

Mental Health Legislation & Mental Capacity Act Committee

Tue 26 April 2022, 10:00 - 12:00

Agenda

1.
Welcome & Introductions

Ceri Phillips

2.
Apologies for Absence

Ceri Phillips

3.
Declarations of Interest

Ceri Phillips


4.
Minutes of the Meeting held on 09 February 2022

Ceri Phillips

 4 MHCLC Minutes 090222MD.NF.CP ds.pdf (10 pages)

5.
Action Log from the meeting held on 09 February 2022

Ceri Phillips

 5 Action Log Mental Health CommitteeMD.NFMD(3).pdf (2 pages)

6.
Chair's Action taken since last meeting

Ceri Phillips

7.
Any Other Urgent Business Agreed with the Chair

Ceri Phillips

Saunders, Nathan
04/14/2022 13:09:00





8.

Mental Capacity Act

8.1.

Mental Capacity Act Monitoring Report: To include DOLs Monitoring Report

Rebecca Aylward

-  8.1 MHCLC ASSURANCE REPORT APRIL 2022.pdf (3 pages)
-  8.1a MCA and DoLS Indicators.pdf (1 pages)
-  8.1b MCA and DoLS Indicators.pdf (1 pages)
-  8.1c MCA and DoLS Indicators.pdf (1 pages)

8.2.

Liberty Protection Safeguards



Rebecca Aylward

-  8.2 MHCLC Liberty Protection Safeguards April 2022.pdf (3 pages)

8.3.

DOLs Audit update on recommendations

Rebecca Aylward

-  8.3 MHCLC Internal Audit Report on Deprivation of Liberty Safeguards.pdf (3 pages)
-  8.3a Internal Audit Report Deprivation of Liberties Safegaurds (DoLS).pdf (16 pages)



9.

Mental Health Act

9.1.

Mental Health Act Monitoring Exception Report

Caroline Bird / Daniel Crossland

-  9.1 Mental Health Act Monitoring Exception Report April 2022 (final).pdf (7 pages)
-  9.1a Mental Health Act Monitoring Report January - March 2022.pdf (49 pages)

10.

Mental Health Measure

10.1.

Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report

Caroline Bird / Daniel Crossland

-  10.1 Mental Health Measure February 2022 AMS and CAMHS Final.pdf (11 pages)

11.

Items to bring to the attention of the Committee for Noting / Information

11.1.

HIW MHA Inspection Reports – Verbal Update

Caroline Bird


11.2.

Sub-Committee Meeting Minutes:

Jeff Champney Smith / Robert Kidd

i) Hospital Managers Power of Discharge Sub Committee Minutes – 05.04.22

ii) Mental Health Legislation and Governance Group Minutes – 08.04.22

 11.2i PoD minutes April 2022 Final.pdf (4 pages)

 11.2ii MHLGG Minutes April 2022 Final.pdf (8 pages)

11.3.

Corporate Risk Register

Nicola Foreman

 11.3 MHCLC Corporate Risk Register Report - April 2022 AF.NF.pdf (3 pages)

 11.3a MHCLC Corporate Risk Register Entries - Mar 2022 AF.NF.pdf (1 pages)

12.

Items for Approval Ratification

12.1.


Policies

Caroline Bird

12.1.1.

Consent to Examination or Treatment under The Mental Health Act 1983 Policy & Procedure

 12.1.1 MHCLC Consent to Examination Cover Report.pdf (3 pages)


 12.1.1a CONSENT TO EXAMINATION OR TREATMENT UNDER THE MHA 1983 POLICY.pdf (43 pages)


 12.1.1b CONSENT TO EXAMINATION OR TREATMENT UNDER THE MHA 1983 PROCEDURE.pdf (20 pages)

12.1.2.

Hospital Managers' Scheme of Delegation Policy & Procedure

 12.1.2 MHCLC Hospital Managers Cover Report.pdf (3 pages)

 12.1.2a Hospital Managers' Scheme of Delegation POLICY.pdf (36 pages)

 12.1.2b Hospital Managers Scheme of Delegation PROCEDURE.pdf (17 pages)

13.

Review of the Meeting

Ceri Phillips

14.

To note the date, time and venue of the next meeting:

July 26 2022 at 10am via MS Teams

Saunders, Nathan
04/14/2022 15:09:00

Saunders Nathan
04/14/2022 13:09:00

**Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held On 09th February 2022 10.00-12.00
Via MS Teams**

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present		
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Caroline Bird	CB	Interim Chief Operating Officer
Daniel Crossland	DC	Deputy Director of Operations - Mental Health
David Seward	DS	Interim Mental Health Act Manager
Rose Whittle	RW	Directorate Manager – Child Health
Catherine Wood	CW	Director of Operations – Children & Women's
Robert Kidd	RK	Consultant Clinical & Forensic Psychologist
Observers:		
Hannah Stevenson	HS	Graduate Management Trainee
Secretariat		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Sara Moseley	SM	Independent Member – Third Sector
Akmal Hunak	AH	Independent Member - Community

Item No	Agenda Item	Action
MHCLC 09/02/001	<p>Welcome & Introductions</p> <p>The Chair welcomed everyone to the Committee and acknowledged that the Committee meeting was not quorate.</p> <p>The Director of Corporate Governance advised that the meeting could still go ahead and that any decisions which the Committee was required to approve today, should be ratified by Board in March.</p> <p>The Committee Resolved that:</p> <p>a) The Committee meeting went ahead and any formal decisions that the Committee was due to make would be referred to full Board for ratification.</p>	NF
MHCLC 09/02/002	<p>Apologies for Absence</p> <p>The Committee Resolved that:</p> <p>a) The apologies were noted.</p>	
MHCLC 09/02/003	<p>Declarations of Interest</p> <p>The Committee Resolved that:</p>	

	a) No declarations of Interest were given.	
MHCLC 09/02/004	Unconfirmed Minutes of the Meeting held on 19 October 2021 The Committee Resolved that: a) The minutes of the meeting held on 19 th October 2021 were agreed as a true record.	
MHCLC 09/02/005	Action Log from the meeting held on 19 October 2021 The Director of Corporate Governance (DCG) noted the action 20/10/14 was on-going. The Committee Resolved that: a) The Action Log was noted.	
MHCLC 09/02/006	Chair's Action taken since last meeting The Committee Resolved that: a) No Chair's Actions were taken since the last meeting.	
MHCLC 09/02/007	Any Other Urgent Business Agreed with the Chair The Committee Resolved that: a) No other urgent business was agreed with the Chair.	
MHCLC 09/02/008	Mental Capacity Act & DoLs Monitoring Report – Update The Committee received a report on The Liberty Protection Standards (LPS) The Executive Nurse Director (END) updated on the following: - <ul style="list-style-type: none"> - The Liberty Protection Standards (LPS) was delayed, with consultation on the LPS Code of Practice and Welsh Regulations expected in the Spring. - The Project Manager would align with the work. - There should be further funding confirmed and staff resource model will be clear following publication of the LPS Code of Practice and Welsh Regulations. - Training will be an important component of LPS and a training programme would be planned together with how best to deliver the same to front-line staff. The Consultant Clinical & Forensic Psychologist (CCFP) queried that it was unclear if the Health Board did the monitoring of Section 49 reports. He queried what the mechanism was to look into the reports and whether the Health Board should bring in a mechanism to look at the Section 49 reports.	

Saunders, Nathan
04/14/2022 13:09:00

	<p>The END noted that Committee members should have some training to enable them to have a further understanding of the LPS.</p> <p>The Chair noted that when the LPS was released, no one had known the full extent and that may be why it had been delayed. Clarity was needed for training requirements. The delay could be due to potential demands and excessive pressures.</p> <p>The END noted areas of concern were identified when the DOLs portfolio was an agenda inherited by the END. As a Health Board, there was a need to better understand the legislation and to educate the work force</p> <p>The END commented that a new Mental Capacity Act Manager has recently been appointed and would need time to settle into the role.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) The contents of the report and the current compliance with MCA and DoLs indicators (noting that these were incomplete due to the recent recruitment to the MCA Manager role), were noted. 	
<p>MHCLC 09/02/009</p>	<p>Mental Health Act Monitoring Exception Report</p> <p>The Interim Mental Health Act Manager (IMHA) highlighted the main points of the Mental Health Act Monitoring Exception Report, which included: –</p> <ul style="list-style-type: none"> - A patient had been held without authority for 28 days but that had only been highlighted in October. - The patient was detained in University Hospital Llandough (UHL) before being moved to Mental Health Services for Older People (MHSOP). - Papers had been left on a ward at UHL and the papers could not be formally accepted. - To ensure that such an incident would not happen again, all AMHP's would complete a receipt so the MHA Office know who to chase for detention papers. <p>The IMHA explained that Welsh Government (WG) had not authorised the digital forms. The digital forms were used in England, but COVID had delayed the digitalisation.</p> <p>It was explained that the patient was told they were held without authority and could seek legal advice.</p> <p>The IMHA noted that the Section 135 numbers had risen, which may have been due to patients not allowing access to the assessing team.</p>	

	<p>The CCFP noted that the process to apply for a warrant had become more streamlined and had helped being able to obtain a Section135.</p> <p>The IMHA explained MS Teams had been trialled for hearings to take place and had a positive impact. A meeting had been planned with the Tribunal manager and they were looking to roll out, as standard, the approach for all hearings to be via MS Teams. An issue had arisen where observers had been refused attendance at hearings and were told it was not within their scope to attend.</p> <p>The Chair noted that discussions with HEIW on the issue were required given that HEIW were to provide the training for that.</p> <p>The Deputy Director of Operations - Mental Health (DDOMH) raised the “social circumstances report”. Nursing colleagues were asked to submit these, and he had thought that it had presented a quality, support & training issue.</p> <p>The END said she would raise with Chief Nursing Officer (CNO) and HEIW so they are aware of the challenge around the social circumstances report which were to be submitted by nurses.</p> <p>The IMHA noted that a relative had applied for a patient to be sectioned under Section 2 which was rare.</p> <p>The DCG suggested to take this to the Board as the meeting was not quorate and to reflect in the chairs report.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA as set out in the body of the report, was supported. 	RW
MHCLC 09/02/010	<p>Update on the Reform of the Mental Health Act – Verbal Update</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) No further update was given on the reform of the Mental Health Act. 	
MHCLC 09/02/011	<p>Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report</p> <p>The DDOMH presented the agenda item and highlighted the following: –</p> <ul style="list-style-type: none"> - There were consistently high numbers. 	

- On graph 2, a steady turn around could be seen.
- There were challenges in December 2021 due to staff leave / sickness.
- His team were anticipating lower activity on the Quarter reports.
- Adult performance was at 100%.
- There had been an improvement with Older People.
- Areas of improvement were highlighted for CAMHS.
- Self-referral was highlighted and the compliance figures were good, albeit there were digital issues. New automated reports had now been set up.

The Chair noted the issues but given the pressures it was positive. He congratulated the teams for what had been achieved. He acknowledged that the effects of the pandemic were now being seen in Mental Health services.

The Director of Operations – Children & Women’s (DOCW) added her thanks to the Directorate Manager – Child Health (DMCH) and the DDOMH for their generosity of time. She drew the Committee’s attention to the approach of the 2 Clinical Boards and how they intended to progress the agenda, collaborative working and the transition of patients. A workshop had been held with the 2 Clinical Boards to discuss the issues and how to ease the transition between the 2 services.

The Interim Chief Operating Officer (ICOO) was pleased to see the reduction in waiting lists, but commented that they should look at how the headline performance was presented. Increased staff absence had caused issues. She added that all Mental Health teams had shown dedication and commitment and she thanked those teams.

The Chair noted that colleagues should be aware of what the Health Board was asked to measure and ensure that the narrative was provided in order to give the complete picture.

The CCFP reminded the Committee that other Health Boards had chosen to report the data in a different way.

The DDOMH noted that the 31 days for assessment had reflected the January figures.

The END echoed the difficult target. She commented that it could change quickly, and that it would only take to be out by one day to cause issues.

The Committee Resolved that:

- a) The proposed approach taken by the Mental Health Clinical Board to ensure compliance with the Mental Health (Wales) Measure 2010 as set out in the body of the report, was supported.

<p>MHCLC 09/02/012</p>	<p>HIW MHA Inspection Reports</p> <p>The DDOMH highlighted the following in relation to the agenda item: –</p> <ul style="list-style-type: none"> - HIW's report covered 41 visits to different healthcare providers, which included a visit to Hazel Ward. - The majority of inspections were done virtually. <p>Some key items were: –</p> <ul style="list-style-type: none"> - New groups which related to PPE provision. - Digital exclusion which affected some patients (re visiting). There were 3 items raised in relation to assessment and risk: – - Visiting – there was more frustration due to people wanting direct contact with relatives. - Seclusion facilities – the Health Board did not have a seclusion facility. There were some developments regarding a seclusion facility on site. - There were some quality and safety concerns regarding the independent providers. - Some of the items raised had been closed since the report. <p>The END commented that the issues should be taken to the Quality, Safety and Experience Committee (the QSE Committee).</p> <p>The END suggested that HIW attend the Committee.</p> <p>The DGC explained that the HIW report cut across a number of services. This Committee was the appropriate committee to see the report, and the QSE Committee could have had the oversight. The quality governance impact should be picked up. Such reports should all be sent to the Chief Executive's office and be sent out to all from there.</p> <p>END commented that there was a problem with Primary Care. That was because it was slightly "siloed" but she hoped to put it back on the right track.</p> <p>The Chair noted to add the HIW report for next Committee.</p> <p>The Committee Resolved that:</p> <ul style="list-style-type: none"> a) The content of the HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021 was noted. 	<p>NF</p> <p>CP/DC</p>
<p>MHCLC 09/02/013</p>	<p>Sub-Committee Meeting Minutes:</p> <p>The Committee received copies of the Sub-Committees' meeting minutes.</p>	

	<p>The CCFP noted the following: –</p> <ul style="list-style-type: none"> - Discharging with Section 117 aftercare had been an issue. - There was a discussion around a potential issue with South Wales Police regarding “when the clock starts”. - The SW Police representative should be notified following the legal advice to see if a position of understanding could be made. - It was important to note it had been discussed at length. - A potential shortage of Section 12 doctors was expected. - More young people were in the Health Board’s facilities. - In terms of the Committee, it was strictly looking at the legislation and quality and safety relating to the same. - There was change in the Mental Health Clinical Board to ensure the structures were replicated and further work in that arena was being undertaken. <p>The Committee Resolved that:</p> <ul style="list-style-type: none"> a) The Hospital Managers Power of Discharge Minutes from 4 January 2022, were noted and; b) The Mental Health Legislation and Governance Group Minutes from 6 January 2022, were noted. 	
<p>MHCLC 09/02/014</p> <p>Saunders, Nathan 04/14/2022 13:09:00</p>	<p>Corporate Risk Register</p> <p>The DCG explained the following: –</p> <ul style="list-style-type: none"> - The Corporate Risk Register detailed the Corporate Risks which were relevant to the Committee. - The full Corporate Risk Register went to the Board. - The Register had been recently updated and showed those risks which scored 20 and above. - That was to ensure focus on the highest-level risks. - For this Committee there was one risk – Health & Well Being to Minor inpatients. - The risk was likely to be de-escalated. <p>The DCG explained the issue may be due to staffing. She would liaise with Aaron Fowler, especially when there is more than one young person on the admissions ward.</p> <p>The DCG advised that the risk should be kept on the Register.</p> <p>It was noted that at the recent workshop there had been an extensive discussion regarding young people. They could not be ignored but may have been admitted to a medical ward and not a Mental Health (MH) ward. It was questioned how young people could be appropriately cared for and the need to ensure they were safe.</p>	<p>NF</p>

	<p>The END acknowledged the challenge. There were not enough staff who could care for those children. Currently the team was caring for 2 high risk children, as there is no suitable alternative. The END was liaising with local colleagues regarding that issue.</p> <p>The Chair noted that there had been examples where children had been placed in a safe location, but their safety had been compromised.</p> <p>The END acknowledged the incident in Ty Lydiard, where the investigation had focused upon a child who had been placed in an area of safety. The child required considerable help and that had impacted upon another children's care. It was important to recognise that a place of safety was not always right if the care was not right.</p> <p>The Committee Resolved that:</p> <p>a) The Corporate Risk Register risk entry linked to the Mental Health Capacity and Legislation Committee and the work which was now progressing was noted.</p>	
MHCLC 09/02/015	<p>Committee Terms of Reference</p> <p>The DCG explained that the Committee's Terms of Reference (ToR) were due to go to Board in March for formal approval, but it was important for the Committee to review the same beforehand.</p> <p>The DCG explained the changes which were highlighted in the ToR.</p> <p>The Committee resolved that:</p> <p>a) The changes to the Terms of Reference for the MHLMCAC were reviewed; and</p> <p>b) The changes to the Terms of Reference for the MHLMCAC were to be presented to the Board on 31 March 2022 for formal approval.</p>	
MHCLC 09/02/016	<p>Committee Work Plan 2022/23</p> <p>The DCG explained the Work Plan reflected the ToR to ensure that the Committee delivered against the ToR.</p> <p>The Committee resolved that:</p> <p>a) The Work Plan 2022/23 was reviewed;</p> <p>b) The Work Plan 2022/23 was to be presented to the Board for approval at the Board Meeting on 31st March 2022.</p>	
MHCLC 09/02/017	Committee Annual Report 2021/22	

	<p>The DCG explained that the Annual Report fed in to the end of year annual arrangements and into the full Board Annual Report which would be reviewed by WG & Audit Wales.</p> <p>The Committee Resolved that:</p> <ul style="list-style-type: none"> a) The draft Annual Report 2021/22 for the Mental Health Capacity Legislation Committee was reviewed and; b) The draft Annual Report was to be presented to the Board for formal approval on 31 March 2022. 	
<p>MHCLC 09/02/018</p>	<p>Policies/Procedures for approval:</p> <p>The following Policies and Procedures were presented to the Committee for approval: -</p> <ul style="list-style-type: none"> - Section 5(2) Doctor's Holding Power Procedure - Section 5(4) Nurse's Holding Power Procedure <p>The DCG noted the need to ensure that the Board approved those Policies and Procedures and that an amendment was required given that Sunni was no longer the Mental Health Act manager.</p> <p>The Committee Resolved that:</p> <ul style="list-style-type: none"> a) The following policies and procedures and associated actions as set out under (i) to (iv) below were to be approved, via the Chair's Report, at the Board meeting on 31 March 2022, namely: <ul style="list-style-type: none"> (i) The Section 5(2) Doctors Holding Power Policy and Procedure; (ii) the full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme; (iii) the Section 5(4) Nurses' Holding Power Policy and Procedure; and (iv) the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme 	<p>CP</p>
<p>MHCLC 09/02/019</p>	<p>AOB</p> <p>The Chair noted the vigil for Dr Gary Jenkins and wanted to convey his best wishes to Dr Jenkins' family, friends and colleagues.</p>	
<p>MHCLC 09/02/020</p>	<p>Review of the Meeting</p>	
	<p>To note the date, time and venue of the next meeting:</p> <p>April 26 2022 at 10am</p>	

ACTION LOG
MENTAL HEALTH LEGISLATION AND MENTAL CAPACITY ACT COMMITTEE
UPDATE FOR 26th APRIL 2022 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCLC 09/02/001	Ratification of decisions to be made by Committee on 9 February 2022.	As the February Committee meeting was not quorate, any decisions which the Committee was required to approve that day, should be ratified by Board in March.	31/03/2022	Nicola Foreman	COMPLETED. Chair's Report was presented to the Board on 31 March 2022 whereupon the decisions of the Committee at its meeting held in February 2022 were ratified by full Board. (See Actions MHCLC 09/02/018.
MHCL 09/02/012	HIW MHA Inspection Reports	To bring the HIW report to the next Committee meeting.	26/04/2022	Caroline Bird	COMPLETED Verbal update to be provided in April's meeting – agenda item 11.1
MHCLC 09/02/014	Corporate Risk Register	With regards to the Corporate Risk attached to this Committee, the DCG to liaise with Aaron Fowler for an update, especially when there is more than one young person on the admissions ward.	26/04/2022	Nicola Foreman	COMPLETED update to be provided in April under the standing item for the Corporate Risk Register (agenda item 11.3)
MHCLC 09/02/009	Mental Health Act Monitoring Exception Report	The END TO raise with Chief Nursing Officer (CNO) and HEIW so they are aware of the challenge around the social circumstances report which were to be submitted by nurses.	26/04/2022	Ruth Walker	COMPLETED Update to be given at the meeting in April 2022.
Actions in Progress					
Actions referred to committees of the Board					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 19/06/008	Mental Capacity Act Monitoring Report	To discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave.	Date to discuss at HSMB – <i>Awaiting further clarification from Meriel Jenney and Rachel Gidman</i>	Meriel Jenny	IN PROGRESS Agreement not reached with LNC at present. Discussions are ongoing.
MHCL 20/02/005		The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee.			This item will be reviewed by the S&D Committee and reported back to a future meeting – Added to S&D Action Log
MHCLC 09/02/015	Committee Terms of Reference	Committee Terms of Reference to go to Board in March for formal approval	31/03/2022	Nicola Foreman	COMPLETED The Terms of Reference were approved by the Board On 31 March 2022.
MHCLC 09/02/016	Committee Work Plan 2022/23	Committee Work Plan 2022/23 to go to Board in March for formal approval	31/03/2022	Nicola Foreman	COMPLETED The Committee's Work Plan 2022/23 was approved by Board on 31 March 2022.
MHCLC 09/02/017	Committee Annual Report 2021/22	Committee Annual Report 2021/22 to go to Board in March for formal approval	31/03/2022	Nicola Foreman	COMPLETED The Committee's Annual Report 2021/22 was approved by Board on 31 March 2022.
MHCLC 09/02/018	Policies/Procedures for approval	Section 5(2) Doctor's Holding Power Procedure and Section 5(4) Nurse's Holding Power Procedure referred to Board for formal approval, via the Chair's Report.	31 March 2022	Caroline Bird	COMPLETED – These policies/procedures were ratified by full Board on 31 March 2022.

Saunders Nathan
04/14/2022 13:09:00

Report Title:	Mental Health Capacity Act (MCA) and DoLS monitoring report			Agenda Item no.	8.1	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	26.04.2022	
		Private	<input type="checkbox"/>			
Status (please tick one only):	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information	<input type="checkbox"/>
Lead Executive:	Executive Nurse Director					
Report Author (Title):	Director of Nursing for Professional Standards, Governance and Improvement					
Main Report						
Background and current situation:						

The purpose of this report is to provide a general update on current issues and to introduce a set of key Mental Capacity Act (MCA) and Deprivation of Liberty indicators, which have been identified in order to provide the Committee with a greater level of assurance and monitoring, appendix A. Indicators relating to Independent Mental Health Advocacy service (IMCA) are unavailable, however MCA Lead is working with IMCA service to ensure indicators will be available to report at next committee.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Deprivation of Liberty Safeguards.

Agenda item 8.3 provides an update to Committee on progress to the Deprivation of Liberty Safeguards (DoLS) Internal Audit, which was undertaken August – October 2019, the purpose of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of DoLS. Item 8.3 report details progress against 4 Recommendations. Outcomes and learning from DoLS internal audit will inform the implementation of Liberty Protection Safeguards which will supersede the DoLS processes.

Liberty Protection safeguards (LPS)

In 2019 the Law Commission's review of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (2009) (DoLS) resulted in new legislation; the Mental Capacity [Amendment] Act 2019 (MC(A)A).

Agenda item 8.2 provides an update on the Welsh Government LPS draft Code of Practice and Regulations.

Consultation was launched on 17th March 2022. The consultation will last for 16 weeks and the deadline for responses end 7th July 2022. It is essential the Cardiff & Vale engages with LPS Consultation. It is important to note; Cardiff & Vale currently has no staff resource to manage the implementation of LPS and it is therefore essential the resources required are clearly stated to enable a seamless transfer from DoLS and operationalizing of LPS.

LPS will apply to all patients who are deprived of their liberty as a consequence of the arrangements for their care and treatment, and do not have mental capacity to consent to those care arrangements. The scope of this new legislation will be far reaching and have an impact on health professionals and managers across our acute and community hospitals, mental health and learning disabilities services, nursing/care homes caring for patients in receipt of CHC funding, and in any independent hospitals within the Cardiff & Vale geographical area.

Hyperlink to LPS Consultation:

<https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps>

Mental Capacity Act

MCA Lead has been in post for 3 months and is prioritizing MCA training, and has trained staff groups within: HM Prison health staff, Physiotherapy, Critical Care, Endoscopy, Mental Health and North West Locality Community Nurse Leaders.

In preparation and utilizing the funding from Welsh Government to support Liberty Protection Safeguards (LPS). 20 places have been secured to attend Level 7 MCA and external provider to deliver Mental capacity assessment training to 700 staff.

Recommendation:

The Mental Health Legislation and Mental Capacity Act Committee is asked to:-

- a) **NOTE** the contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Safety: No

Financial: Yes

As outlined in report, currently no resource to support implementation LPS

Workforce: Yes

As outlined in report, currently no resource to support implementation LPS	
Legal No	
Risk of Non-compliance to the Mental Capacity Amendment Act 2019	
Reputational: Yes	
Risk of Non-compliance to the Mental Capacity Amendment Act 2019	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
04/14/2022 13:09:00

MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE INDICATORS

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
DoLS												
1. Number of DoLS applications made	67	79										
2. No of DoLS applications completed	92	99										
a. No of DoLS applications assessed	31 (9)	50 (12)										
b. No of DoLS applications withdrawn	61 (6)	49 (11)										
4. Breach of timescales including length of breach												
a. Urgent authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
b. Standard authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
c. Further authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
5. Requests for reviews of the DoLS authorisation	0	0										
6. Appeals made to Court of Protection												
a. No of 21a Application		1										
b. No of Joined as Party / Welfare order	1											
8. Appointment of IMCA as RPR												
MCA												
9. Number of queries to MCA Manager	9	13	7									
10. Number of IMCA referrals												
11. Number of monitoring reports from the IMCA service												
12. Appointment of IMCA under:												
a. s39a												
b. s39c												
c. s39d												
13. Number of HIW reports received regarding compliance of clinicians	0	0	0									
14. Number of complaints received from patients/carers regarding compliance of clinicians		1										
15. Number of Public Service Ombudsman for Wales Reports citing issues around MCA	0	0	0									
16. Number of staff who have undertaken MCA training												
a. Children & Women Clinical Board	Not available as yet											
b. CD&T Clinical Board												
c. Medicine Clinical Board												
d. Mental Health Clinical Board												
e. PCIC Clinical Board												
f. Specialist Clinical Board												
g. Surgery Clinical Board												

*Any figures in brackets correlates to applications rec'd in that month

Urgent Jan 22				
Date Signed	Date Rec'd	Assessment	Authorised	Breach
20/08/2022	20/08/2022	19/01/2022	21/01/2022	146 Days
11/10/2022	11/10/2022	06/01/2022	18/01/2022	92 Days
22/11/2022	22/11/2022	06/01/2022	18/01/2022	50 Days
23/11/2021	23/11/2021	06/01/2022	28/01/2022	59 Days
24/11/2021	24/11/2021	06/01/2022	18/01/2022	49 Days
17/12/2021	17/12/2021	19/01/2022	21/01/2022	28 Days
24/12/2021	24/12/2021	05/01/2022	19/01/2022	19 Days
24/12/2021	24/12/2021	24/01/2022	28/01/2022	28 Days
13/01/2022	13/01/2022	19/01/2022	25/01/2022	5 Days

Standard/Further Jan 22				
Date Signed	Date Rec'd	Assessment	Authorised	Breach
22/11/2021	22/01/2022	25/01/2022	28/01/2022	46 Days

Urgent Withdrawn Jan 22				Information rec'd for w/d by				
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleansed	MA	New App
30/11/2021	04/01/2022		01/01/2022		25 Days			x
08/11/2021	04/01/2022	24/12/2021			39 Days	x		
17/12/2021	04/01/2022	30/12/2021			6 Days	x		
15/12/2021	04/01/2022	30/12/2021			8 Days	x		
10/12/2021	04/01/2022	23/12/2021			6 Days	x		
16/11/2021	05/01/2022		21/12/2021		28 Days	x		
25/11/2021	05/01/2022		30/12/2021		28 Days	x		
12/12/2021	06/01/2022	06/01/2022			18 Days		x	
26/12/2021	07/01/2022	05/01/2022			3 Days	x		
25/10/2021	10/01/2022	04/01/2022			64 Days	x		
28/09/2021	10/01/2022	07/01/2022			95 Days	x		
15/11/2021	17/01/2022		11/01/2022		56 Days	x		
15/11/2021	17/01/2022	21/12/2021			29 Days	x		
17/11/2021	18/01/2022		18/01/2022		45 Days			x
14/12/2021	18/01/2022		11/01/2022		21 Days	x		
23/12/2021	18/01/2022	14/01/2022			15 Days	x		
25/12/2021	18/01/2022	15/01/2022			14 Days	x		
27/12/2021	18/01/2022	14/01/2022			11 Days	x		
27/12/2021	18/01/2022	07/01/2022			4 Days	x		
20/12/2021	18/01/2022	17/01/2022			21 Days	x		
05/12/2021	18/01/2022	10/01/2022			19 Days	x		
15/11/2021	19/01/2022		14/01/2022		53 Days	x		
16/11/2021	19/01/2022		13/12/2021		20 Days	x		
22/12/2021	19/01/2022	19/01/2022			21 Days	x		
15/12/2021	19/01/2022	13/01/2022			28 Days	x		
24/12/2021	19/01/2022		13/01/2022		19 Days	x		
15/12/2021	19/01/2022	14/01/2022			28 Days	x		
27/12/2021	19/01/2022		19/01/2022		17 Days	x		
17/12/2021	20/01/2022		04/01/2022		27 Days	x		
06/12/2021	20/01/2022		04/01/2022		38 Days	x		
25/11/2021	21/01/2022	24/12/2021			22 Days	x		
01/11/2021	24/01/2022	17/11/2021			9 Days	x		
21/11/2021	25/01/2022	25/01/2022			58 Days		x	
13/12/2021	26/01/2022	12/01/2022			23 Days	x		
14/12/2021	26/01/2022	25/01/2022			35 Days		x	
15/12/2021	26/01/2022	04/01/2022			13 Days	x		
24/12/2021	27/01/2022			08/01/2021	8 Days	x		
01/12/2021	28/01/2022	20/12/2021			12 Days	x		
12/11/2021	29/01/2022		20/01/2022		62 Days	x		
20/12/2021	29/01/2022		24/01/2022		28 Days	x		
26/12/2021	29/01/2022	13/01/2022			11 Days	x		

Standard/Further Withdrawn Jan 22				Information rec'd for w/d by				
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleansed	MA	New App
09/12/2021	28/01/2022	06/01/2022			29 Days	x		
14/12/2021	28/01/2022		11/01/2022		7 Days	x		

Saunders, Nathan
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Urgent Feb 22				
Date Signed	Date Rec'd	Assessment	Authorised	Breach
01/12/2021	01/12/2021	01/02/2022	28/02/2022	82 Days
17/12/2021	17/12/2021	03/02/2022	14/02/2022	52 Days
21/12/2021	21/12/2021	01/02/2022	04/02/2022	38 Days
21/12/2021	21/12/2021	07/02/2022	28/02/2022	52 Days
29/12/2021	29/12/2021	07/02/2022	08/02/2022	35 Days
04/01/2022	04/01/2022	02/02/2022	04/02/2022	24 Days
12/01/2022	12/01/2022	02/02/2022	28/02/2022	40 Days
12/01/2022	12/01/2022	10/02/2022	28/02/2022	40 Days
19/01/2022	19/01/2022	01/02/2022	08/02/2022	13 Days
19/01/2022	19/01/2022	16/02/2022	28/02/2022	33 Days
25/01/2022	25/01/2022	15/02/2022	18/02/2022	17 Days
28/01/2022	28/01/2022	09/02/2022	19/02/2022	15 Days

Standard/Further Feb 22				
Date Signed	Date Rec'd	Assessment	Authorised	Breach
08/12/2021	08/12/2021	02/02/2022	28/02/2022	61 Days
08/12/2021	08/12/2021	02/02/2022	07/02/2022	40 Days
12/01/2022	12/01/2022	10/02/2022	14/02/2022	12 Days
06/11/2022	06/11/2022	17/02/2022	23/02/2022	88 Days

Urgent Withdrawn Feb 22				Information rec'd for w/d by				
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleanse	MA	New App
03/01/2022	02/02/2022		31/01/2022		21 Days			x
10/01/2022	03/02/2022	21/01/2022			4 Days	x		
14/01/2022	03/02/2022	31/01/2022			10 Days	x		
10/01/2022	03/02/2022	03/02/2022			17 Days	x		
09/01/2022	03/02/2022	03/02/2022			18 Days	x		
06/01/2022	03/02/2022	31/01/2022			18 Days	x		
04/01/2022	09/02/2022		06/02/2022		26 Days	x		
12/01/2022	09/02/2022		03/02/2022		15 Days	x		
11/01/2022	14/02/2022	08/02/2022			21 Days	x		
25/01/2022	14/02/2022		11/02/2022		10 Days	x		
07/01/2022	14/02/2022		11/02/2022		27 Days	x		
27/01/2022	15/02/2022		14/02/2022		11 Days	x		
01/02/2022	15/02/2022		14/02/2022		6 Days	x		
21/01/2022	16/02/2022		15/02/2022		17 Days	x		
27/01/2022	16/02/2022		15/02/2022		12 Days	x		
10/01/2022	17/02/2022	17/02/2022			31 Days	x		
06/01/2022	17/02/2022		11/02/2022		29 Days	x		
21/01/2022	23/02/2022		21/02/2022		24 Days	x		
22/01/2022	23/02/2022		23/02/2022		25 Days	x		
09/02/2022	23/02/2022		23/02/2022		7 Days	x		
24/01/2022	23/02/2022	22/02/2022			22 Days	x		
31/01/2022	23/02/2022	11/02/2022			16 Days	x		
07/02/2022	23/02/2022	18/02/2022			4 Days	x		

Standard/Further Withdrawn Feb 22				Information rec'd for w/d by				
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleanse	MA	New App
06/12/2021	01/02/2022	31/01/2022			35 Days	x		
04/01/2022	02/02/2022		31/01/2022		20 Days	x		
05/12/2021	03/02/2022	03/02/2022			39 Days		x	

Saunders, Nathan
04/14/2022 13:09:00

Report Title:	Liberty Protection Safegaurds				Agenda Item no.	8.2
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	26.04.2022	
		Private				
Status <i>(please tick one only):</i>	Assurance	x	Approval		Information	
Lead Executive:	Executive Nurse Director					
Report Author (Title):	Director of Nursing for Professional Standards, Governance and Improvement					

Main Report

Background and current situation:

The purpose of this report is to provide an update on Liberty Protection Safeguards (LPS). The Deprivation of Liberty Safeguards (DoLS) is the existing scheme under the Mental Capacity Act 2005 to protect those who lack the mental capacity to consent to their care and treatment where that involves being deprived of their liberty. In 2019, the UK Government passed the Mental Capacity (Amendment) Act which will repeal DoLS and replace it with the LPS.

Unlike DoLS (which only applied to arrangements in care homes and hospitals and to people aged 18 and above), the LPS will apply in all settings and to anyone aged 16 and over. For the first time, the LPS will also extend to people's homes providing equivalent safeguards for individuals whilst respecting their private spaces. The new safeguards will embed and promote into practice Article 5 (right to liberty) and Article 8 (right to respect for private and family life) of the European Convention on Human Rights.

The Mental Capacity (Amendment) Act 2019 provides the regulation-making powers for the Welsh Ministers to address the widely recognised challenges associated with the current DoLS system.

The consultation on draft Regulations for Wales is aligned with the [UK Government's consultation on draft Regulations for England and a new Code of Practice for the Mental Capacity Act and the LPS for England and Wales \(external link\)](https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps). <https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps>

The Regulations for Wales and the Code of Practice go hand in hand all stakeholders in Wales are asked to also consider and respond to the UK Government consultation on the draft Code of Practice.

The Consultation Welsh Government LPS draft Regulations, was launched on 17th March 2022. The consultation will last for 16 weeks and the deadline for responses end 7th July 2022.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The consultation on new Regulations for Wales which will support the implementation of the Liberty Protection Safeguards (the LPS).

The four sets of draft Regulations for Wales are:

- The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) (Amendment) Regulations 2022 These Regulations will amend the existing Regulations 2 on the role and appointment of Independent Mental Capacity Advocates (IMCAs). IMCAs are

there to support the cared-for person under the LPS and those individuals who have been identified as the cared-for person's Appropriate Person.

- The Mental Capacity (Deprivation of Liberty: eligibility to carry out assessments, make determinations and carry out pre-authorisation reviews) (Wales) Regulations 2022 These Regulations set out who can undertake assessments, make determinations and carry out pre-authorisation reviews as part of the new process for authorising arrangements that amount to a deprivation of liberty, for people who lack the mental capacity to agree to those arrangements.
- The Mental Capacity (Deprivation of Liberty: training and criteria for approval as an Approved Mental Capacity Professional) (Wales) Regulations 2022 These Regulations set out arrangements regarding the role and approval by local authorities of Approved Mental Capacity Professionals (AMCPs). This is a new role within the LPS, designed to provide additional safeguards for people by undertaking a pre-authorisation and / or determining whether the authorisation conditions are met.
- The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) (Wales) Regulations 2022 These Regulations support the monitoring and reporting of the new system and the implementation of the LPS. The Regulations identify the three monitoring bodies – Care Inspectorate Wales (CIW), Health Inspectorate Wales (HIW) and Her Majesty's Inspectorate for Education and Training (Estyn) – who will be responsible for monitoring and reporting on the new safeguards.

