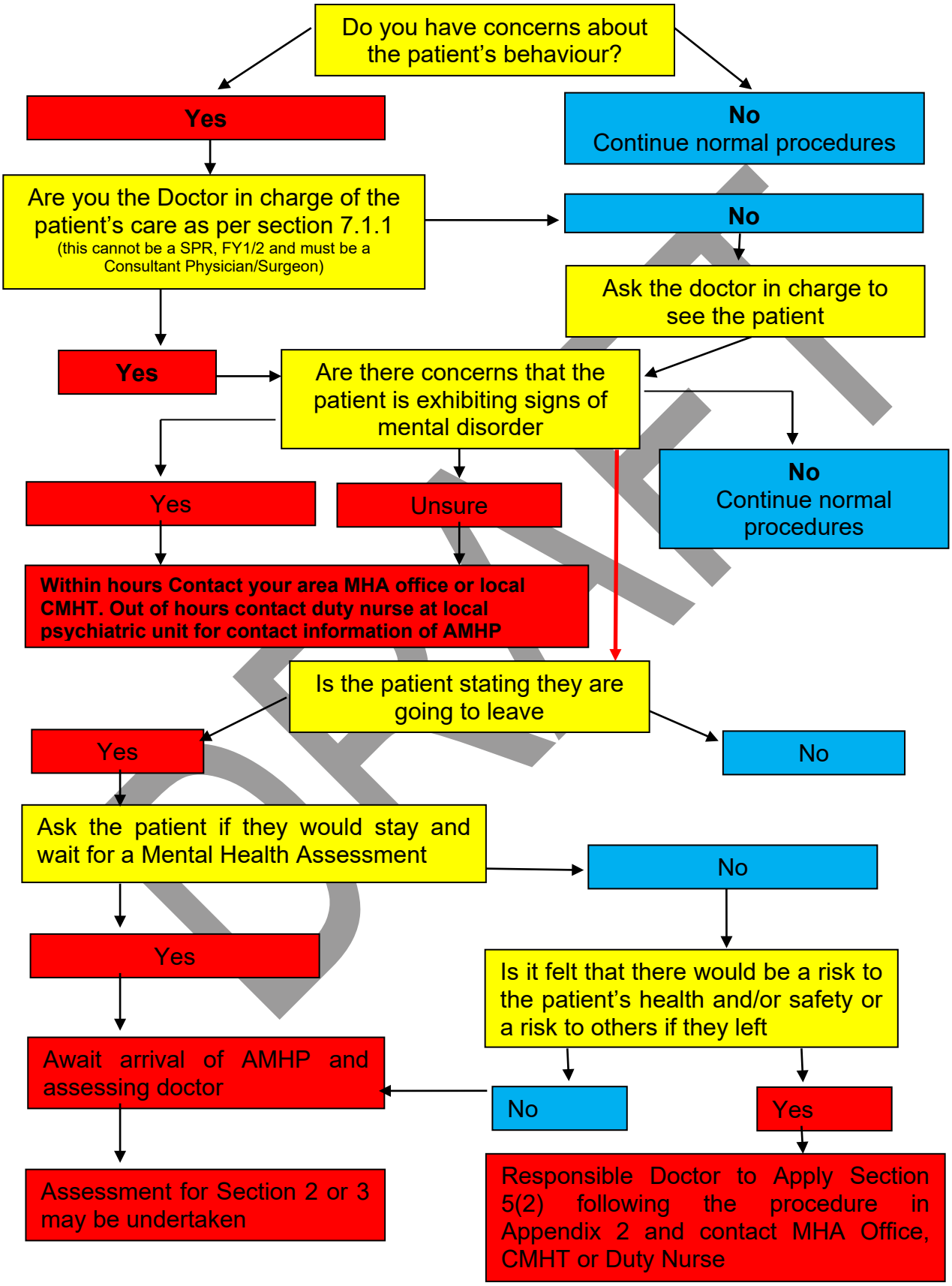
Appendix 1a

FLOWCHART (ACUTE HOSPITALS) SECTION 5(2)



Appendix 1b

FLOWCHART (COMMUNITY HOSPITALS) Section 5(2)



Appendix 2

Section 5(2) Procedure Summary

1. Ensure that you are the doctor in charge of the patient's treatment under the terms of the Mental Health Act see point 9.4.2.
2. Contact Liaison Service to inform and seek advice (General Hospitals only).

- Assess and personally examine the patient.

  Note: Psychiatrists will not undertake 5(2) assessments in general hospitals or on Paediatric wards as they are not the treating doctor.

- If you decide to hold the patient under section 5(2), complete form HO12 **legibly,** as follows:

  Note: The forms must be written – no patient labels are to be used.

1. Provide the **full and correct address** of the hospital in which the patient is to be detained under section 5(2).
2. Enter your **full** name
3. Declare by deleting **(a) or (b),** your status for the purpose of Section 5(2)
4. Enter the patient's full name
5. Give **full reasons why informal treatment is no longer appropriate. Support this with evidence**:

   1. Suggesting the presence of a mental disorder
   2. Suggesting that the patient was at risk
   3. That the patient would no longer remain on the ward informally
   4. That there is a need for a further assessment under the Act

6. State the **exact time** when you furnished the report to the Hospital Managers. In BCUHB this means hand deliver or fax to the Mental Health Act Office (normal working hours) or Duty staff/Nurse in Charge of the Psychiatric units (outside of normal working hours). This is the start time of the Section 5(2). **Do not use the Health Boards Internal Mail system!**
7. Make sure that you sign and date the completed Form HO12
8. Record your actions.
9. Patient to be given information leaflet regarding their rights.
10. For patients over 18 Confirm with Liaison or Inform the Nurse in Charge of the Psychiatric Unit or the Mental Health Act Office to instigate a Mental Health Act Assessment. If part of a community hospital contact can also be through local CMHT within hours. For children and young persons contact child and adolescent services as outline in point 10.6

Appendix 3 HO12 **available from NHS website** HO Forms - National Collaborative Commissioning Unit (nhs.wales) **must be printed on pink paper**

Appendix 4 Example of completed S5(2) HO12 form

Regulation 4(1)(g)

Mental Health Act 1983 section 5(2) – report on hospital in-patient

PART 1

(To be completed by registered medical practitioner or approved clinician in charge of the treatment of the patient under section 5(2) or any person nominated under section 5(3))

To the managers of

(name and address of hospital)

Ysbyty Gwynedd
BANGOR
Gwynedd LL57 2PW

Other addresses would be
Glan Clwyd Hospital
Bodelwyddan
Denbighshire
LL18 5UJ

Wrexham Maelor Hospital
Croesnewydd Road
Wrexham
LL13 7TD

For Community Hospitals the full hospital address needs to be written acceptance will be by the area MHA office or Psychiatric Unit Duty Staff.

Full name

I am **Christian Name, Surname**

and I am

Delete (a) or (b) as appropriate

Delete the phrase which does not apply

(a) the registered medical practitioner/the approved clinician (who is not a registered medical practitioner)

OR

(b) a registered medical practitioner/an approved clinician who is the nominee of the registered medical practitioner or approved clinician

in charge of the treatment of

(full name of patient)

Full (not abbreviated) Christian Name, Middle Names, Surname

Who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons

(the full reasons why informal treatment is no longer appropriate must be given)

Give Reasons why the detention is needed ie describe patient's behaviour, is the patient threatening other patients/staff, is the patient a danger to self or others, is the patient trying to leave hospital, risks, further assessment needed, be clear on why informal treatment is no longer an option.

Delete the phrase which does not apply

NOTE: BCUHB do not use internal mail systems for original section papers (see section 8)

I am furnishing this report by:

Consigning it to the hospital managers' internal mail system today.

(time) at ***20:30 (Time S5(2) put on)***

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed: ……Your Signature……

Date: ……Ensure correct date ……

PART 2

To be completed by Hospital Managers ONLY - The Mental Health Act Office will ensure the correct person signs as this must be a nominated person within the MHLD scheme of delegation.

To be completed on behalf of the hospital managers

(delete the phrase which does not apply) (time and date)

This report was:

Furnished to the hospital manages through their internal mail system

Delivered to me in person as someone authorised by the hospital manager to receive this report at [ ] on [ ]

Signed: …….. on behalf of the hospital managers

Name: ……

Date: ……..

Appendix 5

CHECKLIST FOR SECTION 5(2)

1 x FORM HO12 REQUIRED

APPLICATION IN RESPECT OF PATIENT ALREADY IN HOSPITAL

1 The form must be correctly address to the appropriate hospital (Eg: Ysbyty Gwynedd, Glan Clwyd or Wrexham Maelor)

2 **Full** correct name of the Doctor

3 **Full** forename(s), surname of patient

4 The form must be signed by the registered medical practitioner in charge of the patient's treatment, or his nominee*.

5 The doctor must give sufficient reasons why informal treatment is no longer appropriate. Full description of the patient's mental state and possible reluctance to stay in hospital.

6 Correctly signed, dated and time*

***ERRORS WHICH CANNOT BE RECTIFIED**

PROCEED TO COMPLETE 'RECORD OF ACCEPTANCE'

Appendix 6

MENTAL HEALTH ACT 1983
RECEIPT OF MENTAL HEALTH ACT DOCUMENTS

This form must be completed by the Duty Nurse in Charge of the Unit for any patient admitted under the following Sections –

Section 5(4) ……
Section 5(2) ……
Section 4 ……
Section 2 ……
Section 3 ……
Section 17E (CTO recall – CP5) ……
Section 17F (CTO revocation – CP7) ……

PATIENTS NAME: _____

As the Duty Nurse in Charge of the Unit, I have received the section papers for the above named patient on behalf of the Hospital Managers of Betsi Cadwaladr University Local Health Board – (Insert Names of Unit below)

_____

Date and time of section (if already an inpatient) **OR** date and time of admission into hospital under section: ***(Time is when patient is sectioned/arrives in unit, NOT when paperwork is checked by Duty Nurse)***

Date: __ __ / __ __ / __ __ __ __ **Time:** _____

Was Patient admitted from England: ***Yes* / No***

****If yes paperwork must contain a 'wet' signature, typed will invalidate.***

I have checked the papers with the checklist attached (**Appendix 2, 3, 4 or 5 as appropriate**).

