Bundle Mental Health and Capacity Compliance Committee 29 April 2022

0.0 09:30 - MC22/1 Patient Story - Adult Mental Health

Matthew Joyes in attendance

MC22.1 Eleni's story (Carer's Story) - MHCCC April 2022 v2.0.docx

0.1 09:40 - MC22/2 Patient Story Follow up

Chris Stockport
Louise Bell in attendance
Recmmendation
The Committee is asked to note the learning from the patient story

MC22.2a CAMHS Learning from Patient Story.docx

MC22.2b Appendix 2 - MHCCC Patient Story CAMHS Transcript.docx

1.0 GOVERNANCE

1.1 MC22/3 Apologies

1.2 MC22/4 Declaration of Interest

1.3 09:45 - MC22/5 Draft minutes of the Committee meeting held on 17.12.21 for approval

MC22.5 Draft minutes 17.12.21 MHCCC v.05.docx

1.4 09:47 - MC22/6 Matters arising and table of actions

MC22.6 Table of actions.doc

1.5 MC22/7 Report of the Chair

Lucy Reid

1.6 MC22/8 Report of the Lead Executive

Teresa Owen

2.0 STRATEGIC ITEMS FOR DECISION - THE FUTURE

2.1 Developing Strategies or plans

2.1.1 09:55 - MC22/9 Reforming the Mental Health Act White Paper - verbal

Teresa Owen
Wendy Lappin in attendance

2.1.2 10:00 - MC22/10 Liberty Protection Safeguards (LPS) Update - verbal

Gill Harris
Michelle Denwood in attendance

2.1.3 10:05 - MC22/11 Mental Health Policy : MHLD 0026 – Policy for admission, receipt and scrutiny of statutory documentation.

Teresa Owen
Recommendation
The committee is asked to approve the policy.

MC22.11a Mental Health Act Policy.docx

MC22.11b MHLD 0026 Admission receipt and scrutiny of Statutory Documentation RV2.doc

MC22.11c MHA Policy BCU EQIA - MHLD 0026.docx

2.2 Monitoring Existing Strategies or plans

2.3.1 10:15 - MC22/12 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales

Nick Lyons
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.

MC22.12 AC and S12 Report for April 2022 MHCC.docx

2.3.2 10:15 - MC22/13 Update on Section 12(2) Doctors

Teresa Owen
Dr Alberto Salmoiraghi
Recommendation:
For the Mental Health and Capacity Compliance Committee to:
1. acknowledge the report and progress on the matter, and
2. support the actions detailed in the report – so that the detail can be further progressed by operational teams.

MC22.13 Report on Section 12(2) Doctors v2.0.docx

3 THE PRESENT for assurance

3.1 10:30 - MC22/14 Corporate Risks

Justine Parry in attendance
Recommendation:
The Committee is asked to
1. Review, note and approve the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1:
a) Note the transfer of this risk to the MHCC for future oversight from the QSE Committee on 11th January 2022.
b) Note the controls have been updated to include the successful bid from Welsh Government for interim funding to support increased bespoke Mental Capacity Act training in primary and community settings and to increase physical capacity in the out of hours service delivery.
c) Note an additional assurance has been included to cover the monitoring and reporting of training compliance and DoLS backlog by the Safeguarding and Performance Governance Group and Welsh Government.
d) Note the ET recognise the progress in the management of the risk including the alignment with the Intermediate Medium Plan to support additional resources and the strengthening of the governance arrangements for the Liberty Protection Safeguards (LPS) Implementation Group in preparation for the publication of the LPS Code of Practice.
e) Note the clarification regarding the inherent risk score being lower than the current risk score due to the unforeseen significant increase in activity (44%).
f) Note the completion of the Actions ID15705, 15709, 18983 and 18984 approved by ET, so that they will be archived and removed from the next report, recognising that a new action has been captured to support the increase in activity within Safeguarding until the LPS Code of Practice is published.
2. Note there are no new risks being presented to this Committee for escalation approval at this time.
3. Note there are no risks being presented to this Committee for closure or de-escalation consideration at this time.

MC22.14a CRR Cover Sheet V1.0-Final.docx

MC22.14b Appendix 1 Corporate Risk register CRR21-14.docx

MC22.14c Appendix 2 Full List Corporate Risks V.4.docx

MC22.14d Appendix 3 Risk Key Field Guidance V2-Final.docx

3.2 10:40 - MC22/15 CAMHS Transformation & Improvement Programme - Crisis Care Response for Children and Young People

Chris Stockport
Louise Bell in attendance
Recommendation
The Committee is asked to note the report

MC22.15 - CAMHS Crisis Pathway Update - April 2022 (003).docx

3.2 10:55 - MC22/16 Deprivation of Liberty Safeguards (DoLS) Quarterly Report January 2022

Gill Harris
Michelle Denwood in attendance
The Committee is asked to:
Accept the Deprivation of Liberty Safeguards Quarterly Report and the identified activity for the period of Q4 2021-22.
Receive the DoLS Action Plan and progress.
Accept the position in preparation for the implementation of Liberty Protection Safeguards (LPS).

MC22.16 DoLS MCA LPS Report and Action Plan Q4 2021-2022 V1.00.docx

3.2.1 11:10 - Comfort break

3.3 11:20 - MC22/17 Associate Hospital Managers Update Report

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

MC22.17a Associate Hospital Managers Update Report V2.docx

MC22.17b Assoc HM Scrutiny Report 2021 v2.doc

3.4 11:25 - MC22/18 MHA Performance Report

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

MC22.18a MHA Performance Report.docx

MC22.18b App1 MHAct Report.pdf

MC22.18c App2 Divisional S136 Report March 22.pdf

MC22.18c App3 CAMHS S136 Report March 22.pdf

4 LEARNING FROM THE PAST

4.1 11:40 - MC22/19 HIW Monitoring reports

Teresa Owen
Hilary Owen in attendance

MC22.19a HIW Monitoring Report incl App1.docx

MC22.19b App2 HIW Tan Y Coed Inspection Report.pdf

MC22.19c App3 HIW Hergest Unit Inspection Report.pdf

4.3 11:50 - MC22/20 Compliance with the Mental Health Act Audit

Teresa Owen
Wendy Lappin in attendance
Recommendation
The committee is asked to note the report.

MC22.20 Compliance with the Mental Health Act Audit v2.docx

5.1 12:00 - MC22/21 Power of Discharge Group report

Teresa Owen
Wendy Lappin in attendance
Recommendation
The Committee is asked to:
(1) note the report,
(2) approve three new POD appointments,
(3) confirm the POD representative requirement at MHaCCC.
Also, to support the POD group and the Associate Hospital Managers with progression of their requests relating to overnight accomodation (to attend the all Wales event – 11 May 2022), and support the progression of work on the electronic equipment request.

MC22.21 POD Report V2.docx

5.2 MC22/22 Court of Protection - verbal update

Matthew Joyes in attendance

7 CLOSING BUSINESS

7.1 MC22/23 Agree Items for referral to Board / Other Committees

Lucy Reid

7.2 MC22/24 Review of risks highlighted in the meeting for referral to Risk Management Group

Lucy Reid

7.3 12:05 - MC22/25 Agree items for Chair's Assurance report

Lucy Reid

7.4 MC22/26 Review of meeting effectiveness

Lucy Reid

7.5 12:20 - MC22/27 Date of next meeting 17.6.22

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Carer Story – Eleni's story
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality
Awdur yr Adroddiad Report Author:	Matthew Joyes, Associate Director of Quality Carolyn Owen, Assistant Director of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality
Atodiadau Appendices:	Carer Story

Argymhelliad / Recommendation:
The Committe is asked to receive and reflect upon the carer story.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	**Y**
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Betsi Cadwaladr University Health Board
Patient Story

Eleni's Story

This story is a personal account of Eleni's experiences in her own words and describes the struggle her son Paolo has experienced in trying to access mental health support in Wrexham and the impact this has had on her as her son's carer.

Overview of Eleni's story

I am a well-educated person; I have a Masters and two diplomas and I have worked as a Lawyer but I had to stop working in 2013 when my son Paolo went through a mental health crisis. Since then, I have dedicated my time to supporting him and became my son's carer. Paolo is thirty-six years old and lives with me in our family home. When he was, sixteen Paolo had a serious sailing accident and we thought he was going to die. He had to have operations on his head and since the age of 22 years old has experienced mental health difficulties.

Since 2013, my son has seen 18 Psychiatrists who have diagnosed him with Bipolar with schizoaffective disorder. My Son's doctor for the past 3 years has changed my son's diagnosis at least 3 times ranging from ASD to the latest diagnosis of Autism. I have a family history of Bipolar, my mother, grandfather, my son's grandmother from his father's side and other family members (my sisters and their children) have been diagnosed with Bipolar. I am confident my son has Bipolar but they now say his last Psychiatrist claims he is autistic without any proven evidence or explanation on his diagnosis. I do not believe he is autistic. My family all do not believe in the diagnosis of autism because we have experience of supporting family members who have Bipolar. It is hard, as we do not have a Doctor to understand or tell us how we can help Paolo.

The first Doctor my son Paolo saw was in 2013 as part of the Colwyn Bay Mental Health Team, she was excellent she paid a lot of attention to Paolo giving him medication, psychological support, and advice. My son had regular follow-up appointments with the Doctor. Paolo was doing really well being supported by this doctor. One and a half years later, in 2015, we had to move to Wrexham and that is when the problems started when accessing support from Ty Derbyn. The Psychiatrist in Ty Derbyn did not help he made Paolo like a zombie putting him on strong medication that was also making him gain weight fast. My son could not do anything he was lethargic and depressed. At that, time Paolo had an NHS Mental Health Care Coordinator who was really good and supportive, he would come to the house, take Paolo for a coffee, which also helped support me and give me some time. The Care Coordinator then went off sick and then no one cared about my son. He has not had a Care coordinator since, or a care plan.

My son has not received the mental health support he needs. Over the last four-year period, my son saw a Psychiatrist three times in Wrexham. Since being under the care of Ty Derbyn my son feels isolated he cannot cope with life, he experiences anger and frustration and society is not helping him. Paolo feels all alone with no help and if it was not for me, he would not be alive.

This all has a very negative impact on my family and me as we are watching my son suffering and being isolated. It is endless he needs help and I have requested this so many times.

My son is on antipsychotic medication but he has never had a medication review, no one has ever followed up about my son's medication. Paolo is very sensitive to medication and has had many negative side effects, which has meant he has spent a lot of time in bed trying to rest and feel better. His doctors were giving him additional medications and the interactions were causing very serious side effects. We could not get access to anyone to help us. They do not care about my son. Because the medication is so expensive, we have been advised not to go private to seek help. I am asking to leave the Welsh NHS system so my son can get the correct diagnosis, medication, and treatment he needs.

In September 2021, we received two calls from Ty Derbyn; they never saw my son face to face. I received a care plan that had never been seen before or been signed by my son. No one had met my son to develop and agree with a care plan and he did not sign the document.

Just under a year ago, when we had to go to A&E in Wrexham as my son was in crisis. When he was in crisis, he was struggling to be around people but unfortunately, we had to wait for seven hours in the waiting room to see a member of staff. I repeatedly told staff that Paolo was in a crisis and he could not be with people because he was so anxious but they could not help. I was holding him there by force because I was desperate for help. A nurse then saw my son; there was no Doctor available. I told the nurse about ICAN myself out of desperation. After numerous telephone calls somebody came, he then walked with us in the hospital to find a quiet place where he spoke about the ICAN service. They told us to ask Ty Derbyn for a Doctor's appointment and that's was all.

When ringing Ty Derbyn for the support it is not easy to speak to a member of staff. At times, I have been on the phone waiting whilst it has been ringing out for up to two hours. If they answer, they will say someone or the duty staff will ring you back, but they never do. They might not come back to you for up to 3 days. My son struggles with this he cannot communicate anymore. Neither Paolo nor I have not received any offer of support or information to help us from the health board or agencies. I am in contact with NEWCIS who are giving me ten counselling sessions. I receive regular calls and support from them. I am carrying mental and more health issues because of all of this.

I have experienced Psychiatrists who have ignored my right as my son's carer. For example, I have not been allowed to go into appointments with my son, as they do not want me in the room when they are assessing him. Because of this, I do not know what was said or how I can support my son. It is important to exercise the rights of a carer. The professionals should ask the patient's carer and family questions, as we know what normal behaviour is for him. Family is very important.

I think it is very important that there are activities for people who are struggling with their mental health. For example, to help support them to go out to the shops and to groups. When I joined a group called Caniad eight years ago, they organised trips. At that time, Paolo was engaging with the service he was sociable and enjoyed it. Then Caniad changed and started working differently. Caniad now runs a big chat online, which I participate in, as it is good to hear other people's stories and get support from others.

Paolo is a member of Pen y Maes General Practise in Summerhill. I think it is important that Primary Care GPs are easy to access so you can ask for help. They never have anyone available to answer the phone or offer an appointment. His Psychiatrist gave him an appointment online and they did not see my son face to face. We need support from a good Professional for Paolo to be treated and improved. We need someone to follow up on his mental health progress and

to do medication reviews and follow-up appointments with to support his through this care process. So far, he has not had this luxury.

Paolo was on the list for Psychological therapy for 7 years, then he was offered 7 months ago psychological therapy online. The person who was doing counselling gave him 3 sessions and then he stopped the therapies without informing him, as he decided that he could not help him. My son told me that instead of supporting him the staff member was just listening and after 30 minutes ending the session.

My son has no care plan, no Care Coordinator, and he does not currently have access to any psychological support and no medication review. I do not agree with the Psychiatrists diagnosis saying that he is autistic and he could get psychotic medication from his GP. That is the worst scenario and nightmare from the system. The diagnosis does not explain his behaviours. Everyone suffering from a mental health difficulty has a right to be supported by a Care Coordinator.

I am disabled and have to look after my thirty-six-year-old son. I am desperate and need help for my son. My son has the right to have a normal supported life, not a life that is isolated. To have a supported life he needs a Care Coordinator, a carer to help give me a rest, activities to attend, good medication with regular reviews, and access to psychological support.

Over the past couple of years we have complained several times in writing to the Clinical Lead at Ty Derbyn about the change in my sons diagnosis and releasing Paolo from care but we have had not had a satisfactory outcome. Following my complaints, I had received telephone calls promising that they will arrange regular reviews, offer a second opinion by an independent Psychiatrist and provide my son with a Care Coordinator. The Psychiatrist offered to provide a second option works at the health board and I was not confident that they would be independent so we declined. A recent outcome of a formal complaint my son raised does not offer any help, the only thing they offered to do is to appoint a Care Coordinator. I have no choice but to move my family to England as soon as possible to register Paolo with another Mental Health Service. My husband is a Surgeon Consultant and I will ask him to find a job in England.

Key issues identified:

- Negative communication between service and patient/carer.
- Difficulty accessing mental health services.
- Lack of understanding for carers
- Lack of co-ordination of care.

Summary of learning and improvement

The carer story was shared at the Mental Health Division Patient and Carer Experience Group on 20th January 2022. The following learning points were discussed and are captured in the formal meeting minutes:

- It was acknowledged that the patient and carer had experienced difficulties communicating with the Health Board and they had found it difficult to access mental health services.
- It was discussed that there was a difference of opinion between the son, mother and care coordinating team, which is usually resolvable however, it is noted that this was at a time when there were no face-to-face appointments. As a statutory mental health service, we are limited to what we can provide and it was recognised that the hard work and impact of our partners ICAN and Caniad is vital in supporting patient and carers. In terms of learning, it would be that face-to-face appointments do benefit most patients.

- It was noted that it was a powerful story, the carer experienced challenges in accessing Ty Derby. In terms of the learning, it is something that the East region have been very proactive with since the story was raised. The East region have developed an action plan around working with admin and staff on reception as to how they take messages from people they're closely monitoring the action plan which is reported through Divisional QSE and PCE. This issue also sits within the concerns and incidents in the AAA report. There are some communication challenges that remain within the division and suggestions have been made around the East region to develop a learning bulletin around effective communication.
- A representative from Caniad raised at the meeting that this is a common theme when patients are feeding back to Caniad about their experiences. Eleni is frustrated and does not know how to get the right support for her son.
- It was raised that this was an issue that Advocacy Services came across quite frequently. This information has been feedback to the relevant service.
- A discussion took place around the ongoing need to invest more in the 3rd sector as we move forwards because this has a very big impact on patient and carer experience.
- A question was raised asking when the division had last reviewed its approaches to information sharing and how it would be easy to add a footnote to posters and letters signposting people to services available.
- Concerning the comment made about lack of resources with the community services, in the East area between 2019 to 2021, there has been an additional £1million investment into CMHT. The problem is the vacancy levels, in 2019-2020 there were 14 whole time equivalent vacancies and in 2021, this rose to 18. The group was reassured that it was not a financial matter but was about being able to fill those posts.
- An update was provided on the ongoing work with primary care where service users have been encouraged to participate and provide feedback in the physical health pathway.

The Patient and Carer Experience Team extend their gratitude and appreciation to Paolo for sharing his experience.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Children and Mental Health Service (CAMHS) – Patient Experience Update**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport Executive Director Primary Care and Community Services
Awdur yr Adroddiad Report Author:	Louise Bell, Assistant Director, CAMHS
Craffu blaenorol: Prior Scrutiny:	Bethan Jones, Area Director Central
Atodiadau Appendices:	Appendix 1: MHCCC September Agenda Appendix 2: Patient Story Transcript

Argymhelliad / Recommendation:

The Committee is asked to note the learning from the CAMHS Patient Story

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

A CAMHS Patient Story was presented to the September MHCCC Committee (Appendix 1) and CAMHS are reporting back on learning from the young person's story and improvements made.

Cefndir / Background:

The story is of a young person who provided us with their experience of being a patient within CAMHS between 2015-2019, accessing community services in East area, the inpatient General Adolescent Unit, NWAS, and out of area specialist placements for inpatient services that are not provided in Wales (Low Secure and PICU level care).

The young person had a background of trauma and struggled with her mental health. There were many admissions into hospital onto the paediatric ward initially where she felt that she wasn't listened to or understood.

Asesu a Dadansoddi / Assessment & Analysis
Refer to Appendix 2 – Patient Story Transcript.
Opsiynau a ystyriwyd / Options considered Not applicable
Goblygiadau Ariannol / Financial Implications Not applicable
Dadansoddiad Risk / Risk Analysis Not applicable
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance Not applicable
Asesiad Effaith / Impact Assessment Not applicable

Betsi Cadwaladr University Health Board
Patient Stories Transcript Form

Who took the story?	Facilitators name: Tiffany Arnold Facilitators role / department: Art Therapist, NWAS, CAMHS Contact details: Date taken: 15/09/2022 Venue taken: NWAS Any other information:	
What is the title of the story?	A Patient Experience Story - CAMHS Journey	
What area does the story relate to?	Child and Adolescent Mental Health Services (CAMHS)	
What is the format of the story?	Powerpoint	
Overview of the story	The story is of a young person who provided us with their experience of being a patient within CAMHS between 2015-2019, accessing community services in East area, the inpatient General Adolescent Unit, NWAS, and out of area specialist placements for inpatient services that are not provided in Wales (Low Secure and PICU level care). The young person had a background of trauma and struggled with her mental health. There were many admissions into hospital onto the paediatric ward initially where she felt that she wasn't listened to or understood. Her time following admission into NWAS was more positive initially but her mental health deteriorated and she was placed on Section 3 of the MHA and had to be nursed separately from the open ward in the general unit for her safety and didn't understand why – this was never explained to her. She transferred to a Psychiatric Intensive Care Unit (PICU) in Manchester and then was stepped down to a low secure specialist placement in South Wales, before moving onto an inpatient facility in London. She had been in inpatient services away from home for 2 years in 3 separate placements, missed her family and felt trapped.	

	As her mental health improved following therapeutic treatment she was able to come back to our general adolescent mental health unit, NWAS, and was able to go on home leave to reintegrate back into family life. She struggled with the therapy and some of the approaches offered, but made progress and was taken off the section and able to be discharged home with community support after a few months. She feels that if she had been listened to when initially opened to CAMHS her mental health may not have deteriorated to a point where she required specialist mental health support, there were many positive experiences for her in NWAS and it was where she felt safe, but at times decision making around her care and treatment planning were not felt helpful to her or her family. Therapy approaches offered were not always understood or explained fully to her.
Key themes emerging and lessons learned	The young person felt that she wasn't being listened to at the time. It may not always be apparent that a young person is struggling to communicate, and this possibility should always be taken into account and additional steps taken to ensure the person has understood what is being communicated. One of the learning points from this story is that although the young person was very articulate, they were some difficulties with communication at most parts of the treatment journey and the extent of this difficulty, which was trauma related, was not fully understood by staff at the time. The story highlights the need for improved shared understanding of care pathways of young people who are placed out of area. Along with the need for improved liaison with our commissioners (WHSCC) so that families and young people are supported and don't feel disconnected from local services while being so far away from home receiving care and treatment. A letter of thanks was sent to the young person for bringing us her story which had truly impacted us as a reader and helps us understand what more could be done to improve the experiences of other young people accessing our services. This young person's contribution has helped demonstrate that stories are an effective method for identifying areas for staff training and development, especially outside of a mental health setting.
Suggested service	Improved links with CAMHS crisis teams for general paediatric ward staff to join up assessment and care planning and offer earlier intervention.

improvements to be made	Improved communication channels with the childrens safeguarding team to access advice and support so that young people describing adverse childhood experiences are listened to and their concerns understood have been implemented. The All Wales Mental Health Specialist Services Strategy 2022 – 2025 details improvements to be made in commissioning of specialist services out of area. CAMHS have contributed to the development of the Strategy and associated delivery plan. Improved communication between families and patients while in inpatient services, to ensure that care and treatment is fully explained and that families remain connected
Responsibility for actions required	Information shared with relevant manager/s: Bethan Jones, Area Director, Central Louise Bell, Regional Assistant Director for CAMHS
Actions taken (You Said, We Did)	Timeframe to action changes How will the story be used? This story has been shared across all CAMHS and Paediatric Teams How the story has had an impact on service development as a result? Services have developed and improved over the past 5 years since this young person accessed care but further improvement is required. Most of the concerns received in CAMHS relate to communication and we need to ensure that the patients and families have the space to feel listened to, understand and are more involved in the care and treatment planning A patient and family liaison officer has been appointed in NWAS. This post will be the key link between professionals, patients and families so that experiences are shared and concerns around care provision and communication are addressed. The Family Liaison Officer will support every young person entering inpatient services either in North Wales or out of area to ensure that families stay connected and ensure family support is available. Identified trauma related training across all services that provide crisis care for children and young people within BCUHB to enable improved therapeutic approached. This training has been commissioned over a 2 year period commenced Dec 2021. We are working with mental health planners in WHSCC to better understand the early part of a patient's pathway, oversight when a young person is

	placed out of area and the recovery following a specialist service intervention. There is now a weekly All Wales Bed Meeting chaired by WHSCC where all young people placed out of area are discussed with our clinical leads and care co-ordinators in CAMHS. Improved communication with regular CAMHS/Acute Paediatrics crisis safety meetings 3 times per week. There is now a regional governance structure in place to support the crisis pathway when young people require inpatient services on a General Paediatric Ward. BCUHB local Care Co-ordinators work more closely with providers in England and this has improved greatly during the pandemic with the ability to join MDT meetings virtually on digital platforms. Appointment of a dedicated CAMHS Patient Experience Lead. Engagement and participation work stream under TI Framework to develop an engagement strategy with children young people and families across North Wales.	
Consent / Sign off	Patient Sign off: Yes	Thank you letter sent? Yes
	Story is being shared with teams to encourage reflection and change in practice. • MHCCC – Sept 2021 • CAMHS Clinical Advisory Group • NWAS Tier 4 Programme Team • Area CAMHS Community Emotional Health Programme Teams • WHSCC – Mental Health Planning Leads	

Mental Health Capacity and Compliance Committee (MHCCC)
Draft minutes of the meeting held on 17.12.21 via Teams

Present:	
Lucy Reid	Health Board Vice Chair (Chair)
Cheryl Carlisle	Independent Member
John Gallanders	Independent Member
In Attendance:	
Louise Bell	Assistant Director Children and Adolescent Mental health Services (CAMHS)
Frank Brown	Associate Hospital Manager
Wayne Davies	Locality Manager, Welsh Ambulance Services Trust
Michelle Denwood	Director of Safeguarding and Public Protection
Gill Harris	Executive Director Nursing and Midwifery / Deputy Chief Executive (part meeting)
Bethan Jones	Area Director - Centre
Matthew Joyes	Interim Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience
Ruth Joyce	Criminal Justice Liaison Service Manager, MHLD
Wendy Lappin	Mental Health Act Manager, MHLD (part meeting)
Hilary Owen	Head of Governance and Compliance MHLD
Teresa Owen	Executive Director of Public Health
Steve Riley	Consultant Nurse CAMHS
Dr Alberto Salmoiraghi	Consultant Psychiatrist/Medical Director, MHLD
Mike Smith	Interim Director of Nursing MHLD
Iain Wilkie	Interim Director, MHLD
Diane Davies	Corporate Governance Manager – for minutes

Agenda item	**Action**
MC21/24 Patient Story and Patient Experience update - **MC21/24.1** The Acting Associate Director of Quality Assurance introduced this item which describes Z 's experience as she went through gender reassignment surgery, but also describes a difficult upbringing with an extensive history as a service user of mental health services over a decade, including some periods of detention under the Mental Health Act. In addition, difficulty in accessing some services and the raising of a complaint which is currently under investigation was highlighted. The Quality Team was grateful for the sharing of this experience in order that future training, planning around equality and signposting for staff and patients could be improved going forward.	

MC21.24.2 The Committee was concerned to hear of Z's experiences and raised a number of issues. This included multiple referrals that were missed, the difficulty of navigating MH services, and training regarding LGBT which was understood to be in hand. The most concerning being that the patient stated that her complaint was used against her. In response to the Committee's request to address issues, the Interim Director of Quality Assurance confirmed that a revised policy would be brought to the next available slot on the Quality, Safety and Experience Committee agenda. **MC21/24.3** The Committee questioned how long it would be before the patient's complaint would reach conclusion and it was noted that a response was due to be provided by the new year. Following questioning in relation to the patient's experiences in primary care, the Committee acknowledged that the experience highlighted mental health did not solely lie within the MHLD division. The MH Director provided assurance that transgender pathways had improved significantly since Z's experience, citing examples of various changes from initial referral to a shortened gender dysphoria journey. In response to the Committee Chair's concerns the Interim MH Director provided further detail of the change to the pathway, and expressed his sadness was to hear of the complaint issues highlighted by the Committee. **MC21/24.4** The Committee Chair acknowledged that the complaint was currently still under investigation, however she emphasised that all Patient Stories should highlight lessons to be learned and corresponding actions undertaken to address them in order to have sufficient assurance to close the action/learning loop. The Committee Chair expressed her disappointment that North Wales did not continue to have the flagship gender reassignment service (previously led by a now retired North Wales clinician) and also that Z's discharge was not followed up by a CPN as promised. She requested that the Interim Director of Quality Assurance circulate a briefing to explain how these issues were being taken forward and to also ensure an end of year report was provided to the Committee on the implementation of learning from the Patient Stories provided during the year. **It was resolved that** the Committee noted the patient story	MJ MJ
MC21/25 Apologies Apologies had been received from Marilyn Wells, for whom Steven Riley deputised.	
MC21/26 Declarations of Interest Lucy Reid and Hilary Owen declared they were serving Justices of the Peace for the Central North Wales Bench, as a paper on the Criminal Justice Liaison service was to be discussed. In addition, Hilary Owen	

advised that she had recently been appointed as a Mental Health Act reviewer for Healthcare Inspectorate Wales (HIW).	
MC21/27 Draft minutes of the inaugural meeting held on 24.9.21 The minutes were confirmed as an accurate record subject to a typographical error at MC21/16.2 being amended to 'Medacs'.	
MC21/28 Matters arising and table of actions There were no matters arising from the minutes and the table of actions updates were accepted.	
MC21/29 Report of the Chair The Committee Chair reported that, due to the escalating pandemic response, the time allocation for all Committee meetings had been reduced. Therefore all Committee papers would be taken as read by Committee members and questions would be raised at the outset of each agenda item.	
MC21/30 Report of the Lead Executive The Executive Director of Public Health reported that a paper on local progress with S12 doctors would be provided to the next meeting, supported by the MH Medical Director. In addition, she sadly highlighted that the coming festive period would inevitably see more patient demand for mental health services and potentially its own challenges in terms of Mental Health Act compliance.	AS/TO
MC21/31 Notification of matters referred from other Board Committees on this or future agendas None.	
MC21/32 Terms of Reference (ToRs) **MC21/32.1** The Executive Director of Public Health advised that she had consulted with the Interim Director of Governance in moving forward the suggestions made at the previous meeting, which had now been incorporated. In response to the Committee it was clarified that should the Committee need to meet in private session, only members and officers in attendance were required to be present as set out in the ToRs. **MC21/32.2** It was acknowledged that the ToRs would require further amendment following role changes set out in the new operating model when approved. The Executive Director of Public Health undertook to	TO

verify if staffside groups were included in all the new Committee ToRs following the Integrated Governance Review **It was resolved that the Committee** approved the Terms of Reference which would be reported to the Board via the Chair Assurance report.	
The Future **Developing Strategies and plans** **MC21/33 Liberty Protection Safeguards (LPS) Update** **MC21/33.1** The Director of Safeguarding and Public Protection advised that a Welsh Government briefing the previous day advised that a proposed date for the new Code of Practice was not currently known. It was understood that, when it became available, a 3 month consultation period would be undertaken and significant challenge was expected. **MC21/33.2** A discussion ensued on training needs within the organisation in regard to capacity assessment, and attention was particularly drawn to how this was addressed in BCU's utilisation of agency staff. The Interim MH Nurse Director clarified that there was not a great reliance within adult Mental Health services on agency staff, unlike other services. The Director of Safeguarding and Public Protection advised of various safeguarding checks undertaken (such as on wards through desk top reviews when required) however, she acknowledged the challenges. The Committee was pleased to hear that bank staff received appropriate training through contractual arrangements, and that the Workforce department was supportive in respect of safeguarding training which was an integral part of the mandatory staff training programme. **It was resolved that the Committee** noted the LPS position report in preparation for the implementation of Liberty Protection Safeguards (LPS) on 1st April 2022.	
The Present **MC21/34 Deprivation of Liberty Safeguards (DoLS) Quarterly Report September 2021** **MC21/34.1** The Director of Safeguarding and Public Protection assured that work was being undertaken with the Patient Liaison service to address the production of 'easy read' documentation and leaflets in regard to the use of language for many different patient groups; and consideration being given to a targeted and simplified approach that would ensure BCU was above the curve in relation to embedding the revised legislation. Discussion ensued on 'parental comment no longer being required' as set out in the report. The Director of Safeguarding and Public Protection assured that there was a plan and programme in place, along with additional work within paediatrics. In regard to the complex case outlined on page 51, she was unable to provide a timeline on when	

learning could be shared from review of the high court case however, assurance was provided that appropriate teams were involved in working together to bring the learning to the forefront. **It was resolved that the Committee** noted the report	
MC21/35 Associate Hospital Managers Update Report (Aug 2021 – October 2021) **It was resolved that the Committee** noted the report The Committee and Lead Executive took the opportunity to thank the Associate Hospital Manager for his commitment and dedication over many years as a valued colleague, as this was to be his last meeting.	
MC21/36 Mental Health Act Performance report **MC21/36.1** In regard to Mental Health Act data storage and reporting, the MHA Manager advised that meetings were currently being held with both IT and Performance departments to explore an alternative system (eg Sharepoint), at pace to address the risks which the Committee had previously highlighted. The MHA Manager directed the Committee to the data provided within the report on prisoner admissions, in response to a query raised. In regard to the Committee's concern on the level of 21% rectifiable errors reported, the MHA Manager pointed out this was an improvement on previous performance and much work had been undertaken to address this. The MHA Manager highlighted the type of data error this might involve eg missing postcodes. The Associate Hospital Manager observed that most rectifiable errors occurred within the community however, the scrutiny process in place would enable these to be identified at an early stage. **MC21/36.2** Discussion ensued on S136 data for Young People in which it was highlighted that, due to the low numbers involved, there might appear to be a skew within certain Local Authority area presentations. It was agreed this would be explored further. **It was resolved that the Committee** noted the report	WL
MC21/37 Mental Health services – Management of crisis and s136 detentions of Children and Young People presenting in a hospital setting **MC21/37.1** In response to the Committee, the Area Director Centre clarified that young people were defined as below 18 years of age. In regard to questions raised around the out-of-hours (OOH) service data provided, the Assistant Director CAMHS described the work taking place with North Wales Police partners around education and training of patient presentations and admissions processes. She highlighted the current difficulties in recruiting to BCU child health psychiatry services and the	

efforts being made to address them with alternative practitioners. In addition she emphasised the importance of ideally avoiding the need to use s136 as advised within the report. The Assistant Director CAMHS also referred to joined up pathway work being progressed with the Interim MHLD Nursing Director. The Consultant Nurse CAMHS described how most young people who were detained were in an emotional crisis and that options were needed going forwards in providing safe alternatives and meeting with them earlier in the crisis process so that the need to use the Mental Health Act could be avoided. The analysis showed that a very small number of young people went on to be sectioned from the s136. **MC21/37.2** The Executive Director of Primary and Community Services was supportive of the work being undertaken however, he reminded that it was important to consider the importance of working in partnership to provide solutions rather than consider some areas to be outside of BCU control. A discussion ensued on work in this area, including reflections from the Criminal Justice Liaison Service Manager. In discussion of the S136 graph it was agreed that the MHA Manager would explore ways to provide information on admission times, with the aim to provide greater clarity on CAMHS OOHs presentations. The Assistant Director CAMHS also advised that on recruitment of a Mental Health Act administrator for CAMHS services, data provision and analysis would improve and thereby inform future community provision. **MC21/37.3** In response to the Committee's question regarding progress on the three crisis project schemes which were in the early planning stages, the Assistant Director CAMHS advised timelines for Care Homes and 111, however others were more challenging. She undertook to advise the Committee of the pilot work being undertaken and further details on timelines. **MC21/37.4** Following a question raised on the current condition of S136 suites, the Interim Director MHLD Nursing gave a brief overview but agreed to follow up this up and provide more comprehensive information for the member who pointed out that good surroundings were beneficial in calming crisis situations. He also agreed to advise the Committee Chair should the stagnant water issue remain, in order that she could seek assistance to remedy the issue. **It was resolved that the Committee** noted the report	WL LB MS MS
MC21/38 Criminal Justice Liaison report **MC21/38.1** The Committee Chair reflected on her experience as a magistrate dealing with defendants whom had reached crisis point whilst trying unsuccessfully to access mental health services and, on occasion, resorted to self medication with drugs and alcohol. A discussion ensued in which other examples of people in this form of crisis were raised and how previously co-located services worked together at an earlier stage for the benefit of individuals under probation. The Criminal Justice Liaison	

Manager (CJLM) spoke of potential strategic developments in recovery and the challenges of meeting day to day management with other expectations of the service as outlined in the report. **MC21/38.2** The Committee Chair suggested that this issue be discussed at the Together for Mental Health Partnership Board (T4MHPB) as appropriate organisations would be around the table to work towards finding a solution, such as the viability of a fast track referral pathway based upon risk. The Head of MHLD Governance also concurred with these experiences as a magistrate, especially welcoming the potential to work in partnership with the probation service. **MC21/38.3** In response to the Committee the CJLM confirmed that, preCovid, a member of the Criminal Justice Liaison Team would be in attendance at courts and she outlined how the service was provided. The Executive Director of Public Health agreed to arrange to move this conversation forward through the T4MHPB, following which there could be potential for discussion at other relevant Boards. The Associate Director Safeguarding and Protection advised that during a recent conversation with the Probation service, they confirmed that they would welcome engagement with the T4MHPB. It was agreed this would be moved forward following a discussion to take place between the Committee Chair, CJLM and the Deputy Director of Mental Health and Learning Disabilities. **It was resolved that the Committee** noted the report	TO
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 to seek further guidance from the Interim Director of Governance on this matter. It was acknowledged that the risks previously discussed by the Committee were at level 2 or 3 and therefore not required to be monitored further by MHCCC. **It was resolved that the Committee** agreed to seek further governance advice on whether Corporate risk CRR21-14 would transfer from QSEC.	TO
MC21/40 Court of Protection cases **MC21/40.1** The Committee welcomed the provision of this new report which would help to improve efficiency and safety, it was envisaged to be provided on a regular basis.	

MC21/40.2 The Interim Associate Director of Quality clarified that a recent case under the oversight of the Court of Protection drew criticisms which the assurance report sought to address. He indicated that he will now hold regular Court of Protection Case Oversight meetings in order to ensure awareness and oversight of all cases. A central register of cases would be maintained and it was noted that a qualified and practicing solicitor was to be recruited as Head of Legal Services, supported by a newly created Legal Services Department that would bring together various healthcare law strands into a single unified service. An escalation process had also been developed and put into policy to ensure complex cases were escalated in a timely manner to senior staff. **MC21/40.3** In response to the Committee Chair, the Interim Associate Director of Quality Assurance confirmed that future reports would not provide details of individual cases but rather key themes and learning from them as well as providing assurance on compliance with any Court orders issued. He undertook to advise when future reports would be provided for incorporation to the Cycle of Business. The Interim Director of Nursing MHLD welcomed the report and pointed out that the themes would be broader than just mental health. **It was resolved that the Committee** noted the report	MJ
MC21/41 Approval for All Wales Approved Clinicians and Section 12(2) Doctors) **It was resolved that the Committee** noted • the report • appropriate governance arrangements, processes and activities were in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.	
Learning from the Past **MC21/42 Healthcare Inspectorate Wales (HIW) monitoring reports** **It was resolved that the Committee** noted the report.	
MC21/43 Compliance with the Mental Health Act quarterly report **MC21/43.1** The Committee Chair highlighted concern in regard to the rates of compliance with care and treatment plans and particularly the large performance level variation of medical record keeping within different units. She reflected that these areas also featured in a number of complaints and incidents. **MC21/43.2** In response to the Committee Chair, the Head of Governance and Compliance MHLD explained that moving forward a HIW audit tool would be used in order to provide greater level of detail. She also advised that an action plan was being developed in regard to a serious untoward incident with specific actions around care and treatment plans, and particularly around risk. These would be built into morning huddles. The	

Committee Chair requested that future reports include a brief summary in order to bring wider perspective for those particular actions in order that the audit loop could be closed. **It was resolved that the Committee** noted the report.	HO/WL
MC21/44 Power of Discharge Group chair's assurance report **It was resolved that the Committee** noted the report.	
MC21/45 Agree items for referral to Board / Other Committees None were identified.	
MC21/46 Review of risks highlighted in the meeting for referral to Risk Management Group None	-
MC21/47 Agree items for Chairs Assurance report To be considered following the meeting.	
MC21/48 Review of meeting effectiveness Whilst the Committee timing overran slightly, the Committee Chair reflected that the depth of discussion had been helpful and worthwhile.	
MC21/49 Date of next meeting 25.3.22	

BCUHB Mental Health Capacity and Compliance Committee Table of actions – last updated 22/04/2022 18:27				
Executive Director	**Minute reference and action agreed**	**Original timescale**	**Latest update position**	**Revised timescale**
24.9.21 Inaugural meeting				
Bethan Jones	**MC21/1.2 Patient Story** Provide greater clarity on how BCU processes enable 'real time' tracking of a young person's transfer through multiple treatment centres and social workers in order that the organisation was cogniscent, along with consideration of the patient's family	~~2.12.21~~	Work is ongoing to draw together the learning and recommendations from this patient story with support from Matt Joyes. This will be addressed fully at the March meeting. (March meeting postponed to April) Agenda item 29.4.22 MC12/2	1.3.22 19.4.22 Item to be closed
Teresa Owen/ Diane Davies/ Molly Marcu	**MC21/3 Cycle of Business** The Executive Director of Public Health invited members to discuss the initial cycle of business. It was agreed that the ToRs would be cross referenced to the Cycle of Business in order to ensure the future annual report objectives would be met, and members were asked to advise of any gaps identified before the next meeting.	2.12.21	No new items/ gaps have been identified. Work on finalising the Cycle of Business underway.	21.4.22 Action to be closed
Teresa Owen (Iain Wilkie)	**MC21/10 Reforming the Mental Health Act (MHA) White Paper - Update** The Interim Director of MHLD would discuss with Workforce &OD colleagues potential requirement for further resource to enable compliance with the reform amendments	11.11.21	21.4.22 A range of potential resource requirements are being considered in relation to the reforms, and given the need for compliance. Conversations with WOD team are ongoing	21.4.22
17.12.21 meeting				

Matt Joyes	**MC21/24 Patient Story and Patient Experience update – Z's story** • Circulate a member briefing to explain how the issues discussed were being taken forward (see minutes)	19.4.22	In response to the Committee's questions on the service, we can advise that it is now operated on a national basis, commissioned by the Welsh Health Specialised Services Committee and hosted by Cardiff and Vale University Health Board. The new Welsh Gender Service was first announced by the Health Minister, Vaughan Gething MS in 2017. Since the Health Minister's announcement, the Welsh Gender Service (WGS) was created and is based at St David's Hospital in Cardiff with outreach Local Gender Teams (LGT) based in each health board area. The Local Gender Teams are made up of a doctor, who prescribes hormone therapies and a speech and language therapist, who are both located closer to the patient's home. The Welsh Gender Service are a multidisciplinary administrative and clinical team, made up of Consultants, Gender Clinicians, Clinical Psychologists, Speech and Language Therapists and Management. The service aim to work together to provide holistic patient-centred care focussing on hormonal, psychological, and social aspects of transition. The Medical Director for MHLD has advised that the new service has improved access to specialist clinical skills and improved clinical governance.	Action to be closed

Matt Joyes	• Ensure an end of year report was provided to the Committee on the implementation of learning from the Patient Stories provided during the year.	14.3.23	Patient Story learning report to be added to Cycle of Business annually at March meeting going forwards (DD added to current COB) MJ advises that the Patient and Carer Experience Team have started provided patient stories for the Committee – in-keeping with the QSE model this will be provided annually, from April 2023 (this is because the team only provided one story in 2022/23).	Action to be closed
Alberto Salmoiraghi / Teresa Owen	**S12 Doctor update** Provide a paper on local progress with S12 doctors to the next meeting, supported by the MH Medical Director.	19.4.22	Agenda item 29.4.22 meeting	Action to be closed
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.	
Wendy Lappin	**MC21/36 Mental Health Act Performance report** Discussion ensued on S136 data for Young People in which it was highlighted that, due to the low numbers involved, there might appear to be a skew within certain Local Authority area presentations, it was agreed this would be explored further.	19.4.22	Following discussion it was agreed that further clarity in regards to the tables and information would be provided verbally at the next meeting. A verbal update to be provided as per agenda item.	 21/4/22
Wendy Lappin	**MC21/37 Mental Health services – Management of crisis and s136 detentions of Children and Young People presenting in a hospital setting** In discussion of the S136 graph it was agreed that the MHA Manager would explore ways to	19.4.22	Admission times are now included in the monthly S136 report.	Action to be closed

	provide information on admission times, with the aim to provide greater clarity on CAMHS OOHs presentations.			
Louise Bell	**MC21/37 Mental Health services – Management of crisis and s136 detentions of Children and Young People presenting in a hospital setting** In response to the Committee's question regarding progress on the three crisis project schemes which were in the early planning stages, the Assistant Director CAMHS advised timelines for Care Homes and 111, however others were more challenging. She undertook to advise the Committee of the pilot work being undertaken and further details on timelines.	19.4.22	25.3.22 At agenda setting meeting it was requested that this response be included within a CAMHS Pathway paper to be prepared for April meeting Agenda item 29.4.22	Action to be closed
Mike Smith	**MC21/37 Mental Health services – Management of crisis and s136 detentions of Children and Young People presenting in a hospital setting** • **MC21/37.4** Following a question raised on the current condition of S136 suites, the Interim Director MHLD Nursing gave a brief overview but agreed to follow up this up and provide more comprehensive information for the member who pointed out that good surroundings were beneficial in calming crisis situations. • He also agreed to advise the Committee Chair should the stagnant water issue remain, in order that she could seek assistance to remedy the issue.	19.4.22	Member briefing circulated 20.4.22	Action to be closed
Teresa Owen to arrange	**MC21/38 Criminal Justice Liaison report** The Executive Director of Public Health agreed to arrange to move this conversation forward		Meeting held, and a follow up meeting held between the Executive DPH and the CJLM.	Action to be closed

	through the T4MHPB, following which there could be potential for discussion at other relevant Boards. The Associate Director Safeguarding and Protection advised that during a recent conversation with the Probation service, they confirmed that they would welcome engagement with the T4MHPB. It was agreed this would be moved forward following a discussion to take place between the Committee Chair, CJLM and the Deputy Director of Mental Health and Learning Disabilities.		Agreement that probation service be invited to T4MHPB	
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 to seek further guidance from the Interim Director of Governance on this matter.	19.4.22	Further work is required on the risk register. Verbal update to be provided alongside the risk paperwork for the Committee.	21/4/22
Matt Joyes	**MC21/40 Court of Protection cases** Advise when future reports would be provided for incorporation to the Cycle of Business.	19.4.22	25.3.22 At agenda setting meeting Committee Chair clarified that high level *thematic* reports (ensuring no patient identifiable content) are required to include areas of good practice, issues arising and what actions BCU has/is undertaken to resolve them along with lessons learned. Added to COB to be reported as arise. MJ advises : The new Head of Legal Services commences in post in April 2022 which will enable centralisation of the oversight function, and	Action to be closed

			thereafter will provide a written report for each meeting.	
Hilary Owen /Wendy Lappin	**MC21/43 Compliance with the Mental Health Act quarterly report** The Committee Chair requested that future reports include a brief summary in order to bring wider perspective for those particular actions in order that the audit loop could be closed.	19.4.22	This is now included.	Action to be closed

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Mental Health Act Policy: MHLD 0026 – Policy for admission, receipt and scrutiny of statutory documentation**
Cyfarwyddwr Cyfrifol: Responsible Director:	Iain Wilkie, Divisional Director, MHLD
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Hilary Owen, Head of Governance and Compliance, MHLD Division Iain Wilkie, Divisional Director, MHLD Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	• Appendix 1 - MHLD 0026 – Policy for admission, receipt and scrutiny of statutory documentation. • Appendix 2 – EQIA MHLD 0026

Argymhelliad / Recommendation:

The committee is asked to approve the policy.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

An EQIA has been completed in line with BCUHB Policy on Policies / WP7 Procedure for Equality Impact Assessments and is appended at appendix 2.

Following discussion with MH&LD Senior Management Team, the Office of the Board Secretary and the Equality Team, the assessment is that a SEIA is not required. The Policy submitted to the Committee for approval involves 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 policy has been assessed as 'not strategic'.

The government hosted a public consultation from 13 January 2021 to 21 April 2021 on a set of proposals to reform the Mental Health Act. They received over 1,700 responses. Further details on the impact of costs and benefits can be found in the impact assessment. The Welsh response is currently being translated and will be uploaded as soon as possible. Discussions are ongoing between the UK and Welsh Government.