The scope of this new legislation will be far reaching and have an impact on health professionals and managers across our acute and community hospitals, mental health and learning disabilities services, nursing/care homes caring for patients in receipt of CHC funding, and in any independent hospitals within the Cardiff & Vale geographical area.

Welsh Government funding strategy has been agreed which includes £8million transitional costs for the LPS in 2022/23. This will facilitate the rollout of training, development of workforce plans, plans.

However, it is important to note, Cardiff & Vale currently has no staff resource to manage the implementation of LPS and the required complex ongoing requirements of LPS Regulations. The UHB will be required to support investment to a team. The LPS Welsh Regulations and the transition period will inform the size and skills of resource required to enable a seamless transfer from DoLS and operationalizing of LPS.

Cardiff & Vale UHB are developing an implementation plan and associated staff resources which will be shared with MHCL committee.

Recommendation:

The Mental Health Legislation and Mental Capacity Act Committee is asked to:-

- a) **NOTE** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	✓

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	
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Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Safety: No

Financial: Yes

As outlined in report, currently no resource to support implementation LPS

Workforce: Yes

As outlined in report, currently no resource to support implementation LPS

Legal: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Reputational: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Saunders,Nathan
04/14/2022 13:09:00

Report Title:	Internal Audit Report on Deprivation of Liberty Safeguards (DoLS)			Agenda Item no.	8.3
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	26.04.2022
		Private	<input type="checkbox"/>		
Status (please tick one only):	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Director of Nursing for Professional Standards, Governance and Improvement				

Main Report

Background and current situation:

The purpose of this report is to provide assurance of the work that has been undertaken in response to the Internal Audit Report on Deprivation of Liberty Safeguards, which was undertaken August – October 2019, appendix 1. The purpose of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of DoLS. The Audit was assessed as reasonable assurance, as there have been improvements made since the previous Internal Audit review in early 2018.

In April 2020 the Executive Nurse Director became the responsible officer for DoLS. The Outcomes and learning from DoLS internal audit will inform the implementation of Liberty Protection Safeguards (LPS) which will supersede the DoLS processes. Welsh Government LPS draft Code of Practice and Regulations, began a 16-week consultation on 17th March 2022.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The internal audit report made 4 recommendations for improvement;

1. Timescales for undertaking DoLS Urgent Authorisations High Priority
2. DoLS training Medium Priority
3. Timescales for approval of Standard authorisations Low Priority
4. Produce Implementation plan for Liberty Protection Safeguards Low Priority

Recommendation 1 – High Priority

Staff should attempt to ensure that all urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Standards.

➤ Management response

All attempts are made to ensure DoLS assessments are carried out within the specified timescales, however, this continues to be a challenge due to current inadequate resource. Only 1.5 wte, which equates to 6 assessments per week; to consistently meet the time frame of 7 days, 6 assessments will be required each day. Covid 19 has also impacted on the ability to achieve timeframes.

However, as part of the implementation of LPS, which began consultation March 17th 2022.

The new LPS Code of Practice and regulations will inform the new process and resources required, this planning work is in progress within UHB

Recommendation 2 – Medium Priority

The Health Board should ensure that staff are provided with the appropriate DoLS training and where areas have low compliance these areas should be targeted.

➤ Management response

Training continues to be a challenge due to the difficulty to release clinical staff to attend training. However, DoLS awareness training is now provided as part of Mandatory Safeguarding training and is also provided on an adhoc basis to clinical areas of particular concern. The new LPS regulations and process will require focused training as there will be fundamental changes and increased responsibility for clinical staff. A review of training requirement is in progress. The foundations of LPS are Mental Capacity assessments therefore, in preparation and utilizing the funding from Welsh Government to support Liberty Protection Safeguards (LPS). 20 places have been secured to attend Level 7 MCA and external provider to deliver Mental capacity on line assessment training to 700 staff.

Recommendation 3 - Low Priority

Staff should attempt to ensure that all standard and further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

➤ Management response

3 Directors of Nursing have been trained to undertake standard authorizations and this has made a difference and improvement to compliance. The process of approval will change following implementation of LPS.

Recommendation 4 – Low Priority

The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the Production of the Code of Practice.

➤ Management response

The Health Board has been unable to plan for implementing LPS due to the delay of issuing the LPS draft Code of Practice and Regulations. This has recently been launched and a 16-week consultation process began on 17th March 2022 the consultation will last for 16 weeks and the deadline for responses end 7th July 2022. It is essential the Cardiff & Vale engages with LPS Consultation and an implementation plan will be developed. It is important to note; Cardiff & Vale currently has no staff resource to manage the implementation of LPS and it is therefore essential the resources required are clearly stated to enable a seamless transfer from DoLS and operationalizing of LPS.

Recommendation:

The Mental Health Legislation and Mental Capacity Act Committee is asked to:-

a) **NOTE** the contents of the report and the assurance provided to transition recommendations as part of the implementation of the Liberty Protection Safeguards.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time			10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives						
Five Ways of Working (Sustainable Development Principles) considered <i>Please tick as relevant</i>									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	
Impact Assessment: <i>Please state yes or no for each category. If yes please provide further details.</i>									
Risk: Yes									
Risk of Non-compliance to the Mental Capacity Amendment Act 2019									
Safety: No									
Financial: Yes									
As outlined in report, currently no resource to support implementation LPS									
Workforce: Yes									
As outlined in report, currently no resource to support implementation LPS									
Legal: Yes/No									
Risk of Non-compliance to the Mental Capacity Amendment Act 2019									
Reputational: Yes/No									
Risk of Non-compliance to the Mental Capacity Amendment Act 2019									
Socio Economic: No									
Equality and Health: No									
Decarbonisation: No									
Approval/Scrutiny Route:									
Committee/Group/Exec			Date:						

Saunders, Nathan
04/14/2022 13:09:00

Deprivation of Liberties Safeguards (DoLS)

Final Internal Audit Report

Cardiff and Vale UHB

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Saunders, Nathan
04/14/2022 13:09:00

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Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating
Review reference:	C&V-1920-19
Report status:	Final Internal Audit Report
Fieldwork commencement:	7 th August 2019
Fieldwork completion:	3 rd October 2019
Draft report issued:	4 th October 2019
Management response received:	21 st November 2019
Final report issued:	21 st November 2019
Auditor/s:	Lucy Jugessur, Cara Vernon
Executive sign off:	Stuart Walker, Medical Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director Julia Barrell, Mental Capacity Act Manager Susan Broad, MCA / DoLS Co-ordinator
Committee:	Audit Committee

Saunders, Nathan
04/14/2022 13:09:00



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the Deprivation of Liberties Safeguards (DoLS) has been completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive Director for this review is the Medical Director.

The Deprivation of Liberty Safeguards were introduced to prevent breaches of the European Convention of Human Rights (ECHR), Article 50 Right to Liberty and security of Person. The safeguards were introduced as an amendment to the Mental Capacity Act 2005 and came into force on the 1st April 2009. Thus, a legal framework now exists to provide authorisation to deprive vulnerable adults of their liberty in a care home or hospital setting. The safeguards are for adults aged 18 years and over who have a mental disorder and who lack capacity to decide where they need to reside to receive treatment and/or care.

If a hospital or care home, referred to as a Managing Authority, needs to deprive a person of their liberty, in their best interests, to keep them safe from harm, then the Managing Authority needs to apply for a DoLS authorisation (i.e. permission) through the DoLS team. Following assessment by a Best Interests assessor and a Doctor, if appropriate/needed the Supervisory Body (Local Authority or Health Board) gives permission to deprive a person of their liberty by granting a DoLS Authorisation.

DoLS is governed by law, Regulations and a Code of Practice that has statutory force- i.e. it must be followed, unless there is good reason not to. There is also a considerable body of case law on deprivation of liberty and DoLS.

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. This is due to come into force on 1st October 2020.

The DoLS process within the Health Board was previously subject to Internal Audit review in 2015/16. The resultant limited assurance report was subject to detailed follow-up in early 2018 when it was identified that a number of issues were still outstanding. Given the time elapsed since the original review, it has been decided that the DoLS process will now be subject to a new full review.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of DoLS, in order to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if adequate procedures are in place within the Health Board to ensure that DoLS are consistently complied with and authorisations are obtained for all relevant patients.

The main areas that the review has sought to provide assurance on are:

- The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty;
- Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes;
- Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales;
- All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales;
- All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met;
- All DoLS authorisations are correctly signed by the Supervisory Body;
- Processes are in place for monitoring and reporting compliance with DoLS and any issues are appropriately escalated and addressed: and
- The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards.

3. Associated Risks

The potential risks considered in this review are as follows:

- Non-compliance with DoLS due to lack of processes / awareness;
- Patients may be unlawfully deprived of their liberties; and
- The Health Board is unaware of issues relating to DoLS compliance.


OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Deprivation of Liberties Safeguards (DoLS) is **Reasonable assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

The Audit was assessed as reasonable assurance as there have been improvements made since the previous Internal Audit review in early 2018. There has been a decrease overall in the number of DoLS standard and further requests being submitted and it was identified that they were being completed in a timelier manner. In addition, the review highlighted that the DoLS assessments were being authorised on a timely basis as the Health Board have identified additional staff members to undertake signing off the DoLS assessments.



There are still some issues identified as part of the review as there has been a vast increase in the number of urgent DoLS requests and staff are not able to always complete them within the required seven days as documented within the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Whilst this is a serious issue that the Health Board will need to seek to address, it is noted that all the sampled urgent DoLS requests have been completed but not in line with the stipulated time limits.

It was evident from our review that there has been a significant increase in awareness of DoLS as identified from our discussions with ward staff and having a specific Nurse managing the process within the Stroke unit. However, there has only been one DoLS training session carried out this year as the others have been cancelled due to the lack of numbers of staff attending.

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5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Processes and Guidance				✓
2	Training & Awareness			✓	
3	Raising DoLS requests				✓
4	Assessment of Urgent requests		✓		
5	Assessment of Standard requests			✓	
6	Authorisations				✓
7	Monitoring and Reporting				✓
8	Liberty Protection Safeguards			✓	

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for Deprivation of Liberties Safeguards (DoLS).

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Deprivation of Liberties Safeguards (DoLS).

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6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty

We note the following areas of good practice:

- There is a section on the Cardiff and Vale UHB Intranet for DoLS and available on there is documentation relating to DoLS such as the Law Societies document on "Identifying a deprivation of liberty: a practical guide" and the Department of Health document titled "Mental Capacity Act 2005 Deprivation of Liberty Safeguards".
- The UHB utilises and complies with the DoLS Code of Practice.
- A proforma has been developed within the Health Board to assess whether the ward should apply for a DoLS authorisation assessment for a patient.
- Audit selected a sample of wards to establish whether ward staff were able to identify patients that required DoLS. It was evident from discussions that ward staff were able to identify patients that require a DoLS and the forms that required completion.

We did not identify any findings under this objective.

Objective 2: Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes

We note the following areas of good practice:

- It was evident that the awareness of DoLS has increased within the Health Board based on discussions with ward staff. In addition, there has been an increase in the DoLS requests made to the DoLS team which shows an awareness of DoLS.

We identified the following findings:

- There are only 33 staff who have undertaken the statutory and mandatory training on DoLS.
- Audit was advised that a number of planned DoLS training sessions have had to be cancelled due to the number of employees that have been unable to attend. It was reported in the DoLS Annual Report that only one monthly training session has taken place so far this year and all others have been cancelled due to non-attendance.

Objective 3: Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales

We note the following areas of good practice:

- Audit visited a sample of four wards and the requests for urgent and / or standard DoLS authorisations were undertaken in a timely fashion. It was identified during the review that all DoLS documentation was available on the patients' files.

We did not identify any findings under this objective.

Objective 4: All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales

We note the following areas of good practice:

- All sampled urgent requests had been appropriately assessed and outcomes determined.

We identified the following findings:

- Audit reviewed a sample of 25 urgent requests to establish if they had been completed in line with the required statutory timescales and 22 urgent requests had failed to be completed within the seven days.

Objective 5: All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met

We note the following areas of good practice:

- It was identified from review of standard and further DoLS authorisations that they were adequately assessed and outcomes reached.

We identified the following finding:

- Audit selected a sample of 5 standard and further DoLS authorisations and two of the five had been completed within the 21 days. It was evident that there had been a vast improvement in the time taken to complete the standard and further authorisations.

Objective 6: All DoLS authorisations are correctly signed by the Supervisory Body

We note the following areas of good practice:

- It was identified in the previous Internal Audit review that there was a delay in the authorising of DoLS requests. As part of the current review Audit selected a sample of 30 DoLS requests and all had been authorised in a timely manner. The Health Board has increased the number of senior staff that are authorised to approve DoLS requests.

We did not identify any findings under this objective.

Objective 7: Processes are in place for monitoring and reporting compliance with DOLs and any issues are appropriately escalated and addressed

We note the following areas of good practice:

- The MCA / DOLs Coordinator provides a report to the quarterly Partnership Board which includes the Health Board, Cardiff Council and Vale Council on number of DOLs requests. This is broken down by the type of requests, withdrawn applications and applications completed and outstanding.
- There is a Health Board Safeguarding Steering Group which meets every two months and the DOLs information is reported into this group.

We did not identify any findings under this objective.

Objective 8: The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards

We note the following areas of good practice:

- The Health Board is aware that DoLS are being replaced by Liberty Protection Safeguards (LPS). The law is in place and the Standards come into force in October 2020. The associated Code of Practice has not been produced yet detailing the process to follow.

We identified the following finding:

- Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice to be produced.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	1	1	2	4

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Finding 1 - Timescales for undertaking DoLS Urgent Authorisations (Operating effectiveness)	Risk
<p>Audit obtained a report of all DoLS authorisation requests from January to July 2019 which included 230 urgent requests. A sample of 25 urgent requests was reviewed to establish if they had been completed in line with the required statutory timescales.</p> <p>Below are our findings:</p> <ul style="list-style-type: none"> • 22 of the urgent requests had failed to be completed within the required 7 days. • The longest time it took to complete an urgent request was 26 days. For those 22 urgent requests not completed within 7 days it took on average 15 days to complete the urgent requests. 	<p>Patients may be unlawfully deprived of their liberties</p>
Recommendation	Priority level
<p>Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.</p>	<p>High</p>
Management Response	Responsible Officer/ Deadline
<p>All attempts are made to ensure the DoLS assessments are carried out within the specified timeframes, however this remains a challenge with the current resource. Only 1.5 wte (out of 6 wte) staff are funded by health with the remaining staff funded by LA. This means that resource is shared between LA assessments also. This position will be reviewed in 2020 with introduction of LPS.</p>	<p>To be confirmed / October 2020</p>

Finding 2 - DOLs Training (Operating effectiveness)	Risk
<p>Audit were advised that July 2019 was the first month that any DoLS training has been carried out formally as there had not been the numbers previously. Six staff are required to undertake the training session for it to be feasible and they were not receiving the numbers so subsequently the training was cancelled.</p> <p>In addition, the DOLs Annual Report submitted to the Safeguarding meeting on the 25 July 2019 confirmed that only one monthly training session took place this year and all others have been cancelled.</p> <p>Audit was provided with DOLs training figures from Workforce and there had been 33 staff who had carried out the statutory and mandatory training on DOLs. Despite the low level of training undertaken, it is noted that the staff members on the wards visited as part of the review, demonstrated a good level of awareness of DoLS requirements and the associated processes.</p>	<p>Non- compliance with DOLs due to lack of processes / awareness</p>
Recommendation	Priority level
<p>The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted.</p>	<p>Medium</p>

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Management Response	Responsible Officer/ Deadline
DoLS training has remained challenging, as it is directly related to the ability of clinical areas to release staff. The inability to release staff for Mandatory and Statutory training remains high on the UHB risk register. Formal monthly training continues to be supported by staff, although attendance poor. Bespoke training (one hour) drop in sessions are now being provided. Training is also incorporated into the general Safeguarding Training to continue to raise awareness of DoLS, however these results are captured in the safeguarding training numbers and not a formal record of DoLS training.	To be confirmed / October 2020

Finding 3 - Completion of standard and further authorisations (Operating effectiveness)	Risk
<p>There were only 27 standard and further DoLS authorisation requests between January - July 2019 and therefore Audit reviewed three standard and two further DOLs authorisation requests to establish if they had been completed in line with the required statutory timescales of 21 days.</p> <p>For the three standard DOLs authorisation requests the following was noted:</p> <ul style="list-style-type: none"> One had been completed on the day it was received; One had been completed in 26 days whilst the third had been completed in 85 days. <p>The average time taken was therefore 37 days.</p> <p>For the two further DoLS authorisation requests the following was noted:</p>	Patients may be unlawfully deprived of their liberties

<ul style="list-style-type: none"> • One further DOLs authorisation request was completed in 21 days • The other request was completed in 24 days, just marginally over the required timescales for completion. <p>There has however been an improvement in the number of days taken for the completion of standard and further DoLS authorisation requests as it took on average 80 days to undertake a standard and further DoLS assessment when we carried out the previous review.</p>	
Recommendation	Priority level
<p>Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.</p>	Low
Management Response	Responsible Officer/ Deadline
<p>All assessments that are deemed as a priority have to be undertaken before the Standard and further assessments as outlined in line with WG priority tool.</p>	To be confirmed / October 2020

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Finding 4 - Liberty Protection Safeguards (Operating effectiveness)	Risk
<p>The new Liberty Protection Safeguards (LPS) are coming into force in October 2020. The law is already in place but the Code of Practice has not been produced yet detailing the process to follow.</p> <p>DoLS will be running alongside LPS for a year from October 2020 – October 2021. Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice being produced.</p>	<p>The Health Board is unaware of issues relating to DOLs compliance</p>
Recommendation	Priority level
<p>The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.</p>	<p>Low</p>
Management Response	Responsible Officer/ Deadline
<p>Whilst LPS will come into force in October 2020, we are unable to formulate a plan without the implementation of the code. Scoping meeting planned for 12th December 2019 to develop framework and code and produce work plan across wales for 2020.</p>	<p>To be confirmed / October 2020</p>

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings



Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.



Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.



Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.



No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

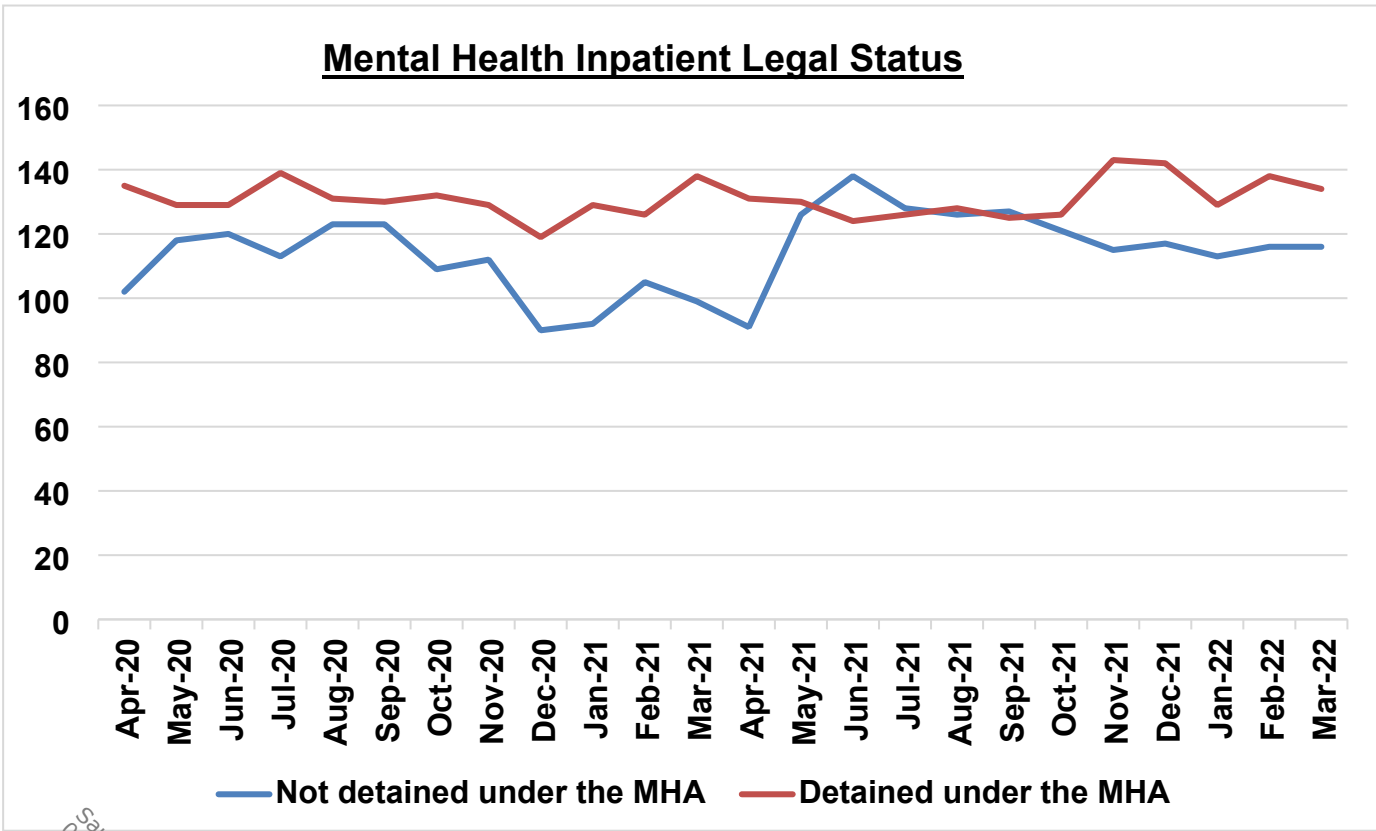
* Unless a more appropriate timescale is identified/agreed at the assignment.

Report Title:	Mental Health Act Monitoring Exception Report			Agenda Item no.	9.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	26 April 2022
		Private			
Status (please tick one only):	Assurance	X	Approval		Information
Lead Executive:	Interim Chief Operating Officer				
Report Author (Title):	Mental Health Clinical Board Director of Operations				
Main Report					
Background and current situation:					

This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee’s awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to a community treatment order is only as the MHA allows.

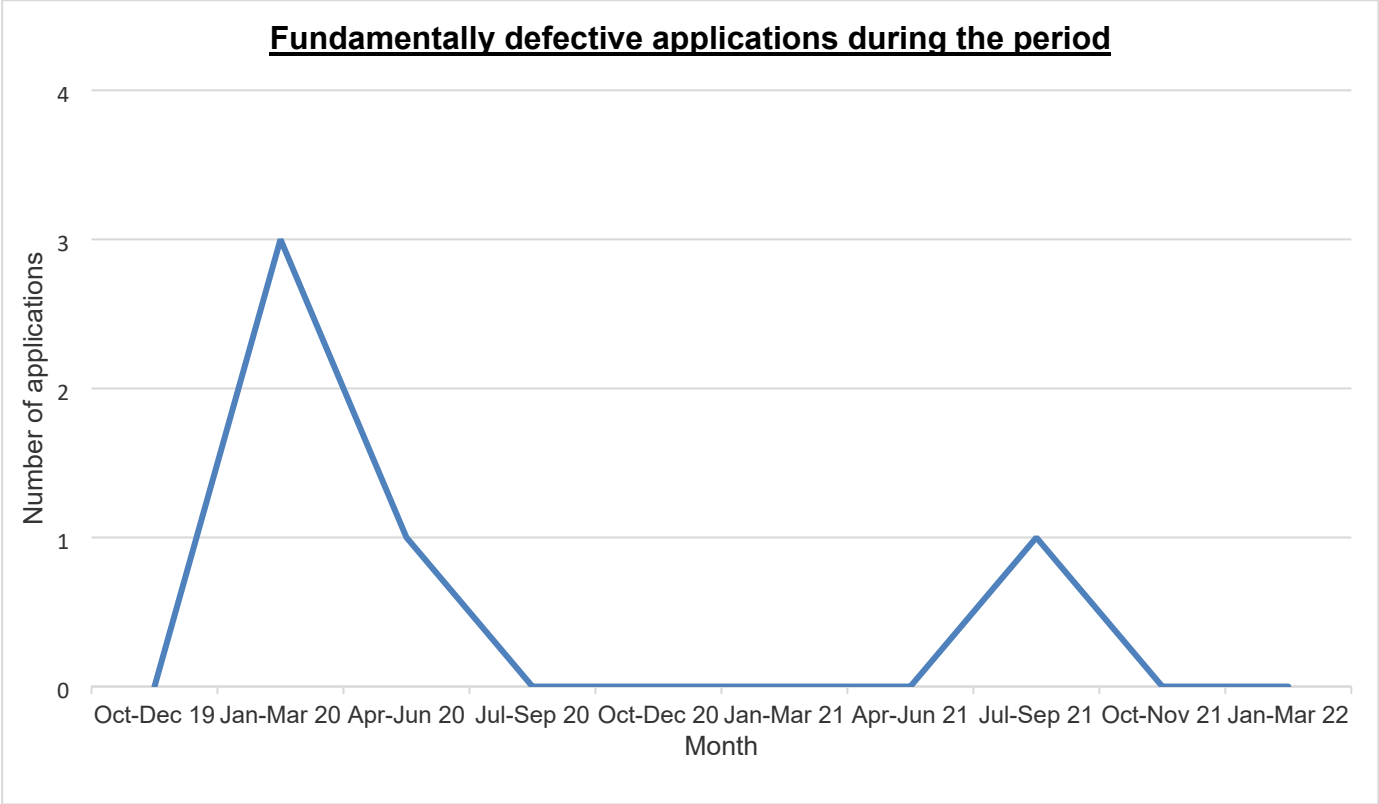
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Use of the Mental Health Act has remained consistent this period with 53% of inpatients being detained under the Act at the end of Qtr.4 with 53% at the end of Qtr.3.



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Fundamentally defective applications



There were no fundamentally defective applications during this period. However, a query was raised by an independent provider about the lawfulness of one of our section 3 renewal documents. I was confident in my interpretation of the law but for clarity I sought legal advice, which confirmed the renewal was lawful. This advice has been incorporated into the relevant policy/procedure for future use.

Section 136 A&E

Further legal advice will need to be sought in relation to any 136's where the treatment is related to the mental disorder but the patient is not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse, for example,

Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.

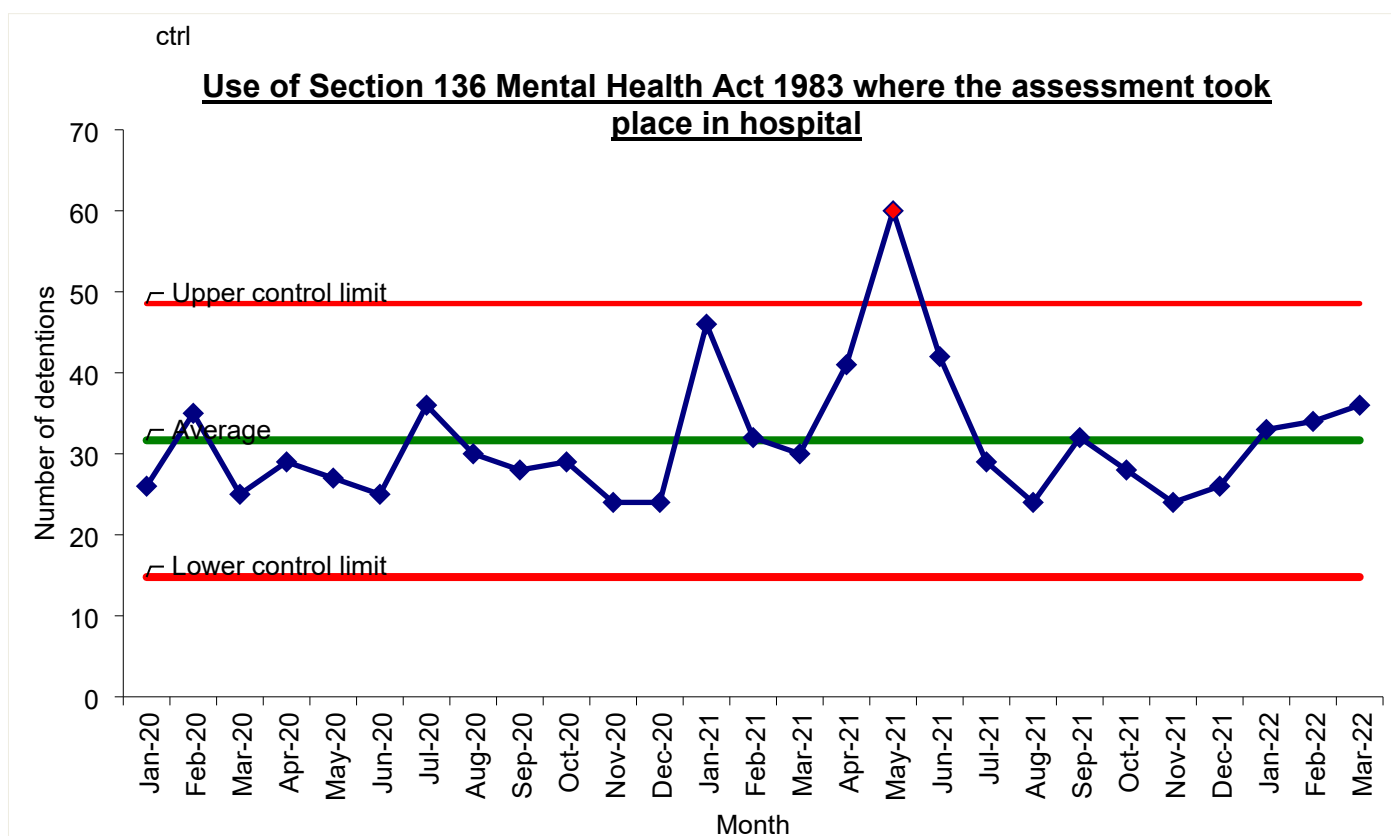
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

During the period, the use of section 136 has increased.

It was noted that 63.4% of individuals assessed were not admitted to hospital, with 51.9% being discharged with community support and 11.5% were discharged with no follow up. Overall during the period 32.7% of patients were admitted to hospital following a 136 assessment which is higher than the previous quarter at 30.7%. During the period 3.8% of patients didn't have an assessment because the 24-hour time had lapsed and no extension had been requested.

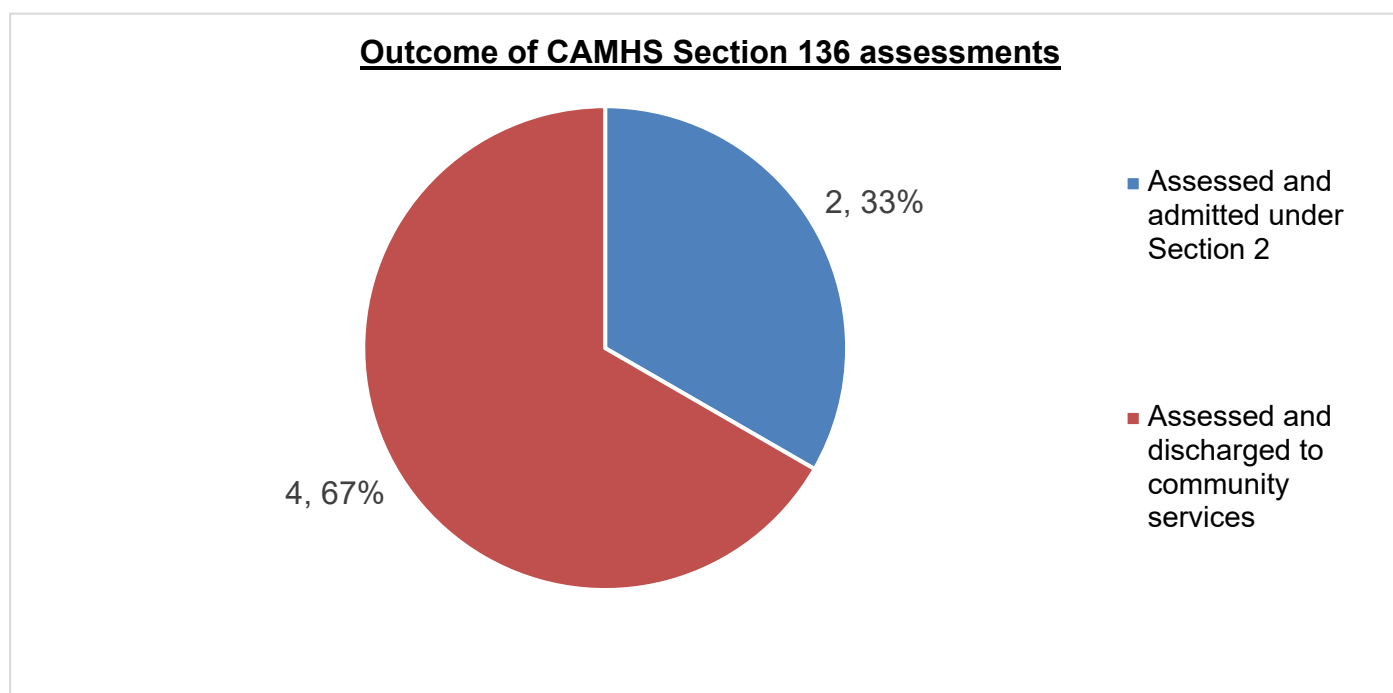
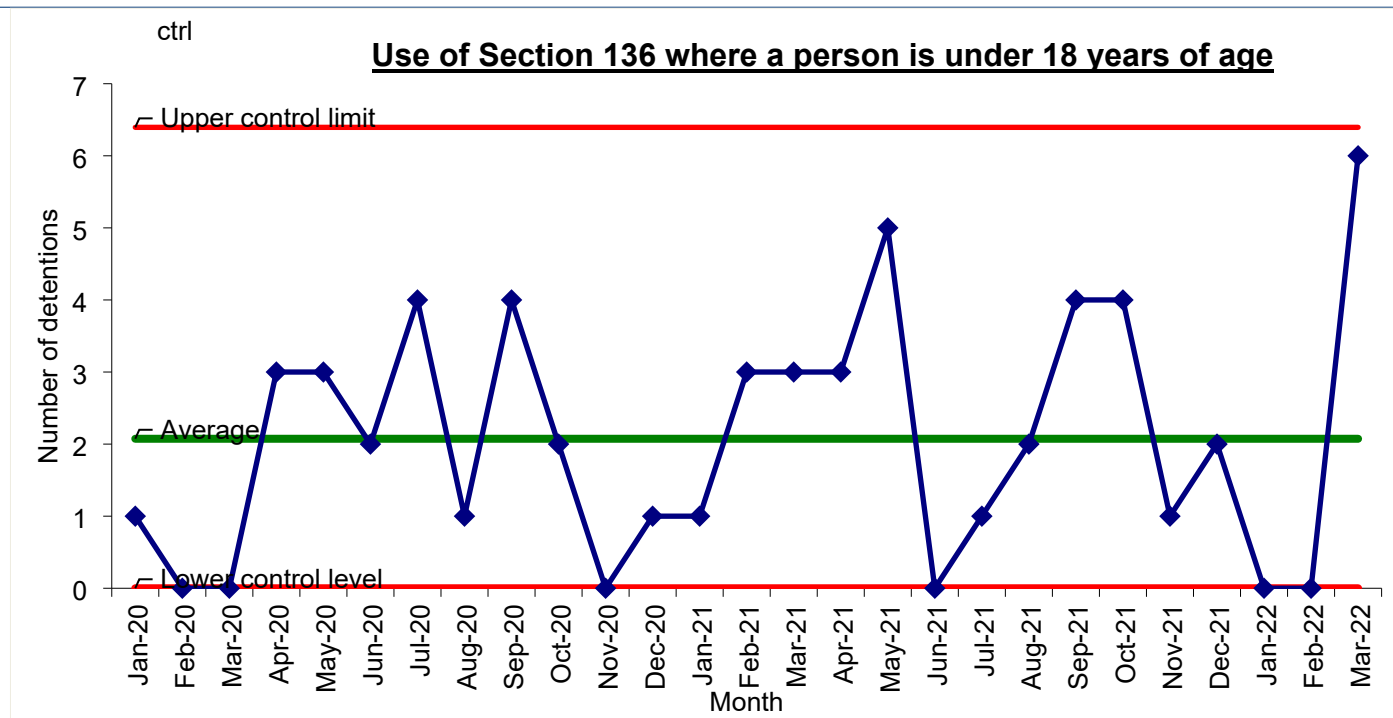
Period	% not admitted to hospital
January – March 2022	63.4%
October – December 2021	68.0%
July – September 2021	74.1%
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%
April – June 2020	70.4%
January – March 2020	62.8%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has decreased from 7 in the previous quarter to 6 in this quarter. There were 4 repeat presentations recorded.

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Mental Health Review Tribunal for Wales (MHRT) – Teams hearings

I am waiting for an update from the Operations Manager at MHRT regarding the rollout of Teams as standard for all Tribunal hearings. In the meantime, we have been authorised to request hearings take place via Teams at patient/professional request. Since February, 4 requests for Teams hearings have been put forward to the MHRT and all have been granted.