The following errors need to be amended:

……
……
……

REPORT BY AMHP (REQUIRED UNDER 'CODE OF PRACTICE 14.87')

FORM RECEIVED: **YES** ☐ † **NO** ☐ †

Senior Nurse Full Name: _____

Designation: _____ Signature: _____

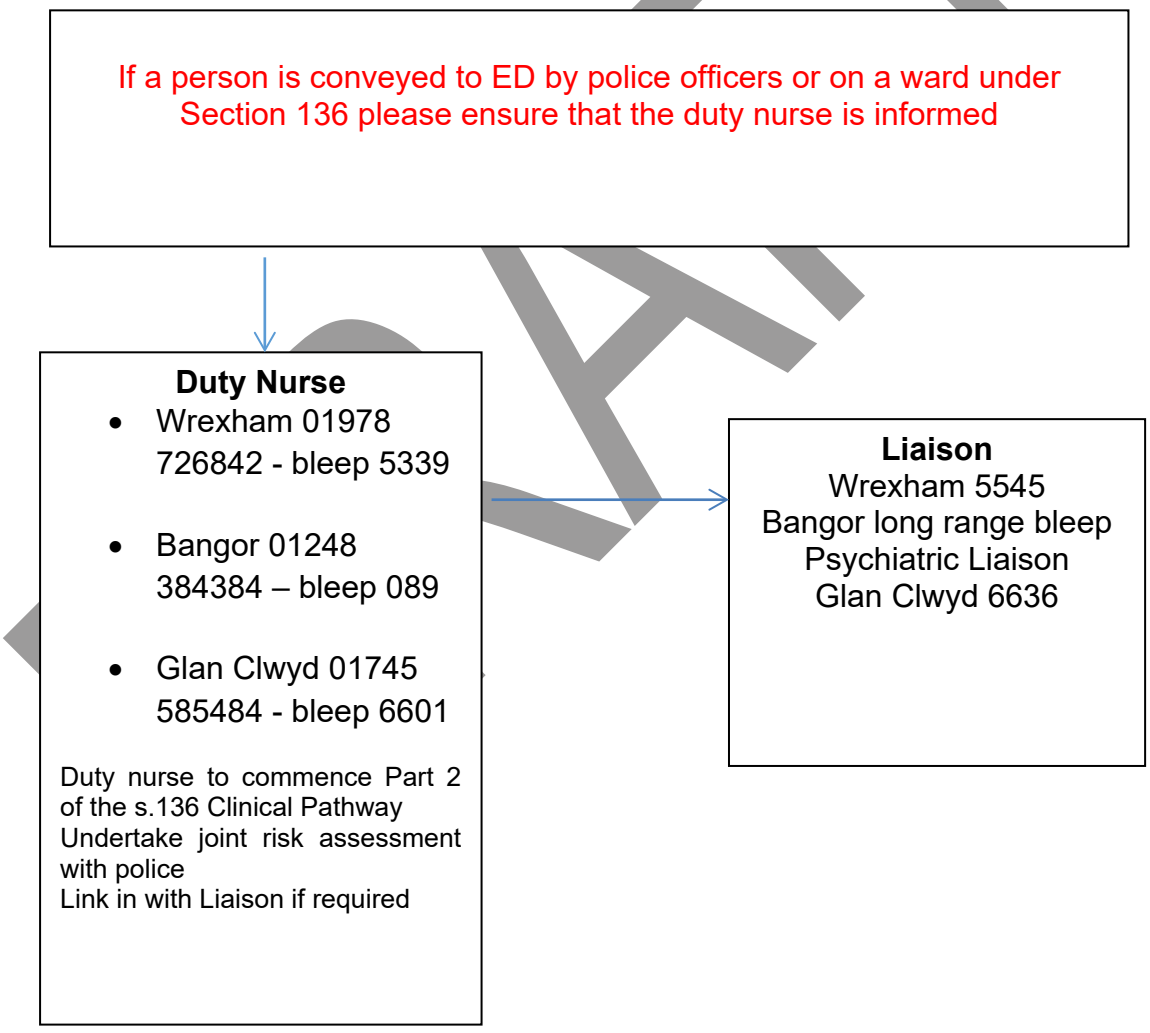
This form and the Section Papers must be forwarded to the Mental Health Act Office ***AS SOON AS POSSIBLE***

Appendix 7

FLOWCHART (ACUTE HOSPITALS) SECTION 136

For the majority of persons detained under s.136 police will convey them to one of the three registered health based place of safety (s.136 Suites).

This process is for persons detained under Section 136 of the Mental Health Act (1983) who have entered the Emergency Department or who the police have brought to a medical ward. The aim is to ensure that the person is assessed within the detention period (24 Hours). If this process is not followed the patient may not be assessed prior to the s.136 detention expiring.



If a person is not assessed within the period of detention then the detention will lapse after 24 hours or 36 hours if an extention was applied. Any lapse will be subject to Serious Untoward Investigation.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	Policy on: Application for admission to hospital under Part II of the Mental Health Act 1983
Date form completed:	June 2018 Reviewed June 2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or a disability as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ *How does your policy / proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?*
- ✓ *What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce / remove these?*
- ✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / proposal? Can these barriers be reduced or removed?*
- ✓ *Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.*
- ✓ *How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?*

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Policy on: Application for admission to hospital under Part II of the Mental Health Act 1983.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy provides relevant professionals with guidance to facilitate compliance with the requirements in respect of admission to hospital under Part II of the Act 1983. Part II of the Act relates to the following: • Section 2 – Admission for assessment • Section 3 – Admission for treatment • Section 4 – Admission for assessment in cases of emergency • Section 5 - Application in respect of a patient already in hospital • Section 6 – Effect of application for admission The purpose is to ensure that all employees/workers are aware of their responsibilities and avenues to follow to obtain assistance and ensure the needs of the patient are met and are safeguarded. The document is applicable to all areas of the Health Board (General and Psychiatric setting) and covers all ages. The Act is applicable to all and does not have a minimum age for detentions. The aims of the policy are to: • Ensure all employees/workers are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Act • Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended 2007. • Ensure that statutory requirements under the Mental Health Act 1983 are met. • To facilitate the development of good practice.

Part A Form 1: Preparation

		The policy describes: • The purpose of admission to hospital under Part II of the Act. • The process for assessing the suitability for admission to hospital under Part II of the Act. • The duties of the practitioners and agencies involved in the management of patients subject to admission to hospital under Part II of the Act. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the guiding principles when they are considering the use of detention. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Mental Health and Learning Disabilities Division Policy/Procedure Sub Group. Mental Health and Learning Disabilities Division Senior Leadership Team Quality and Safety Experience Group.
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Act 1983 (as amended 2007) Mental Health Act Code of Practice for Wales (Revised 2016) Mental Capacity Act Code of Practice (2020) County Court Act 1984 Mental Health Act Scheme of Delegation MHLD AC008 Missing absconding Patient Policy MPO1 – Procedure for missing persons from BCUHB premises – Emergency Department and General Wards MHLD 0047 Physical Restraint Policy MHLD 0057 North wales Section 135 and 136 MHA Protocol MHLD 0030 Policy for information to patients (s132/3 MHA) MHLD 0026 Policy for admission, receipt and scrutiny of statutory documentation

Part A Form 1: Preparation

		MHLD 0044 Section 17 Leave of Absence Policy
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Service Users, Employees and workers, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators and Assistants, Approved Mental Health Professionals, Qualified Nursing staff and other professionals working within mental health services.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Training for employees / workers who may be involved in the care of detained patients. Communication to employees / workers Workflow chart and examples. Cooperation of employees / workers Time constraints
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This policy ensures that any person working within mental health and acute hospital services has an understanding of the sections under Part II of the Mental Health Act, and the police powers used under S135/136 to include the associated detail such as leaves, timescales, and discharge avenues. It allows for people working within mental health and acute hospital services to be aware of their responsibilities and avenues to follow to ensure the needs of the patient are met and are safeguarded.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? i.e. Will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	√			√	This policy relates to all persons of any age who will be detained under the MHA under part II or a police section. As North Wales has a large demographic of older persons it is highly likely that the detained patients could be suffering from dementia. Older person may be more likely to have a sensory impairment or a physical impairment which may lead to a lack of understanding of the implications of wanting to leave the unit.	Easy read leaflets are available to assist people who may have an impairment due to their age. Staff are aware of how to access translation services which are available for sign language, braille and languages.
Disability (think about different types of impairment and health conditions:-	√			√	Mental Health Illness can affect anyone and it is acknowledged that people with learning impairments may require additional support to understand their detention. Persons who are detained under the MHA will often initially be in a state of crisis and not fully understand the information given to them or why they are no longer allowed to leave the unit. Sensory and physical impairments can	Discrimination is eliminated by everyone being treated in accordance with the current legislation. Easy read leaflets will be available for people to assist their understanding of why they

i.e. physical, mental health, sensory loss, Cancer, HIV)					apply at all ages and may render understanding and communication difficult.	are being placed under a Section when previously they may have been under an informal status. Provisions have been considered for specialised services such as sign language and assistance by learning disability staff. Staff will explain to the patient their rights and leaflets are not simply handed over with the expectation of the patient to understand.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		√			We do not consider there are any impact for persons who are undergoing gender reassignment.	
Pregnancy and maternity		√			Having considered potential impacts none have been identified considerations will be given to pregnant women and nursing mothers under workforce policies.	

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.	√			√	We are aware that people from BAME backgrounds can be more likely to have a Mental illness. If someone meets the criteria for detention race would not affect the decision. This policy applies to all who meet the criteria. There is evidence that BAME populations are disproportionately more likely to be detained.	Discrimination will be eliminated through the understanding of cultural values and communication needs will be met by where possible providing information and leaflets in alternative languages. Translators are also available as required.
Religion, belief and non-belief		√			We do not consider there are any impact for persons due to their belief or non-belief.	
Sex (men and women)		√			We do not consider there are any impact due to a person's sex.	
Sexual orientation (Lesbian, Gay and Bisexual)		√			We do not consider there are any impact due to a person's sexual orientation.	
Marriage and civil Partnership (Marital status)		√			We do not consider there are any impacts due the marital status.	