Sefyllfa / Situation:

Extant policies are required to be reviewed at regular periods. The attached Mental Health Act Policy has been in situ for a number of years and has progressed through review and requires sign off for it to be uploaded to the health board's policy page to ensure staff are working to an up to date document.

Cefndir / Background:

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).

The Health Board has a number of Mental Health Act policies, procedures and guidance to ensure staff fully understand the legalities of the detentions, their roles and responsibilities, with detailed information on how to process and progress detentions.

The policy attached as an appendix is in reference to the admission, receipt and scrutiny of statutory documentation in relation to the legislative documentation of the Mental Health Act.

Documents scrutinised are detention papers and medication certificates on a daily basis, with the Associate Hospital Managers conducting scrutiny on detention papers and casenotes on a monthly basis as part of a regular audit programme.

The health board operates a fourfold scrutiny process of detention papers, initially by the receiving officer (MHA administrator or duty nurse if out of hours), followed by Medical scrutiny, Approved Mental Health Professional (AMHP) scrutiny and lastly by the Associate Hospital Managers as part of an audit process.

Medication certificates are scrutinised by the administrators and passed to pharmacy for their expert scrutiny of the medications and doses.

It is important for the health board to operate a scrutiny policy to ensure that detentions are legal, and medications are prescribed appropriately and correctly, the policy ensures that there is a robust system of checking documentation with a clear process.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Documentation scrutinised under the Mental Health Act require monitoring, errors are reported to the Mental Health Compliance and Capacity Committee on a quarterly basis and benchmarked with the other health boards in Wales.

Opsiynau a ystyriwyd / Options considered

Not applicable.

Goblygiadau Ariannol / Financial Implications
An illegal detention or medication error may incur a financial implication supporting the need for a robust scrutiny policy to ensure that all detentions are legal and medication certificates are appropriate.

Dadansoddiad Risk / Risk Analysis
Risks are associated with sections not being correct documented and patients detentions deemed invalid.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Monitoring of Mental Health Act activity is captured on a quarterly basis and reported to the Mental Health Capacity and Compliance Committee.

Benchmarking data is submitted on a quarterly basis to Cardiff and Vale UHB - who produce a benchmarking report.

Asesiad Effaith / Impact Assessment

The policy has undergone an Impact Assessment attached as appendix 2.

MHLD 0026 EQIA January 2017 reviewed November 2021

Version: 0.1 Review

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

MHLD 0026

Policy for: Admission, Receipt and Scrutiny of Statutory Documentation

Author & Title	Wendy Lappin, Mental Health Act Manager				
Responsible Dept / Director:	Director of Mental Health and Learning Disabilities Division				
Type of Document	Policy				
Approved by:	MHLD Policy/Procedure Sub Group – 05/10/2021 MHLD Divisional Senior Leadership Team Quality Safety and Experience Group – 19/10/2021 Clinical Policies and Procedures Group – 13/12/2021 PSQG – 14/02/2022 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) Code of Practice for Wales (Revised 2016) MHLD 0030 Policy for Information to Patients (S132/3 MHA)				
Date of next review:	Maximum 3 years from approval				
Date EqIA completed / reviewed:	20 January 2017 Reviewed November 2021				
First operational:	03 November 2008				
Previously reviewed:	Jan 2017				
Changes made yes/no:	Yes				
Details of changes since last review	Formatting and template update.				

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11. Medical Scrutiny of Section Forms
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13. Associate Hospital Managers Scrutiny Form – Section papers and casenotes
14. Administrators Scrutiny Checklist

GLOSSARY

Key words and acronyms used within the policy:

AMHP	Approved Mental Health Professional.
CoPW	Mental Health Act Code of Practice for Wales (revised 2016).
CTO	Provisions which allow a patient with a mental disorder to live in the community whilst still being subject to powers under the Mental Health Act 1983.
CTT	Consent to Treatment.
ECT	Electroconvulsive Therapy.
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.
Form HO14	Statutory Welsh Form to be completed on acceptance into hospital signed by a hospital manager.
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.**
MHA	Mental Health Act 1983 legislation for England and Wales.
MHAA	Mental Health Act Administrator.
MHA Associate Hospital Managers (MHA AHMs)	The MHA AHMs are a group of individuals who sit on hospital managers discharge panels to review a patient's detention on renewal or appeal. Scrutiny is conducted by the MHA AHMs on a monthly basis.
Out of Hours	Any time between 17:00 hours and 09:00 hours. Any time period between 17:00 Friday to 09:00 Monday.
Part IV, 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.
RC	Responsible Clinician, the approved clinician with overall responsibility for the patient's case.
Section 5(2)	Enables a doctor (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 initially 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.
SOAD	Second Opinion Appointed Doctor.
Within Hours	Office working hours 09:00 to 17:00 Monday to Friday are classed as within hours.

1. Introduction

1.1 Any reference to legislation 'section', 'part' or 'schedule' is with reference to the Mental Health Act 1983 (MHA) unless otherwise specified.

1.2 When an application is made to the managers of a hospital for the admission of a person into hospital under compulsory powers of the MHA there are certain requirements imposed on those accepting the application. Hospital Managers as defined in the Code of Practice for Wales 2016 as the Local Health Board must ensure that those administering the MHA have a full understanding and knowledge of those requirements in order to protect patient's rights and provide protection from litigation.

1.3 The power to detain a person under Part II of the MHA is permitted following the completion and receipt of prescribed forms, those set out in part 2, part 4 and part 8 of the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*. The forms must also be scrutinised to ensure all information contained is accurate and meets with requirements.

1.4 Someone with the authority to receive admission document should be available whenever patients are admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents. (CoPW 35.8)

2. Purpose of the Document

2.1 This policy has been developed to guide all staff on the receipt and scrutiny of legislative documentation of patients who are detained under a section of the Mental Health Act.

2.2 The purpose is to ensure that all staff are aware of their responsibilities and avenues to follow to obtain assistance.

3. Scope

3.1 The scrutiny of documentation is applicable to:

- **All Statutory Forms** supporting detention under short-term powers and civil applications, including renewals.
- **Consent to Treatment Documentation**
- **Community Treatment Orders (CTO),** although not covered by 'section 15' of the MHA 1983, [rectification of errors] these, too, should be scrutinised by the Mental Health Act Administrator (MHAA) on receipt.

3.2 Not Applicable to:

- **Guardianships**, 'section 7' of the MHA 1983, the responsibility for the correct administration lies with the Local Authority.
- **Hospital Orders -** issued by the Court are not 'accepted' by the Hospital Managers, thus paperwork is not corrected. Any serious errors must be raised with the Clerk of the Court, but should not invalidate a section unless there is direction to this effect from the Court.

4. Responsibilities

4.1 This policy must be read by all staff caring for detained patients or patients under a CTO and by MHA Office Staff.

4.2 Staff completing section papers **must** ensure that the paperwork is fully completed to the required standards as set out within the MHA.

4.3 Following detention the ward staff have a responsibility to ensure the patient is aware of their rights and understand the detention. Information should be provided in accessible formats in line with MHLD 0030 Policy for Information to patient's (s132/3 MHA).

4.4 The MHA Office Staff will undertake scrutiny in conjunction with Approved Mental Health Professional's (AMHP's), Medics, Pharmacy, Electroconvulsive Therapy (ECT) and MHA AHMs.

4.5 This policy will be made available to the Mental Health Act Associate Hospital Managers (MHA AHMs). The MHA AHMs are a group of individuals who sit on hospital managers discharge panels.

4.6 The MHA Manager will be responsible for monitoring the standard of completed section papers and escalating to the appropriate senior manager.

5. General Procedure

5.1 An application under the MHA can be made either in the community or for someone already in hospital. When applications are made in the community, the person liable to be detained is conveyed to the admitting unit with completed documentation (application and medical recommendation(s) and AMHP report). It is the responsibility of the AMHP to ensure the admission documentation is provided to the receiving hospital at the same time as the patient arrives.

5.2 However, if the AMHP is not travelling with the patient, the documents must be given to the person authorised to take the patient with instructions for them to be presented to the member of staff authorised to receive them. If the AMHP is not travelling with the patient, he/she will arrive at the hospital at the same time as the patient or as soon as possible afterwards. The AMHP will ensure the admission documents have been delivered.

5.3 The AMHP will provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know.

5.4 There may be circumstances where the receiving hospital is a considerable distance from the area where the AMHP operates, which would make it impracticable for the AMHP to go to the hospital with the patient. In these circumstances, the AMHP report will be delivered by telephone or other means which comply with local or national procedures for passing confidential information.

5.5 If the nearest relative is the applicant and they need help to ensure the safe transport of their relative, the local authority will ensure the availability of an AMHP to help them. If this is not possible, other professionals involved in the admission to hospital will help.

6. Receipt and Scrutiny of Admission Papers

6.1 Main District Hospitals (Ablett Unit, Heddfan, Hergest Unit)

6.1.1 The statutory paperwork, as well as AMHP report, must be received in a timely manner during normal working hours ie Monday to Friday, 9.00am – 5.00 pm, by the MHA Administrator (MHAA), who will scrutinise paperwork and arrange for the completion and acceptance by the Hospital Managers on Form HO14.

6.1.2 Out of normal working hours, the statutory paperwork will be received by the Duty Nurse, who will check all documentation[1] and complete the Out of Hours form[2]. Original documentation will be taken to the MHAA at the earliest available opportunity, who will scrutinise paperwork and arrange for the completion and acceptance by the Hospital Managers on Form HO14. A copy will be returned to the ward for filing.

6.2 Other Units

6.1.3 The statutory paperwork must be received by the Ward Manager or the Duty Nurse, who will check documentation and complete the Acceptance Form[3] and scan/fax through to the MHAA at the earliest available opportunity. The original paperwork should be posted to the appropriate MHA Office in accordance with local or national procedures for passing confidential information. Once scrutinised and accepted a copy will be returned to the unit for filing.

6.2 Where an application is considered by the AMHP, the AMHP has a duty to check that the medical recommendations are sufficient to justify detention, before completing the application and proceeding with the admission.

[1] Checklists for appropriate section (1-5)
[2] Receipt of Mental Health Act Documents Appendix 6
[3] Receipt of Mental Health Act Documents. Appendix 6

6.3 All statutory documentation will be scrutinised by the **MHAA**, who can immediately act upon any anomalies. There will also follow **Medical** and **AMHP** scrutiny as well as being scrutinised by the **MHA AHMs**. This four-way process will ensure that the paperwork is correct and that the clinical reasons given are sufficient. The Medical and AMHP scrutiny will always be carried out by someone who is independent of the patient.

6.4 As part of the scrutiny process, the MHAA will also consider details provided in the AMHP report which should be able to corroborate information on the statutory documentation, specifically with regards to the nearest relative, or highlight any inaccuracies which may cast doubt on the lawfulness of the section.

6.5 Once scrutinised and any corrections allowed under section 15 have been made, the original papers will be filed in the correspondence folder, which is kept by the MHA Office, but will always be accessible to the Duty Nurse. A duplicate copy will be sent to the ward for filing within the relevant section of the patient's case notes.

6.6 When amended paperwork is returned to the MHA Office, a fresh set of section papers will be forwarded to the ward and the initial set should be destroyed.

7 Errors on Section Papers

7.1 Hospital Managers will receive statutory documentation and detain a patient on the basis of an application which appears to them to have been correctly completed and supported by the appropriate and necessary medical recommendations.

7.2 Hospital Managers **MUST NOT ACCEPT** an application if the documents contain one of the following errors:

- A statutory form (either an application or medical recommendation) is not signed or signed by someone not empowered to do so.
- The time limits of each section are not compliant with regulations.
- Neither doctor (where two recommendations are required) is approved under section 12(2) of the MHA.
- The application completed by the AMHP is not accompanied by the correct number of, or appropriate, medical recommendations. (See appendix 1 – 3 checklists for the forms required).
- The application and recommendations do not relate to the same person and/or names the wrong hospital for admission (section 3 application).

7.3 If any of the above faults are found, there is no legal authority for a patient's detention. Authority can only be obtained through a new application.

7.4 On discovery of an illegal detention the patient must be informed immediately, asked if they are willing to wait for an assessment and appropriate actions taken. Alternative powers of detention may include a section 5(4) or 5(2) if the patient is already admitted or the assistance of the police required to initiate a section 136 if not admitted.

7.5 In the eventuality of an illegal detention being discovered a Datix must be completed by the MHAA.

7.6 A record of the time and date of admission using a Form HO14 (record of detention section 2, 3, or 4) must be attached to the application and will form part of the detention documents.

7.7 The Hospital Managers may delegate their duties of receipt and scrutiny to officers to receive applications on their behalf and keep all necessary records. Those authorised to sign receipt of documents on behalf of the Hospital Managers are the senior management staff of the Health Board or duty nurses for out of hours.

8 Errors which can be rectified ('section 15' of the MHA 1983)

8.1 Section 15 allows for any documents containing rectifiable errors, listed below, to be amended by the professional who completed the form within 14 days[4] of the date the person was admitted on a section:

- Leaving spaces blank on the form which should have been completed (other than the signature)
- Failure to delete one or more alternative in places where only one can be correct
- A patient's details (name, address etc) differing in all the places they appear on the application and medical recommendations.
- Spelling mistakes

8.2 In addition, further information may be required on the medical recommendation (clear, concise clinical description and reasons for detention, unwillingness to remain informally, other services not suitable, etc).

8.3 Replacement of insufficient medical recommendations (section 15(3))

8.3.1 A medical recommendation may be insufficient because:

- It has been signed on a date after the application was made
- If the delay between the examination of the patient by the two doctors is more than five clear days apart.
- Neither doctor was section 12(2) approved

[4] An application under section 4 of the MHA, cannot be corrected after it has ceased to have effect unless it has become a section 2 MHA application because a second medical recommendation has been completed.

8.4 The above may be accuracy errors in the way the forms were completed such as the date entered incorrectly, the doctor may have crossed out the wrong criteria etc. If that is the case, they can be corrected. If not, the application is invalid and a fresh recommendation is obtained.

8.5 The MHA Office on behalf of the Hospital Managers must notify the AMHP in writing of the status of the recommendation, the AMHP will then have 14 days to replace the faulty recommendation with a new recommendation. Good practice states that the doctor should also be notified in writing.

8.6 A new recommendation accurately completed and delivered to the Hospital Managers within the 14 days of the date of the original documents were received, will be treated as if the original section were complete.

9. Consent to Treatment Documentation

9.1 Under the Part IV provisions of the MHA there are now eight statutory forms which can authorise treatment:

- ***Form CO1*** – section 57 certificate of consent to treatment (CTT) and second opinion
- ***Form CO2*** – section 58 – certificate of consent to treatment - when a patient is consenting to medication after 3 months of compulsory detention
- ***Form CO3*** – section 58 – certificate of second opinion -when a patient is incapable or is refusing medication after 3 months
- ***Form CO4*** – section 58A – certificate of consent to treatment - when a patient, who is at least 18 years, is consenting to ECT
- ***Form CO5*** – section 58A – certificate of consent to treatment and second opinion - for patients under the age of 18 years, for ECT.
- ***Form CO6*** – section 58A – certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment) for ECT for patients over the 18 years or over.
- ***Form CO7*** – Part 4A – Certificate of appropriateness of treatment to be given to a community patient (SOAD Part 4A Certificate)
- ***Form C08*** – Part 4A – Certificate of consent to treatment for community patient (Approved Clinician Part 4A Certificate)

9.2 Medication or ECT which is not covered by a correctly completed Form as stated above, may not be lawfully administered. This may expose staff and the Health Board to the risk of legal action.

9.3 It will be the responsibility of the Responsible Clinician (RC) or covering RC to accurately complete a Form CO2 or CO8 within the appropriate time periods and amend them as and when necessary. (The MHA Office will send timely reminders to the RC/AC of the CTT date, and a copy to the ward). However, it will be responsibility of the Second Opinion

Appointed Doctor (SOAD) to accurately complete the Form CO3, CO6 or CO7.

9.4 It will be the responsibility of the nurse administering medication or arranging for ECT to ensure they are covered by a correctly completed Form C04/CO5/CO6.

9.5 Paperwork in relation to ECT must be forwarded at the earliest opportunity to the Lead ECT nurse to ensure this is received in advance of any appointment.

9.6 It will be the responsibility of the MHA Office to notify the Mental Health Pharmacist for the area of any Form CO2 or CO3.

9.7 The MHA Office will ensure a copy of any amended CO2/CO3 will be sent to the wards for attachment to the medication cards and for filing within the case notes.

9.8 The MHA Office will complete an administrative scrutiny of the appropriate CO Form[5] and will then forward accordingly to either the **Mental Health Pharmacist** for the area or to the **ECT** Department for Scrutiny.

9.9 On a weekly basis, the Duty Nurse, will complete medication scrutiny on each patient subject to Form CO2/Form CO3. Any irregularities must be highlighted to the Consultant and the MHA Office.

9.10 On completion of new CO7 and CO8 forms for CTO patients a copy must be forwarded to the MHA Office to enable scrutiny to be conducted by the Pharmacy Department.

10. Monitoring

10.1 The MHA Office will maintain a database to record the scrutiny of statutory documentation, recording errors and monitoring discrepancies.

10.2 Inappropriate/illegal detentions or patient safety issues will be recorded on Datix by the MHAA. Under 18's will be recorded on Datix in line with the Process for Under 18's, through these processes this will enable Line Managers to initiate conversations with staff regarding legislative paperwork and the importance of such.

10.3 The list of errors will be reviewed by the Mental Health Compliance and Capacity Committee when necessary during its regular meetings and actions will be taken as required.

10.4 All documents and scrutiny forms will be forwarded to the relevant person within a timely manner to ensure they can be completed and returned within seven days of receipt to enable any rectifiable errors to be

[5] Admin Scrutiny Form(1-4)

amended within the 14 days as per guidance of the Code of Practice for Wales 2016.

10.5 Data and errors will be shared with other NHS local health boards within Wales as part of the MHA core data set to be used as benchmarking between the Health Boards.

10.6 The checklist Form (Appendix 14) will be completed by the MHAA and filed in the patient's clinical notes and MHA Office correspondence file.

11 Appendices

Appendix 1

(NAME OF UNIT HEDDFAN, HERGEST, ABLETT)

CHECKLIST FOR SECTION 2

Items listed in red and with an asterisk (*) are errors which cannot be rectified as per section 7.2 of the MH&LD admission, Receipt and Scrutiny of Statutory Documentation Policy

FORMS REQUIRED

1 x FORM HO2 – Application by AMHP	**OR**	**1 x FORM HO1 – Application by nearest relative**
2 x FORM HO4 – Separate Medical Recommendations	**OR**	**1 x FORM HO3 – Joint Medical Recommendation**
(2 x A4 if assessed in England)		**(1 x A3 if assessed in England)**

1. * The Application must be correctly addressed to the Appropriate Unit (Eg: **Hergest Unit, Ablett Unit, Heddfan**)
2. **FULL name and address** of the Doctors/Approved Mental Health Professional (AMHP) or (nearest relative)
3. The AMHP must state in the appropriate 'box/boxes' which authority they are acting on behalf of, and who approved them, if different from who they are acting for (mainly applicable to those working for the EDT).
4. **FULL forename(s), surname and address** of the patient correct on each form. ***ALL DETAILS MUST MATCH ACROSS THE FORMS.***
5. If the application is on **Form HO1** – this form must be completed by the patients nearest relative under the Act. If not, a written authority for the person signing should accompany the application.
6. **If application is on Form H01 the Managers of the Local Authority will need contacting to request a report under s14.**
7. * The date on which the Applicant last saw the patient must be within **14 days** of the application
8. * At least one of the medical recommendations completed by a section 12(2) Approved Doctor
9. Joint medical recommendations may only be used where the two doctors will be interviewing the patient at the same time, and completing the form together.
10. Only one medical recommendation may come from a doctor on the staff of the hospital where the patient is to be admitted.

11. One of the doctors should (if practicable) have had previous acquaintance with the patient. If not, the AMHP must state in the relevant section (box on top of page 3) on **Form HO2** why this was not possible.

12. * If the doctors examine the patient separately, not more than **five** days must have elapsed between the days on which the examination took place.

13. Both recommendations dated the same day or before the date of the application.

14. * Date of admission/application within **14 days** of the last examination.

15. The AMHP must take all reasonable steps to inform the nearest relative of the application. The AMHP **must** leave a copy of their outline report with the section papers.

16. Both medical recommendations must give full reasons why informal admission is not appropriate.

17. All forms must be signed and dated.

18. All corrections must be initialled and dated

PROCEED TO COMPLETE APPENDIX 6 AS 'RECORD OF ACCEPTANCE'

Appendix 2

(NAME OF UNIT HEDDFAN, HERGEST, ABLETT)

CHECKLIST FOR SECTION 3

Items listed in red and with an asterisk (*) are errors which cannot be rectified as per section 7.2 of the MH&LD admission, Receipt and Scrutiny of Statutory Documentation Policy

FORMS REQUIRED

1 x FORM HO6 - Application by AMHP	**OR**	**1 x FORM HO5 - Application by nearest relative**
2 x FORM HO8 - Separate Medical Recommendations	**OR**	**1 x FORM HO7 – Joint Medical Recommendation**
(2 x A8 if assessed in England)		**(1 x A7 if assessed in England)**

1. * The Application must be correctly addressed to the **appropriate unit. (Eg: Ablett Unit, Heddfan, Hergest Unit)**

2. **FULL name and address** of the Doctors/Approved Mental Health Professional (AMHP) or (nearest relative)

3. The AMHP must state in the appropriate 'box/boxes' which authority they are acting on behalf of, and who approved them, if different from who they are acting for (mainly applicable to those working for the EDT).

4. **If application is on Form H05 the Managers of the Local Authority will need contacting to request a report under s14.**

5. **FULL forename(s), surname and address** of the patient correct on each form. ***ALL DETAILS MUST MATCH ACROSS THE FORMS.***

6. * The date on which the Applicant last saw the patient must be within **14 days** of the application

7. * At least one of the medical recommendations completed by a section 12(2) Approved Doctor

8. Joint Recommendations may only be used where the two doctors will be interviewing the patient at the same time, and completing the form together

9. Only one medical recommendation may come from a doctor on the staff of the hospital where the patient is to be admitted.

10. One of the doctors should (if practicable) have had previous acquaintance with the patient. If not, the AMHP must state in the relevant section (last box on page 2) of **HO6** why this was not possible.

11. * If the doctors examine the patient separately, not more than **five** days must have elapsed between the days on which the examination took place

12. Both medical recommendations dated the same day or before the date of the application.

13. * Date of admission/application within **14 days** of the last examination

14. Check if the AMHP has deleted nearest relative options, and indicated whether consultation has taken place, if practicable (s11(3)). From AMHP's report, check whether the nearest relative appears to have been correctly identified.

15. Both doctors must give a detailed clinical description of the patient's mental condition to warrant detention under the Act. Reasons should indicate why informal admission is not appropriate.

16. Last box on medical recommendation should state the Unit where appropriate medical treatment will take place. If two medical recommendations, both should state the same Unit.

17. * All forms must be signed & dated.

18. All amendments should be initialled and dated.

PROCEED TO COMPLETE APPENDIX 6 AS 'RECORD OF ACCEPTANCE'

Appendix 3

(NAME OF UNIT HEDDFAN, HERGEST, ABLETT UNIT)

CHECKLIST FOR SECTION 4

Items listed in red and with an asterisk (*) are errors which cannot be rectified as per section 7.2 of the MH&LD admission, Receipt and Scrutiny of Statutory Documentation Policy

FORMS REQUIRED

1 x FORM HO10 - Application by AMHP **OR** **1 x FORM HO9 - Application by nearest relative**

1 x FORM HO11 - Medical Recommendation

(1 x A11 if assessed in England)

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1. The Application must be correctly addressed to the appropriate unit (Eg: Hergest Unit, Heddfan, Ablett Unit)

2. **FULL name and address** of the Doctors/Approved Mental Health Professional (AMHP) or (nearest relative)

3. The AMHP must state in the appropriate box/boxes which authority they are acting on behalf of, and who approved them, if different from who they are acting for (mainly applicable to those working for the EDT).

4. **FULL forename(s), surname and address** of the patient correct on each form. ***ALL DETAILS MUST MATCH ACROSS THE FORMS.***

5. If the doctor completing the recommendation has not had previous acquaintance with the patient, the appropriate section on **Form HO9/HO10** must be completed by the applicant (AMHP or nearest relative).

6. * The date and time the applicant saw the patient must be **within 24 hours** of the application being made.

7. * The patient must be admitted **within 24 hours** starting with the time of the earliest medical examination or of the application whichever is the earliest.

8. The doctor must complete the estimate number of 'hours of delay' (last box **Form HO11**) **and state valid reasons**

9. * Both forms must be signed and dated but the applicants date and time must be the same or after that of the medical recommendation.

10. * Any alterations must be initialled and dated.

PROCEED TO COMPLETE APPENDIX 6 AS 'RECORD OF ACCEPTANCE'

***Please note**: Section 4 may be converted to section 2 by receiving a second recommendation (FORM HO4) within 72 hours, as long as it and the original recommendation comply with the requirements for a section 2 admission. The section 2 will begin from the time the patients section 4 began.*

ONLY the Responsible Clinician can discharge the patient from section 4

Appendix 4

(NAME OF UNIT HEDDFAN, HERGEST, ABLETT UNIT)

CHECKLIST FOR SECTION 5(2)

Items listed in red and with an asterisk (*) are errors which cannot be rectified as per section 7.2 of the MH&LD admission, Receipt and Scrutiny of Statutory Documentation Policy

1 x FORM HO12 REQUIRED

APPLICATION IN RESPECT OF PATIENT ALREADY IN HOSPITAL

1 The form must be correctly address to the appropriate unit (Eg: Hergest, Heddfan or Ablett Unit)

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 – i.e. The Duty Doctor who does not have to be approved under section 12(2) of the Act

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

PROCEED TO COMPLETE APPENDIX 6 AS 'RECORD OF ACCEPTANCE'

Appendix 5

(NAME OF UNIT HEDDFAN, HERGEST, ABLETT UNIT)

CHECKLIST FOR SECTION 5(4)

Items listed in red and with an asterisk (*) are errors which cannot be rectified as per section 7.2 of the MH&LD admission, Receipt and Scrutiny of Statutory Documentation Policy

1 x FORM HO13 REQUIRED

FORM HO13 – NURSES POWER TO DETAIN

1 The form must be correctly address to the appropriate unit (Eg: Hergest, Heddfan or Ablett Unit)

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

3 * Complete prescribed class of Registered Nurse.

4 * Correctly signed, dated and time

PROCEED TO COMPLETE APPENDIX 6 AS '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***

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

NAME OF UNIT _____

Scrutiny of Consent to Treatment Papers (Form CO2 / CO8)

Name: **Ref:**
Ward:
Section 3 Dated: **Form CO2 / CO8 Dated:**

ADMINISTRATION SCRUTINY

		Yes	No
1	Has the form been completed by the patient's RC?	☐	☐
2	Has the patient's full name & address been inserted?	☐	☐
3	Is the form signed and dated?	☐	☐
4	Have any alterations been initialled?	☐	☐

Signed: _____ Date: _____

TREATMENT SCRUTINY (PHARMACY) **Date received: _____**

Are the following on this form? (Please tick box)

		Yes	No
1	Therapeutic group (eg Antipsychotic drugs)	☐	☐
2	Maximum number of drugs in each category including PRN	☐	☐
3	Maximum dose specified according to BNF limits (general statement)	☐	☐
4	Route (or routes) specified	☐	☐
5	Are there any drugs within the class noted to be excluded	☐	☐

Any Queries	Yes	No
Medication queried with prescriber	☐	☐
New form required	☐	☐
Additional comments		

Signed: _____ Designation:_____

Date: ___/___/_____

Please complete and return to the Mental Health Act Office within 7 days

Appendix 8

NAME OF UNIT _____

Scrutiny of Consent to Treatment Papers (Form CO3 / CO7)

Name: **Ref:**
Ward:
Section 3 Dated: **Form CO3 / CO7 Dated:**

ADMINISTRATION SCRUTINY

		Yes	No
1	Has the form been completed by SOAD?	☐	☐
2	Has the SOAD's full name & address been inserted?	☐	☐
3	Has the patient's full name & address been inserted?	☐	☐
4	Is the form signed and dated?	☐	☐
5	Have any alterations been initialled?	☐	☐

Signed: _____ Date: _____

TREATMENT SCRUTINY (PHARMACY) **Date received: _____**

Are the following on this form? (Please tick box)

		Yes	No
1	Therapeutic group (eg Antipsychotic drugs)	☐	☐
2	Maximum number of drugs in each category including PRN	☐	☐
3	Maximum dose specified according to BNF limits (general statement)	☐	☐
4	Route (or routes) specified	☐	☐
5	Are there any drugs within the class noted to be excluded	☐	☐

Any Queries	Yes	No
Medication queried with prescriber	☐	☐
New form required	☐	☐
Additional comments		

Signed: _____ Designation: _____

Date: ___/___/_____

Please complete and return to the Mental Health Act Office within 7 days

Appendix 9

NAME OF UNIT (HERGEST, HEDDFAN, ABLETT UNIT)
Scrutiny of Consent to Treatment Papers (Form CO4)

Name: **Ref:**
Ward:
Section 2/3 Dated: **Form CO4 Dated:**

ADMINISTRATION SCRUTINY

		Yes	No
1	Has the form been completed by SOAD?	☐	☐
2	Has the SOAD's full name & address been inserted?	☐	☐
3	Has the patient's full name & address been inserted?	☐	☐
4	Is the form signed and dated?	☐	☐
5	Have any alterations been initialled?	☐	☐

Signed: _____ Date: _____

TREATMENT SCRUTINY (ECT)

Are the following on this form? (Please tick box)

		Yes	No
1	Maximum numbers of ECT treatments	☐	☐
2	Does this include any given under section 62?	☐	☐
3	Has capacity been recorded?	☐	☐

IF NOT SATISFACTORY - GIVE REASONS

The certificate of Consent to Treatment has been scrutinised and found to be *satisfactory/not satisfactory to continue treatment under the Mental Health Act 1983.

*** delete as appropriate**

Signed: _____ Designation: _____

Date: ___/___/_____

Please complete and return to the Mental Health Act Office.

Appendix 10

NAME OF UNIT (HERGEST, HEDDFAN, ABLETT UNIT)
Scrutiny of Consent to Treatment Papers (Form CO6)

Name: **Ref:**
Ward:
Section 2/3 Dated: **Form CO6 Dated:**

ADMINISTRATION SCRUTINY

		Yes	No
1	Has the form been completed by SOAD?	☐	☐
2	Has the SOAD's full name & address been inserted?	☐	☐
3	Has the patient's full name & address been inserted?	☐	☐
4	Is the form signed and dated?	☐	☐
5	Have any alterations been initialled?	☐	☐

Signed: _____ Date: _____

TREATMENT SCRUTINY (ECT)

Are the following on this form? (Please tick box)

		Yes	No
1	Maximum numbers of ECT treatments	☐	☐
2	Does this include any given under section 62?	☐	☐
3	Is there a record of discussion with Consultees?	☐	☐
4	Are full reasons for treatment given included?	☐	☐

IF NOT SATISFACTORY - GIVE REASONS

The certificate of Consent to Treatment has been scrutinised and found to be *satisfactory/not satisfactory to continue treatment under the Mental Health Act 1983.

*** delete as appropriate**

Signed: _____ Designation: _____

Date: ___/___/_____

Please complete and return to the Mental Health Act Office.

Appendix 11

(Name of Unit - Hergest, Heddfan, Ablett)

MEDICAL SCRUTINY OF SECTION FORMS

Patients Name: REF: MH No:

RC: Section Date:

I, being an Approved Clinician (Medical) not currently responsible for the care and treatment of the above-named patient confirm that I have examined the attached Medical Recommendation(s) and am satisfied that:

	Sec 5(2)	Sec 2	Sec 4	Sec 3	CTO
Informal Admission was not appropriate in the circumstances of this case (Is this stated clearly *YES/NO) *** please delete**	☐	☐	☐	☐	
Compliance with non-emergency procedures might have resulted in harm to the patient or others			☐		
The patient suffers from the form of mental disorder specified of a nature and degree to warrant admission for treatment (Is there a sufficient clinical description of symptoms? *YES/NO) ***please delete**				☐	☐
Other methods of care or treatment were not available or appropriate				☐	☐

The recommendations are insufficient because:

Scrutinised by: _____ Date: _____

Appendix 12

(Name of Unit - Hergest, Heddfan, Ablett Unit)

SECTION PAPERS FOR SCRUTINY BY APPOINTED AMHP

Patients Name: REF: MH No:

RC: Section Date:

Please find attached forms for scrutiny. **If any comments please enter below**:-

This form should be returned to this office no later than 7 days of receipt so that any rectifiable errors that may have been missed can be sorted within the 14 days deadline

Signed: …… Print: .....

Date: ……

If section papers need to be altered, you will be required to check them again.

Please return this form to:

Administrator
Mental Health Act Office
(Address)

Appendix 13

(Name of Unit - Hergest, Heddfan, Ablett Unit)

Associate Hospital Managers Scrutiny
Section Papers and Casenotes

Venue:
Names of Managers undertaking Scrutiny:
Number of files scrutinised:
Date:
Any issues of concern which need raising:

Please note a separate page 2 and 3 of Appendix 13 should be used for each file scrutinised.

Appendix 13 p.2

Associate Hospital Managers Scrutiny
Section Papers and Casenotes

Patient's Name:

Ref No: Section: Section Date:

PLEASE NOTE:

- All forms must be for the same section detailing the patients name and address identically on each form.
- Forms should be signed and dated.
- If the section papers need to be amended you will be required to check them again.

Please check the medical recommendation(s) for the following:

		Yes	No
1	Do the doctors appear to be independent of each other?	☐	☐
2	Has the doctor stated why informal admission is not appropriate?	☐	☐
3	Have all forms been completed correctly?	☐	☐
4	Are dates of examination no more than five clear days apart? (not including the dates of the examinations)	☐	☐
5	Are you satisfied with the recommendation(s)? If not please details reasons below:	☐	☐

_____

_____

_____

_____

Please check the Application by the AMHP for the following:

		Yes	No
1	Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)	☐	☐
2	Has the AMHP given sufficient explanation of his/her determination of the nearest relative? (unable to ascertain may be appropriate at the time)	☐	☐

Appendix 13 p.3

Please check the casenotes for the following:

		Yes	No
1	Has Ethnicity been recorded in the casenotes? (Admission form)	☐	☐
2	Has an Explanation of Rights been given to the patient and recorded in the notes?	☐	☐
	Was the Explanation offered in the patient's primary language?	☐	☐
	If not have reasons been recorded? (MHA section)	☐	☐
3	Has the patient been referred to the IMHA? (MHA section)	☐	☐
4	Is there an up to date Care and Treatment Plan? (Care planning section)	☐	☐
5	Are the section papers filed in the correct place in the casenotes? (MHA section)	☐	☐

Any further Comments:

_____

_____

_____

_____

_____

_____

Signature(s): .....

Print Name(s): .....

Date undertaken: .....

Appendix 14

ADMINISTRATOR SCRUTINY CHECKLIST

Patient Name: **REF:** **MH No:**

RC: **Section:** **Date:**

Scrutiny Type	Date Sent / Undertaken	Person sent to / undertaking	Date Received Back	Satisfactory Yes /No Comments
Pharmacy				
ECT				
Medical				
AMHP				
Associate Hospital Managers				

Once completed form to be filed in MHA Office Correspondence file, copy to be sent to the ward for filing in casenotes

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 0026 Policy for Admission, Receipt and Scrutiny of Statutory Documentation
Date form completed:	(Reviewed) August 2021 and updated November 2021

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 0026 Policy for admission, receipt and scrutiny of statutory documentation.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms. The forms must also be scrutinised to ensure all information contained is accurate and meets with requirements. This policy ensures that appropriate paperwork is scrutinised by Hospital Managers for the admission of a person under the powers of the Mental Health Act. This will ensure compliance with the Mental Health legislation and ensure that patients' rights are upheld.
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?	Code of Practice for Wales Revised 2016 Mental Health Act 1983 (as amended by the Mental Health Act 2007) Mental Health Measure for Wales 2010 Welsh Language Standards Document under the Welsh Language (Wales) Measure 2011 The policy is prescriptive and administrative in nature (ensuring correct documentation). Mental health legislation is highly prescriptive and not open to interpretation. The policy decisions as to the content and application of the legislation (and required forms) are made at a national level by the UK Government (the Mental Health Act is not devolved) and the Health Board has a legal obligation to ensure that the documentation is processed in the prescribed way.

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, Nursing Staff, Pharmacy Staff, ECT Staff Mental Health Act Administrators and Assistants, Associate Hospital Managers Approved Mental Health Professionals (AMHPs)
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Communication to staff Cooperation of staff Time constraints Training for all Mental Health Staff and Health Board staff on general wards. Workflow charts
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 will guide staff completing paperwork to the standards required by the Mental Health Act 1983 for all persons who are detained under the Mental Health Act 1983 (as amended 2007). The Mental Health Act allows for patients to be detained for their own health and safety or for the protection of others. It is imperative that the detention paperwork is correct and checked by the appropriate personnel. The policy will ensure that detentions are in accordance with the law and that the administrative requirements (paperwork) is completed.

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 is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. In relation to detentions, there is likely to be higher prevalence of older groups who may experience from dementia. These people may also be supported by older carers / partners. Older groups are more likely to experience sensory impairment or a physical impairment. This will impact on the communication methods for sharing information and any communications should be identified and met. This is also in accordance with the Welsh Standards for Accessible Communication and Information for People with Sensory Loss. This requires Health Boards to ensure that individual communication needs are met. E.g. providing information in an accessible format. Examples include larger font, and easy read. North Wales has a large demographic of older persons.	Potential impact identified within the policy for providing patient and carers with information. Reduce any potential negative impact for older groups providing information in formats to meet individual communication needs. The scrutiny of documents ensuring compliance to the Mental Health Act should have a positive impact on patients and their carers.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

					This policy should not have any impact negative in regards to age.	
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	√				This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. In relation to people who are detained, and their carers, who may have sensory related impairments or a learning impairment, there is a requirement for ensuring that shared information is in an accessible format – that meets their needs. This is also in accordance with the Welsh Standards for Accessible Communication and Information for People with Sensory Loss. This requires Health Boards to ensure that individual communication needs are met. E.g. providing information in an accessible format. Examples include larger font, and easy read. The policy makes reference to this within Appendix 13, p3. In terms of mental health – which falls within the definition of disability within the Equality Act 2010, the policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally). Mental Health Illness can affect anyone and it is acknowledged that people with learning impairments may require additional support to understand the information being given to them.	Potential impact identified within the policy for providing information to patients and carers that have sensory impairments and learning impairments. Reduce any potential negative impact by providing information in formats to meet individual communication needs. The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).

					The scrutiny of documents does not impact negatively on this characteristic. The impact on having accessible patient and carer information in accessible formats should have a positive impact.	
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. Completed paperwork should reflect the correct use of name and pronouns as appropriate. We do not consider there are any impact for persons who are undergoing gender reassignment. However this assessment acknowledges the following: Stonewall (an LGBT support organisation) produced a report called LGBT in Britain Health. This notes that a high proportion (46%) of trans people surveyed said they had thought about taking their own lives. The report notes that LGBT people are at higher risk of experiencing mental health problems. Source: LGBT in Britain - Health (stonewall.org.uk) accessed 23/11/2021	Completed paperwork should reflect the correct use of name and pronouns as appropriate. The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).
Pregnancy and maternity		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act.	The policy should ensure that Hospital Managers are completing and checking

					We do not consider there are any potential negative impacts for persons with this characteristic.	paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.	√				This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. The policy and scrutiny documents reference the recording of ethnic background within Appendix 13, p3. This will enable monitoring in relation to this characteristic. In relation to people who are detained, and their carers, who are Black, Asian and minority ethnic backgrounds, there may be considerations to be given for information provided. This may need to consider translation services to explain and communication admission process. Providing information in accessible language formats should impact positively on this group. This assessment acknowledges that people from Black, Asian and minority ethnic groups can be more likely to have a Mental illness. This also includes refugees and people seeking asylum who experience higher rates of depression and PTSD. Source: BAME and mental health | Mental Health Foundation	Considerations to be given for information provided. This may need to consider translation services to explain and communication admission process. The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

					We do not consider there are any negative impacts for persons with this characteristic.	
Religion, belief and non-belief		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. We do not consider there are any negative impacts for persons in relation to this characteristic.	The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).
Sex (men and women)		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. We do not consider there are any negative impacts for persons in relation to this characteristic.	The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).

Sexual orientation (Lesbian, Gay and Bisexual and heterosexual)		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. There is a specific hierarchy in regards to Section 26 of the Mental Health Act and who is classified as a person's Nearest Relative. This procedure conforms to this and sexual orientation of the patient or their carer or nearest relative does not affect. We do not consider there are any impact for persons in relation to this characteristic. However this assessment acknowledges the following: Stonewall (an LGBT support organisation) produced a report called LGBT in Britain Health. This notes that a high proportion (31%) of LGB people surveyed said they had thought about taking their own lives. The report notes that LGBT people are at higher risk of experiencing mental health problems. Source: lgbt_in_britain_health.pdf (stonewall.org.uk)	The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).
Marriage and civil Partnership (Marital status)		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act.	

					Section 26 of the Mental Health Act is regulated by law, the marital status of a patient or staff has no impact on this policy. Equality Act 2010 protections for this group are in relation to employment and not service provision.	
Low-income households		√			This policy is for Hospital Managers to ensure that all relevant document is completed in accordance with the Mental Health Act. We do not consider there are any impact for persons in relation to income in relation to 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)**			
√		√		Article 5	Article 5 protects your right to liberty and security. There are restrictions in relation to this right which includes having a mental health condition which makes it necessary to detain a person.	The policy should ensure that Hospital Managers are completing and checking paperwork that ensures compliance with the Mental Health Act. This in itself is a

					The MHA provides the legal framework to ensure the *restriction* of article 5, the individual's right to freedom (detainment) is lawful. The policy ensures that all relevant paperwork is completed to ensure that all people detained is appropriate and lawful within Mental Health legislation. Source: Article 5: Right to liberty and security | Equality and Human Rights Commission (equalityhumanrights.com)	mitigating action to ensure any detainments are lawful (i.e. no one is detained illegally).

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		√			There are no impacts in regards to the Welsh Language. Information to patients and carers will be available in Welsh Language formats.	
Treating the Welsh language no less favourably than the		√				

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

English language						

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.	None
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

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 0026 Policy for admission, receipt and scrutiny of statutory documentation.

2. Brief Aims and Objectives: (Copy from Form 1)	The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms. The forms must also be scrutinised to ensure all information contained is accurate and meets with requirements. This policy ensures that appropriate paperwork is scrutinised by Hospital Managers for the admission of a person under the powers of the Mental Health Act. This will ensure compliance with the Mental Health legislation and ensure that patients' rights are upheld.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x
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?	Yes	No X

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
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 detention paperwork is correct and legal. It is felt this procedure has a positive effect on all as it ensures the law is upheld and patients are lawfully detained. Article 5 and Article 8 are considered in ensuring the patient is not deprived of their liberty and is aware that this is not appropriate and that their privacy if requested is respected.		
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:		
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?	Quarterly audits are maintained to ensure that documentation is accurate and correct. The Associate Hospital Managers also conduct monthly scrutiny on medical files to ensure the legal documentation is in place.
	Who is responsible?	Mental Health Act Manager and Governance Department of MHLD Division
	What information is being used?	Medical doctors being independent of each other. The Approved Mental Health Professional completing the application correctly and all documentation is in the patients file.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	3 years' time 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. Safeguarding Policy Sub Group BCUHB Clinical Policy Group Mental Health Capacity and Compliance Committee

Part B Form 5: Summary of Key Findings and Actions

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
	Jennifer Dowell-Mulloy	Equality and Inclusion Manager – Equality Team
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?	N/A		
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?	N/A		
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?

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee. 29.4.22**
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 Meryl Roberts 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 –18.11.2021-14.4.2022 Appendix 2 – Additions and Removals to the All Wales register of Section 12(2) Doctors – 18.11.2021-14.4.2022 Appendix 3 - Breakdown of Section 12(2) GPs currently approved in Wales as at 14.4.2022.

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 February 2022 Induction and Refresher training was held via Webinar. The next induction and refresher training will take place 7th, 8th and June 2022 and will also be facilitated via Webinar. Training dates have been agreed up to February 2023.

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

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

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

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

18th November 2021 – 14th April 2022

New Applications Received:	**11**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	0
Social Worker	0
Occupational Therapist	0
Psychologist	1
Number of applications approved	8
Number of ACs already approved in England	8
Number of applications with panel (including portfolios)	2
Number of applications not approved	1
Re-approval Applications Received (5 Yearly):	**30**
Number of applications with panel	1
Number of applications approved	29
Number of applications not approved	0
Number of ACs reinstated	0
Number of re-approvals which have come to an end:	**21**
Expired	11
Retirement	0
No longer working in Wales	9
No longer registered with professional body	0
AC requested	1
Registered without a licence to practise	0
Awaiting CCT	0
Suspended	0
RIP	0
Total Number of Approved Clinicians	**373**
Total Number of Approved Clinicians from previous report	**379**

APPENDIX 2

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

18th November 2021 – 14th April 2022

New Applications Received	**14**
Applications from GPs	1
Applications from Psychiatrists	10
Application from Forensic Medical Examiner	0
Number of Applications Approved	11
Number of Applications Not Approved	0
Number of Applications with Panel	2
Incomplete Applications	1
Re-approval Applications (5 years)	**14**
Applications from GPs	5
Applications from Psychiatrists	9
Applications from Forensic Medical Examiners	0
Number of Applications Approved	14
Number of Applications Not Approved	0
Number of Applications with Panel	0
Transferred from AC register	**1**
Transferred from England	**5**
Number of Approvals which have come to an end:	**10**
Ended	5
Become an Approved Clinician	3
No longer working in Wales	1
No longer registered	1
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	**181**
Total Number of S12(2) Doctors from previous report	**172**

APPENDIX 3

Breakdown of Section 12(2) Doctors currently approved in BCUHB area

As at 14th April 2022

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	2	4	1	0	3	3	**13**
Section 12(2) Psychiatrists	0	6	6	3	2	9	**26**
Approved Clinicians	3	17	18 (HB) + 2 (Independent Hospital)	10 (HB) + 3 (Independent Hospital)	12	18	**78** (Health Board ACs) **5** (Independent Hospital ACs)

Number of 12(2) GPs per Health Board

As at 14th April 2022

BCUHB	13
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 and Capacity Compliance Committee** 29.4.22
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Section 12(2) doctors – update report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health (Lead for Mental Health and Learning Disabilities - MHLD)
Awdur yr Adroddiad Report Author:	Prof Alberto Salmoiraghi, Medical Director for MH&LD
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Divisional Director MHLD
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

For the Mental Health and Capacity Compliance Committee to:

1. acknowledge the report and progress on the matter, and
2. support the actions detailed in the report – so that the detail can be further progressed by operational teams.