Mental Health Review Tribunal for Wales (MHRT) - Observers

The issues of observers attending Tribunals is still on-going. I am waiting for an update from the Operations Managers at MHRT. Internally we have agreed a process that may help student nurses to be able to observe. This is directing all observer requests to myself where I will forward onto the MHRT and keep a log of all requests being sent, approved or rejected. This will enable me to put a case forward to the MHRT with significant data in order to gain a reasoning as to why requests are being rejected when we are following their guidance.

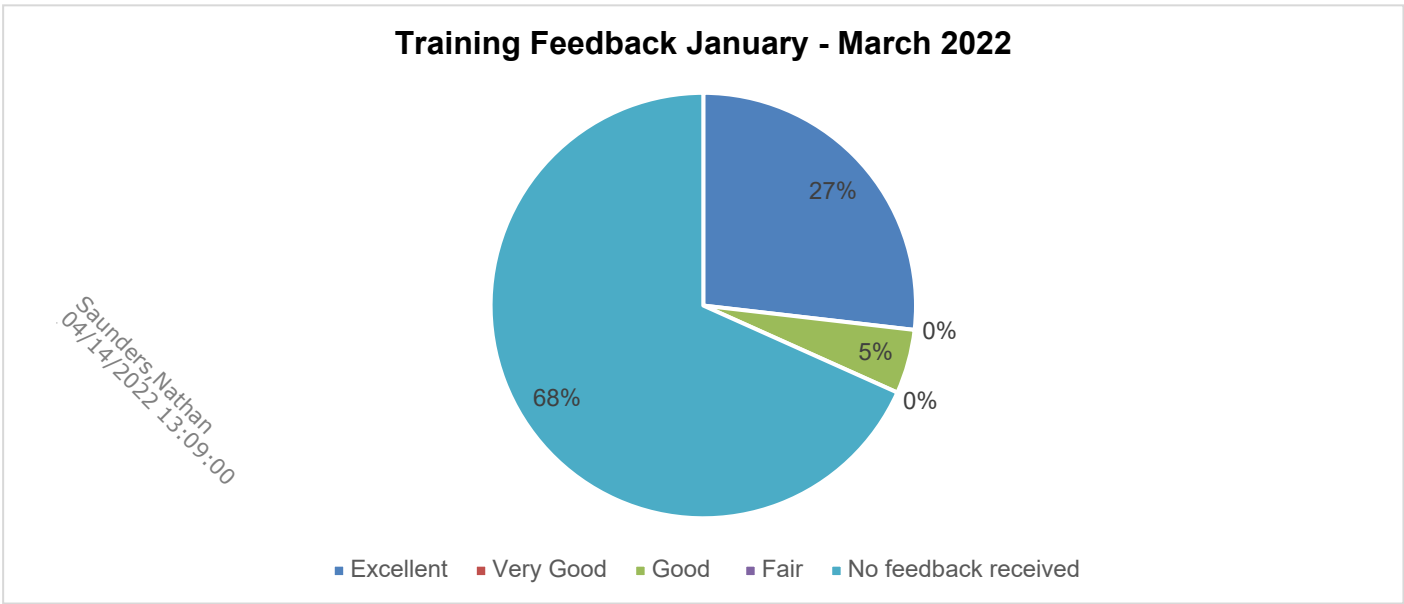
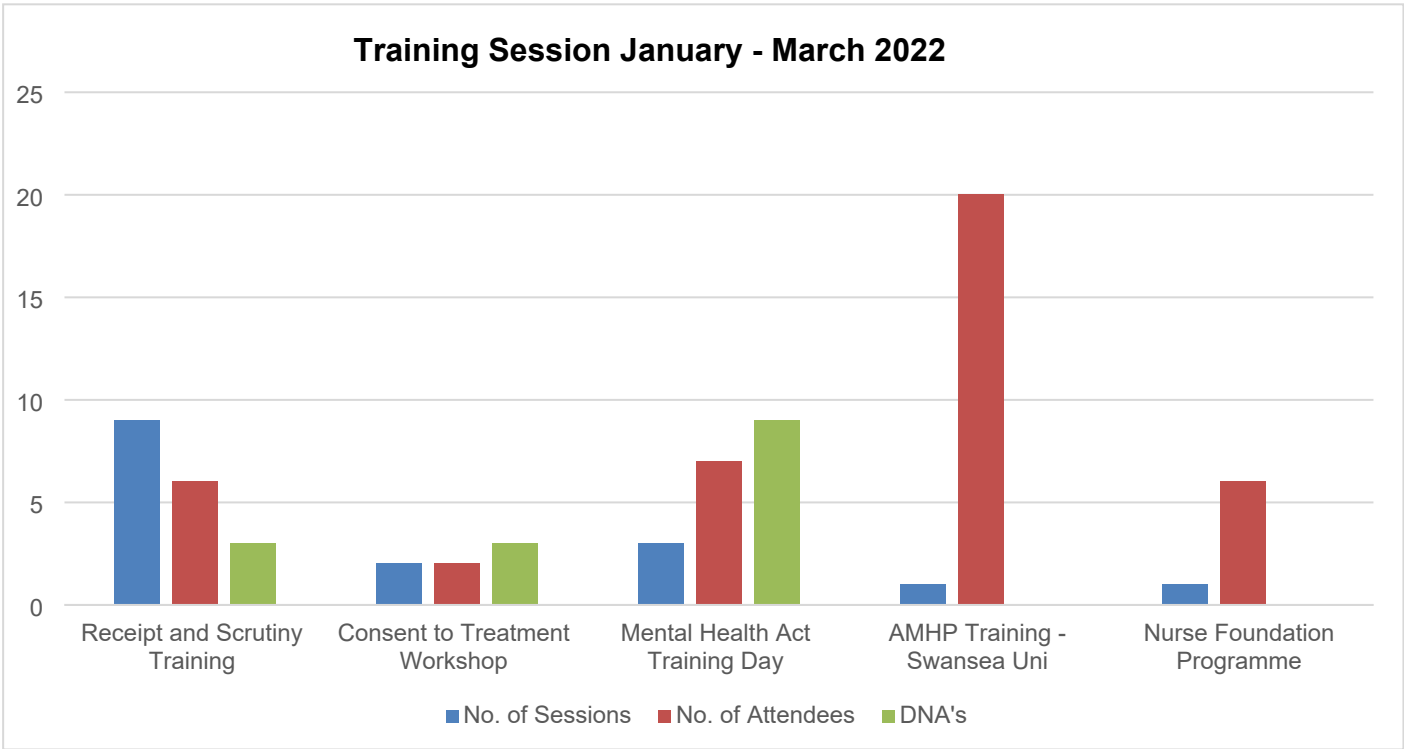
Recently a consultant psychiatrist requested that two doctors, who have been very involved in the patients care and treatment, observe the tribunal which a deputy president rejected with the following:

“On this occasion, having taken account of all the relevant factors including the impact upon the patient of the requested observations it will not be possible to allow the request.”

The consultant who made the request detailed that the two doctors have reviewed the patient when they were unavailable so the patient knows them and they knew not to give evidence, just observe. The MHRT didn’t give detailed reasons for the rejection therefore, I have forwarded the e-mail to the Operations Manager and asked they investigate further.

Development Sessions

The Mental Health Act office continues to run Mental Health Act awareness sessions including a monthly Mental Health Act training day, which is available to all staff within the Health Board, Receipt and Scrutiny, Consent to Treatment and a Rights workshop. Also we were asked to attend the AMHP (Approved Mental Health Professional) training in Swansea University to provide guidance on the statutory documentation that’s used within the Mental Health Act.



The Mental Health Clinical Board continues to take the following approach:

Fundamentally defective applications

Continue to ensure effective communication between the Local Authority and UHB and promote Mental Health Act training across the UHB.

Lapsed Detention

Continue to work with South Wales Police to ensure Section 135(1)/135(2) warrants are executed promptly.

Section 136

Continue to monitor with colleagues in South Wales Police and ensure any incidents related to an assessment not being completed within the 24/36-hour period due to physical health issues are reported accordingly.

Section 136 – CAMHS

Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal

Continue to work with the MHRT for Wales to find a suitable resolution, to ensure that action is taken to protect the patients' right to a fair hearing and ensure any incidents are reported accordingly. This should be resolved shortly with the MHRT potentially offering Teams hearings as standard to all patients.

Mental Health Review Tribunal for Wales (MHRT) - Observers

Continue to work with the MHRT for Wales to find a suitable resolution and to protect the patients' right to a fair hearing.

Development sessions

Continue to develop a robust training rota to ensure that development sessions in relation to all areas of the Mental Health Act are available and easily accessible. This will be provided by creating a Mental Health Act e-learning module. Refresher Receipt & Scrutiny training should be completed yearly and new shift coordinators should attend the relevant training before undertaking that role.

Recommendation:

The Committee is requested to:

- a) NOTE the approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X

4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
------------	---	-----------	---	-------------	---	---------------	---	-------------	---

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

Yes – there is a potential risk that if a 136 lapses with no assessment being completed the patient will be allowed to leave and could harm themselves or others.

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – communication between the UHB, Local Authority and South Wales Police needs to continue to be monitored to ensure all risks regarding detaining someone without authority are mitigated.

Reputational: Yes/No

No

Socio Economic: Yes/No

No

Equality and Health: Yes/No

No

Decarbonisation: Yes/No

No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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NHS
WALES
GIG
CYMRU

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

**Report to the
Mental Health and Capacity Legislation Committee
on the use of The Mental Health Act, 1983**

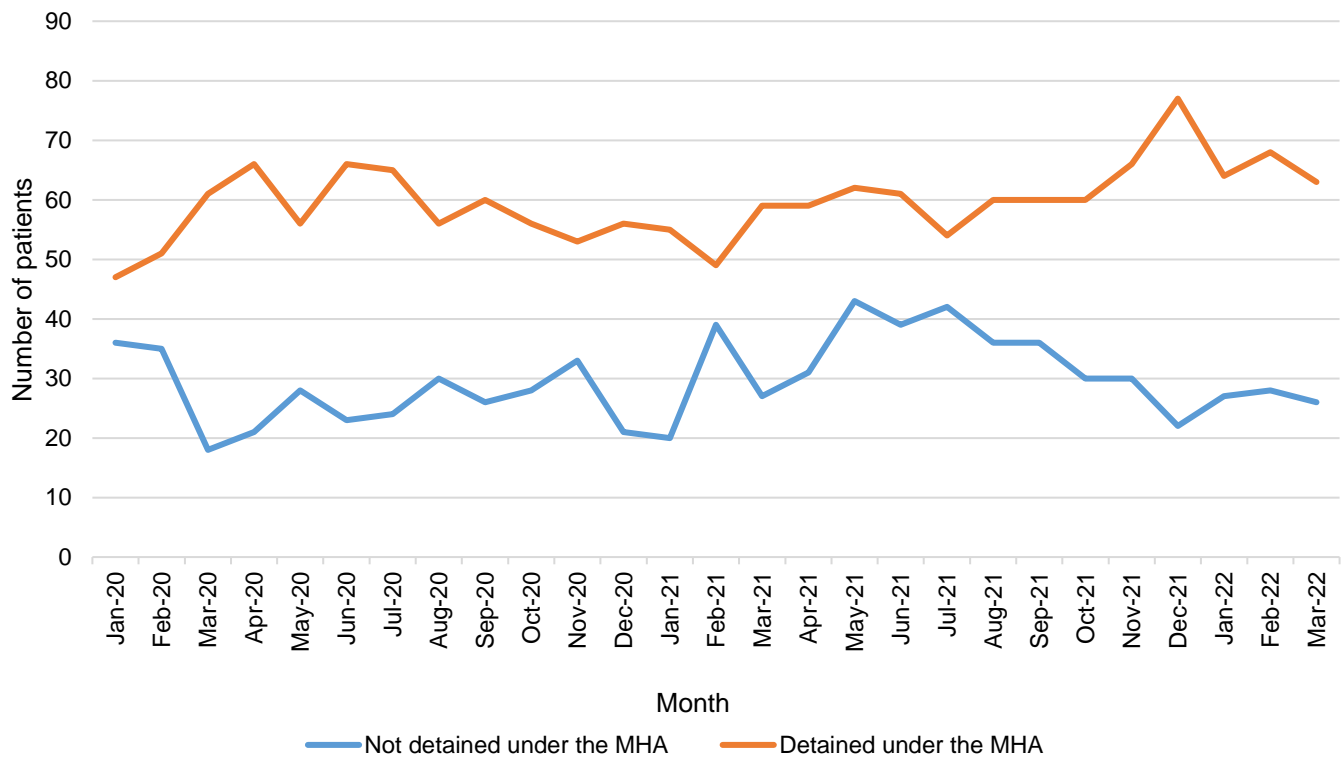
January- March 2022

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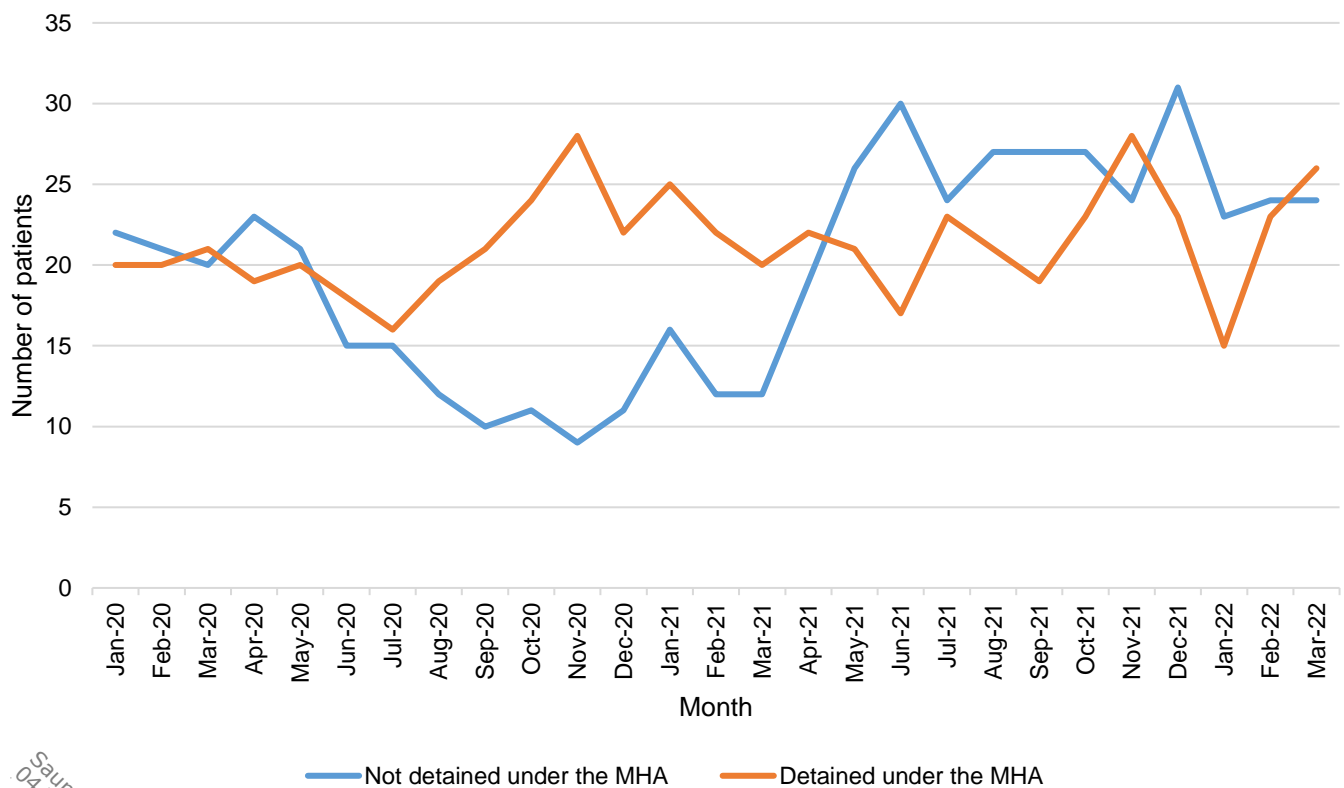
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Adult Acute- Detained/ Not detained MHA

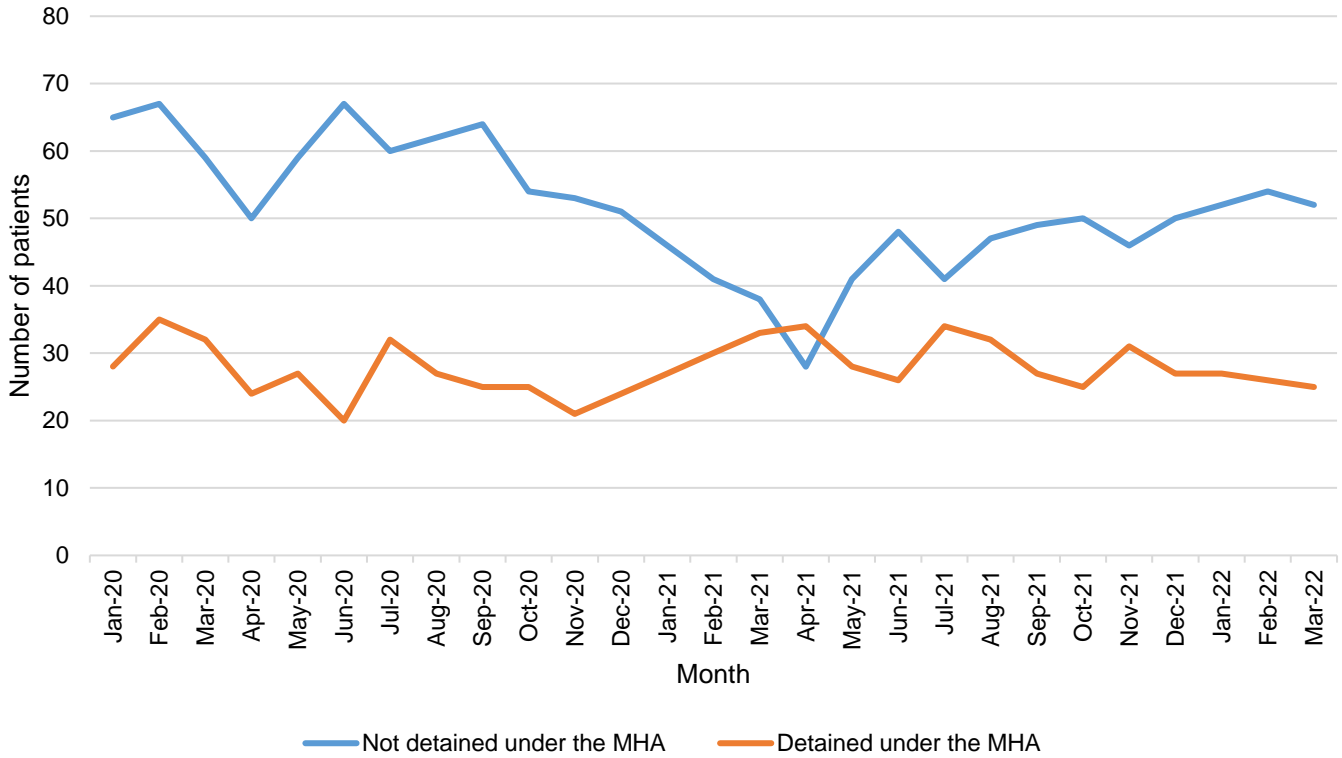


Rehabilitation- Detained/ Not detained MHA

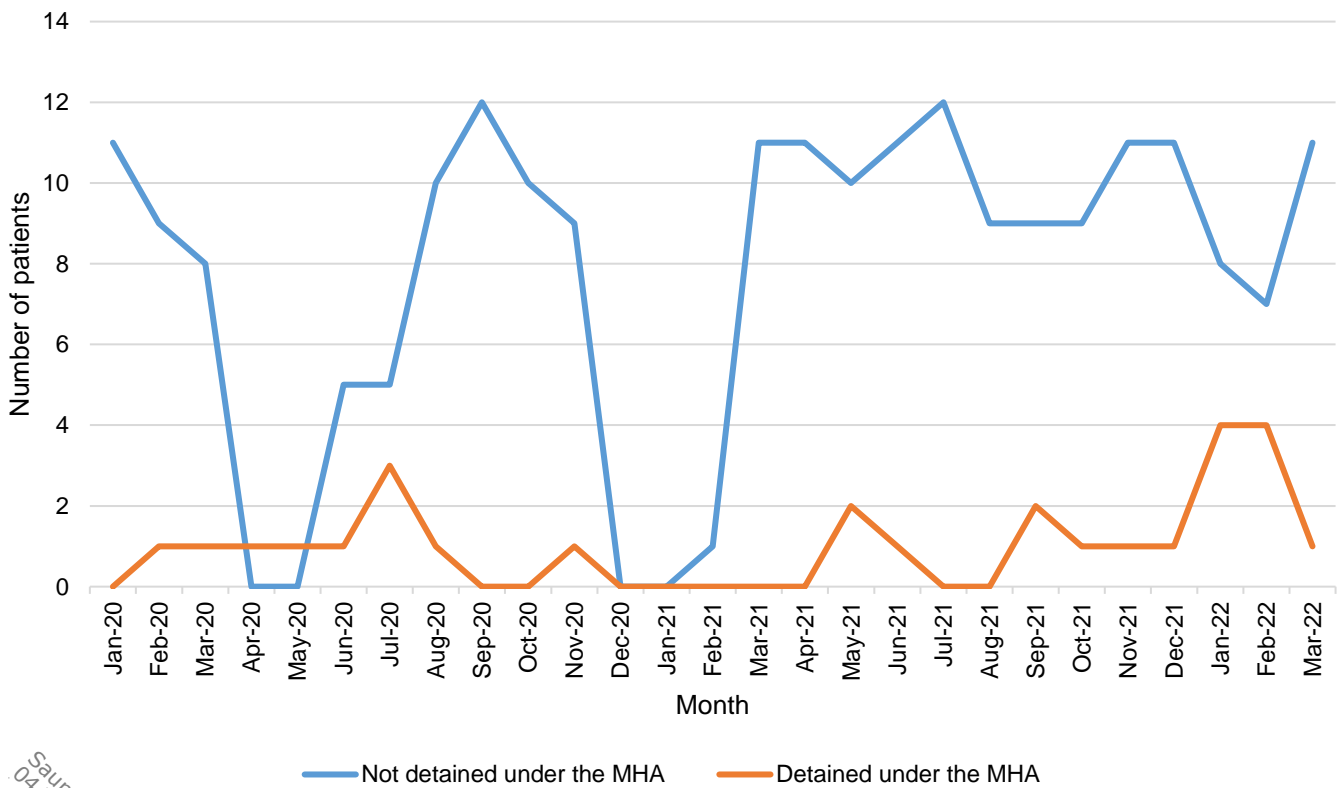


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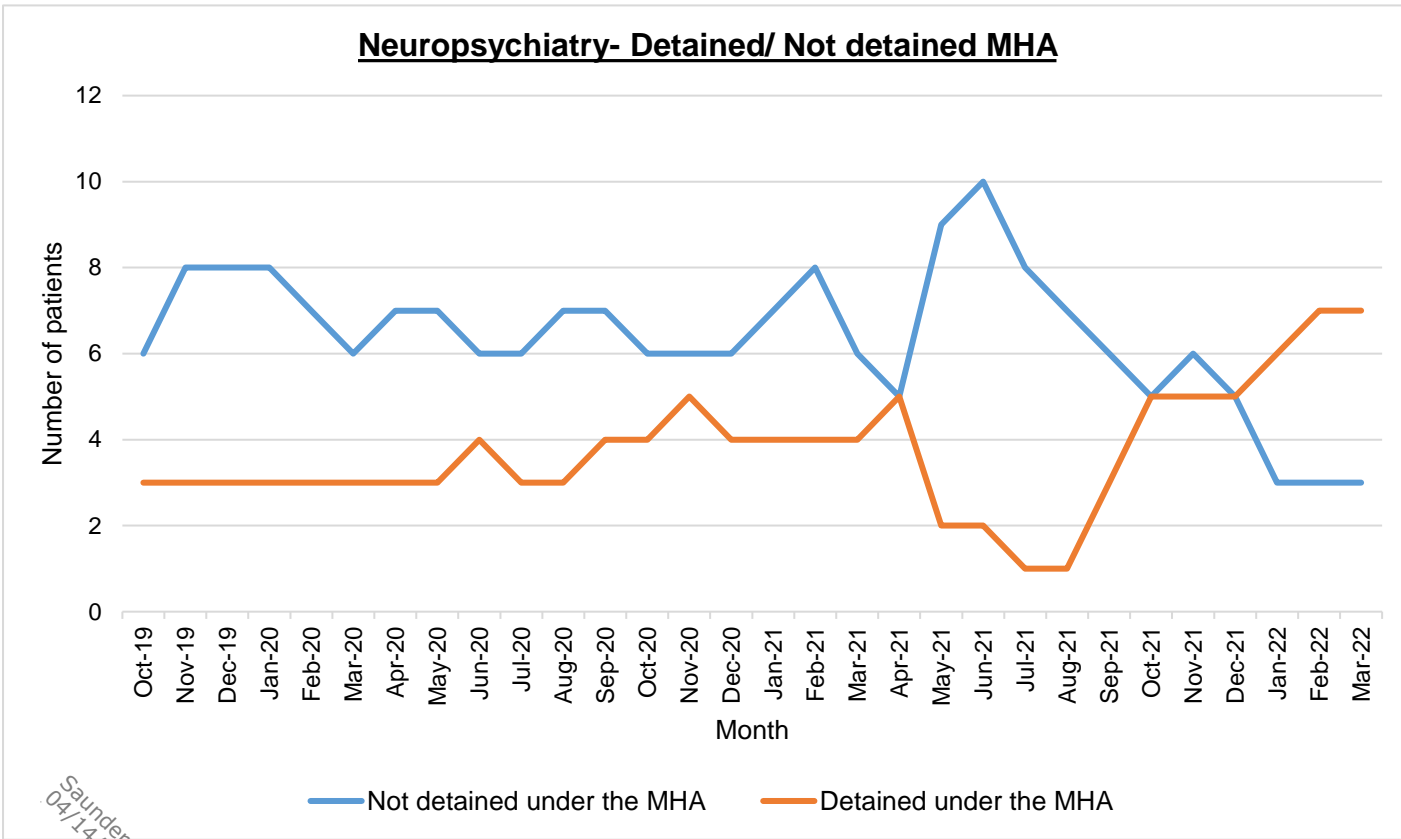
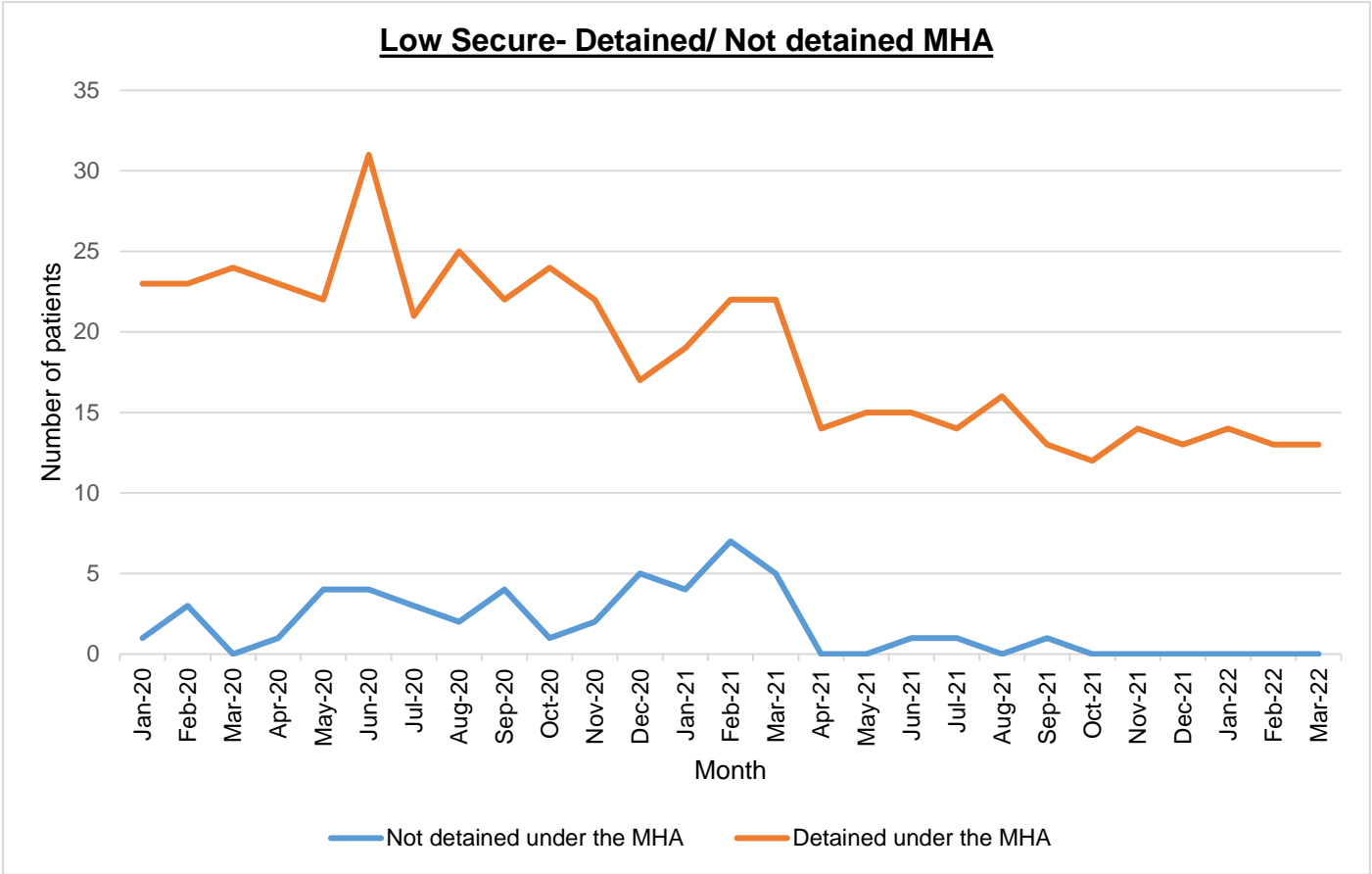
Mental Health Services for Older People- Detained/ Not detained



Addictions- Detained/ Not detained MHA



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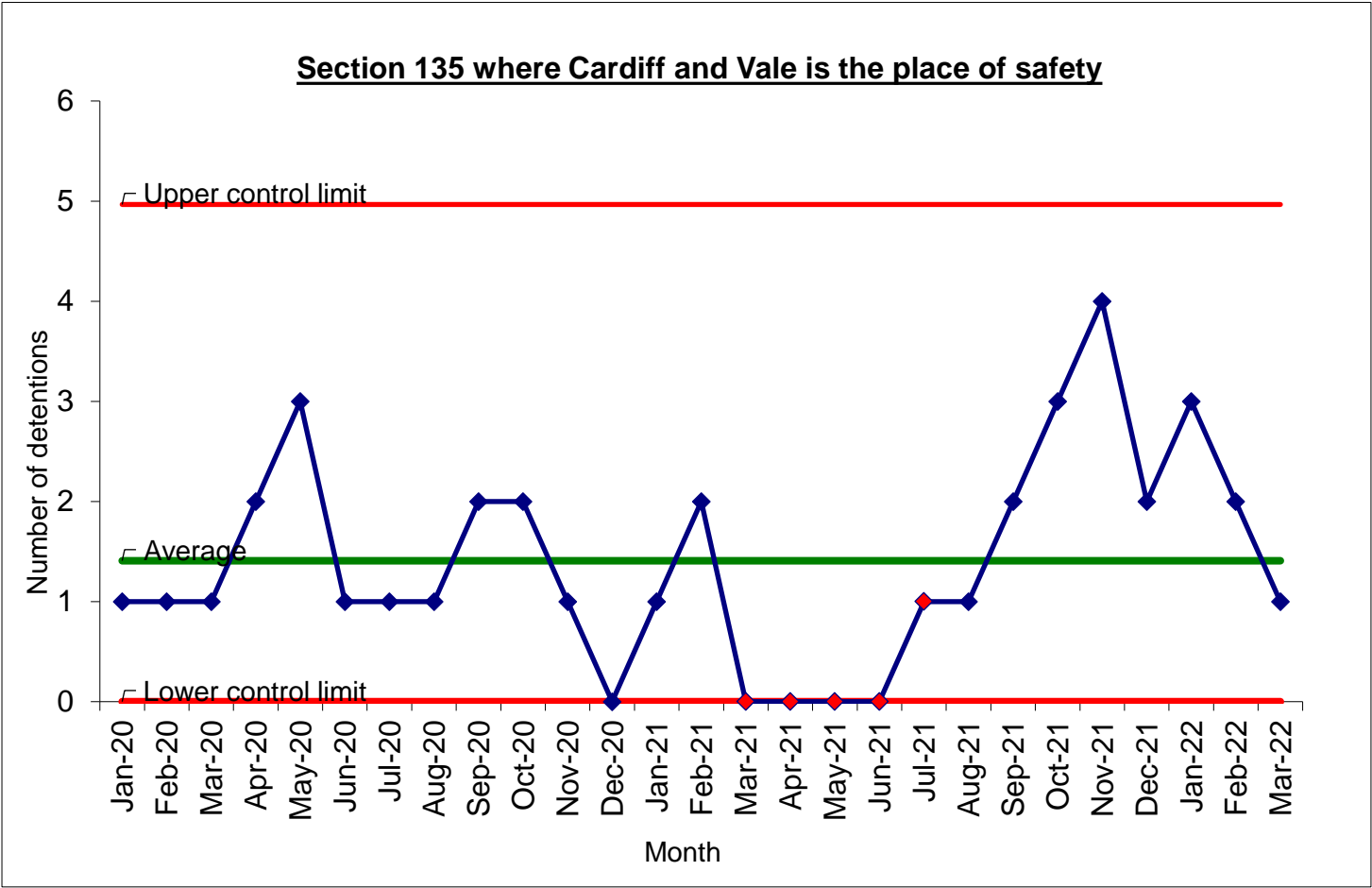


Saunders, Nathan
04/14/2022 13:09:00

Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used five times. All the patients were placed on Section 2.

Section 135(2) powers were used once during the period. The patient was then brought back to hospital under Section 3.



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Voluntary Assessment

During Summer 2020, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

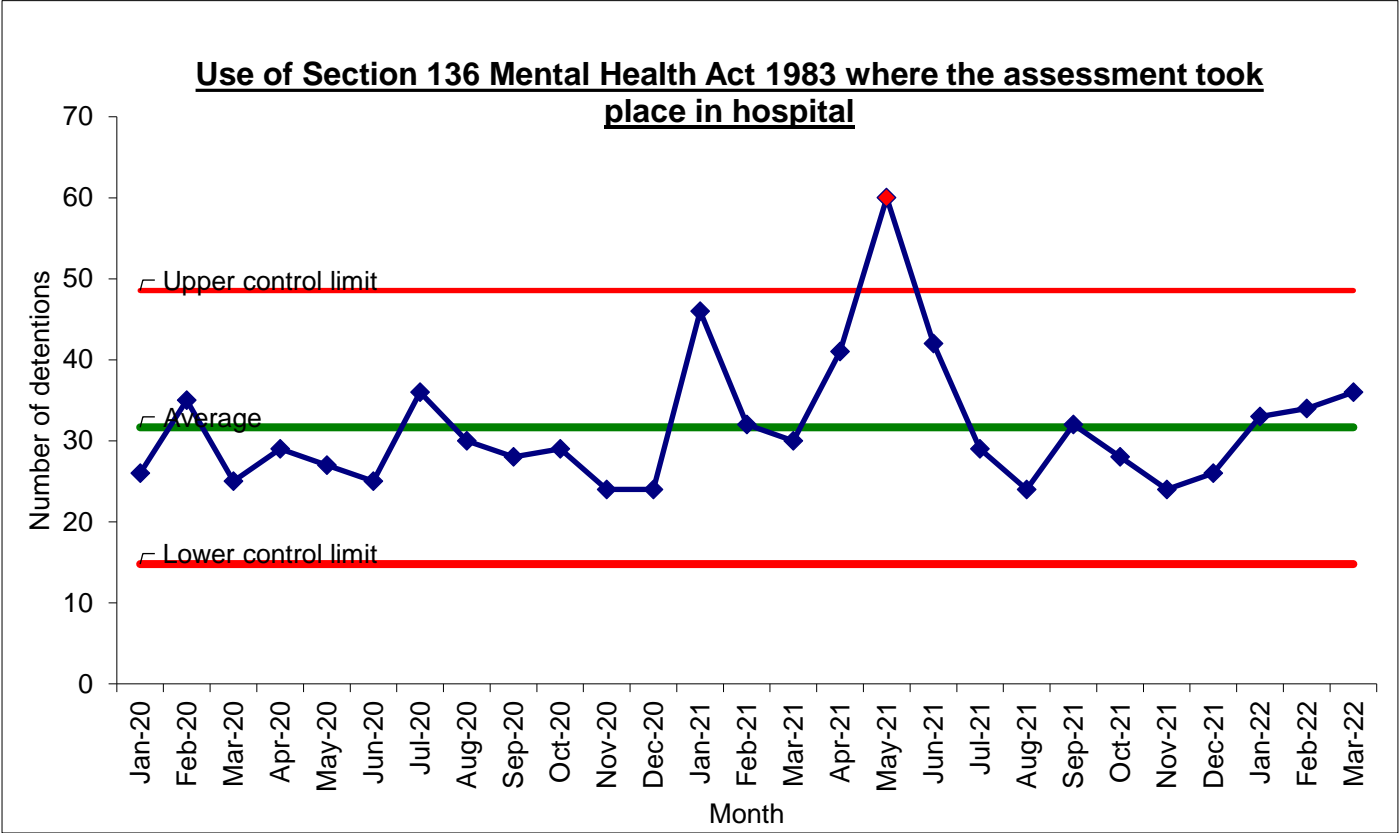
We continue to work with South Wales police to ensure the AWMF is completed each time a person is brought to hospital for an assessment and hope to see an improvement in the use of the electronic form going forward.

