Draft Minutes of the Mental Health Legislation Committee
Held on 27th January 2026 via MS Teams

To view the meeting: CAVUHB Mental Health Legislation Committee 27.01.2026 - YouTube

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Rachna Upadhya	RU	Committee Vice Chair / Independent Member - General
Clive Curtis	CC	Independent Member - Community
Kirsty Williams	KW	UHB Chair
In Attendance:		
Rim Al-Samsam	RAS	Clinical Board Director – Mental Health
Chloe Evans	CE	MCA & Consent Lead
Jason Roberts	JR	Executive Director of Nursing
David Seward	DS	Mental Health Act Manager
David Fluck	DF	Executive Medical Director
Matt Phillips	MP	Director of Corporate Governance
Julian Willett	JW	Transformation & Innovation Lead - Mental Health
Samuel Barrett	SB	Interim Director of Operations – Mental Health
Additional Attendees:		
Amanda Morgan	AM	Chair of the Power of Discharge Group
Neil Kitchiner	NK	Director & Consultant Clinical Lead - Veterans
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Alex Nute	AN	Vice Chair of the Power of Discharge Group
Susan Lloyd-Selby	SLS	Independent Member – Local Authority

Item No	Agenda Item	Action
MHL 2026/01/1.1	**Welcome, Introductions and Apologies for Absence** Ceri Phillips (CP), the Committee Chair, welcomed everybody to the meeting in English and in Welsh.	
MHL 2026/01/1.2	**Declarations of Interest** *No declarations of interest were declared*.	
MHL 2026/01/1.3	**Minutes of the Meeting held on 21.10.2025** The Minutes of the Meeting held on 21.10.2025 were received and approved. **The Committee Resolved that:** a) The minutes of the meeting held on 21.10.2025 were agreed as a true and accurate record.	
MHL 2026/01/1.4	**Action Log from the meeting held on 21.10.2025** The Action Log was received and discussed.	

	The Committee Resolved that: a) The Action Log was noted.	
MHL 2026/01/1.5	**Committee Chair's Actions** *No Chair's Actions were taken since the last meeting.*	
	Mental Health Act	
MHL 2026/01/2.1	**Mental Capacity Act Monitoring Report and DoLS Monitoring** Chloe Evans (CE), the MCA & Consent Lead, 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: • Mental Capacity Act Monitoring Actions (October - December 2025) • Mental Capacity IMCA Referral type • Awareness Raising / Training Sessions • Mandatory MCA Training • MCA Practitioner Led Training • MCA Team Advice and Support, and MCA Team Resources • MCA Audit Action Plans • Deprivation of Liberty Safeguards Monitoring Actions - Quarterly Overview from October - December 2025 • Referrals and Assessments • Actions from DoLS Internal Audit report CP asked for more clarification on the expected improvement for mandatory MCA Level 2 training across all professional groups. CE responded that following the MCA team's audit, all clinical boards produced action plans. They were starting to see more staff booking onto the practical training, and the online ESR option should support further uptake. They would monitor the figures monthly. Kirsty Williams (KW), the UHB Chair, highlighted concern around low compliance in all staff groups, particularly medicine and dentistry. She asked whether they understood the barriers for this group, and were they explaining the potential consequences for patients and the organisation if progress wasn't made. CE responded that they always emphasised the importance of the training in protecting patient's rights, and they ran awareness campaigns on issues. This staff group had faced similar challenges with other mandatory training as well. David Fluck (DF), the Executive Medical Director, added that they were currently clarifying the consequences for not completing the mandatory training. Rim Al-Samsam (RAS), the Clinical Board Director – Mental Health, explained that psychiatrists completed a more detailed MCA certification, which should be recorded so they did not have to also do the online module.	

DF responded that they were reviewing mandatory training to confirm what truly was required, and they were also making sure that equivalent training was properly recognised and recorded on the system. This was a Wales-wide issue.

Rachna Upadhya (RU), the Committee Vice Chair, asked the following questions:

1. Could they split the mandatory training into two two-hour sessions to help clinicians who struggled to block out the time?
2. Over 70-referrals data - did CAVUHB's approach differ between the 70-79 and the 80-89 age group, or was it the same?
3. There were 29 urgent assessment breaches of the statutory timeframe – how would this be addressed going forward?