Please tick as appropriate

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

Sefyllfa / Situation:

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

Local Authority colleagues have formally raised concerns about the availability of Section 12(2) Doctors across North Wales – both to the Committee and directly to the Chief Executive Officer. This has been raised as particularly problematic during Out of Hours periods and in the most rural parts of North Wales.

In some instances, people who have needed to be assessed under the Mental Health Act have been left for a significant period of time before the assessment was completed due to the difficulties in finding an appropriate medical practitioner for the medical recommendation.

The former Mental Health Act Committee acknowledged the situation, and the risks of potentially not complying with medico-legal requirements, and asked for an action plan to be prepared.

Cefndir / Background:

The issue was escalated and reported to the former Mental Health Act Committee.

Dr David Fearnley, the Executive Medical Director for Betsi Cadwaladr University Health Board at the time when the concern was raised, asked for a Task & Finish Group to produce a report with more details about the current situation and potential solutions. The aim was to trigger further discussions with colleagues in the Local Authorities and the Board. The initial T&F group examined the situation across the Health Board and more widely across Wales.

The lack of Section 12(2) doctors was and is a national issue. It is also a complex problem as it depends upon a number of factors such as financial incentives, overall recruitment and training of General Practitioners and Consultants Psychiatrists in Wales. Regrettably, there are chronic vacancy levels amongst Consultants Psychiatrists. Furthermore, for a portion of General Practitioners there is an increase in the medical indemnity fees when this type of activity is completed.

As already mentioned, the availability of Sec 12(2) is a UK wide issue, as well documented in the King's College London report published in January 2022 (*https://doi.org/10.18742/pub01-072*). In the report they indicated a sufficient number of sec 12(2) doctors overall, with low number of General Practitioners. However, availability is a problem and they suggested reviewing the fees as a possible incentive to increase the availability. The report indicates other causes for the delay in completing an assessment under the MHA:

- Lack of Approved Mental Health Practitioners (AMHPs)
- Shortage of mental health beds
- Waiting for the involvement of Police or Ambulance services
- Problems with the person being assessed (intoxication)
- Problems accessing medical notes

Considering the importance for the Health Board to comply with this medical-legal requirement, the Chair of the Mental Health Capacity and Compliance Committee asked the MHLD Division to lead on a plan to mitigate the situation.

This report focuses on the actions made only to ameliorate the availability of sec 12(2) doctors in North Wales and not on other potential causes of delay in completing MHA assessments. The Division continues to monitor the number of incidents related to delays in finding a Sec 12(2) doctor.

To be able to produce a comprehensive plan, a number of meetings have been organised by the MHLD Medical Director, involving representation from the executive team, the area medical directors, the Local Authorities and the MHA office. The following is a concise summary of the meetings:

Meeting on the 14th May 2021: the issue was shared and there was a more detailed discussion around training, budget and approval process. A number of proposals were put forward, such as reviewing the fee, meeting with Local Authorities to have a memorandum of understanding of conduct in case a doctor is not immediately available, involving the GP Academy in training. It was agreed to organise a further meeting to have a detailed action plan with names against each action.

Meeting on the 16th June 2021: an action log was discussed. It was agreed that realistically most actions could be completed in a six months timeframe. Actions included escalation to the executive team via the Executive Medical Director, who at the time was Prof. Arpan Guha:

- to explore financial incentives and discuss with the Local Medical Committee,
- to clarify the indemnity fee,
- to develop a workforce plan for GPs to work within the MHLD services,
- to develop a proposal to increase the number of GP trainees placements in MHLD,
- to use the Primary Care Academy to deliver lectures and seminars on MHA legislation,
- to send a reminder to GP who have attended the Sec 12(2) course but have not applied for the approval, and,
- to meet with the Local authority colleagues to agree on a memorandum of understanding and to discuss roles and responsibilities in and out of hours.

Meeting on the 24th September 2021: it was agreed that training to GP trainees will be delivered by Sec 12(2) doctors and AMHPs via the GP Academy.
LA colleagues expressed some concerns about potential availability of AMHPs due to workload, but supported the proposal in principle. The memorandum of understanding had been discussed in depth, following advice.
It is not possible to shift the responsibility for the MHA process from the Local Authorities as per legislation. Hence, the responsibility remains with the LAs until the person is conveyed to a place of safety. We have explored the mitigations in place with other Health Boards, such as the use of Section 135, police, family members, emergency services and use of Section 4 of the MHA.

Meeting on the 25th October 2021: Primary care colleagues explored remuneration and stated that the fee has not been increased substantially for a number of years. The discussion was around whether it was more appealing to increase the fee or considering hourly payment in line with other out of hours activities. The agreement was to send an email to GPs for comments and it was discussed at the following Local Medical Committee meeting on the 9th November. Following discussion and feedback with LMC members, it was an unanimous opinion that hourly rates would have been less attractive and an increase of the fee was more appropriate. AS could not find evidence that the rates are agreed nationally and many rates already differ amongst the Health Boards.

Subsequent actions include:

- clarification about the indemnity for GPs: according to the General Medical Practice Indemnity, Sec 12(2) work by GPs indemnity depends upon the Health Board agreement. This also applies to non Sec 12(2) doctors who carry out MHA work. As in North Wales there are different arrangements in regards to primary care clinical work, the indemnity issue has to be worked out individually.
- clarification of the procurement process: the budget for MHA related work sits with the MHLD Division for historical reasons. The payment is via a simple claiming process to the MHA Office that proceeds to payment. As this method is very well established, follows process and is auditable, the general opinion is to continue in the same way.
- In regards to training and teaching, AS made contact with the Associate Medical Director for Medical Education, who is fully supportive of adding training on the MHA and will facilitate it. Contact was also made in relation to the outstanding GP training programme. Support is in place for both the teaching and special interest development.

AS was contacted at the beginning of November and subsequently met with colleagues from HEIW. HEIW decided to decrease the number of GP trainees from three to two from August 2022 in favour of a placement in Palliative Care. This was a decision taken without prior consultation, which may have consequences in the out of hour's rota.

On the 15th November AS met with colleagues from the National Health Collaborative and a HEIW representative. The meeting was requested by the National Adult Mental Health Clinical Lead, as she was made aware of the work we were doing on this national issue. The outline plan was discussed and it was agreed that a national action and approach would have been appropriate. The national lead has agreed to arrange a meeting with HIW, MHA Policy lead, National Health Collaborative, Sec 12(2) Approval office and AS to take this issue nationally, and hopefully to reach a national position.

A meeting on the 29th November 2021 focused on the outstanding GP Programme, and how MHLD can link in the programme. It was agreed that MHLD will offer 1 year part time work to GP, supervised by consultants to acquire the level of competencies necessary for the application. The special interest placements will be in all sub-specialities (OPMH; SMS; Community; Forensic; etc.), depending upon availability. Hence, the placements will be discussed individually. One potential candidate was discussed, but unfortunately, this person has subsequently accepted a position in England.

The MHLD training and placement opportunity is going to be part of the new GPs recruitment campaign to be launched in Spring.

Following the publication of the King's College report, AS contacted a private company called S12 Solutions, which is used frequently by the majority of the MHLD Trusts in England to ascertain likely costings.

Asesiad / Assessment & Analysis

Strategy Implications

The Health Board has responsibility to comply with the requirement of the law, hence it is essential to have a strategy for the sustainability of Sec 12(2) doctors availability

Options considered

The Mental Health Capacity and Compliance committee is asked to support the following proposals (discussed extensively with the main stakeholders) and that the operational teams can further progress the detail:

- to increase the fee for sec 12(2) related work to £250.00 per call
- to continue to pay travel expenses
- to increase the fee for non sec 12(2) doctors to £100.00 per call
- to support the ongoing teaching and training within the GP Academy and Outstanding GP training
- to pay for the indemnity to GPs who commit to carry out Sec 12(2) work if not already covered by the Health Board
- to support a national position along with National Collaborative, HEIW, MHA Policy Group and Approval Office
- to support special interest placements in MHLD with consultants psychiatrist supervision to gain sufficient expertise to apply for Sec 12(2) approval
- to support the funding of Sec 12 Solutions, an app used by a number of MH Trusts in England, which provides an electronic support to find approved doctors available within and outside the area. The app provides electronic support for the documentation related to the Act and the claiming process. The current estimate is circa £43,250.00 (Health Board procurement rules will need to be followed).

Financial Implications

Some of the solutions proposed in this paper will incur in extra costs for the Health Board. The Head of Finance MHLD, had a preliminary discussion with the Executive Director of Finance. Based on the current activity, the extra cost is calculated to be £73,000.00, but this amount may vary according to the level of activity. This amount does not take into account the cost of the placements within the Division. However, this issue has been discussed at the medical workforce meeting and the cost will be offset with the current vacancies. The next step (If agreed) is to bring the costings to the Pay and Remuneration Board for approval.

The cost of S12 Solutions (or similar) is not included in the calculation and further work is required to source funding following appropriate procurement work – if the approach is approved.

Risk Analysis

The lack of Sec 12(2) doctors may pose risk to people in need of urgent assessments under the MHA. Furthermore, the Approved Mental Health Practitioners hold the responsibility for the assessment process until either the opinion is not to use the detention power or the patient is in a place of safety in the hospital.

Legal and Compliance

The lack of sufficient number of sec 12(2) doctors has legal implications for the Health Board. There is also the risk that the Health Board does not comply with the medical legal requirements as per law, unless it is demonstrated that all the mitigations are in place.

Impact Assessment

N/A

Cyfarfod a dyddiad: **Meeting and date:**	Mental Health and Capacity Compliance Committee 29th April 2022
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk David Tita, Head of Risk Management.
Craffu blaenorol: **Prior Scrutiny:**	Risk Management Group on the 5th April 2022 Executive Team on the 13th April 2022
Atodiadau **Appendices:**	Appendix 1 - CRR Report for MHCC Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels

Argymhelliad / Recommendation:

(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)

That the Committee:-

1. Review, note and approve the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1:

a) **Note** the transfer of this risk to the MHCC for future oversight from the QSE Committee on 11th January 2022.
b) **Note** the controls have been updated to include the successful bid from Welsh Government for interim funding to support increased bespoke Mental Capacity Act training in primary and community settings and to increase physical capacity in the out of hours service delivery.
c) **Note** an additional assurance has been included to cover the monitoring and reporting of training compliance and DoLS backlog by the Safeguarding and Performance Governance Group and Welsh Government.
d) **Note** the ET recognise the progress in the management of the risk including the alignment with the Intermediate Medium Plan to support additional resources and the strengthening of the governance arrangements for the Liberty Protection Safeguards (LPS) Implementation Group in preparation for the publication of the LPS Code of Practice.
e) **Note** the clarification regarding the inherent risk score being lower than the current risk score due to the unforeseen significant increase in activity (44%).
f) **Note** the completion of the Actions ID15705, 15709, 18983 and 18984 approved by ET, so that they will be archived and removed from the next report, recognising that a new action has been captured to support the increase in activity within Safeguarding until the LPS Code of Practice is published.

2. Note there are no new risks being presented to this Committee for escalation approval at this time.

3. Note there are no risks being presented to this Committee for closure or de-escalation consideration at this time.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates how the Health Board is mitigating and managing high rated risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is reported separately.

Each Corporate Risk has been reviewed and updated. The full CRR will next go to the Board in July 2022.

Cefndir / Background:

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.

The Corporate Risk Register will enable the MHCC to scrutinise, oversee and gain assurance that systems and processes are in place to identify, monitor and address current and future risks deemed high enough to negatively impact on the delivery of the operational objectives of the Health Board. It will also support the Committee to evaluate the effectiveness of controls assigned to the risk and associated action plans. Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees.

Work is currently underway to reset the BAF for the 2022/23 period, during this period the corporate risk register continues to be aligned to the BAF with a view to ensuring consistency.

Summary Table of the Full Corporate Tier 1 Risk Report:

CRR21-14: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.

This Risk was reviews at the Risk management Group on 5th April 2021 during a `deep dive` and advised:-

- Review of the target risk date set for October 2022 in light of the delay of the legal footprint, which underpins implementation of the code of practice and the activities.
- Review of risk to ensure that corresponding outcome of controls and actions will support effective mitigation and management of actual risk as articulated.

CRR21-14 was signed off for escalation and presentation to the MHCC Committee for approval at the ET meeting of 13th April 2022 as the above changes from the RMG have been made.

Current Tier 1 Risks for the Mental Health and Capacity Compliance Committee oversight (full details and progress can be found in Appendix 1):

Risk Title	**Inherent risk rating**	**Current risk rating**	**Target risk rating**	***Movement**
CURRENT RISKS – Appendix 1				
CRR21-14 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	16	20	6	⟷ unchanged

*movement in risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions.

Below is a heat map representation of the current corporate risk scores for this Committee:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR21-14	
	Likely - 4					
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications The implementation of the Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.
Opsiynau a ystyriwyd / Options considered Continuing with Corporate Risk Register.
Goblygiadau Ariannol / Financial Implications 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.
Dadansoddiad Risk / Risk Analysis See the individual risks for details of the related risk implications.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.
Asesiad Effaith / Impact Assessment No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which CRR reports are aligned. Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

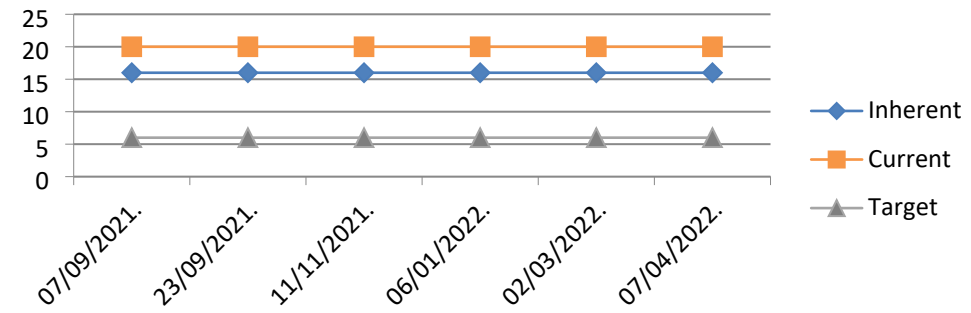
Appendix 1 – Corporate Risk Register CRR21-14

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 07 April 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:** 01 March 2022
		Target Risk Date: 31 October 2022

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 is 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	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 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	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.

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 by unlawfully detained to prevent harm to patients.	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 Mental Health and 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.

Progress since last submission

1. Controls in place updated to reflect current position with the identification of additional controls.
2. Assurance sources updated to reflect the addition of new controls in place being monitored.
3. Proposal to extend the target risk due date from the 31/10/2022 to 31/10/2023 due to the delay in the publication to the code of practice, from the Government. The Health Board will continue to put in place interim arrangements during this time until the final code of practice is published.
4. Proposal to increase the target risk impact score from 3 to 4 to bring the overall target risk score up to 8 and align with the risk appetite.
5. Intermediate Medium Term Plan has acknowledged funding for additional safeguarding resources, however awaiting allocation of funding to take place.
6. Terms of reference for the Liberty protection safeguards (LPS) implementation group have been ratified by the Mental Health Act consent and capacity committee and the safeguarding governance and performance group including the relevant governance structures, in preparation for the publication of the LPS code of practice.
7. Action ID 15705, 15709, 18983, 18984 - Proposal to close the actions following Welsh Government and Central Government not indicating a release date for the publication or receipt of the Liberty Protection Safeguards Code of Practice, this is therefore outside the control of the Health Board. The identification of a new action has been captured to utilise the agreed funding for the increased activity within Safeguarding until such a time when the code of practice is published.
8. Action ID 15708 - Action remains delayed with the Deprivation of Liberty Safeguards governance arrangements and reporting structures circulated for wider consultation. Anticipated for re-submission to the safeguarding governance and performance group on the 26/04/2022.
9. Action ID 18117 – Action delayed, awaiting funding, finalisation and implementation of Business case, anticipated release of monies in quarter 3 2022/23.
10. Action ID 18118 - Action for the implementation of a Court of Protection Engagement and Procedure remains delayed due to a further revision and after wider scrutiny of the draft Standard Operating Procedure. Anticipated for re-submission to the safeguarding governance and performance group on the 26/04/2022.
11. Following discussions at the Risk Management Group it was considered to split the risk, however due to the risk being in relation to patient restraint there is a clear interface with both, therefore the risk remains as it was.
12. The Risk Management Group also identified a wider Health Board risk relating to the number of patients cared for in incorrect settings, including delayed discharged. This will be a new risk which will be progressed within the Office of the Executive Director of Nursing.

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	15705	The National Task and Finish Group Finish Group will support the implementation of the Liberty Protection Safeguards legislation and Code of Practice ensuring National consistency for NHS organisations.	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business Support Manager	31/12/2021	ACTION CLOSED 31/12/2021 The National Task and Finish Group will develop indicators specific to the NHS which will reduce unlawful detention and risk. December 2021 – Welsh Government confirmed that the UK Government have not released the date of publication of Liberty Protection Safeguards Code of Practice. Welsh Government have confirmed they will no longer provide an expected date of publication or implementation. Proposal to close the action following the delay in national publication, recognising that a new action as an alternative has been identified.	Close
	15708	The Deprivation of Liberty Safeguards Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business	31/10/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention. March 2022 progress update - Presented to Safeguarding	Delay

		Authority and Supervisory Body.	Support Manager		Governance and Performance Group on the 25/01/2022, wasn't approved and has been circulated for wider consultation. Anticipated for re-submission to the safeguarding governance and performance group on the 26/04/2022.	
	15709	The BCUHB Liberty Protection Safeguards Implementation Task and Finish Group will be implemented and will support the transition of Deprivation of Liberty Safeguards as guided by the new Liberty Protection Safeguards legislation.	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business Support Manager	31/12/2021	ACTION CLOSED 31/12/2021 Additional resource will enable the implementation of the Social Services and Well-being [Wales] Act and Mental Capacity [Amendment] Act 2019 and will reduce unlawful detention and risk. Proposal to close the action following the delay in national publication, recognising that a new action as an alternative has been identified.	Close
	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. Progress to date – the Integrated Medium Term Plan 2022-2025 has been agreed and internal process is to be followed before the release of monies, which will support the recruitment to new posts within a schedule of work to prepare and support implementation. March 2022 progress update - Action delayed, awaiting funding and	Delay

					finalisation of Business case, anticipated release of monies in quarter 3 2022/23.	
	18118	Implement and monitor a Court of Protection Engagement and Standard Operating Procedure for Deprivation of Liberty Safeguards / Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the Court of Protection and meet the needs and safeguards of service users. March 2022 progress update - Presented to group on the 25/1/2022, wasn't approved and has been circulated for wider consultation. Anticipated for re-submission to the safeguarding governance and performance group on the 26/04/2022.	Delay
	18983	Implement changes in line with publication of new code of practice which will include revised job descriptions, training packages, audits, supervision, and strengthened court of protection activity.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	ACTION CLOSED 31/12/2021 Reduce the risk by improving education and implementation of legislation which will reduce unlawful detention. Progress to date, Welsh Government and Central Government have not released a date for publication or receipt of the code of practice. Due to the lack of deadline date, this activity has been superseded by the identification of the new action ID 20597.	Close
	18984	Review of all policies, procedures and guidance in	Michelle Denwood, Director of	31/10/2022	ACTION CLOSED 31/12/2021 BCUHB will be compliant with	Close

		line with publication of the new code of practice.	Safeguarding and Public Protection		legislation and provide guidance to service users. Progress to date – Welsh Government and Central Government have not released a date for publication or receipt of the code of practice. Due to the lack of deadline date, this activity has been superseded by the identification of the new action ID 20957.	
	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.	On track
	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.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes	Executive Director of Primary and Community Care	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU	Executive Director of Primary and Community Care	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Awaiting closure from Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Cyber Security	Executive Director of Primary and Community Care	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	Executive Director of Primary and Community Care	Partnerships, People and Population Health	20
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients	Executive Director of Nursing and Midwifery	Mental Health and Capacity Compliance	20
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours	Executive Director of Primary and Community Care	Quality, Safety and Experience	16

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels

BAF / Risk Template Item	Please refer to the Risk Management Strategy and Policy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**CAMHS Transformation & Improvement Programme - Crisis Care Response for Children and Young People**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport Executive Director Primary Care and Community Services
Awdur yr Adroddiad Report Author:	Louise Bell, Assistant Director CAMHS
Craffu blaenorol: Prior Scrutiny:	Bethan Jones, Area Director, Central
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Mental Health and Capacity Compliance Committee is asked to note this update report.

Please tick as appropriate

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

Sefyllfa / Situation:

A steady increase in demand for our crisis services has been recognised across North Wales during the Covid pandemic which has informed the need to expand capacity and access to child and adolescent mental health crisis support.

CAMHS are currently undergoing a programme of transformation within the WG Targeted Intervention Framework which includes our unscheduled care and the crisis response. A Regional CAMHS Crisis & Unscheduled Care Workstream with a series of focused task and finish groups has been established to develop and improve services, extend the hours of service delivery and offer assessments in community locations and the emergency department as part of an assess to admit approach.

The aim of the Workstream is to develop and deliver a cohesive multi-agency integrated model of care for children and young people across North Wales who may experience a mental health crisis with a focus on prevention; early identification, early intervention; assessment and support 24/7.

Workstream leads are developing a clear strategic intent as part of the wider CAMHS Strategy which will include a CAMHS unscheduled care plan for an enhanced crisis response.

Cefndir / Background:

The current CAMHS unscheduled care teams based within each area of the health board generally deliver timely responses for crisis assessments against the 48 hour response standard, delivering assessments usually within 24 hours of referral. However, this could be improved further by extending the hours of service and offering assessments in alternative community settings with the aim to reduce attendances to hospital.

Investment has been made across the Region to increase the workforce required to deliver an enhanced care pathway for rapid response crisis care. A further 9 posts have been out to advert to further develop our out of hours services however to date only 3 posts have been recruited to. CAMHS have launched a National recruitment campaign working closely with BCUHB workforce senior leads to enhance our digital attraction strategy for CAMHS.

Joint working with partners is ongoing to ensure that children and young people have effective access to support before crisis point, and to receive improved quality of treatment and care when in crisis. A multi-agency North Wales Crisis Response Task & Finish group has been established as part of a longer term improvement workstream, with representation from each local authority area and North Wales Police (NWP).

The CAMHS Strategic Improvement and Development Group oversees the improvement plan and the development of an overarching Workforce Strategy, workforce profile and action plan to build a sustainable CAMHS workforce which meets the needs of the service.

Asesiad / Assessment & Analysis

1. **Crisis Pathway Guidance**

MHLD and CAMHS have jointly developed BCUHB guidance for managing Children and Young People (C&YP) under 18 years of age presenting in crisis to hospital out of hours and under Section 136. This is in final draft and out for consultation.

This guidance covers Crisis Pathways for C&YP to include:

- CAMHS weekend provision for C&YP-under 18, admitted to Paediatric Wards
- CAMHS weekend provision for C&YP-under 18, admitted to Adult Mental Health Wards
- Out of Hours CAMHS Consultant Psychiatrist cover
- C&YP-under 18 detained under Section 136 of the Mental Health Act (MHA)

A Regional CAMHS Service Manager for unscheduled and crisis care has been appointed and commenced in post at the beginning of April 2022.

2. **Crisis Care Safety Meetings**

The introduction of the safety meeting to enhance joint working through regional prioritisation of demand, management of capacity, coordination of care, and escalation of concerns is working well. Regional meetings are held with stakeholders across 3 areas of BCUHB, including Paediatric Ward Managers, CAMHS Clinical Service Managers, Heads of Nursing Childrens, CAMHS Intensive Outreach Services and Tier 4 Inpatient Services.

The meeting is focused on staffing pressures and any blockages in the system. Case discussion takes place for all patients waiting for assessments in liaison, on the s.136 suite, and on Paediatrics wards to ensure that relevant parties were aware and working towards a timely assessment and care plan of each young person. The meeting has improved relationships regionally and helped staff understand the pressures across the geographical footprint. There has also been enhanced joint working across the three areas whenever necessary.

There are often situations where there are delays for the transfer of children and young people awaiting social care placements with Local Authority. Heads of Childrens Services and Social Services Directors, where necessary, are involved in daily case meetings when required. A SITREP is able to escalate any issues across the organisation and management detail is provided for out of hours on-call managers. Young People are currently admitted to Paediatric Wards in a crisis for short stays. In many cases these short stays result in positive outcomes with de-escalation and the young person is discharged home with a family support package and follow-up care. However on occasions children and young people with complex social care needs remain as inpatients in the Paediatric ward when their needs would be more appropriately met elsewhere, this is not due to the relationships between services, but rather the lack of appropriate social care placements.

Likewise, MHLD and CAMHS are working collaboratively to ensure that in exceptional circumstances where C&YP are placed in an Adult inpatient facility that there is a joined-up approach to care and safety planning that best meets the needs of the young person. Although rare there are occasions when this occurs for C&YP with high risk and complex presentations which require a specialist mental health placement that cannot be provided by BCUHB, or a requirement for a social care secure welfare placement. Services are committed to working together to support a timely transfer to a more appropriate environment in each and every case, putting the needs of the C&YP at the forefront of decision making..

3. Improvement Plan with Partner Agencies – Crisis Care

Joint working with partners is ongoing to ensure that C&YP have effective access to support before crisis point and to receive improved quality of treatment and care when in crisis. A multi-agency North Wales Crisis Response Task & Finish group has been established as part of the Crisis Care Workstream, with representation from each local authority area, MHLD services and North Wales Police (NWP) to ensure shared service development.
The overarching aims of the Group are to:

- Develop the plan for unscheduled care and enhanced crisis response
- Offer timely, safe and effective care and support for C&YP presenting in crisis
- Avoid unnecessary attendance to our emergency departments and s.136 suites
- Avoid unnecessary admissions to the paediatric wards
- Extend access to CAMHS assessments out of hours
- Further enhanced training with NWP - six point care and safety plan.

There have been some key challenges experienced by public services both in hours and out of hours to support children and young people across North Wales who may experience a mental health or psycho-social crisis. With recent funding from WG, we are now able to consider the opportunities to develop and implement a consistent & collaborative response to supporting these young people and their families when experiencing a crisis. It is recognised that it is a complex system with many points of access across agencies with crisis situations often involving systemic or care breakdown.

CAMHS and wider Childrens Services within BCUHB have also been working in collaboration with colleagues across mental health, local authority, social care, education and third sector partners to develop a multi-agency North Wales No Wrong Door Strategy (2022-2027). The implementation of the strategy will be overseen by the newly formed Childrens Sub-Group of the North Wales Regional Partnership Board.

The models of care will vary, depending on local need. As well as additional staffing to expand early intervention and consultation services provided by BCUHB children services, we will look at developing blended models of care which includes support from appropriately trained staff in other agencies i.e education, social care and across the voluntary sector.

4. Pilot Schemes

There are a number of pilot schemes underway to support the improvement of crisis and out of hours provision for children and young people experiencing a mental health crisis

- *Children & Young Person Crisis Safe Space Project (Sanctuary)*

  This project pilot has established a community facility to support young people, aged 13-18, to manage an urgent mental health or emotional welling issue. As part of the pilot the facility provides an out of hour's community space in Wrexham to support young people, aged 13-18 to deal with an urgent mental health or emotional welling issue when medical intervention is not required. Initially, the facility will be open in the evenings from 8pm to midnight and operated by trained and compassionate staff provided by Wrexham Local Authority in partnership with BCUHB. The pilot aims to offer support and advice to prevent or reduce deterioration in a young person's emotional, behavioural or wellbeing state which may otherwise result in an application of section 136 of the MHA, calls to emergency services, admission into hospital or presentation and long waits at the local Emergency department. The pilot went live in February 2022 and will The project will be reviewed every three months and discontinued after 12 months if positive impact cannot be detected. If positive outcomes/benefits are realised following an initial 3 month period consideration of roll-out across other areas within North Wales will be given. This will include data on clinical outcome measures and service user feedback on experience.

- *Children & Young Person Care Home Education and Support Team.*

  This project pilot aims to ensure accommodation providers caring for children looked after have rapid access to specialist support from mental health professionals. The pilot is to be Centrally based in North Wales (Denbighshire and Conwy) and a number of residential care homes have been identified to be part of the pilot. CAMHS are in the process of visiting care homes and meeting with Managers and front line staff to agree support/training that might be helpful to them with a plan to deliver a programme of training over the coming months.

  This specialist support will be through the provision of resident specific advice, training and education to care home staff by a NHS CAMHS link worker. The C&YP must have complex and acute needs and be at risk of hospital admission. This project may prevent or reduce deterioration in a child or young person's emotional, behavioural or wellbeing state which may result in possible crisis presentation in ED and subsequent inpatient admission. This pilot is

due to commence this month supported by the WG NCCU. A clinical lead has been appointed.

- *Mental Health Response/Local Emergency Duty Teams (EDT)*

  Running in parallel to this initiative will be the development of CAMHS professionals joining Local Authority EDTs to ensure a rapid response to crisis with appropriate advice and support and provision of assessment out of hours if required. Early discussions have taken place with LA colleagues and the project plan for piloting with EDTs in specific areas is to be agreed.

5. **NHS Wales Delivery Unit (DU) – All Wales Assurance Review of Crisis and Liaison Services for children and young people.**

A review of CAMHS unscheduled care services in BCUHB took place between November 2021 and February 2022. The aim of this review was to explore the crisis response and provision of Psychiatric Liaison and Crisis Services for people of all ages across Wales, to understand the demand upon these services, to explore the support available and review referral criteria to access support.

Early feedback from the DU to BCUHB has highlighted positive relationships between staff and stakeholders. Clinicians were observed to deliver compassionate care with children and young people at the centre of clinical decision making and care delivery. The CAMHS integrated model of care was found to afford staff and stakeholders a good degree of flexibility to deploy services from a range of functions that are C&YP needs focussed. The introduction of the regional Safety/SITREP meeting has been cited as a positive introduction that has enhanced joint working and governance of the crisis response across areas and departments.

Goblygiadau Strategol / Strategy Implications

Mental Health services working collaboratively with partners to support a whole system approach in delivering the emotional and mental health services provided for children, young people and their families in crisis in line with:

- Crisis Care Concordat
- Together for Mental Health
- Childrens Commissioner's No Wrong Door Report

Opsiynau a ystyriwyd / Options considered

NA

Goblygiadau Ariannol / Financial Implications

NA

Dadansoddiad Risk / Risk Analysis

There is a risk that young people in crisis presenting out of hours with suicidal behaviour/ideation and actual self-harm to our Emergency Departments and Paediatric wards and those detained under the Mental Health Act may not always receive timely access to CAMHS assessment and ongoing care and treatment in the most appropriate enviroment. This risk has been escalated to Tier 1 level – Corporate Risk.

This may be caused by a number of contributory factors:

- 55% vacancy factor across the Region in CAMHS psychiatry. Current rota is limited out of hours to complete a s136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section which is also not available out of hours

- Crisis presentations to ED with associated social care placement breakdowns leading to young people who are deemed medically fit for discharge, remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority

- C&YP requiring an out of area specialist inpatient bed not provided in Wales for PICU level inpatient care or secure placements that can not be safely managed in NWAS Tier 4 General Adolescent Unit are not transferred in a timely manner due to National bed pressures.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
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 Q4 Update**
Cyfarwyddwr Cyfrifol: Responsible Director:	Michelle Denwood, Director of Safeguarding and Public Protection Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Chris Walker, Head of Adult Safeguarding (MHLD) supported by Michelle Denwood, 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 Deputy CEO/Executive Director of Nursing and Midwifery and this update has been reviewed by; Michelle Denwood, Director of Safeguarding and Public Protection; and Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery
Atodiadau Appendices:	Appendix 1. DoLS 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 Q4 2021-22.
2. Receive the DoLS 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 DoLS and the Mental Capacity Act (MCA) 2005 for the period of Q4 2021-22). The activity includes key actions and activities to ensure that MCA/DoLS, 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 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 2021 and this revised legislation was expected to be implemented in April 2022.

On the 17th of March 2022 the Welsh Government published the consultation on the LPS draft Regulations for Wales. The consultation will last for 16 weeks. An MCA/LPS 'working' group to address and engage in the consultation programme is in progress and will include all key BCUHB stakeholders.

We can now actively progress the BCUHB LPS Strategic and Operational Implementation Groups. Oversight and reporting will be by the Safeguarding Governance and Performance Group.

Additional monthly Safeguarding MCA/LPS Bulletins will be shared from May 2022 onwards to provide real time updates on the consultation process and the implementation of LPS.

In addition, the UK Government is consulting on the 'Liberty Protection Safeguards Draft Regulations for England' and the 'Liberty Protection Safeguards Draft Code of Practice for England and Wales'. This consultation will follow the same 16 week period and will be included within the BCUHB implementation work programme.

The key changes to current DoLS legislation are as follows:

- The Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS).
- The new safeguards will protect people's rights and freedom if they lack the mental capacity to make their own decisions.
- The LPS will apply to 16 and 17 year olds and be applied in all settings including people's own homes.
- Wales will have its own Regulations and Code of Practice for LPS.

As previously reported the implementation of LPS will have an impact across all BCUHBs services. The priority over the next 12 months is to ensure all clinical staff are complaint and are able to act in accordance with the principles of the MCA and MCA training.

The responsibility for assessment under LPS will lie with frontline staff. We await training programmes from Welsh Government to ensure that staff are fully aware of their role, responsibility and accountability.

Following the consultation period the Mental Capacity Act 2005 Code of Practice including the Liberty Protection Safeguards will need to be brought before Parliament for 40 days. Once the Regulations are in place the necessary training for the role of the Approved Mental Capacity Professional (replacing the role of the Best Interest Assessor (BIA)) will need to commence at the earliest opportunity to allow at least six months to plan for implementation.

The Health Board are awaiting instruction from Welsh Government with regards to the funding strategy for the LPS.

Cefndir / Background:

Performance and Activity

It remains evident that the trend for DoLS applications is an upward trajectory within BCUHB. This situation is not unique to BCUHB. Other Health Boards and Local Authorities are in a similar position to BCUHB with an identified 6 week delay between receipt of a DoLS application and the subsequent authorisation (where applicable).

Welsh Government made funding available to Health Boards and Local Authorities with the aim of reducing waiting lists and promoting and embedding the Mental Capacity Act (MCA) into practice in preparation for the new legal framework, Liberty Protection Safeguards (LPS).

Prior to this funding our reporting position recorded we had over 114 unauthorised DoLS applications within BCUHB. This posed a risk to the patient and the organisation. Utilising the additional funding a strategic and targeted approach was implemented, this has resulted in a significant improved position in March 2022 and reported 36 applications were awaiting an assessment.

As of the 31st of March 2022 BCUHB are recording a 16 day delay which has evidenced a downward trajectory.

Between January and March 2021-22 a total of 437 DoLS applications have been submitted. BCUHB have received 1629 DoLS applications during 2021-22. This is a 40% increase in applications when compared to 2020-21. As a result of the unprecedented increase in DoLS applications the risk of non-compliance that may lead to an unlawful deprivation has been recorded as a Tier 1 Corporate Risk.

Table 1: Annual DoLS applications

Year	West	Central	East	England	Other	Applications
2018-19	89	257	343	55	0	743
2019-20	177	282	483	72	0	1014
2020-21	208	322	550	82	0	1162
2021-22	251	333	925	120	0	1629

Figure 1: BCUHB Applications 2018 – 2022. Which represents the increase in the number of DoLS applications received each year.

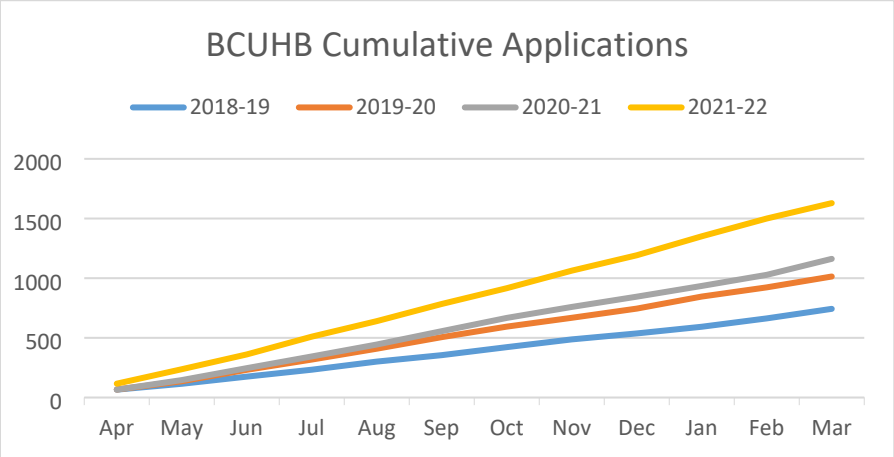


Figure 1 above demonstrates the number of DoLS applications is increasing year on year and even during the COVID-19 Pandemic there was a gradual and sustained increase in applications.

Welsh Government Monies

Following the Welsh Government (WG) bidding process to secure funds to support Health Boards in their efforts to reduce what is referred to as the 'DoLS backlog' and to promote MCA understanding and compliance across BCUHB, the Corporate Safeguarding Team secured £344,086 in total for 6 months on behalf of BCUHB.

Welsh Government identified that Health Boards and Local Authorities across Wales may struggle to enact their initial proposals due to the onset of the COVID-19 Omicron variant.

To date we have:

- Completed additional Best Interest Assessments (BIAs) to tackle the current backlog of DoLS applications. This was achieved by offering BIA's the opportunity to complete out of hours assessments.
- Strengthened the current MCA/DoLS administration and management team.
- Reviewed current MCA training and adapted a 'practical' 30-minute training module with supporting information for all staff. This training is delivered across services with plans in place to deliver outside of normal working hours i.e. between the early hours to target night staff.
- MCA/DoLS/LPS Leads for specific areas within the organisation have been appointed and are scoping services to ascertain current levels of MCA understanding and the need for additional support. Leads for Secondary Care, Primary Care, Commissioning and Paediatrics are in place.
- MCA resources have been sourced with the aim to empower staff in their roles. This includes 'banner pens' Wallet sized guides for staff, patients and families. These will also be presented in an 'easy read' format and will be available in both English and Welsh.
- All materials are in the final stages of approval and are due to be delivered in Q1 2022-23.

Welsh Government were specific in their request to ensure that no LPS work is undertaken prior to the formal start of the consultation process.

As a result of the progression made in promoting the MCA and addressing the DoLS backlog WG have made available additional funding (separate to LPS funding). BCUHB Corporate Safeguarding can confirm that a further £181,000 has been secured following the successful bidding process.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategic Implications Assessment and Analysis

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

Audit

Out of the 437 DoLS applications received and reviewed 21% of the applications contained some issues or concerns that resulted in them having to be returned to the Managing Authority (Ward). Although there has been an improvement in the completion of documentation during 2021-22 there are still concerns that Mental Capacity Assessments are either not completed correctly or are not provided as part of the DoLS application process.

DoLS applications are prioritised according to the risks and urgency identified within the application and the accompanying documentation. The Corporate Safeguarding MCA/DoLS Team, conducted an audit of the DoLS documentation completed by the Managing Authority in Q4 2021-2022.

The submitted applications continue to identify three (3) main themes;

- No inclusion of the Mental Capacity Assessment Form.
- Mental Capacity Assessments are completed incorrectly or not decision specific.
- The DoLS application documentation is not completed correctly, not signed, and not dated correctly.

Bespoke DoLS training has been/is delivered by the team as well as bespoke MCA awareness raising sessions delivered directly to staff and wards. BCUHB Emergency Departments are a key target area to ensure that the MCA is fully adopted into every day practice.

Legal and Risk services have agreed to deliver expert training for staff. This will target colleagues who complete MCA assessments and DoLS applications to reiterate the legal implications and expectations, their statutory responsibility and the potential benefits and consequences of completing paperwork correctly or incorrectly. The training is due to be delivered in Q1-Q2 2022/2023.

Mandatory Training

To mitigate risk and gain assurance additional and bespoke training programmes are available to facilitate learning for clinical staff Band 5 and above, and will focus upon the audit findings.

Analysis

Safeguarding training compliance is a key target for Corporate Safeguarding with a targeted approach in place for areas or departments with reduced compliance. An increase in compliance was reported during 2021-22, see Table 2.

Table 2:

Training Module	March 2021	March 2022	Trajectory
MCA – Level 1	74.0%	76.5%	↑
MCA – Level 2	75.4%	77.0%	↑

A revised virtual training programme is also available and remains in place to encourage ongoing training during the COVID-19 pandemic. MCA training is also included within the mandatory Adult Level 2 Safeguarding Module.

Deprivation of Liberty Safeguards 16/17 year old
In 2019 the Supreme Court ruling decided where a 16/17 year old lacks capacity to consent to arrangements which meet the 'Acid Test' for deprivation of liberty, parental consent no longer applies and the Court Protection will authorise the Deprivation of Liberty.

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

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

Safeguarding DoLS/MCA/LPS Business Case
A Safeguarding Business Case has been submitted for consideration and approval. This will support the implementation of legislation and increased activity to ensure BCUHB has the capacity and expertise to safeguard those who may be deprived of their liberty and reduce risk and potential harm.

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 Court of Protection activity has increased significantly. Legal challenge and engagement has resulted in intensive Court of Protection activity and has required Senior BCUHB Board member attendance.

Analysis
A recent Court of Protection case has resulted in a BCUHB patient having been unlawfully deprived of their liberty for 63 days. The delay in the Standard Authorisation being granted was due to staffing levels and capacity within the DoLS Team and the impact of COVID-19, specifically the Omicron variant. As a result of the patient not having a legal framework in place, BCUHB are subject to financial implications. In mitigation the delay in DoLS Authorisations is a national issue that has been recognised by the Welsh Government.

In an attempt to address the delays BCUHB secured additional Welsh Government funding to expedite the ongoing challenges faced by the Supervisory Body which has resulted in an improved position. Activity is reviewed weekly with cases escalated where appropriate. Investment in the DoLS Team is seen as a long term solution.

There have been two (2) new case relating to a Section 21A Challenge during Q4.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications
There are no financial implication for this report, however, as part of a wider Corporate Safeguarding Team review, an Integrated Medium Term Plan (IMTP) was submitted for approval in March 2022. The IMTP was placed on the 'reserve' list pending Executive Team agreement on the revised Corporate Safeguarding Team Business case.

As part of the proposed changes the strengthening of the MCA/DoLS (LPS) Service is seen a priority to ensure compliance with legislation and statutory actions.

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

Risk ID 2548. The increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful deprivation 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 (meet the legal framework).

This is due to the Case Law, P v Cheshire West Council (see Legal and Compliance below) which widens the parameters of activity resulting in more patients requiring assessment for a deprivation of liberty, and the Supreme High Court Judgement in September 2019 which removed the consent of parents when detaining a young person aged 16-17 years old 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.

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

Action Plan

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

	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 FM	Update 30/03/2022 UK and Welsh Government have delayed the implementation of LPS. The Code of Practice has been published with the 16 week consultation process now having started (April 2022). National LPS Working Groups are being reconvened to support current DoLS/MCA activity and for future LPS planning. BCUHB engaged. LPS Implementation Groups, strategic and operational, to begin April/May 2022.	**1.04.2022** **(request for agreement on revised completion date, 1.08.22, due to recent WG activity and announcement)**	**AMBER**

2.0	Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service	• Weigh up the benefits and negatives to the costings of providing a seven day service. • Consultation with staff and appropriate services i.e. workforce. • Assessment of staff members, working days, working hours. • Task and Finish Group with agreed reporting framework.	MD CW FM	Update 30/03/2022 IMTP placed upon the 'reserve' list pending approval of the finalised Business Case by the Executive Team. Corporate Safeguarding in final stages of an updated Business Case.To be submitted for Executive approval April/May 2022.	**1.04.2022** **(amended completion date requested, 1.08.22, due to IMTP having been placed on the reserve funding list)**	**AMBER**
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 01/03/2022 Work remains ongoing with ESR to ensure that accurate training figures are recorded.	**1.04.2022** **(amended completion date requested, 1.05.22, due to delays in activity)**	**AMBER**
4.0	Ratify and Monitor the implementation of the strengthened CoP and S21A Appeal process.	• Documents have been written and shared with the Corporate Safeguarding Senior Team for comments and amendments.	MD CW	Update 01/03/2022 S21A SoP has been presented at SGPG for comments. Approval of final version to be agreed at SGPG in April 2022.	**01.05.2022**	**AMBER**
5.0	Documentation Audit	• Planned DoLS Application Audit during Q4. • Report findings to be and shared within the MHCCC DoLS Report.	CW	Update 01/03/2022 Final 'year-end' audit to be completed during Q1 2022-23 to include all 2021-22 DoLS data.	**30.04.2022**	**AMBER**

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 FM	Update 01/03/2022 This action is inherently linked to action 2.0 above and is in progress. In progress.	**1.04.2022** **(amended completion date requested, 1.08.22, due to IMTP having been placed on the reserve funding list)**	**AMBER**
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 MD	Update 01/03/2022 Increased activity in relation to BIA Assessments and MCA awareness raising has been undertaken. Final stages of the amended plan to be completed in March 2022.	**Completed**	**GREEN**
8.0	Welsh Government MCA/LPS Consultation Programme	• Welsh Government published the consultation on the LPS draft Regulations for Wales. • The consultation will last for 16 weeks. • MCA/LPS 'working' group to address and engage in the consultation programme is in development and will include all key BCUHB stakeholders.	CW	Update 30/03/2022 BCUHB MCA/LPS Working Group set up to support and engage in the consultation process. Services being contacted directly, week beginning 18/4 to identify lead and support consultation activity. Consultation shared across BCUHB for information.	**1.08.2022**	**AMBER**

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Associate Hospital Managers Update Report (November 21 – January 2022)**
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Hilary Owen, Head of Governance and Compliance MHLD Iain Wilkie, Interim Director, Mental Health & Learning Disability Division
Atodiadau Appendices:	Appendix 1 – 2021 Scrutiny Audit

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

This report does not inform strategic decisions, it relates to the day to day operations of the Associate Hosptial Managers who 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.

Sefyllfa / Situation:

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 of: Hearings, Scrutiny, Training, Recruitment, Forums and Meetings and Key Performance Indicators.

Cefndir / Background:

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

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

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

In particular, 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).

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 November 2021 – January 2022.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

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

Goblygiadau Ariannol / Financial Implications

The Associate Hospital Managers are paid a sessional fee for each activity. Additional safeguards in relation to Information Governance, has an impact on financial costings due to security requirements for posting reports. Hearings held via virtual means has reduced the claims for travel, but has incurred additional costs given ‘back up’ arrangements. Since the last quarterly report, there have been no changes to these arrangements.

Dadansoddiad Risk / Risk Analysis

The number of Associate Hospital Managers must be kept at 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.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.

Asesiad Effaith / Impact Assessment

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

Quarterly Activity

1 Hearings

At the time of writing (07.02.2022) hearings continue to be held remotely via Microsoft Teams.

Four Associate Hospital Managers are sourced for virtual hearing in case of technological difficulties. When face-to-face hearings reinstate, the panel members attending the units will revert to three.

