

## Minutes of the Mental Health Legislation Committee Held on 29th April 2025 via MS Teams

To view the meeting: [CAVUHB Mental Health Legislation Committee 29.04.2025 - YouTube](#)

<b>Chair:</b>		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
<b>Present:</b>		
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
<b>In Attendance:</b>		
Rim Al-Samsam	RAS	Clinical Board Director – Mental Health
Samuel Barratt	SB	Deputy Director of Operations Children & Women's Clinical Board
Daniel Crossland	DC	Director of Operations - Mental Health
Chloe Evans	CE	MCA & Consent Lead
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Jason Roberts	JR	Executive Director of Nursing
David Seward	DS	Mental Health Act Manager
Matt Phillips	MP	Director of Corporate Governance
Amanda Morgan	AM	Chair of the Power of Discharge Group
Radhika Oruganti	RO	Consultant Psychiatrist
<b>Secretariat:</b>		
Rachel Chilcott	RC	Corporate Governance Officer
<b>Apologies:</b>		

Item No	Agenda Item	Action
MHL 29/04/001	<u><a href="#">Welcome &amp; Introductions</a></u>  The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHL 29/04/002	<u><a href="#">Apologies for Absence</a></u>  Apologies for Absence were noted.  <b>The Committee Resolved that:</b> a) The Apologies for Absence were noted.	
MHL 29/04/003	<b>Declarations of Interest</b>  <i>No declarations of interest were declared.</i>	
MHL 29/04/004	<u><a href="#">Minutes of the Meeting held on 28th January 2025</a></u>  The Minutes of the Meeting held on 28th January 2025 were received and approved.  <b>The Committee Resolved that:</b> a) The minutes of the meeting held on 28.01.2025 were agreed as a true and accurate record.	

<p><b>MHL 29/04/005</b></p>	<p><a href="#"><u>Action Log from the meeting held on 28<sup>th</sup> January 2025</u></a></p> <p>The Action Log was received and discussed.</p> <p><b>The Committee Resolved that:</b></p> <p>a) The Action Log was noted.</p>	
<p><b>MHL 29/04/006</b></p>	<p><b>Committee Chair's Actions</b></p> <p><i>No Chair's Actions were taken since the last meeting.</i></p>	
<p><b>MHL 29/04/007</b></p>	<p><b>Any Other Urgent Business Agreed with the Chair</b></p> <p><i>No other urgent business was agreed with the Chair.</i></p>	
<b>Mental Health Act</b>		
<p><b>MHL 29/04/008</b></p>	<p><a href="#"><u>Mental Capacity Act Monitoring Report and DoLS Monitoring</u></a></p> <p>The MCA &amp; Consent Lead (MCA-CL) presented the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring report which provided a general update on current issues related to the MCA and DoLS which included the following:</p> <ul style="list-style-type: none"> <li>• MCA Team Audit 2024/25</li> <li>• Mental Capacity Act Monitoring Actions (January – March 2025)</li> <li>• Mental Capacity IMCA Referral type</li> <li>• Awareness Raising / Training Sessions</li> <li>• Mandatory MCA Training</li> <li>• MCA Practitioner Led Training – 2024/25</li> <li>• MCA Team Advice and Support</li> <li>• MCA Team Resources for Staff</li> <li>• Deprivation of Liberty Safeguards Monitoring Actions</li> <li>• Referrals and Assessments</li> </ul> <p>The Independent Member – General (IM-G) sought assurance that the proformas being used were effectively capturing the necessary data for both internal monitoring and auditing, whilst also serving as an informed decision-making tool for clinicians.</p> <p>In addition, the IM-G asked for more detail around the DoLS withdrawal rate of 274, specifically:</p> <ul style="list-style-type: none"> <li>• The number of inappropriate referrals.</li> <li>• Cases resolved before assessment</li> <li>• Cases where the DoLS expired before the assessment took place.</li> </ul> <p>The MCA-CL responded that the new proforma was more detailed and followed the MCA process. It prompted essential questions and included the guidance note as an appendix to help users complete it accurately. This ensured a robust capacity assessment, and it was supported by optional training on the practical application of the Act. The updated form was being finalised and would be shared at the following meeting.</p> <p>In terms of withdrawals, the MCA-CL responded that there was no detailed breakdown of withdrawal types. Withdrawals often occurred when patients were discharged or moved between wards. The DoLS team were working on reusing assessments for similar ward moves. Detailed breakdowns could be requested for future reports.</p> <p>The IM-G sought confirmation that elderly care wards were being targeted to promote the necessity of DoLS assessments, as referrals seemed more prevalent in this group.</p>	