Low-income households		√			No impact on this policy.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	√				The powers under the MHA do not violate human rights because the procedural safeguards established under convention case law do not apply to emergency situations.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	√			√	The Welsh Language Standards are to be adhered to in Wales this involves ensuring that it is clarified at the outset as to what language a patient wishes to communicate in.	Once someone is detained under a section they must be explained their rights and information given to them with confirmation they have understood. Within the explanation of rights form this now details if the information has been given in the patients preferred language and will be reported on.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Treating the Welsh language no less favourably than the English language	√			√	Information for the patients are available in both English and Welsh. When it is explained to a patient the reason for the section and the use this should be done in Welsh if this is the patients first language.	Forms are also in English and Welsh for staff to choose which they wish to complete.

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Engagement has been via the Health Boards consultation page of the intranet and distribution to appropriate groups. The document was distributed to the MHLD divisional staff, Local Authority, Childrens services both mental health and paediatric staff, safeguarding and the Welsh Language Department. This enabled care coordinators / safeguarding to consider the impact on those with protected characteristics and discuss if necessary.	
Have any themes emerged? Describe them here.	No	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	N/A	

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Policy on: Application for admission to hospital under Part II of the Mental Health Act 1983.

2. Brief Aims and Objectives: (Copy from Form 1)	This policy provides relevant professionals with guidance to facilitate compliance with the requirements in respect of admission to hospital under Part II of the Act 1983. Part II of the Act relates to the following: • Section 2 – Admission for assessment • Section 3 – Admission for treatment • Section 4 – Admission for assessment in cases of emergency • Section 5 - Application in respect of a patient already in hospital • Section 6 – Effect of application for admission The purpose is to ensure that all employees/workers are aware of their responsibilities and avenues to follow to obtain assistance and ensure the needs of the patient are met and are safeguarded. The document is applicable to all areas of the Health Board (General and Psychiatric setting) and covers all ages. The Act is applicable to all and does not have a minimum age for detentions. The aims of the policy are to: • Ensure all employees/workers are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Act • Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended 2007. • Ensure that statutory requirements under the Mental Health Act 1983 are met. • To facilitate the development of good practice.

Part B Form 5: Summary of Key Findings and Actions

	The policy describes: • The purpose of admission to hospital under Part II of the Act. • The process for assessing the suitability for admission to hospital under Part II of the Act. • The duties of the practitioners and agencies involved in the management of patients subject to admission to hospital under Part II of the Act. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the guiding principles when they are considering the use of detention. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes x	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? This policy will ensure that the law is complied with under the MHA and the provision of ensuring appropriate use of detention. It is felt this policy has a positive effect on all as it ensures the law is upheld and it is evidenced that patients are being detained to ensure their safety and the safety of others. Article 5 is considered in ensuring the patient is not deprived of their liberty . Although potential negative impacts have been identified these have been mitigated against.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes x	
	Record Details: Negative impacts have been identified under Age, Disability, and Race but these have been mitigated within the document.	
6. Are monitoring	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	How is it being monitored?	The use of the MHA is monitored on a quarterly basis and reported to the Mental Health Capacity and Compliance Committee (MHCCC) where further scrutiny takes place. Changes are monitored and agreed via the MHLD Policy/Procedure Sub Group and the MHLD SLT QSE.
	Who is responsible?	Mental Health Act Manager.
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? The number/activity of each sections used. The area of use. The timeframe of some sections and the outcome.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	3 years from re-approval.

7. Where will your policy or proposal be forwarded for approval?	MHLD Policy/Procedure Implementation Group MHLD Senior Leadership Team Quality, Safety and Experience Group.

Part B Form 5: Summary of Key Findings and Actions

	BCUHB Clinical Policy and Procedure Group BCUHB PSQG MHCCC

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Wendy Lappin	Mental Health Act Manager
	Catherine Baker	Liaison Consultant Psychiatrist
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	These are already in place as described in mitigating actions		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	These are already in place as described in mitigating actions		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?

Version review
MHLD 0044

Mental Health & Learning Disabilities Section 17 Leave of Absence Policy

Author & Title	Wendy Lappin, Mental Health Act Manager				
Responsible Dept / Director:	Matthew Joyes, Associate Director of Quality, Quality Directorate.				
Type of Document	Policy				
Approved by:	MHLD Policy/Procedure Group – 02/08/2022 MHLD Divisional Senior Leadership Team Quality Safety and Experience Group – 16/08/2022 Patient Safety Quality Group – 12/09/2022 Mental Health Capacity Compliance Committee -				
Date approved:					
Date activated (live):					
Documents to be read alongside this document:	MHLD 0025 – Ty Llywelyn Section 17 and Therapeutic Leave Policy relating to Patients detained under the MHA 1983(2007) MHLD AC008 – Missing Absconding Person Policy Code of Practice for Wales (revised 2016) Mental Health Act 1983 (as amended 2007)				
Date of next review:	Maximum 3 years				
Date EqIA completed / reviewed:	August 2018 reviewed June 2022				
First operational:	3 November 2008				
Previously reviewed:	August 2018				
Changes made yes/no:	Yes				
Details of changes since last review	Updated information section 7 regarding restricted patients medical appointments, Annexes added. Case law regarding longer periods of leave acknowledged. Absence without leave (S18) includes reference to the Ministry of Justice.				

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1. Introduction and Policy Statement

A patient currently liable to be detained in a Hospital or specified Hospital Unit can only leave that Hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act.

Section 17 of the Act requires the Responsible Clinician to authorise personally any leave from Hospital of a patient detained under the Act.

Section 17 applies to patients who are detained under Sections 2, 3, 37 and 47 of the Act.

For patients on Restriction orders (i.e. Section 37/41) the Responsible Clinician must seek the agreement of the Ministry of Justice before granting leave under Section 17. The Responsible Clinician is also not able to grant leave of absence to patients detained under Section 35, 36 or 38 of the Act.

Sections 35 and 36 the remanding court must be in agreement with the leave, the Responsible Clinician would need to request in writing permission from the court prior to the leave being granted. For Section 38 no leave can be granted and the court must be made aware in instances of emergency treatment.

Informal patients are not subject to Section 17 leave under the Mental Health Act. A patient who is not detained has the right to leave, other than those patients subject to authorisation under the Deprivation of Liberty Safeguards (DoLS). However, patients may be asked by staff to inform them when they want to leave the ward. In the case of children, safeguarding needs and the opinion of the person with parental responsibility as determined by s3(1) of the Children Act 1989 should be taken into account.

2. Purpose of the Document

The purpose of this policy is to ensure that leave arrangements under Section 17 comply with the Mental Health Act provisions.

The policy informs Hospital employees/workers how to manage and record Section 17 leave.

3. Scope

This policy is concerned with inpatients who are detained under the Mental Health Act 1983 as amended 2007within the facilities managed by Betsi Cadwaladr University Health Board.

The policy is concerned with Section 17 leave only (17A or Supervised Community Treatment is addressed within a separate policy).

4. Aims and Objectives

This policy provides guidance on the use of leave of absence and the procedure that must be followed when granting Section 17 leave. As the Mental Health Act is prescriptive by law the use of section 17 leave must be adhered to and followed as described within the policy.

5. Roles and Responsibilities

The responsibilities of the Responsible Clinician and other professional staff involved with the patient's care remain the same whilst the patient is on leave, although it is exercised in a different way. The duty to provide after-care under Section 117 Aftercare provisions applies to patients who are on leave of absence, provided they qualify.

Ward Managers and the Nurse in Charge are responsible for the implementation of the policy.

5.1 Responsible Clinician

Only the patient's Responsible Clinician can grant leave of absence to a patient detained under the Act. Responsible Clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual Responsible Clinician, e.g. if they are on leave, permission can be granted only by the Approved Clinician who is, for the time being, acting as the patient's Responsible Clinician.

Responsible Clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

The Responsible Clinician can authorise the Nurse in Charge of the ward to curtail leave at their discretion. In practice, this is likely to be leave granted for specific occasions or specific periods.

When a patient is transferred or a change of Responsible Clinician is made, the new Responsible Clinician MUST review any previously granted leave and either agree for continuation by completing a new Section 17 leave form or recording that this has been revoked.

5.2 Nurse in Charge

The nurse in charge has the authority to curtail leave. Leave should only be curtailed where, in the opinion of the Nurse in Charge of the ward, there is a marked deterioration in the mental state of the patient. Where the nurse considers it necessary to curtail leave, a record must be made in the patient's case notes and the Responsible Clinician must be informed at the earliest opportunity.

5.3 Escorting staff

Staff who are responsible for escorting patients may be of a profession such as nursing, therapy, psychology but can also include assistants and those employees/workers deemed appropriate.

Prior to leave, the escorting staff should familiarise themselves with the conditions of the Section 17 leave.

Following the leave, the escorting staff are responsible for communication in relation to how the leave went and documentation appertaining to the leave process. If at any time the escorting staff have safety concerns whilst on leave they can end the leave and return to the unit.

6. Procedure

The flowchart should be consulted (Appendix 1)

The Responsible Clinician should ensure that when considering and planning leave the criteria identified within the Mental Health Act 1983 Code of Practice for Wales 2016 paragraph 27.7 should be adhered to.

Leave of absence granted for specified occasions may include:

- Outpatient appointments
- Therapy sessions
- Attendance at weddings/funerals
- Shopping expeditions
- Home leave

Leave of absence granted for specified periods may include:

- Overnight leave at home
- Weekend leave
- Weeks leave

The Section 17 leave form must be completed and the dates of the leave specified. To include leave details, duration, frequency and number of escorts if required. The determination of the number of escorts will be by the Responsible Clinician following discussion with the Multi Disciplinary Team to include the consideration of risks identified in risk assessments.

NOTE: Leave with relatives is regarded as UNESCORTED Leave unless this is specified as custodial leave (please see section 10).