A total of 20 hearings were held during the months November – January 2022. The hearings consisted of seven Community Treatment Orders (CTO) renewals, one section 37 renewal and 12 section 3 renewals.

Two patients appealed their detentions this quarter but subsequently withdrew their appeal prior to the hearing being held.

A breakdown of the hearing activity is detailed below:

November

- ***Sixteen hearings arranged (Nine held)***
  All hearings were in relation to renewals. Two hearings were for community patients.

  Two hearings were cancelled – The Responsible Clinician (RC) regraded the patients to informal.

  Five hearings were postponed / adjourned – three due to sickness of solicitor or RC, one due to IMHA attendance being required and one due to the community RC being unable to attend.

  Outcomes of hearings held

  - Eight detentions were upheld.
  - One hearing was postponed due to the translator cancelling at short notice. The hearing was held a month later and the detention upheld.

December

- ***Five hearings arranged (Four held)***
  All hearings were in relation to renewals. One hearing was for a community patient.

  One hearings was cancelled – The Responsible Clinician (RC) regraded the patient to informal.

  Outcomes of hearings held

  - All detentions were upheld.

January

- ***11 hearings arranged (Seven held)***
- All hearings were in relation to renewals. Four hearings were for community patients.

  Four hearings were cancelled – One patient was subject to a different detention, and two patients withdrew their appeals.

  One hearing was postponed - the RC could not attend due to sickness.

  Outcomes of hearings held

  All detentions were upheld

Feedback forms received from the patients this quarter all stated they would like the opportunity to decide how their hearing would be held in the future. One patient specifically requested that the managers were thanked for conducting their hearing; this has been communicated to the panel.

Hearing KPIs

Following a renewal, there is no timeframe specified within the Mental Health Act of when a hearing must 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 Responsible Clinician can renew a detention two months prior to the section expiry date. In some instances when the paperwork has been returned in advance the hearing will be held prior to the renewal date.

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

There were no applications from patients this quarter to measure within the KPI, and there were no 'barring' hearings. 85% of hearings were held within the KPI.

Renewal Date	Hearing Date	KPI (31 days)
22/10/2021	19/11/2021	28 days
24/10/2021	(03/11/2021) 15/12/2021	10 days 52 days *1
26/10/2021	(12/11/2021) 01/12/2021	36 days *2
27/10/2021	26/11/2021	30 days
28/10/2021	30/11/2021	33 days
29/10/2021	17/11/2021	19 days

04/11/2021	25/11/2021	21 days
04/11/2021	26/11/2021	22 days
05/11/2021	29/11/2021	24 days
19/11/2021	13/12/2021	24 days
21/11/2021	01/11/2021	Held before
10/12/2021	21/12/2021	11 days
19/12/2021	14/01/2022	26 days
21/12/2021	05/01/2022	15 days
23/12/2021	12/01/2022	20 days
24/12/2021	12/01/2022	19 days
14/01/2022	14/01/2022	Held on renewal day
21/01/2022	31/01/2022	10 days
21/12/2021	18/01/2022	28 days
Appeal by Patient Date	**Hearing Date**	**KPI (31 days)**
NONE		

Issues which extended the KPI dates are:

1 52 days – the patients hearing was initially held within the KPI, but was postponed on the day due to the translator cancelling at short notice.

2 Initial hearing was scheduled within the KPI timeframe, the RC was sick therefore this had to be rearranged.

2 Scrutiny

The scrutiny audit report is attached as appendix 1 to this report. In light of further covid restrictions Scrutiny for 2022 has been scheduled and planned to be reinstated from March 2022.

The scrutiny audit report showed that further work is required in relation to explanation of rights and care and treatment plans. In many instances it was recorded that the explanation of rights form was not within the file therefore the Associate Hospital Managers could not determine an answer for consecutive questions.

There were several comments in relation to care and treatment plans not being signed, reasons consist of care coordinators home working and therefore unable to sign, it is acknowledged that the patients should see their finalised care and treatment plans and be asked to sign in agreement or it be noted they did not wish to.

An action plan has been initiated in relation to information for patients and explanation of rights.

3 Training

All managers who undertake hearings receive 1:1 reviews, and training is discussed to ensure that they can access the ESR system and receive help if required. Reviews have been scheduled for 2022. To date, four managers continue to not participate in hearings:- one has returned to assist the Local Authority as an Approved Mental Health Professional (AMHP), and three prefer not to undertake virtual hearings, (these managers are happy to return once face to face hearings resume and one is happy to continue to assist with scrutiny).

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:

22 persons of which 18 are actively involved in hearings. A longstanding Associate Hospital Manager retired at the end of 2021. The active cohort consists of seven male and 11 female members, of which three are Welsh speakers.

Of the active members, there are nine chairpersons, (four male and five female), of which two are Welsh speakers. A number of members have declared their interest in chairing and a process of supporting these members to become chairpersons is underway.

An interview was held in November for an additional Associate Hospital Manager, the appointed person is currently undergoing the recruitment process, a number of applications have been received at the start of 2022 with interviews scheduled in March.

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 December 2021 involved discussions relating to: expressions of interest for the Power of Discharge Group, recruitment, fees and training needs. The next meeting is due to be held on the 10th of March.

Mental Health and Learning Disabilities Division

Mental Health Act Associate Hospital Managers Scrutiny Analysis 2021

Conducted by: Mental Health Act Associate Hospital Managers

Report produced by: Wendy Lappin, Mental Health Act Manager

February 2022

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Appendices

Appendix A – Associate Hospital Managers Scrutiny Section Papers and Casenotes

INTRODUCTION AND AIMS

This Associate Hospital Managers Scrutiny Analysis is an audit of scrutiny sessions conducted throughout a time period. This audit process began in 2017 and audits have been produced on a yearly basis. Covid 19 has had an impact on the scrutiny conducted by the Associate Hospital Managers, which was suspended in 2020 and re-instated in June 2021. This audit covers the time period June 2021 – December 2021.

The Mental Health Act Associate Hospital Managers assist Betsi Cadwaladr University Health Board, Mental Health Act Department. They are independent persons who are appointed to sit on Managers Discharge Panels for the Health Board to decide unanimously whether a patient is still liable for detention and as such confirming that the Health Board is appropriately detaining patients under the least restrictive option. An additional duty the Associate Hospital Managers fulfil is one of scrutiny.

Betsi Cadwaladr University Health Board undertakes various forms of scrutiny in relation to the Mental Health Act, (statutory documents and local documents). This enables the Board to monitor and be satisfied that professionals are detaining patients legally, and to ensure patients are advised of their entitled rights, and are aware of help they can receive.

The Policy for 'admission, receipt and scrutiny of statutory documentation' (MHLD 0026) details how scrutiny is conducted. The requirements are set out below:

Admin/Pharmacy Scrutiny – Relates to medication forms. The completion and signature elements of the form are checked by the Mental Health Act office. Pharmacy check the medication elements are written up correctly with the correct doses and routes for administering.

Admin/ECT Scrutiny – Relates to ECT forms. The completion and signature elements of the form are checked by the Mental Health Act office. ECT colleagues check the detail regarding the maximum numbers of ECT, including under S62 (Emergency Treatment Certification), and consider the patient capacity.

Medical Scrutiny – A senior Medic will scrutinise the section papers and renewal papers to be satisfied that the patient has been admitted under the least restrictive option, and that the use of the Mental Health Act was an appropriate decision due to the patient's presentation and needs.

Approved Mental Health Professional (AMHP) Scrutiny – A Senior AMHP will check the AMHP paperwork and report, to ensure that the correct process was followed in relation to identifying the nearest relative and the papers are completed correctly.

Associate Hospital Managers Scrutiny – The Managers conduct scrutiny within the ward areas, focusing on sections papers and case-notes. This consists of a checklist (Appendix A) which covers documents completed by Medics, AMHPs, nursing staff and the provision of help highlighted to the patients. The general order of the documents is also considered, and whether these are contained within the files.

This structure of scrutiny provides the Health Board with assurance that errors are highlighted at the earliest opportunity and informs improvement requirements.

Previous reports showed an improvement in all areas compared to the initial report in 2017, The aim of this report is to show (within 202) the results of the scrutiny sessions which will highlight whether improvements have continued to be made and any areas that may need further guidance/support.

STANDARDS

The standards used for the purpose of this audit are:

1. The Mental Health Act 1983 as amended 2007
2. The Mental Health Act Code of Practice for Wales (revised 2016)

"The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms, those set out in schedule 2 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to

Treatment) (Wales) Regulations 2008. The forms must also be scrutinised to ensure all information contained is accurate and meeting the requirements".

"Hospital Managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers, who may include clinical staff on wards. Someone with the authority to receive admission document should be available whenever patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents". (CoPW 35.8)

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

METHODOLOGY

Data for the period June 2021 to December 2021 has been collected. The data was collected using the checklists (Appendix A).

Within the period the three adult psychiatric units (Ablett, Heddfan and Hergest) were visited for Scrutiny only. This decision was made due to these units safely accommodating a room, not within the ward areas, for the Associate Hospital Managers which allowed for social distancing and their protection against possible contraction of Covid 19.

A total of 18 scrutiny sessions were held, a total of 123 files scrutinised consisting of 78 persons on a Section 3 and 45 on a Section 2.

RESULTS

Each part of the Scrutiny form has been considered in relation to the answers obtained e.g. Yes (Positive) or No (Negative). These have been broken down into the relevant sections on the form to discover the percentage of compliance as a whole but also for the units scrutinised. As some records did not distinguish between the ward scrutinised the results have been recorded as the unit. Feedback has been given to each ward/unit scrutinised following the attendance of the Associate Hospital Managers this is therefore a collective and retrospective report.

1 Medical Recommendations

Each scrutiny form was analysed. The table below shows the number of positive responses in relation to the five relevant questions for the areas scrutinised.

1. Do the doctors appear to be independent of each other?
2. Has the doctor stated why informal admission is not appropriate?
3. Have all forms been completed correctly?
4. Are dates of examination no more than five clear days apart? (not including the dates of the examinations)
5. Are you satisfied with the recommendation(s)?

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	Q3	Q4	Q5
Heddfan (6)	41	41	41	41	41	41
Ablett (7)	46	46	46	46	46	46
Hergest (5)	36	36	36	36	36	36
TOTALS	**123**	**123**	**123**	**123**	**123**	**123**

COMMENTS

Ablett

- *There was evidence of corrections being highlighted and made to section papers*.
- *There was evidence of why neither doctors knew the patient and detailed explanations given*.

Hergest

- *Clear recommendations, and clear and concise documentation*.

2 Application by the AMHP

Each scrutiny form was analysed. The table below shows the number of positive in relation to the two relevant questions for the areas scrutinised.

1. Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)
2. Has the AMHP given sufficient explanation of his / her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2
Heddfan (6)	41	41	41
Ablett (7)	46	46	46
Hergest (5)	36	36	36
TOTALS	**123**	**123**	**123**

COMMENTS

Ablett

- *Detailed assessment reports from the AMHPs.*
- *Whilst sufficient information was given by the AMHP the incorrect Nearest Relative was named within one application.*

Hergest

- *One AMHP report could not be found on file, two patients had only just been detained and the AMHP reports were still to be received the applications were checked to ensure these detailed the correct information.*
- *Clear reasons for detention noted.*
- *AMHP reports not signed.*

Heddfan

- *There was sufficient information on the application but no AMHP report present due to recent admission.*

3 Casenotes

Each scrutiny form was analysed. The table below shows the number of positive in relation to the relevant questions for the areas scrutinised, question 2b is shown as a negative if the patient was not offered the explanation in their primary language and no reason was recorded.

1. Has Ethnicity been recorded in the casenotes? (Admission Form)
2. Has an Explanation of Rights been given to the patient and recorded in the notes?
   a) Was the Explanation offered in the patient's primary language?
   b) If not have reasons been recorded?
   (MHA Section)
3. Has the patient been referred to the IMHA?
   (MHA Section)
4. Is there an up to date Care and Treatment Plan?
   (Care Planning Section)
5. Are the section papers filed in the correct place in the casenotes?
   (MHA Section)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	2a	2b	Q3	Q4	Q5
Heddfan (6)	41	29	30	27	-14	27	36	41
Ablett (7)	46	41	40	32	-14	41	41	44
Hergest (5)	36	31	31	31	-4	26	36	35
TOTALS	**123**	**101**	**101**	**90**	**-32**	**94**	**113**	**120**

COMMENTS

Ablett

- *Explanation of rights form included but not completed.*
- *All document present and correct in appropriate sections of the file.*
- *No signatures on the care and treatment plans.*
- *Ethnicity not always recorded on the file, noted an interpreter coming in but not documented that rights were given in primary language.*
- *Patient rights forms not found.*
- *All files are of a good standard although some files did not indicate if explanation offered was in patient's primary language.*
- *No care and treatment plan filed but a very recent admission*.

Hergest

- *Care plans not signed.*
- *Well organised files.*

Heddfan

- *Patient's explanation of rights forms missing.*
- *Care Plan blank but fairly recent admission.*
- *Care and Treatment Plan not signed.*
- *Recent admissions meant documentation was not in the file although this may have been completed.*

CONCLUSIONS & DISCUSSION

Medical Recommendations

It is expected that the Medical Recommendations section would produce a return of 100% for all questions otherwise a patient may potentially be detained illegally.

All units showed 100% compliance to the questions.

Application by AMHP

During this audit it has been highlighted that there are instances where the AMHP reports were not on the files, when investigated these were either still to be forwarded by the AMHP or within the filing of the wards. In one instance the nearest relative had been named incorrectly this was rectified at the time.

The AMHP application will initially be part of the section documentation with the AMHP report on occasions received at a later date, all applications noted the nearest relative and that the application was not completed prior to the medical recommendations.

100% for both questions was obtained by all units.

Casenotes

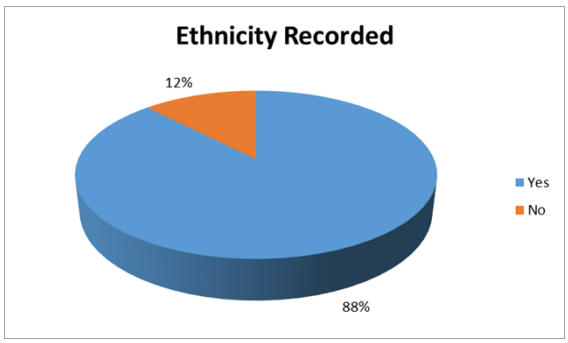
From the 123 files scrutinised no area produced a return of 100% for all questions. A total of 58 files (47%) produced a return of 100% for all five questions including that the patient was offered the explanation in their language of choice. This is an increase of 11% from the previous audit.

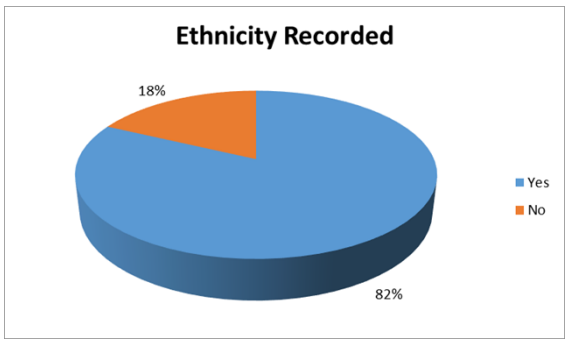
In many instances it was recorded that the explanation of rights form was not within the file therefore the Associate Hospital Managers could not determine an answer for questions 2 and 3 which produces a negative for these questions automatically as there is no evidence to the contrary.

There were several comments in relation to care and treatment plans not being signed, reasons consist of care coordinators home working and therefore unable to sign, it is acknowledged that the patients should see their finalised care and treatment plans and be asked to sign in agreement or it be noted they did not wish to.

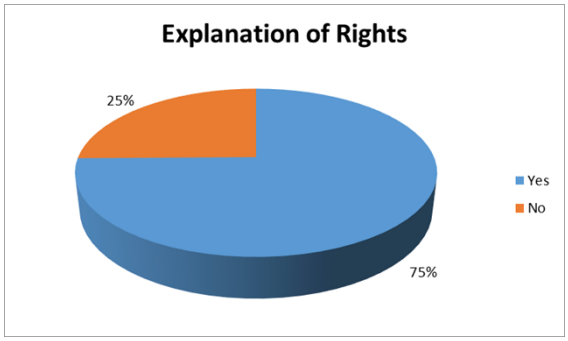
The charts below show the percentages for each question for all the areas scrutinised in comparison to the results obtained from the last audit in 2019.

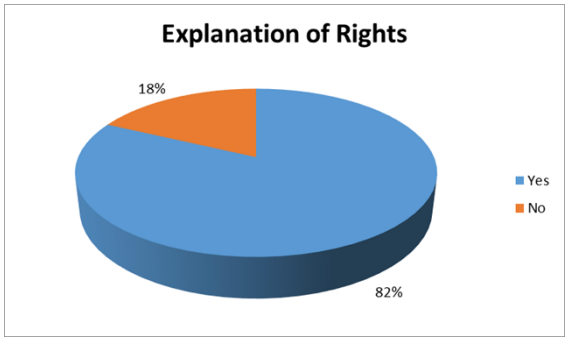
2019 **2021**



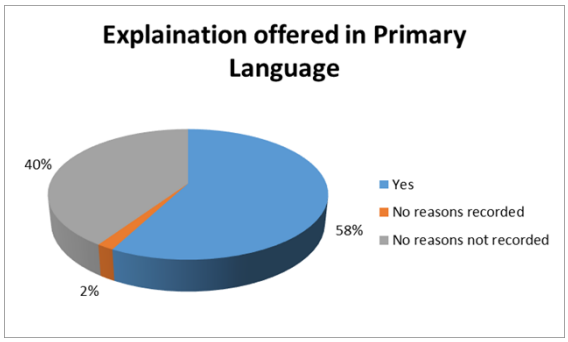


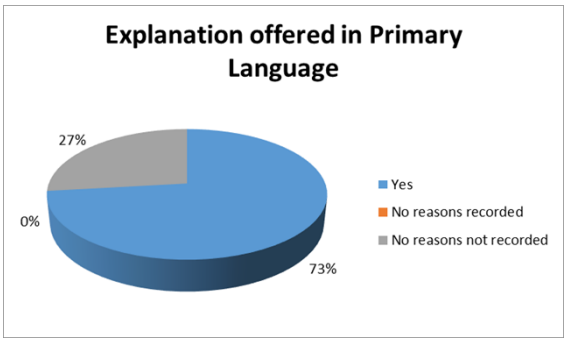
There has been a decrease of 6% in relation to ethnicity being recorded within the files.



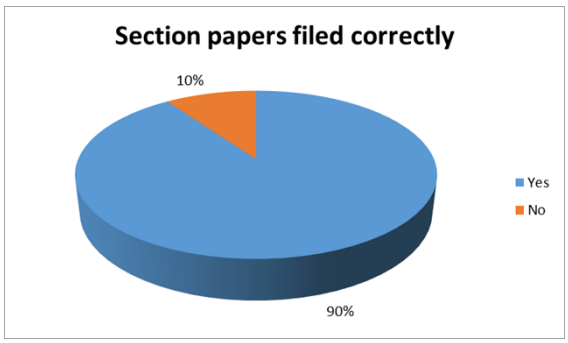


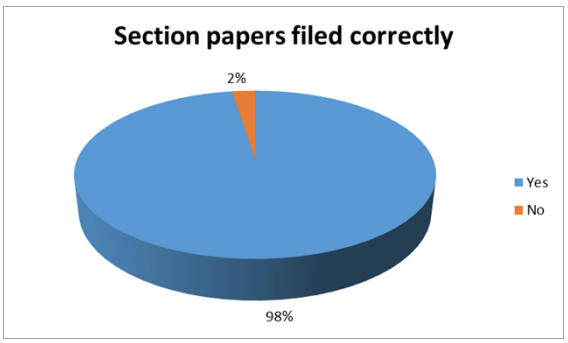
There has been an improvement in relation to the explanation of rights by 7%. It was noted within a number of the files scrutinised, the explanation of rights forms could not be found this would therefore have had an impact on this question.



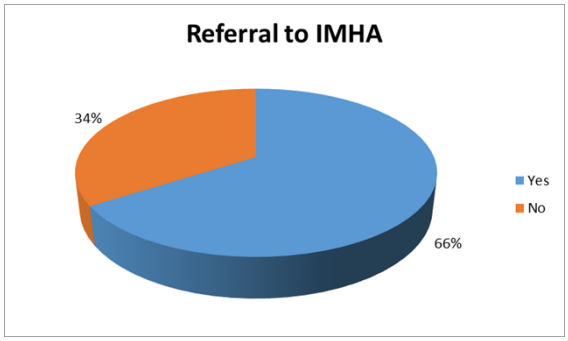


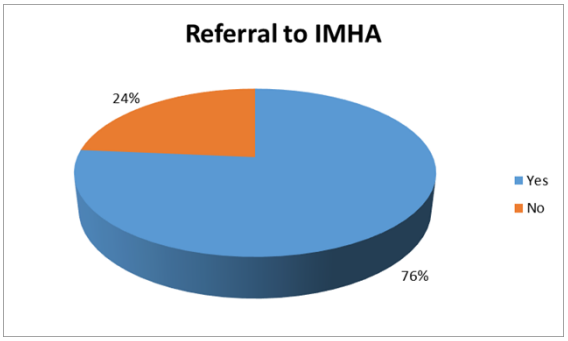
There has been an improvement for the explanation of rights being offered in the patient's primary language by 13%. There has been a decrease in the reasons being recorded for when explanation has not been given in the primary language. It is noted that the explanation of rights form has to be within the file to be able to answer this question.



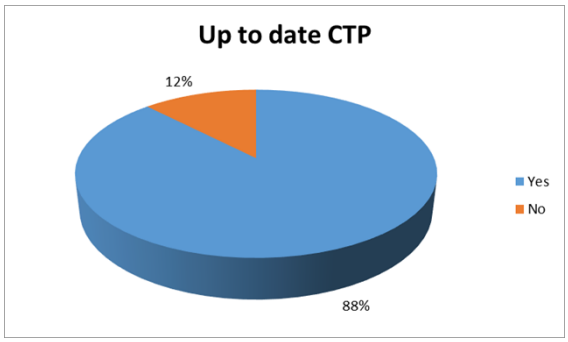


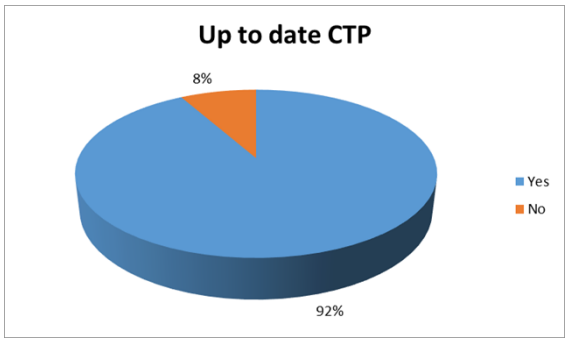
There has been an improvement of 8% in the section papers being filed in the correct place.





There has been an improvement of 10% in referrals made to the IMHA service. The lack of explanation of rights forms within the files will have had an impact on this question.





There has been an improvement in an up to date CTP's being within files by 4%.

Whilst improvements have been seen within the casenote section of the audit further work is required to ensure that all patients are given their rights at the appropriate time of admission and referred to an IMHA.

ACTIONS TAKEN

Following each scrutiny session the areas have been informed of their results and areas of concern highlighted.

All issues raised by the Associate Hospital Managers have been looked into, assurance provided that everything is in order or amendments and corrections made immediately.

ACTION PLAN

Target Area	Action Required	Lead	Evidence of completion	Target Date	RAG
Explanation of Rights Referral to IMHA	The MHLD 0030 Policy for Information to Patients (S132/3 MHA) to be distributed through area monthly Quality and Safety Group meetings for dissemination to staff.	MHA Manager Governance Leads	Confirmation from the Governance lead for each area this is on the agenda.	01.04.2022	
Explanation of Rights Referral to IMHA Care and Treatment Plan	The revised Mental Health Act Pathway approved December 2021 to be shared via Quality and Safety Group meetings for dissemination to staff.	MHA Manager Governance Leads	Confirmation from the Governance lead for each area this is on the agenda.	01.04.2022	
Explanation of Rights	The Mental Health Act office each week within the weekly reminder emails to the ward managers will include any outstanding Explanation of Rights forms.	Area MHA Administrators	MHA manager to be copied into emails	28.02.2022	GREEN
Explanation of Rights	The Mental Health Act office at the end of each month when conducting their monthly stats to report any outstanding Explanation of rights to the Mental Health Act Manager who will escalate to the Head of Operations.	Area MHA Administrators MHA Manager	Confirmation within the monthly stats that all current patients have an explanation of rights form.	Monthly 28.02.2022	GREEN

RECOMMENDATIONS / SHARING OF INFORMATION

Scrutiny to be conducted for 2022, the MHA office staff inform the areas prior of the attendance of the Associate Hospital Managers and they are given the opportunity to select a timeframe or change a date if necessary. It is therefore recommended that unless a serious incident occurs or HIW attend for an unannounced visit scrutiny should proceed as planned.

The report will be shared with the Mental Health Capacity and Compliance Committee, Associate Hospital Managers, the Head of Operations, Clinical Operations Managers and Heads of Nursing for each unit.

The Information to Patients Policy to be highlighted to staff by the Heads of Nursing in relation to Explanation of Rights and the process, work still needs to be undertaken to ensure that the forms are fully completed. This policy with the form can be accessed and is available on the intranet. MHLD 0030 Policy for information to patients (s132/3 MHA).

The audit will be shared with the Business Support Managers in relation to filing so that this can be shared in admin meetings with administration staff.

A yearly audit to be conducted.

Appendix A
(Appendix 13 of Admission receipt and Scrutiny of Statutory Documentation Policy)

(Name of Unit - Hergest, Heddfan, Ablett Unit)

Associate Hospital Managers Scrutiny Section Papers and Casenotes

Venue:
Names of Managers undertaking Scrutiny:
Number of files scrutinised:
Date:
Any issues of concern which need raising:

Please note a separate page 2 and 3 of Appendix 13 should be used for each file scrutinised.

Appendix 13 p.2

Associate Hospital Managers Scrutiny
Section Papers and Casenotes

Patient's Name:

Ref No: Section: Section Date:

PLEASE NOTE:

- All forms must be for the same section detailing the patients name and address identically on each form.
- Forms should be signed and dated.
- If the section papers need to be amended you will be required to check them again.

Please check the medical recommendation(s) for the following:

		Yes	No
1	Do the doctors appear to be independent of each other?	☐	☐
2	Has the doctor stated why informal admission is not appropriate?	☐	☐
3	Have all forms been completed correctly?	☐	☐
4	Are dates of examination no more than five clear days apart? (not including the dates of the examinations)	☐	☐
5	Are you satisfied with the recommendation(s)? If not please details reasons below:	☐	☐

_____

_____

_____

Please check the Application by the AMHP for the following:

		Yes	No
1	Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)	☐	☐
2	Has the AMHP given sufficient explanation of his/her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)	☐	☐

Appendix 13 p.3

Please check the casenotes for the following:

		Yes	No
1	Has Ethnicity been recorded in the casenotes? (Admission Form)	☐	☐
2	Has an Explanation of Rights been given to the patient and recorded in the notes?	☐	☐
	Was the Explanation offered in the patient's primary language?	☐	☐
	If not have reasons been recorded? (MHA Section)	☐	☐
3	Has the patient been offered referral to the IMHA? (MHA Section)	☐	☐
4	Is there an up to date Care and Treatment Plan? (Care Planning Section)	☐	☐
5	Are the section papers filed in the correct place in the casenotes? (MHA Section)	☐	☐

Any further Comments:

_____

_____

_____

_____

_____

Signature(s): .....

Print Name(s): .....

Date undertaken: .....

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Mental Health Act Performance Report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 MHA Committee Performance Report November 2021 – January 2022 Appendix 2 S136 BCUHB Report – February Appendix 3 S136 CAMHS Report – February

Argymhelliad / Recommendation:

The Committee is asked to discuss and note the report.

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

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

Sefyllfa / Situation:

The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during November 2021 – January 2022.

Cefndir / Background:

The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections.

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

Lapsed sections are reported as ‘exceptions’ throughout the report, and invalid detentions recorded as ‘fundamentally defective’.

Up to date S136 reports are submitted to the Committee.

Asesiad / Assessment & Analysis

Strategy Implications
The use of the Mental Health Act is determined by patient need, and the priority is always to care for the patient under the least restrictive option.

Options considered
Not Applicable

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

Risk Analysis
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 underway as to a more safe and robust way of storing and reporting data between Performance and Information Technology (IT) exploration is being made into what English NHS Trusts.

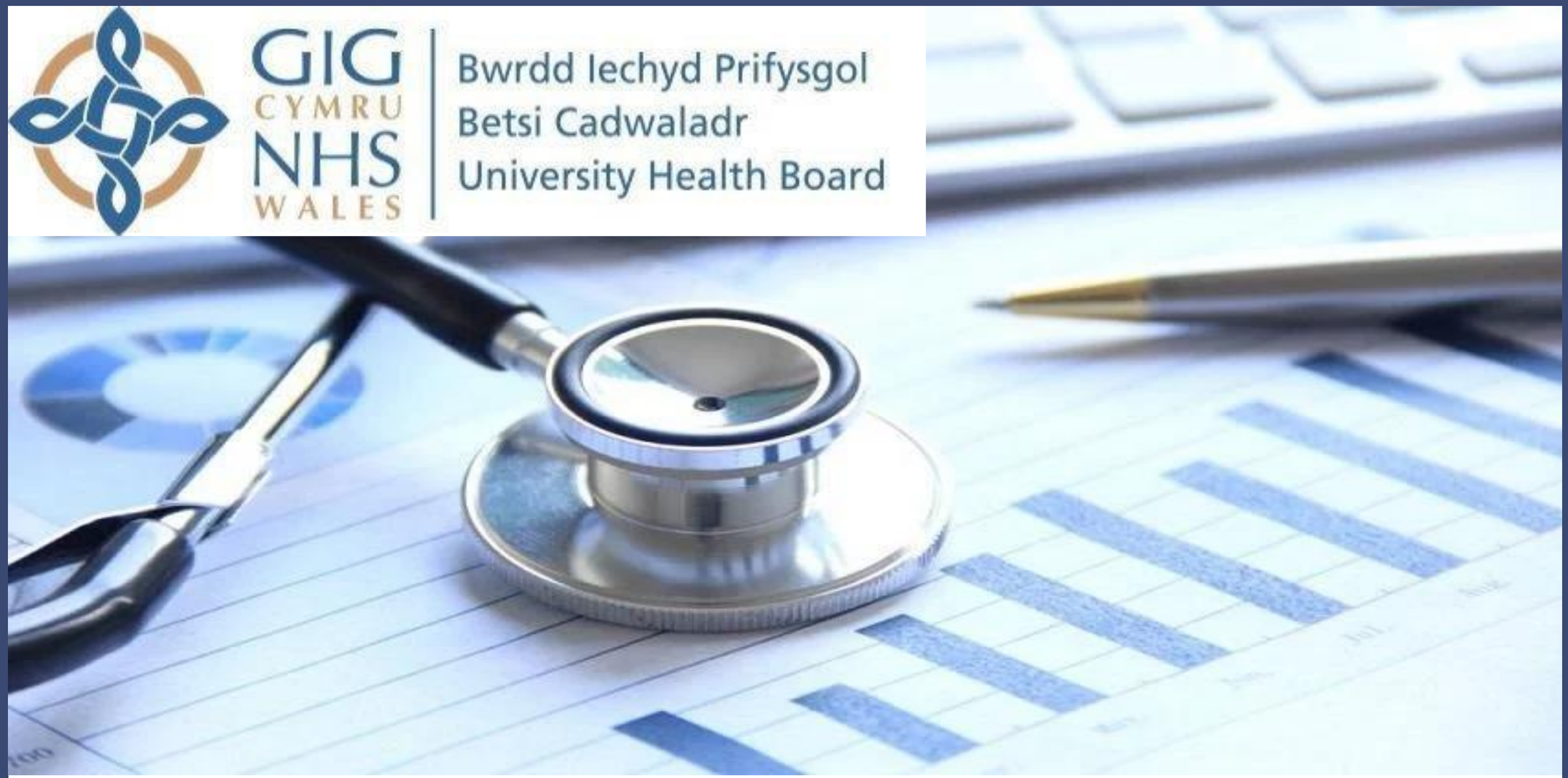
The Mental Health Act detentions fall into categories of being either legal or illegal (invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked for validity, and any invalid detentions are reported through Datix, investigated and escalated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

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

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

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

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



Mental Health Capacity and Compliance Committee Performance Report

January 2022

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There are two exceptions to report this period.

CENTRAL: A section 2 was found to be invalid on transfer from another unit, it was

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.

Advisory Reports & Exception reports

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

Exceptions are noted throughout the report within this period three sections lapsed: 1 x S5(2) lapsed following the weekend, the first medical recommendation was completed in time and left in an office, no records were made within the handover book for the ward that this required dealing with before the Monday morning, patient was detained on a section 3. (INC290240) . A section 2 lapsed as there was no recommendation for a section 3 the RC covering did not feel it was appropirate to take off the section although they were not recommending a section 3. They were aware this was not good practice. (INC289229) and a section 3 lapsed over the weekend, the RC had gone on leave and had not completed the renewal forms prior, no other RC accepted responsibility for renewing. The patient was subject to a 5(2) and was reassessed for a section 3. (INC293682).

There are two fundamentally defective sections to report: A section 2 was found to be invalid on transfer from another unit it was discovered the AMHP application was made out to a unit which was not the admitting unit, this therefore rendered the section invalid, the patient was reassessed and detained under a section 2. (INC286008) A section 37 was found to be invalid due to the section expiry beiing miscalculated. (INC286709).

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

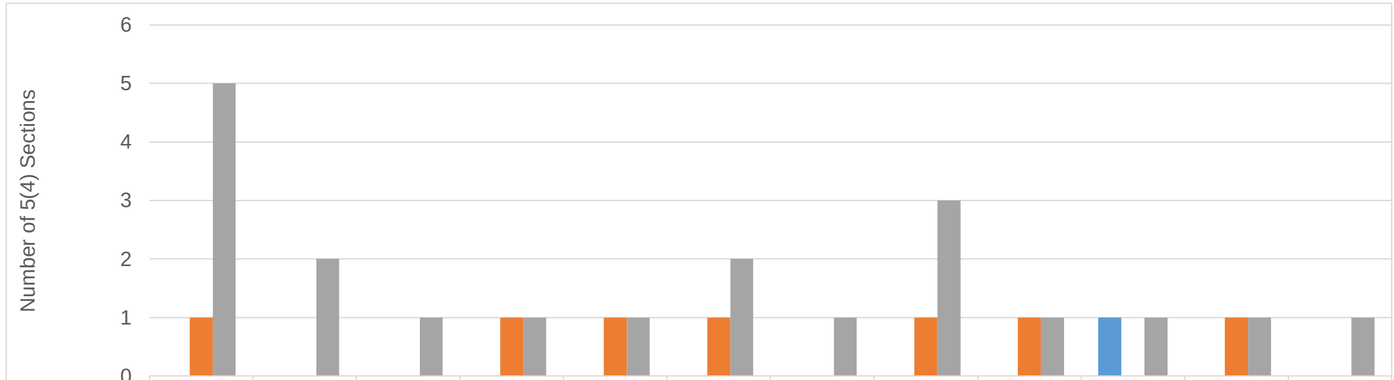
Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

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	January 2022	December 2021	Monthly Trend
Section 5: Application in respect of patients already in hospital	1	2	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
5	7	↓	7

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



	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	0	0	0	0	0	0	0	0	0	1	0	0
Centre	1	0	0	1	1	1	0	1	1	0	1	0
East	5	2	1	1	1	2	1	3	1	1	1	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

	Duration (hh:mm)	Outcome
Nov_21	02:30	Section 5(2)

CENTRE

Month	Duration (hh:mm)	Outcome
Dec_21	03:40	Informal

EAST

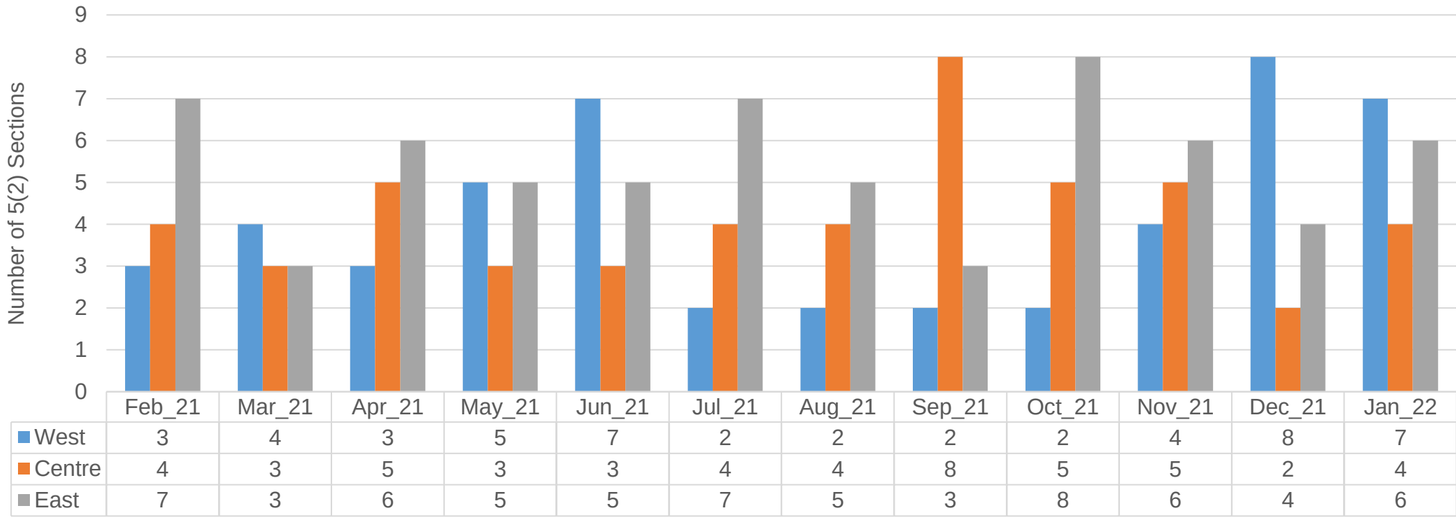
Month	Duration (hh:mm)	Outcome
Nov-21	04:10	Informal
Dec_21	03:28	Section 5(2)
Jan_22	00:32	Section 5(2)

Advisory Report - Section 5(2)

Section 5(2) - BCUHB	January 2022	December 2021	Monthly Trend
Section 5: Application in respect of patients already in hospital	17	14	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
46	39	↑	41

Area Rank by numbers of Section 5(2) during Quarter		Quarter 5(4) Sections
1	West	19
2	East	16
3	Centre	11



	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	3	4	3	5	7	2	2	2	2	4	8	7
Centre	4	3	5	3	3	4	4	8	5	5	2	4
East	7	3	6	5	5	7	5	3	8	6	4	6

Section 5(2) Outcomes

	Nov 2021	Dec 2021	Jan 2022
Section 2:	6	8	6
Section 3:	2	4	3
Informal:	3	3	4
Lapsed:	0	0	1
Invalid:	0	0	0
Discharged:	3	0	0
Other:	0	0	0

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. One young person was detained under a 5(2) within this quarter.

EXCEPTIONS

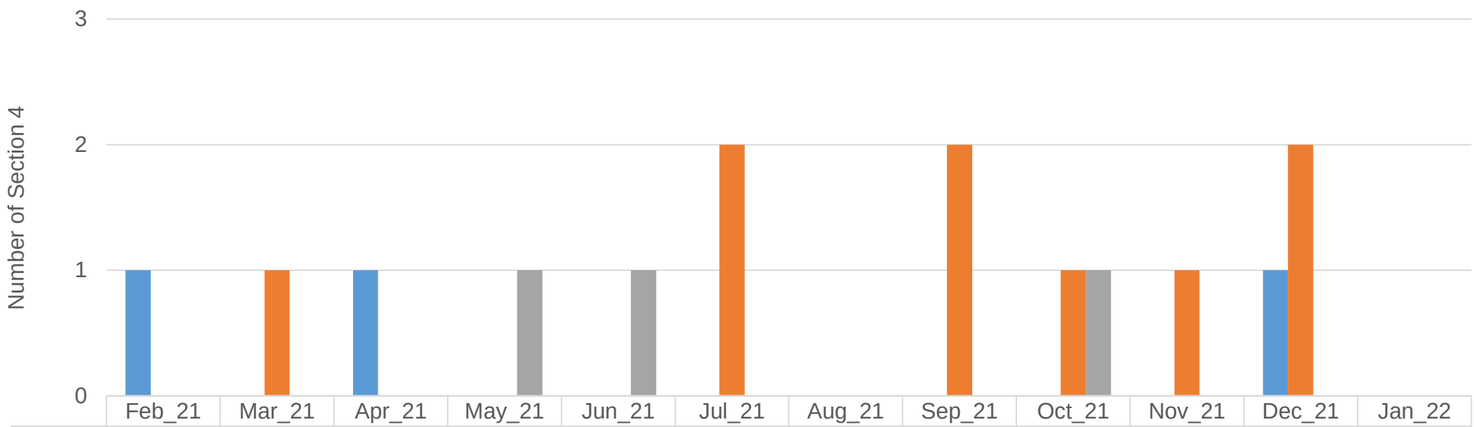
There is one exception to report this period:

WEST: The 5(2) lapsed following the weekend, the first medical recommendation was completed in time and left in an office, no records were made within the handover book for the ward that this required dealing with before the Monday morning, patient was detained on a section 3. (INC290240) . Learning has included handover book to detail sections which are due to lapse.

Advisory Report - Section 4

Section 4 - BCUHB	January 2022	December 2021	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	0	3	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
4	4	→	4	1	Centre	3
				2	West	1
				3	East	0



	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	1	0	1	0	0	0	0	0	0	0	1	0
Centre	0	1	0	0	0	2	0	2	1	1	2	0
East	0	0	0	1	1	0	0	0	1	0	0	0

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

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

There are no exceptions to report.

The documents are considered to reveal if the S4 was used for emergency purposes or due to a lack of doctor availability. In two of the instances a second doctor could not be located and there was a requirement to keep the patient safe and for admission to be immediate.

WEST

	Duration (hh:mm)	Outcome
Dec_21	12:00	Informal

CENTRE

Month	Duration (hh:mm)	Outcome
Nov_21	04:05	Section 2
Dec_21	15:20	Section 2
Dec_21	20:15	Section 2

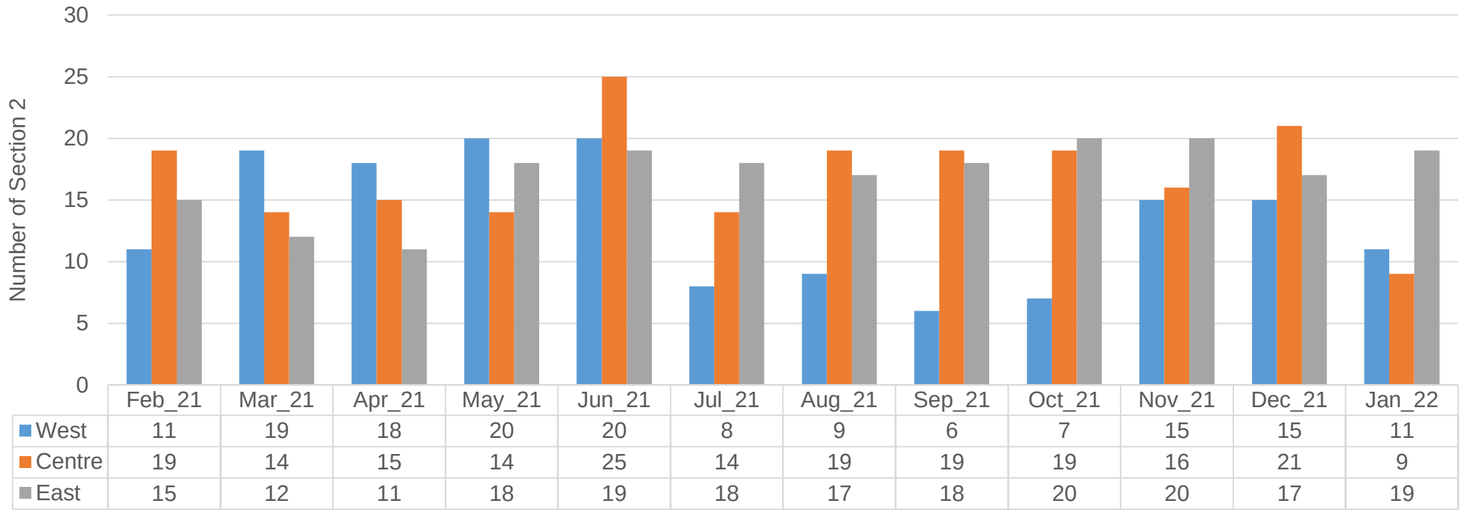
EAST

Month	Duration (hh:mm)	Outcome

Advisory Report - Section 2

Section 2 - BCUHB	January 2022	December 2021	Monthly Trend
Section 5: Admission for assessment	39	53	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
143	134	↑	142	1	East	56
				2	Centre	46
				3	West	41



	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	11	19	18	20	20	8	9	6	7	15	15	11
Centre	19	14	15	14	25	14	19	19	19	16	21	9
East	15	12	11	18	19	18	17	18	20	20	17	19

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

Section 2 Outcomes

	Nov 2021	Dec 2021	Jan 2022
Section 3:	9	12	11
Informal:	16	18	18
Lapsed:	0	0	1
Pending:	0	0	0
Discharged:	14	7	5
Transferred:	12	9	11
Invalid and Other:	0	1	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 four under 18s placed on a Section 2 this period, all direct admissions.
.

EXCEPTIONS:

There are two exceptions to report this period.