The MCA-CL responded that the aim was to ensure that there was a focus on patients who may lack capacity to consent to their admission. Their administrator logged issues with referrals, which were addressed with wards and used to help target training. DoLS resources would be sent to all inpatient wards to encourage discussions and improve understanding.

The Independent Member – Local Authority (IM-LA) expressed concern that there was a lack of significant overall improvement from the MCA audit. She highlighted the first recommendation for each area to develop an action plan to address concerns and asked whether this was a new requirement.

The MCA-CL responded that MCA team felt that clinical boards needed to take more direct responsibility for improving practices. The Directors of Nursing had been supportive which had led to recent improvement. Developing their own action plans would give clinical boards control and help with implementation.

The IM-LA asked how, given capacity issues, would the action plans be followed up to ensure they were effective and achieving improvements.

The MCA-CL responded that the MCA team would have oversight of the action plans to ensure they addressed the issues. An audit would be conducted in the summer, and it was hoped that areas would perform mini audits throughout the year to monitor practices.

The CC suggested that the MCA-CL report back in Q3 on how the action plans are progressing.

Regarding the Court of Protection (COP), the Clinical Board Director – Mental Health (CBD-MH) noted the reluctance from some senior decision-makers in mental health and medicine to take risky decisions, preferring to defer responsibility to the COP. The Head of Corporate Governance (HCG) sent a guidance document in January 2025 on when to go to the COP, but suggested it needed to include scenarios for borderline decisions. The lack of distribution of this guidance was causing delayed discharges and back-and-forth between senior teams and legal about going to the COP.

The Director of Corporate Governance (DCG) acknowledged the issue of risk aversion which led to decisions being delegated to the Court, even in non-mental health matters, where disciplinary teams should be making these decisions. He would address the issue with the HCG and provide feedback.

The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) suggested the inclusion of raw figures on Section 49 requests in the report to better understand the volume and origin.

The ICDPPT asked whether the MCA team were getting enough support digitally.

The MCA-CL responded with the following:

- There had been very few Section 49 requests corporately, with only around two the previous year. However, some requests may be handled within individual clinical areas without broader awareness.
- The All-Wales Group for DoLS, along with the medical illustration department, had developed digital forms to streamline the process and reduce paper use. These forms would soon be circulated and can be emailed directly to the DoLS team.

	<ul style="list-style-type: none"> <li>The forms would be shared at the following meeting, with positive feedback already received from the legal team.</li> </ul> <p>The CC noted that whilst the report mentioned improvement in mandatory training for medical and dental staff, the figure was still below 50%. The low compliance rate was significantly affecting the UHB's overall compliance rate and emphasised this should not be seen as an accomplishment. He asked that relevant colleagues be informed that there was still a lot more work to be done.</p> <p>The MCA-CL agreed and noted the issue had been raised with the Executive Medical Director (EMD) and was being addressed as part of a broader approach to all mandatory training. Compliance figures were shared monthly with clinical boards and highlighted that medical and dental staff were significantly behind other professionals.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>The contents of the report were noted.</li> </ol>	
<b>Mental Capacity Act</b>		
<p><b>MHL</b> <b>29/04/009</b></p>	<p><b><u><a href="#">Mental Health Act Monitoring Exception Report</a></u></b></p> <p>The Mental Health Act Manager (MHAM) presented the Mental Health Act (MHA) Monitoring Exception Report to the Committee which provided a summary of the below:</p> <ul style="list-style-type: none"> <li>Use of the MHA</li> <li>Fundamentally defective applications and reports</li> <li>Section 136 - A&amp;E and CAMHS</li> <li>Nearest relatives discharge requests</li> <li>Development sessions</li> <li>Audits</li> </ul> <p>The MHAM provided a summary of the following reported during the quarter:</p> <ul style="list-style-type: none"> <li>Two fundamentally defective reports</li> <li>The use of Section 136s had decreased</li> </ul> <p>The Committee Vice Chair (CVC) asked about the conclusions being drawn regarding the reasons behind the observed divergence in the data presented in the first graph on Mental Health Inpatient Legal Status.</p> <p>The MHAM responded that often the reasons for increased detentions were unclear.</p> <p>The ICDPPT explained that the team was examining changes in guidance on using DoLS or the MHA, particularly for older people. There was a shift towards formally using the MHA due to changes in the DoLS criteria. The goal was to be as least restrictive as possible whilst ensuring safeguards through independent review.</p> <p>The CVC asked for the figures on Section 117 aftercare, as there could be a correlation between the current data and Section 117 figures.</p> <p>The MHAM responded that the full monitoring report showed the detention rate in the Mental Health Services for Older People (MHSOP) directorate had increased, possibly due to changes in the DoLS and MHA. Section 117 aftercare figures had also risen, but the clinical board had been reviewing out of area patients, leading to an increase in discharge rates. Financially there were more cases due to not using DoLS, but teams were</p>	