CE clarified that the four-hour session was not the mandatory training – the mandatory MCA training was either an online ESR module or a two-hour face-to-face session. The four-hour session was the practical MCA application training, aimed at building confidence in preparing, assessing and documenting capacity assessments.

RU responded her question was about the four-hour practical application training sessions. She asked whether the training session being split in two would disturb the flow of the session.

CE responded that splitting the session would not work as well, as the content flowed continuously, and releasing staff twice would be just as difficult as people may not attend the second session. They were always open to suggestions on improving training delivery.

CE asked whether RU's query about a different approach for over-70 referrals were from an advocacy perspective or from the adult process perspective.

RU responded she meant for both. She assumed there was no major difference, but now they had been split the data by age group, it would be helpful to know whether their approach varied.

CE responded with the following:

- They had not seen differences between the age groups, as the DoLS process was strictly set by statute. Advocacy remained flexible, and it was always expected that older adults made up a high proportion.
- For the MCA team, the breakdown helped to emphasise in training that older patients were more likely to lack capacity, so they were targeting areas like trauma and orthopaedics and key hospital entry points to ensure capacity was assessed correctly from the start.
- Regarding the 29 urgent assessment breaches – although still high, this was a significant improvement compared to previous years, when breaches were around two thirds of cases. DoLS pressures were a national issue, which was why Liberty Protection Safeguards (LPS) was due to replace it. They prioritised using a RAG-rated matrix, focusing on patients likely to stay longer or those at high risk.

Clive Curtis (CC), the Independent Member – Community, asked whether there were reputational or legal risks for the Board if statutory assessment timescales weren't met.

CE responded that there were some risks, but Welsh Government (WG) and the Court of Protection (COP) recognised the system's limitations. Despite additional funding, the

	system remained overstretched, which was why LPS was being developed to replace it. Referral numbers continued to rise as awareness improved, so whilst they managed it as best as they could, the current system was unlikely to ever fully meet demand. **The Committee resolved that**: a) The contents of the report were noted.	
	Mental Capacity Act	
MHL 2026/01/3.1	**Mental Health Act Monitoring Exception Report** DS presented the Mental Health Act (MHA) Monitoring Exception Report to the Committee which provided a summary of the below: • Use of the MHA • Fundamentally defective applications and reports • Section 136 • Nearest relatives discharge requests • Development sessions • Audits DS provided a summary of the following reported during the quarter: • No fundamentally defective applications • One fundamentally defective report • One lapse of a Section 5(2) • The use of Section 136s had increased. KW asked for the timescale for completing the larger piece of work to understand why more people were being legally detained. Julian Willett (JW), the Transformation & Innovation Lead - Mental Health, responded that the quantitative data showed a widening gap, but they needed more detailed qualitative work to understand why. This would involve speaking to AMHPs and Section 12 doctors to explore issues around potential changes in thresholds. JW believed this could be completed before the next Committee meeting, using available resources, including a redeployed AMHP who could support the work. KW noted her concern was the opportunity cost, and whether there were more important tasks that the Committee should support. She asked for advice on where this sat within the overall hierarchy of needs before agreeing to proceed. JW asked for the Committee's feedback. CP noted that qualitative work would not fully test the hypothesis, and that they needed more detailed quantitative analysis. **Obtain and present more granular quantitative data to examine the determinants of the widening gap between legally detained and informal patients, and to report findings at the following Committee meeting – ACTION.** RU asked the following questions: 1. Regarding the Section 136 case involving a patient under 18 who had three repeat admissions – what happened in this case, and what safeguards were in place to prevent recurrences? 2. With the increase in detention rates, how was this clinically justified? Were factors like DoLS, safeguarding issues, or ineligibility contributing to the rise?	