The form must be signed and dated by the Responsible Clinician or the covering Responsible Clinician.

On return from leave whether escorted or unescorted the nursing staff must complete a mental state examination and feedback in relation to the leave, any further information from family/relatives should also be obtained as appropriate.

7. Restricted Patients

Where the courts or the Secretary of State have decided that a restricted patient is to be detained in a particular unit of a hospital, that patient will require the Secretary of State's permission to have leave of absence, to go to any other part of that hospital as well as outside the hospital. (CoPW 27,35)

Following Multi-Disciplinary Team agreement and completion of risk assessments, the Responsible Clinician must apply to the Ministry of Justice for Escorted and or Unescorted leave with the completion of leave request form available from Request leave for restricted patients - GOV.UK (www.gov.uk) Responsible Clinicians should submit any additional information they consider would assist in reaching a decision.

Written authorisation from the Ministry of Justice must accompany the Section 17 documentation and be stored in the patient's notes.

The Responsible Clinician should notify the Ministry of Justice if they need to suspend the leave of any restricted patients. Consideration will then be given as to whether to revoke or rescind the leave or allow the leave to continue.

All Responsible Clinicians at any hospital have general consent to exercise their power to grant leave for medical treatment. The terms differ, depending on the type of patient (whether the patient is a transferred prisoner or whether they have been diverted to hospital for treatment by way of a hospital order). The precise terms are set out in the attached annexes (Appendix 5). If the Responsible Clinician wishes to deviate from these criteria, they should contact the Mental Health Casework Section at the Ministry of Justice and seek written approval to do so, explaining why the change is sought and considered to be appropriate.

It is accepted that there will be times of acute medical emergency where the patient requires emergency treatment. In these situations, the Responsible Clinician may use their discretion, having due regard to the emergency or urgency being presented and the management of any risks, to have the patient taken to hospital.

The Secretary of State (through the Ministry of Justice Casework Section) should be informed as soon as practicable that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient has been returned to the secure hospital. (CoPW 27.37).

8. Short Term Leave

The Responsible Clinician may decide to authorise short-term leave, managed by other staff. If the patient is subject to restrictions the authority of the Secretary of State for Justice will also be required. As an example, the patient may be given leave for a shopping trip of two hours every week, with the decision on which particular two hours left to the discretion of the responsible nursing staff. The parameters within which this discretion may be exercised should be clearly set out by the Responsible Clinician to ensure the terms of the leave prescribed, cannot be interpreted differently by the staff managing the leave of absence.

9. Longer periods of Leave

Leave may be used to assess a patient's suitability for discharge from detention. The patient should be fully involved in the decision to grant leave and should be able to demonstrate that they will be able to cope outside of the hospital.

When considering whether to grant leave for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, Responsible Clinicians should also consider whether the patient should go on to a Community Treatment Order (CTO) instead. This does not apply to restricted patients, or, in practice, to patients detained for assessment under Section 2 of the Act as they are not eligible to be placed on a CTO (CoPW 27.8)

The option of using a CTO does not mean the Responsible Clinician cannot use longer-term leave if that is the more suitable option, but they will need to be able to

show both options have been considered. Decisions should be fully documented in the patient's notes (CoPW 27.9)

Long term section 17 leave cannot be used if the patient is not required to need any medical treatment within a hospital, 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also subsection (4) below); …

(4) Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. (Upper Tribunal case no: HMW/1727/2020 [2021] UKUT 53 (AAC) *DB v Betsi Cadawaldr University Health Board*)

Subject to patient consent, there should be detailed consultation with appropriate relatives and friends, including, where appropriate, independent advocacy and community services.

Where relatives/friends are to be involved in the patient's care, but the patient does not agree that they should be consulted, leave should not be granted.

It is essential carers, especially where the patient is residing with them while on leave, and professionals who support the patient while on leave, should know who to contact if they feel consideration should be given to return of the patient before their leave is due to end.

10. Custodial Leave

Under the Mental Health Act a Responsible Clinician may direct that a patient remains 'in custody' while on leave of absence. Patients may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the Hospital Managers.

Custodial Leave may be used in circumstances to allow patients to participate in escorted trips or to have compassionate home leave.

The code of practice 27.25 states while it may often be appropriate to authorise leave subject to the condition a patient is accompanied by a friend or relative, responsible clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if it is appropriate for that person to be legally responsible and that the person understands and accepts the responsibilities of being the patient's legal custodian. In the case of children, it may be appropriate for the person with parental responsibility to be the legal custodian. Otherwise leave with friends or relatives is classed as unescorted.

If custodial leave is to be used the S17 leave form must be countersigned by a suitable person to sign on behalf of the Hospital Manager as specified under the MHLD Mental Health Act Scheme of Delegation.

11. Recording of Leave

The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. The prescribed leave should be recorded on the Section 17

leave form (Appendix 2) be duly signed by the patient and forwarded immediately to the Mental Health Act Office.

All expired section 17 leave authorisation forms should be clearly marked as no longer valid.

Copies of the authorisation of leave form should be given to the patient, any appropriate relatives or friend and any professionals in the community who may need to be informed.

The outcome of leave, whether or not it went well, benefits achieved and particular problems encountered or concerns raised should be recorded in the patient's case notes to inform future decision-making.

The leave will be updated and recorded on any relevant IT Patient Information Systems as used within the Health Board.

12. Conditions of leave

The Responsible Clinician can attach any conditions that are considered appropriate: for example, that the patient remains in the custody of any officer on the staff of the Hospital or of any person authorised in writing by the Hospital Managers for the duration of the leave, or that they reside at a particular address during the time they are on leave

.

Patients, who are sent for assessment to other hospitals, should be transferred under the provisions of section 17 leave. E.g. transfer to Whiston Hospital.

Patients on section 17 leave from one hospital to a second hospital remain liable to be detained in the first hospital.

> ***EG**: a patient is placed in Tan Y Castell from Ablett for a short time under S17 leave, the current Responsible Clinician will remain the Responsible Clinician for the patient as the patient has not been transferred under Section 19 of the Act.*

Section 17 leave is not required to allow a patient to be transferred from one hospital to another, transfers should be enacted under Section 19 of the Act.

> ***EG**: A patient is within the Hergest Unit and needs to go to the Ablett Unit, this is a transfer of care and a transfer should be facilitated under Section 19 of the Act by completion of the internal transfer documentation.*

13. Care and Treatment whilst on leave

The responsibility held by the Responsible Clinician and the nursing staff remain the same whilst the patient is on Section 17 leave.

Where it is necessary to administer treatment to a patient who is on Section 17 leave but the patient is not consenting under Part 4 of the Act, the Responsible Clinician should decide if it would be in the best interests of the patient's health or safety or for the protection of other persons for their Section 17 leave to be rescinded.

However the refusal of treatment may not on its own be sufficient grounds for such an action and a decision should take into consideration the guiding principles in (chapter 1 Code of Practice for Wales 2016), including the least restrictive care and treatment option and maximisation of independence should be given.

13.1 Physical Disorder

Occasionally, patients detained under the provisions of the Mental Health Act will be transferred under Section 17 to local Acute Hospital for the purpose of treating their physical disorders.

Section 17 leave is not required if the patient is detained within a psychiatric unit considered part of that hospital site, eg Heddfan to Wrexham Maelor. Section 17 leave will be required for offsite treatment, eg Hergest to Ysbyty Glan Clwyd.

However the Responsible Clinician will be responsible for ensuring that the staff of the receiving Acute Hospital understand the specific implications and requirements of the Section of the Mental Health Act under which the patient is detained and of the implications of Section 17 leave. In particular, the explanation must include the following:

- That detention under the Mental Health Act provides no authority to proceed with most physical treatments without the patient's valid consent.
- That the responsibility for the patient's mental health treatment remains with the Responsible Clinician and that the patient continues to be detained by the Hospital Managers of the Psychiatric Service.
- The receiving Hospital should be provided with information which will allow them speedy access to psychiatric advice and support.
- A full explanation of any risk assessments undertaken and their outcome. A risk assessment which shows any risk of absconding or the possibility of self-harm or harm to others should result in a robust assessment of whether psychiatric nursing support should be provided for the duration of the patient's stay.
- Following conclusion of the physical treatment the patient should not be discharged but returned to the care of the Psychiatric Service.

14. Extension of Section 17 Leave

Section 17 leave can be extended without the patient returning to hospital. This can only be authorised by the Responsible Clinician.

15. Rescinding of Section 17 Leave

The Responsible Clinician can rescind the leave of absence under Section 17 where it is considered necessary in the interests of the patient's health or safety or for the protection of other people.

The Responsible Clinician must carefully consider the reasons for rescinding Section 17 leave and the effect it may have on the patient's care and treatment.

If rescinding the Section 17 leave is considered necessary, the Responsible Clinician must record in writing the reasons for doing so and for this record to be included in the patient's case notes. The patient must be informed of the reasons.

The current Section 17 leave form must be struck through and cancelled clearly being evident, a copy must be forwarded to the Mental Health Act Office.

The nurse in charge has the discretion to end the leave if it is felt necessary, the reasons must be communicated to the Responsible Clinician and documented in the patient's case notes.

16. Absence without leave (AWOL) (S18)

Where detained patients on section 17 leave in the community are absent without leave, the duty nurse should be informed immediately who will contact the Responsible Clinician.

The Responsible Clinician will decide whether the patient should be returned to Hospital and agree with the duty nurse who should be informed and how the patient should be returned, e.g. by involving the Police or the Ambulance Service.

The procedures identified in the MHLD AC008 Missing Absconding Persons Policy should be followed.

The Ministry of Justice must be informed immediately if a restricted patient is AWOL and informed on their return.

17. Information to relevant individuals

The information leaflet (Appendix 4) will be provided to the patient, carer, family member or any other relevant person as necessary once Section 17 leave has been agreed. The contact details will be completed by the nursing staff prior to the leaflet being distributed.

A copy of the S17 leave form will be provided to the patient, carer, family member or any other relevant person as necessary in accordance with General Data Protection Regulations (GDPR) and the common law of confidentiality.