For this period we have seen twelve people for a Voluntary Assessment and one was brought into hospital under the Mental Capacity Act.

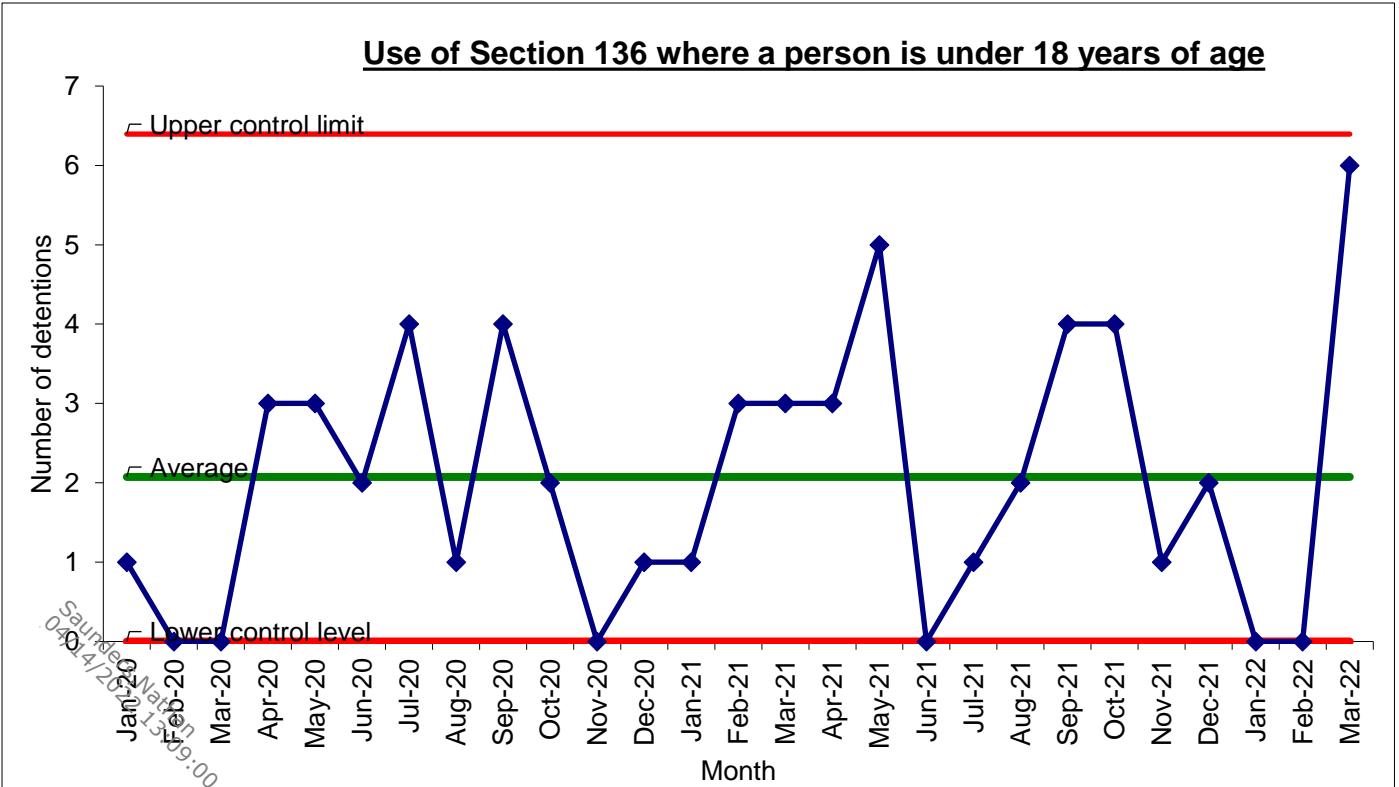
Saunders, Nathan
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Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

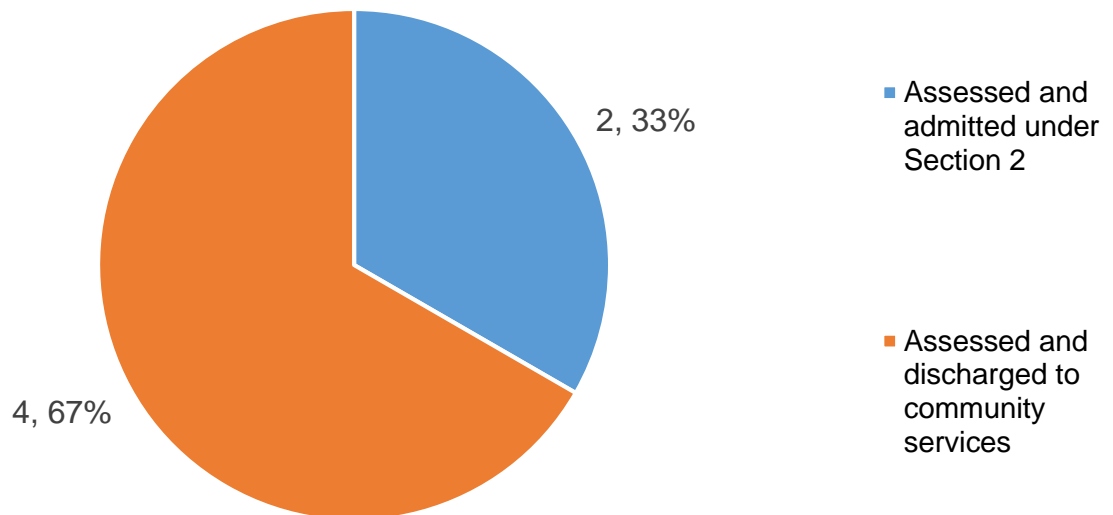
During the period a total of 104 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



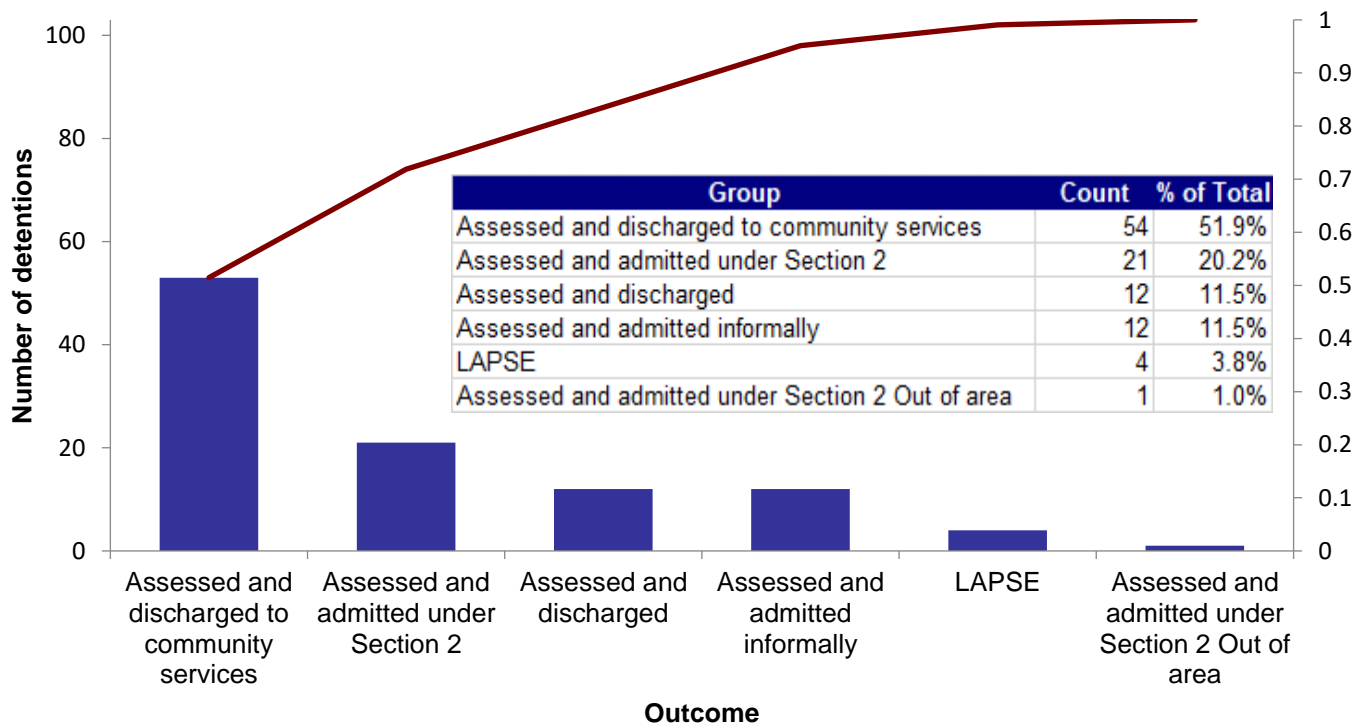
Six of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. This is extracted below;-



Outcome of CAMHS Section 136 assessments



Outcome of Section 136 where assessment took place in hospital during the period January- March 2022

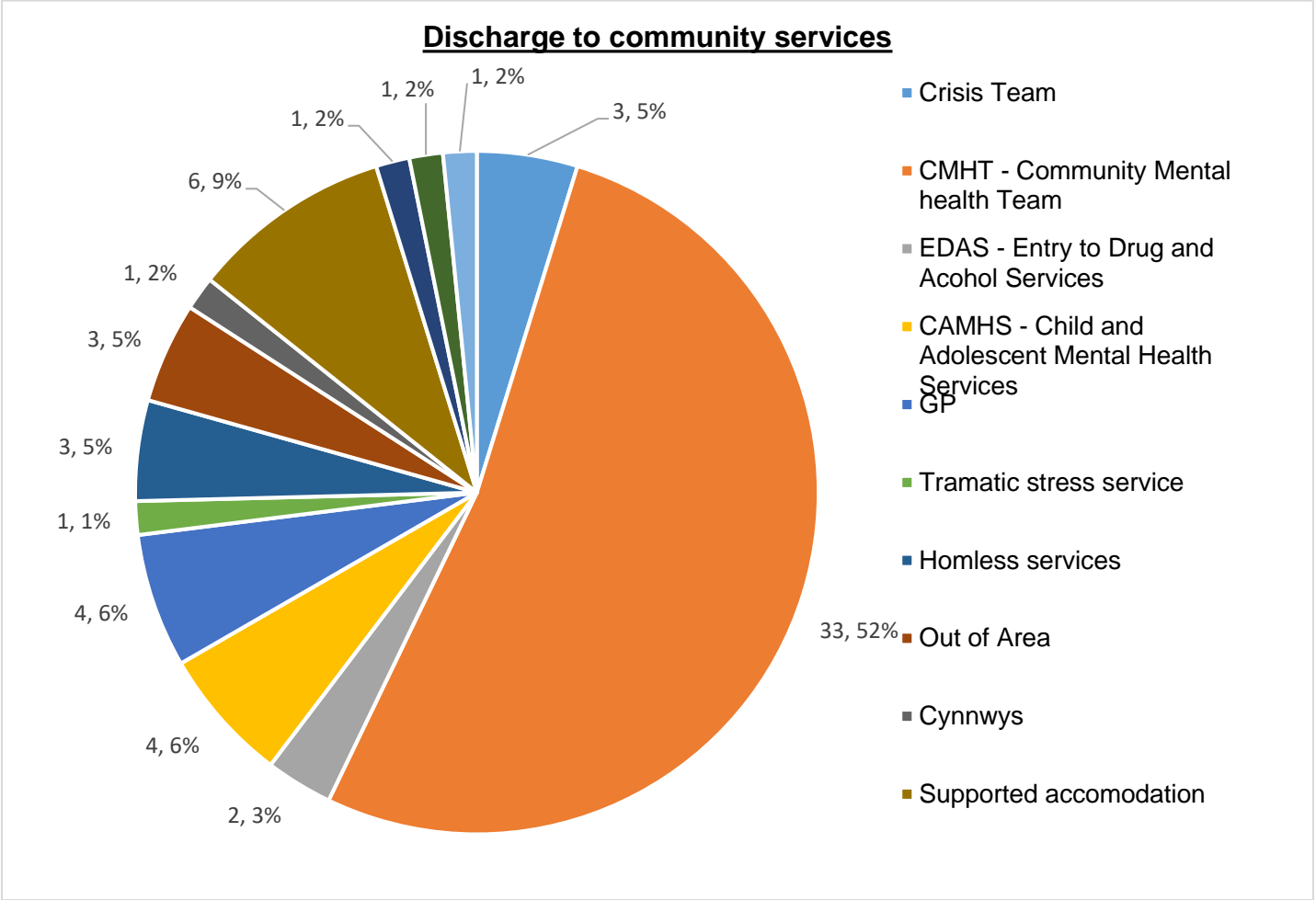


The pareto chart highlights that 63.2% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

Included in the above data are the outcomes for those under 18 years of age.

- Four section 136's lapsed during the period as the patients were assessed outside of the 24hour period and no extension had been requested.
- Four of the CAMHs assessments were on the same patient.

The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

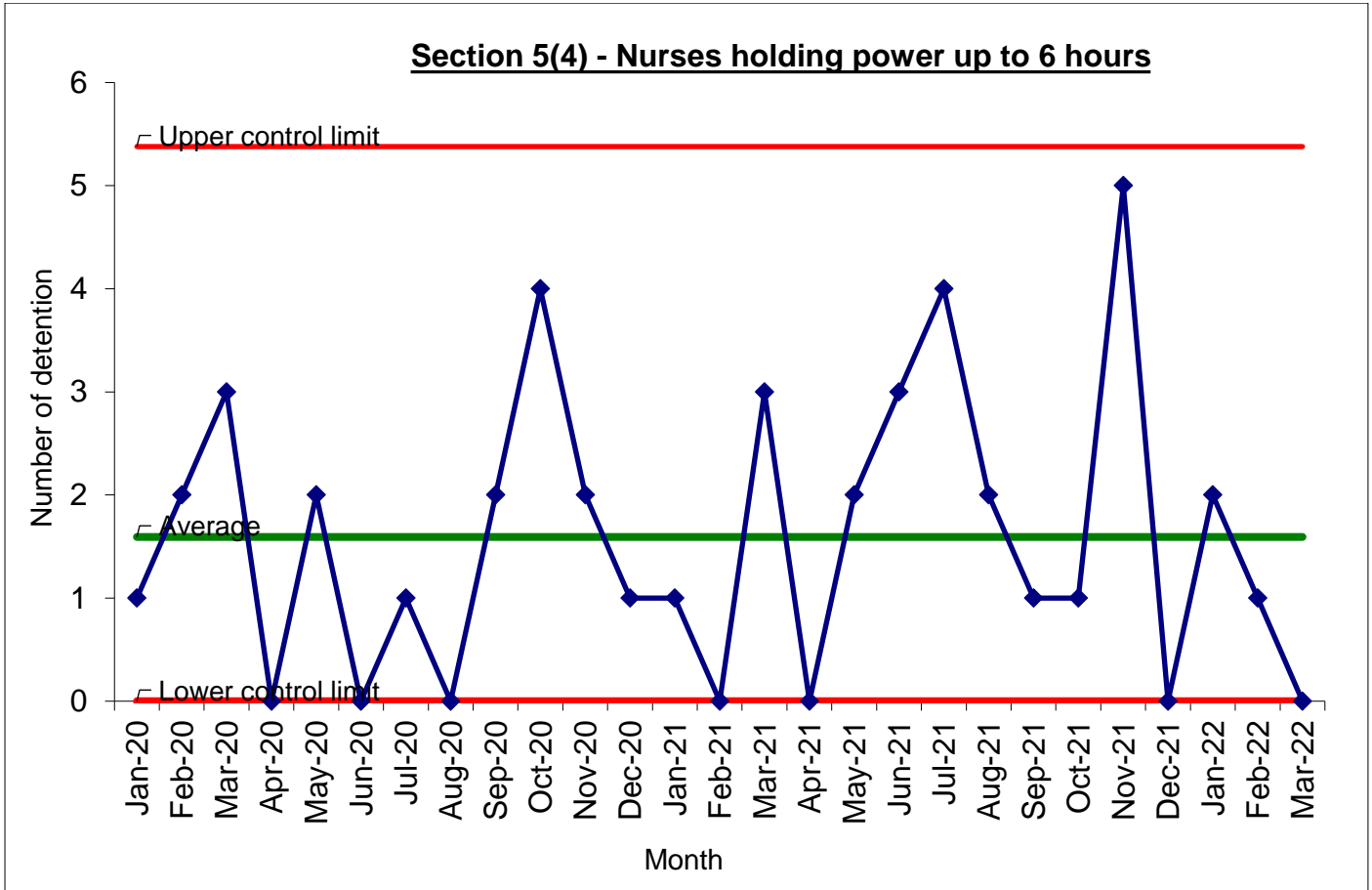


Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

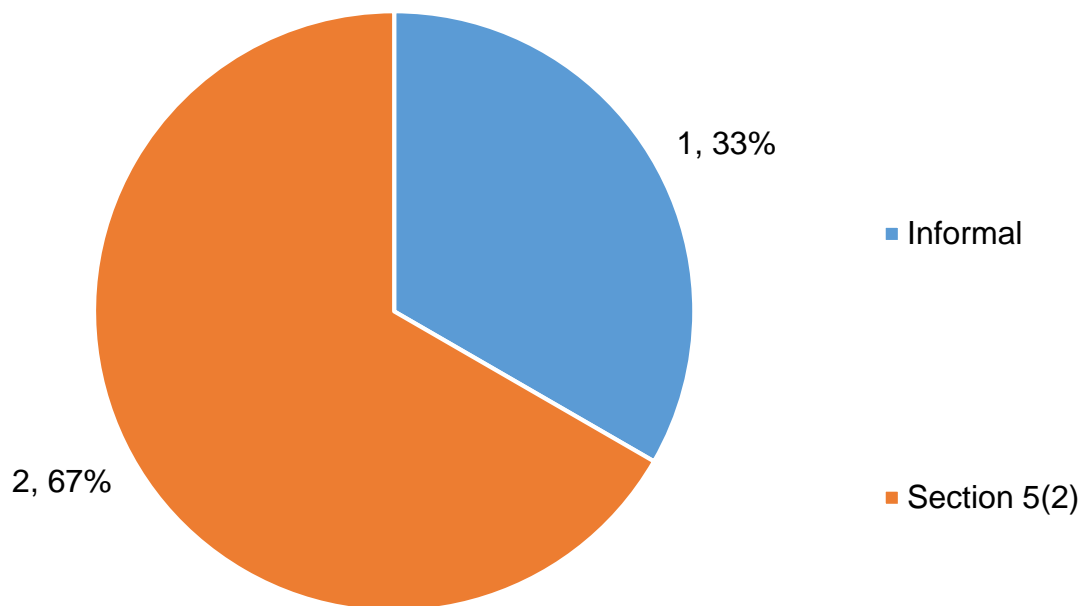
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

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Section 5(4) - Nurses Holding Power

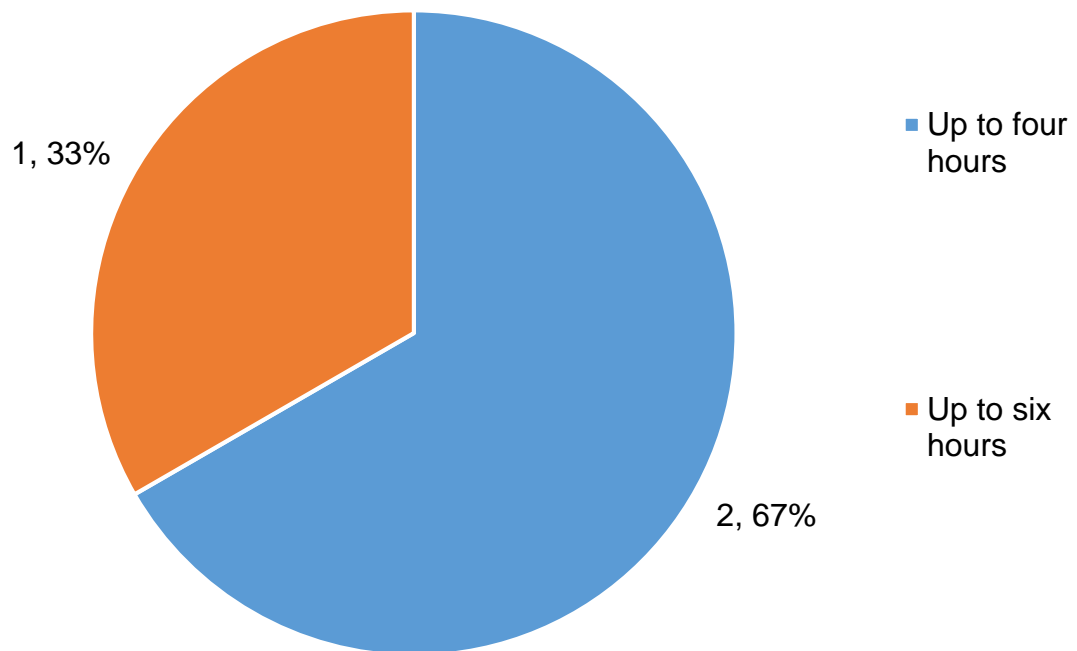


Outcome of Section 5(4) during the period January - March 2022



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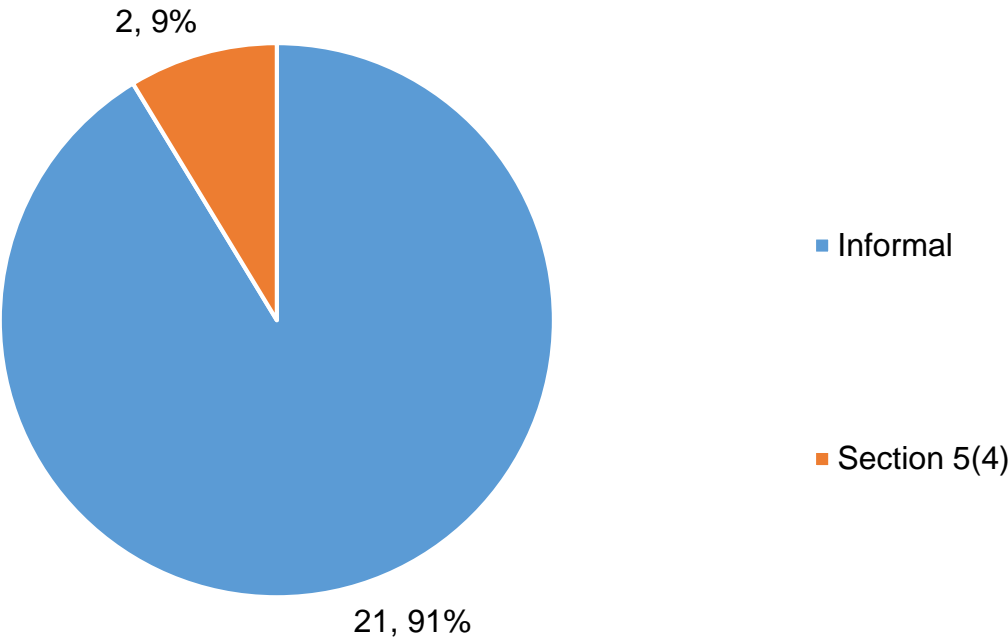
**Number of hours patients were detained under Section 5(4) during
the period January - March 2022**



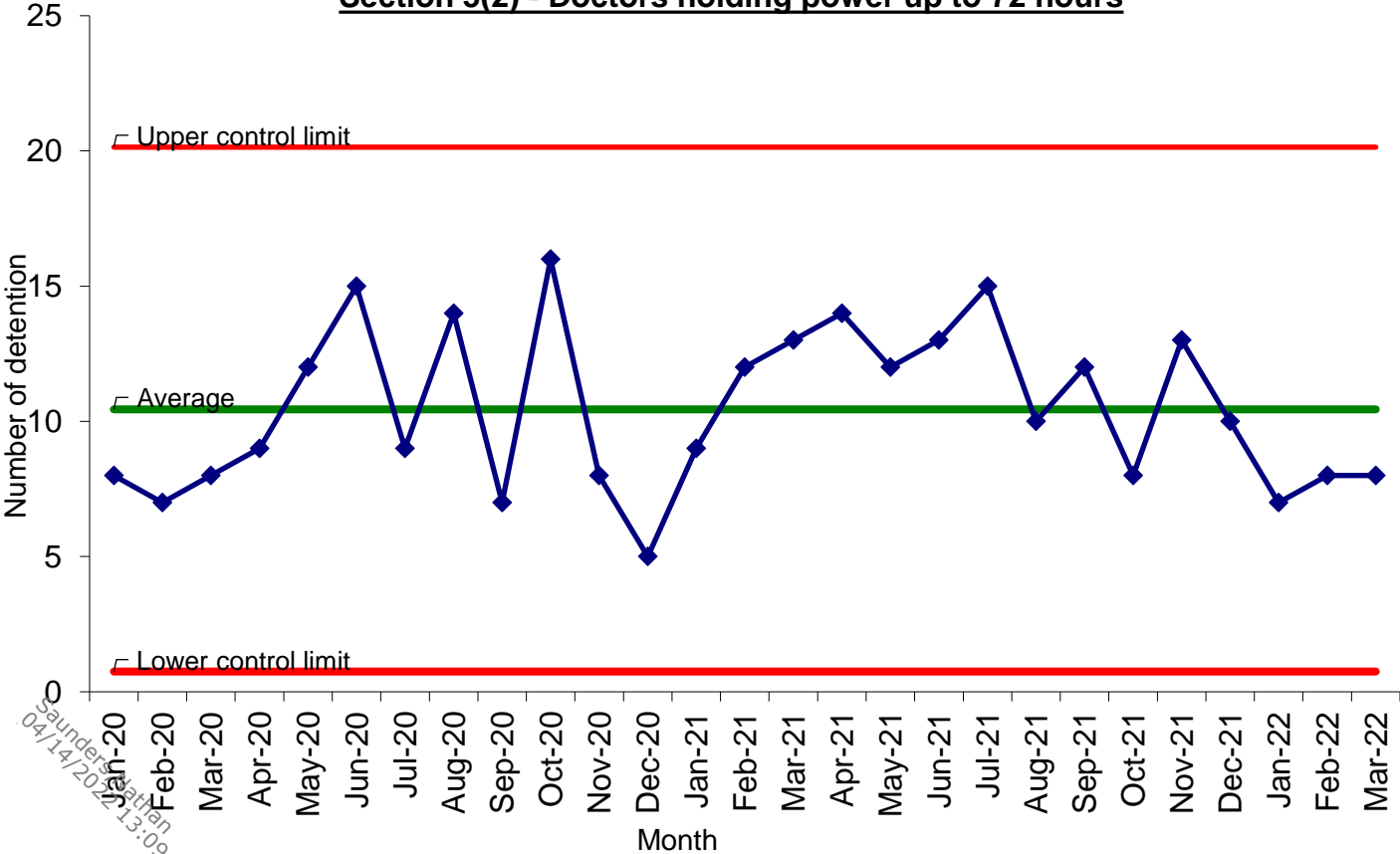
Saunders, Nathan
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Section 5(2) - Doctors holding power

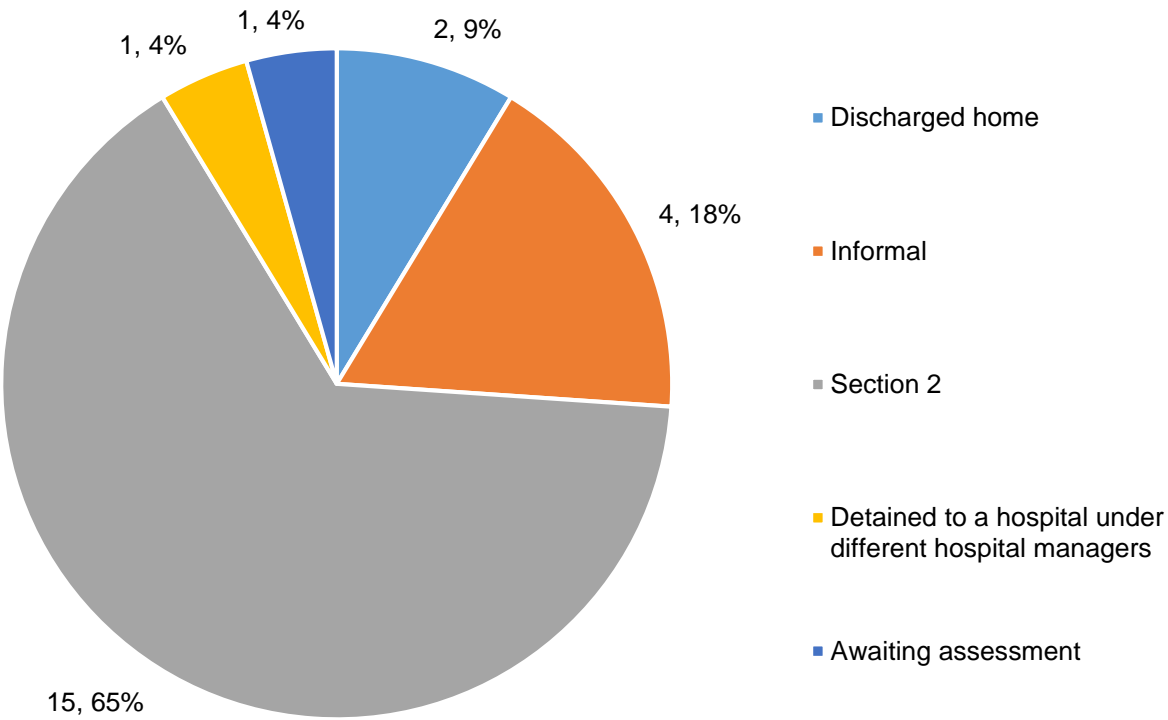
Legal status prior to Section 5(2) during the period January - March 2022



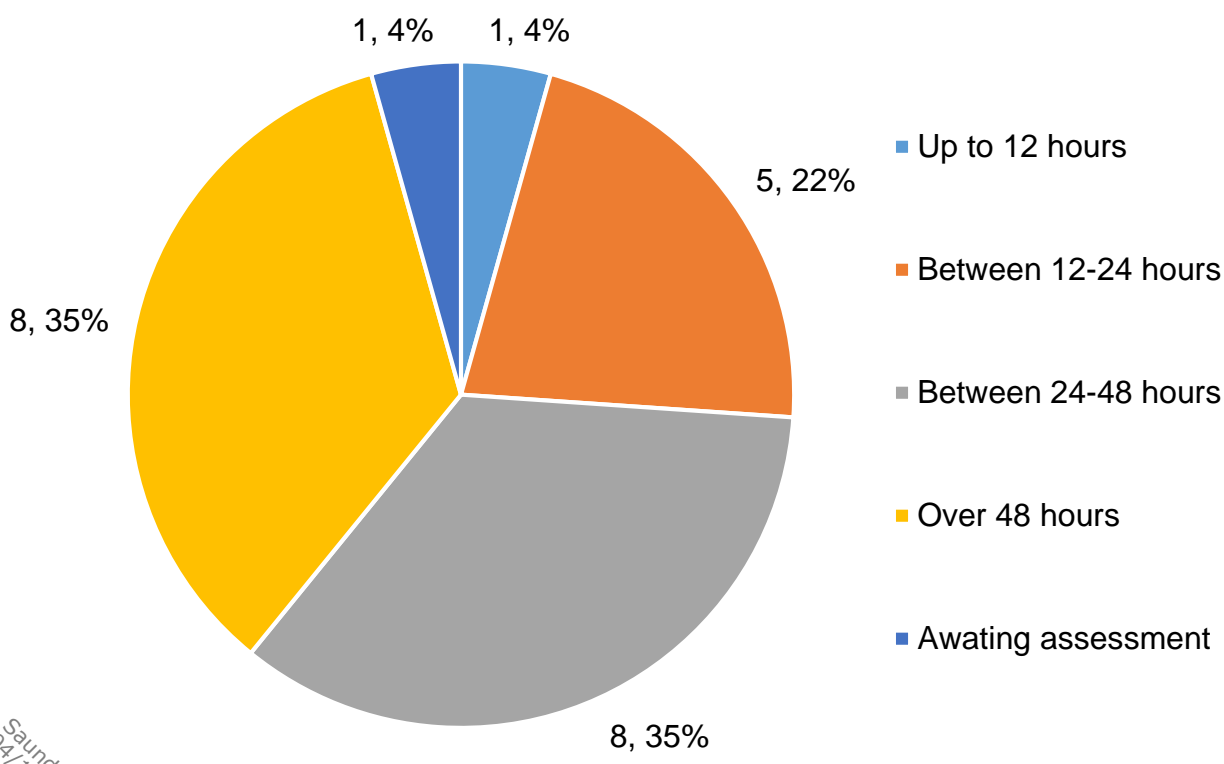
Section 5(2) - Doctors holding power up to 72 hours



Outcome of Section 5(2) during the period January - March 2022



Number of hours patients were detained under Section 5(2) during the period January - March 2022

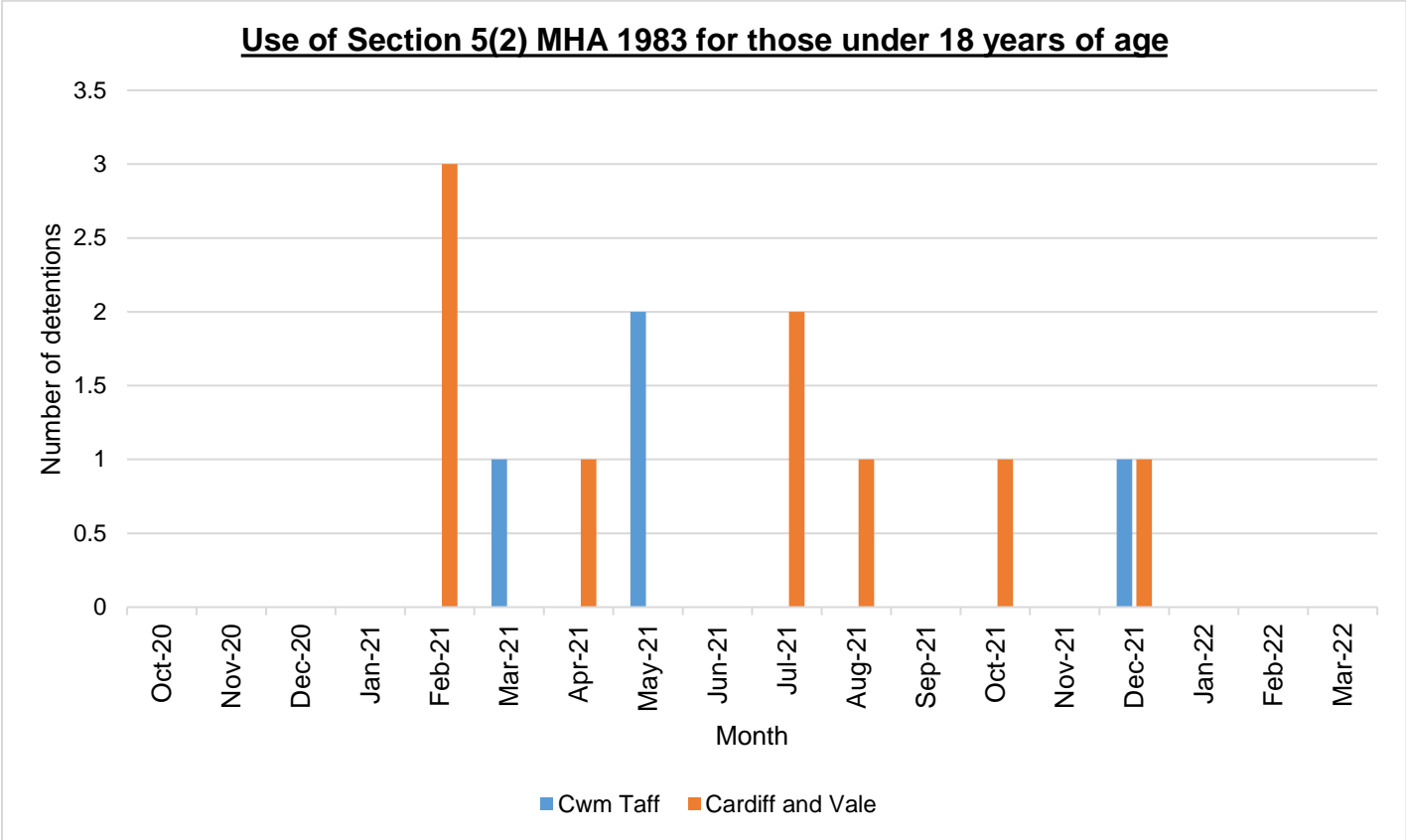


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CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

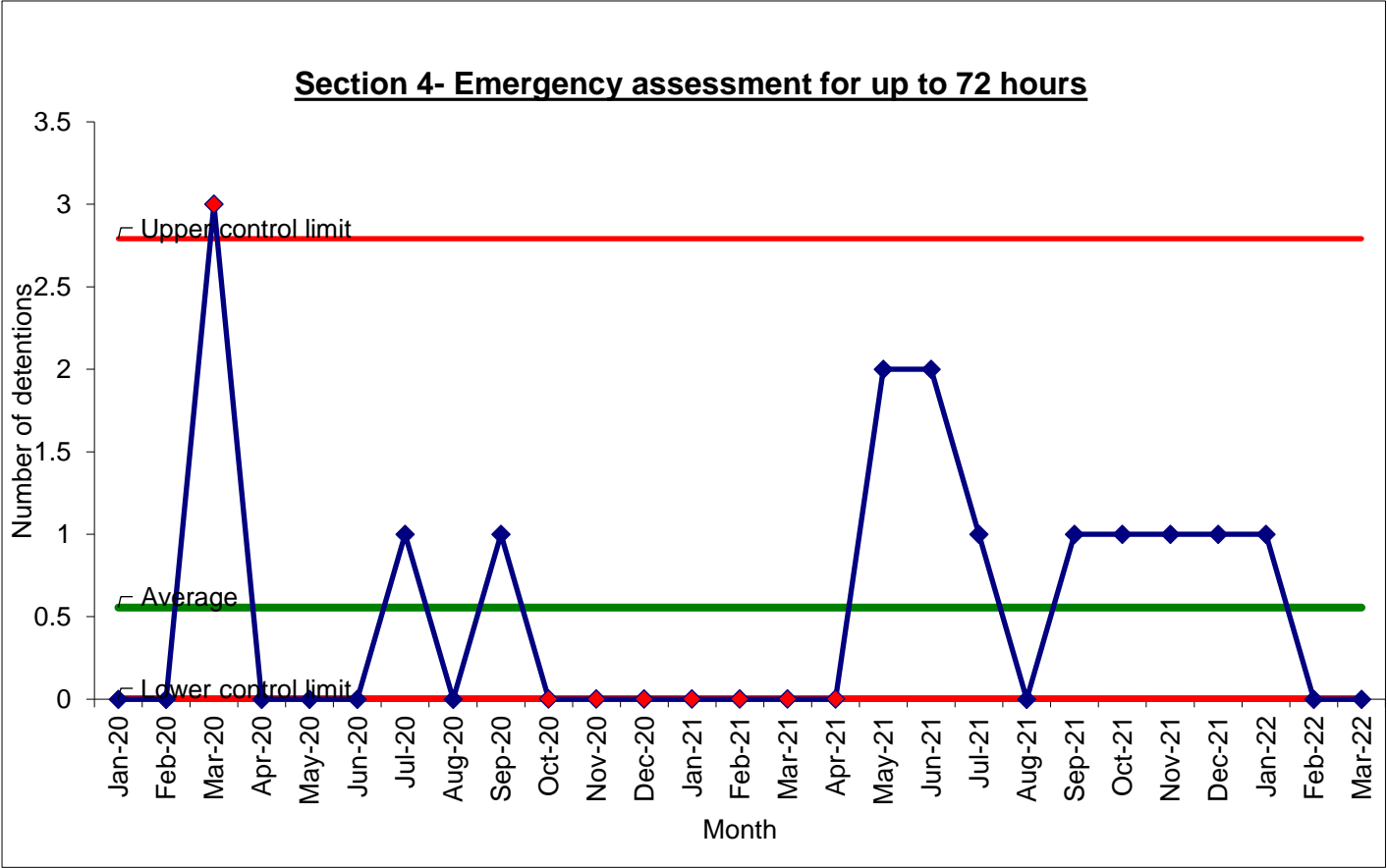
During the period there was no use of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB.