	<p>proactively identifying and discharging individuals who did not meet the criteria for Section 117.</p> <p>The IM-G asked whether the increase in detentions under the MHA could be related to seasonal issues.</p> <p>The Director of Operations - Mental Health (DO-MH) responded with the following:</p> <ul style="list-style-type: none"> <li>• Seasonal variation in mental health was seen mainly in Part One patients (mild to moderate), with spikes in October and March, likely due to student influxes and family challenges around holidays.</li> <li>• Research showed no consistent pattern in fluctuations for formal patients and Part Two patients, making it difficult to predict trends.</li> <li>• The RCRP initiative aimed to reduce admission rates for Section 136 cases, with additional sanctuary provisions working with the police as alternatives.</li> <li>• Cardiff and Vale had the highest Section 136 rates in Wales, accounting for 28% of all cases in 2023.</li> <li>• Current data showed a small drop in admission rates, but it was too early to definitively link this to the RCRP initiative. Monitoring would continue to observe trends.</li> </ul> <p><b>The Committee resolved that:</b></p> <p>a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report, was noted.</p>	
<p><b>MHL</b> <b>29/04/010</b></p>	<p><a href="#"><u>Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy</u></a></p> <p>The DO-MH provided the following verbal update to the Committee:</p> <ul style="list-style-type: none"> <li>• Both strategies were expected to be launched on the same date, however Welsh Government (WG) decided to launch the Suicide and Self-Harm Prevention Strategy early to give it its own parity.</li> <li>• The Suicide and Self-Harm strategy emphasised six key areas: listening and learning, involving lived experiences, prevention, empowerment, support, equipping services, and responding. A distinct focus was on giving self-harm equal importance with suicide.</li> <li>• The Mental Health and Wellbeing Strategy was expected to launch by the end of the month.</li> <li>• The last local strategy meeting for the previous Suicide and Self-Harm Strategy was held recently, and implementation of the new strategy would begin soon.</li> <li>• A significant challenge was the lack of third-sector provision for self-harm, which would be addressed through a commissioning strategy with various partners.</li> <li>• A detailed briefing would be provided at the following meeting.</li> </ul> <p>The CVC requested an assessment of the progress and changes from the previous strategy.</p> <p><b>The Committee resolved that:</b></p> <p>a) The verbal update was noted.</p>	
<p><b>MHL</b> <b>29/04/011</b></p>	<p><a href="#"><u>MHA / DoLS Interface</u></a></p> <p>The Consultant Psychiatrist (CP) presented the report to the Committee which discussed the interface issues between the MHA and DoLS, including the impact on patient flow, transfer requests, and Section 117 aftercare costs.</p>	

The CBD-MH asked whether the MHA was intended solely for the assessment and treatment of mental health, not physical health. She referred to cases where the MHA was applied for physical treatment.

The CP explained that if a physical health issue arose because of a mental health condition, it could be treated under the MHA.

The CBD-MH highlighted instances where patients under the MHA, who had physical issues like diabetes, needed court intervention to make decisions about their treatment because they were not receiving mental health treatment.