18. Monitoring, Escalation and Implementation Arrangements

Ward Managers will be made aware of the policy and will be responsible for ensuring that all staff follow the procedures when leave is granted.

Mental Health Act Administration staff will continue to deliver regular training updates to staff within BCUHB to ensure staff are compliant with leave of absence for detained patients.

Records of all periods of leave will be documented in the patient's case notes. Compliance with this policy will be monitored as an integral part of the divisional clinical governance systems and audited by the area head of nursing and reported through the Quality and Safety Experience Groups (Appendix 3)

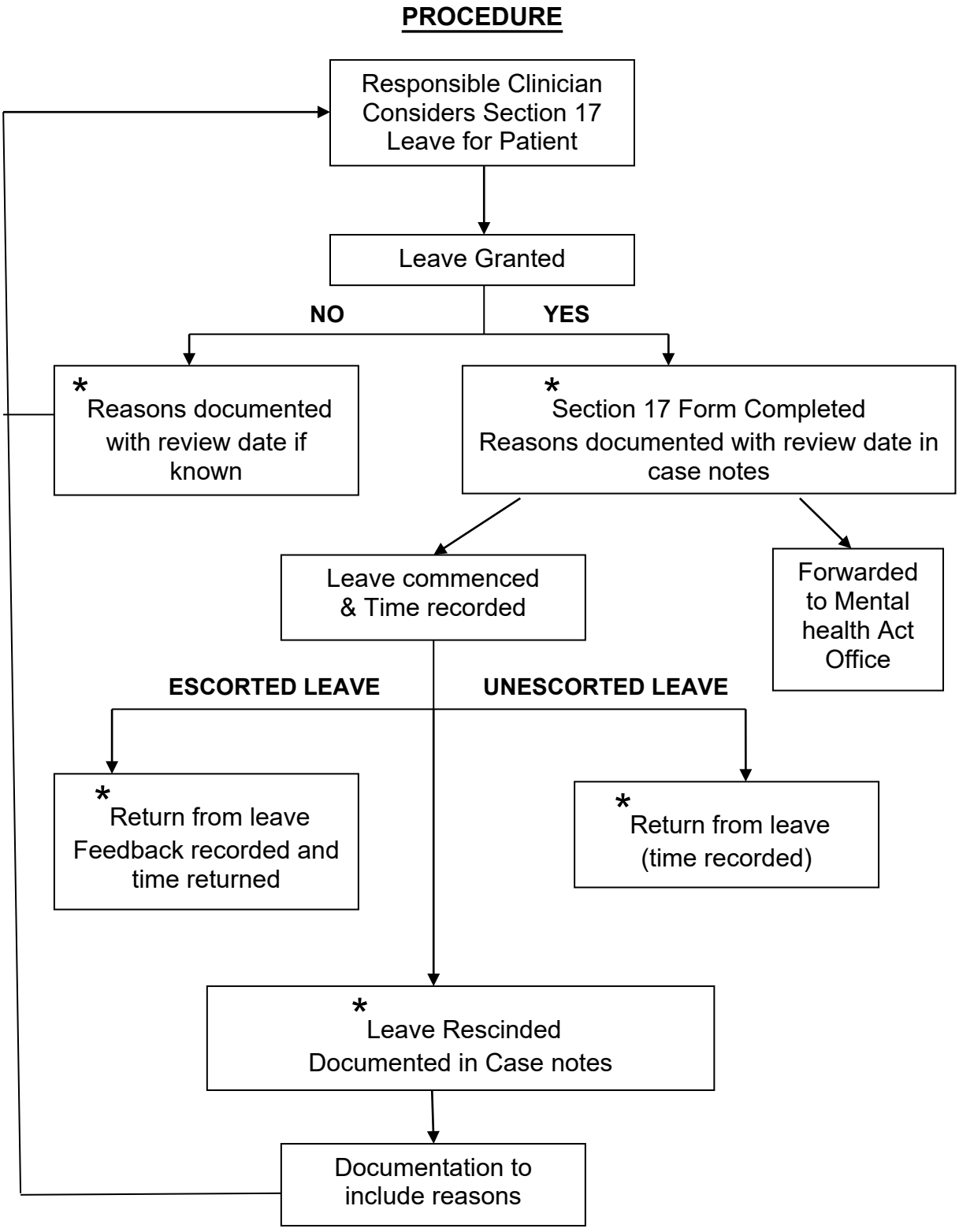
19. Reference to Legislation

Department of Health and Welsh Office, Mental Health Act revised Code of Practice for Wales 2016 ISBN 978-1-4734-7176-4

Jones R., 2016 Mental Health Act Manual 23rd Edition. London: Sweet and Maxwell

Upper Tribunal case no: HMW/1727/2020 [2021] UKUT 53 (AAC) DB v Betsi Cadawaldr University Health Board

Appendix 1 - Procedure



* Denotes for Audit purposes as per Audit Form Appendix 3

Appendix 2 – S17 Leave form

PATIENT'S LEAVE OF ABSENCE
SECTION 17–MENTAL HEALTH ACT 1983

From: Dr _____
Responsible Clinician

Unit/Ward: _____

Section: _____

AFFIX ID LABEL HERE

Section 17 Leave of absence CANNOT be granted to patients detained under S37/41unless the appropriate written permission has been obtained from either the Court or Ministry of Justice.

S37/41 Has authorisation for proposed leave been received from Ministry of Justice? YES / NO (please delete as appropriate)
If leave is for more than 7 consecutive days has a CTO been considered? YES / NO (please delete as appropriate)
Please document reasons in notes.

NB: LEAVE WITH RELATIVES IS REGARDED AS UNESCORTED LEAVE UNLESS CUSTODIAL AND AGREED BY HOSPITAL MANAGERS
Custodial leave: Yes/No Signed on behalf of Hospital Managers: Signature:_____ Date: _____

	LEAVE DETAILS	DURATION	FREQUENCY	ESCORTS
Within Hospital Perimeter				
Specified Location				
Unlimited Area/Specific Trips				
Overnight Leave				

This arrangement is authorised from _____ (date) to _____ (date)

Other conditions:
- **Leave will only be allowed at the discretion of the Nurse in Charge of the ward at the time leave is to be taken.**
- **Patient may be subject to random drug or alcohol screening following leaves and/or pat down search upon return to the ward.**

Signature – RC _____ Date _____

To be completed by the patient: I understand the terms and conditions of the above leave and that leave will only be allowed at the discretion of nursing staff.

Signature – PATIENT _____ Date _____

Witness – NURSE _____ _____(print and sign) Date _____

Copy to (please tick): Patient: ☐ GP: ☐ Keyworker: ☐ Relative/Friend (if appropriate): ☐ Other _____: ☐

Feedback regarding leave has been documented for the period above: YES / NO (please delete as appropriate)

Atodiad 2 - Ffurflen absenoldeb S17

ABSENOLDEB CLAF
ADRAN 17 - DEDDF IECHYD MEDDWL 1983

Gan : Dr_____
Clinigydd Cyfrifol

Uned / Ward: _____

Adran: _____

AFFIX ID LABEL HERE

Ni ellir caniatau absenoldeb Adran 17 i gleifion sy'n cael eu cadw dan S37/41 oni bai bod y caniatad ysgrifenedig priodol wedi'i gael gan un ai y Llys neu'r Weinyddiaeth Gyfiawnder.

S37 / 41 A gafwyd caniatâd ar gyfer absenoldeb arfaethedig gan y Weinyddiaeth Gyfiawnder? DO / NADDO (dileer fel sy'n briodol)
Os yw absenoldeb am fwy na 7 diwrnod yn olynol a oes CTO wedi cael ei ystyried? DO / NADDO (dileer fel sy'n briodol). Cofnodwch y rhesymau yn y nodiadau.

DS: MAE ABSENOLDEB GYDA PERTHNASAU YN CAEL EI YSTYRIED FEL ABSENOLDEB HEB GWMNI ONI BAI EI FOD YN WARCHODOL NEU WEDI'I GYTUNO ARNO GAN REOLWYR YR YSBYTY.
Absenoldeb gwarchodol: Ia / Na Llofnodwyd ar ran Rheolwyr yr Ysbyty: Llofnod:_____Dyddiad: _____

	MANYLION YR ABSENOLDEB	HYD	AMLDER	HEBRYNGWYR
O fewn perimedr yr ysbyty				
Lleoliad penodol				
Ardal annherfynol / teithiau penodol				
Absenoldeb dros nos				

Cymeradwywyd y trefniant hwn o_____ (date) i _____ (date)
Amodau eraill:

- **Caniateir absenoldeb yn ôl cyfarwyddyd y Nyrs Mewn Gofal y ward ar amser y cymerir yr absenoldeb.**
- **Efallai y bydd cleifion yn cael prawf sgrinio cyffuriau neu alcohol yn dilyn absenoldebau a/neu archwiliad wrth ddychwelyd i'r ward**

Llofnod - RC _____ Dyddiad _____

I'w gwblhau gan y claf: Rwy'n deall amodau a thelerau'r absenoldeb uchod a bydd absenoldeb yn cael ei ganiatáu ar ddisgresiwn y staff nyrsio yn unig.
Llofnod – CLAF _____ Dyddiad _____

Tyst – NYRS _____ _____(printiwch a llofnodwch) Dyddiad _____

Copi i (ticiwch): Claf: ☐ **Meddyg Teulu:** ☐ **Gweithiwr allweddol:** ☐ **Perthynas/ffrind (os yw'n briodol):** ☐ **Arall _____:** ☐

Mae adborth ar gyfer absenoldeb wedi'i gofnodi ar gyfer y cyfnod uchod: DO / NADDO (dileer fel sy'n briodol)