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Section 4 - Admission for Assessment in Cases of Emergency

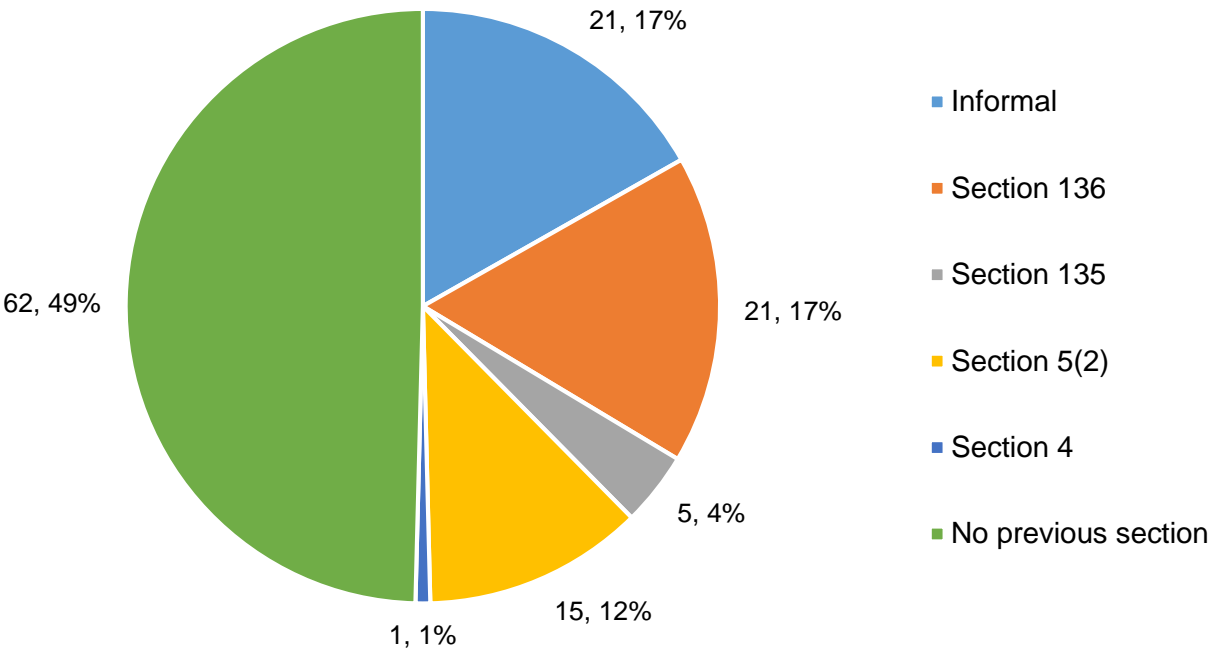
Section 4 was used on one occasion during the period due to an immediate and significant risk of mental or physical harm to the patient or others. The patient was detained under Section 2.



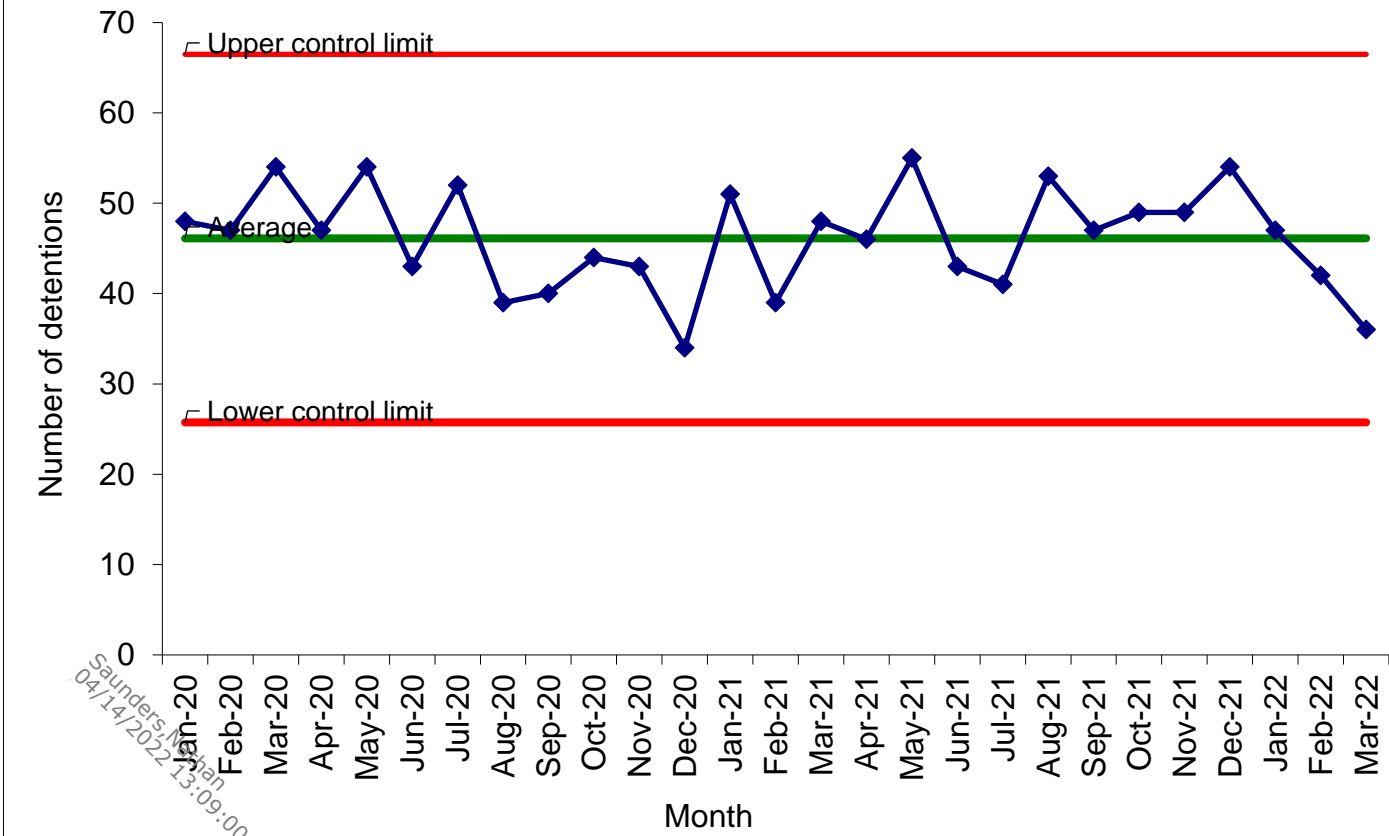
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Section 2 – Admission for Assessment

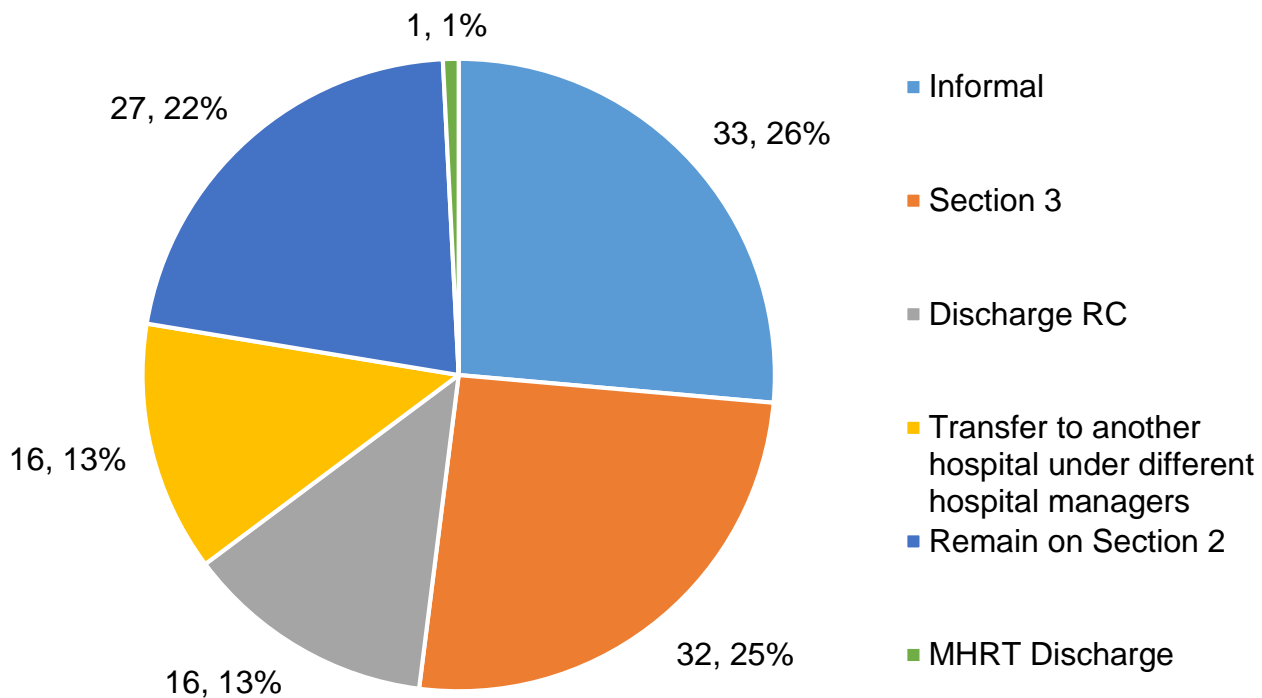
Legal status prior to Section 2 during the period January - March 2022



Section 2 - Admissions for assessment up to 28 days



Outcome following Section 2 detention during the period January - March 2022

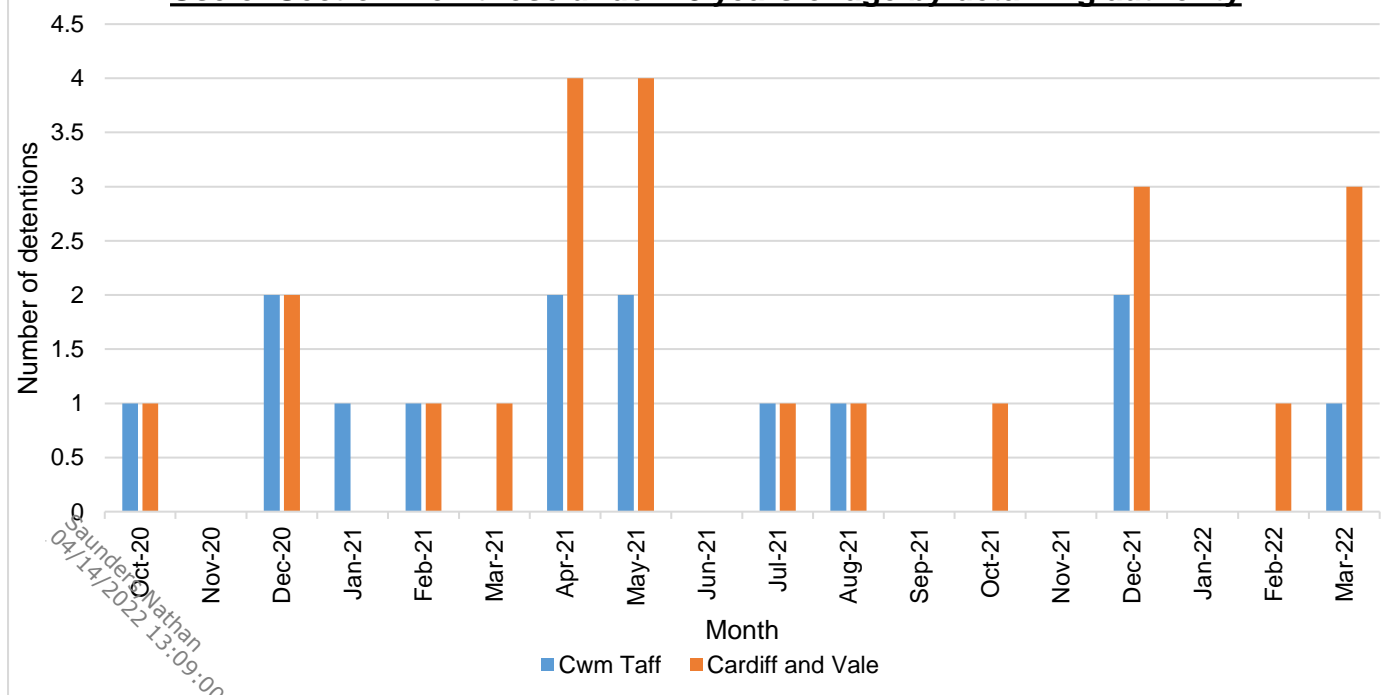


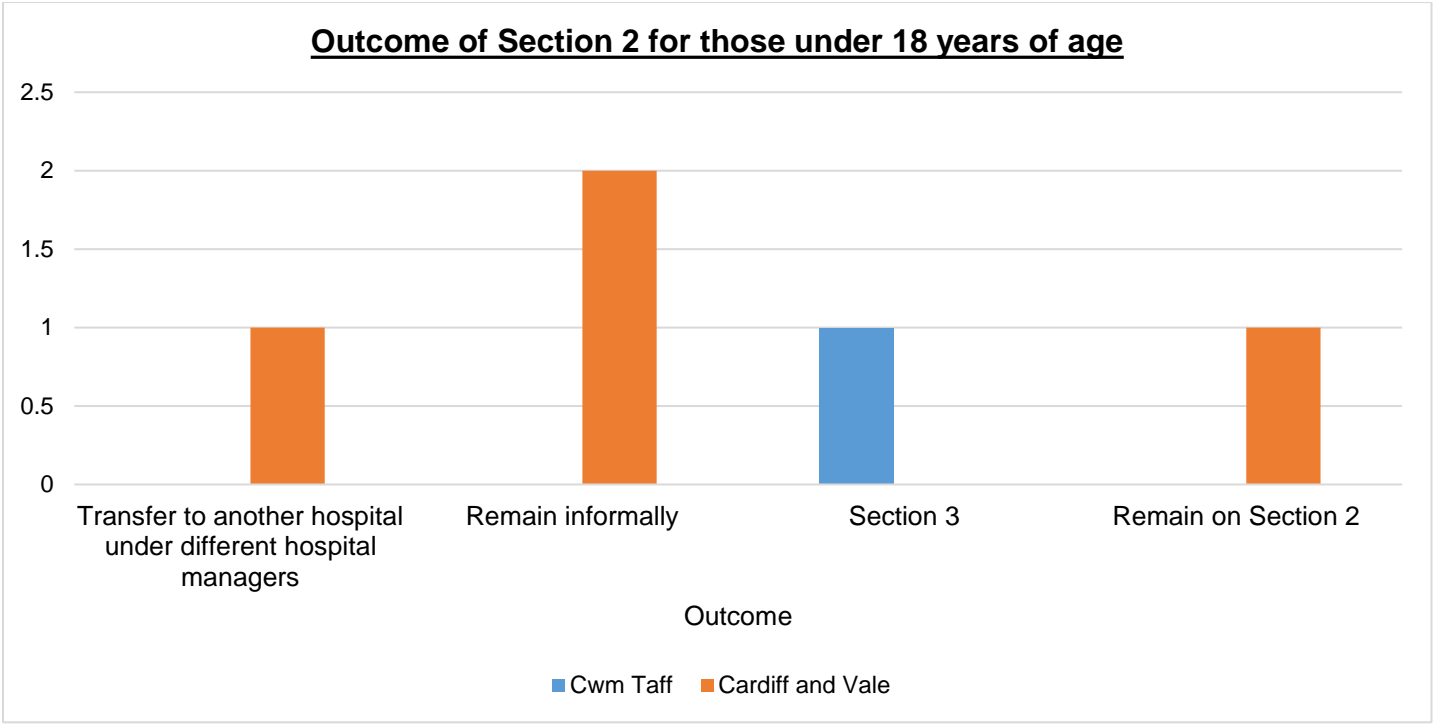
CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

Included in the above data are those under 18 years of age. This is extracted below:-

Use of Section 2 on those under 18 years of age by detaining authority



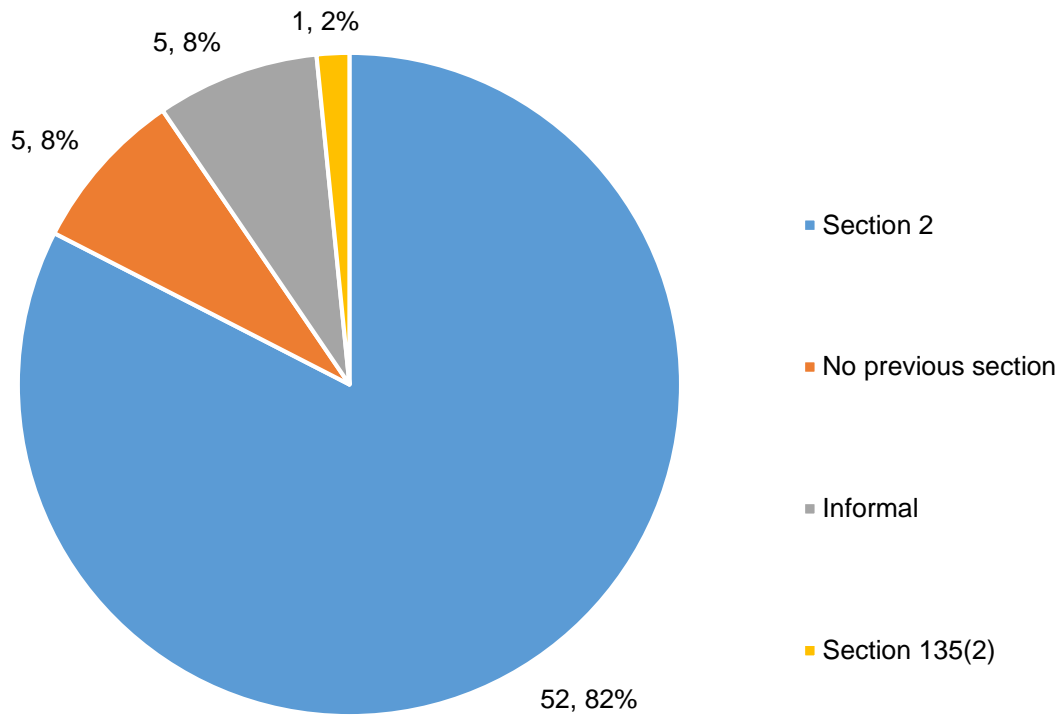


Two of the detentions listed are in relation to the same patient as they appear on both Health Boards figures.

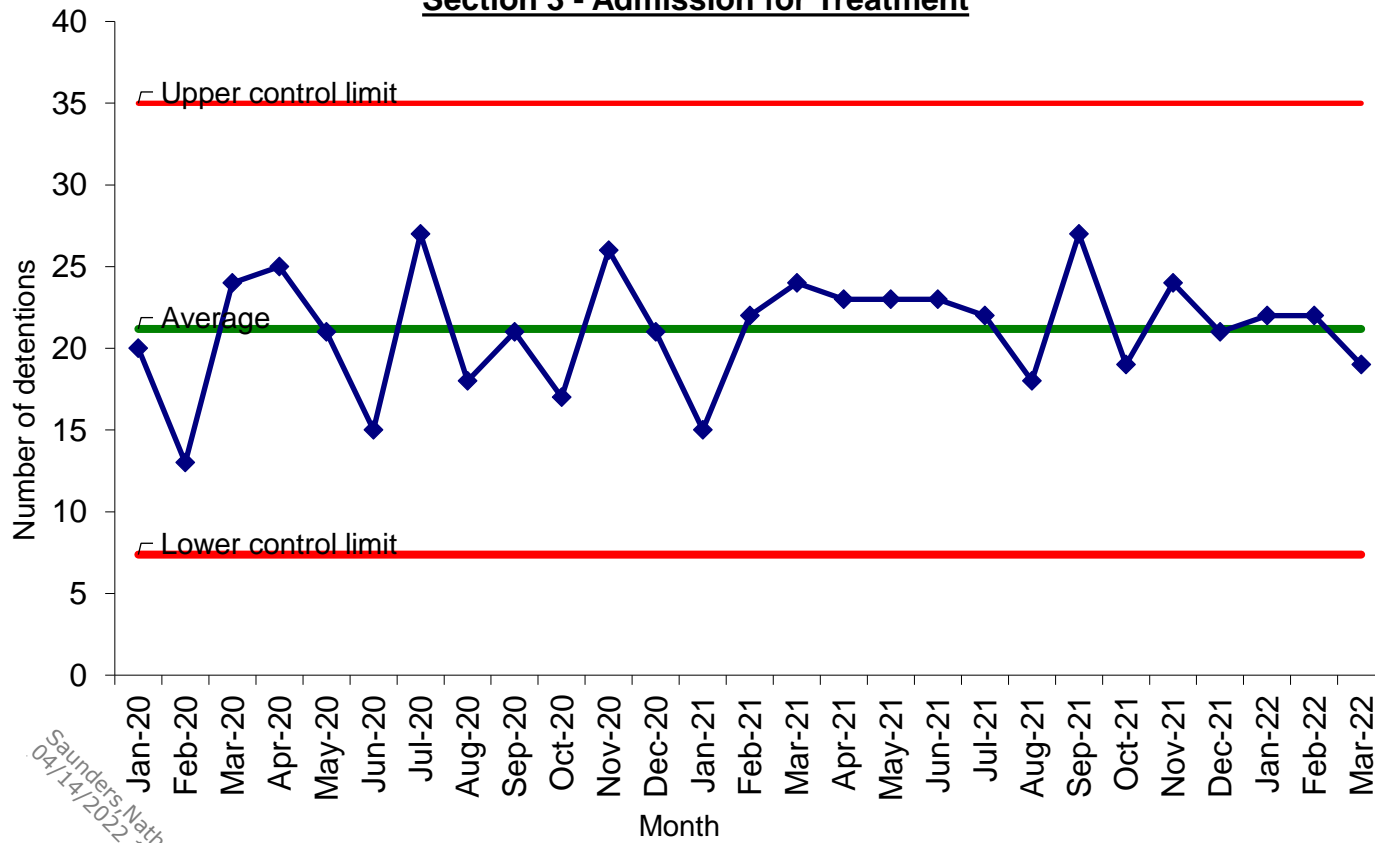
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Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period January - March 2022

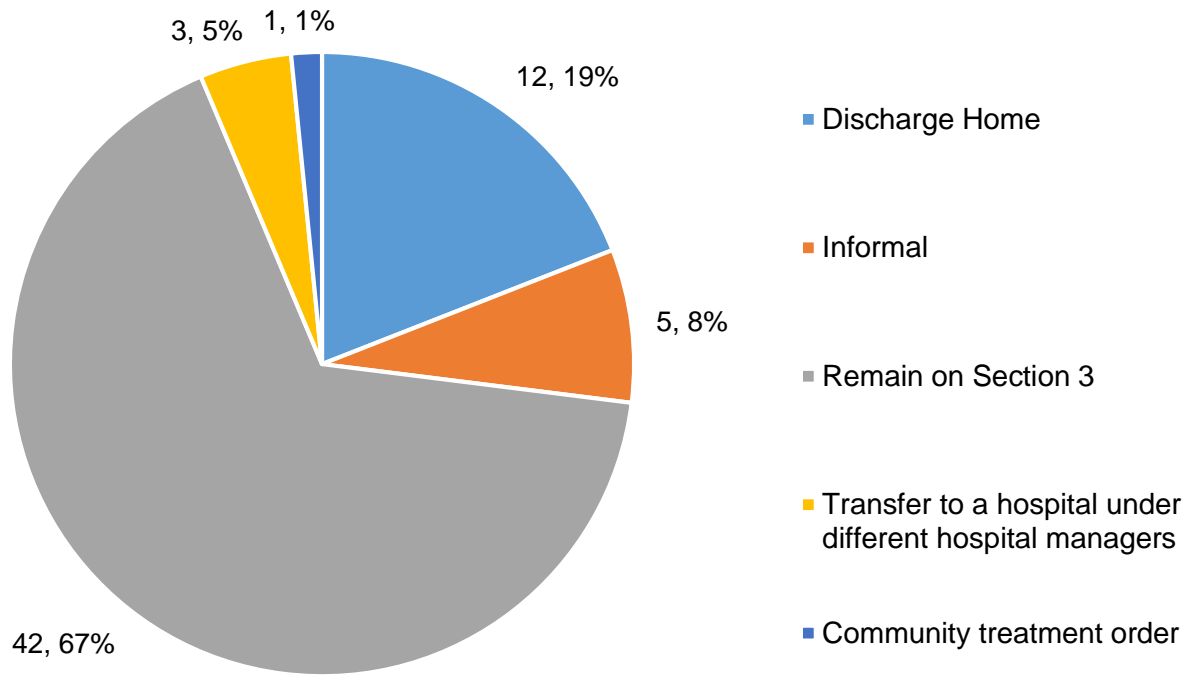


Section 3 - Admission for Treatment



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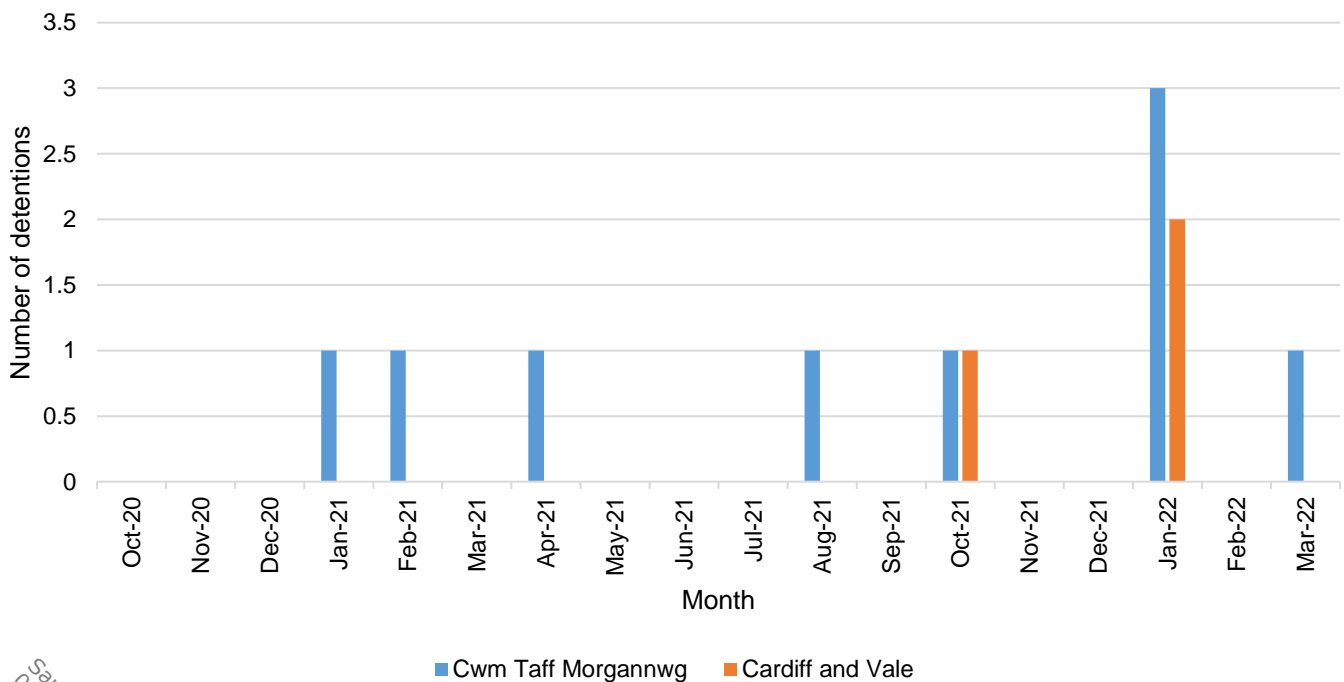
Outcome following Section 3 during the period January - March 2022



CAMHS Commissioned Inpatient Data

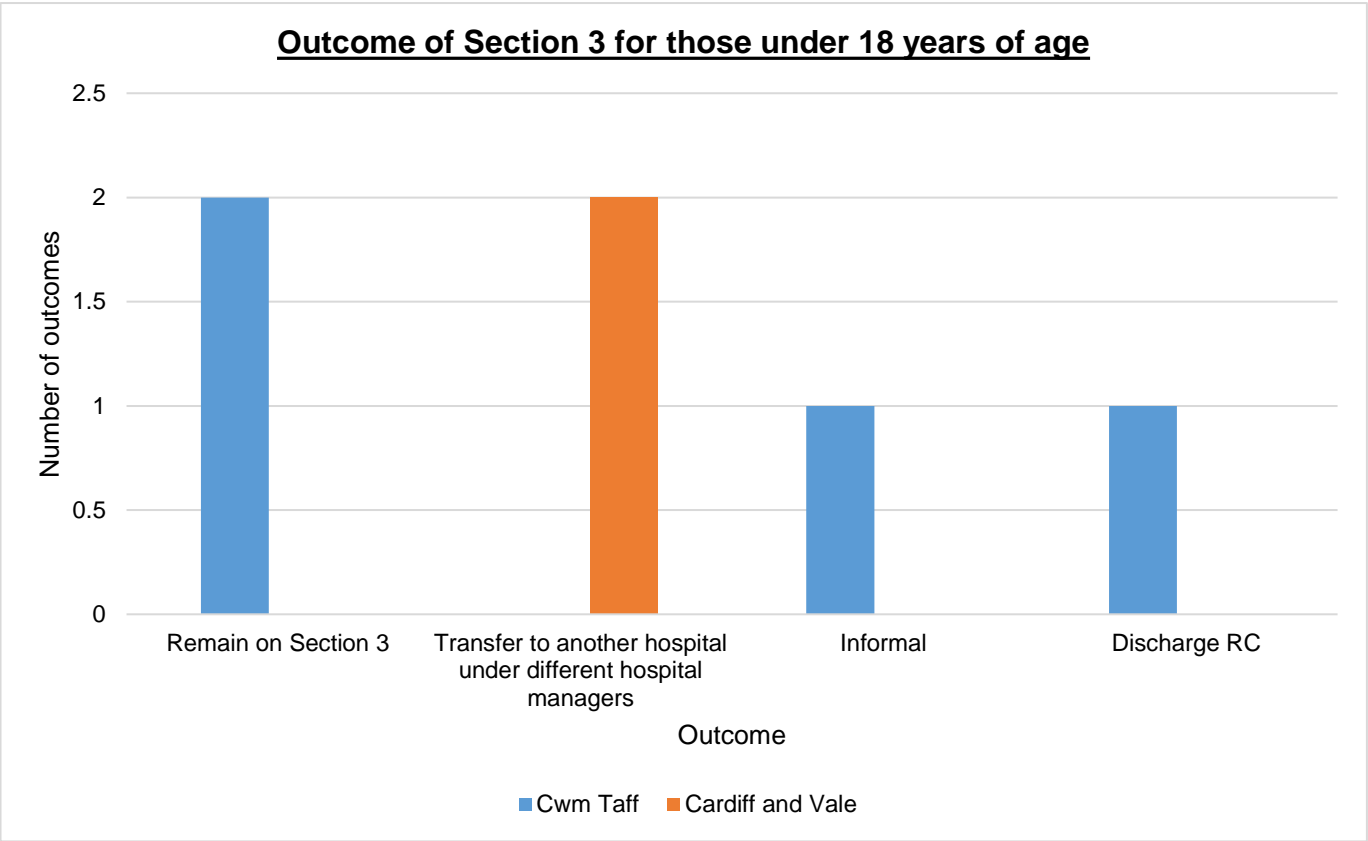
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

Use of Section 3 on those under 18 years of age by detaining authority



The above data would include those under 18 years of age. Two of the detentions are in relation to the same patient due to being transferred to a hospital under a different set of hospital managers.