	Regarding the Section 136 case, DS explained that this was a new presentation experiencing a new episode, which led to three detentions in a short period. A care plan and community support was now in place to prevent future detentions. Regarding rising detention rates, DS explained that they were exploring whether this reflected repeated detentions of the same individuals. They were working with teams to reinforce that patients should not be discharged from Section 3 before a DoLS authorisation was granted, as this may contribute to higher detention numbers. They were breaking down the data to if this was the case. RU requested that once the additional data was available, whether it could be brought to the Committee to review. DS responded that in the next quarter he will break down the data to show how many detentions involved the same individuals. The information existed, but DS would need to review each patient record, and so would take some time. Once complete, he would include it within his Exception Report. CP noted that the team had sent questionnaires out after nearest-relative discharge requests and asked if they could ask for their reasons when the request is made to gather clearer information. DS responded that as soon as a nearest-relative discharge request came in, DS sent the questionnaire and tried contacting them. They cannot require them to justify the request as it was their legal right. Without repeatedly chasing (which would not be appropriate), it was difficult to gather further information. **The Committee resolved that:** 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.	
MHL 2026/01/3.2	**36 Degrees Summary Report** Samuel Barrett (SB), the Interim Director of Operations – Mental Health, provided a presentation to the Committee which summarised the findings and recommendations from the 36 Degrees independent review of the Mental Health Clinical Board. It outlined transformation priorities, operational workstreams, and governance. RU asked how resilient the transformation programme was, given the ongoing workforce pressures and time required to work on this. SB responded that this was a major, long-term transformation, and would take years to fully embed. They were concentrating their resources on the two key operational priorities. The Executive team had been very supportive, and additional help (such as a project manager) would strengthen oversight and ensure KPIs were monitored. RU asked how they were considering the additional workload on the workforce, and how this would impact staff capacity. SB responded that there would not be much manual data gathering, as they had strong systems already in place. The focus would be on ensuring teams fully used those systems to minimise manual input wherever possible.	.

	CC asked how they ensured governance was enabling rather than adding another layer of process. From a people and culture perspective, CC also asked what the plan was to unlock disempowerment and hidden talent quickly. SB responded that governance could feel burdensome, so they were asking each ward to describe how it would run in an ideal world and use this as the basis. It was a fully collaborative MDT process. Regarding culture, SB noted that improvement was needed. Their focus is on being more visible and approachable across all sites, building transparency and trust. DF noted this was a major transformation programme, but they needed the full vision before beginning. Everyone recognised the scale of the task, but they were approaching this in a way that avoided overwhelming colleagues. RAS commented that with the right governance structure, clear decision-making processes, proper documentation, and clarity on what authority the Clinical Board had would enable autonomy. CP asked whether consideration was being given to neurodevelopmental disorders as a priority, given the political focus. SB responded that data from their informatics team showed that many CMHT referrals related to ADHD, using significant psychiatrist resource. By improving CMHT processes, they could also address ADHD demand. DF asked whether the plan had been well received by the Clinical Board. RAS responded that tackling all six areas was not realistic, but focusing on out-of-area placements and CMHTs reflected what the teams said they needed most. They would confirm the two priority areas with the Clinical Board after the following meeting with 36 Degrees in a few days' time. SB added that ward managers were clear that acute flow and out-of-area were priorities. Ward rounds needed more consistency and full MDT involvement. A wider communication plan would start the following week so that everybody understood the aim and could join the workshops. This would not be Clinical Board-led. CP thanked the team and 36 Degrees for their hard work. **The Committee resolved that:** a) The update was noted.	
MHL 2026/01/3.3	**MHA / DoLS Interface - Verbal Update** CE explained that the content of the guidance booklet had been finalised and had gone out for comments. It was now with Medical Illustration for design and formatting. CE noted that she would bring a finalised copy to the following meeting. **The Committee resolved that:** A) The update was noted.	
MHL 2026/01/3.4	**Section 12 Challenges** JW provided the following summary to the Committee: • It had been increasingly difficult to secure Section 12 doctors quickly, which can leave vulnerable patients waiting many hours. This had been an issue for years.	