The CP noted that the case law focused on determining whether a mental disorder was causing a physical health problem. If it was, treatment could be provided under the MHA. In cases of disagreement or differing opinions, the COP is consulted to decide.

The CVC highlighted the significant issue of increasing elderly patients and dementia rates, particularly in medical wards. There were strategic implications for how to best care for these patients and ensure the right staff were assigned. Additionally, she noted the need for effective care patterns to enable rapid discharge and addressed both legal and structural consideration for the medium and long term, given the changing population dynamics.

The CC noted the issue would be addressed and shared with other committees. Further work was needed to understand the full extent of the implications for the organisation.

The CP noted the case law from 2021/23 was relatively new and reached clinicians around 2024. This change highlighted the need for awareness regarding the interpretation of objections. This new legal framework would impact the number of beds and resources available.

The DO-MH highlighted three major issues for the Mental Health Clinical Board:

1. Rising CHC costs and limited CHC provision created a challenging position. It was crucial to avoid rerouting patients quickly to avoid costs and ensure patient care was appropriate. This situation could significantly impact mental health services.
2. The capacity to meet and deliver additional requirements was a concern – these included obligations under Section 117 for care and treatment planning allocations.
3. The overall system was under considerable pressure, and any additional demands would only increase this. Balancing finances, patient safety, governance, and meaningful delivery of services under new rules was a significant challenge.

The IM-G noted concern about the financial impact of patients moving from Section 2 to Section 3 under new case law. She asked if any preliminary calculations had been done to quantify the costs associated with this transition, including the implications of Section 117.

The CP responded that there were four dementia wards, each with 14-15 beds. Patients admitted for mental disorder assessment and treatment were typically under Section 2, which lasted 28 days. The first 2-3 weeks were used for assessment, after which decisions were made about moving to Section 3 or 4. With the new standard DoLS authorisation, most patients would likely move to Section 3 unless they became compliant and non-objecting. The exact numbers were not available, but the impact was expected to be significant.

The DO-MH explained it was more of a process change which involved deciding whether patients should follow the DoLS or the MHA route. Key metrics to monitor included the detention rate and Section 117 activity, particularly in care homes. Data would be gathered to understand the impact of more patients transitioning to Section 3 and the associated costs. Monitoring these metrics would help assess the overall impact and facilitate discussions.

The CC suggested bringing this back to a future committee for discussion.

The DO-MH responded that the CHC data was gathered monthly and could be easily accessed. Whilst diagnostic data wasn't available, age ranges could be used as a rough tool to capture the mental health services for older people, though it may miss early-onset dementia cases under 65. Data from the 65+ cohort would be examined for changes and included in the exception report.

The ICDPPT noted that in the previous MHLAGG meeting, the graphs showing detained and undetained patients by service area was discussed and provided valuable insights into age demographics. It was agreed this analysis would be done more routinely going forward.

The ICDPPT acknowledged the anxiety around the issue but noted that the UK Government was reforming the MHA, and there may be amendments to the DoLS process during this process. This could lead to a more optimistic future in the medium term.

The CC asked for an update at a future committee meeting on the potential impact of the new case law for DoLS and MHA.

The IM-LA asked for more information on the following:

1. The process for timely dissemination of case law implications to the UHB.
2. The effectiveness of the COP given the timescales and potential pressure on patients and resources.
3. On national level discussions regarding the issue's impact.

The DCG explained the reliance on professional networks and sectors to disseminate information, rather than a comprehensive legal system, and suggested that he would consult with Legal and Risk departments to understand if relevant updates were being communicated to the appropriate teams.

The DO-MH noted that legal updates often percolated through UHBs and Local Authorities (LAs) rather than being formally communicated. Monthly meetings with LA colleagues helped share significant legal changes. Sometimes, direct instructions came from WG.

The DO-MH suggested raising this issue with the NHS Executives.

**The Committee resolved that:**

- a. The contents of the report was noted.