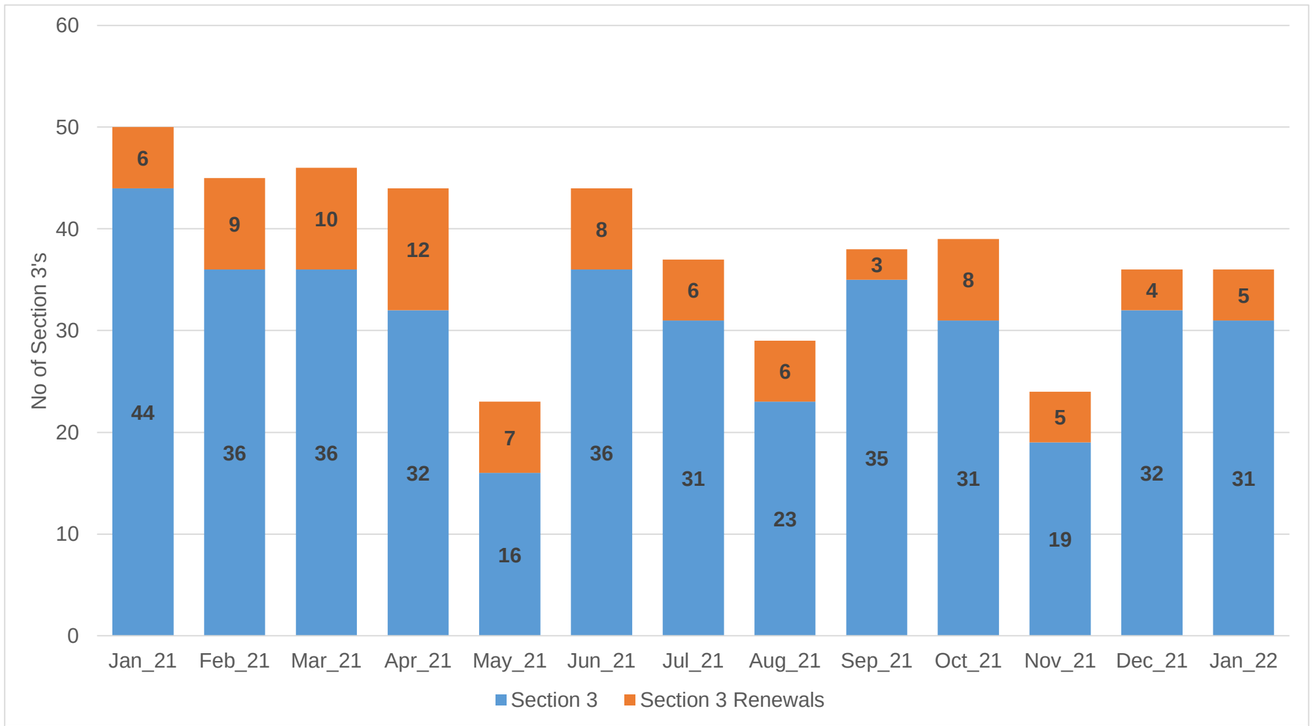
CENTRAL: A section 2 was found to be invalid on transfer from another unit, it was discovered the AMHP application was made out to a unit which was not the admitting unit, this therefore rendered the section invalid. The patient was reassessed and detained under a section 2. Learning has included citing the new scrutiny checklist forms to staff. (INC286008)
A section 2 lapsed as there was no recommendation for a section 3 the RC covering did not feel it was appropriate to take off the section although recommendation for section 3 was felt to not be needed. The RC is aware this was not good practice. (INC289229)

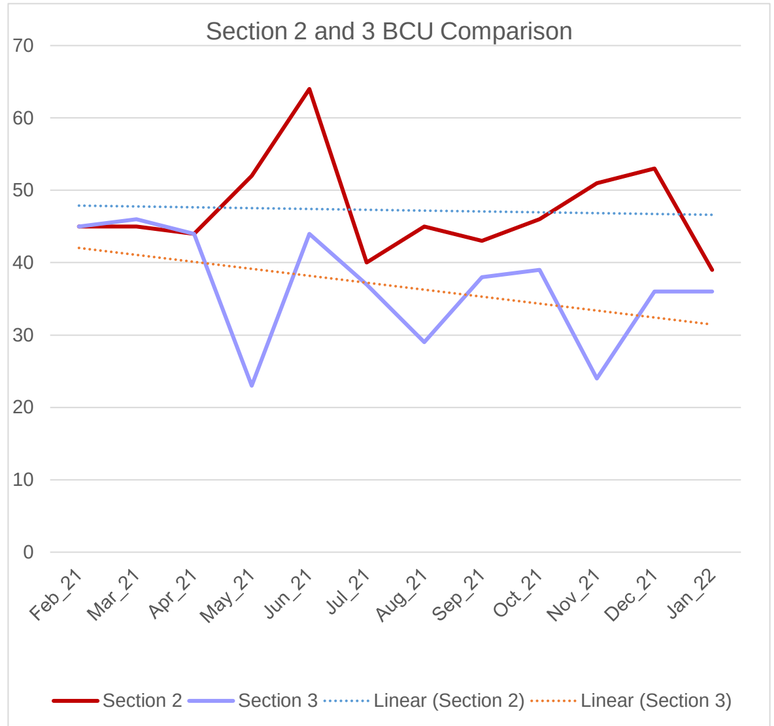
A

Section 3 - BCUHB	January 2022	December 2021	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	36	36	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
96	106	↓	110

Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
1	East	33
2	West	32
3	Centre	31





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

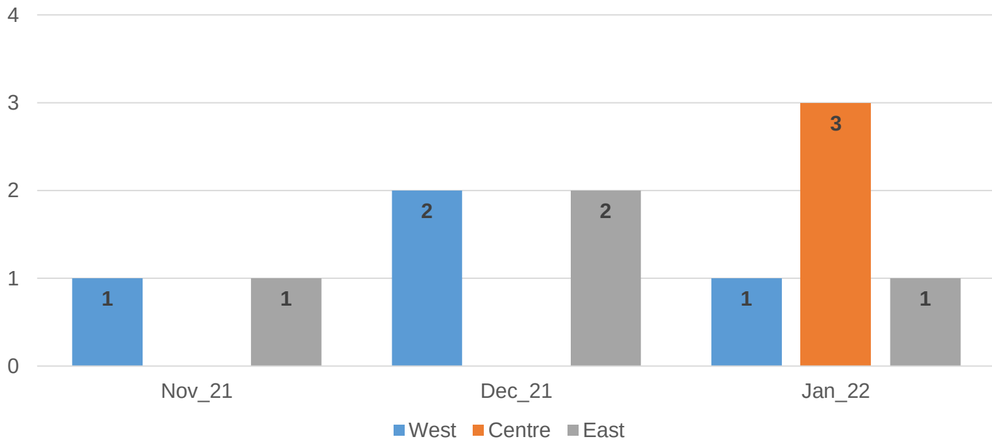
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

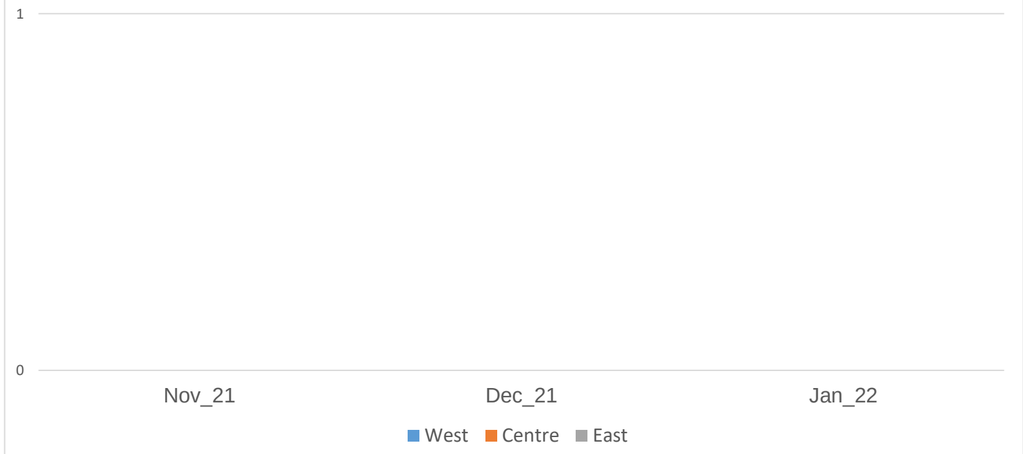
This period there were three under 18s made subject to a section 3, all were regraded, one from informal, section 2 and a 5(2). The trend over the 12 months at the end of January shows downwards for section 3 and section 2.
There are two exceptions to report: (WEST) One section 3 lapsed over the weekend, the RC had gone on leave and had not completed the renewal forms prior, no other RC accepted responsibility for renewing. The patient was subject to a 5(2) and was reassessed for a section 3. (INC 293682).

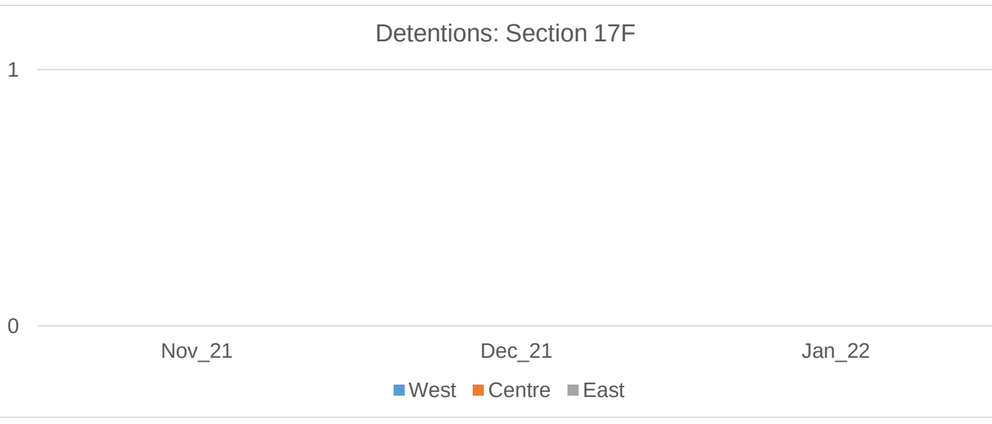
Section 17 A-F - BCUHB	January 2022	December 2021	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	5	4	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
11	9	↑	14

Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
1	East	4
1	West	4
3	Centre	3







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. There are no patients who were recalled or revoked this quarter.

The number of patients subject to a CTO at the end of January West:9, Central: 5 and East: 5.

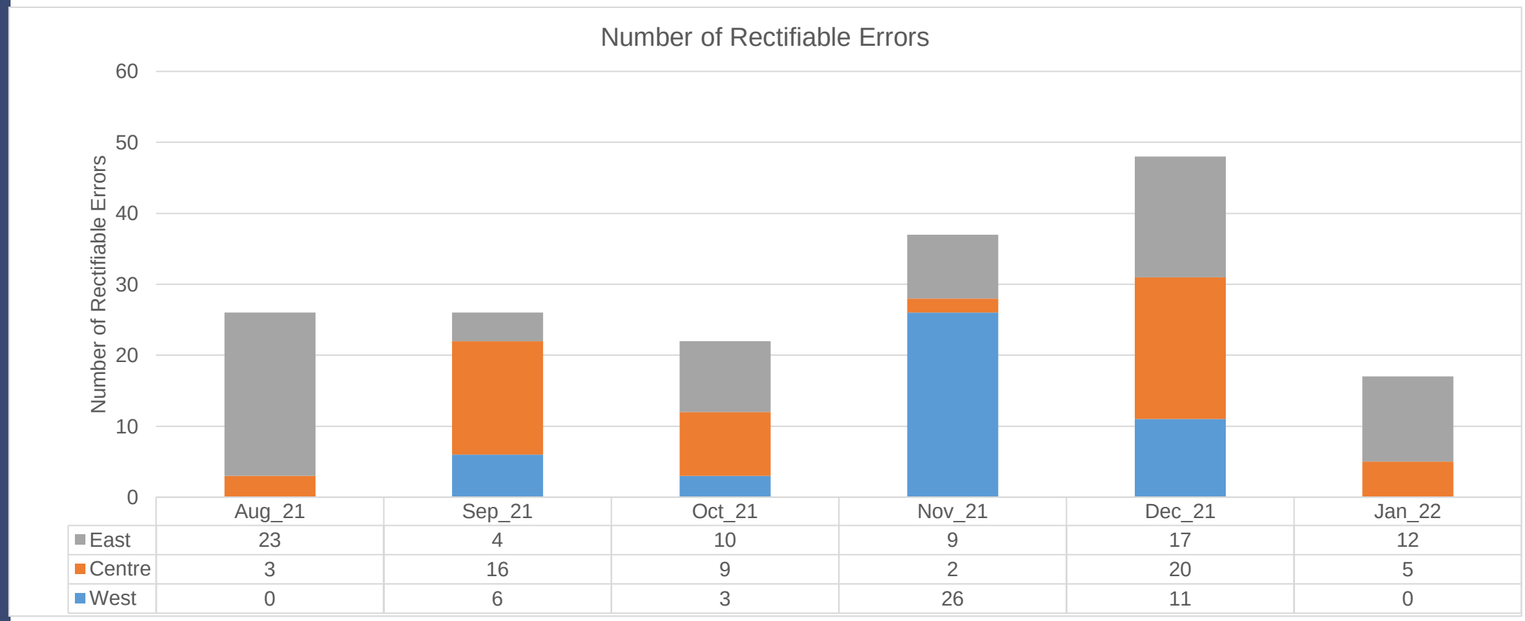
There has been a decrease in the number of patients subject to a CTO for West and an increase for Central and East this quarter.

Exceptions: none to report.

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	January 2022	December 2021	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	17	48	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	East	39
				2	West	37
				3	Centre	28



Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales.The report produced covers October - December 2021.
The report confirms BCUHB is not an outlier for rectifiable errors or fundamentally defective errors with the Health Board accounted for 26% of rectifiable errors throughout Wales with one Health Board accounting for 43%.

There was an increase in November and December regarding errors which has decreased again in January. A total of 21% November, 20% December and 16% January of section papers contained errors. Some documents contained more than one error, all were recitified.

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.

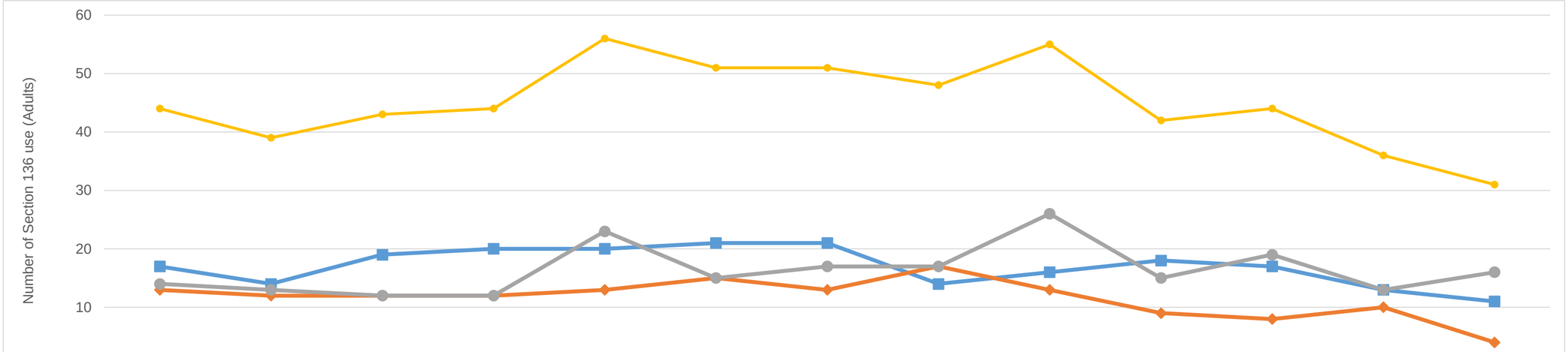
This period there have been two fundamentally defective sections, one under section 2 and one under section 37.

This period there have been three lapsed Sections:- 1 x section 5(2), a section 2 and a section 3.

Section 135 - 136	January 2022	December 2021	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	31	36	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
111	145	↓	135

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	48
2	West	41
3	Centre	22



	Jan_21	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	17	14	19	20	20	21	21	14	16	18	17	13	11
Centre	13	12	12	12	13	15	13	17	13	9	8	10	4
East	14	13	12	12	23	15	17	17	26	15	19	13	16
BCU	44	39	43	44	56	51	51	48	55	42	44	36	31

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

There have been five S135 detentions this period resulting in two detentions under S2 and three under S3.
Two Section 136s lapsed this quarter, INC282766 and INC282853 both people were unfit for assessment, one detention was extended by 12 hours, both people have not been subject to any further detentions to date.
During this period there were no custody detentions.
One S136 12 hour extensions were granted this period due to not being fit for assessment this is noted above as lapsed due to the person remaining unfit for assessment, no further detentions have been noted for the individual.

Advisory Report - Section 135 and 136

Section 136	January 2022	December 2021	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	31	36	↓

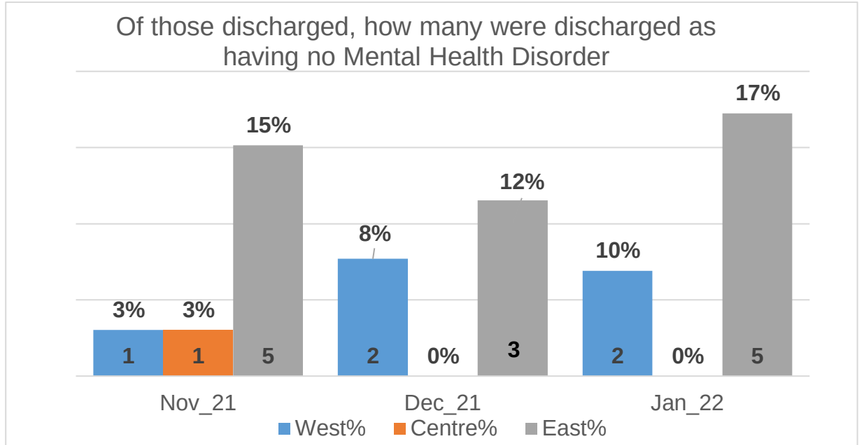
Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
111	145	↓	135	1	East	48
				2	West	41
				3	Centre	22

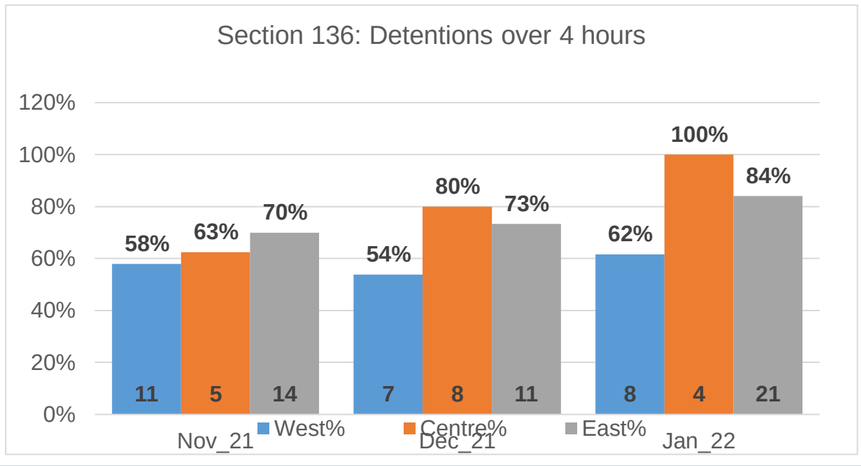
Section 136 Outcomes

	Nov 2021	Dec 2021	Jan 2022
Discharged:	33 73.33%	26 68.42%	29 69.05%
Informal Admission:	7 15.56%	5 13.16%	1 2.38%
Section 2:	5 11.11%	4 10.53%	9 21.43%
Section 3:	0 0.00%	3 7.89%	3 7.14%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Nov 2021	Dec 2021	Jan 2022
Yes	35	25	34
Yes (percentage)	76.09%	65.79%	82.93%





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

Total percentages of all detentions for those discharged with no mental disorder (rounded up) are:
November 21%
December 19%
January 24%

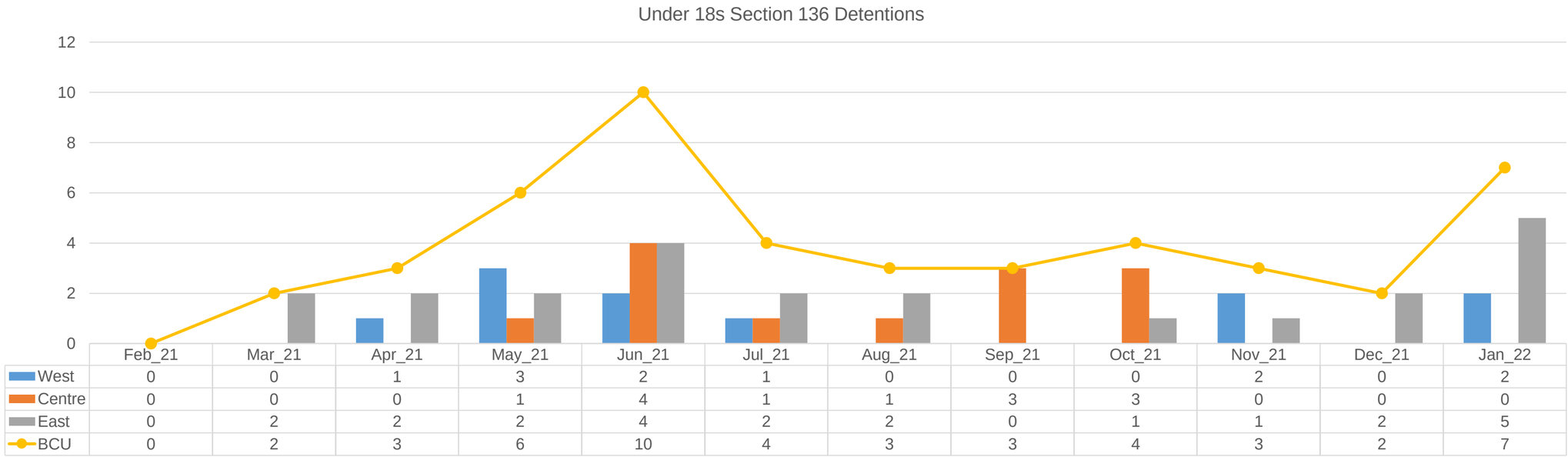
Data below shows the percentage of the detentions discharged that are followed up by services or new referrals into services these figures are rounded up/down as appropriate:

November 58% discharged with follow up and 21% referred to services.
December 54% discharged with follow up and 27% referred to services.
January 56% discharged with follow up and 20% 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 212 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,

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	January 2022	December 2021	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter		Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	7	2	↑	12	10	↑	12	1	East	8
								2	West	4
								3	Centre	0



	Feb_21	Mar_21	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22
West	0	0	1	3	2	1	0	0	0	2	0	2
Centre	0	0	0	1	4	1	1	3	3	0	0	0
East	0	2	2	2	4	2	2	0	1	1	2	5
BCU	0	2	3	6	10	4	3	3	4	3	2	7

A total of 12 under 18's were assessed this period between the ages of 13 and 17 years. Two assessments resulted in admissions to adolescent services, one under section 2 and one as a voluntary admission. Eight assessments resulted in discharge with follow up to services, one resulted in an out of area placement and one young person was discharged with no mental disorder.

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

Under 18 Assessments	
AGE	**Number of Assessments**
12	1
13	7
14	6
15	7
16	6
17	18

Outcome of Assessments	
Outcome	**Number**
Returned Home	22
Returned to Care Facility	7
Admission to childrens ward	8
Admission to Adult ward / S136 suite	1
Admission NWAS / CAMHS	5
Admission OOA	1
Other (Friends, Hotel, B&B)	1

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
November	Heddfan	Discharged	CAMHS	14:48:00	14
November	Hergest	Discharged	CAMHS	17:15:00	17
November	Hergest	Admission	CAMHS	19:13	17
December	Heddfan	Admission	CAMHS	21:14:00	15
December	Heddfan	Discharged	CAMHS	13:40	17
January	Hergest	Discharged	CAMHS	03:45	14
January	Heddfan	Admission	CAMHS	18:12:00	14
January	Heddfan	Discharged	CAMHS	07:15	17
January	Heddfan	Discharged	CAMHS	08:15	16
January	Heddfan	Discharged	CAMHS	15:30	17
January	Heddfan	Discharged	CAMHS	14:20	13
January	Hergest	Discharged	CAMHS	15:00	15

Out of the 12 young persons assessed 7 originated from their own home, two from temporary addresses and three from care facilities.

Ten of the detentions were initiated out of hours.

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

Average PoS hours: 14:02 hrs this is a decrease on the previous quarter figures of (14:08 hrs).

Under 18's admitted to Adult Psychiatric Wards

There were no admissions to an Adult Psychiatric Ward this quarter one from a S136. There was an admission to a unit under section 2 of a young person for a total of 8 days and 16:25 hours prior to transfer to an appropriate unit.

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

County Originated from and where assessed:

	East	Central	West
Wrexham	7	1	1
Flintshire	9	1	1
Denbighshire	2	7	1
Conwy	2	2	4
Gwynedd	0	0	2
Ynys Môn	0	1	1
Out of Area	1	0	1

Section	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Section 35:	0	0	0	0	0	0	0	0	0	0	1	1
Section 37:	0	0	0	0	1	0	0	1	1	1	1	1
Section 37/41:	9	9	9	9	9	9	8	8	8	8	8	8
Section 38:	1	1	0	0	0	0	0	0	0	0	0	0
Section 47:	2	2	2	1	0	2	2	2	1	1	1	1
Section 47/49:	4	4	1	3	2	3	3	3	3	3	3	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	1	0	0	0	0	0	0	1	1	1
Section 3:	3	3	3	4	4	4	4	4	4	4	5	5
Section 45A	1	1	0	0	0	0	0	0	0	0	0	0
Total:	20	20	16	17	16	18	17	18	17	18	20	20

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 is one exception to report - a section 37 was miscalculated which resulted in a detention expiring (INC286709),extra checks have been put in place to support the administrator in calculating forensic detentions.

Advisory Report - Transfers

Total Transfers for the Quarter

	Nov 2021	Dec 2021	Jan 2022
Internal Transfers	16	13	11
External Transfers (Total)	6	2	8
External Transfers (In)	3	0	5
External Transfers (Out)	3	2	3

Internal Transfers
This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway. 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.

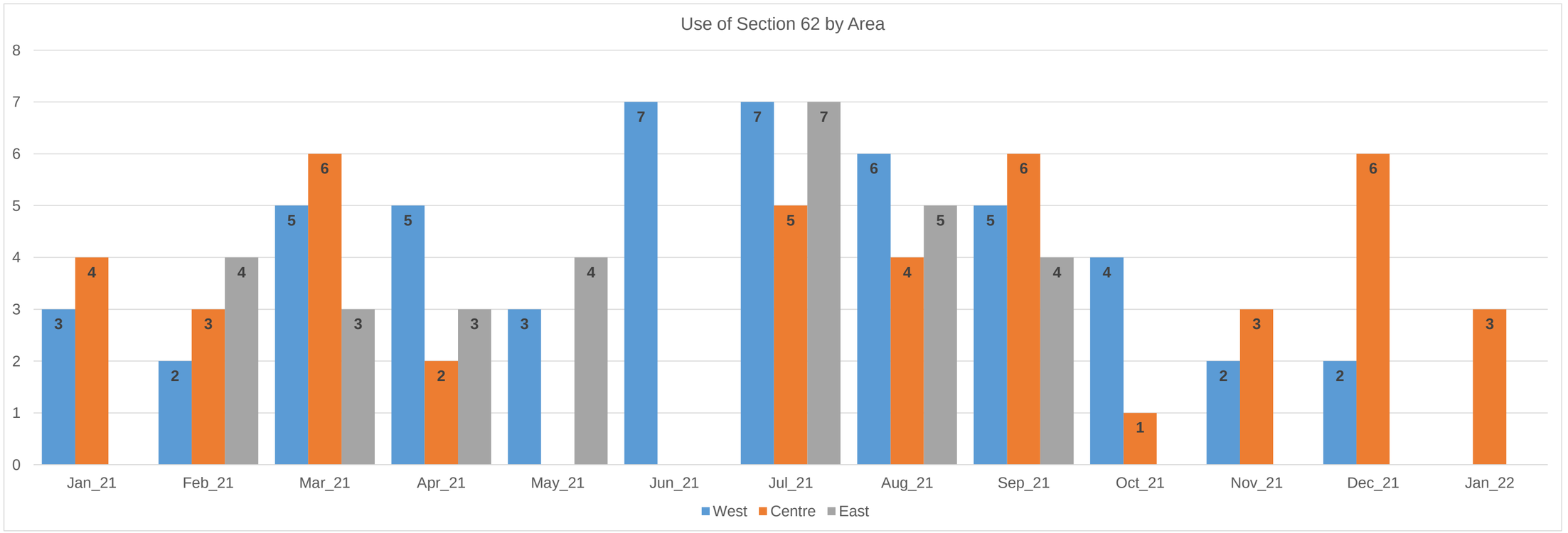
The table details IN - where the patient has come from and their local area and OUT where the patient has gone to.

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 73 detained patients within independent hospitals this is a decrease on the last figures reported. 30 of these are outside of Wales ie out of area placements, this is the same as the previous figures reported.

Month	Transfers In
Nov_21	Cygnet Alders, Glouster (Denbighshire)
Nov_21	CoCH (Flintshire)
Nov_21	John Radcliffe Hospital (Wrexham)
Jan_22	Delfryn Lodge (Denbighshire)
Jan_22	Priory Bristol (Flintshire)
Jan_22	Cygnet Hospital (Gwynedd)
Jan_22	Delfryn Lodge (Gwynedd)
Jan_22	Ty Grosvenor (Gwynedd)

Month	Transfers Out
Nov_21	Transferred out to The Priory Bristol (Ynys Mon)
Nov_21	Harplands Hospital, Stoke on Trent (Repatriated)
Nov_21	Coventry (Denbighshire)
Dec_21	Lakeside, Bedfordshire (Flintshire)
Dec_21	Joyce Park Hospital, Coventry (Ynys Mon)
Jan_22	Priory Bristol (Flintshire)
Jan_22	Joyce Parker Hospital, Coventry (Denbighshire)
Jan_22	Cygnet Hospital, Sevenoaks (Repatriated)

Advisory Report - Section 62



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

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

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APPENDIX 2

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

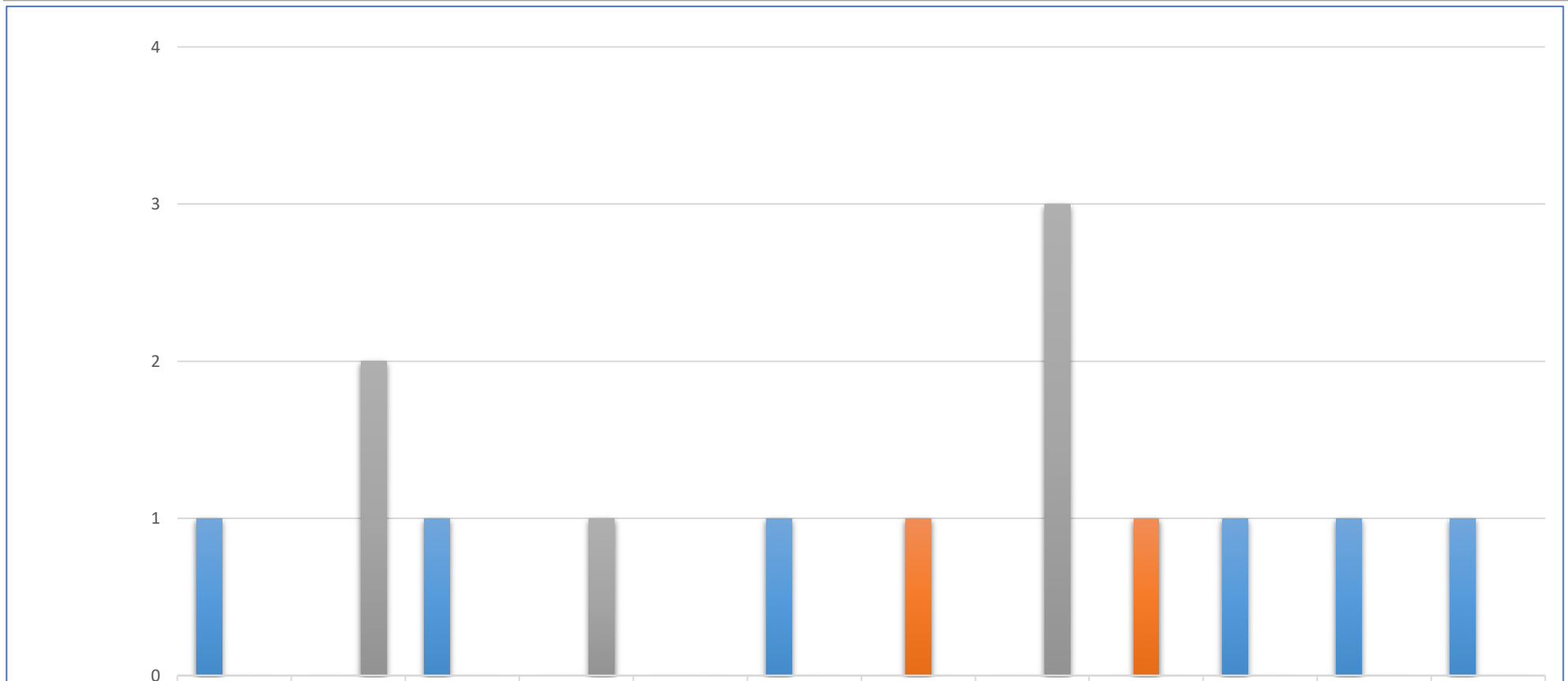
S.136/135 use in BCUHB

KPI Report for: March 2022

Data Source:	BCUHB MHA Database
Report Created on:	07/04/2022
Report Created by:	Performance Directorate

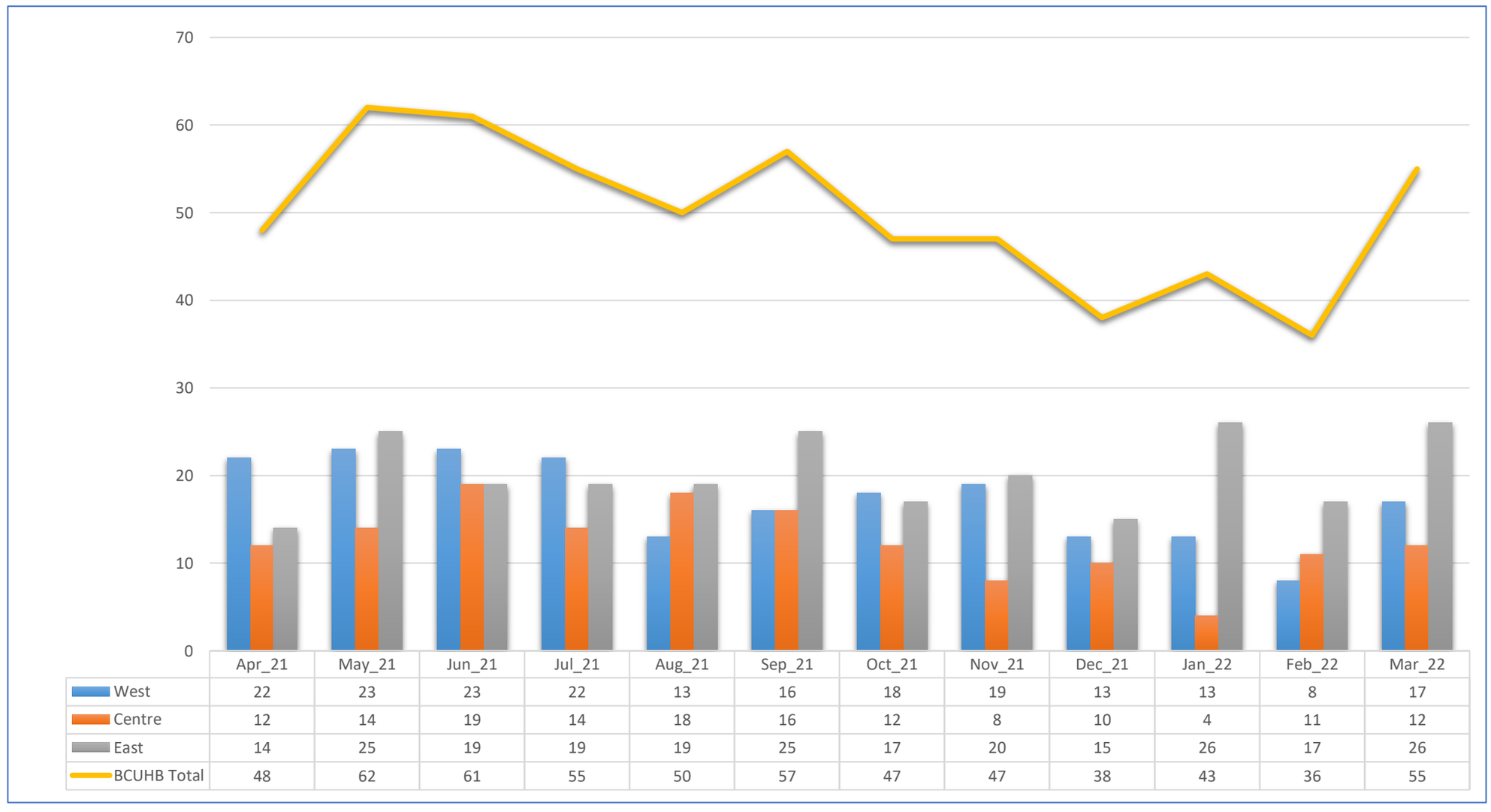
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Mar_22



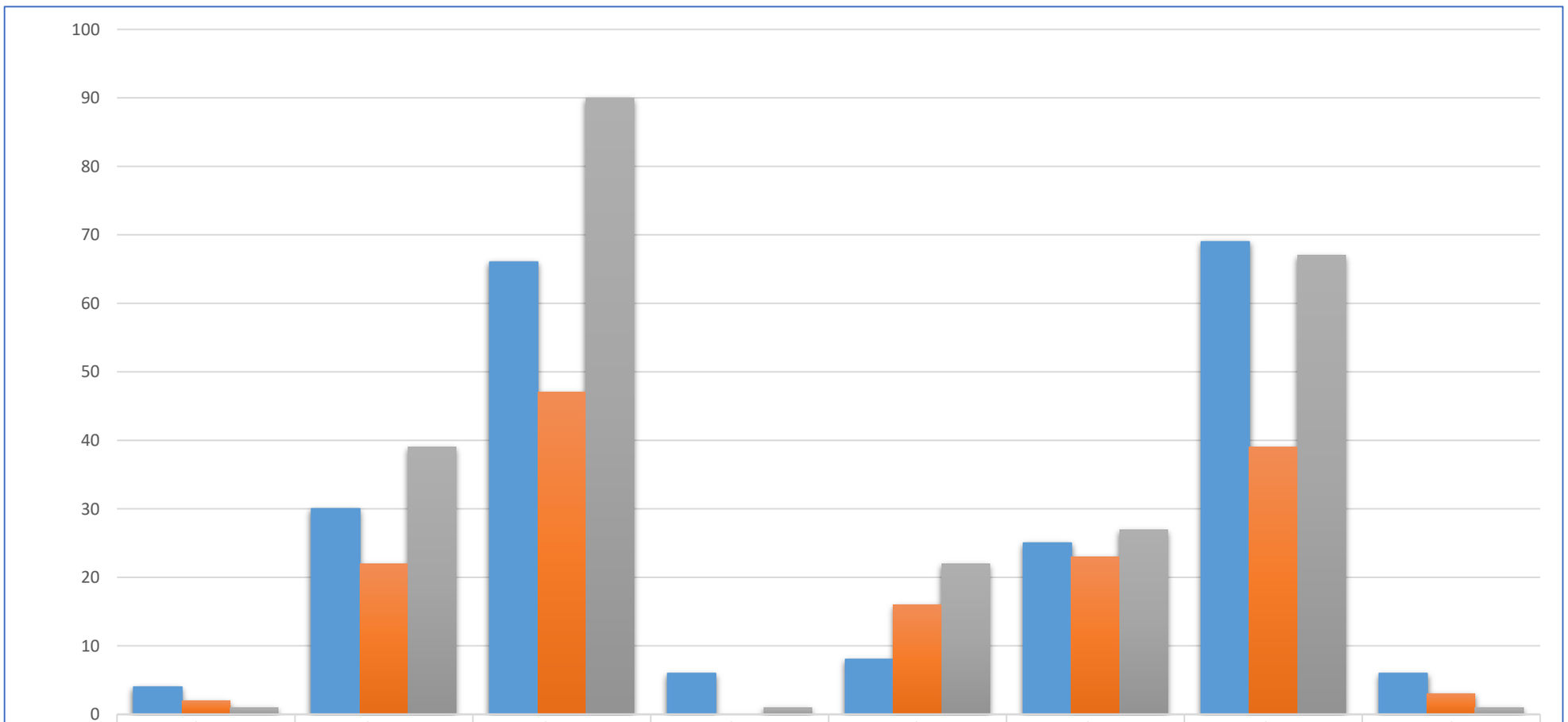
	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	1	0	1	0	0	1	0	0	0	1	1	1
Centre	0	0	0	0	0	0	1	0	1	0	0	0
East	0	2	0	1	0	0	0	3	0	0	0	0

2.1: Section 136 twelve month trend up to and including Mar_22



	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	22	23	23	22	13	16	18	19	13	13	8	17
Centre	12	14	19	14	18	16	12	8	10	4	11	12
East	14	25	19	19	19	25	17	20	15	26	17	26
BCUHB Total	48	62	61	55	50	57	47	47	38	43	36	55

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	4	30	66	6	8	25	69	6
Centre	2	22	47	0	16	23	39	3
East	1	39	90	1	22	27	67	1

4: 1st Place of Safety 12 month trend up to and including Mar_22

Area Split - 1st Place of Safety by category

	Mar_22			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	5	7	6	55	36	63
Ward	0	0	0	0	0	0
PICU	0	0	0	0	0	0
136 Suite	12	5	20	150	113	177
Hospital	0	0	0	1	0	0
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	1	0	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	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	5	9	5	6	1	7	4	4	2	4	3	5
Centre	1	3	4	1	5	6	4	0	2	1	2	7
East	3	6	5	2	6	9	2	7	6	7	4	6

1st Place of Safety: 136 Suite Split	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	16	13	18	16	13	8	14	15	11	9	5	12
Centre	11	10	15	13	13	10	8	8	8	3	9	5
East	11	19	14	17	13	17	14	12	9	18	13	20

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

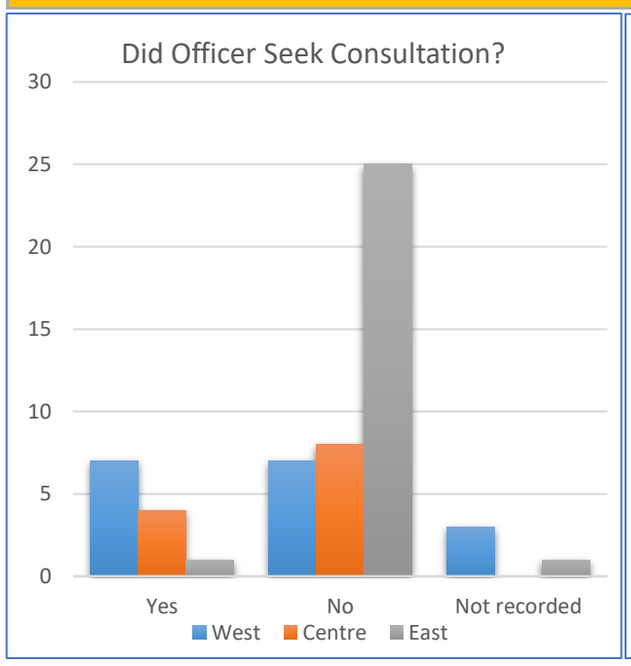
5.1: Area split 3 month table up to and including Mar_22 and latest 12 month total

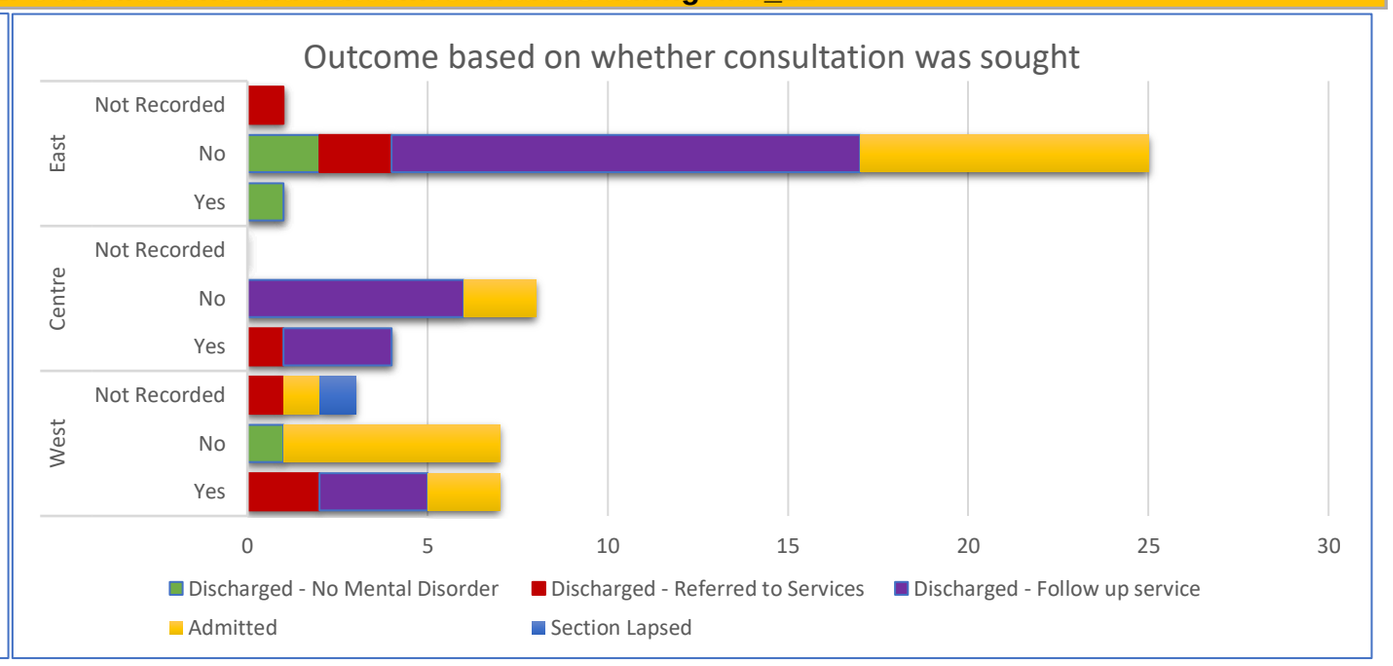
West	Jan_22	Feb_22	Mar_22	**12 Month Total**	**Centre**	Jan_22	Feb_22	Mar_22	**12 Month Total**	**East**	Jan_22	Feb_22	Mar_22	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	2	0	5	**48**	Ynys Mon	0	0	1	**8**	Ynys Mon	1	0	0	**6**	Ynys Mon	**8.84**
Gwynedd	8	2	6	**86**	Gwynedd	2	2	0	**18**	Gwynedd	1	0	2	**16**	Gwynedd	**9.70**
Flintshire	0	1	1	**7**	Flintshire	0	2	1	**16**	Flintshire	8	7	9	**78**	Flintshire	**6.52**
Wrexham	2	0	1	**7**	Wrexham	0	2	0	**17**	Wrexham	8	6	13	**101**	Wrexham	**8.98**
Conwy	0	5	1	**37**	Conwy	0	3	3	**25**	Conwy	4	2	0	**15**	Conwy	**6.59**
Denbighshire	1	0	3	**14**	Denbighshire	2	2	7	**62**	Denbighshire	3	2	3	**22**	Denbighshire	**10.26**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	0	**0**	OOA	0	0	0	**1**	OOA	0	0	0	**2**	OOA	**#N/A**
Incident Rate per 10,000 population	0.67	0.41	0.88	**10.27**	Incident Rate per 10,000 population	0.19	0.52	0.56	**6.92**	Incident Rate per 10,000 population	0.85	0.58	0.92	**8.16**	BCUHB	**8.37**