	• When an assessment was requested, the duty AMHP must find a Section 12 doctor, but the current pool had limited availability, leading to time-consuming 'cold calling' • To address this, they recommended increasing the Section 12 doctor pool (especially those willing to work out of hours); reviewing the payment structure to reflect the urgency and unsocial hours; considering retainers for nights and weekends; and adopting the app currently being trialled in another UHB. CP asked if these recommendations had been costed. JW responded not yet, but the next steps would be to look at the financial implications. Matt Phillips (MP), the Director of Corporate Governance, clarified that the Committee were unable to decide on changing pay, but that it was raised for discussion to get the Committee's thoughts. The work would be undertaken separately. RU asked when they could expect financial modelling on the potential impact of the options discussed. JW responded that the work could start immediately, and that the funding sat with the PCIC Clinical Board. **Undertake financial modelling of the proposed recommendations to improve the Section 12 challenges and presented the findings to the Committee – ACTION.** **The Committee resolved that:** A) The update was noted.	
	Mental Health Measure	
MHL 2026/01/4.1	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** Samuel Barrett (SB), the Interim Director of Operations – Mental Health, presented the Mental Health Measure Report and slides which outlined the performance of CAVUHB against the various mental health specific targets, which included: • Part 1 – Primary Mental Health Support Services • Part 2 – Care and Treatment Planning (CTP) • Part 3 – Self-Referral and Advocacy • Key Risks and Capacity Pressures Regarding Part 2 adult work, CP asked when they should start seeing better compliance from the five-month improvement programme. SB responded that the trajectory presented to NHS Performance & Improvement (P&I) showed 90% compliance by the end of March, and they were currently at 63%. Progress was slow, so they needed to work in smaller sections – first validating the list, then focusing on individual specialties, and after they could address the wider issues. Ultimately, this would provide clear assurance that all CTPs were completed. **Report back on the steps being undertaken currently to reflect the needs of children and young people in care and treatment planning, whilst awaiting the outcome of the national review – ACTION.** **The Committee Resolved that:** a) The contents of the report was noted.	

	Items to bring to the attention of the Committee for Noting / Information	
M MHL 2026/01/5.1	**Sub-Committee Meeting Minutes** The Committee noted the below Sub-Committee Meeting Minutes: • Hospital Managers Power of Discharge (POD) Sub-Committee Minutes – 13.01.2026 • Mental Health Legislation and Governance Group (MHLGG) - 15.01.2026 Hospital Managers Power of Discharge (POD) Sub-Committee Minutes – 13.01.2026 Amanda Morgan (AM), the Chair of the Power of Discharge Group, summarised the following key points to the Committee: • Concerns had been raised around WARRNs, which had since been resolved • The remaining issue was the preparedness of nurses attending hearings. CP asked to be kept updated. Mental Health Legislation and Governance Group (MHLGG) - 15.01.2026 JW summarised the following key points to the Committee: • Actions had been raised regarding Section 12 doctors and the related SBAR • WARRNs had been reinstated for hospital manager hearings • The POD Group highlighted late report submissions and subsequent challenges • Clarity was needed on the locked-doors policy • The Cardiff AMHP Service Pilot for using the Hub to request MHA assessments seemed to be working well, and would continue to be monitored • Advocacy colleagues raised concerns about understaffing in Hafan y Coed affecting Section 17 leave • CTPs, interface issues, and informal patients in out-of-area beds were discussed – out-of-area placements remained a key issue. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
MHL 2026/01/5.2	**Veterans NHS Wales Annual Report** Neil Kitchiner (NK), the Director & Consultant Clinical Lead – Veterans, presented the Veterans NHS Wales Annual Report which described referral trends, service delivery, and ongoing efforts to address treatment completion and regional differences. MP informed the Committee that he was the organisation's SRO for armed forces, and as a veteran himself, he was particularly invested. The veterans and armed forces sector were usually a patchwork of public bodies, charities, and various services, so having a national system that worked coherently was rare. DF asked why the referrals were lower in the Cardiff area than elsewhere. NK responded that CAV had consistently lower referral numbers, potentially because fewer veterans live in this area compared with places like North Wales and the Valleys. They were not concerned about CAV's figures.	

	The Committee Resolved that: A) The Veterans NHS Wales Annual Report was noted.	
MHL 2026/01/5.3	**DoLS Internal Audit report** Jason Roberts (JR), the Executive Nurse Director, presented the DoLS Internal Audit report and noted the below: • The audit was complete, with one 'limited' recommendation, two 'reasonable' recommendations, and one 'substantial' recommendation • An improvement plan was in place. • All actions were due by March 2026 **The Committee Resolved that**: A) The DoLS Internal Audit report was noted.	
	Items for Approval / Ratification	
MHL 2026/01/6.1	*No items.*	
	Any Other Business	
MHL 2026/01/7.1	JW informed the Committee that the NHS P&I would set up a Section 117 working group. The group would map current Section 117 practices and work towards standardising processes and procedures. They would provide updates as the work progressed.	
MHL 2026/01/8.1	**To note the date, time and venue of the next meeting:** 28th April 2026 via MS Teams - TBC	