Outcome of Section 3 for those under 18 years of age

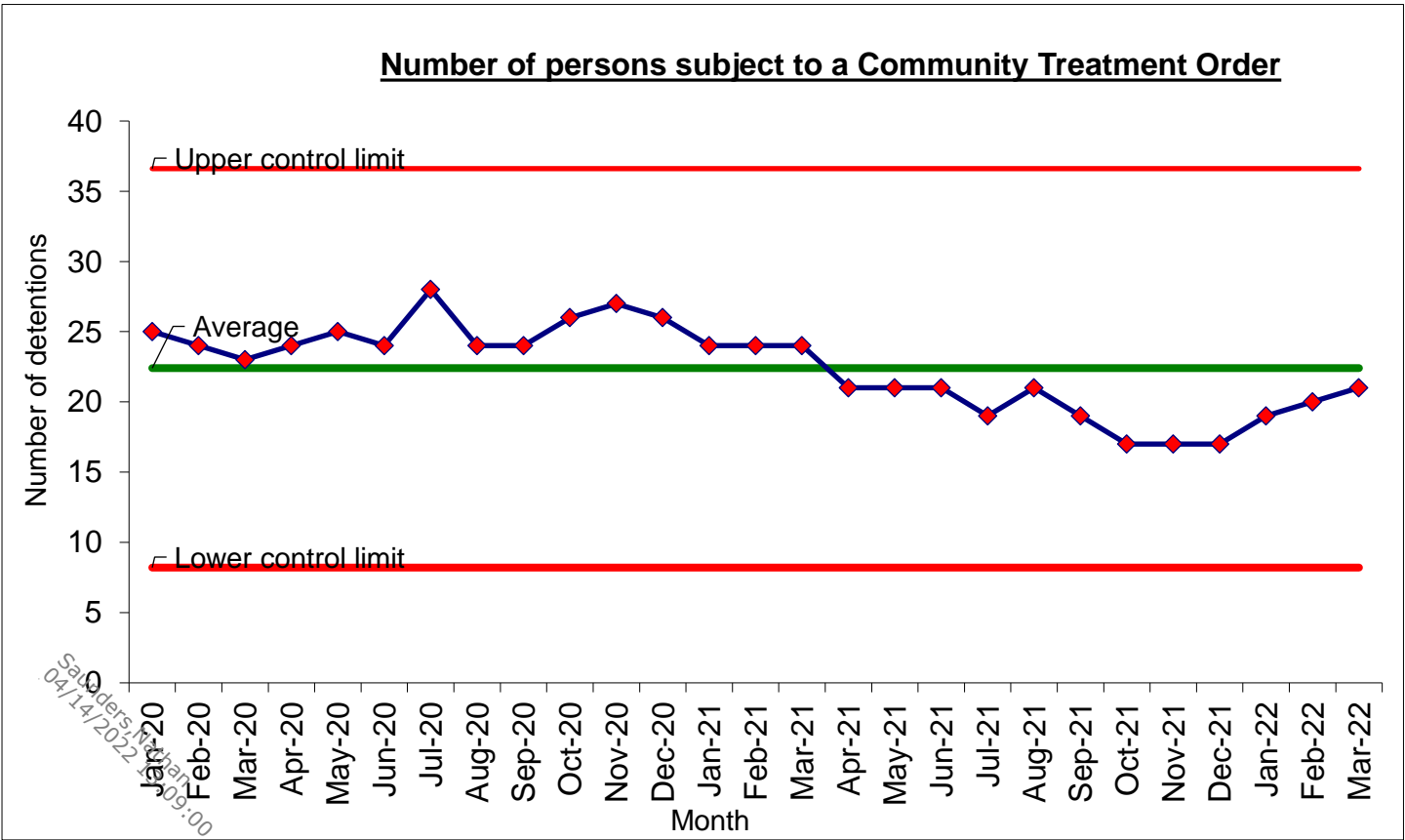
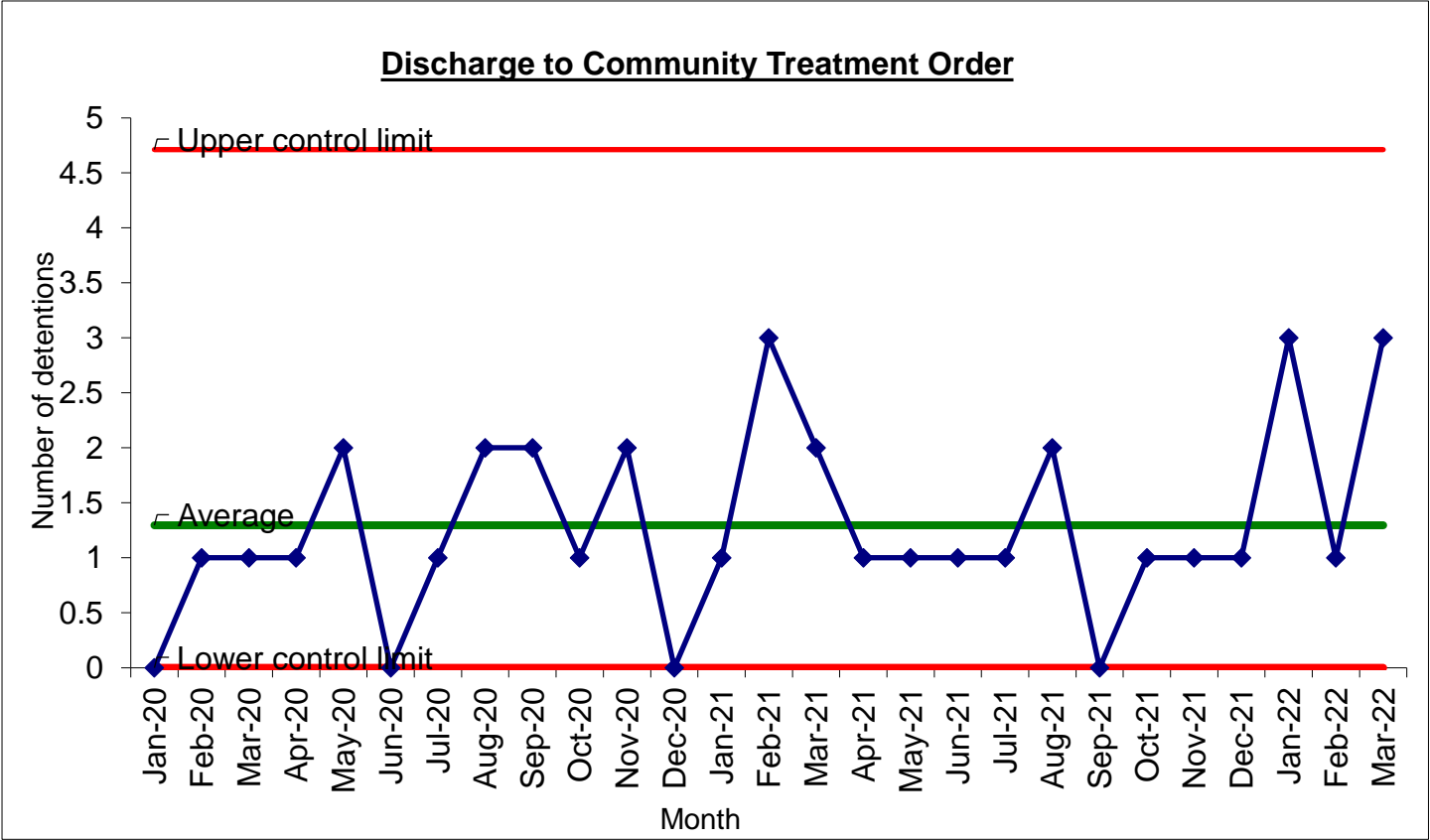


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Community Treatment Order

During the period January- March 2022 seven patients were discharged to Community Treatment Order.

As at 31st March 2022, 21 patients were subject to a Community Treatment Order (CTO).



Recall of a community patient under Section 17E

During the period, the power of recall was not used.

CAMHS Commissioned Inpatient Data

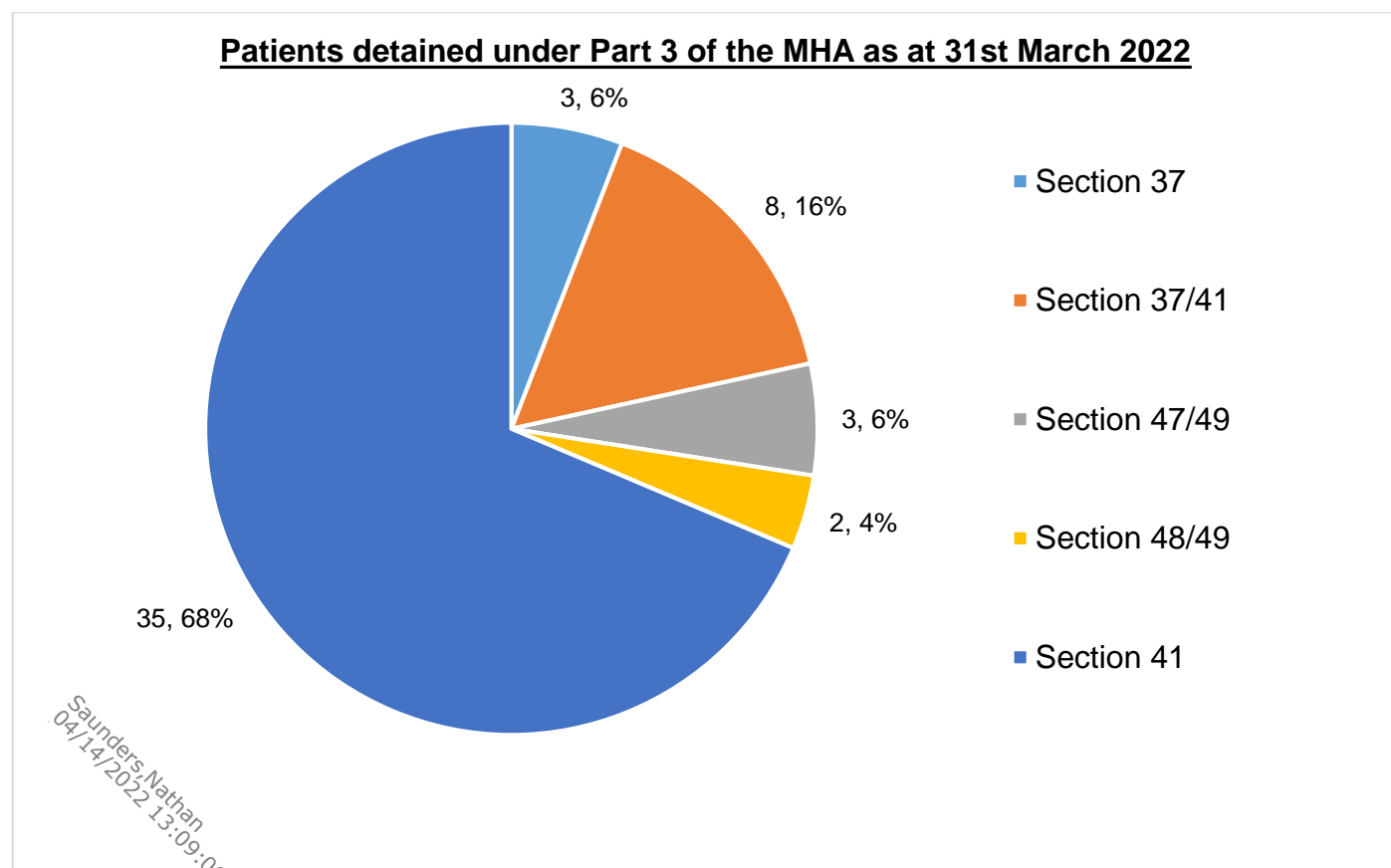
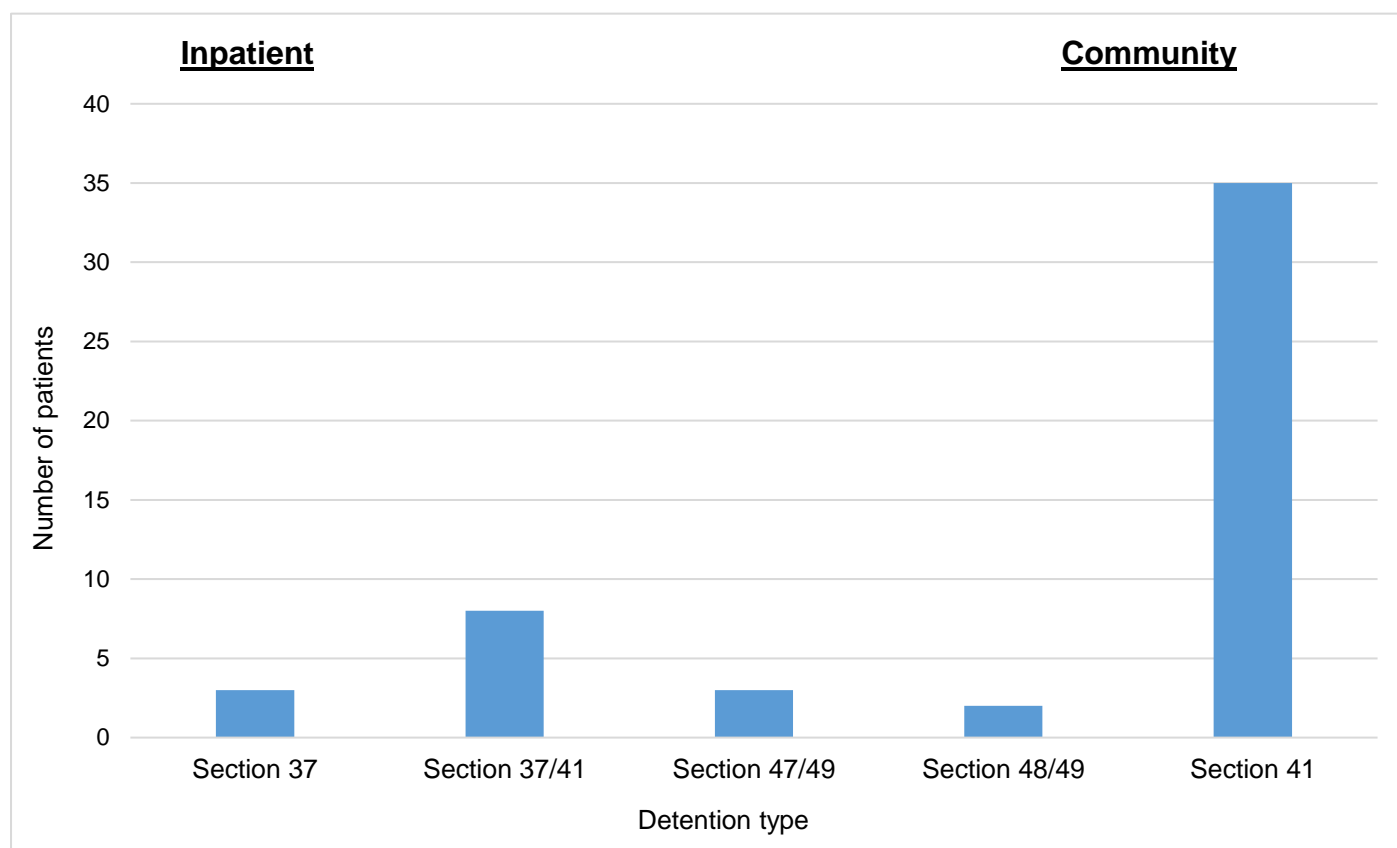
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During this period there were no CAMHS patients who became subject to a Community Treatment Order

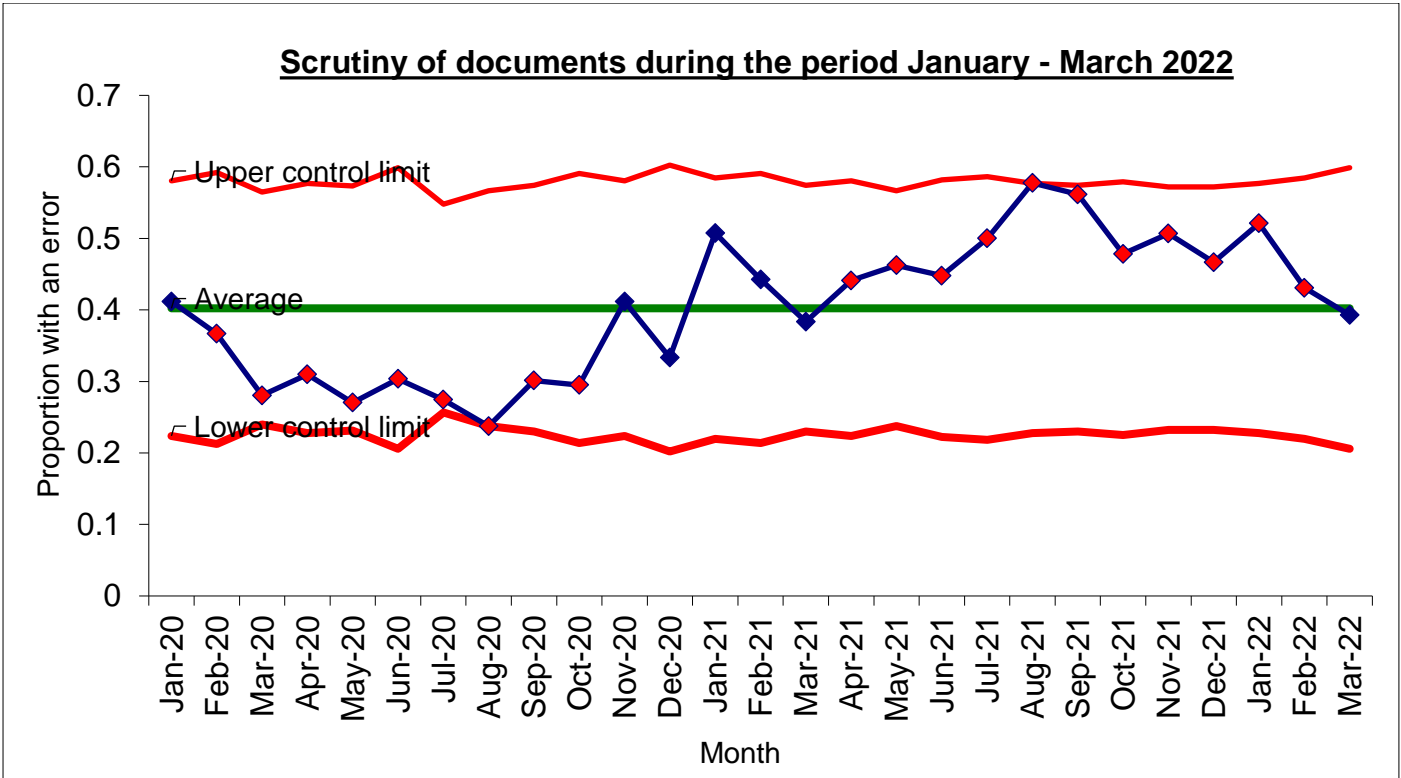
Saunders, Nathan
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Part 3 of the Mental Health Act 1983

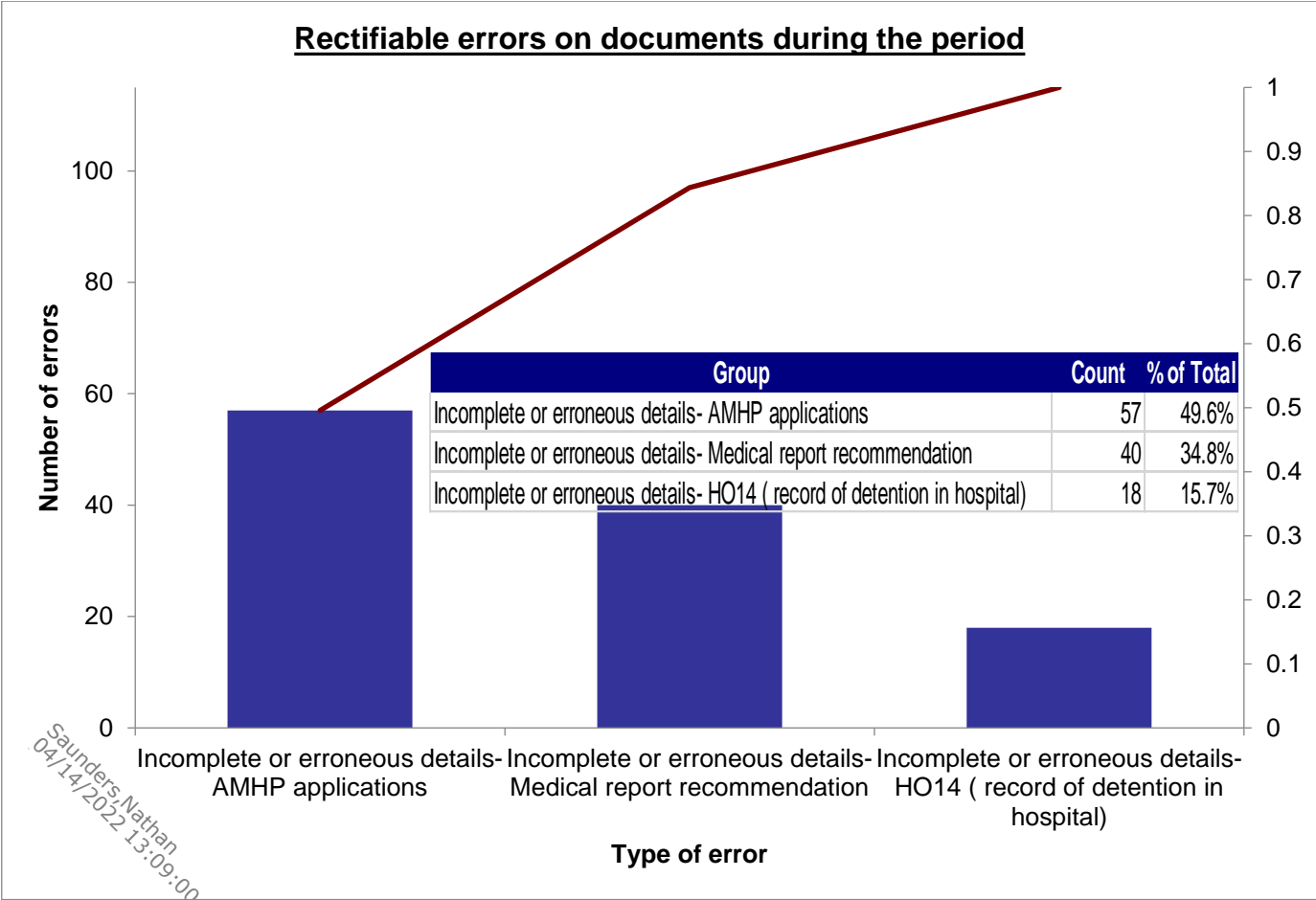
The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st March 2022.



Scrutiny of documents during the period

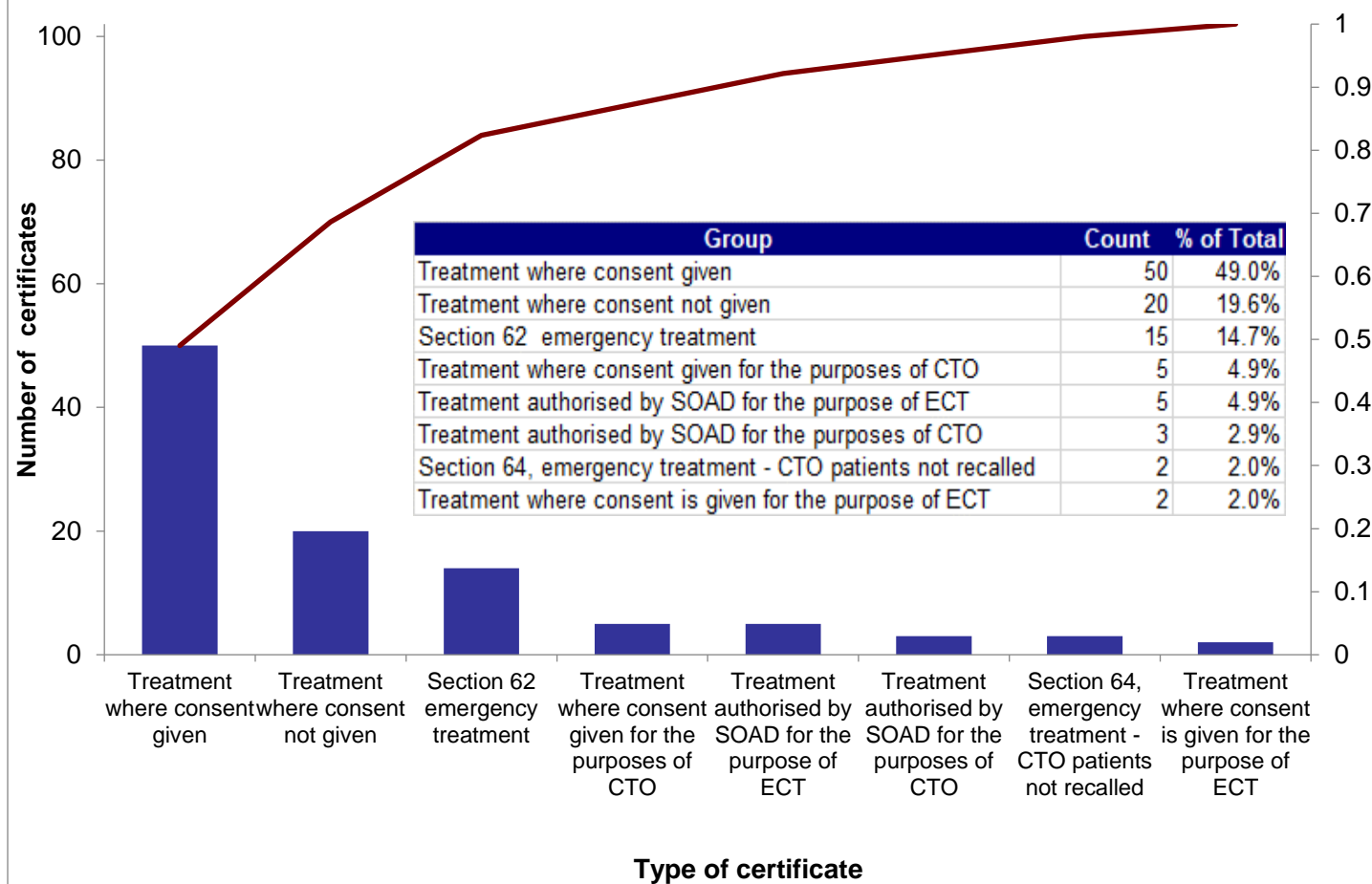


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.



Consent to Treatment

Analysis of the treatment provisions under Part 4 and Part 4A MHA during the period January - March 2022



Urgent Treatment

There are some circumstances in which the approved clinician may authorise a detained patient's urgent treatment under section 62 however this applies only to patients whose treatment is covered by Part 4 of the Act which is concerned with the treatment of detained patients and Part 4A supervised community treatment patients recalled to hospital.

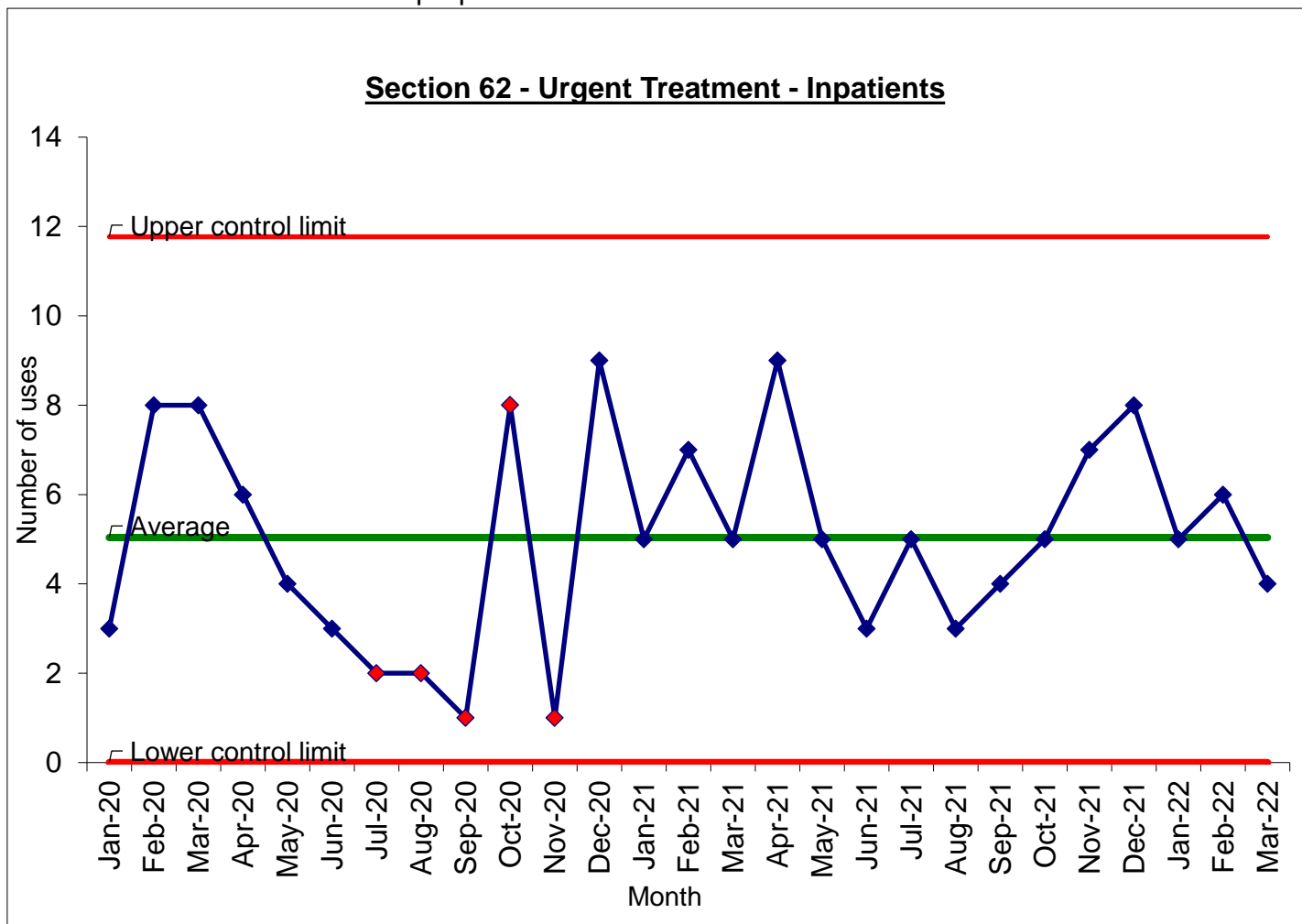
Urgent treatment is defined as treatment that is:

- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That is not irreversible or hazardous but is immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself or others.

A patient's treatment may be continued pending compliance with s.58, if discontinuation would cause serious suffering to the patient.

Urgent treatment can be used in any of the following instances:

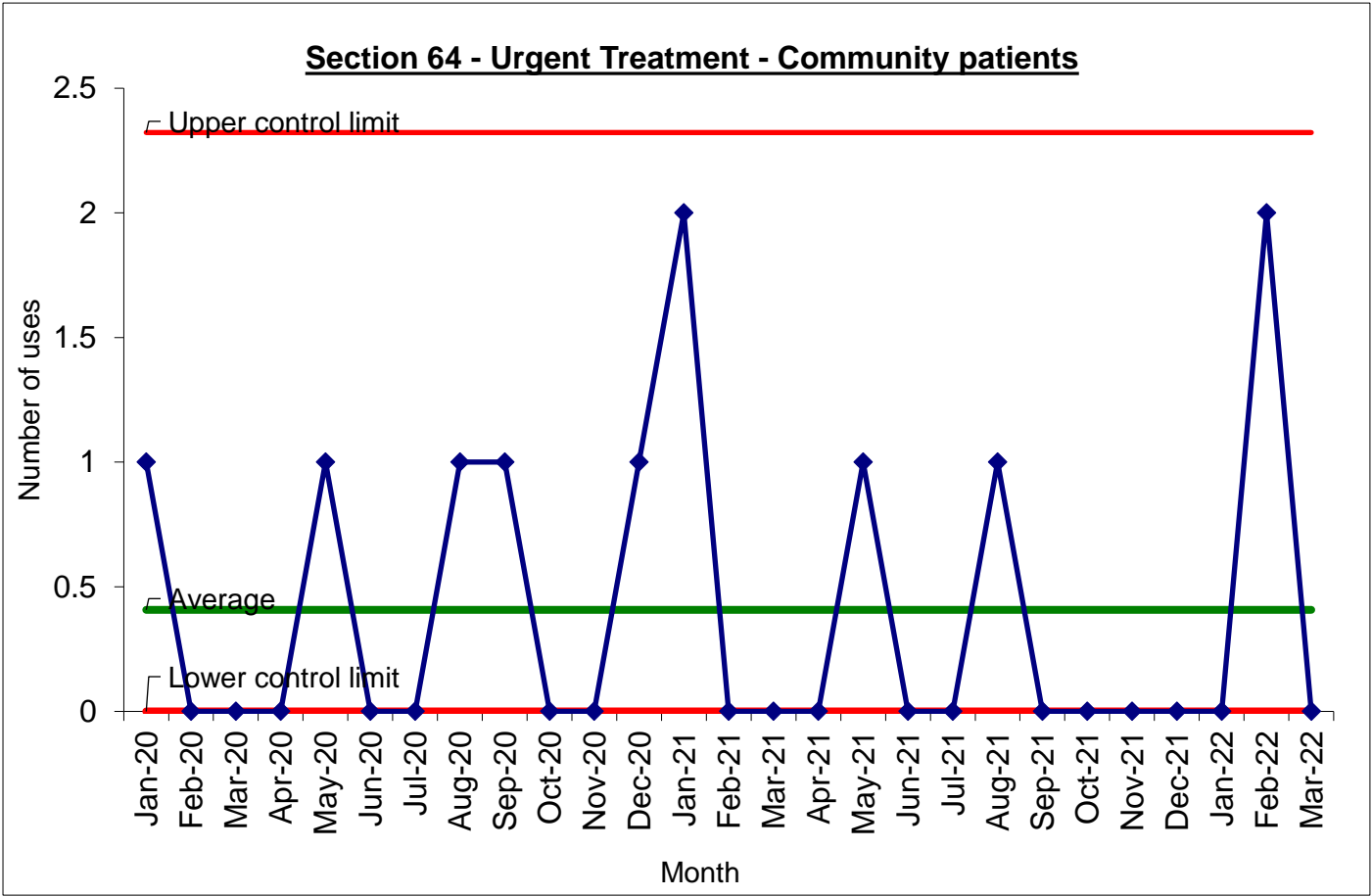
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.