Appendix 3 – Audit Form

Section 17 Leave for Patient Audit Form

Patient Name: **Reference No:**

Section Status: **Date of Audit:**

<table>
<tr><td colspan="6">SECTION 17 LEAVE GRANTED</td></tr>
<tr><td colspan="3">YES</td><td colspan="3">NO</td></tr>
<tr><td colspan="3">Type of leave granted and review date</td><td colspan="3">Reasons and review date</td></tr>
<tr><td>Noted in Case Notes</td><td>Yes</td><td>No</td><td rowspan="2">Noted in Case Notes</td><td rowspan="2">Yes</td><td rowspan="2">No</td></tr>
<tr><td>Section 17 Form completed</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">TYPE OF SECTION 17 LEAVE</td></tr>
<tr><td colspan="3">ESCORTED LEAVE</td><td colspan="3">UNESCORTED LEAVE</td></tr>
<tr><td>Feedback recorded</td><td>Yes</td><td>No</td><td rowspan="2">Time returned from leave recorded</td><td rowspan="2">Yes</td><td rowspan="2">No</td></tr>
<tr><td>Time returned from leave recorded</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">Additional Information</td><td colspan="3">Additional Information</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>Has leave been rescinded</td><td>Yes</td><td>No</td><td>Reasons documented in case notes</td><td>Yes</td><td>No</td></tr>
</table>

Appendix 4 – Information Leaflet

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

TAFLEN WYBODAETH DEDDF IECHYD MEDDWL, 1983 CYFNOD O'R YSBYTY DAN ADRAN 17

MENTAL HEALTH ACT, 1983 SECTION 17 LEAVE INFORMATION LEAFLET

Beth yw cyfnod o'r ysbyty dan Adran 17?
Mae Adran 17 yn gyfnod o'r ysbyty wedi'i drefnu sy'n rhan bwysig i baratoi'r defnyddiwr gwasanaeth ar gyfer cael ei ryddhau o'r ysbyty yn y pendraw. Bydd yn galluogi'r tîm gofal i ganfod sut mae'r defnyddiwr gwasanaeth yn datblygu, ac mae hefyd yn caniatáu ffordd o gadw mewn cysylltiad â ffrindiau a theulu, a mynychu pethau y tu allan i'r ysbyty.

Pryd y caniateir cyfnod o'r ysbyty dan Adran 17?
Bydd hyn yn wahanol ym mhob achos. Bydd yn ddibynnol ar nifer o wahanol bethau er enghraifft; effeithiau'r salwch a'r amgylchiadau, a manteision a'r risgiau y bydd y cyfnod o'r ysbyty yn eu hachosi.

Pwy sy'n gallu awdurdodi cyfnod o'r ysbyty?
Dim ond y meddyg sy'n gyfrifol am ofal y defnyddwyr gwasanaeth (a elwir yn y Clinigydd Cyfrifol neu RC) sy'n gallu awdurdodi cyfnod o'r ysbyty. Y meddyg ymgynghorol yw hwn fel arfer, ond gall fod yn feddyg arall os yw'r RC arferol i ffwrdd o'r gwaith.

Am ba mor hir y gellir caniatáu Adran 17?
Gellir ei roi am gyfnod penodol neu amhenodol. Pan fo cyfnod o'r ysbyty am fwy na 7 niwrnod yn cael ei roi, bydd y RC yn ystyried a fydd Gorchymyn Triniaeth Cymuned yn fwy addas.

I ble y gellir caniatáu Adran 17?
Bydd y RC yn cwblhau manylion y cyfnod o'r ysbyty yn ysgrifenedig megis y dyddiadau a'r amseroedd, ac unrhyw amodau sy'n berthnasol. Dylid trafod hyn â'r defnyddiwr gwasanaeth, y tîm gofal a'r teulu / gofalwyr. Dylid rhoi copi o'r ffurflen cyfnod o'r ysbyty Adran 17 i'r defnyddiwr gwasanaeth ac unrhyw unigolyn arall sydd angen gwybod am y cyfnod o'r ysbyty, er enghraifft perthynas agosaf.

What is Section 17 leave?
Section 17 is planned leave from hospital which is an important part in preparing the service user for eventual discharge from hospital. It will enable the care team from finding out how well the service user is progressing and it also allows means of keeping in touch with friends and family and attending to things outside of hospital.

When is Section 17 leave granted?
This will be different in each case. It will be dependent on a number of different things for example; the effects of illness and circumstances and the benefits and risks the leave will have.

Who can authorise leave?
Only the doctor in charge of the service users care (known as the Responsible Clinician or RC) can authorise leave. This is usually the consultant but may be another doctor if the usual RC is away.

How long can Section 17 be granted for?
It can be given for a specific or indefinite period. Where leave is given for more than 7 days the RC will consider if a Community Treatment Order will be more appropriate.

Where can Section 17 be granted to?
The RC will complete the details of the leave in writing such as the dates and times and any conditions that apply. This should be discussed with the service user, the care team and family / carers. A copy of the Section 17 leave form should be given to the service user and any other people who need to know about the leave for example the nearest relative.

A ellir atal Adran 17?
Efallai y bydd y RC wedi gadael cyfarwyddiadau i'r nyrs, na ddylid caniatáu cyfnod o'r ysbyty os yw'r defnyddiwr gwasanaeth yn sâl iawn, a bod risg os yw'r cyfnod o'r ysbyty yn cael ei ganiatáu. Bydd y RC wedi trafod y math hwn o sefyllfa pan fydd yn caniatáu'r cyfnod o'r ysbyty.
Amod o'r cyfnod o'r ysbyty yw bod y defnyddiwr gwasanaeth yn cael ei hebrwng gan aelod o staff, ac efallai y bydd oedi achlysurol i ddarparu nyrs sy'n hebrwng. Ni ddylai hyn ddigwydd yn aml iawn, ac mae'n well ei osgoi drwy gynllunio ymlaen llaw gyda'ch nyrs benodol.

A ellir ymestyn y cyfnod o'r ysbyty heb ddychwelyd i'r ysbyty?
Gellir, er hynny dim ond y RC all wneud hyn.

Pan rydych ar gyfnod o'r ysbyty dan Adran 17
Dylai defnyddwyr gwasanaeth bob amser geisio bod yn ôl ar y ward ar yr amser a gytunwyd arno, ac a nodwyd ar y ffurflen cyfnod o'r ysbyty dan Adran 17.
Gellir rhoi'r gorau i absenoldeb wedi'i hebrwng os yw'r hebryngwr yn y cwestiwn.
Os nad yw rhywun yn dychwelyd i'r ward, mae'r Ddeddf Iechyd Meddwl yn datgan bod yn rhaid i staff ysbyty ddod â'r unigolyn yn ôl i'r ysbyty, gyda chymorth eraill os oes angen.

Gwybodaeth i ofalwyr a pherthnasau
Dylai gofalwyr, perthnasau ac unigolion eraill yn y gymuned sydd angen gwybod am y cyfnod o'r ysbyty gael copi o'r awdurdodiad. Os yw'r cyfnod o'r ysbyty dan Adran 17 yn amlinellu bod yn rhaid i'r defnyddiwr gwasanaeth fod yng ngwarchodaeth gyfreithiol ffrind neu berthynas, bydd angen i'r unigolyn hwnnw ddeall y cyfrifoldeb a'i dderbyn.

Manylion cyswllt:
Cydlynydd Gofal:.....

Ward.....

Tîm Crisis.....

Gwasanaeth IMHA.....

Can Section 17 be withheld?
The RC may have left instructions for the nurse that leave should not be given if the service user is particularly unwell and that there is a risk if the leave were to go ahead. The RC will have discussed this kind of situation when granting the leave.
It a condition of the leave is that that the service user is to be escorted by a staff member there may be an occasional delay in providing a nurse escort. This should not happen very often and is best avoided by planning ahead with your named nurse.

Can leave be extended without returning to hospital?
Yes however only the RC can do this.

Whilst out on Section 17 leave
Service users should always try to be back on the ward at the time agreed and stated on the Section 17 leave form.
Escorted leave can be stopped if the escort is concerned.
If someone does not return to the ward the Mental Health Act provides that hospital staff must bring that person back to hospital with the help of others if necessary.

Information for carers and relatives
Carers, relatives and other people in the community who need to know about the leave should be given a copy of the authorisation. If the Section 17 leave specifies that the service user is to be in the legal custody of a friend or relative that person will need to both understand and accept the responsibility.

Contact details:
Care Coordinator:……..

Ward……....

Crisis Team ……

IMHA Service …..……...

Appendix 5 – Ministry of Justice Annexes

Annex B

Terms of medical leave for all hospitals, other than high secure, for patients detained under sections 45A, 47/49, 48/49:

Medical Leave

In accordance with section 41(3)(c) of the Mental Health Act 1983 ("the 1983 Act"), the Secretary of State consents to the exercise of the power in section 17 of the 1983 Act to grant a leave of absence for the purposes of attending medical appointments subject to the following conditions:

a) Emergencies

In the case of emergency medical leave the priority is to deal with the physical health crisis. Responsible Clinicians may apply appropriate security arrangements at their discretion. Responsible Clinicians are asked to seek to ensure the usual security arrangements as set out in b) are in place, but the Secretary of State recognises that this will not always be possible or appropriate in an emergency situation.

There is no need to inform the Secretary of State of the emergency medical leave immediately, but an email to the MHCS team as soon as practicable is requested. Where appropriate, the Responsible Clinician should also inform the local Police. If the admission to general hospital develops into overnight leave, the arrangements at c) should be put into place and the Secretary of State should be informed.

b) Routine Day Appointments

In the case of routine appointments, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- They must travel in a secure vehicle with a separate driver (in addition to the 2 escorting staff)
- Handcuffs must be carried and are to be worn as necessary
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following the appointments
- If any concerns arise, leave must be immediately suspended

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

c) Overnight Medical Leave

In the case of overnight medical leave appointments for one or more nights, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The Responsible Clinician must inform the Secretary of State in writing in advance of the overnight leave setting out the reason for the overnight stay and the expected length of time such leave will take
- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- They must travel in a secure vehicle with a separate driver (in addition to the 2 escorting staff)
- Handcuffs must carried and are to be worn as necessary
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following discharge from general hospital
- If any concerns arise, leave must be immediately suspended, or security arrangements increased to protect the public

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

This consent for medical leave at b) and c) applies only to situations where there is a medical need for the treatment/appointment outside the secure hospital site. The Secretary of State does not generally consider that cosmetic surgery, tattoo removal, or similar treatments by choice are essential. Where the RC is of the view that such an appointment is essential, you must seek authority for such an appointment from the Secretary of State by application.