***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

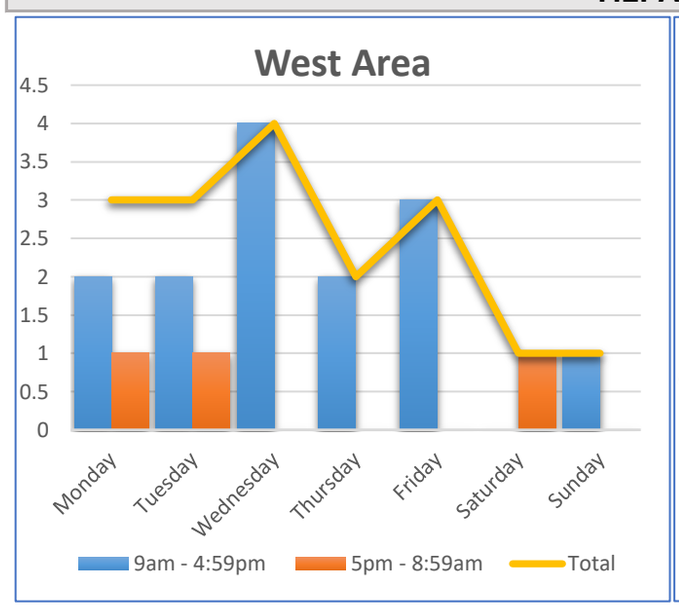
Section B: 12 Month Data for Mar_22

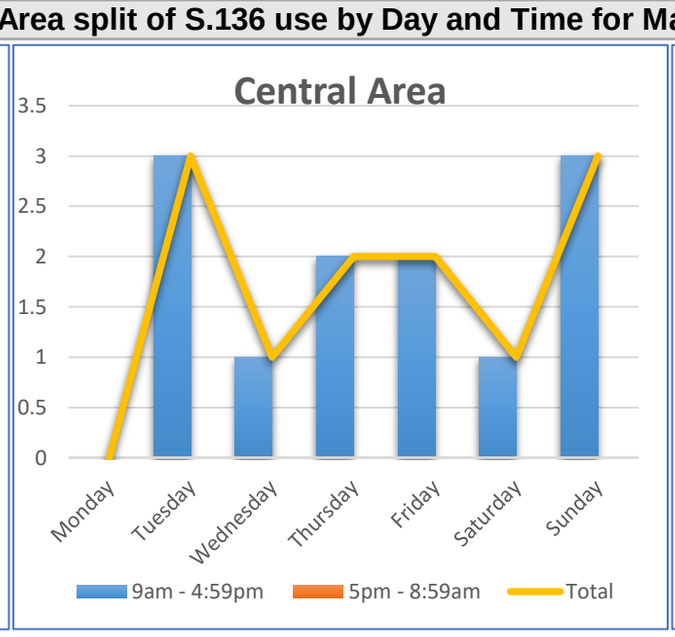
6.1: Consultations and Outcomes all areas during Mar_22

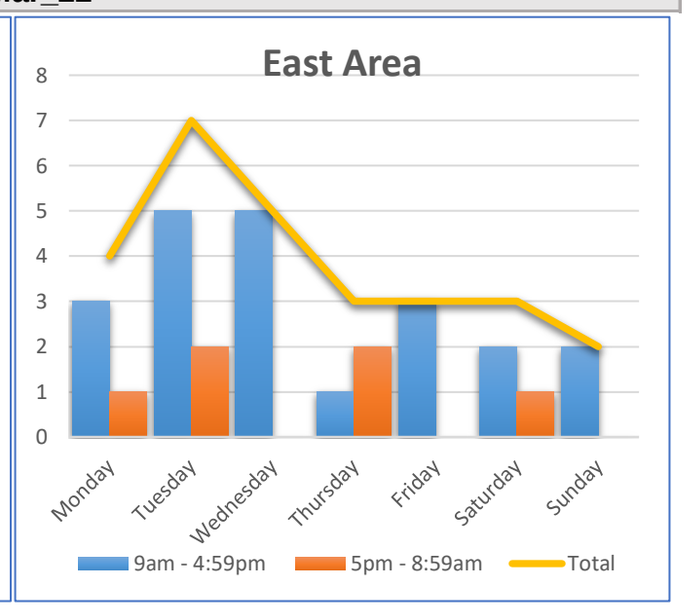




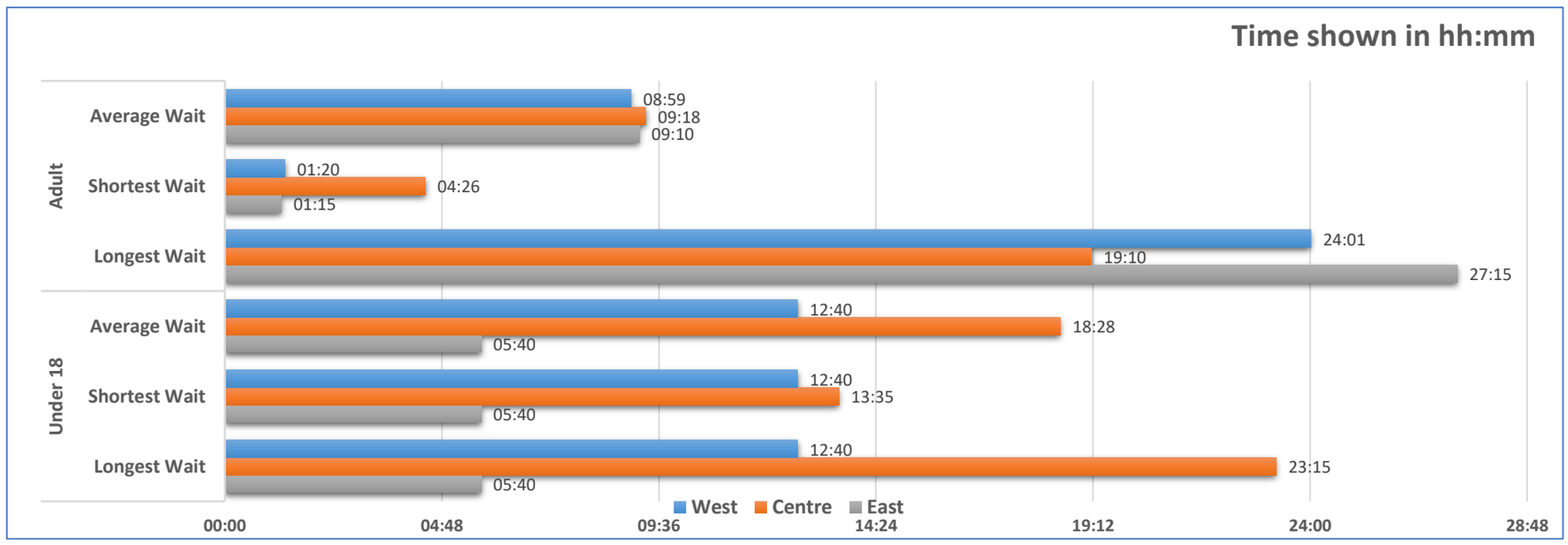
7.1: Area split of S.136 use by Day and Time for Mar_22



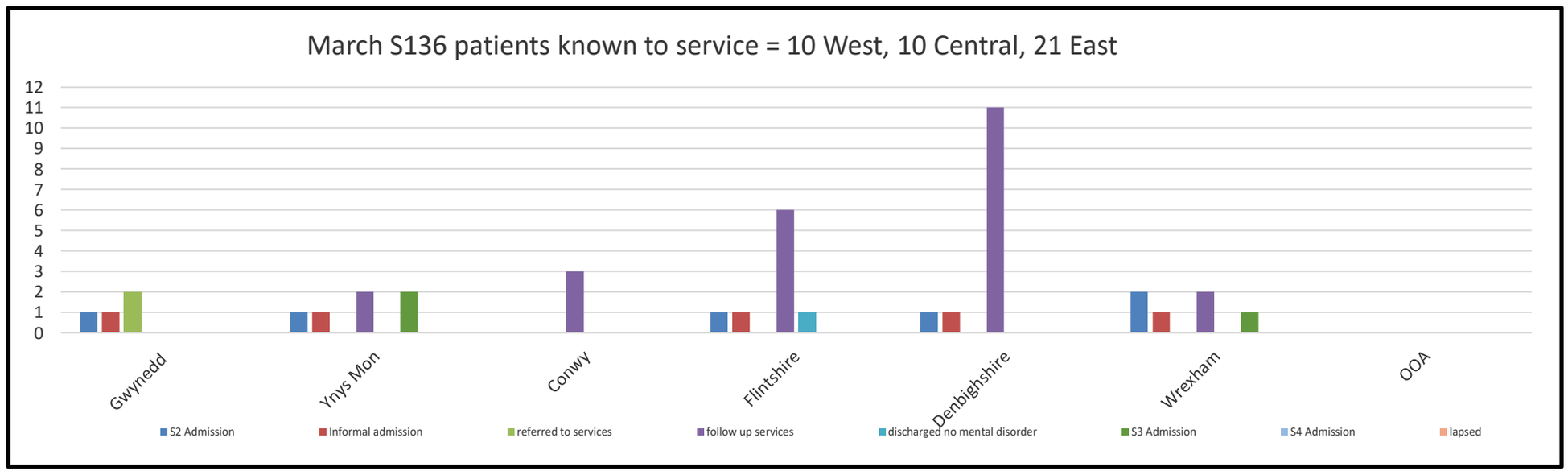




8.1: Duration in S.136 Suite for Mar_22



One S136 lapsed in March 2022 due to the person being unfit for assessment, a 12 hour extension would still not enable the person to be assessed in time.
One S135 was undertaken resulting in an admission under S3
39 assessments were noted to be delayed, 16 due to the detainee not being fit for assessment, 21 had no reason noted, one due to AMHP availability, and one due to doctors avaiabliity (CAMHS).



The table below shows the area that someone originates from, where they were detained and which S136 suite they were taken to. Out of the 55 S136 detentions 12 people were not seen within the closest S136 suite.

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

Local Authority Originates from	Detained in	S136 Suite assessed at
Wrexham	Wrexham	Hergest
Conwy	Denbighshire	Hergest
Flintshire	Flintshire	Hergest
Denbighshire x 2	Denbighshire x 2	Hergest
Flintshire	Flintshire	Ablett
Ynys Mon	Ynys Mon	Ablett
Gwynedd	Gwynedd	Heddfan
Denbighshire x 3	Denbighshire x 3	Heddfan
Denbighshire	Gwynedd	Heddfan

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

There was one consultation with the service which lead to a S136 detention.

There were 42 instances where the police did not consult.
These resulted in the outcomes as below:

S2 admission x 8
S3 admission x 2
Informal admissions x 6
Discharged no mental disorder x 3 (total for the month = 4)
Discharged referred to services x 3
Discharged with follow up x 19
Lapsed detention x 1 (not fit for assessment)

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Appendix 3

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

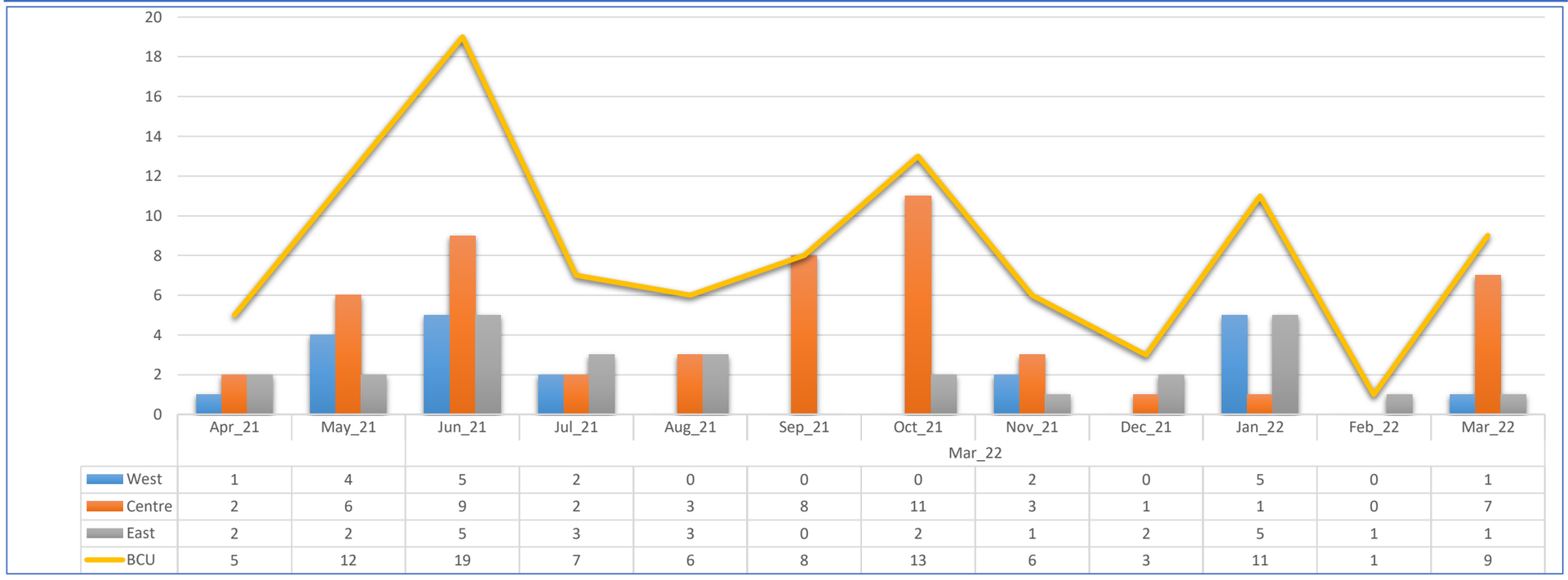
Under 18's detentions in North Wales

KPI Report for: March 2022

Data Source:	BCUHB MHA Database
Report Created on:	05/04/2022
Report Created by:	Performance Directorate

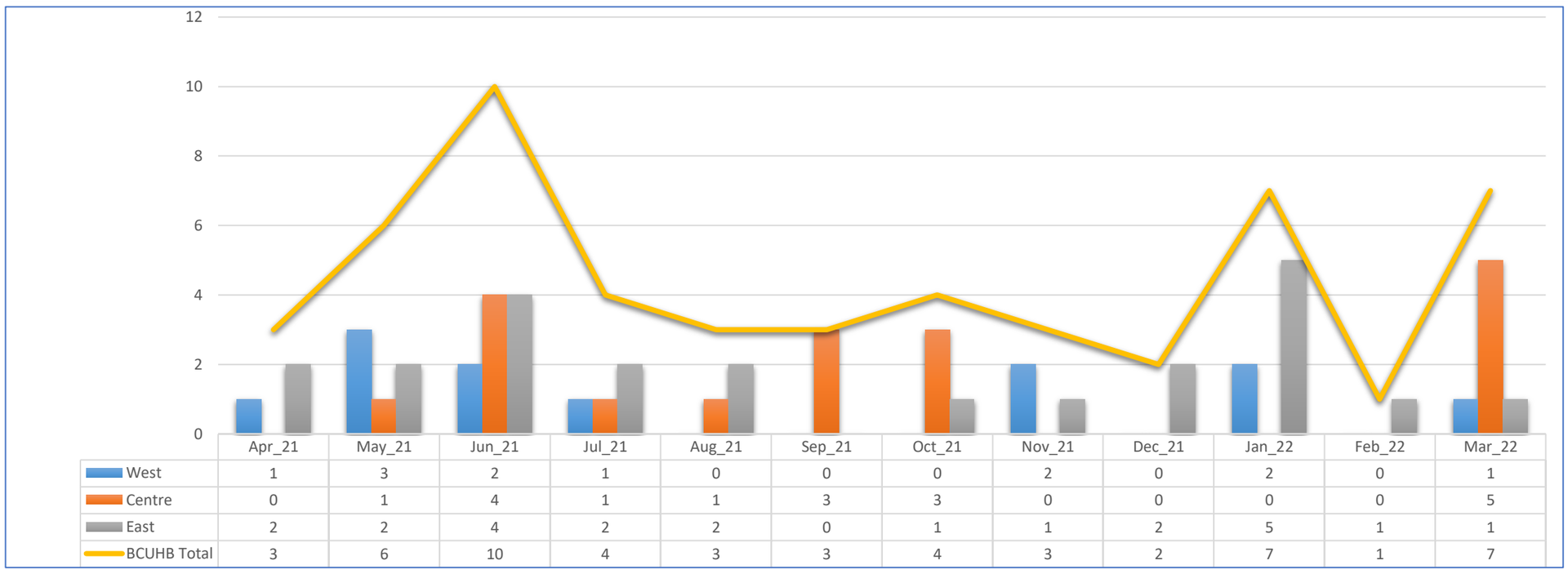
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Mar_22



	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	1	4	5	2	0	0	0	2	0	5	0	1
Centre	2	6	9	2	3	8	11	3	1	1	0	7
East	2	2	5	3	3	0	2	1	2	5	1	1
BCU	5	12	19	7	6	8	13	6	3	11	1	9

2.1: Section 136 twelve month trend up to and including Mar_22

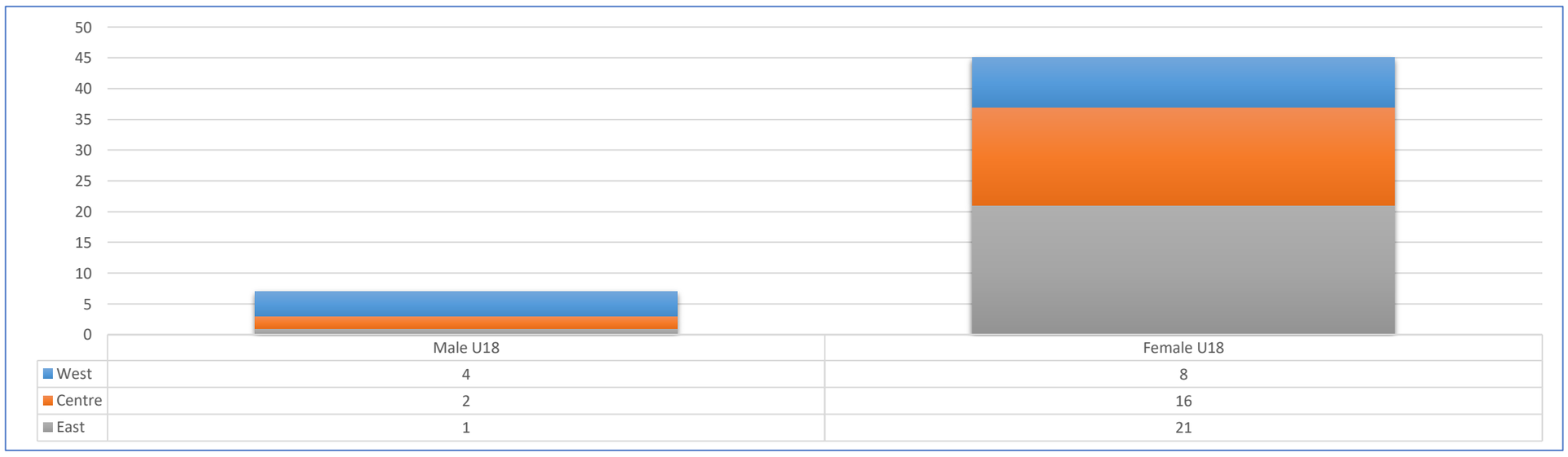


	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	1	3	2	1	0	0	0	2	0	2	0	1
Centre	0	1	4	1	1	3	3	0	0	0	0	5
East	2	2	4	2	2	0	1	1	2	5	1	1
BCUHB Total	3	6	10	4	3	3	4	3	2	7	1	7

2.2: Section 136 Outcomes twelve month trend up to and including Mar_22

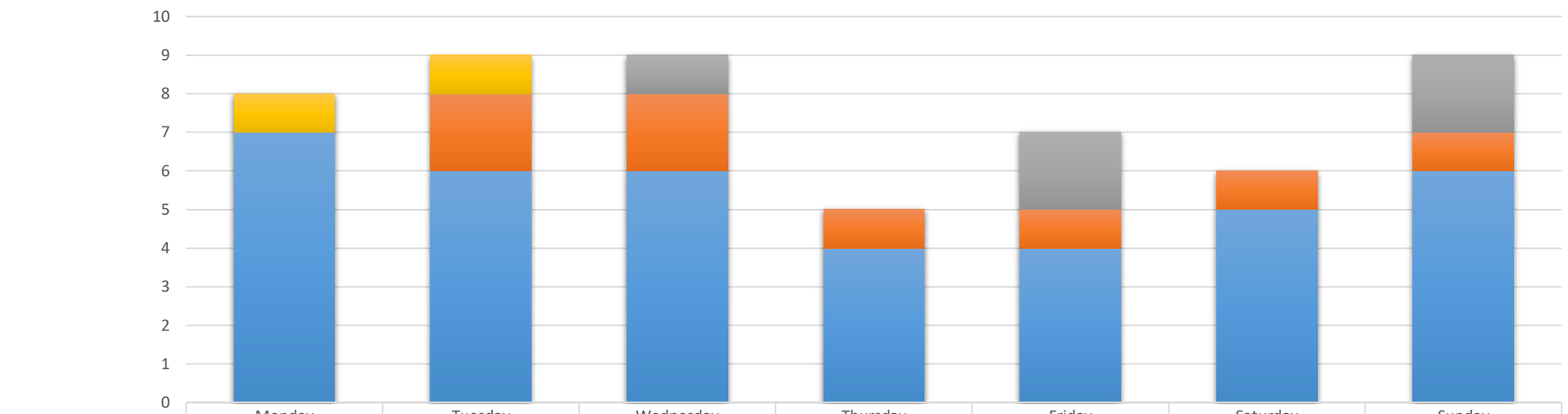
Outcome of 136 detention	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
Discharged - No Mental Disorder	0	0	1	1	0	0	0	0	0	1	1	0
Discharged - Referred to Services	1	0	1	2	0	0	1	0	1	0	0	0
Discharged - Follow up service	1	4	4	1	1	2	2	3	1	5	0	6
Admitted	1	2	4	0	2	1	1	0	0	1	0	1
Section Lapsed	0	0	0	0	0	0	0	0	0	0	0	0

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



	Male U18	Female U18
West	4	8
Centre	2	16
East	1	21

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



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Male 5pm - 8:59am	1	1	0	0	0	0	0
Male 9am - 4:59pm	0	0	1	0	2	0	2
Female 5pm - 8:59am	0	2	2	1	1	1	1
Female 9am - 4:59pm	7	6	6	4	4	5	6

4: 1st Place of Safety 12 month trend up to and including Mar_22

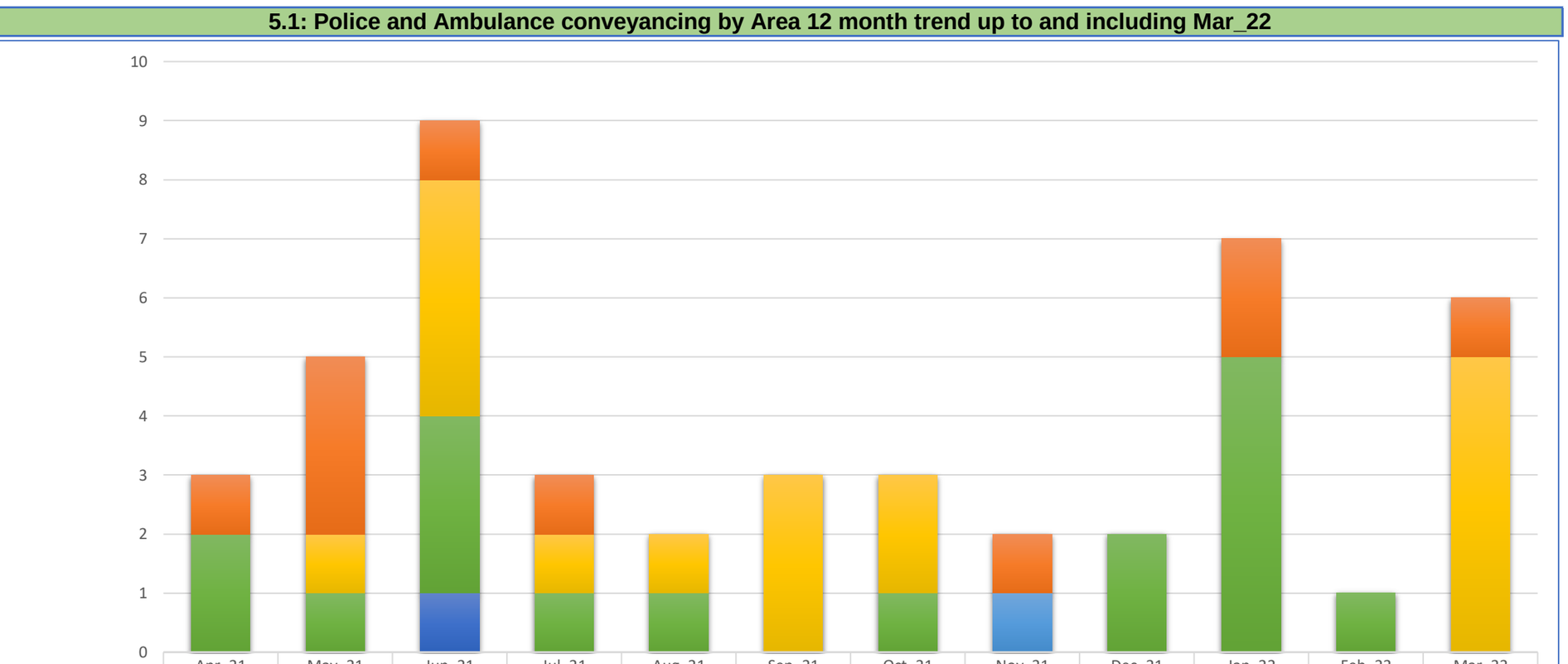
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
A&E	1	2	2	1	2	2	3	2	1	4	0	5
Ward	0	0	0	0	0	0	0	0	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	2	4	8	3	1	1	1	1	1	3	1	2
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	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West	1	2	0	0	0	0	0	2	0	1	0	1
Centre	0	0	0	0	1	2	2	0	0	0	0	3
East	0	0	2	1	1	0	1	0	1	3	0	1

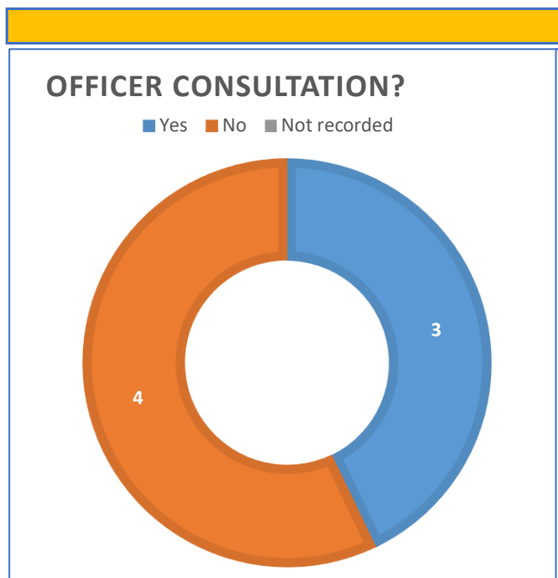
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Mar_22

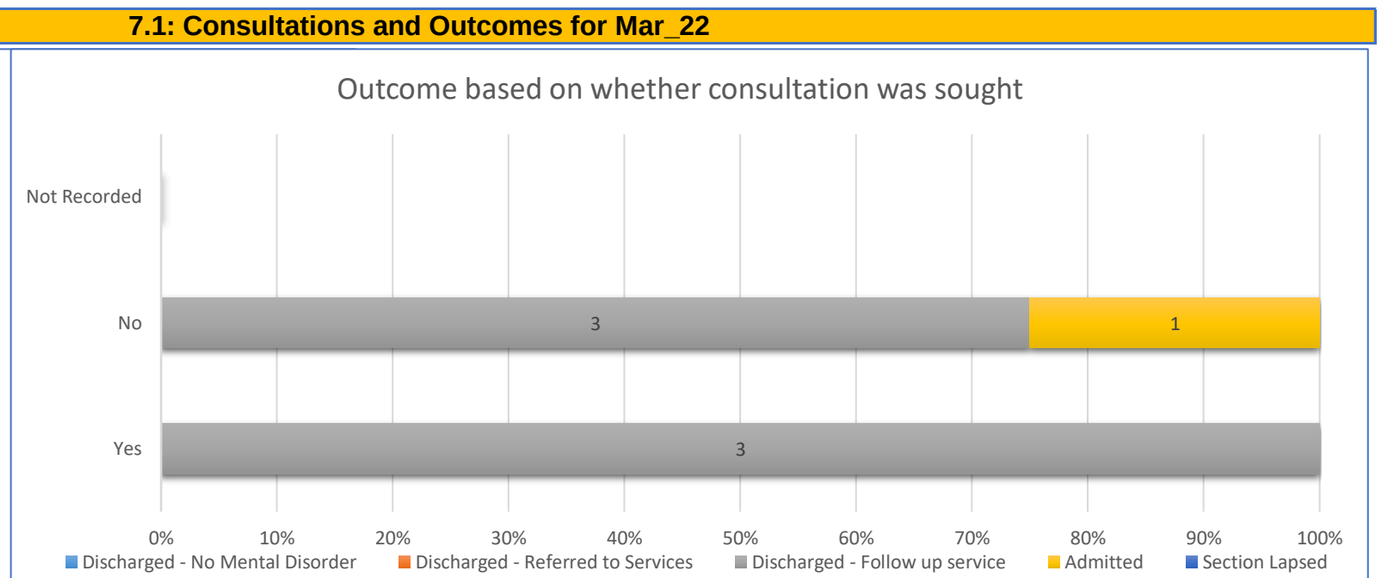


	Apr_21	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22
West Police	1	3	1	1	0	0	0	1	0	2	0	1
Centre Police	0	1	4	1	1	3	2	0	0	0	0	5
East Police	2	1	3	1	1	0	1	0	2	5	1	0
West Ambulance	0	0	0	0	0	0	0	1	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	1	0	0	0	0	0	0	0	0	0

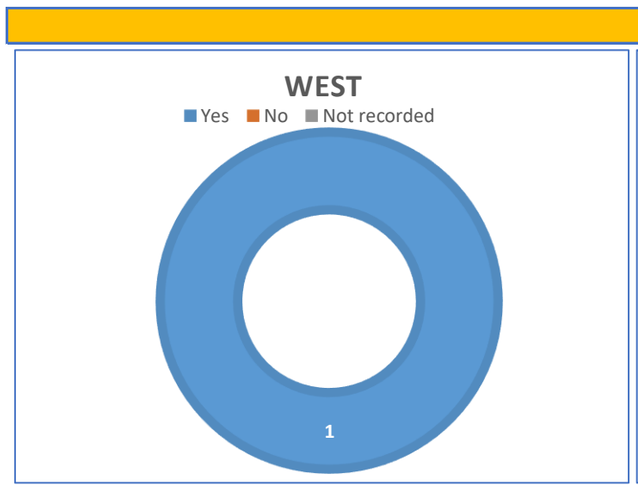
Section B: Data for Mar_22

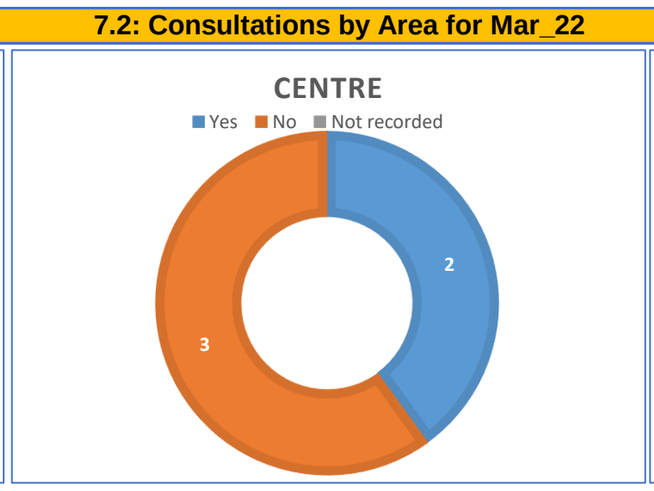
7.1: Consultations and Outcomes for Mar_22

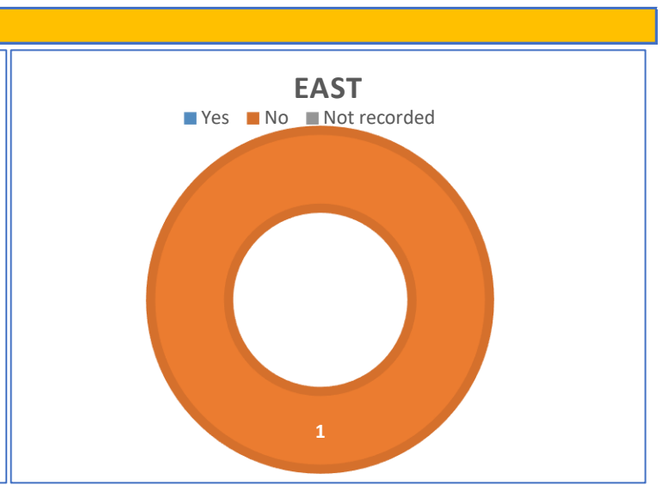




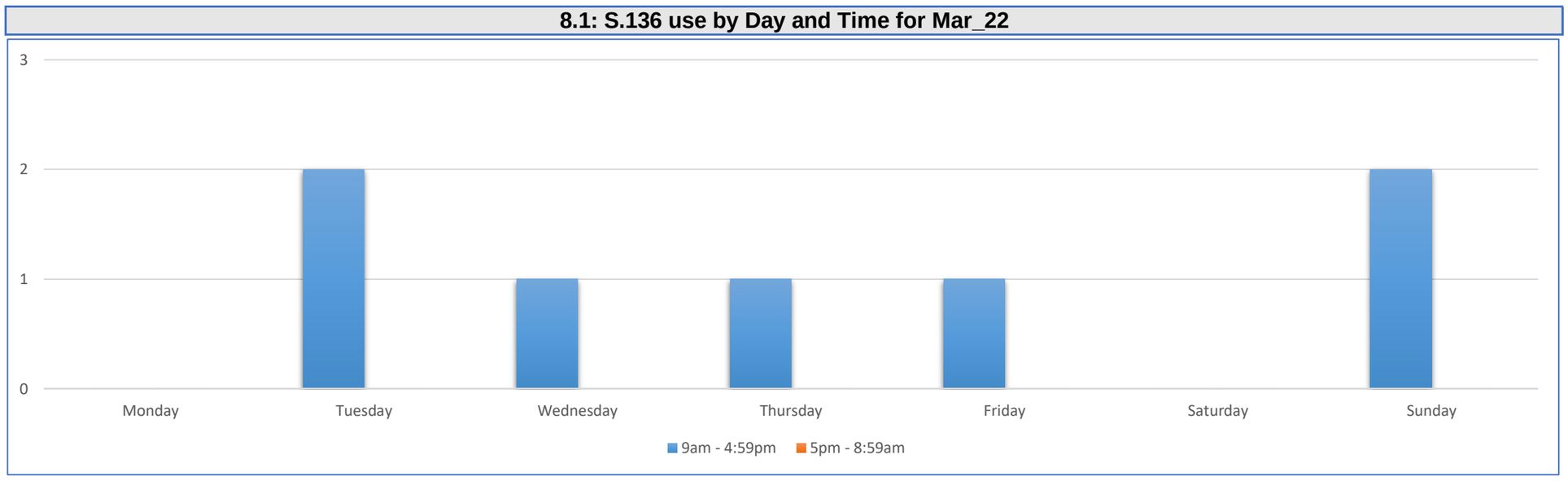
7.2: Consultations by Area for Mar_22



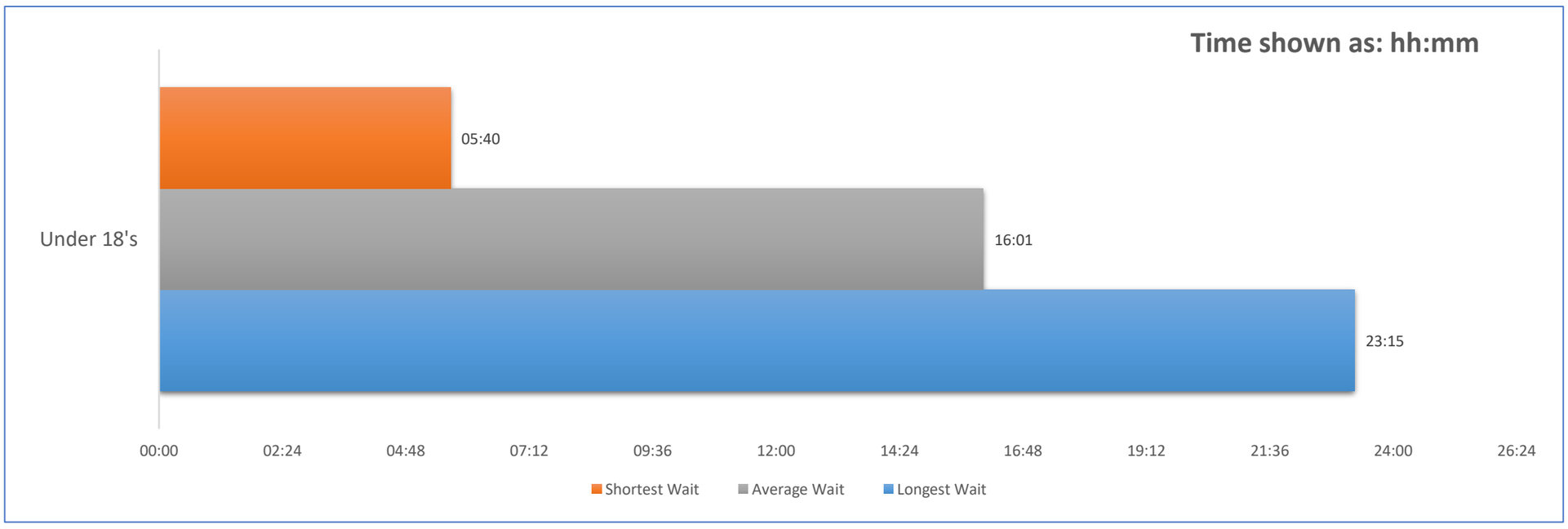




8.1: S.136 use by Day and Time for Mar_22

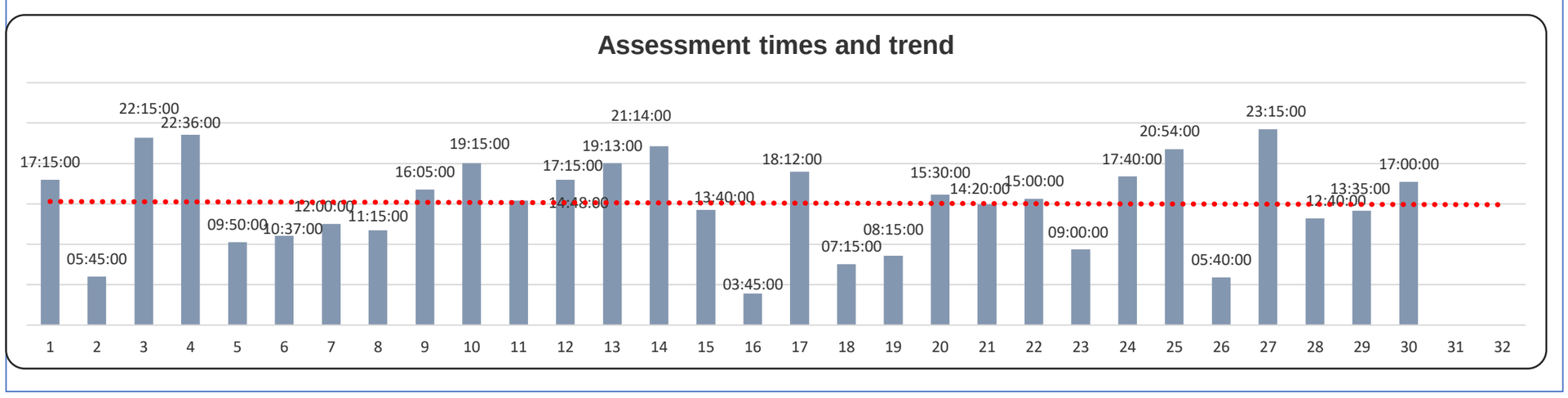


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Mar_22



10.1: Narrative for Mar_22

There were 9 detentions recorded this month, one young person accounted for three detentions due to transfers and section changes. Seven detentions were under S136.
The chart below details the length of time that young people have been detained under a S136 and a trend line for the last 30 detentions. All assessments were conducted by a CAMHS Consultant.



The below information details the detentions in March
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
24 - 17:40	21:40	21:50	OOH
25 - 20:54	14:45	14:45	Within
26- 05:40	07:00	07:00	OOH
27 - 23:15	15:42	17:30	OOH
28 - 12:40	01:36	02:30	OOH
29 - 13:35	00:05	00:05	OOH
30 - 17:00	21:44	22:00	OOH

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Healthcare Inspectorate Wales (HIW) Monitory Report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director Of Quality Assurance, Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 – Inspections Appendix 2 – Tan Y Coed, Bryn Y Neuadd Hospital unannounced visit report. Appendix 3 – Ysbyty Gwynedd, Hergest Unit Unannounced visit report.

Argymhelliad / Recommendation:

The Committee is asked to note the report.

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

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

Sefyllfa / Situation:

The paper (Appendix 1) provides an update in relation to the inspections conducted by Healthcare Inspectorate Wales (HIW) covering a period of 12 months. New and updated inspections are included.

The HIW Learning Disability Inspection (Unannounced) report for Tan Y Coed, Bryn Y Neuadd Hospital published on the 21 January 2022 is included in this report as Appendix 2. The HIW NHS Mental Health Service Inspection (Unannounced) Ysbyty Gwynedd, Hergest Unit report published on the 23 December 2021 is included as Appendix 3.

Cefndir / Background:

HIW is the independent inspectorate and regulator of all health care in Wales.

HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board, considering how the services are meeting the Health and care Standards 2015.

HIW note within their reports their purpose is '*to check that people in Wales receive good quality healthcare*'. Their values include placing patients at the heart of what they do and they are:

- Independent, Objective, Caring, Collaborate and Authoritative.

Through the inspections and their work they aim to provide assurance, promote improvement and influence policy and standards.

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.

Asesiad / Assessment & Analysis

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

Options Considered
Not applicable for this report.

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

Risk Analysis
Outstanding HIW Actions are reviewed within the MHLD division area Quality Safety and Experience (QSE) meetings on a monthly basis.
Policies –Policies regularly require updating and change as statute and documents change.

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

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

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

Appendix 1

Inspections within the last 12 months

New inspections, 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 which link in with the Mental Health Act are in relation to 3.1 Safe and Clinically Effective Care.

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.	Ward Manager. Matron. Head of Nursing.	February 2022 Monthly December 2021
The Health Board must ensure that care and treatment plans have been made accessible and	Care Coordinators will ensure that patients or their representatives are part of the development of	Head of Nursing	February 2022

communicated appropriately to patients (and relatives where applicable).	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.		
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.	Ward Manager. Matron. Head of Nursing LD.	February 2022

2 Unannounced Visit: Hergest Unit UPDATE

Inspection Date: 6 – 8 September 2021 and 20 – 22 September 2021

Publication Date: 23 December 2021

HIW conducted two visits to Hergest focussing on: Management of Coronavirus, staffing levels, staff welfare, infection prevention and control, patient care plans, environment of care and governance and staffing.

There were no immediate concerns noted within the improvement plan.

There was reference to the Mental Health Act under S136 and staffing of the 136 suite within the report noting the closure of suites is detrimental to a person's wellbeing if they need transporting to a different area for assessment. An improvement was noted to be required in the organisation and completion of care plans.

The below actions which link in with the Mental Health Act are in relation to 3.5 Record keeping, 5.1 Timely access and 6.2 Peoples rights.

It has been confirmed that a staff briefing was sent to incorporate all the record keeping improvements which was also shared in the putting things right bulletin. An audit tool has also been completed which incorporates all improvements.

Improvement needed	Service Action	Responsible Officer	Timescale
• The Health Board must ensure that the Section 136 suite remains open and there are sufficient staff available to cover admissions.	To ensure effective E-roster planning, aligned to KPIs. To ensure efficient planning to known absences through allocation of duties locally, bank, overtime or agency where required. To continue with a daily review of staffing through the Acute Care Meetings and Safety huddles to support resolution of any staffing issues locally. To ensure any outstanding staffing issues are escalated into the Divisional huddle for resolution/mitigation. For out of hours, escalation to MH&LD Divisional Bronze/Silver on call for resolution/mitigation.	Head of Operations / Head of Nursing	Completed and reviewed daily.
The Health Board must ensure that a pathway is developed in the health board for older adult care.	OPMH Pathway: Divisional meetings have commenced with clear terms of reference. Second meeting held 26/10/2021. Options appraisal to be completed based on the qualitative baseline data for the areas. Project plan to be developed and progressed via monthly OPMH meetings. OPMH service model development to be identified and progressed through the Clinical Strategy Group.	OPMH Pathway Lead. OPMH Pathway Lead. Head of Transformation. OPMH Pathway Lead.	Completed and monthly meetings held. Completed Completed data and evidence informed cohort plan. 30/06/2022
The Health Board must ensure that capacity assessments are completed and recorded in patient records.	Bulletin to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments. MH&LD Staff Briefing to include above correspondence.	Head of Operations Head of Operations	Completed Completed within PTR bulletin

	Further development of the patients notes audit checklist to ensure inclusion of all necessary standards, including capacity assessments	Head of Nursing	Completed
	Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	Completed
	Copies of the bulletin are displayed on ward notice boards and discussed at handovers.	Head of Operations	Completed
The health board must ensure that the unmet needs are evidenced and documented within patient care plans.	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of unmet needs.	Head of Operations.	Completed
	MH&LD Staff Briefing to include above correspondence.	Head of Operations	Completed
	Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	Completed
	Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	Completed
	Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Clinical Site Manager	Completed
The Health Board must ensure that review dates are recorded in care plans.	Correspondence to be sent to staff reaffirming Good Record keeping guidance, to include highlighting the importance of accurate completion of care plans.	Head of Nursing	Completed
	MH&LD staff briefing to include above correspondence.		Completed
	Further development of patient notes audit checklist to ensure inclusion of all required standards.		Completed
	Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute		Completed

	Care Site Manager to ensure consistency of implementation. Copies of correspondence are displayed on ward notice boards and discussed at handovers.		 Completed
The Health Board must ensure that capacity assessments are completed.	Correspondence to be sent to staff reaffirming Good Record keeping guidance, to include highlighting the importance of accurate completion of capacity assessments. MH&LD staff briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	Completed Completed Completed Completed Completed
The Health Board must ensure that care coordinators are identified and named in patient records.	Correspondence to be sent to staff reaffirming Good Record keeping guidance, to include highlighting the importance of accurate completion of all professionals involved in patients' care. MH&LD staff briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	Completed Completed Completed Completed Completed

Learning Disability Inspection (Unannounced)

Tan y Coed, Bryn y Neuadd Hospital

Inspection date: 19-20 October 2021

Publication date: 21 January 2022

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

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Tan y Coed Residential Unit based in Bryn y Neuadd Hospital on the 19-20 October 2021. We attended the unit briefly on the evening of the 18 October to confirm the COVID-19 status of the unit and to observe how the service delivered patient care during evening hours.