The above chart highlights that Section 62 was used on fifteen occasions for the following reasons:

- Pending SOAD – 3 month rule x 5
- Change of capacity to consent x 2
- Change of medication x 3
- Until permanent certificate in place x 1
- Time limited certificate- waiting for new certificate x 1
- Emergency ECT x 2
- Previous certificate void- waiting on new consent x 1

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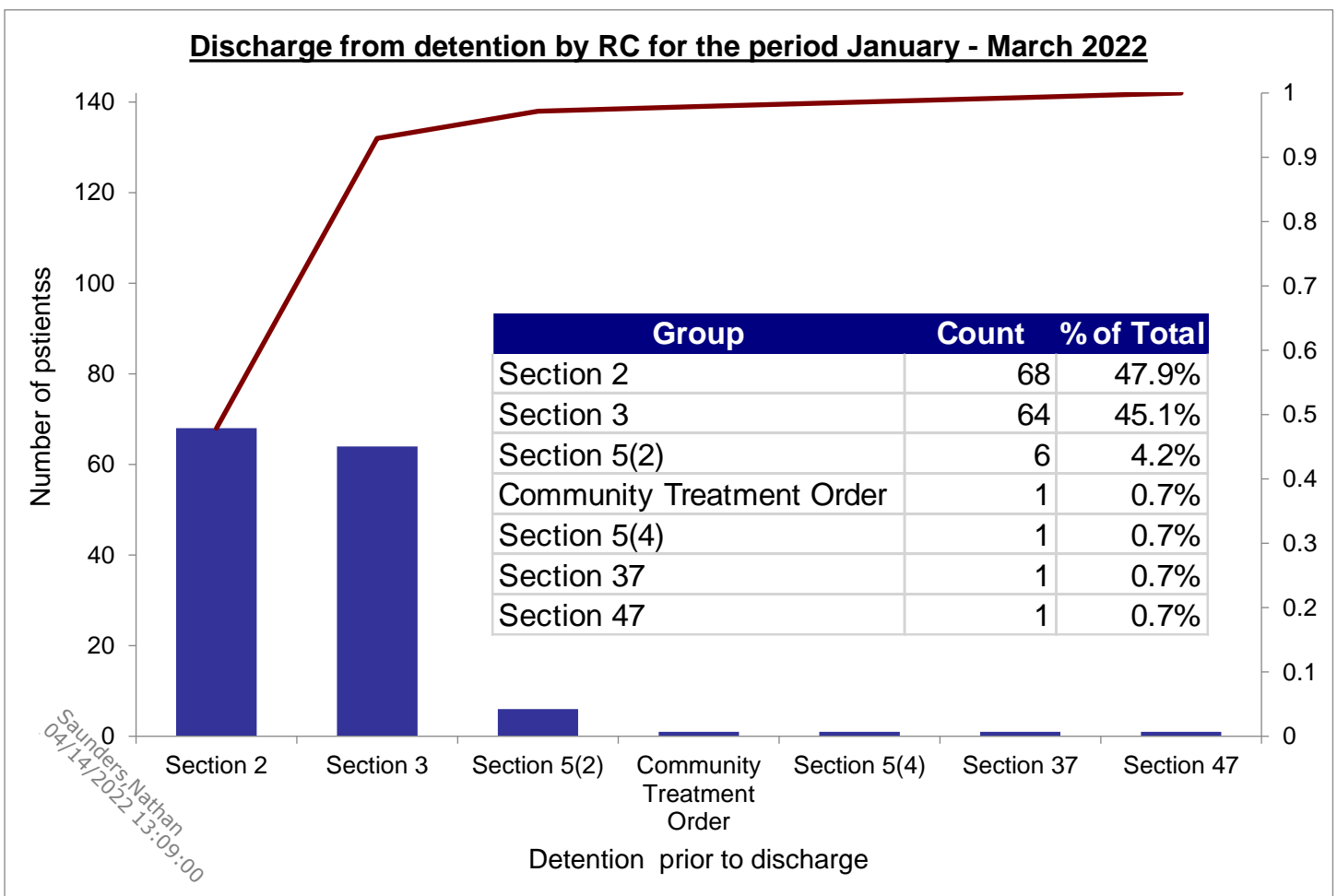
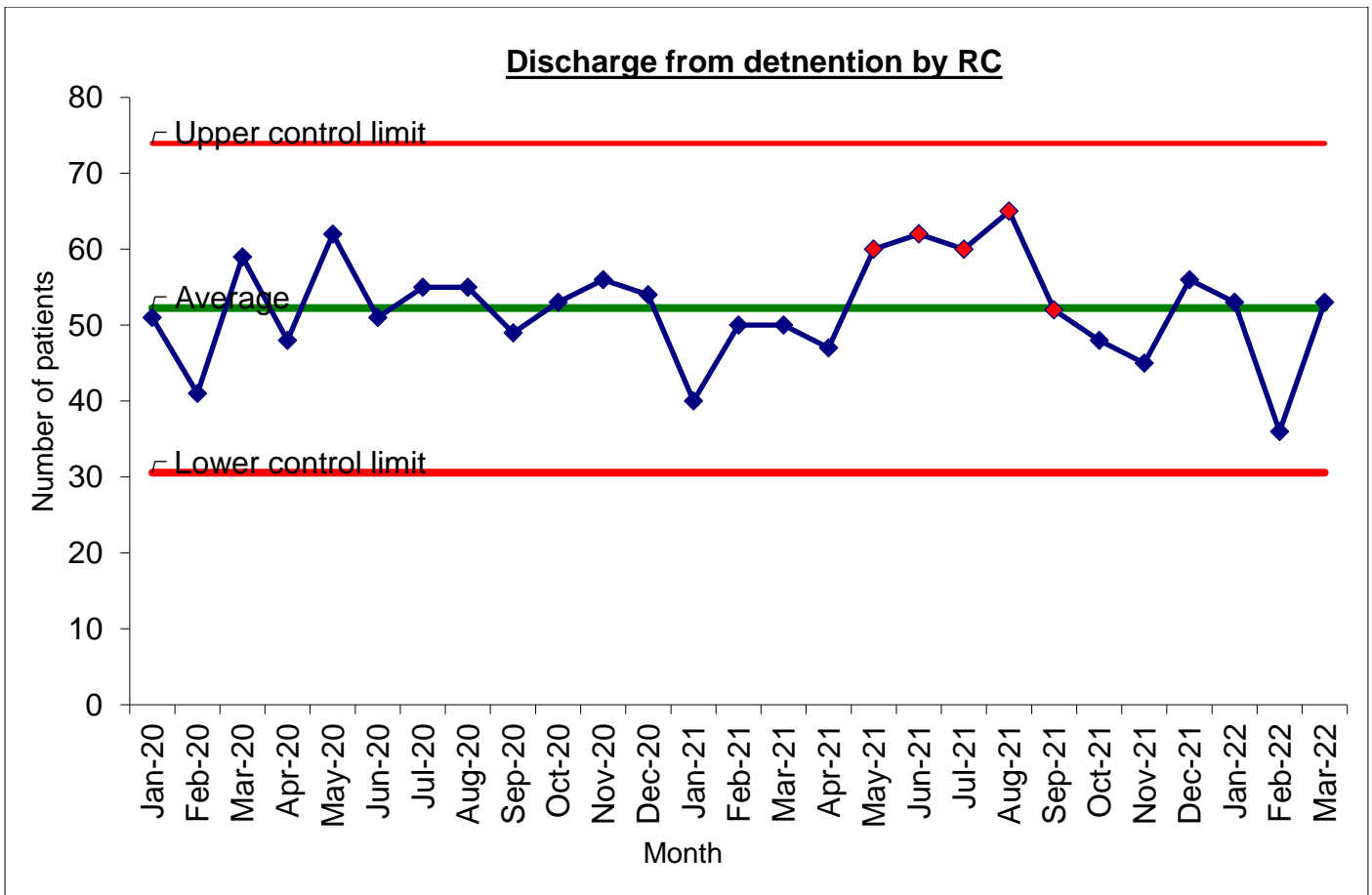


The above chart highlights that Section 64 was used on two occasions during the period for the following reasons:

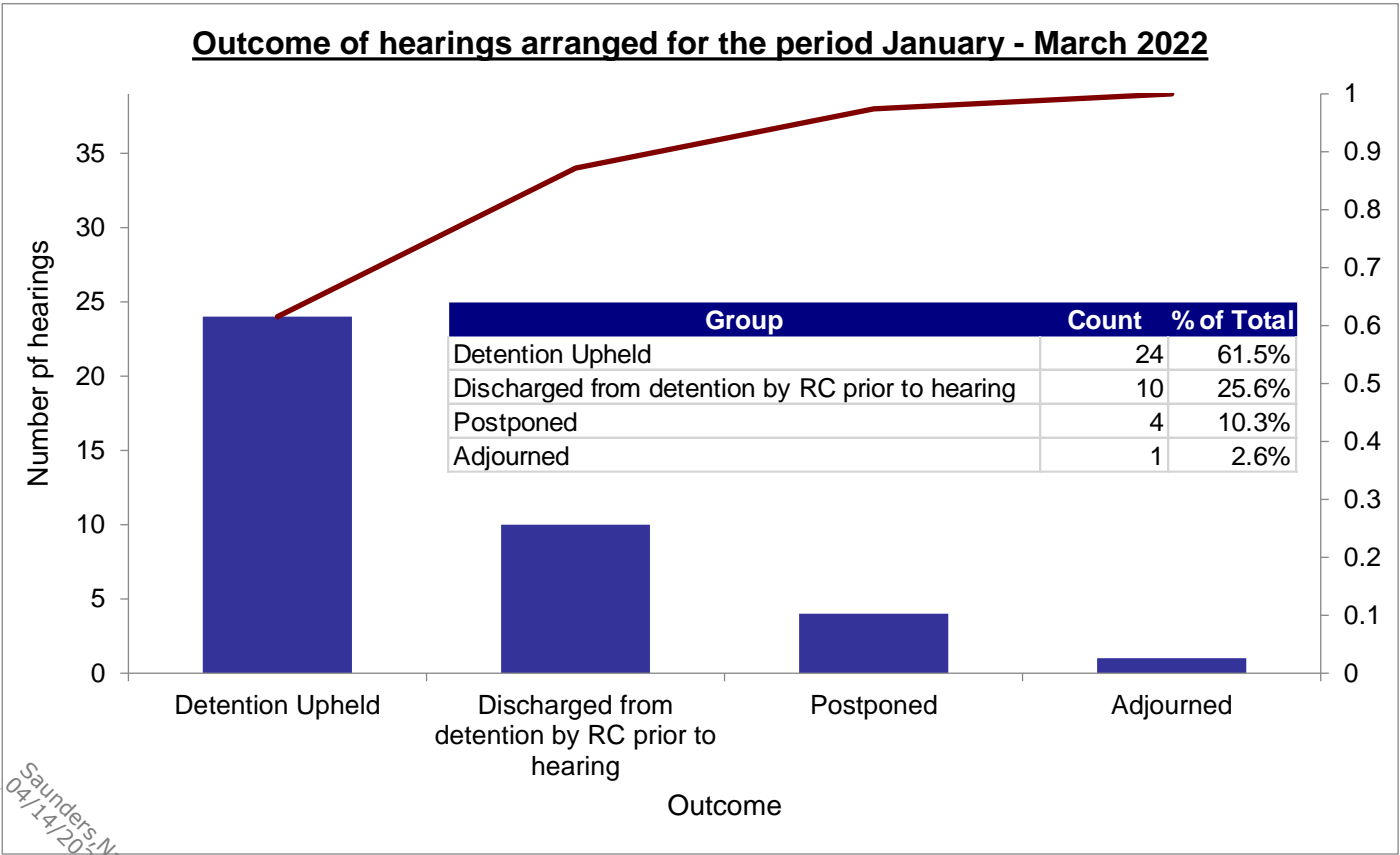
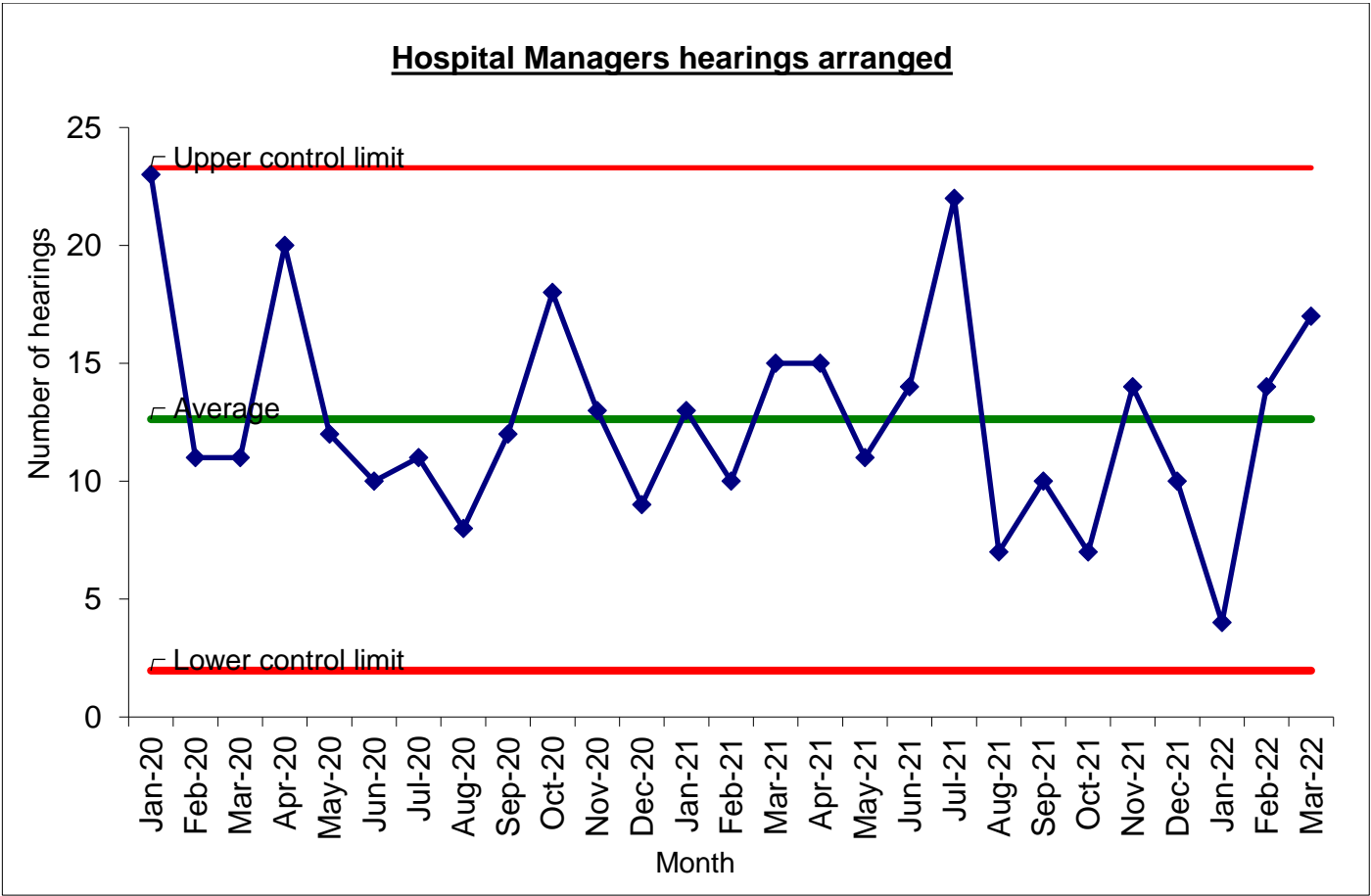
- One month rule awaiting SOAD x1
- Until permanent certificate in place x 1

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Discharge



Hospital Managers – Power of Discharge



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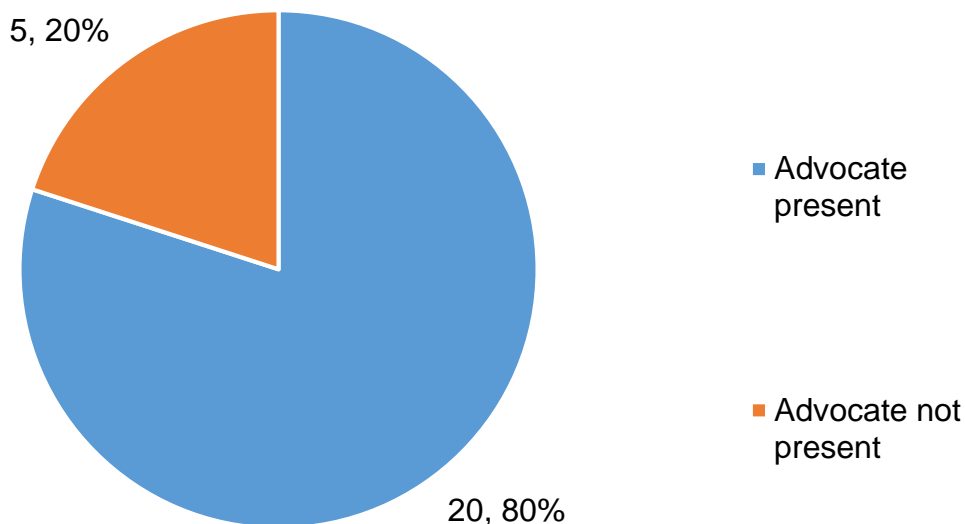
Four hearings were postponed for the following reason:

- Advocate tested positive for Covid x3
- RC tested positive for Covid x1

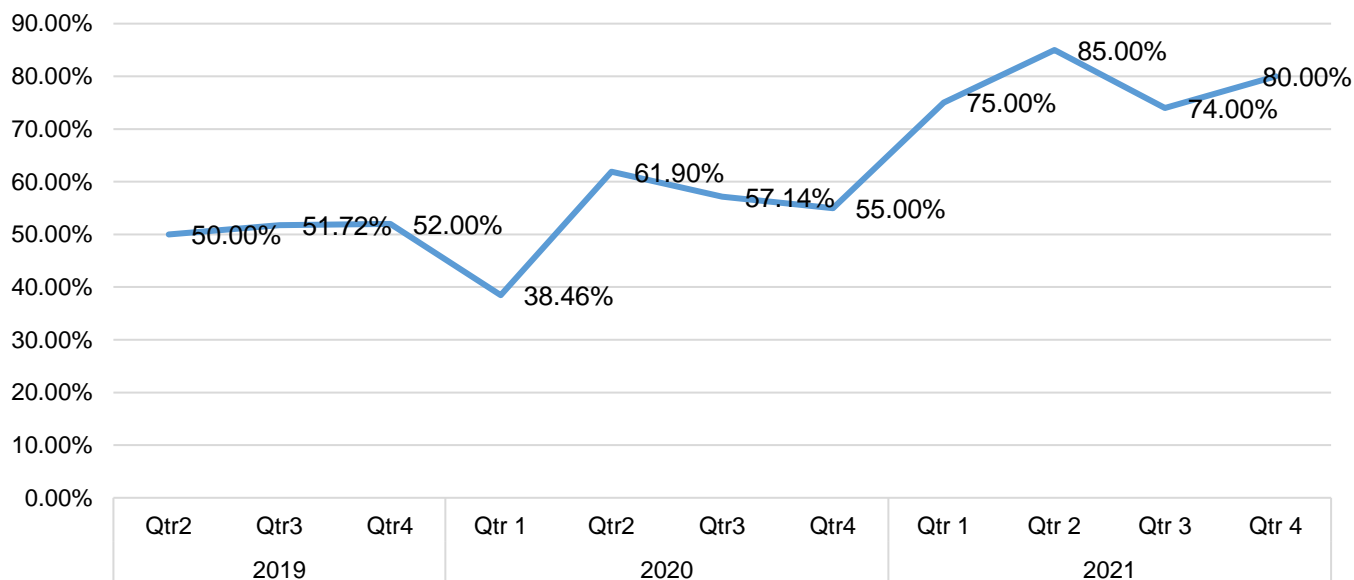
One hearing was adjourned for the following reason:

- Patient denied having received the reports

Number of patients represented by Advocacy Support Cymru



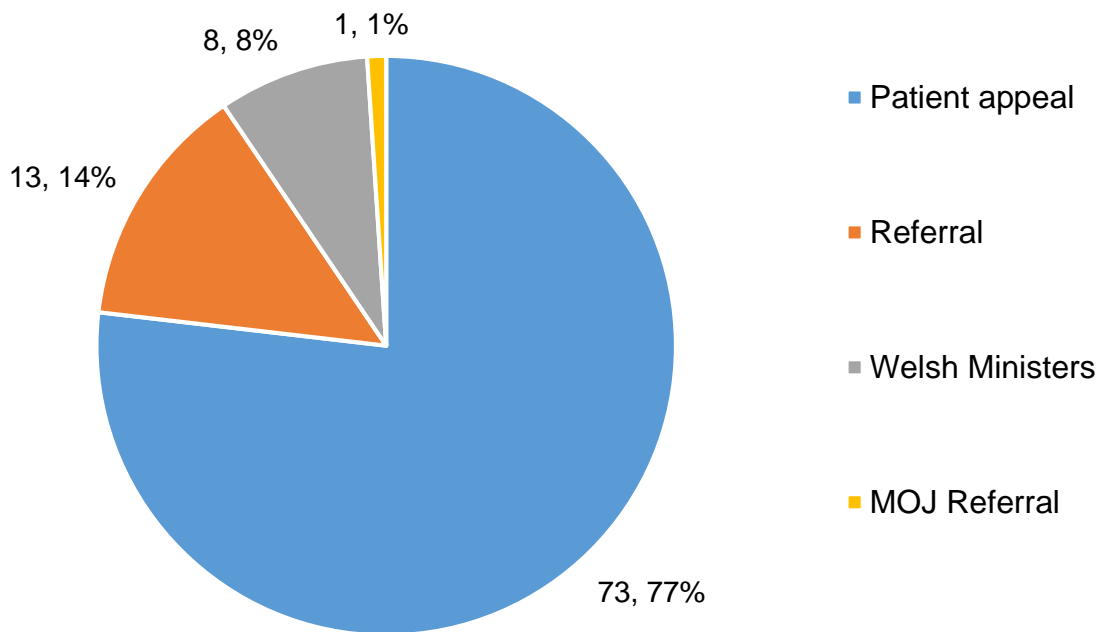
Percentage with independant Mental Health Advocate present



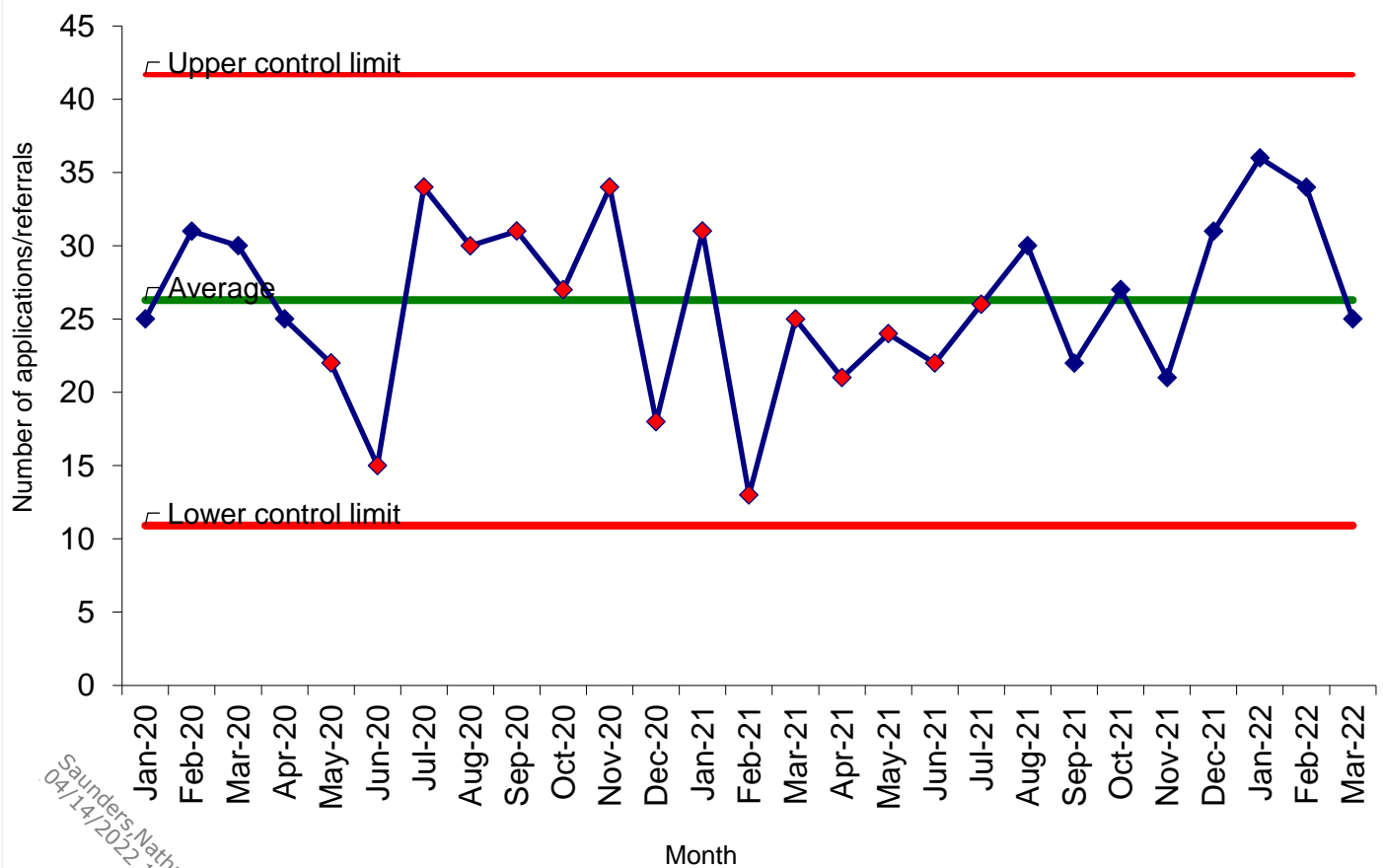
During the period the Mental Health Act Office made twenty-seven referrals to Advocacy Support Cymru where the patient was deemed not to have capacity to make this decision. Seven of the hearings were either postponed/cancelled and therefore weren't attended by an advocate.

Mental Health Review Tribunal (MHRT) for Wales

Source of applications to the Mental Health Review Tribunal (for Wales)

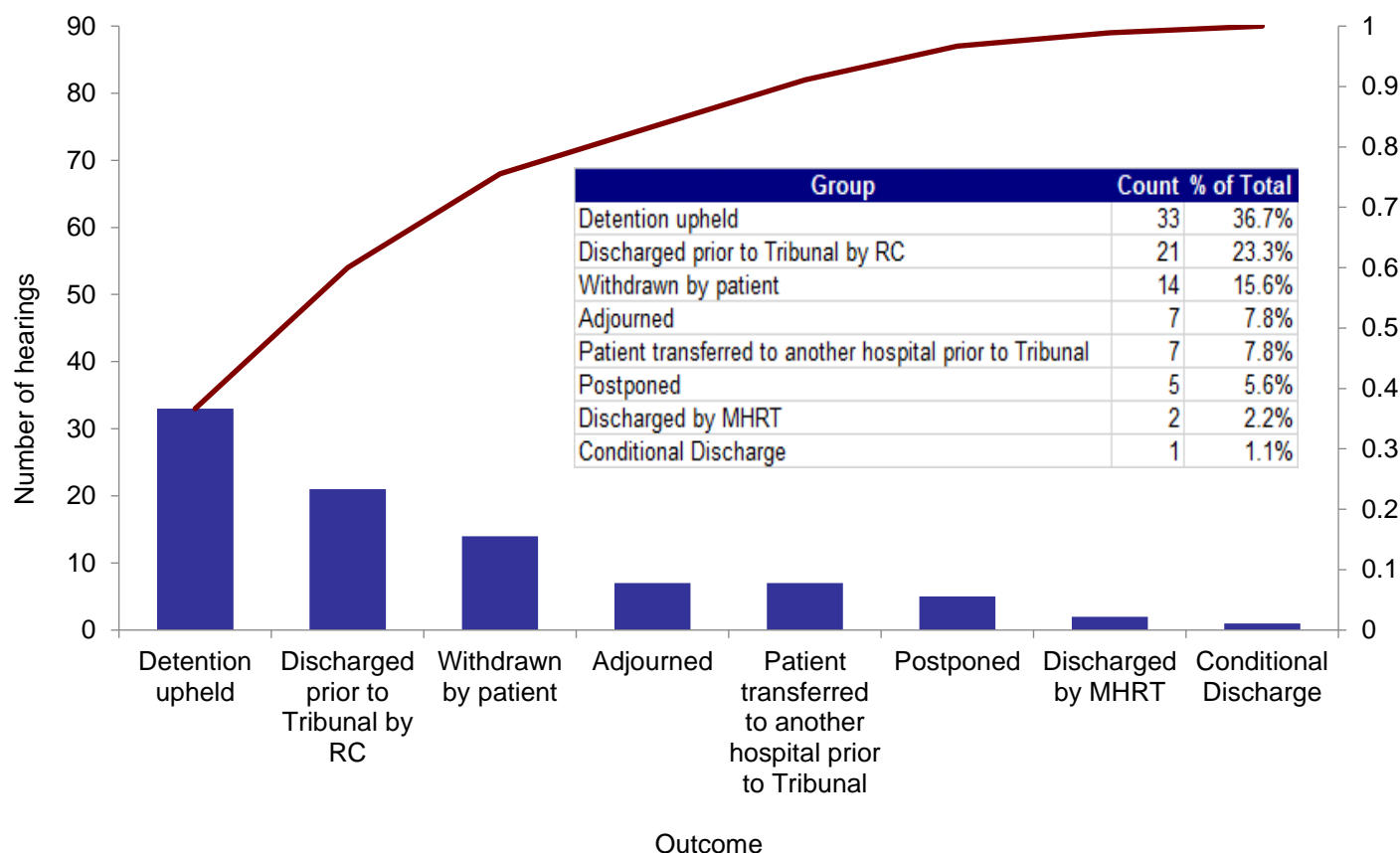


Number of applications and referrals to the Mental Health Review Tribunal (for Wales)



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Outcome of Mental Health Review Tribunals (for Wales)



Seven hearings were adjourned for the following reasons:

- Patient tested positive for Covid x1
- Complication arranging an interpreter x1
- More information needed in reports x4
- Patient was on 3:1 observation and panel felt unfair to go ahead x1

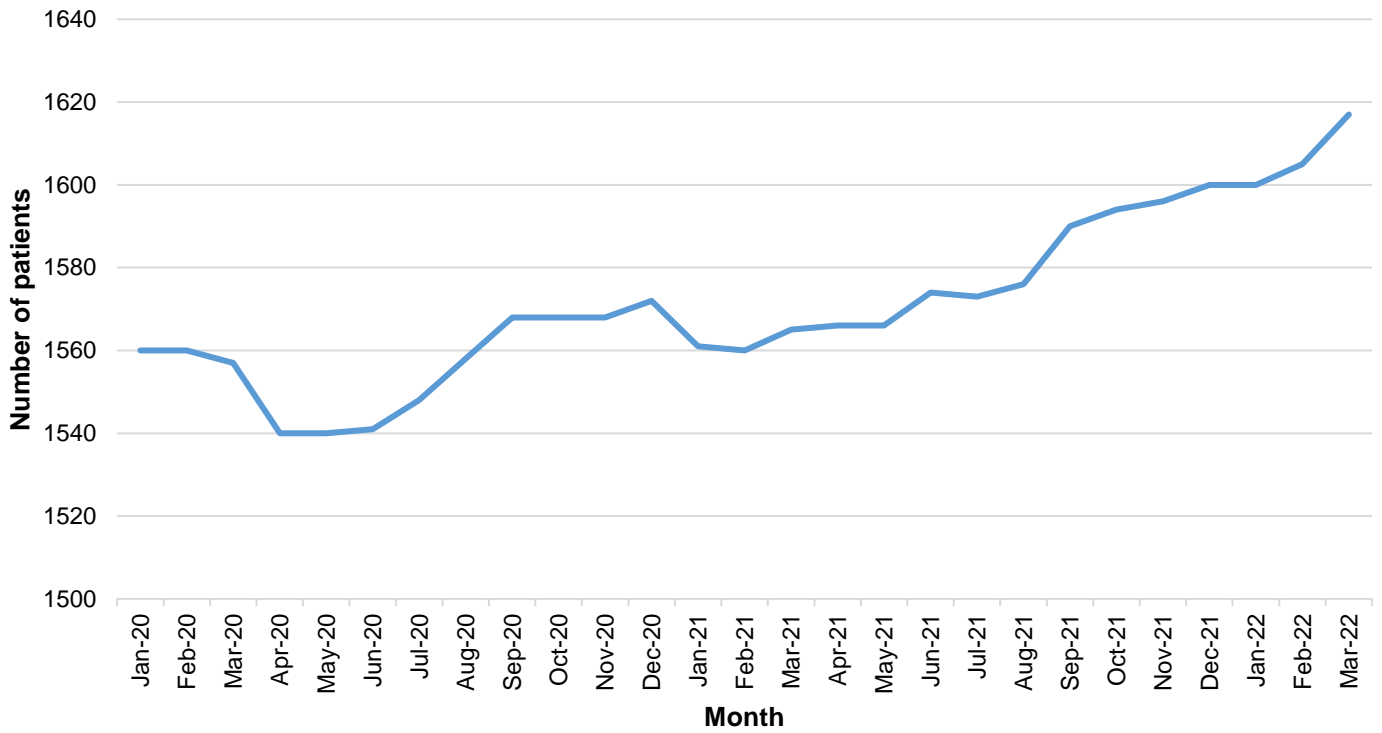
Five hearings were postponed for the following reasons:

- Patient awaiting nursing home assessment x1
- No medical report received x1
- Patient was ill x1
- Solicitor was ill x1
- Out of area solicitor caused delay x1

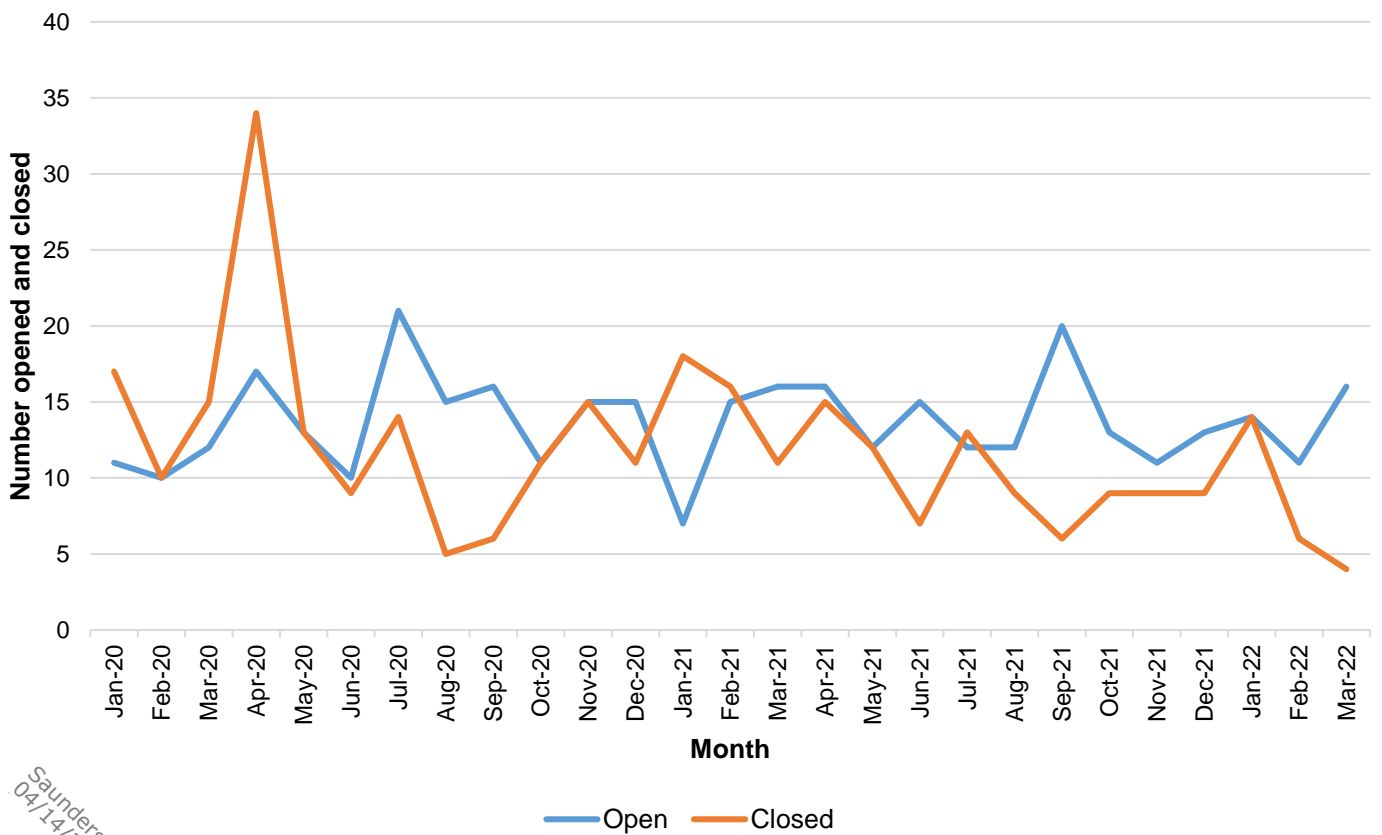
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Section 117 Aftercare

Patients eligible for Section 117

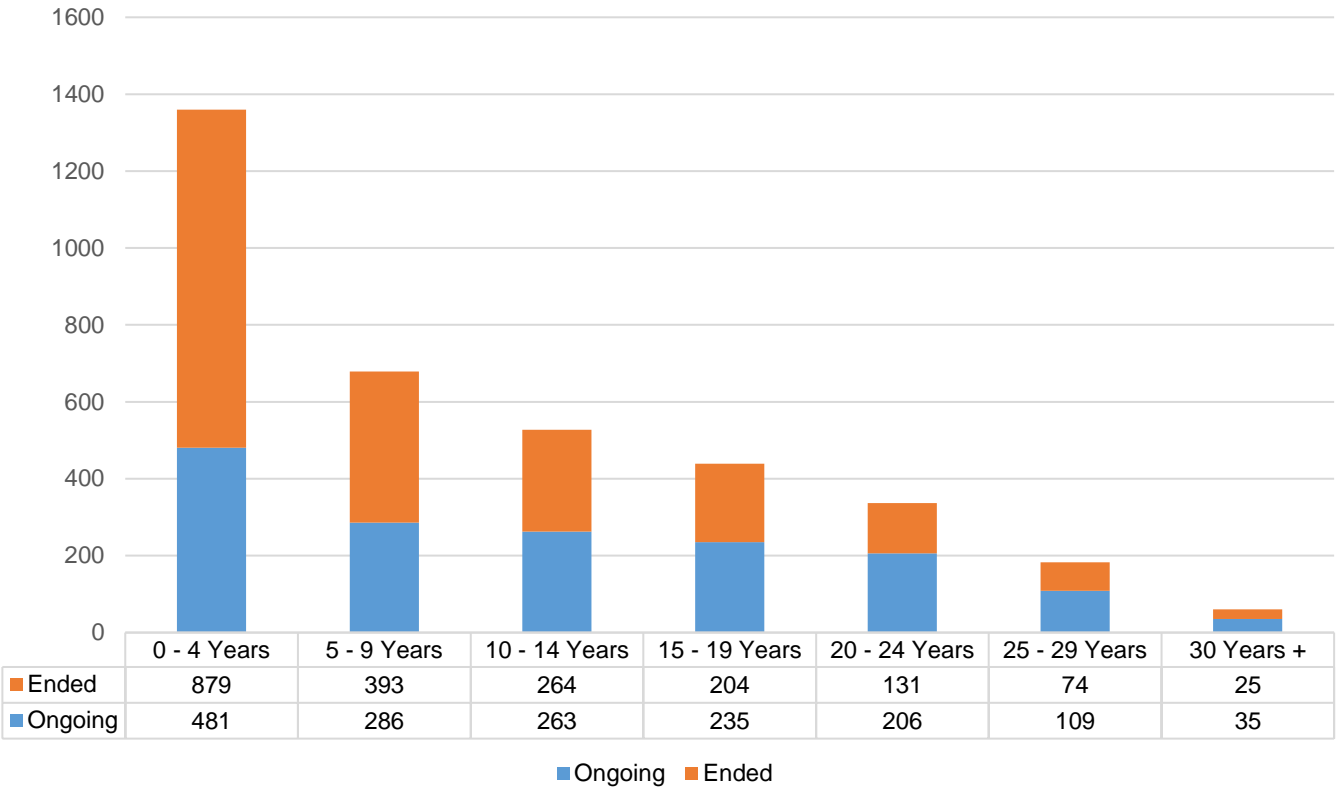


Section 117 Activity



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Periods of time that patients remain eligible for Section 117 aftercare