In all cases an appropriate risk assessment should be carried out by the care team in advance of any medical appointment and consideration should be given as to whether it is necessary to impose further security measures based on the level of risk identified

If there are incidents of the leave being misused or evidence of behaviours which pose a risk to the public or patient, the Responsible Clinician must suspend the leave.

The Secretary of State's consent is given on the understanding that the granting of section 17 leave involves no undue risk to the patient or to others and that there is a medical need for the treatment/appointment outside the secure hospital site.

The local police should be contacted at once and the Mental Health Casework Section should be informed by telephone, with a follow up written report from the responsible clinician, if the patient fails to return to hospital from leave by the agreed time.

Annex C

Terms of medical leave for all hospitals, other than high secure, for patients detained under sections 37/41 hospital orders (or equivalent):

Medical Leave

In accordance with section 41(3)(c) of the Mental Health Act 1983 ("the 1983 Act"), the Secretary of State consents to the exercise of the power in section 17 of the 1983 Act to grant a leave of absence for the purposes of attending medical appointments subject to the following conditions:

a) Emergencies

In the case of emergency medical leave the priority is to deal with the physical health crisis. Responsible Clinicians may apply appropriate security arrangements at their discretion. Responsible Clinicians are asked to seek to ensure the usual security arrangements as set out in b) are in place, but the Secretary of State recognises that this will not always be possible or appropriate in an emergency situation.

There is no need to inform the Secretary of State of the emergency medical leave immediately, but an email to the MHCS team as soon as practicable is requested. Where appropriate, the Responsible Clinician should also inform the local Police. If the admission to general hospital develops into overnight leave, the arrangements at c) should be put into place and the Secretary of State should be informed.

b) Routine Day Appointments

In the case of routine appointments, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- Use of handcuffs is at the Responsible Clinician's discretion
- Use of secure transport is at the Responsible Clinician's discretion
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following the appointments
- If any concerns arise, leave must be immediately suspended

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

c) Overnight Medical Leave

In the case of overnight medical leave appointments for one or more nights, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The Responsible Clinician must inform the Secretary of State in writing in advance of the overnight leave setting out the reason for the overnight stay and the expected length of time such leave will take
- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- Use of handcuffs is at the Responsible Clinician's discretion
- Use of secure transport is at the Responsible Clinician's discretion
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following discharge from general hospital
- If any concerns arise, leave must be immediately suspended, or security arrangements increased to protect the public

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

This consent for medical leave at b) and c) applies only to situations where there is a medical need for the treatment/appointment outside the secure hospital site. The Secretary of State does not generally consider that cosmetic surgery, tattoo removal, or similar treatments by choice are essential. Where the RC is of the view that such an appointment is essential, you must seek authority for such an appointment from the Secretary of State by application.

In all cases an appropriate risk assessment should be carried out by the care team in advance of any medical appointment and consideration should be given as to whether it is necessary to impose further security measures based on the level of risk identified

If there are incidents of the leave being misused or evidence of behaviours which pose a risk to the public or patient, the Responsible Clinician must suspend the leave.

The Secretary of State's consent is given on the understanding that the granting of section 17 leave involves no undue risk to the patient or to others and that there is a medical need for the treatment/appointment outside the secure hospital site.

The local police should be contacted at once and the Mental Health Casework Section should be informed by telephone, with a follow up written report from the responsible clinician, if the patient fails to return to hospital from leave by the agreed time.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	MHLD 0044 Section 17 Leave of Absence Policy
Date form completed:	October 2018 Reviewed June 2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or a disability as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ *How does your policy / proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?*
- ✓ *What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce / remove these?*
- ✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / proposal? Can these barriers be reduced or removed?*
- ✓ *Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.*
- ✓ *How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?*

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	MHLD 0044 Section 17 Leave of Absence Policy.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983. The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016. The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Mental Health and Learning Disabilities Division Policy/Procedure Sub Group. Mental Health and Learning Disabilities Division Senior Leadership Team Quality and Safety Experience Group.
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Act 1983 (as amended 2007) Mental Health Act Code of Practice for Wales (Revised 2016) MHLD AC008 Missing absconding Patient Policy Welsh Language Act 2016 MHLD 0025 Ty Llywelyn Section 17 and Therapeutic Leave Policy relating to patients detained under the MHA 1983

Part A

Form 1: Preparation

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Service Users, Employees and workers, Registered Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators and Assistants, and other professionals working within mental health services.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Training for employees / workers who may be involved in the care of detained patients. Communication to employees / workers Workflow chart. Cooperation of employees / workers Time constraints
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This policy ensures that any person working within mental health and acute hospital services has an understanding of Section 17 Leave. It allows for people working within mental health and acute hospital services to be aware of their responsibilities and avenues to follow to ensure that Section 17 leave is used appropriately.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? i.e. Will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	√			√	This policy relates to all persons of any age who will be detained under the MHA that will have access to Section 17 leave. As North Wales has a large demographic of older persons it is highly likely that the detained patients could be suffering from dementia. Older person may be more likely to have a sensory impairment or a physical impairment which may lead to a lack of understanding of section 17 leave	Staff are aware of how to access translation services which are available for sign language, braille and languages.
Disability (think about different types of impairment and health conditions:- i.e. physical,	√			√	Mental Health Illness can affect anyone and it is acknowledged that people with learning impairments may require additional support to understand their detention. Persons who are detained under the MHA will often initially be in a state of crisis and not fully understand the information given to them or why they require permission to leave the unit. Sensory and physical impairments can apply	Discrimination is eliminated by everyone being treated in accordance with the current legislation. Provisions have been considered for specialised services such as sign language and

mental health, sensory loss, Cancer, HIV)					at all ages and may render understanding and communication difficult.	assistance by learning disability staff. Staff will explain to the patient their rights under section 17 leave and leaflets are not simply handed over with the expectation of the patient to understand.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		√			We do not consider there are any impact for persons who are undergoing gender reassignment.	
Pregnancy and maternity		√			Having considered potential impacts none have been identified considerations will be given to pregnant women and nursing mothers under workforce policies.	Leave would be risk assessed prior to permission being granted.
Race (include different ethnic minorities, Gypsies and Travellers)	√			√	We are aware that people from BAME backgrounds can be more likely to have a Mental illness. If someone meets the criteria for detention race would not affect the decision. This policy applies to all who meet the criteria. There is	Discrimination will be eliminated through the understanding of cultural values and communication needs will be met by where possible providing

Consider how refugees and asylum-seekers may be affected.					evidence that BAME populations are disproportionately more likely to be detained.	information and leaflets in alternative languages. Translators are also available as required.
Religion, belief and non-belief		√			We do not consider there are any impact for persons due to their belief or non-belief.	
Sex (men and women)		√			We do not consider there are any impact due to a person's sex.	
Sexual orientation (Lesbian, Gay and Bisexual)		√			We do not consider there are any impact due to a person's sexual orientation.	
Marriage and civil Partnership (Marital status)		√			We do not consider there are any impacts due the marital status.	
Low-income households		√			No impact on this policy.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	√				The powers under the MHA do not violate human rights because the procedural safeguards established under convention case law do not apply to emergency situations. The proposed policy promotes human rights in ensuring that all patients are detained lawfully and receive	

					appropriate care in accordance with their needs and have access to section 17 leave if this is deemed appropriate.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	√			√	The Welsh Language Standards are to be adhered to in Wales this involves ensuring that it is clarified at the outset as to what language a patient wishes to communicate in.	Once someone is detained under a section they must be explained their rights and information given to them with confirmation they have understood. Within the explanation of rights form this now details if the information has been given in the patients preferred language and will be reported on.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Treating the Welsh language no less favourably than the English language	√			√	Information for the patients are available in both English and Welsh. When it is explained to a patient the reason for the section and the use this should be done in Welsh if this is the patients first language.	Forms are also in English and Welsh for staff to choose which they wish to complete. The Section 17 leaflet within the policy is translated to Welsh.

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Engagement has been via the Health Boards consultation page of the intranet and distribution to appropriate groups. The document was distributed to the MHLD divisional staff, Local Authority safeguarding and the Welsh Language Department. This enabled care coordinators / safeguarding to consider the impact on those with protected characteristics and discuss if necessary.	
Have any themes emerged? Describe them here.	It was noted that escorting staff may not always be nursing staff.	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	The policy has been amended to reflect that there could be a number of escorts from different professions. (Therapy staff, psychological staff)	

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	MHLD 0044 Section 17 Leave of Absence Policy

2. Brief Aims and Objectives: (Copy from Form 1)	A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983. The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016. The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes x	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes	No x

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? This policy will ensure that the law is complied with under the MHA and the provision of ensuring appropriate use of section 17 and that the correct procedures are followed. It is felt this policy has a positive effect on all as it ensures those who have access to section 17 leave will be escorted, monitored and information recorded, an audit structure ensures the granting and recording of section 17 leave is recorded adequately. Article 5 is considered in ensuring the patient is not deprived of their liberty . Although potential negative impacts have been identified these have been mitigated against.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes x	
	Record Details:	

Part B Form 5: Summary of Key Findings and Actions

	Negative impacts have been identified under Age, Disability, and Race but these have been mitigated within the document.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No
	How is it being monitored?	Section 17 forms are forwarded to the Mental Health Act office. Records of all periods of leave will be documented in the patient's care notes. Compliance will be monitored as an integral part of the divisional clinical governance systems and suited by the Matrons and reported through the QSE groups. The document contains an audit form for this purpose.
	Who is responsible?	Matrons.
	What information is being used?	The audit proforma highlights if leave has been granted and the reasons. Time returned from leave and feedback, if leave is rescinded the reasons why.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	3 years from re-approval.

Part B Form 5: Summary of Key Findings and Actions

7. Where will your policy or proposal be forwarded for approval?	MHLD Policy/Procedure Implementation Group MHLD Senior Leadership Team Quality, Safety and Experience Group. BCUHB Clinical Policy and Procedure Group BCUHB PSQG MHCCC

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Wendy Lappin	Mental Health Act Manager
	Sean Gallagher	Interim Head of Nursing, RSS, LD, SMS
Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	These are already in place as described in mitigating actions		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	These are already in place as described in mitigating actions		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?