Our team for the inspection comprised of two HIW Senior Inspectors and one Clinical Peer Reviewer. The inspection was led by a HIW Senior Inspector.

HIW explored how the service met the Health and Care Standards (2015) and other relevant guidelines.

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall we found evidence that the service provided a positive patient experience, with a good level of safe and effective care delivered to its patients.

We have recommended several areas for improvement which will strengthen existing practice at the unit in line with the Health and Care Standards.

We found evidence of a well-established management team, which was supported by a committed workforce and sound local governance arrangements.

This is what we found the service did well:

- We observed kind and respectful interactions between staff and patients at all times
- There were regular and effective service user group meetings, facilitated by therapeutic support services
- There was a suitable range of standardised assessment processes in place to support patient care

This is what we recommend the service could improve:

- Develop and implement a clear service model and ethos
- Aspects of care planning, including strengthening care and treatment plans
- Aspects of risk management, particularly in relation to the environment.

Refer to Appendix C for the full improvement plan.

3. What we found

Background of the service

Tan y Coed Residential Unit is based within the wider Bryn y Neuadd Hospital site and provides a rehabilitation service for people with learning disabilities. It can provide care for up to ten patients and is divided into four separate bungalows, however only three bungalows were in use at the time of our inspection due to maintenance issues.

At the time of our inspection, there were eight people staying at Tan y Coed, including one patient who was on authorised leave. This included people who had been at Tan y Coed for short and longer periods of time.

The staff team includes a unit nurse manager, deputy managers, registered nurses and healthcare support workers. Student nurses are also encouraged to work on the unit as part of their training. The unit is supported by a range of medical and therapeutic teams, including psychiatry, psychology, speech and language therapy.

The service sits in the Mental Health and Learning Disability Directorate within Betsi Cadwaladr University Health Board.

Quality of patient experience

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

Overall we found that Tan y Coed was providing patients with a positive patient experience. We observed staff engaging with patients in a caring and respectful manner at all times.

Patients were able to provide their feedback through regular service user group meetings, with evidence of actions taken based on this feedback.

We identified a small number of improvements to further promote a quality patient experience.

We spoke to some patients and observed numerous interactions between staff and patients as part of forming a view on the quality of patient experience.

Staying healthy

We found good evidence of standardised physical health care bundles[1] in all patient care records that we reviewed. These had been reviewed at appropriate intervals, with the exception of one plan where we noted there was confusion in relation to the frequency of blood sugar monitoring.

GP services are contracted through a local GP practice who attend the wider Bryn y Neuadd site on a weekly basis. Ward staff were complimentary about the service provided by the practice.

[1] Care bundles are used across healthcare settings with the aim of cohesively preventing and managing different health conditions

We reviewed a sample of three health passports[2] and found that these were comprehensive and up-to-date. This ensures that other health professionals are able to quickly identify the care preferences and medical needs of patients in a timely and effective manner.

Staff told us that access to other health professionals is arranged when required. For example, we confirmed patients are able to access the community dental health team based at the Bryn y Neuadd site.

Improvement needed

The Health Board must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified.

Dignified care

We observed kind and respectful interactions between staff and patients at all times throughout the course of the inspection.

The environment benefited from a small number of patients residing in each bungalow, with space across the unit maximised for individuals to all have access to their own bedrooms and smaller, shared facilities.

All patients had their own bedrooms and we found that some rooms had been personalised to provide a more homely feel. However, we noted that other rooms lacked a sense of personalisation.

We found that patients were assisted with their personal hygiene needs when required and that staff were responsive in meeting these needs. For example, we observed one patient requesting a shave, who was then promptly helped by a member of staff.

[2] The hospital passport is designed to give hospital staff helpful information that isn't only about illness and health, but likes, dislikes and preferences.

Visiting had re-started following its pause during the pandemic. Patients were able to see relatives in a designated building a short distance from the unit. We were told that this had been welcomed by patients and their relatives.

Improvement needed

The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit.

Patient information

We did not see information relating to the Putting Things Right[3] scheme or to the health boards own feedback process on display. However, we confirmed that there were suitable provision for this patient group. Patients had access to advocacy services to support them in decisions relating to the care and treatment. We also confirmed that there was an effective service user group in operation, which met the needs of the patient group in a timely and consistent manner.

Communicating effectively

We observed staff engaging with patients at a suitable pace and communication style according to their needs. We also noted that a first language Welsh speaking patient was able to hold conversations in Welsh with a number of staff.

The patients that we spoke with told us about some of the activities that they like to participate in and we found that activity schedules had been tailored to meet these needs.

We found evidence that patients were encouraged to attend multi-disciplinary team (MDT) meetings and service user group meetings. Relatives were invited to attend where appropriate.

3

Individual care

Planning care to promote independence

Staff we spoke with had an in-depth knowledge of the patients, which demonstrated a commitment towards providing patients with individualised care.

We found that therapeutic support services (TSS) scheduled a range of on-site activities for patients on a weekly time-tabled basis. It was positive to note that patient wishes from the service user group directly fed into the activity offering supported by TSS and the unit.

We were told that there was no dedicated occupational therapy service (OT) available on the unit, instead the resource operated across the wider Bryn y Neuadd site on a referral basis. In one patient record that we reviewed, we noted that there was a lack of sensory assessment for the patient, which highlighted a potential gap in service provision. We also noted that a lack of provision of OT services was highlighted as part of the units recent ward accreditation.

We found that there were active discharge planning arrangements in place for patients who were ready for discharge. We confirmed that decisions in relation to discharge and future placements were discussed with the patients, and relatives where appropriate, as part of their MDT reviews.

We noted that one patient had expressed dissatisfaction with their intended placement. However we were informed that proactive steps had been taken by the unit to assess the on-going suitability of the placement. In this instance unit staff had visited the intended premises. Unit management assured us that the patient would remain at the centre of the decision making process to ensure their needs and wishes were acknowledged.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Improvement needed

The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met.

People's rights

We reviewed a sample of three patient records and found that all patients who were subject to Deprivation of Liberty Safeguards (DoLS)[4] had received timely assessments. All patients had access to advocacy services, although we were told that access to advocacy is used by some patients more than others.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members of advocates was encouraged where possible. One patient confirmed that they had been invited to their MDT meeting, but had declined on the most recent occasion.

Listening and learning from feedback

It was positive to find that therapeutic support services had resumed service user group meetings, which we were told had been paused during the pandemic. We found that the group enabled patients to voice their views and opinions on a range of topics, including how safe they feel, what they would like to see improved and views on the activities provided.

The meetings had been held regularly and contained clear outcomes for patients. There were minutes written after each meeting, which made use of symbol based communication to help patients to understand.

4

Delivery of safe and effective care

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

Overall we found that Tan y Coed was providing patients with a good level of safe an effective care. We observed direct care needs being met at all times by a staff team who had an in depth knowledge of individual patient preferences and needs.

However, we identified some areas for improvement in relation to care and treatment planning, and the need to implement an audit programme to monitor these.

Safe care

Managing risk and promoting health and safety

We found that the outside environment and interior of each of the bungalows was in generally good condition and met the needs of the patients.

However, we found that bungalow three was awaiting urgent remedial works. As a result, two patients had been temporarily located in bungalow two, which was co-located with the unit manager's office. We confirmed that remedial works were due to start imminently and that there were active plans in place to re-locate these two patients to a more suitable location on the unit.

The environmental risk assessment had been reviewed the month prior to the inspection, however, consideration had not been given to the risk of patients being able to access sharp items. We noted an inconsistent approach to securing these items that could potentially compromise the safety of staff and patients. Whilst we were told that this risk was mitigated by 1-1 observations, a consistent, risk assessed approach must be adopted towards the storage of these objects.

Storage of kitchen detergents must also be COSHH[5] risk assessed in all areas of the unit.

We checked up to date ligature risk assessments. Whilst these appeared to be comprehensive, we found some inconsistencies which must be reviewed. These include:

- Each assessment and action plan identified areas where a review is required of a ligature risk, and alternative arrangements are to be considered, but no dates of action were recorded

- Where reference to alternative arrangements is documented, it is not clear that any follow-up action has been taken, with the exception of maintaining observations.

We identified a fire extinguisher located in bungalow two that had not been serviced since February 2020. The need for annual servicing of fire extinguishers had not been identified as part of a recent fire risk assessment. We immediately raised this with management to ensure prompt action was taken.

We found that emergency resuscitation kit checks were undertaken using an electronic system and that these checks had been undertaken on a regular basis. We noted that the adrenalin within the resuscitation kit was expiring during the month of the inspection (October 2021). We brought this to the attention of management so that a replacement could be ordered in a timely manner.

Improvement needed

The Health Board must:

- Provide HIW with an updated schedule for the completion of the on-going remedial works at the unit.

- Review the environmental risk assessment to ensure that all risks have been identified and mitigated.

[5] Control of substances hazardous to human health

- Review the COSHH risk assessment to ensure that all risks have been identified and mitigated.
- Review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded.

Infection prevention and control

We found a range of infection, prevention and control policies, processes and procedures were in place to protect staff, patients and visitors. In addition there were a number of audits in place to monitor and review compliance with these policies.

Overall, we found the environment to be clean and tidy. There were some minor cleanliness issues that we brought to the attention of staff who immediately remedied these. We observed domestic services staff attending and cleaning the bungalows at the time of our inspection.

We reviewed a sample of cleaning records and schedules. We found evidence that staff were not completing the schedules in full, particularly on night shifts. In response, staff told us that there are occasions when cleaning is not undertaken to protect patients sleep. We emphasised the need to maintain complete and accurate cleaning schedules and the requirememt to note in full the reasons why cleaning was not rescheduled or undertaken.

It was positive to note that there had been no patient cases of COVID-19 on the unit throughout the pandemic. We found that staff and patients had received the COVID-19 vaccination. We saw that there was access to appropriate personal protective equipment (PPE) in all bungalows and staff were observed wearing this correctly at all times.

We found that there was a dedicated visiting space, which had its own visiting policy and risk assessment. This ensures patients can receive visitors in a safe environment.

We reviewed a sample of IPC related audits, including hand hygiene, and found high levels of compliance. These were supported by regular ward manager and matron audits.

Improvement needed

The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.

Nutrition and hydration

We found that patients had access to a small range of daily meal options, which catered for different dietary requirements and preferences. We saw examples of preferences being taken into account through the service user group meetings.

We observed that patients were supported in a flexible manner at meal times. This helped to meet the nutritional needs of patients, as they were able to eat in an unhurried and individualised manner.

We were informed that the family of one patient regularly provided meals that embraced the family's culture. To support this, arrangments had been made to allow the family and patient to enjoy the meals together on the Bryn y Neuadd site.

We reviewed a sample of three patient records and found that nutritional needs had been assessed, with evidence of a recent review and monitoring of weight, bowel movement and body mass index.

We confirmed that access to speech and language therapy (SALT) services was available and we saw evidence in the sample of records that we reviewed that relevant assessments had been completed.

We noted that staff provided snacks to patients in between meal times and that patients could access the on-site canteen with staff members.

Medicines management

We reviewed three medication charts and found that these were completed appropriately, including notes and reasons where medications had been refused.

We found that there was an appropriate electronic medicines management system in place at the unit. We confirmed that nursing staff had responsibility for checking and ordering medication on a weekly basis and there was evidence of staff checking stock as it arrived at the unit.

Stock control of clonazepam, which is a controlled drug, required improvement. We identified it was not always checked and counter signed in line with controlled

drugs procedures. We also noted incomplete stock control records for the same drug.

We saw evidence that patients had individualised medications management plans and medication reviews in place. However, there was no indication that these plans had been discussed with patients to help them understand what medicines they take and their effects.

In the sample of patient records that we reviewed, we found that there were low uses of PRN medication[6] on the unit and we found no evidence of an overuse or reliance on this as required sedation.

We found evidence of an appropriate pain assessment tool being used on the unit, which assists in the management of pain for patients who may be unable clearly articulate their needs.

Improvement needed

The Health Board must ensure that:

- Standards for stock control controlled drugs are maintained in accordance with its own medications management policy
- Appropriate communication with patients regarding their medication plan is undertaken and suitably documented.

Safeguarding children and adults at risk

The staff we spoke with were aware of how to access the local safeguarding procedure. All staff told us that they felt supported by management and confirmed they would feel comfortable to raise any concerns they had.

We saw training records that showed that the vast majority of staff had completed adult safeguarding training.

There we no open safeguarding cases at the time of the inspection.

[6] Medication that is administered when required by the patient, rather than at scheduled times.

Effective care

Safe and clinically effective care

We found that all patients had care and treatment plans in place, which were coherent and had been subject to MDT review. However, care planning could be strengthened by placing emphasis on the voice of the patient (and relatives where appropriate) and ensuring a person-centred approach towards goals and objectives. We noted:

- Care plan goals and objectives did not always contain a strength and independence focus, but instead were problem orientated
- In one record, the clinical review contained a review of incidents. However, the community and engagement section had been copied and pasted from a previous version. Therefore, the same goal was in place for a three month period
- In another record, there was a breadth of positive understanding and clinical formulation that gave a real sense of understanding of this patient, yet this was not translated into their care plan goals and objectives
- Staff expressed a clear understanding of patient wishes. However, there were missed opportunities to translate these into care plan goal and objectives.

The unit told us that aspects of care planning were identified as an area to strengthen in their recent ward accreditation and that they are keen to strengthen this within the staffing team.

We advised the health board to look at learning from previous audits (e.g. Welsh Government Delivery Unit All-Wales Care and Treatment Plan audit) undertaken on the site to aid and facilitate learning where applicable.

We further reviewed a sample of patient records and made the following observations regarding the documentation of evidence in relation to the management of patients care and treatment needs:

- In one record, there was no documented evidence that a sepsis screen had been undertaken, despite a high NEWS[7] score

- There was a strong urine odour in one of the bungalows on the evening of our arrival. We later found that a patient had recently became incontinent, as a result of a hernia. However, there was a lack of documented evidence on file to indicate how this had been investigated and diagnosed

- One incident involved a patient viewing sensitive material. Whilst we saw that an outcome had been documented, we considered there to be a lack of documented investigation or evidence of appropriate support or intervention following this incident.

Improvement needed

The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to:

- Ensuring that plans and objectives are goal and person centred

- Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times

Safe and clinically effective care – Behaviours that challenge

Upon our arrival at the unit and throughout the course of the inspection, the environment was calm and settled. We saw no evidence to indicate patients were distressed or overly challenging.

We saw evidence that patients were supported through use of a positive behavioural support (PBS) plan. This provided consistent information to help staff understand patients' likes, dislikes and causes for behaviours that challenge.

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It was positive to note in the PBS plans we reviewed that proactive and reactive strategies had been considered, with effective formulations seen in relation to causes of identified behaviours. New staff on the unit were able to demonstrate their familiarity with the detail of these plans.

We confirmed that the strategies for managing behaviours that challenge had been considered in the sample of records that we viewed. However, in some cases there was a lack of evidence that care and treatment plans had been made accessible for patients to assist in their understanding and involvement in their care and treatment. Similarly, in two of the records, there was a lack of evidenced family involvement, despite staff confirming that there had been on-going family involvement.

We found that there was a minimal use of restrictive practice interventions (RPI's) on the unit, with staff using least restrictive de-escalation methods. Where physical interventions were deemed necessary, we found that these were documented in the patients care plans and that individual best interest decisions towards interventions were documented by the MDT.

It was positive to note that there was access to a behaviour analyst on the unit to support the MDT approach to supporting patients. We confirmed that all incidents of behaviours that challenge and interventions are recorded on behavioural charts. These are reviewed at weekly behaviour management support group (BMSG) meetings, with action plans drawn up where necessary.

We found that staffing on the unit permitted one to one care to be provided. We were told that this was used as an enabling experience for patients, whilst providing patients with the opportunity to undertake additional on and off site activities. However, through our observations, we considered the effectiveness of the one to one care whilst on the unit could be strengthened. This is to ensure that all interactions are consistently used as a positive form of engagement through an active model of care.

Improvement needed

The Health Board must ensure that care and treatment plans have been made accessible and communicated appropriately to patients (and relatives where applicable).

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.

Quality improvement, research and innovation

It was positive to note that the unit had recently received its bronze accreditation as part of the Health Board's quality measure accreditation scheme. The Ward Manager and staff nurse who co-ordinated the accreditation demonstrated a clear knowledge of the unit's strengths and areas to improve upon.

Members of the unit and senior management that we spoke with spoke openly and were receptive to the suggestions and recommendations put forward by the HIW inspection team.

Record keeping

We found that patient files were structured and easy to navigate and that all members of the multi-disciplinary team recorded notes in a consistent format. This helps to ensure that there is a consistent approach to patient care.

Quality of management and leadership

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

Overall we found a committed staff team, many of whom were long-standing members on the unit. The team was supported by a dedicated unit manager, who staff told us was supportive and visible on the unit.

We found good working relationships within the unit, other inpatient wards and the wider management structure within Bryn y Neuadd, with clear local governance arrangements in place to support this.

However, we have highlighted areas for improvement that aim to strengthen existing practice at an operational level. We also identified the need for the Health Board to support the unit at a strategic level by developing and implementing a clear service model and ethos.

Governance, leadership and accountability

Tan y Coed provides a residential rehabilitation service to its patients. However, we found that some legacy issues had resulted in a mixed service model, which had not been reviewed for some time. As a result, there was an inconsistent approach to the care provided on the unit based on patient profile. For example, the unit provides care to some older patients who would likely stay at the unit for the foreseeable future, but also to a younger patient group who require a more comprehensive and active offer of rehabilitative care to aid their transition back into the community.

We acknowledge that ward management have a vision for the future service and that some discussions had already taken place with staff and senior management to develop ideas.

The unit is managed on a day-to-day basis by a Band 7 ward manager and supported by two deputy ward managers, all of whom are registered nurses.

On our arrival at the unit, we found that there was an experienced Band 5 nurse in charge who was overseeing that particular night shift. The nurse was able to respond to all of our queries regarding patients in a clear and comprehensive manner, and was able to escalate and communicate our arrival to senior on-call management without difficulty or delay.

During our inspection we spoke to a range of staff on the unit. Feedback received from staff was overwhelmingly positive. Without exception, all staff told us that they felt supported in their roles and that there was visible and accessible management on the unit.

All staff told us that they would feel comfortable to raise any concerns that they had, which helps to demonstrate a positive culture on the unit.

We found a clear management structure and staff we spoke with were aware of the roles and responsibilities of senior colleagues. The ward manager was complimentary of the support provided by the clinical services manager, who was enthusiastic and proactive in delivering their role.

There were appropriate governance arrangements in place in the unit and the wider structure that it is part of. We observed meetings, reviewed meeting minutes, and found that there was a suitable day-to-day flow of information between the ward and senior management:

- Team meetings on the ward included a comprehensive and relevant agenda
- Daily inpatient meetings enabled the inpatient wards and units at Bryn y Neuadd to feedback any immediate issues or concerns to the clinical site manager
- Twice daily safety huddles across the site were focused and well attended. We observed issues being raised in the morning huddle, with an effective resolution to these issues being given at the huddle prior to the night shift.

Improvement needed

The Health Board must support the unit in developing and implementing a clear service model and ethos.

Staff and resources

Workforce

We reviewed a sample of staffing rotas, including an analysis report, and found no indication of staffing issues on the unit. The staffing numbers and skill mix appeared to be sufficient to meet patient needs and required observation levels. The staff we spoke with expressed positive comments in relation to staffing levels and the ability to provide patents with a good level of care on the unit. We found there to be a suitable process in place for the escalation of staffing issues

We found that there were a number long-standing and committed staff at the unit, which helps to provide important continuity of care for this patient group. There were a small number of nursing and healthcare assistant vacancies on the unit, but we noted that recruitment was progressing well.

We noted that there were a number of opportunities on the unit for the training and development of new and existing staff and the unit manager expressed an enthusiasm for this. We found that students are able to undertake placements on the unit as part their nurse training and we were told that the unit had previously been able to employ some of these students following their placements.

The unit manager placed emphasis on the importance of staff development. We found that a number of healthcare support workers had completed, or were in the process of completing, their diploma certifcates which enables them to progress onto a nurse training degree.

The unit had achieved a good level of compliance regarding mandatory training, with the majority of staff having achieved the health board standard of 85%. We explored the reasons why some staff members had fallen below the required level of compliance and were provided with appropriate reasons by the ward manager, which included staff who had very recently joined the unit, long term absences and the impact of COVID-19 on the delivery of face-to-face training.

We found that 72% of staff had an up-to-date personal appraisal development review (PADR). Whilst this was below the health board target of 85%, we were provided with appropriate reasons by the ward manager and noted that appraisals were on-going at the time of the inspection.

4. What next?

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

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

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

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

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

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

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

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found that the adrenalin within resuscitation kit was expiring during the month of the inspection (October 2021).	Expired medication may impact its upon effectiveness.	Whilst the adrenalin had not yet expired, we brought this to the attention of the Ward Manager so that they could re-order this ahead of its expiration.	The Ward Manager informed us that an order would be immediately placed for a replacement.
We identified that one of the fire extinguishers had not been serviced since February 2020 and the fire risk assessment did not identify the need to review the fire extinguishers in the bungalow concerned.	Potential risk to staff and patients in the event of a fire	We immediately brought this to the attention of ward and site management.	The issue was escalated to the health board fire safety / estates department

Appendix B – Immediate improvement plan

Hospital:

Ward/department:

Date of inspection:

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate improvements were identified.				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Bryn y Neuadd Hospital

Ward/department: Tan y Coed Unit

Date of inspection: 19-20 October 2021

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The Health Board must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified.	1.1 Health promotion, protection and improvement	• Weekly recording form introduced (embedded), weekly blood sugar monitoring frequency clarified with staff. • Currently only required for identified patient. • Process will be introduced for future patients if clinically indicated.	Ward Manager. Matron.	Completed 25/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit.	4.1 Dignified Care	• The named nurse for each individual will regularly review the appropriateness of patient's room aligned to changing need and patient's wishes. • This will be reviewed at Multi-Disciplinary Team (MDT) meetings as part of the Care and Treatment Plan (CTP). • Other important people in a patient's life will be involved where appropriate, to support and explore ways of creating a personalised environment.	Ward Manager. Matron.	28/02/2022
The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met.	6.1 Planning Care to promote independence	• Occupational Therapy (OT) capacity will be prioritised across the site to ensure timely assessment and responsive care planning. • A meeting with Head of Operations and OT has been arranged to discuss capacity issues.	Head of Operations.	March 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• SBAR to be developed and presented to the Divisional Senior Leadership Team to highlight any unresolved issues.		
Delivery of safe and effective care				
The Health Board must provide HIW with an updated schedule for the completion of the on-going remedial works at the unit.	2.1 Managing risk and promoting health and safety	• All works completed at Tan Y Coed and signed off on 19/11/2021.	Estates	Completed 19/11/2021
The Health Board must review the environmental risk assessment to ensure that all risks have been identified and mitigated.		• Environmental risk assessment has been reviewed. • Risk identified in relation to kitchen drawers not being locked. • Risk assessment completed on 25/11/2021: • All drawers on Tan Y Coed are now locked. • Individual risk assessments will be developed to enable access to cooking utensils when identified as a requirement.	Ward Manager. Matron.	Completed Completed Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
				December 2021
The Health Board must review the COSHH risk assessment to ensure that all risks have been identified and mitigated.		• All risks identified, risk assessed and mitigated. Process in place to ensure regular review of COSHH risk assessment – reviewed on monthly ward accreditation audit.	Ward Manager. Matron	Completed 24/11/2021
The Health Board must review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded.		• Ligature Risk assessments were being reviewed at the time of the inspection. Monthly reviews in place by Ward Manager; these are sent monthly to Head of Nursing and Head of Operations for review.	Ward Manager. Matron	Completed
The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.	2.4 Infection Prevention and Control (IPC) and Decontamination	• Monitoring and review arrangements are being introduced to ensure adherence to cleaning schedules. • The cleaning schedule recording form will be redesigned to ensure reason cleaning has not been undertaken is clearly documented - this will be reviewed regularly via Ward Manager and Matron Audit.	Ward Manager. Matron	January 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • Standards for stock control controlled drugs are maintained in accordance with its own medications management policy • Appropriate communication with patients regarding their medication plan is undertaken and suitably documented.	2.6 Medicines Management	• All controlled drugs are stored in accordance with the BCUHB policy. • A project will commence in January 2022 developing communication with patients regarding their medication, using resources including Books Beyond Words, and Easy Health.	Ward Manager. Matron Staff across site/ Student nurses.	Completed March 2022
The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to: • Ensuring that plans and objectives are goal and person centred • Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times	3.1 Safe and Clinically Effective care	• 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.	Ward Manager. Matron. Head of Nursing.	February 2022 Monthly December 2021
The Health Board must ensure that care and treatment plans have been made accessible and		• Care Coordinators will ensure that patients or their representatives are part of the development of their CTP, and that accessibility and	Head of Nursing	February 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
communicated appropriately to patients (and relatives where applicable).		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.		February 2022
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	Ward Manager. Matron. Head of Nursing LD.	February 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		engagement to be used to inform CTPs.		
Quality of management and leadership				
The Health Board must support the unit in developing and implementing a clear service model and ethos	Governance, leadership and accountability	• Development of the model and ethos of Tan Y Coed has commenced and will continue to be developed in 2022. This is part of a wider LD transformation project.	Ward Manager. Matron. Clinical Operations Manager. LD Senior Leadership team	September 2022

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

Service representative

Name (print): **CAROLE EVANSON, MIKE SMITH**

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

Date: 30/11/ 2021

NHS Mental Health Service Inspection (Unannounced)

Ysbyty Gwynedd

Hergest Unit

Betsi Cadwaladr University

Health Board

Inspection date: 6 – 8 September 2021 &

20 – 22 September 2021

Publication date: 23 December 2021

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September. The following sites and wards were visited during these inspections:

- Aneurin - Female acute mental health admission ward
- Cynan - Male acute mental health admission ward
- Taliesin - Psychiatric Intensive Care Unit (PICU)

Our team, for the inspection comprised of two HIW inspectors and two clinical peer reviewers. A HIW inspection manager led the inspection.

The first unannounced visit took place on the evening of Monday 6 September 2021. Shortly after arriving at the hospital, HIW were advised of a patient and two staff members who had tested positive for COVID - 19. As a result, the remaining two days of this inspection took place remotely and focussed on the following concerns:

- Management of Coronavirus (COVID-19)
- Staffing levels
- Staff welfare.

HIW completed a second unannounced inspection on the evening of the 20 September and the following days of 21 and 22 September 2021. This inspection focussed on what improvements had been made since our inspection on the 6 September 2021. In addition, we also inspected the following areas:

- Infection Prevention Control
- Patient Care Plans
- Environment of care
- Governance and staffing.

HIW explored how the service met the Health and Care Standards (2015).

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

2. Summary of our inspection

During our inspection commencing 6 September, we identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, we issued an immediate assurance letter, where we write to the service immediately after our inspection with our findings requiring urgent remedial action. We then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care.

Overall, we found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

A number of environmental issues, a lack of infection prevention and control measures relating to COVID-19 procedures, and staffing issues were escalated during both inspections.

Improvements are required in completion of patient care plans and in maintaining accurate staff rota records.

Improvements in communication and engagement between senior managers and ward staff is required to develop a trusting relationship.

This is what we found the service did well:

- We observed that staff interacted and engaged with patients respectfully
- Good team working and motivated staff

- Established governance arrangements.

This is what we recommend the service could improve:

- The maintenance of the hospital facilities
- The capacity of its older adult inpatient mental health service
- Organisation and completion of care plans
- Improvements in welfare and morale of the hospital workforce
- A more stable and consistent senior management team
- Management of staff rota records.

Following the inspection on the 6 September 2021, HIW had some immediate concerns, which were dealt with under our immediate assurance process. This meant that we wrote to the Health Board immediately after the inspection, outlining that urgent remedial actions were required.

Details of the immediate improvements that were required are summarised below and the actions the provider has/is taking to address them are provided in Appendix B:

- We were concerned that some staff were working excessive hours and were regularly working beyond the end of their shift
- Staff informed HIW that they were not always having meal breaks during 12-hour shifts
- Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long-term leave. As a result, this impacted upon the capacity of the Psychiatric Liaison Team to undertake their role
- Staff rotas we reviewed highlighted a number of unfilled shifts
- There is no evidence of a ward acuity assessment to identify if current staffing levels were suitable for the current patient demands on the unit.
- HIW were not assured that all staff were aware of COVID-19 cases on the unit or that correct reporting mechanisms were in place

- As visitors on the unit HIW inspectors were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance

- Staff were not always following infection control protocols, for example, Security Guards were observed coming onto the unit from another area of the hospital. They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols

- Staff were being utilised from other areas of the hospital and across the Health Board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.

These are serious patient safety issues and we issued an immediate assurance letter to the health board following the inspection. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No new areas requiring immediate assurance were identified during the inspection on 20 September 2021.

3. What we found

Background of the service

The Hergest Unit provides NHS mental health services at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW, within Betsi Cadwaladr University Health Board.

The service has three wards:

- Aneurin, a 17 bed female acute mental health admission ward
- Cynan, a 17 bed male acute mental health admission ward
- Taliesin, a 6 bed mixed gender Psychiatric Intensive Care Unit (PICU).
- A dedicated Section 136 Suite[1].

At the time of our inspection, bed capacity had been reduced to help support social distancing measures required due to COVID -19. Aneurin and Cynan Wards bed capacity was 14 and Taliesin remained at 6.

The service employs a staff team, which includes a team of registered mental health nurses and healthcare support workers. The multi-disciplinary team consists of consultant psychiatrists and occupational therapists.

Dedicated teams of administration staff, maintenance, catering and domestic staff support the day-to-day operation of the hospital.

The hospital is overseen by the health board's clinical and administrative structures.

[1] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety.

Quality of patient experience

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

We observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

Patients we spoke to told us they were receiving good care at the hospital.

The health board needs to review the inpatient service provision for older adult mental health care, to ensure it has sufficient capacity and appropriate care to meet the needs of older adult mental health patients.

Staying healthy

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

Hergest Unit had a team of occupational therapists that provided a wide range of activities for patients within the unit. Each ward had their own designated garden area, which provided outdoor space for patients.

The unit had a therapies area, which included an activities area with a pool table and cardio exercise equipment, an arts therapy room, and a crafts room. However, at the time of the inspection we were informed that the gym equipment was not being used by patients due to restrictions relating to the COVID-19 pandemic.

Dignified care

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

We noted locked doors and an intercom system on the entrance to the wards to prevent any unauthorised access. Taliesin was a Psychiatric Intensive Care Unit (PICU)[2] that had six individual bedrooms. Aneurin and Cynan were both designated as 17 bed acute admission wards; both were a mix of individual bedrooms and dormitory areas. At the time of the inspection, both wards were operating at 14 beds due to COVID–19 restrictions. Most patients had access to their own bedroom. However, there was one shared cubicle area on Cynan and Aneurin Ward. The three bedded cubicles had curtains between them, which only afford the basic level of privacy for patients and do not reflect modern mental health care provision.

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required. On the first night of the inspection, we were told that the bath on Cynan Ward had not been working correctly. This matter was immediately brought to the attention of the health board and resolved during the inspection. There was also a blocked toilet on Aneurin Ward, which was also brought to the attention of the health board during the inspection.

Some of the bathroom areas on Aneurin and Cynan Ward were being used for storage, a number of boxes were positioned in corner areas of the bathroom. The health board must ensure that all items are stored in appropriate areas. In addition, three unused hospital beds were being stored in the reception area of

[2] PICUs are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk the patient poses to themselves or others.

Cynan Ward. This was brought to the attention of the health board and the beds were immediately removed.

There was a patient status at a glance board[3] in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards are designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Hospital policies and the staff practices we observed, contributed to maintaining patient dignity and enhancing individualised care at the hospital.

Improvement needed

The health board must ensure that

- The blocked toilet on Aneurin Ward, and the bath on Cynon ward are fixed
- Bathroom areas are not used for storage.

Patient information

We saw advocacy posters that provided contact details about how to access the service. Due to Welsh Government restrictions associated with COVID-19 legislation, Advocacy services were no longer visiting patients, however patients were able to contact a representative of the statutory advocacy service by telephone to speak to a representative.

Across all wards, we saw information relating to patient feedback and posters were displaying QR codes for patients to scan in order to provide feedback directly to the health board. Wi-Fi was available to facilitate this. In addition, there

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

was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[4] process.

Communicating effectively

Patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

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

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

Timely care

Each morning there was an Acute Care Meeting involving all ward managers, multi-disciplinary team members, and representatives from the community services. Each patient being cared for at the hospital was discussed in turn.

Hergest Unit has a designated Section 136 suite where the police could bring people for a Mental Health Act assessment. This unit was closed on the 6 September, and patients were being re-directed to an alternative Section 136 suite in the health board. We were advised that the Section 136 facility had been on divert to Ablett and Heddfan units from 25 August 2021 – 7 September 2021. This had been agreed following discussion with North Wales Police.

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

The reason for the divert was staffing challenges arising from the COVID-19 positive patient requiring 2:1 nursing in an isolated ward next to Aneurin Ward. We were told that this is the contingency plan for all the Section136 facilities and it is not usual practice for Hergest to divert due to staff shortages. The health board must ensure that there are always sufficient staffing numbers on duty to deal with any Section 136 admissions. Transporting a person further to a different Section 136 Suite within the health board is detrimental to the person's well-being.

The Section 136 suite was available for use on the unannounced inspection that took place on the 20 September and there were sufficient staff available to deal with a Section 136 admission.

The Section 136 Suite was adequately equipped to provide comfort and safety for a person awaiting and undergoing an assessment. There was a toilet available within the Section 136 Suite, however, there was no door or screen within the toilet entrance to afford privacy to a person using the facility. This had been highlighted as an area that needed improvement during our last inspection in 2018 but remains a significant dignity issue. The health board must ensure that this work is carried out.

The suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite.

We were told meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these meetings. Close partnership working with the police and effective use of the Section 136 suite is essential to ensure that people presenting with mental health issues are getting the right care at the right setting.

Due to capacity demands across the health board older person's mental health service, there were occasions when older persons mental health beds were unavailable and therefore a person would be admitted to the adult acute admission wards where there was a bed available. Staff told us that there were also occasions when older persons with a diagnosis of dementia were admitted to the adult acute admission wards. The environment of care on acute mental health wards are not the most appropriate environment to meet the specific needs of those patients, lacking visual and orientation aids that are commonplace on dementia wards. Staff on acute mental health wards may also lack the skillset and be unfamiliar with providing care to patients with a diagnosis of dementia, in meeting their needs and managing their behaviours.

Staff spoken to raised concerns regarding the suitability of the environment of care and the complex challenges that present with older patient care. They described situations where some patients would require enhanced observations and different levels of physical care which staff may be unfamiliar with providing.

Improvement needed

The health board must ensure that:

- Section 136 suite remains open and there are sufficient staff available to cover admissions
- There is appropriate privacy measure for the toilet located in the Section 136 Suite
- A pathway is developed in the health board for older adult care.

Individual care

People's rights

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service where a representative could be contacted via telephone or when they attended the hospital. We were told that advocacy were not currently attending the wards, however were available by telephone for patients to make contact.

During the course of reviewing patient records, we noted that there were no capacity assessments being recorded. Therefore, there was no record to determine if the patient had capacity to make informed decision around:

- Administration of medication within the ward environment
- Understanding the inherent restrictions of being admitted onto a locked ward.

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained. Information was displayed on the wards to

inform patients, who were not restricted by the Act[5], about their rights to leave the ward.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the unit. However, some patients could meet with family and friends within the hospital grounds. Other patients could maintain contact with family and friends by telephone and video calls.

There was a designated area for children and families visiting which was off ward. This meant that patients could meet with younger family members away from the ward environment.

Improvement needed

The health board must ensure that capacity assessments are completed and recorded in patient records.

Listening and learning from feedback

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

There was no evidence of regular patient meetings taking place, where patients would have the opportunity to discuss any improvements or patient initiatives.

It was positive to note that there was a large display of thank you cards on display in the nurse's office.

[5] Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

Improvement needed

The health board must put a system in place for patient meetings with ward staff.

Delivery of safe and effective care

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

Whilst overall the physical environment at Hergest Unit was maintained to a good standard, we identified a number of areas that require action.

We also identified areas for improvement concerning staff practice, in particular around completion of care plans to evidence in detail the care being provided.

Safe care

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No immediate assurances were identified when we return to Hergest on the 20-22 September 2021.

Managing risk and promoting health and safety

There were established processes in place to manage and review risks, and to maintain health and safety at the hospital. This assisted staff to provide safe and clinically effective care.

The Hergest Unit is located within the grounds of Ysbyty Gwynedd with its own entrance and staffed reception during the day. During the evening and night, the entrance to Hergest Unit is secured to prevent unauthorised entry, during these times the wards can be contacted via the intercom located at the entrance. However, when the inspection team arrived unannounced on the first evening on 6 September 2021 we were let through the locked doors on to the ward without being asked for identification. Staff must act with vigilance and ensure that the identity of visitors is confirmed prior to allowing their access on to the ward. It was positive to note that on the second unannounced visit, identification was requested.

The inspection team considered the hospital environment during a tour of the hospital on the night of 20 September 2021 and the remaining days of the inspection. We identified a number of decorative and environmental issues that required attention, these included:

- Sticky tape residue marks where items had been stuck to doors and windows. This unfortunately left the wards, in parts, looking scruffy and a unkempt
- Plaster flaking on walls both sides of garden entrance door to Cynan Ward
- Plaster flaking and dampness near the external entrance door to 136 suite
- Cluttered and disorganised storage cupboards
- Hot water tap not working in kitchen on Aneurin Ward
- Patient bathrooms being used as additional storage areas.

These issues were brought to the attention of the health board and the estates team were notified. The health board must ensure that the environmental and decorative issues are resolved.

We told that some of the wards on Hergest had high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility. We were told that risk assessments were in place for individuals who use these beds; however, it was unclear if risk assessments had been completed for other individuals on the wards that could gain access to these beds. Staff had access to personal alarms to call for assistance if required, there were also nurse call points around the hospital so that patients could summon assistance if required.

There were established systems in place for assessing and monitoring patients' level of agitation, and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

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

There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed.

We attended a Putting Things Right meeting. Incidents, safeguarding, staffing and Infection Prevention Control were among the items discussed. It was reassuring to see and hear senior management discussing issues during this meeting, however, no members of the ward staff were available at this meeting. It would be beneficial if ward staff were provided with an opportunity to represent the themselves at these meetings. This would ensure that ward staff have an opportunity to contribute to discussions and improvements made with the senior management team.

There were up-to-date ligature point risk assessments in place for the wards. These identified potential ligature points and what action had been taken to remove or manage these. We reviewed records and confirmed there was evidence of audits.

Improvement needed

The health board must ensure that:

- Staff confirm the identity of visitors prior to allowing access on to the ward
- Sticky residue is removed from windows
- Re-plastering is completed on Cynan Ward and Section 136 suite
- Storage cupboards on all wards are organised
- Patient bathrooms are not used as additional storage areas
- Hot water tap on Aneurin Ward is fixed
- There are regular environmental audits to identify any unreported damaged areas
- Representation from ward staff at meetings.

Infection prevention and control

We found that the arrangements for the prevention and control of infection within Hergest Unit did not protect potential transmission of COVID-19 to other patients and visitors. During the unannounced visit on 6 September, the inspection team

questioned if there were any COVID -19 cases on the ward. We were told that one positive patient was being nursed in isolation. However, the inspection team were later advised by another member of staff that two members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that the correct reporting mechanisms were in place.

In addition, as visitors on the unit, we were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance. We also observed security guards coming onto the unit from another area of the hospital. They were not wearing masks correctly and went straight onto one of the wards without complying with hand hygiene protocols. We also identified that staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues at Hergest. It was unclear what procedures were in place to prevent any potential transmission of infection from other areas of the hospital.

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process.

Following the unannounced inspection on the 6 September 2021, HIW were provided with evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

When we returned unannounced on 20 September 2021, we noted improvements. Staff were checking that we had complied with COVID-19 protocols such as hand hygiene and wearing and changing of face masks. Staff were also aware of the COVID-19 status of the unit.

On the 20 September 2021, two patients were being nursed in the isolation suite. We were unable to inspect this area but through glassed doors, we were able to observe staff donning PPE in an area outside the isolation suite The PPE was being stored on a table outside the isolation suite. The acute manager told us of further improvement plans she was implementing in the isolation area. This included separating a room into designated donning and doffing areas and estates were fitting a cupboard in this area to store supplies of PPE. The health board must provide an update on the further improvements the health board are making to the isolation suite.

Staff we spoke to were aware of infection control obligations. We were told by staff and saw evidence of staff policies relating to self- isolation, and COVID-19

workforce risk assessments. We were also told that any staff who tested positive were discussed at safety huddles, and Datix incidents would be completed. In addition, a 72-hour review would be undertaken to ensure that appropriate safeguards were in place to protect staff and patients. Regular communication via emails ensured everyone has up to date advice and guidance on COVID-19.

Weekly cleaning audits and daily hand hygiene audits were carried out on the unit. The acute care manager also completes a daily walkabout with the senior leadership team on a weekly basis. Any breaches or issues are addressed directly with staff and with ward/team managers. In addition, external audits are undertaken by external health board staff to ensure compliance. The nursing team were very complimentary of the domestic staff and we were told that they all worked well together as a team.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. Bins were available to dispose of medical sharp items and these were not overfilled.

Improvement needed

The health board must ensure that:

- All staff check visitors compliance with COVID-19 procedures
- Isolation suite has suitable storage for PPE
- HIW are provided with details of improvements made to the isolation suite.

Nutrition and hydration

Patients were provided with meals at the hospital making their choice from the hospital menu, and had access to drinks and fresh fruit on the wards. The patients we spoke with were positive about the food provided.

We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind, they can usually be accommodated with another option.

The dining room was clean and tidy and provided a suitable environment for patients to eat their meals. We were also told that patients could also eat meals in their rooms to help with social distancing measures.

Medicines management

Overall, we noted that medication was securely stored. Staff locked the clinic room and medication cupboards to prevent unauthorised access. The automated medication dispensing cabinet was not working correctly on Aneurin ward, however staff were still able to dispense medication. This issue had been reported and was resolved whilst the inspection was ongoing.

Staff locked medication fridges when not being accessed. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, we saw that on both Aneurin and Taliesin wards, the fridge temperatures recorded were outside the required range but staff had not escalated this. This was immediately raised by HIW and both fridges were fixed. The health board must ensure that fridge temperatures are in the required range to ensure that medication is stored at the correct temperature.

Staff told us that since the installation of the automated mediation dispenser unit, the temperature of the clinic in the summer months could be high. We noted that no ambient room temperature checks of the clinical room were routinely monitored or recorded on Aneurin Ward. It is important that temperature checks of the clinical room are taken and recorded to ensure that medication is not affected by temperatures outside of the manufactures' stated temperature range.

There were regular stock checks of medication, including Controlled Drugs and Drugs Liable to Misuse, to ensure that the correct amounts were present. A number of liquid medicines on Taliesin Ward were reviewed, these were appropriately stored, however they were not labelled with a date of opening. It is important that dates of opening are recorded on liquid medication as this may affect the shelf life and quality of the medication.

There was a regular pharmacy input, and audits were undertaken, which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The majority of Medication Administration Records (MAR Charts)[6] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status. However, on one patient chart the allergy section stated ‘as per GP record’. This would require the nurse to look at the GP records, when all allergies should be recorded on the drugs chart to prevent any drug induced allergic reactions. It is important that any allergies and information are documented on patient charts.

A Medication Management Policy was not available in the clinic and staff were unable to demonstrate where the policy was kept. The heath board must make sure that all staff understand the policy, are familiar with the content and that a copy of the policy is available in the clinical area.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)[7].

There were regular checks of resuscitation equipment. Staff had documented when these had occurred to ensure that the correct equipment was present and in date.

Improvement needed

The health board must ensure that:

- Staff record fridge and clinical room temperatures
- Any fridge or clinic room temperatures outside the required range are addressed

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

*7 British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

- Management investigate the raised temperature in clinical room
- Dates of opening liquid medications are recorded
- Allergies are clearly specified on drug charts
- Staff are aware of the location and content of the medication management policy.

Safeguarding children and adults at risk

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

Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to demonstrate knowledge of the process of making a safeguarding referral. As highlighted above all safeguarding referrals are discussed during the putting things right meeting where the health boards safeguarding lead would be present.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required, which documented that all resuscitation equipment was present and in date.

There were a number of ligature cutters located on each of the wards, for use in the event of an emergency. During the inspection, all staff we spoke with were aware of the location of ligature cutters.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. However, as detailed within the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendices A, B and C.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password protected. We observed staff storing the records appropriately during our inspection.

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

We reviewed the Care and Treatment Plans of four patient records provided to us after the unannounced inspection on 6 September 2021, and five patient records were viewed during the unannounced return on the 20 September 2021.

We highlighted a number of errors in the care plans reviewed from both inspections.

The unmet needs of patients were not identified. It is important that any unmet needs are documented, so that these can be regularly reviewed by the multidisciplinary team. It is important to consider options for meeting all needs, as this may result in identifying an alternative placement.

We also noted a number of missing observation recordings in observation recording forms. Signatures of observing staff were missing and forms contained gaps with no entries. During one set of patient notes the fluid balance (input/output) charts, had some discrepancies where the charts had been poorly completed or were incomplete. The charts inspected did not provide sufficient information to document the patients' consumption over a period of time and it was difficult to establish if this patient had access to appropriate amount of fluids. In addition, the care plans did not adequately cover the following areas:

- No date of review was recorded on some care plans
- No evidence of physical assessments taking place
- No entries to show if patient had capacity to agree to treatment plan
- COVID–19 care plans were signed but not fully completed.
- Care co-ordinators were unnamed and just recorded as nursing staff.

The health board must ensure it addresses all the deficiencies with care plans to ensure that accurate and historical data is captured and recorded.

Improvement needed

The health board must ensure that:

- Unmet needs are evidenced and documented within patient care plans.
- Observation record sheets are accurately completed
- Food and fluid charts are completed in full and accurately recorded
- Review dates are recorded in care plans
- There is evidence of physical assessments taking place
- That capacity assessments are completed
- COVID–19 care plans are fully completed
- Care co-ordinators are identified and named.