**Mental Health Measure**

MHL  
29/04/012

**[Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report](#)**

The DO-MH and the Deputy Director of Operations Children & Women's Clinical Board

	<p>(DDOCWCB) presented the Mental Health Measure Report which outlined the performance of CAVUHB against the various mental health specific targets, which included:</p> <ul style="list-style-type: none"> <li>• Part 1a - target: 28-day referral to assessment compliance target of 80% (Adult) and (Children &amp; Young People)</li> <li>• Part 1b – 28-day assessment to intervention compliance target of 80% (Adult) and (Children &amp; Young People)</li> <li>• Part 2 – Care and Treatment Planning (over 18) and (Children &amp; Young People)</li> <li>• Part 3 – Right to request an assessment by self-referral</li> <li>• Part 4 – Advocacy – standard to have access to an IMHA within 5 working days</li> </ul> <p>The CVC highlighted the level of need in Part 1a. She suggested reviewing commissioning arrangements and considering whether assessments could be conducted closer to primary care or within the community. Additionally, she requested the volume of people applying for self-referral assessments rather than percentages.</p> <p>The DO-MH responded that the plan was to invest more into the 111 Press 2 national helpline to provide rapid access to mental health services, aiming to reduce demand on other services. Whilst Part 1 assessment provisions were satisfactory and successful, CAV were experiencing an unusual rise in referrals, unlike other areas in Wales. This increase may require additional investment.</p> <p>The DO-MH suggested providing a breakdown of the Part 3 figures for the following meeting.</p> <p>The CC asked whether there was any intelligence surrounding why CAV were experiencing the increased demand compared to the rest of Wales.</p> <p>The DO-MH responded with the following:</p> <ul style="list-style-type: none"> <li>• There weren't specific reasons identified for the rise in referrals, though structural changes in the primary care liaison service may have contributed.</li> <li>• Socioeconomic factors such as benefits, finances, and community connections were likely to influence the increase.</li> <li>• The focus on future commissioning work would be on addressing these socioeconomic challenges, allowing services to concentrate more on care and treatment.</li> <li>• Further detail would be sought from discussions with stakeholders across Cardiff.</li> </ul> <p><b>The Committee Resolved that:</b></p> <p>a) The contents of the report was noted.</p>	
<b>Items to bring to the attention of the Committee for Noting / Information</b>		
<p><b>MHL</b> <b>29/04/013</b></p>	<p><a href="#"><u>Sub-Committee Meeting Minutes:</u></a></p> <p><a href="#"><u>Hospital Managers Power of Discharge Sub-Committee Minutes – 8<sup>th</sup> April 2025</u></a></p> <p>The Chair of the Power of Discharge Group (CPDG) took the minutes as read, and highlighted that the MCA and Dols Interface and split decision issues were discussed.</p> <p><a href="#"><u>Mental Health Legislation and Governance Group (MHLGG) - 10<sup>th</sup> April 2025</u></a></p> <p>The ICDPPT took the minutes as read and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The activity report was reviewed, and they discussed breaking up graphs on informal and formal detention by service areas</li> <li>• The MHA / DoLS Interface topic was discussed</li> <li>• Discussion with AMHP colleagues was had around relative merits of Section 2 versus Section 3. This was likely to be ongoing debate.</li> </ul>	

	<ul style="list-style-type: none"> <li>• Discussion was had about the St John's Ambulance contract and their transportation cut-off times.</li> <li>• There were difficulties for advocacy colleagues in joining ward rounds of detained patients.</li> <li>• They would keep an eye on the MHA reforms and noted tabled amendments regarding who can receive Section 136s.</li> </ul> <p><b>The Committee Resolved that:</b></p> <p>a) The Sub-Committee Meeting Minutes were noted.</p>	
<b>HL 29/04/014</b>	<p><a href="#"><u>Annual Report of the Mental Health Legislation Committee 2024/25</u></a></p> <p><b>The Committee Resolved that:</b></p> <p>a. The MHL Annual Report 2024/25 was noted.</p>	
	<b>Items for Approval / Ratification</b>	
<b>MHL 29/04/015</b>	<i>No items.</i>	
	<a href="#"><u>Any Other Business</u></a>	
<b>MHL 29/04/016</b>	The DO-MH suggested bringing a paper around the challenges of access to Section 12s and the future proofing of the provision.	
<b>MHL 29/04/017</b>	<p><b>To note the date, time and venue of the next meeting:</b></p> <p>29<sup>th</sup> July 2025 via MS Teams</p>	