Teitl adroddiad: ***Report title:***	Power of Discharge Group Chairs Assurance Report			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The Power of Discharge Group is held on a quarterly basis to review the Associate Hospital Managers activity within the Health Board for a detailed period. The Chair's assurance report informs any issues of significance that require consideration by the Mental Health Capacity and Compliance Committee. The report discussed within the meeting covered the three month period June to August.			
Argymhellion: ***Recommendations:***	The committee is asked to note the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of			

	the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This report does not inform strategic decisions, it relates to the Power of Discharge Group which meets quarterly to discuss the day to day operations of the Associate Hospital Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The chairs assurance report has been approved by Matthew Joyes, Associate Director of Quality Assurance, patient Safety and Experience.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Power of Discharge Group 23/09/2022 Appendix 2 - Terms of reference Appendix 3 - Expression of Interest for the MHCCC	

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. (CoPW 37.4)

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

In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels. They are directly accountable to the Board in the execution of their delegated functions. (CoPW 37.6).

The Power of Discharge Group is held on a quarterly basis, due to the change of the Mental Health Act functions falling under the Legal Department of the Quality Directorate the terms of reference and the membership has been reviewed, to include the meeting being attended by the appointed Associate Hospital Managers, Associate Director of Quality, Director of Nursing MHLD, Director of MHLD and the Mental Health Act Manager.

The Power of Discharge Group meeting was held on the 23rd of September 2022.

Discussions included:

- The change of structure and an introduction to the Legal Department and Quality Directorate from Matthew Joyes.
- A review of the terms of reference.
- The Associate Hospital Manager update report.
- The MHA performance report submitted for information only.
- Expressions of interest for membership to the group.
- Expressions of interest for the Mental Health Capacity and Compliance Committee.

The group felt the following areas required escalation and highlighting to the Mental Health Capacity and Compliance Committee.

- **Terms of Reference**
  The terms of reference were reviewed and agreed as appropriate to include an update to the membership and secretariat. Updated document attached.

- **Power of Discharge Group Members**
  Expressions of interest were received from David Evans and Philip Williams. The Group had one vacancy space. It was agreed that both were excellent candidates and to choose between would not be appropriate considering the attendance at the group was often below ten members this would therefore allow for greater attendance. The committee is asked to agree this decision.

- **Hearings – professionals attendance**
  There have been multiple instances of late whereby professionals have not made themselves available for hearings despite having prior knowledge. It is felt by the AHM's that this is disrespectful to themselves, the patient and as a function under the MHA this is a breach in the Health Boards duty. All instances have been escalated to appropriate senior staff, any future instances will be escalated to include notification to the Director of Quality. It was acknowledged that the MHCCC should be made aware.

- **Devices for Associate Hospital Managers**
  IPADs have been received for distribution to those that requested, laptops are on order once received the cohort will move to a paperless process for hearings.

- **Cross Border Issues**
  Cross border issues has accounted for one fundamentally defective detention this quarter, this was previously discussed, an update on when Wales will go electronic will be discussed within an All Wales Administration Forum meeting with Welsh Government.

- **POD representative for the Mental Health Capacity and Compliance Committee**
  Expressions of Interest to join Helena Thomas have been requested as a second representative for the MHCCC.

APPENDIX 2

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

POWER OF DISCHARGE GROUP
TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

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

2. PURPOSE

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

3. DELEGATED POWERS AND AUTHORITY

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

- Comment specifically upon the processes employed by the Group's Panel in relation to the discharge of patients from compulsory powers, and whether these processes are fair, reasonable and compliant with the Mental Health Act and are in line with other related legislation, including, the Mental Capacity Act 2005, the Human Rights Act 1998 and the General Data Protection Regulations 2018 and that the appropriate systems are in place to ensure the effective scrutiny of associated discharge documentation.

- Undertake the functions of Section 23 of the Mental Health Act 1983, in relation to hearing cases of detained powers ensuring that three or more members of the Group form a Panel and only a minimum of three members in agreement may exercise the power of discharge. The Panel will be drawn from the pool of members formally designated as Associate Hospital Managers as reported to the Group.

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

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

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

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

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

4. MEMBERSHIP

4.1 Members

- Chair: Associate Director of Quality
- Vice Chair: Director of Nursing Mental Health & Learning Disability
- Director of Mental Health & Learning Disability
- Ten (10) appointed Associate Hospital Managers (as nominated and agreed by the Group. Appointed for a period of four years with appointment not to exceed a maximum of eight years in total) a minimum of **six** must be in attendance, it is noted that the Associate Hospital Managers should not be outnumbered by the number of Health Board staff.
- Mental Health Act Manager

4.2 Attendees

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

4.3 Member Appointments

4.3.1 The membership of the Group shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Group'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 Group. The Head of Governance and Compliance shall be the Chair of this Group.

4.4 Secretariat

4.4.1 Mental Health Act Administrators Assistant.

APPENDIX 2

4.5 Support to Group Members

4.5.1 The Mental Health Act Manager, on behalf of the Group Chair, shall:

- Arrange the provision of advice and support to Group members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Group members.

5. GROUP MEETINGS

5.1 Quorum

At least six Associate Hospital Managers must be present to ensure the quorum of the Group and the Chair or Vice-Chair.

The number of Health Board staff cannot outnumber the Associate Hospital Managers.
.

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis.

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

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

6.2 The Group is directly accountable to the Board (via the Mental Health and Capacity Compliance Committee) for its performance in exercising the functions set out in these Terms of Reference.

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

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

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

6.4 In terms of the Board's assurance on the Mental Health Act requirements, the

remit of the Group is limited to the exercise of powers under Section 23 of the Mental Health Act 1983, rather than the wider operation, which would be the remit of the Mental Health and Capacity Compliance Committee.

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Group Chair shall:

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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

9. REVIEW

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

Approval: Power of Discharge Group 23/09/2022
Mental Health Capacity and Compliance Committee: DATE

From: louise.cunliffe@abernet.com
Sent: 13 October 2022 15:08
To: Wendy Lappin (BCUHB - Quality Directorate)
Subject: Expression of interest: MHCCC

Dear Wendy

Re: Member MHCCC, BCUHB

Thank you for raising the need for additional AHM members for the above group at today's AHM
meeting. I would like to express my interest in this role as I believe I have the experience and skills to
enable me to make a positive contribution.

I have been an Associate Hospital Manager for nearly two years and have participated in a variety of
hearings. Through this work and from my previous professional experience, I am very much aware of the
Mental Health Act and its impact upon service users and staff within the Mental Health Service. I have
been a POD group member for several meetings. I believe that my knowledge, ability to listen and
formulate would enable me to be a useful MHCCC member. I am aware of assurance reports and how
they function in providing information, evidence and certainty to the Chair.

I would be grateful if you can take my expression of interest to the next meeting for consideration.

Many thanks

Louise

Teitl adroddiad: ***Report title:***	Management of Court of Protection Cases within the Health Board			
Adrodd i: ***Report to:***	MHCC Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 04 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report has been produced to provide the Committee with assurance, as to measures currently being undertaken, to address concerns identified with the current management of Court of Protection (CoP) cases within the Health Board.			
Argymhellion: ***Recommendations:***	The Committee is asked to note and gain assurance from the actions.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Acting Associate Director of Quality Helen Bull, Interim Head of Legal Services			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	BAF21-10 - Listening and Learning

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Court of Protection Report	

Report into the Management of Court of Protection Cases within the Health Board

1. This report has been produced to provide the Committee with assurance as the to measures currently being undertaken to address concerns identified with the management of Court of Protection (CoP) cases, arising in both the community and acute settings.

1.1 CoP cases move at pace and require prompt attention by the Health Board in order to ensure that the best interests of a patient are met. These patients are vulnerable. In most cases, they are either already under a Deprivation of Liberty Safeguards (DoLS) or have been sectioned under the Mental Health Act and are being considered to move to a DoLS.

1.2 Court deadlines are short and decisions often have to be made that same day.

1.3 There has been no standard process within the Health Board for the management of these cases. If a case arises within an acute setting, a senior clinician will generally refer the case to Legal and Risk Services (LARS). Notification of community cases can be through numerous routes, including via the CEO's office or via the Mental Health Quality Governance Team, who then refer the case to LARS.

1.4 LARS has reported unacceptable delays in responses provided by the Health Board and lack of ownership of cases. Email requests have been passed between staff with no engagement. Court Orders have not been complied with, resulting in added costs for the Health Board and distress for the patient and their family.

1.5 There has been no single point of contact to oversee or manage these cases.

1.6 The following measures are being implemented to address these issues and provide assurance to the Board:

- Legal management of all new CoP cases will be undertaken by the newly formed Legal Services Team (who came into effect from August 2022).
- The Legal Services Team will act as a central point of contact to ensure oversight of all CoP cases from a legal perspective, ensuring legal support is in place and Court orders are complied with.

- LARS are notifying the Legal Service Team with any updates for historical or ongoing cases to ensure that support can be provided as necessary.

- All new referrals to LARS or requests for advice, for both acute and community settings, will be made via the Legal Services Team.

- All new cases will be logged on Datix to ensure robust monitoring and to aid with reporting.

- The Legal Services Team is working with senior clinicians in the Mental Health and Learning Disabilities Division (MHLD) to develop relationships and provide support as required.

- A Learning Event is being organised in conjunction with LARS and the Assistant Director of Nursing (MHLD). Anonymised past cases will be used as learning points together with a general overview of legislation and process.

- A clear policy and procedure document is in development.

2. There are no individual cases that require escalation to the Committee.

3. There are no budgetary implications associated with this report. However, the increasing costs attached to Court of Protection cases, and the devolved nature of costs to divisions, is an area for future improvement in control.

4. A risk relating to Court of Protection oversight and compliance is on the risk register (ref: 4596, score 12).

5. This report does not relate to a strategic decision.