Quality of management and leadership

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

Throughout the inspections and at the feedback sessions, staff and management at Hergest Unit were receptive to our views, findings and recommendations.

Throughout the inspections, staff demonstrated their commitment to provide care for patients within the hospital. However, we are concerned that some staff may be working excessive hours and not taking their required breaks. Fatigue may affect staff well-being and impact upon professional judgements.

Improvements are required in relation to maintaining accurate staff rota records.

We also noted that findings from other inspections within the health board were replicated at Hergest. This identifies a lack of joint learning by the health board on the outcomes of inspections.

Governance, leadership and accountability

The significance of the areas of improvement identified in the below Workforce section, along with Infection Prevention and Control, and Care Planning sections of this report, highlights the need for improvement in audit and governance regarding these areas to support patient safety.

Throughout interviews with staff, it was clear that working relationships built on trust had not yet been fully developed between the ward staff and health board senior management teams. This was partly due to a number of significant changes to the management and multi-disciplinary team. In addition, staff we spoke to raised concerns around the quality of communication from senior leaders around recent staff movements on Hergest Unit. The health board must

ensure it has a communication strategy in place to brief staff when any changes are made.

During interviews with staff, we were told that changes in the senior management teams made it difficult to build up working relationships that allowed them to raise confidential issues or concerns. There was a clear lack of trust in senior management from the ward staff who described working in a culture of blame; this feeling amongst staff was having a significant impact on staff morale and well-being.

Some staff described being ‘petrified’ of making mistakes and were fearful that they would be redeployed or suspended from duties. However all staff spoke positively about their immediate line managers and described working in resilient and supportive teams.

We spoke to ward staff and were told that they escalated some environmental and patient care issues to management. They also told us they were not confident these issues would be dealt with. However, senior staff informed us that they were unaware of these issues. It is unclear if this difference is due to a lack of structured escalation procedures, or a lack of confidence from ward staff in the senior team. The health board must provide a system for escalation of issues for staff to follow, including regular updates of actions taken by management. This system should be clearly communicated to all staff.

The health board have appointed a Clinical Operations Manager, along with a Head of Nursing and Clinical Acute Care Manager. Discussions held with these individuals and the Interim Director of Mental Health highlighted that they were aware of issues on Hergest Unit that require improvement. They indicated they had a commitment to addressing these to raise the standard of the environment and treatment and support to patients and staff.

Senior staff advised us of initiatives they were developing to try to support staff well-being. In order to bridge the gap between senior management and ward staff, senior managers were ensuring that they were a visible presence on the ward and were making efforts to build up confidence and trust between ward staff and senior management. However it was evident through interviews with staff that they did not feel valued or supported by senior management. The health board must ensure that its senior leaders encourage professional integrity, inclusive and supportive relationships so that staff feel valued, respected and confident to report concerns. In order to achieve this the health board needs to provide a stable and consistent senior management team for staff on Hergest Unit.

At the time of the inspection there was no permanent consultant psychiatrists nor psychologists in post, the health board had arranged cover for these positions. However, this had been sporadic and had not provided consistency of care. Ward staff we spoke to told us that they did not feel involved in decisions around patient care and treatment that were being made by the consultant psychiatrists.

As a result there was a lack of collaboration between the disciplines, and whilst there was also occupational therapy input, there was no evidence of cohesive multi-disciplinary team working. The lack of an established multi-disciplinary team impacts negatively on patient care and safety. Patients were not getting timely access to the range of care and support they need. The lack of MDT collaboration also prevents ward staff, including newly qualified nurses, developing clinical judgement skills.

It is vitally important that the health board ensure that the staff at the hospital work together and become a more cohesive team who communicate, consult, and make decisions together to optimise patient care.

A key finding from our our last Mental Health Inspection of Wrexham Maelor Heddfan Unit in July 2020 was a lack of communication and consultation between senior management and ward staff. This highlights a lack of shared learning from other inspections within the health board.

Improvement needed

The health board must ensure that:

- Senior management and ward staff work together to build up confidence and trust
- Senior management improve communication with staff
- MDT work collaboratively with ward staff
- Consistent and stable senior management team is maintained.

Staff and resources

Workforce

During the unannounced inspection on the 6 September 2021, we were given conflicting information on the staffing numbers and the observation needs of the patient group. The health board subsequently provided us with accurate data on the staff who were working on the night of the inspection and the observational levels required. This data reflected that there were sufficient staffing levels to meet the needs of the patient group. However, this was only because staff were not taking their breaks and some staff were working extra hours after their rostered shift to support their team members. Details on the health boards' response are included in Appendix B.

Further examination of previous rotas indicated unfilled gaps. The health board told us that these gaps had been filled with staff, however, this was not reflected on the rotas we examined. The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded, and historical data on resources is captured.

Staff told us that they would often work beyond their rota'd shifts to support colleagues due to staffing shortages. Staff indicated that there were occasions where they felt staffing levels were too low, in particular at night-time and on weekends. In addition, we were told that staff were working through their breaks as they felt it was unsafe to take a break and they were fearful of leaving colleagues short staffed on the unit. This type of working environment will lead to fatigue and affect staff well-being, compromise their professional judgements and impact on patient safety.

Senior management confirmed that they were encouraging staff to have breaks by discussing breaks during morning meetings and arranging coverage on the wards for staff to have breaks. In addition, senior management had developed a weekly accountability meeting where they look at hours staff worked to try and alleviate staff working excessive shifts and becoming fatigued. However, staff told us that even though management were telling them to have breaks they did not always feel that the unit would still be safe if they went on break. This was due to the acuity of patients and staffing levels. The health board must ensure there are sufficient staff to meet the demands of the patients.

During conversations with senior management, it was unclear when the most recent review of safe staffing numbers had taken place on Hergest Unit. This should be based on the current acuity levels and changing demands on the unit. Safe staffing is a fundamental part of good quality care and it is important that the health board undertake a review of its staffing establishment on Hergest Unit, including the S136 suite.

Senior staff confirmed that there were a number of registered nurse vacancies and recruitment had been ongoing for these posts. There were also a number of staff who had been temporarily redeployed or absent due to sickness. Therefore, additional resources were required to fulfil staff rotas. Where possible the ward utilised its own staff and regular registered nurses from the health board's bank staff.

There was a lack of staff break facilities on the unit, and those available were small and cluttered. In addition, due to limited storage space across the unit, staff rooms for the unit included items that should be stored elsewhere. This meant that there were limited suitable places where staff could take their breaks.

Staff told us that team meetings were not taking place. This was something the acute care manager told us she was looking to improve upon. The health board must ensure that regular team meetings can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

The training statistics reviewed identified low compliance with some modules on Aneurin Ward. For example, the compliance rates for fire safety was 44%, Information Governance was 51% and Moving and Handling was 48%. In addition, compliance with staff appraisals was only at 68%. We have recognised that the figures on Aneurin Ward may be due to staff absences and that face-to-face training has been difficult due to the pandemic, however, improvements are still required in these areas.

It was positive that, throughout the inspection, staff engaged openly and were receptive to our views, findings and recommendations.

Improvement needed

The health board must ensure that:

- Staff do not work excessive hours
- Staff have breaks and feel confident leaving the ward for breaks
- There are appropriate areas where staff can take their breaks
- Staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.

- That there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times
- Mandatory training figures are improved
- Regular team meetings take place for staff.

4. What next?

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

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

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

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

5. How we inspect NHS mental health services

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found the bath was not working on Cynan Ward	Patients were unable to use the bath	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection
We found that the toilet was blocked on Aneurin Ward	Patients were unable to use the toilet	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection.
We found that the temperature on the fridges in both clinical rooms were not within the required temperature ranges	Medication may not have been stored correctly	We raised this concern with the health board during the inspection and requested this was immediately resolved	Both fridges were fixed and medication was being stored safely on the ward

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Hergest Mental Health Unit

Date of Inspection: 6 – 8 September 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of patient experience				
No immediate concerns identified at this time.				
Delivery of safe and effective care				
HIW were not assured there was sufficient staffing to provide appropriate clinical care to support and maintain the safety of the ward. The health board must ensure the wards have a sustainable staffing model with the required levels of expertise to meet the clinical needs of all patients.		A Divisional Inpatient Establishment review has recommenced, which was stood down in 2020 due to Covid-19 pandemic priorities. This will enable an understanding of staffing requirements across the Division and a model to be agreed to ensure safe delivery of care in all Divisional inpatient settings.		**24/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action: 1. Local Senior Leadership (SLT) to review and submit their inpatient staffing establishment template to inform the overall Divisional inpatient establishment review. 2. Reaffirm the staffing escalation process across the unit and the Division as a whole. 3. Information sessions to be held with all Hergest unit/ward leads to ensure a strengthened understanding of the Hergest Standard Operational Procedure (SOP), to enable consistent implementation.	**Head of Operations (HON)/Head of Nursing (HOP)** **Director of Operations (DOP)/ Director of Nursing (DON)** **HOP/HON** **DOP/DON** **DOP/DON**	**20/09/21** **15/10/21** **31/12/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
We talked to staff throughout the inspection and examined staff rotas. We identified significant staffing issues on the unit, these were:		4. Continue to progress with the "Stronger Together" Discovery phase across the Division, to give staff the opportunity to work together to shape how the organisation works. This will include attendance at workshops. 5. Progress with a Divisional communication campaign aligned to the "Speak out safely" initiative, so staff are aware and are supported in raising any concerns across BCUHB. This will enable staff to use a confidential and anonymous platform to raise any concerns. 6. Raising awareness with the Respect and Resolution policy as part of developing health working relationships in the workplace.	**Divisional Head of Workforce (DHOW)** **DHOW** **DOP/DON**	**30/10/21** **31/11/21** **15/09/22**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were working excessive hours and were regularly working beyond the end of their shift. Staff informed us they were not always having meal breaks during 12 hour shifts. They had notified management of this but the situation had not changed.		7. Progress with the Maturity Matrix approach to track improvement across the Division. **<u>Current position</u>** When the ward rosters are initially completed and signed off, staff are not rostered to work excessive hours. For any additional hours worked this is in addition to contracted hours which staff have agreed to undertake through either bank or overtime. **Action:** 8. Local arrangements to be implemented to ensure a robust system is in place to closely monitor, review and address timely any issues in relation to staff working	**HOP/HON** **DHOW**	**30/09/21** **15/10/21** **17/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long term leave. As a result this had impacted upon the capacity of		excessive hours and with regularity working beyond their shift, to ensure staff wellbeing in work. 9. A Divisional standard template to be developed to inform decision making regarding authorisation of additional shifts for staff. **<u>Current position - Meal Breaks</u>** The interim SLT have recently been made aware regarding this issue and have commenced renewed focus to ensure that staff are taking their breaks appropriately. **Action:**	**Acute Care Site Manager (ACSM)** **DON/DOP** **ACSM**	 **15/10/21** **18/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the Psychiatric Liaison Team to undertake their role.		10. Strengthen the escalation and action in the daily Acute Care Meeting (ACM) for any issues regarding staff breaks. 11. Through an agreed cycle of business and through a range of communication means i.e. Memo, Staff Briefing, visit to units, staff forums, including the Joint Partnership Forum with staff side partners and Wellbeing Hubs, highlight the importance of staff wellbeing in work and to limit working excessive hours, the importance of staff taking their breaks and reaffirm the appropriate escalation processes. 12. To ensure the importance of working reasonable hours and meal breaks are included in the Staff Induction Pack within	**HOP/HON** **ACSM**	**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff rotas we reviewed highlighted a number of unfilled shifts, for example the shifts for the 6th of September showed that there were 5 unfilled HCA night shifts on Aneurin Ward and 2 HCA night shifts on Taliesin Ward. Similar gaps were highlighted from rotas provided to us for week commencing 6th-11th September 2021 with no staff allocated to some shifts.		the staff Wellbeing Section and also include as part of the checklist for staff supervisions. **<u>Current position regarding utilisation of Psychiatric Liaison staff</u>** In order to provide safe staffing on inpatient environments, there has, on occasion, been the need to use Psychiatric Liaison staff overnight for duty nurse purposes. However, this is considered in relation to the number of liaison nurses on duty to ensure there is a psychiatric liaison service available to the District General Hospital (DGH). In addition, to ensure continuity of service, the doctor on duty will hold the Psychiatric Liaison bleep to be able to support any assessments required.	**HOP/HON** **DON/DOP** **HOP**	**17/09/21** **Completed** **23/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action: 13. Review of the current SOP and the Business Continuity Plan to ensure clarity of the mitigation plans to support continuity of services. 14. The Interim Hergest SLT to ensure discussions are routinely taking place regarding safe staffing levels in daily ACM and Safety Huddles, and that appropriate mitigation and/or escalation is in place where required. 15. To continue to ensure a member of the SLT, or the duty nurse at the weekends, routinely attend the ACM and Safety Huddles and escalate any issues to the Divisional Huddle or Bronze on-call at weekends.	**HOP/HON**	**30/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
It was not evident that up to date ward acuity assessments had been completed to identify the required staffing levels. It is unclear if the current staffing levels were suitable for the current acuity and patient demands on the unit.		16. Reaffirm the requirement aligned to the MH&LD Staffing Escalation Policy across the Division. 17. To monitor and review key performance indicators aligned to Psychiatric Liaison to address any issues where required. **<u>Current Positon regarding unfilled shifts</u>** Unfilled shifts were covered via redeployment of staff from other areas. These were additional staff to the rostered numbers on the E-Roster system e.g. the Duty Nurse was based on the ward. Likewise, other staff were deployed from other areas to enable safe staffing, again these staff would not show on the Hergest E-Roster as they were on the E-Roster for other areas.	**ACSM**	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were unclear what the escalation arrangements were and how to contact an on-call doctor.		The current agreed staffing establishment for the three wards in Hergest unit is:- Aneurin 5/5/3 - 17 established beds (also one escalation bed). Cynan 5/5/3 - 17 established beds (also one escalation bed). Taliesin 5/5/4 - 6 beds. Having reviewed the staffing positon, none of wards on the evening of 06/09/2021, at the time of the inspection, were below the staffing template. Further to this, the staffing template is based on 18 patients for both Aneurin and Cynan, and the bed occupancy at the time of the inspection was 14. Also to note, both Cynan and	**Ward Manager**	**25/09/21** **17/09/2021**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Taliesin on 06/09/2021 were over establishment for HCSW's * **Action:** 18. Through communication and engagement with key unit managers, ensure that there is – a. Clear understanding of the E-Roster processes. b. Timely E-Roster sign-off to enable all additional shift requirements identified to be processed to bank office. c. Putting in place scrutiny on E-Roster controls reporting through to HON and HOP. 19. Reaffirm the requirement for Ward manager to escalate any unallocated shifts within the agreed timeframe to daily ACM huddle for discussion and agreement of any	**DOP** **HOP/HON** **HOP** **DHOW**	**25/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		action/mitigation to be put in place. **Current position aligned to ward acuity assessments** The ACM discuss and agree staffing levels required based on patient acuity. Ward managers/ representative for the ward provide an overview of their ward staffing requirements to ACM, which feeds into the daily Safety Huddles. **Action**: 20. To ensure the bed flow twice weekly meeting includes ward acuity assessments to plan safe staffing levels for the forthcoming days. **<u>Current position aligned to escalation arrangements</u>** Current on-call arrangements include a unit bleep holder, bronze		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		on-call, silver on-call and medical on-call. A rota is circulated on a monthly basis for all these positions, and more frequently if changes or gaps occur. The silver on-call was established at the beginning of the Covid pandemic to provide additional advice and support to the bronze on-call due to the increase in activity across the Division. Bronze and silver on-call communicate on a regular basis as required, and bronze on-call attend local area Safety Huddles and site meetings during their on-call period. There is a Consultant on-call rota and junior doctor on-call rota, with contact details. The rotas are communicated, there is a pan-Division distribution list and this is		**25/09/21** **25/09/21** **15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		evident in the duty nurse room and on the ward areas*. 21. Divisional memo to be circulated to reaffirm the escalation procedure for on-call arrangements. 22. To include this issue in the communication and engagement session with the ward/unit leads. 23. To ensure this is included in the Hergest SOP. 24. Review the current staff mapping undertaken during the second surge of Covid-19 for all staff within the Division for options of deployment.		**15/10/21**
HIW were not assured that there were established Infection Prevention and Control measures in place to manage and mitigate		The safe management of Covid-19 in the MH&LD Division has incorporated a Covid-19 Social		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the risks posed by Covid-19. The health board must ensure that all internal and national Covid-19 policies and measures are complied with to ensure the safety of patients, staff and visitors. On arrival the inspection team questioned if there were any Covid-19 cases on the ward and were told of one positive patient being nursed in isolation. However, the inspection team were later advised by another staff member that two further members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that correct reporting mechanisms were in place.		Distancing Action Checklist and Action Card which provides assurance the Covid-19 guidance has been applied across the Division. An escalation, communication and cascading process is in place with ACM, Daily Safety Huddles, Divisional Huddles, MH&LD Briefings and BCUHB announcements. Daily submission of SITREP including PPE audits, monthly Infection Prevention and Control (IPC) audits and walk around of IPC in all inpatient areas. MH&LD Division has the highest compliance in BCUHB for Covid-19 risk assessments.* **Current position aligned to Covid-19 Cases** A patient tested Covid-19 positive on admission on 24/08/2021. In line with policy, the patient was		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
As visitors on the unit we were not advised to adhere to Covid-19 protocols, such as hand hygiene compliance.		isolated and nursed for the incubation period, returning to the ward once this had ended and advice sought from our IPC team. There were two patients who were considered contacts; one with this particular patient and another who had a socially distanced visit outside with her father, under staff supervision. Her father subsequently tested positive for Covid-19, and following advice from our IPC team the patient was considered to be a contact as a precaution. Both patients were nursed individually in their rooms as per guidance by the IPC team and the unit Covid-19 Standard Operating Procedure (SOP). Neither patients have subsequently tested positive for Covid-19 and the patients are now able to utilise the ward area, with the 2:1 support arrangements to manage the situation, ending on Monday 06/09/2021. This		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		corresponds with the reported daily SITREP position.* No staff were working at the time of the inspection who were Covid-19 positive. **Current position aligned to visitors to the Unit** Covid-19 Guidance posters are clearly visible which are displayed at the Hergest entrance and within the foyer. Each ward entrance also has posters aligned to hand washing and mask wearing. An IPC station is immediately noticeable upon entering the Hergest unit at the foyer, with a stock of hand sanitizer and masks. Aligned to current guidance all visits to the MH&LD are prearranged with agreement by the staff on the unit. A visiting record is completed by the staff and visitors and the visitor log		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		updated. Corporate Covid-19 signage and posters have been provided to all units to advise visitors of the IPC requirements in place when visiting units. There is a requirement that all visitors to the unit are booked in advance.*	**HON**	**31/10/21**
		Guidance on visitors to wards has been shared with staff via the MH&LD Staff Briefing, BCUHB announcements and email to all Ward managers.	**HOP**	**30/09/21**
		The SLT undertakes a 3 monthly self-assessment of 40 standards related to Safe Clean Care and progress against assurance standards reviewed.	**DOP**	**Completed**
		The SLT provides an exception report on IPC to the monthly Divisional IPC meeting. Key metrics requiring improvement and renewed focus is on ensuring	**HOP**	**15/09/21**
Security Guards were observed coming onto the unit from another area of the hospital.			**HOP/HON**	**17/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols. Staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.		daily Covid-19 and hand hygiene audits are consistently undertaken and mandatory IPC training Level 1 and 2 is increased throughout the unit. **Action** 25. To achieve required improvements aligned to IPC key metrics. 26. To review the Covid-19 Action Card and update aligned to the MH&LD Winter Plan. 27. To liaise with the IPC Associate Director in relation to any additional IPC advice, guidance or support to the unit. 28. Recirculate memo, via Safety Huddle, regarding completion of the Visiting Record Checklist and Visitors' Log.	**ACSM** **HOP/HON**	**17/09/21** **21/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		29. All staff to be reminded when receiving visitors into units, that BCUHB IPC guidance is followed at all times, inclusive of hand hygiene. **Current position -** The issues aligned to lack of hand hygiene protocols and inappropriate wearing of face masks by the security guards has been escalated to the appropriate BCUHB department. A Datix has been raised and a 'Make It Safe+' is being progressed aligned to this incident. This will identify any additional learning from this episode**.** **]Action**	**HOP**	**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		30. PTR process to be fully implemented to enable the MIS+ to be completed. 31. Scrutiny of MIS+ investigation to identify any learning from this episode by the West SLT. **Current position regarding Staff utilised from other areas** Any staff who are redeployed across the Division are deployed in accordance with the health board staffing escalation policy and the latest IPC Covid-19 guidance. 32. Local SLT to have monitoring and review arrangements in place to ensure the IPC Covid-19 guidance is consistently implemented aligned to staff deployment.		

Improvement needed Quality of management and leadership	Regulation/ Standard	Service action	Responsible officer	Timescale
No Immediate concerns identified at this time.				

Service / health board Representative:

Name (print):	**Carole Evanson**
Role:	**MH&LD Director of Operations (interim)**
Date:	**17/09/2021**

Appendix C – Improvement plan

Service: Betsi Cadwaladr University Health Board

Ward/unit(s): Hergest Unit

Date of inspection: 6 – 8 & 20 – 22 September 2021

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the bath is fixed on Cynan Ward.	4.1 Dignified Care	The bath within Cynan was LOLER inspected and Planned Maintenance checked by Caretech on 11/08/21, with no faults noted. Additional check of bath on 21/09/21 during HIW Inspection, and no faults noted. Review the need for this bath in the ward area, and progress with informed decision.	Head of Operations	15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the blocked toilet on Aneurin Ward is fixed.	4.1 Dignified Care	Toilet was unblocked during the HIW visit	Head of Operations	Completed
The health board must ensure that the bathrooms are not used as storage areas.	4.1 Dignified Care	Site review to be completed to ensure appropriate storage facilities identified for any mobility aids and equipment on site	Head of Operations	30/11/21
The health board must ensure that the Section 136 suite remains open and there are sufficient staff available to cover admissions.	5.1 Timely access	To ensure effective E-roster planning, aligned to KPI's. To ensure efficient planning to known absences through allocation of duties locally, bank, overtime or agency where required. To continue with a daily review of staffing through the Acute Care Meetings and Safety Huddles to support resolution of any staffing issues locally. To ensure any outstanding staffing issues are escalated into the Divisional Huddle for resolution/mitigation For out of hours, escalation to MH&LD Divisional Bronze/Silver on call for resolution/mitigation	Head of Operations/ Head of Nursing	Completed and reviewed daily

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136 Suite.	5.1 Timely access	Ensure dignity screens are in place at all times to enable appropriate privacy	Head of Operations	Completed
The health board must ensure that a pathway is developed in the health board for older adult care.	5.1 Timely access	OPMH Pathway: Divisional meetings have commenced with clear terms of reference. Second meeting held 26/10/21. Options appraisal to be completed based on the qualitative baseline data for the area. Project plan to be developed and progressed via monthly OPMH meetings. OPMH service model development to be identified and progressed through the Clinical Strategy Group.	OPMH Pathway Lead OPMH Pathway Lead Head of transformation OPMH Pathway Lead	Completed and monthly meetings 30/11/2021 30/12/2021 30/06/2022
The health board must ensure that capacity assessments are completed and recorded in patient records.	6.2 Peoples rights	Bulletin to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence. Further development of the patient notes audit checklist to ensure inclusion of all necessary standards, including capacity assessments. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of the bulletin are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Nursing Head of Nursing Head of Operations	15/11/21 30/11/21 16/11/21
The health board must put a system in place for patient meetings with ward staff.	6.3 Listening and Learning from feedback	Develop fortnightly group meetings between patients and staff, using the model developed by Rehab Services.	Head of Operations	30/11/21
Delivery of safe and effective care				
The health board must ensure that staff confirm the identity of visitors prior to allowing access on to the ward.	2.1 Managing risk and promoting health and safety	Email circulated to all service areas on 14/09/21 reaffirming guidance for any visitors to units.	Head of Operations	Completed 14/09/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review Visitor Logs and Visitor Record Checklist to ensure correct completion weekly. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Include email in staff handover document.		Completed and ongoing 15/11/21 15/11/21
The health board must ensure that sticky tape residue marks where items had been stuck to doors and windows is removed.	2.1 Managing risk and promoting health and safety	Domestic supervisors emailed on 27/10/21 to support full review of all doors and windows, to ensure rectified.	Head of Operations	15/11/21
The health board must ensure that the plaster flaking on walls both sides of the garden entrance door to Cynan Ward is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/2021 and is included in full estates plan for the Hergest site, which is currently going via tendering processes. Continued progress to be monitored via Local Area Estates monthly meetings.	Head of Operations	30/11/21
The health board must ensure the plaster flaking and dampness near the external door to the 136 suite is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/21 and is included in full estates plan for the Hergest site, which is currently going via tendering processes.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continued progress to be monitored via Local Area Estates monthly meetings.		
The health board must ensure that the cluttered storage cupboards are organised.	2.1 Managing risk and promoting health and safety	Full site mapping of all identified storage cupboards that require organising Delegate task of organising cupboards to named member of staff. Ensure spot checks of storage cupboards are incorporated in monthly Matron unit walkabout.	Head of Operations	15/11/21 22/11/21 30/11/21
The health board must ensure that the hot water tap is fixed on Aneurin Ward.	2.1 Managing risk and promoting health and safety	Fixed on 24/09/21.	Head of Operations	Completed
The health board must ensure that the patient bathrooms are not used as storage areas.	2.1 Managing risk and promoting health and safety	The disabled bathrooms are currently not in use where items are stored. Assess the alternative storage requirement needs on a site wide basis. Identify alternative storage and move all items that need to be stored on site.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that risk assessments are undertaken for all individuals on a ward when a high/low profiling bed is being used.	2.1 Managing risk and promoting health and safety	Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed. Further development of patient notes audit checklist to ensure inclusion of all required standards, risk assessments for high/low profiling beds. Routine checks to be added to the manager's weekly ward round and monthly Clinical Site Manager walkabout	Head of Nursing	15/11/21 30/10/21 30/10/21
The health board must ensure that there are regular environmental audits to identify any unreported damaged areas.	2.1 Managing risk and promoting health and safety	Environmental Audits to be completed monthly by the Clinical Site Manager, or designated manager in his/her absence. The Audit outcome will be an Agenda item in the monthly Quality, Safety and Experience (QSE) meeting to ensure actions have been taken, and monitoring and review arrangements are in place.	Head of Operations Head of Nursing Head of Nursing	30/12/21 30/12/21 30/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continuation of the Credits for Cleaning bi monthly audits take place and feed into QSE meetings. To introduce quarterly senior management Hergest walk about together with Estates.	Head of Operations	30/12/21
The health board should ensure that there is representation from ward staff at meetings.	2.1 Managing risk and promoting health and safety	Review the Terms of Reference for core meeting to ensure there is appropriate representation from ward staff.	Head of Nursing	15/11/2021
The health board must ensure that all staff check visitor's compliance with COVID-19 procedures.	2.4 Infection Prevention and Control (IPC) and Decontamination	Email circulated to all areas on 14/09/21 reaffirming guidance for any visitors to the units. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Delegate task of Notice Board responsibility to named member of staff, to ensure regular updates, refresh documents and items are clearly visible	Head of Operations	Completed 15/11/21 15/11/21
The health board must ensure that the isolation suite has suitable storage for PPE.	2.4 Infection Prevention and	Full review of this area has been completed with Infection Prevention	Head of Operations	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Control (IPC) and Decontamination	Lead, Acute Care Site manager, Head of Nursing and Head of Operations. Specific storage containers fixed to walls and in designated areas within this environment		
The health board must ensure that HIW are provided with details of improvements made to the isolation suite.	2.4 Infection Prevention and Control (IPC) and Decontamination	As noted in 2.4. Additionally, designated doffing and donning area is now available. Sink for effective hand hygiene is now in place. Clear signage visible to ensure staff compliance at all times.	Head of Operations	Completed
The health board must ensure that staff record fridge and clinical room temperatures.	2.6 Medicines Management	Communication to be circulated to all inpatient staff in relation to ensuring that staff record fridge and clinical room temperatures. Communication to be discussed during staff handovers. Nominated ward lead for the day to be allocated the responsibility that daily	Head of Nursing	22/11/21 22/11/21 Completed 31/10/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		fridge audits are completed and discussed at all handovers. Acute Care site Manager to routinely undertake spot checks to ensure implementation Continued support from pharmacy leads to ensure compliance during their weekly ward visits.		Completed Completed
The health board must ensure that any fridge or clinic room temperatures outside the required range are addressed.	2.6 Medicines Management	Any fridge or clinic temperatures outside the required range, following the routine checks highlighted above, to be addressed immediately or escalated as required if unable to be resolved. This issue identified during the HIW inspection was resolved at the time, via support from lead pharmacist.	Head of Operations	Completed
The health board must ensure they investigate the raised temperature in the clinical room.	2.6 Medicines Management	Undertake room temperature audit over a month, discuss results with Estates department for informed decision of next steps.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Include clinical room temperature review on the Agenda of local area Estates meeting to ensure action progresses.		
The health board must ensure that dated of opening liquid medications are recorded.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to dating of opened liquid medications. Include spot checking of dates recorded on open medication on weekly ward manager walkabout.	Head of Nursing	05/11/21
The health board must ensure that any allergies are clearly specified on drug charts.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to allergies.	Head of Nursing	05/11/21
The health board must ensure that staff are aware of the location and content of the medication management policy.	2.6 Medicines Management	Communication circulated to reaffirm the location and content of Medication Management policy. Ensure location and content of Medication Management policy is included in staff Induction.	Head of Nursing Education and training lead	05/11/21 31/03/22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ensure the Medication Management policy is continually clearly displayed in all ward areas and clinical rooms.	Clinical Site Manager	05/11/21
The health board must ensure that the unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of unmet needs. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	15/11/21 15/11/21 15/11/21 30/11/21 6/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that observation record sheets are accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of therapeutic, observation and engagement documentation requirements.	Head of Operations	15/11/21
		MH&LD Staff Briefing to also include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards,	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/21
		Copies of correspondence to be displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/21
		Review of the current MH&LD Therapeutic, Observation and	Head of Operations	31/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Engagement policy and training plan to support implementation.		
The health board must ensure that food and fluid charts are completed in full and accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of food and fluid charts documentation is completed for relevant patients. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	15/11/2021. 15/11/2021 15/11/2021 30/11/2021 16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that review dates are recorded in care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of care plans. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	15/11/2021. 15/11/2021 15/11/2021 30/10/2021 16/10/2021
The health board must ensure that patient records have evidence of physical assessments taking place.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of the risk booklet on admission	Head of Operations	15/11/2021.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head Of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that capacity assessments are completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that COVID-19 care plans are fully completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of Covid 19 care plans.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	16/11/2021
The health board must ensure that care co-ordinators are identified and named in patient records.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of details of all professionals involved in patients' care.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that management and ward staff work together to build up confidence and trust.	Governance, Leadership and Accountability	Together with staff identify how confidence and trust can be strengthened. Communicate and engage with staff to listen to and understand how this can be achieved. To review the outcome of the MH&LD Reflect and Learn Survey, currently being undertaken across the Division. Increased visibility and accessibility of Senior Leadership Team across the unit. Implement 'You Said, we did' notice boards, and to enable staff to make suggestions install Suggestion boxes across the ward areas.	Head of Operations	31/12/21 16/11/2021 31/12/21 Completed 31/12/21
The health board must ensure that senior management improve communication with staff.	Governance, Leadership and Accountability	Increased presence on the wards by Senior Leadership Team.	Head of Operations	Develop cycle of visits by 30/11/21 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review and strengthen MH&LD Communication and Engagement plan. Continue with annual MH&LD Staff Briefing cycle of business. Review outcomes of the MH&LD Staff survey themes. Develop staff focus groups to ascertain preferred communication methods for staff.	Director of Nursing/Director of Operations. Director of Operations Head of Workforce Head of Operations	30/11/21 30/11/21 30/11/21
The health board must ensure that MDT work collaboratively with ward staff.	Governance, Leadership and Accountability	Review current function and Terms of Reference of Weekly MDT meetings, to ensure full engagement and collaboration with all disciplines.	Head of Nursing	16/11/2021
The health board must ensure that a consistent and stable senior management team is maintained.	Governance, Leadership and Accountability	The Division recognises the importance of stable leadership, and are actively progressing through workforce processes to enable the long term	Director of Operations/ Director of Nursing	31/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		stability of the Senior Leadership team to be affirmed. In the meantime, consistency of interim arrangements will continue.		
The health board must ensure that staff do not work excessive hours.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be displayed on notice boards and discussed in handovers. To continue with a daily review of any staff working excessive hours through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations	Completed 05/11/21 Completed
The health board must ensure that staff have breaks and feel confident leaving the ward for breaks.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be discussed at staff handovers. Memo to be displayed on ward notice boards.	Head of Operations Clinical Site Manager Clinical Site Manager	Completed 15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		To continue with a daily review of any staff who are unable to take their breaks through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally. Ensure escalation to SLT in hours, or bronze if out of hours, if staff unable to take their breaks.	Head of Operations Head of Operations	Completed Completed
The health board must ensure that there are appropriate areas where staff can take their breaks.	7.1 Workforce	Review of current staff rooms and facilities on site. Continue with the development of Wellness room on site.	Head of Operations	05/11/2021
The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.	7.1 Workforce	Review of E roster KPI compliance on a weekly basis, to ensure actions taken where compliance it not met. Additional E roster training to be completed in order to ensure all managers are aware of KPI's and guidance.	Head of Nursing	Completed 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times.	7.1 Workforce	To continue with a daily review of staffing levels through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally. Staffing establishment review commenced to enable creation of an agreed model, and understanding of staffing requirements to ensure safe delivery of care in all Divisional inpatient settings.	Head of Operations/Head of Nursing Director of Nursing	Completed daily. 30/1/2022
The health board must ensure that mandatory training figures are improved.	7.1 Workforce	Mandatory Training compliance monitored and reviewed weekly at Operational Leadership meeting. Local Area Performance report provides an in-depth summary of mandatory training for all staff disciplines, discussed and reviewed at the monthly Quality, Operational and Delivery meeting, recommended actions to be implemented as required.	Service Managers Head of Operations	Completed and continue to monitor weekly Completed monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Divisional Mandatory training compliance reviewed at DSLT Finance and Performance meeting, recommended actions to be implemented as required.	Head of Operations	Continue monthly
The health board must ensure that regular team meetings take place for staff.	7.1 Workforce	SLT to work with ward managers to support full implementation of team meetings for all disciplines in their areas	Head of Operations.	15/11/2021

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

Name (print): **Carole Evanson, MH&LD Director of Operations (Interim)**

Mike Smith, MH&LD Director of Nursing (Interim)

Date: 01/11/2021

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Compliance with the Mental Health Act Audit**
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 – Quarterly Audit Results

Argymhelliad / Recommendation:

The committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

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

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

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

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

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

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

Cefndir / Background:

An initial audit was conducted in August 2021 for a number of units where patients are detained and a report produced in September, a follow up audit was conducted and produced November 2021 which included all units aside from Heddfan, Hergest and Ablett as these are scrutinised by the Associate Hospital Managers on a monthly basis.

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 a yearly 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.

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

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 audit as below 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.

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

Goblygiadau Strategol / Strategy Implications

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

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

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

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

Dadansoddiad Risk / Risk Analysis

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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

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

APPENDIX 1

Mental Health and Learning Disabilities Division

Compliance with the Mental Health Act

Quarterly Audit Results – February 2022

SUMMARY

There have been a number of significant improvements seen following the commencement of the quarterly audits of these units. The increase in the explanation of rights documents supports the patients and confirms the health board is working towards ensuring all patients are supported by an IMHA if required and are fully aware of their rights under the Mental Health Act. Documentation is easier to locate and allows all who access the notes the ability to confirm that the patient is correctly detained.

Documents which were reported as missing were identified within a matter of hours or completed, all actions have since been addressed.

It is recognised that as the units become accustomed to the regular audit there will be no requirements for action plans as previously seen.

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

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 February, the same ten 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.

64 files were scrutinised:

Specialism and Unit	Number of files scrutinised
Older Persons	
Cefni Hospital	10
Bryn Hesketh	12
Rehabilitation	
Tan Y Castell	4
Coed Celyn	4
Carreg Fawr	6
Forensic	
Ty Llywelyn	17

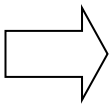
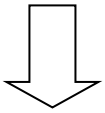
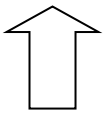
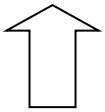
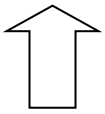
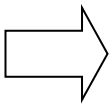
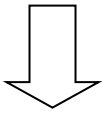
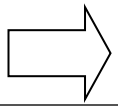
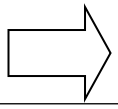
Specialism and Unit	Number of files scrutinised
Learning Disability Villas	
Tan Y Coed	2
Foelas	1
Mesen Fach	5
CAMHS	
North Wales Adolescent Service	3

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.	**80%**	**20%**	⇧
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.	**80%**	**20%**	⇧
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**70%**	**30%**	⇧
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.	**90%**	**10%**	⇩
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**70%**	**30%**	⇩
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.	**90%**	**10%**	⇧

NOTES
There has been an improvement in all standards apart from six and seven.
Standard one and six were rectified the following day.
The ward manager has been asked to ensure up to date CTPs are within the files of the three patients for which they were missing.

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%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**91%**	**9%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**83%**	**17%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**91%**	**9%**	
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%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**58%**	**42%**	
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

There has been an improvement in relation to explanation of rights and the associated functions under the Mental Health Act to ensure the patients have access to IMHAs.
The CTPs have been requested via the ward manager.

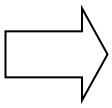
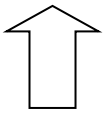
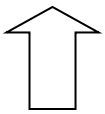
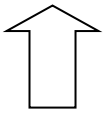
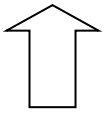
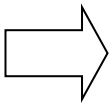
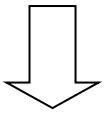
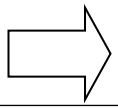
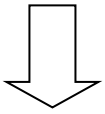
3 Tan Y Castell

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.	**75%**	**25%**	⇩
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 CTP has now been received.

4 Coed Celyn

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%**		
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	**75%**	**25%**	
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%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**75%**	**25%**	
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.	**75%**	**25%**	

NOTES

Coed Celyn has made improvements in relation to explanation of rights and S17 documentation. A CTP review was arranged for February to update the CTP.

5 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.	**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%**		⇨
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**		⇧
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**66.6%**	**33.3%**	⇩
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.	**83.3%**	**16.6%**	⇨

NOTES
Carreg Fawr has made improvements in all areas and has been supported by the MHA department. The missing CTPs have been escalated to the Ward Manager to ensure completion, confirmation has been received that one has been completed.

6 Ty Llywelyn

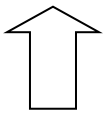
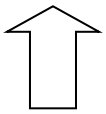
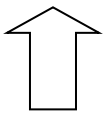
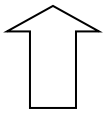
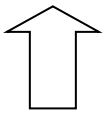
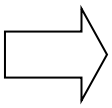
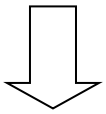
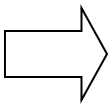
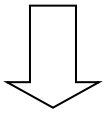
No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**88%**	**12%**	⇧
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**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	**70.5%**	**29.5%**	⇩
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**94%**	**6%**	⇨
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**		⇨
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**82%**	**18%**	⇧
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.	**53%**	**47%**	⇧

NOTES

The Mental Health Measure Department confirmed the unit is 100% compliant with their CTPs the up to date documents have been asked to be printed by the ward managers for the files.

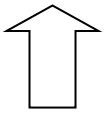
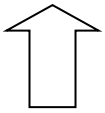
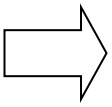
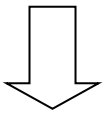
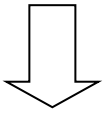
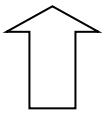
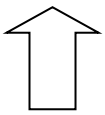
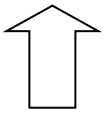
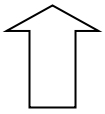
The appointment of the new ward clerk has had a positive impact and a system has been set up so that they are aware of the current section documents that should be carried forward when files are downsized, the missing ones from this audit were rectified the following day.

7 Tan Y Coed

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.	**50%**	**50%**	
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.	**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.	**50%**	**50%**	

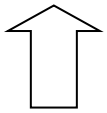
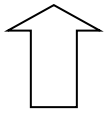
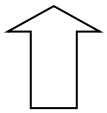
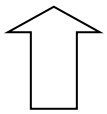
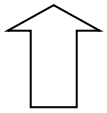
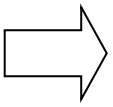
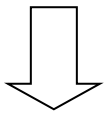
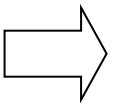
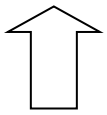
NOTES
There has been improvements within the unit in regard to the explanation of rights and associated standards. The S17 documentation was rectified on the day and the CTP has been requested.

8 Foelas

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.	**0%**	**100%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**0%**	**100%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**0%**	**100%**	
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
There has been improvements within the unit in regard to the documentation but the lack of an explanation of rights form affects the results for standard four and five. This document has now been completed.

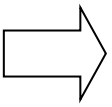
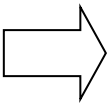
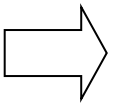
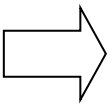
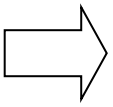
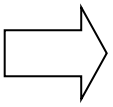
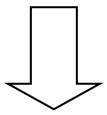
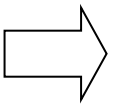
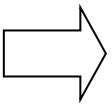
9 Mesen Fach

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**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.	**80%**	**20%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**80%**	**20%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**80%**	**20%**	
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.	**40%**	**60%**	

NOTES

There has been improvements within the unit in regard to the documentation. The CTPs and missing explanation of rights has been highlighted to the ward manager.

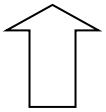
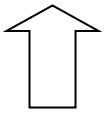
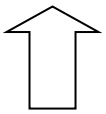
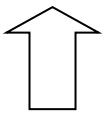
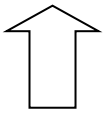
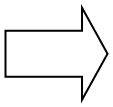
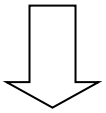
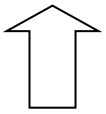
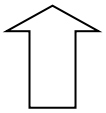
10 CAMHS – North Wales Adolescent Service

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.	**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.	**66.6%**	**33.3%**	
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. There are problems with CTPs for young people who are out of area this is being worked through by the unit and managers.

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.	**93%**	**7%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**83%**	**17%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**90%**	**10%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**81%**	**19%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**95%**	**5%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**98%**	**2%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**70%**	**30%**	
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.	**76%**	**24%**	

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.4.22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Power of Discharge Group report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Hilary Owen, Head of Governance and Compliance MHLD Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to:

(1) note the report,
(2) approve three new POD appointments,
(3) confirm the POD representative requirement at MHaCCC.

Also, to support the POD group and the Associate Hospital Managers with progression of their requests relating to overnight accomodation (to attend the all Wales event – 11 May 2022), and support the progression of work on the electronic equipment request.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

This report does not inform strategic decisions, it relates to the 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.

Sefyllfa / Situation:

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.

Cefndir / Background:

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

Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (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, attended by ten appointed Associate Hospital Managers, Head of Governance and Compliance, Director of Nursing MHLD, Director of MHLD and the Mental Health Act Manager.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The use of the Mental Health Act is determined by patient needs, and the least restrictive option is at the forefront of all professional practice. The Associate Hospital Managers have a duty as independent persons to ensure that the Health Board only detains patients who meet the criteria for detention. The Power of Discharge Group enables the Associate Hospital Managers to review their activity over the quarterly period reported.

The Power of Discharge Group meeting was held on the 25 February 2022. Regrettably this meeting was not quorate, however as the number of Associate Hospital Managers was greater than the number of health board representatives, it was agreed that the meeting should proceed, noting that no major decisions were to be taken.

Discussions included:

- Terms of reference sign off, this had been previously distributed to all members and agreed.
- The Associate Hospital Manager update report.
- The MHA performance report submitted for information only.
- Expressions of interest for new members to bring the POD membership to the required 10.
- All Wales Hospital Managers Conference 2022.
- Electronic support for Associate Hospital Managers.

The group felt the following areas required escalation and highlighting to the Mental Health Capacity and Compliance Committee.

- **Power of Discharge Group Vacancies**
  Expressions of interest were received for the three vacancies on the POD Group, those at the meeting supported all three.

The MHCCC is asked to approve the appointments of Sean Holcroft, Jenny Gilmore and Louise Cunliffe.

- **Gwynfor Williams retirement**
  A notice to retire has been received from Reverend Gwynfor Williams. Rev. Williams was a longstanding Associate Hospital Manager who predominantly assisted within the West area. Following the move to remote hearings Rev. Williams stepped down from hearings due to challenges with technology and later due to ill health, he has since decided he will not be returning. A letter of thanks for his service will be sent.

- **POD representative for the Mental Health Capacity and Compliance Committee**
  Following the retirement of Frank Brown, the Associate Hospital Managers and POD wished to be informed if an expression of interest will be requested from the MHCCC for a replacement representative.

- **All Wales Hospital Managers Conference 2022**
  The Conference (supported by Edge training and organised by Cardiff and Vale UHB) has been scheduled for the 11 May 2022, at the Royal Welsh Showground in Llandrindod Wells. POD members noted that this is an opportunity for networking and liaising with colleagues across Wales. In addition, Associate Hospital Managers from BCUHB have been requested to facilitate one of the workshops. Concern was raised in regards to the lengthy travel time to the venue, in particular the early start to arrive for the conference time, it was noted this would deter some Associate Hospital Managers from attending.

  The Group are requesting that attendance includes overnight accommodation if required. *The committee is asked for support to progress this accommodation request*.

- **Electronic support for Associate Hospital Managers**

  Following a scoping exercise to determine needs of Associate Hospital Managers an SBAR is to be submitted for devices (either iPADs or laptops) to be supplied to the Managers, this will assist in the move to a reduction in patient information sent via the postal system, access to Health Board emails and ESR and a more efficient way of working along with eliminating the risk of patient personal information going astray.
  The Committee is asked for support to progress the electronic support request.

Opsiynau a ystyriwyd / Options considered

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

The Power of Discharge Group is to be held on a quarterly basis to allow for reporting to the Mental Health Capacity and Compliance Committee.

Goblygiadau Ariannol / Financial Implications

Financial support will be required for the electronic devices supplied to the Managers previously an estimate of £10,000 was received to supply 25 Associate Hospital Managers with devices.

Financial support will be required for accommodation for those that wish to attend the All Wales Conference.

Dadansoddiad Risk / Risk Analysis

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.

The Power of Discharge Group membership includes ten appointed Associate Hospital Managers and a number of staff from the Health Board. It is a requirement of the Group that the number of Associate Hospital Managers in attendance should not be less than those attending as representatives of the Health Board.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.

Asesiad Effaith / Impact Assessment

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