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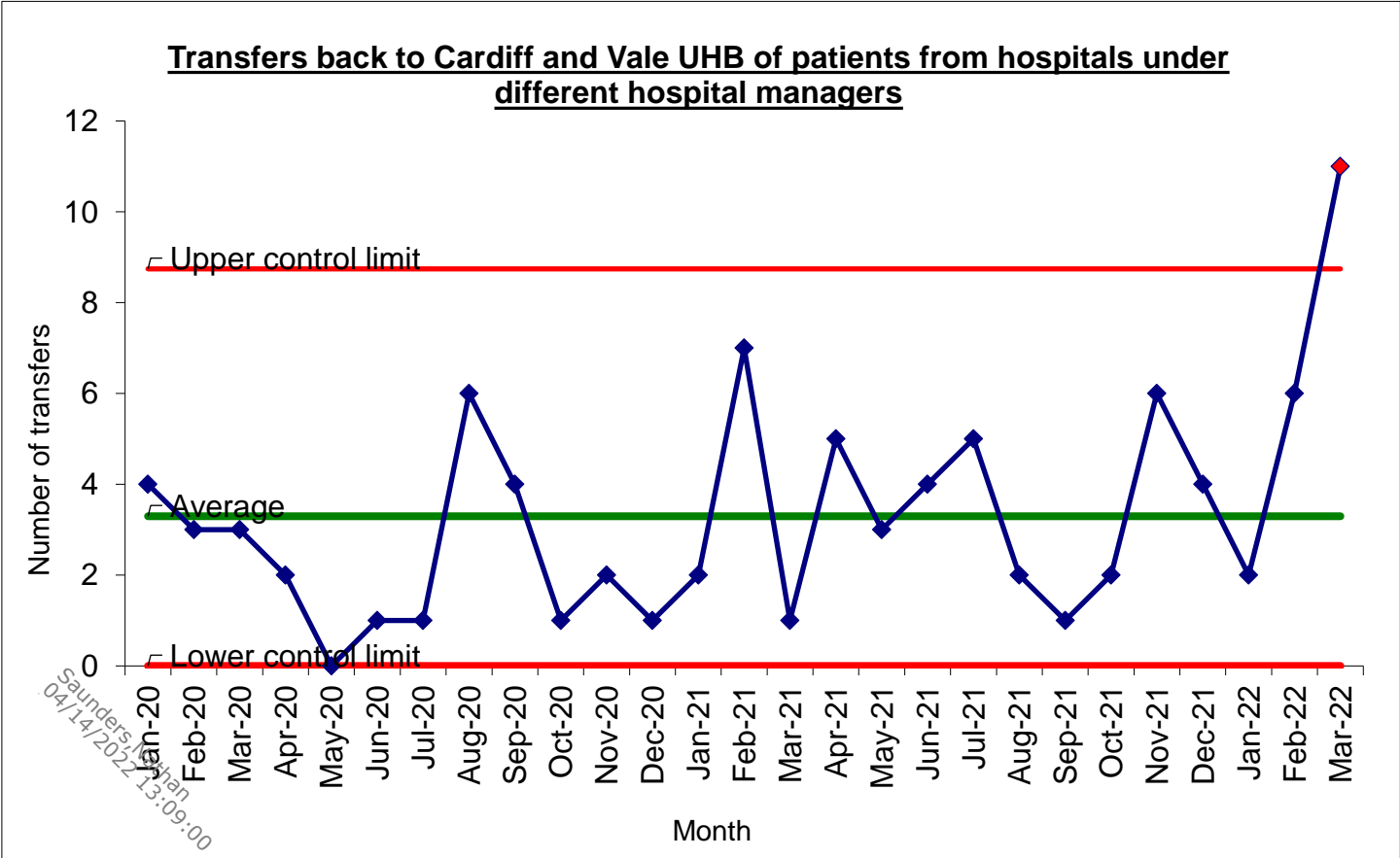
Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- Twenty Three patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
 - Nine to return to their home area
 - Four to CAMHS
 - Six to a private PICU bed
 - Four to a specialist placement
- Eight patients detained under Part 3 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
 - Seven due to Covid-19 bed demands
 - One Specialist placement

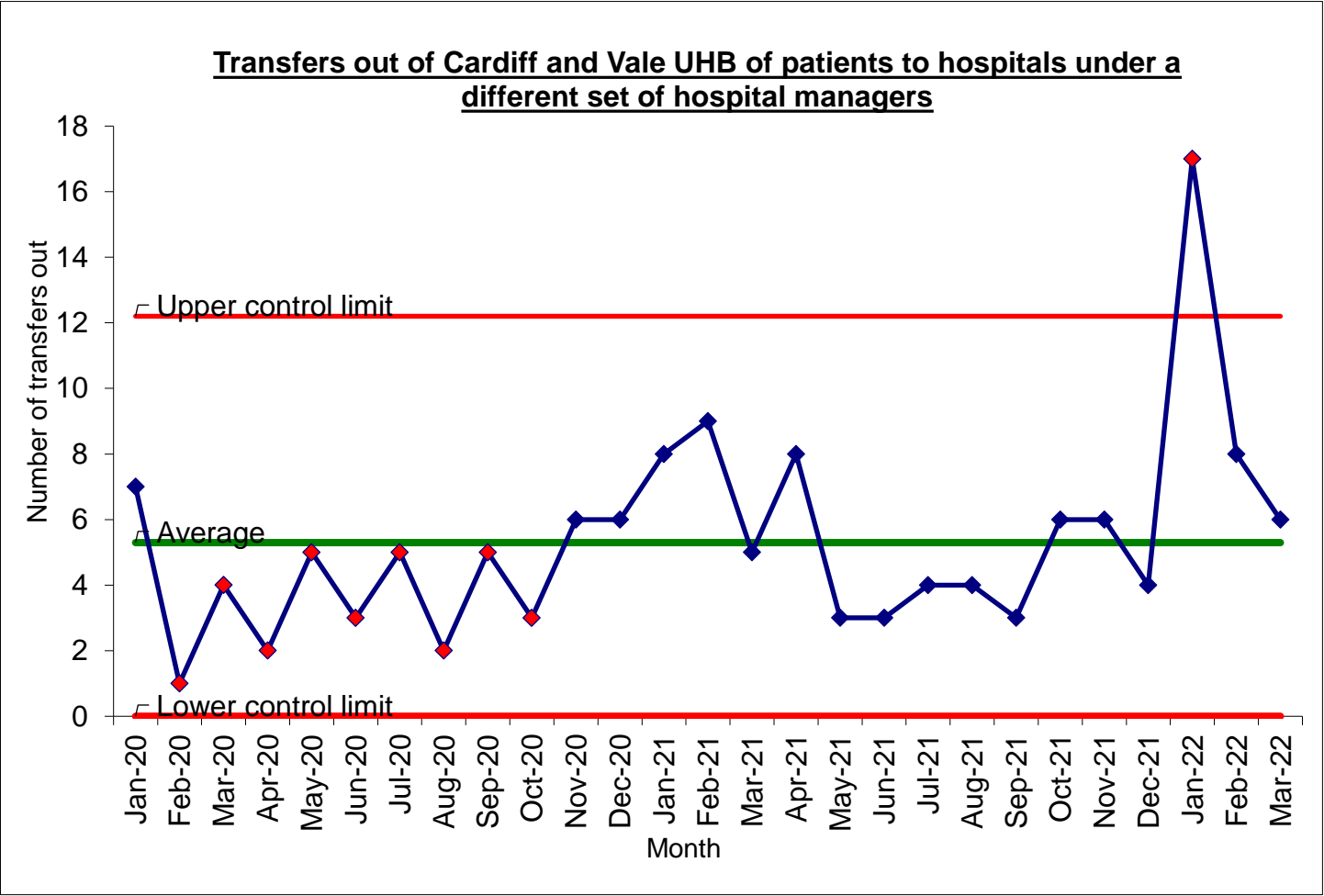
Twelve patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- Three from PICU beds
- Once for specialist placement
- Eight from an out of area bed



Seven patients detained under Part 3 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- Returned as Covid-19 demands easing



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Summary of other Mental Health Activity which took place during the period

January- March 2022

Exclusion of visitors

Visiting on wards at Hafan Y Coed are allowed but by strict appointment only. This is managed through a booking in system. This is due to the ongoing global pandemic.

Death of detained patients

During the period there were no deaths of detained patients.

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Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety initially for up to 24 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her

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	<p>treatment or care. The detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place of safety as long as the maximum time period has not expired.</p>
<p>Part 2 of the Mental Health Act 1983</p>	<p>This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.</p> <p>A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.</p>
<p>Section 5(4)</p>	<p>Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required.</p> <p>During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2).</p> <p>Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.</p>
<p>Section 5(2)</p> <p>Saunders, Nathan 04/14/2022 13:09:00</p>	<p>Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made.</p> <p>The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or</p>

	<p>section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.</p>
Section 4	<p>In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours.</p> <p>An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor.</p> <p>A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of:</p> <ul style="list-style-type: none"> • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. <p>Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made.</p> <p>The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.</p>

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<p>Section 2</p>	<p>Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales.</p> <p>If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met.</p> <p>The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate.</p> <p>Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made.</p> <p>The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative:</p> <ul style="list-style-type: none"> • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest <p>This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of.</p>
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	Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	<p>Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal.</p> <p>Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.</p>
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Section 17E (recall of a community patient to hospital)	<p>Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances:</p> <ul style="list-style-type: none"> • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer

	<p>people from prison to detention in hospital for treatment for mental disorder.</p> <p>Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.</p>
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	<p>Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice.</p> <p>Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person</p>

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	can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	<p>Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options:</p> <ul style="list-style-type: none"> • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position

	is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for CTO
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	<p>Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion.</p> <p>If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for mental disorder.</p> <p>If the patient lacks capacity to consent SOAD authorisation is required.</p>
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)

<p>Section 62 – Urgent treatment</p>	<p>Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is:</p> <ul style="list-style-type: none"> • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
<p>Section 23</p>	<p>Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication.</p> <p>Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders.</p> <p>The Secretary of State for Justice has powers to discharge restricted patients under section 42(2).</p> <p>If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.</p>

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Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.
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Report Title:	Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report			Agenda Item no.	10.1	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	26 th April 2022	
		Private				
Status <i>(please tick one only):</i>	Assurance	X	Approval		Information	
Lead Executive:	Interim Chief Operating Officer					
Report Author (Title):	Director of Operations, Mental Health					

Main Report

Background and current situation:

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee. For the information of the Committee the Delivery Unit has restarted its 90 day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1: PMHSS

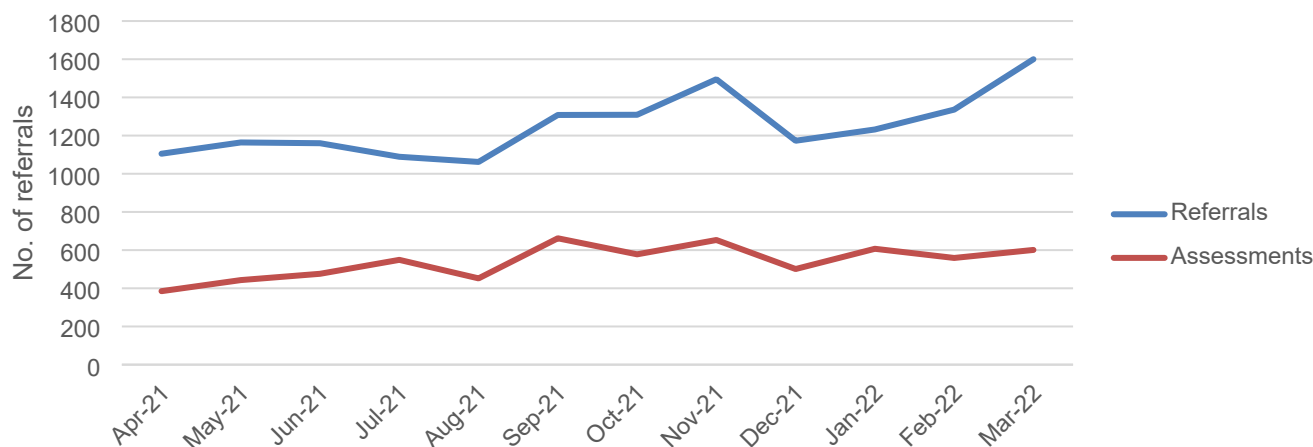
Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)

Q4 has been exceptionally busy with over 4000 referrals received, and a new monthly peak in March 2022 of 1487. Despite staff vacancies, sickness absence and the end of the annual leave year we have been able to maintain assessment activity and following recruitment and the start of a new annual leave year we anticipate an rise in activity in line with the assessment rate (see Graph 1).

Graph 1

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PMHSS Part 1a (all age) run rate



In this reporting period PARIS data reporting inaccuracies were discovered which have now been corrected. Regarding the over-18 Part 1a performance (see Graph 2), every referral is being seen in under 56 days and referrals are moving steadily towards overall compliance. Performance on 08/04/22 was 69% compliance.

The actual waiting list for assessment has dropped from 596 on 31/12/21 to 344 on 08/04/22.

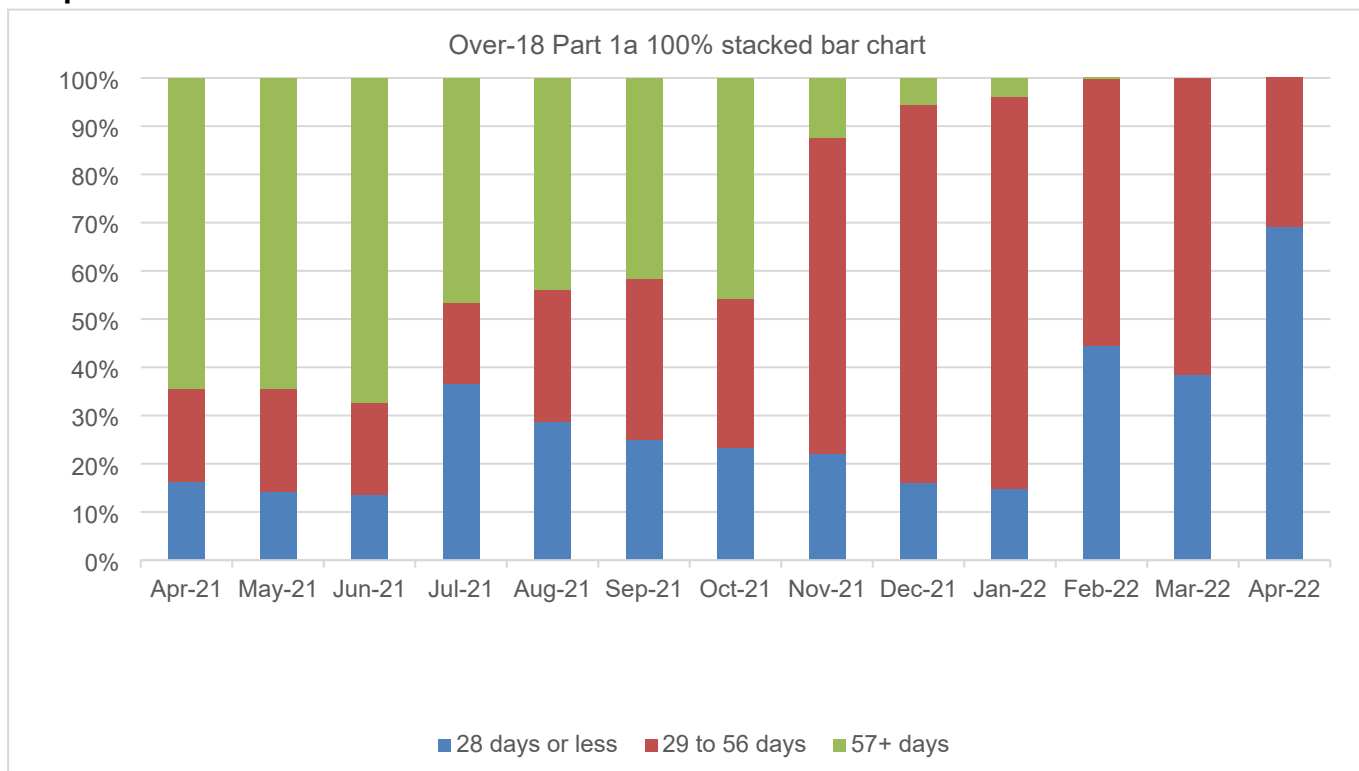
Average waiting times for assessment is 29 days on 31/03/21. At the point of 'opt-in', service users are being offered appointments within 16 days. The trajectories for both of these indicate continued improvement. The longest wait for assessment is 41 days.

The compliance with the Tier 1 target of 28 days has improved gradually in since 2021 (from 16% to 69%) but given the above waiting list and average waiting times this will continue to improve before reaching compliance. Much is dependent on referral numbers referred in Q4 (often being the busiest quarter of the financial year). Early indications are for a Q1 2022/23 less busy than Q4 but still in the region of 3,500+. Clarification was sought from Welsh Government around when the 'clock' starts, WAG have confirmed this is the receipt of the referral, not the date of opt-in by the service user. The impact of this is that some service users who opt-in do so up to 14 days after referral meaning that only 2 weeks are available to book within target. At present assessment diaries run up to 16 days ahead. This is further compounded by there being no postal service from 12pm Friday until Monday meaning days are lost.

It is recommended that Fully Automated Booking is explored for Fridays and SMS Text Notification for Opt-In are developed. Both will not be operational at least until June due to staff availability within the PARIS team.

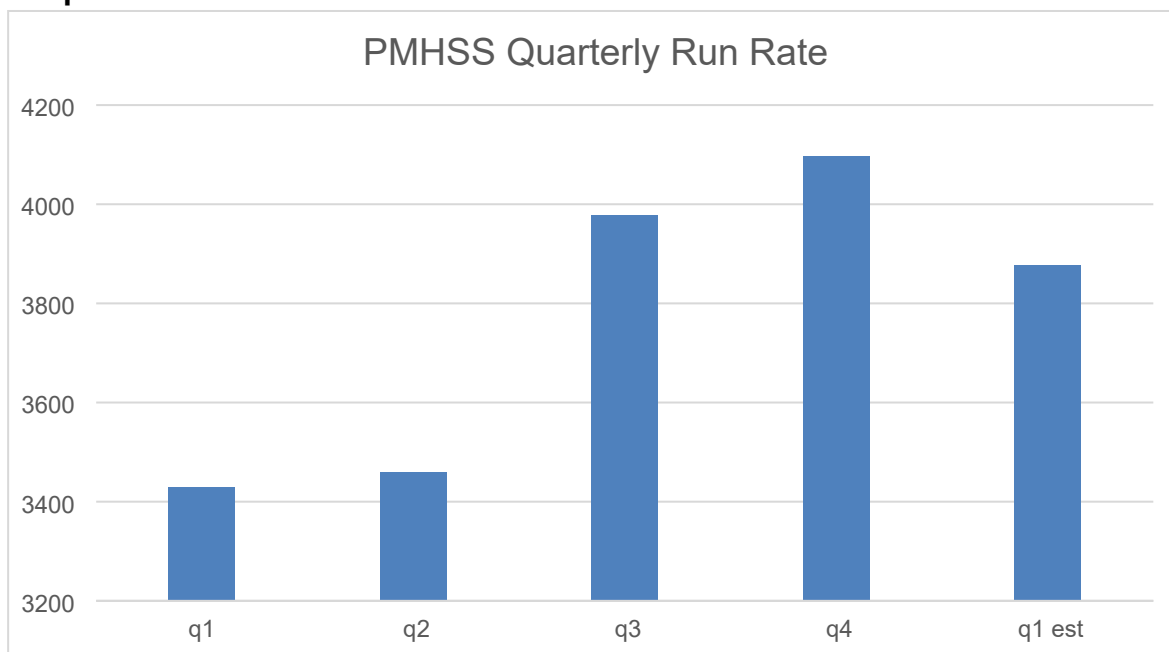
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Graph 2



Post lockdown we continue see new peaks in overall all age referrals to Part One, with 4096 referrals received in March 2022. (Graph 3)

Graph 3



Counselling wait times remain low due to the single point of entry (SPOE)

Actions to restore Part 1 compliance:

- Ensure all referrals that can be accommodated at Tier 0/1 through intervention of the third sector or the GP PCLT are dealt with there - **completed**

- Encourage direct referrals by the public into Tier 0 third sector support through advertising and awareness raising on the UHB website and public health advertising - completed
- Encourage GPs to refer directly to the third sector through awareness raising in the PCIC CD forum and via the cluster development managers - **completed**
- Develop additional capacity within the Primary Care Liaison Team to offer some extra capacity to accommodate staff losses through covid-19 - **completed**
- Develop additional capacity within the third sector to offer some extra capacity to accommodate staff losses through covid-19 – **completed**
- Develop temporary capacity within the PMHSS team assessors, through fast track recruitment, agency block booking and exploration of private companies – **completed**. Although we took on vacancies in January 2022 all post were recruited to and staff were in post by end of March 2022.
- Investment into Tier 0 providers to deliver Tier 0 interventions (Stress Control and ACTion for Living) at scale to reduce referrals into PMHSS- **2 out of 4 Tier 0 providers completed**.
- Request for SMS confirmation via PARIS record system to reduce impact of postal delays over weekends (which can result in letters arriving 6 days after referral receipt, impacting on opt-in)- **for action (due to limited availability of PARIS team unlikely to be implemented until at least June)**.
- Fully Automated Booking is to be developed for Fridays- **for action**.

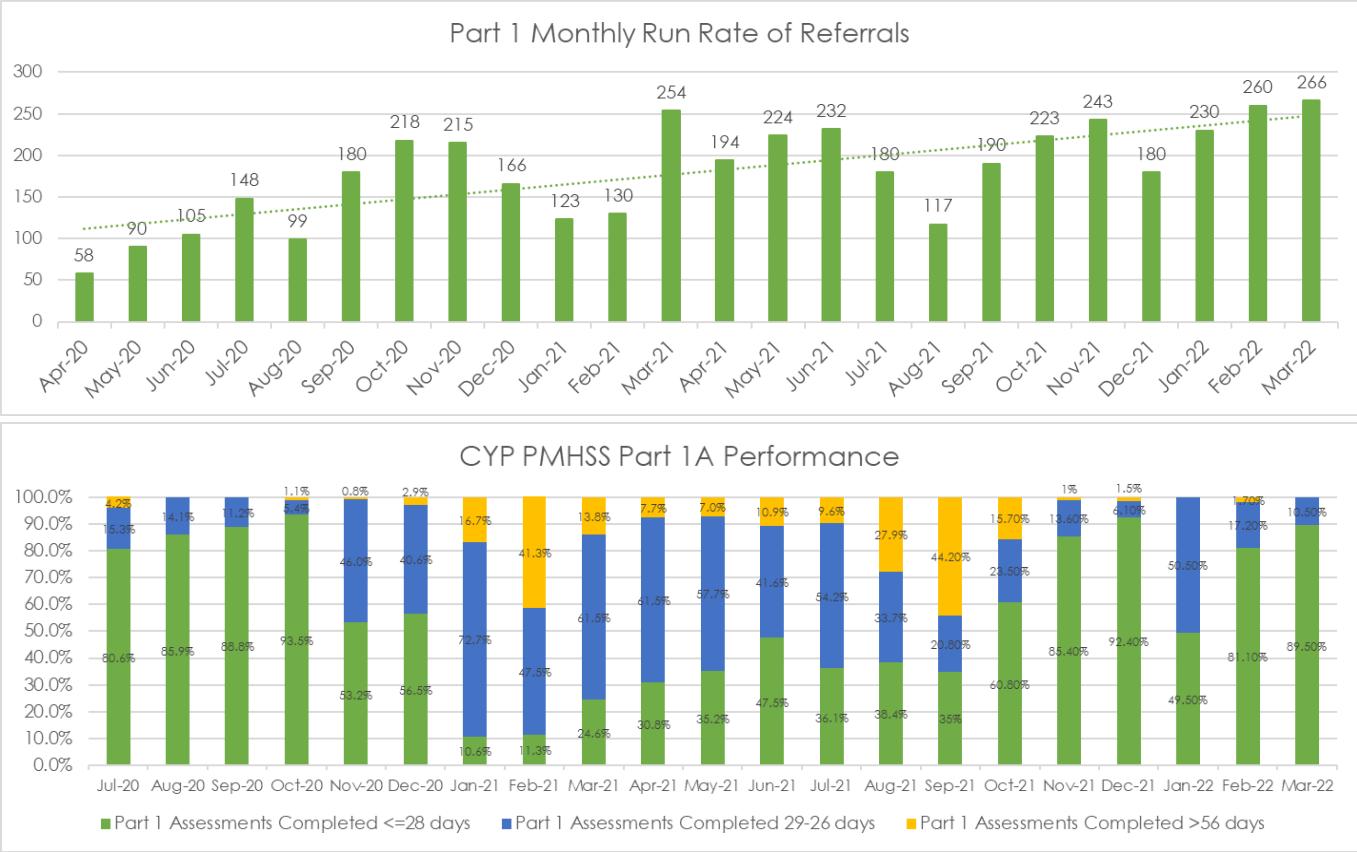
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

Compliance against the part 1 target has been achieved since the middle of November as a result of a waiting list initiative in conjunction with Healios. However, there was a drop in compliance in January as a result of reduced capacity over the festive period but a compliant position has been recovered from February 2022. Since March 2021, the volume referrals have increased and have remained significantly higher than pre-Covid levels. As expected, there was a decrease in referrals during July and August which is as a result of the school summer holidays but since the return to school in September, referrals have been increasing again.

The average wait for assessment is currently 25 days.

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Graphs 4&5



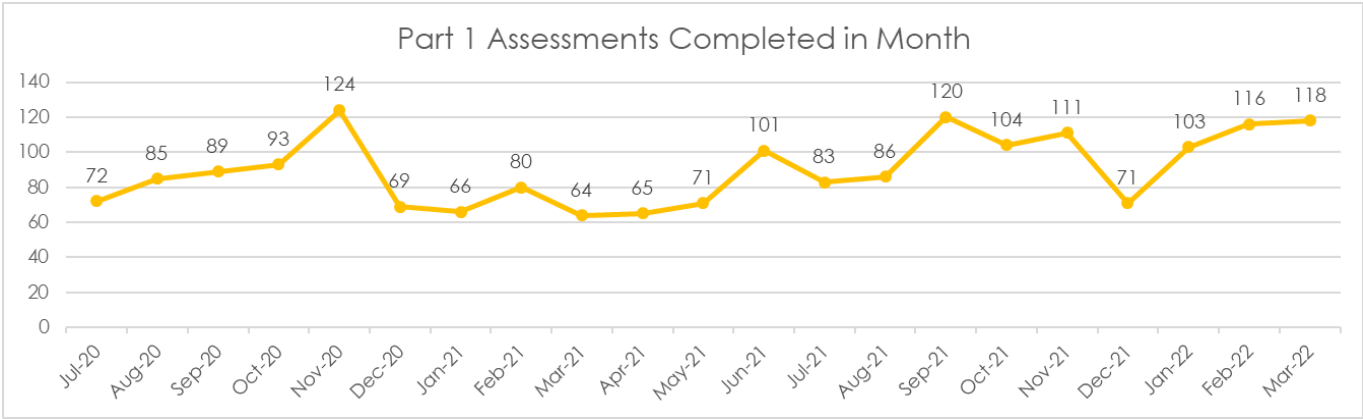
Capacity has been a challenge for the team, with a mixture of short and long-term sickness, the team has been operating on approximately 66% capacity since the beginning of December 2020. There is currently a significant recruitment drive with the development of new services as a result of COVID recovery monies but significant vacancy still remains within the service.

The service is continuing to deliver its full offer via virtual (telephone and video) and face-to-face means and expects to continue to utilise these mediums as part of a blended service offer post-Covid to better meet the needs of children and young people requiring support from the service. The service continues to closely monitor its capacity in order to meet the incoming demand and as such, we will be moving to a Joint Assessment team model which will combine CAMHS and PMH in its current format to create dedicated assessment capacity. This model is anticipated to be fully operationalised from the beginning of quarter 3 in 2022.

The Single Point of Access team was launched at the end of November and will help to manage referrals through improved processes and use of consultation with referrers.

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Graph 6



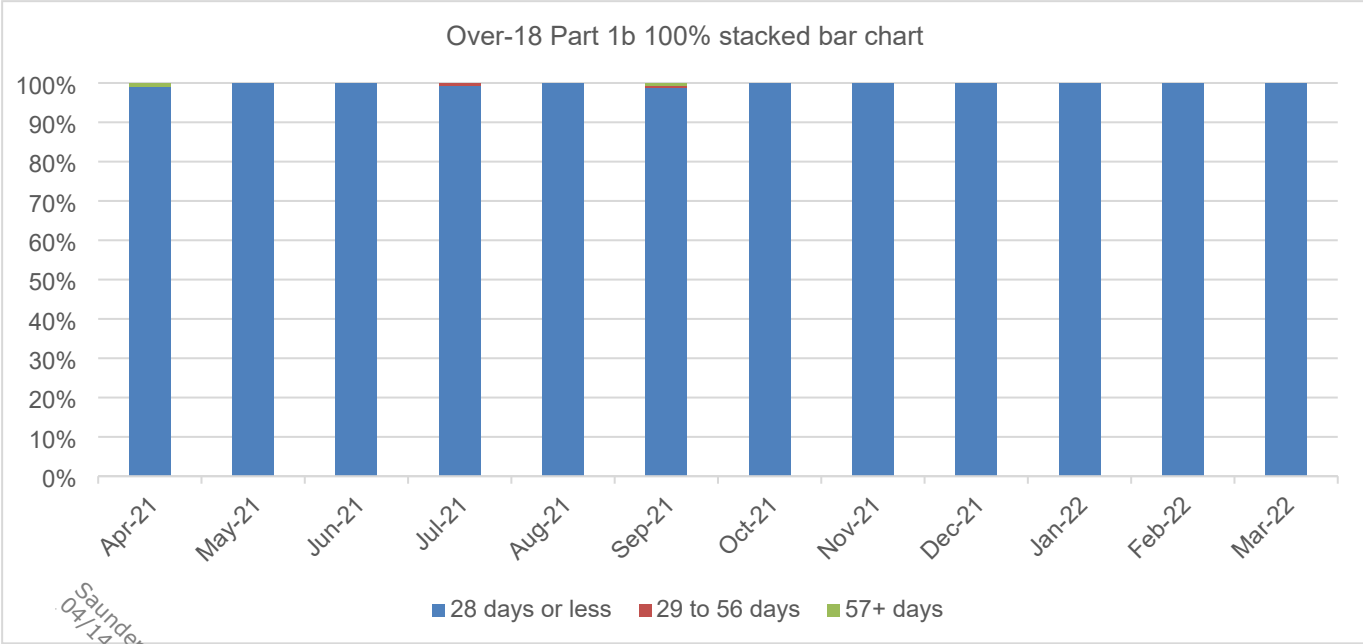
Actions to maintain compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of partnership working with Healios to deliver Part 1 assessments.
- The Leadership Team are seeking to develop a new assessment team model, with dedicated capacity for assessment. It is anticipated that the joint assessment team will have a soft launch in April 2022 but will be fully operationalised from October 2022.

Part 1b – 28 day assessment to intervention compliance target of 80% (Adult)

PMHSS continues compliance with Part 1b performance target (See Graph 7). This has continued during the Covid 19 period. Overall a range of interventions for over 150 participants are running this reporting period.

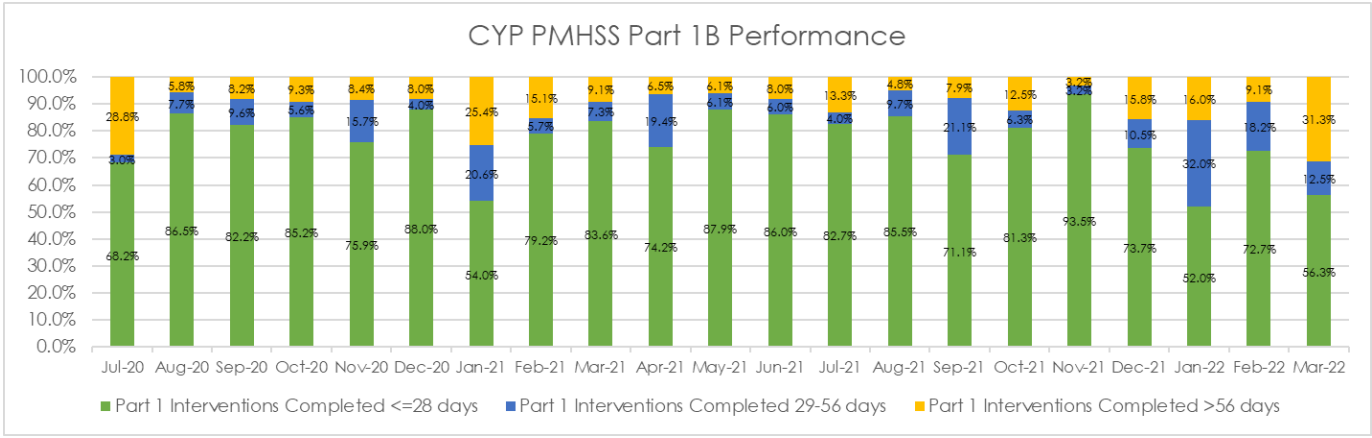
Graph 7



Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)

Compliance against Part 1B of the target has not been achieved since December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over Christmas. January 2022 was a challenging month for the service with significantly reduced capacity due to sickness, maternity leave and annual leave. As part of the move towards a Joint Assessment Team model, a brief intervention pathway will be created to ensure that young people are seen within 28 days of the commencement of their treatment, following assessment.

Graph 8



Part 2 – Care and Treatment Planning (over 18)

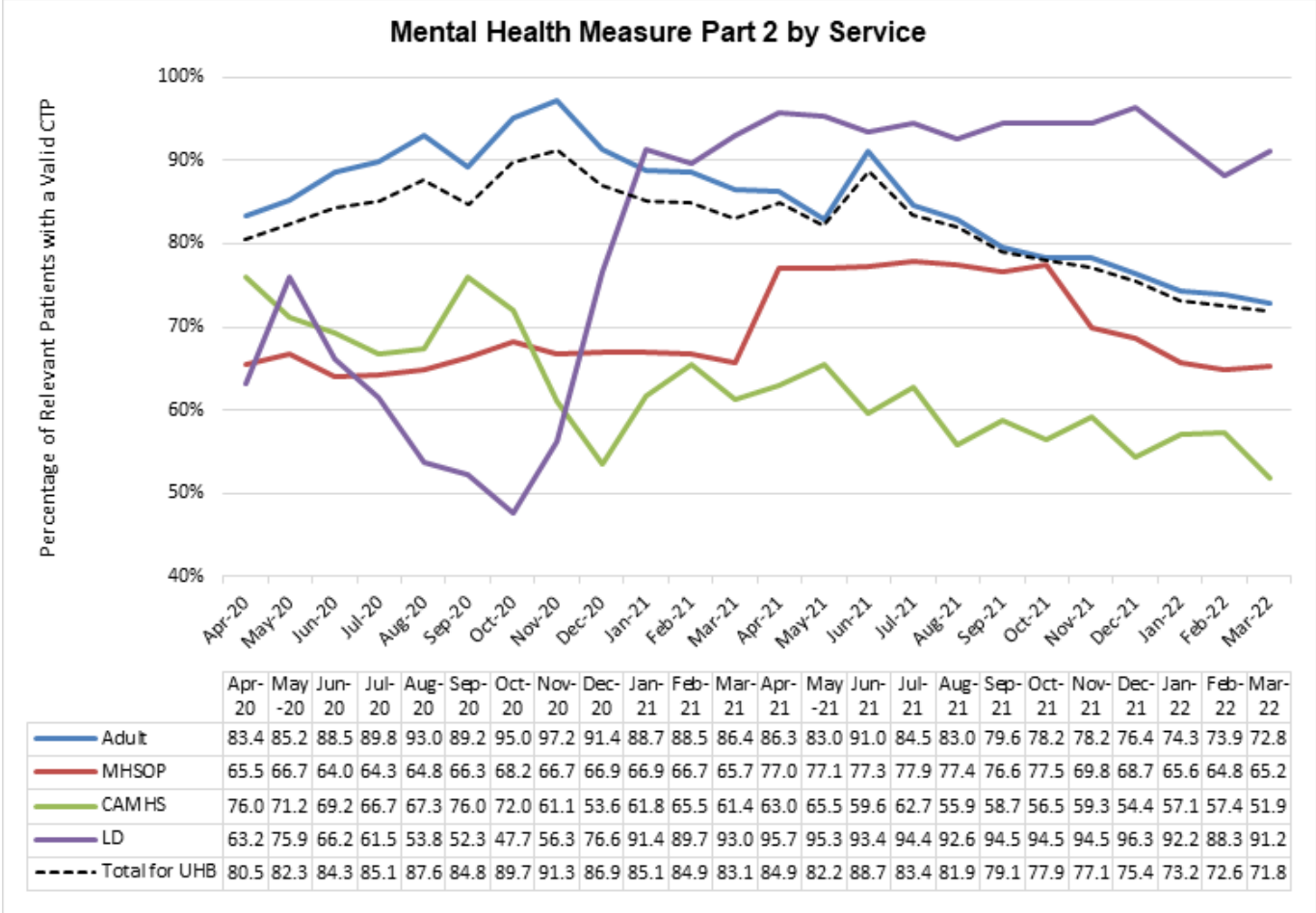
Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

Graph 9 shows average compliance is dropping at around 1% per month with a pattern of reduced discharges and higher allocations. Adult performance (where the majority of Part 2 patients are allocated) shows a continual, 1% decrease in compliance per month. MHSOP compliance has stabilised this month increasing by 0.4%. Staff absences and sickness continue at around 8% in Mental Health services during the pandemic, these absences have resulted in an increased focus around some of the higher risk patients.

MHSOP Care Homes Liaison team have worked towards discharging 600 cases with a focus of streamlining 200 individuals and dedicating time for CTPs. It is expected that this will significantly improve CTP compliance in MHSOP.

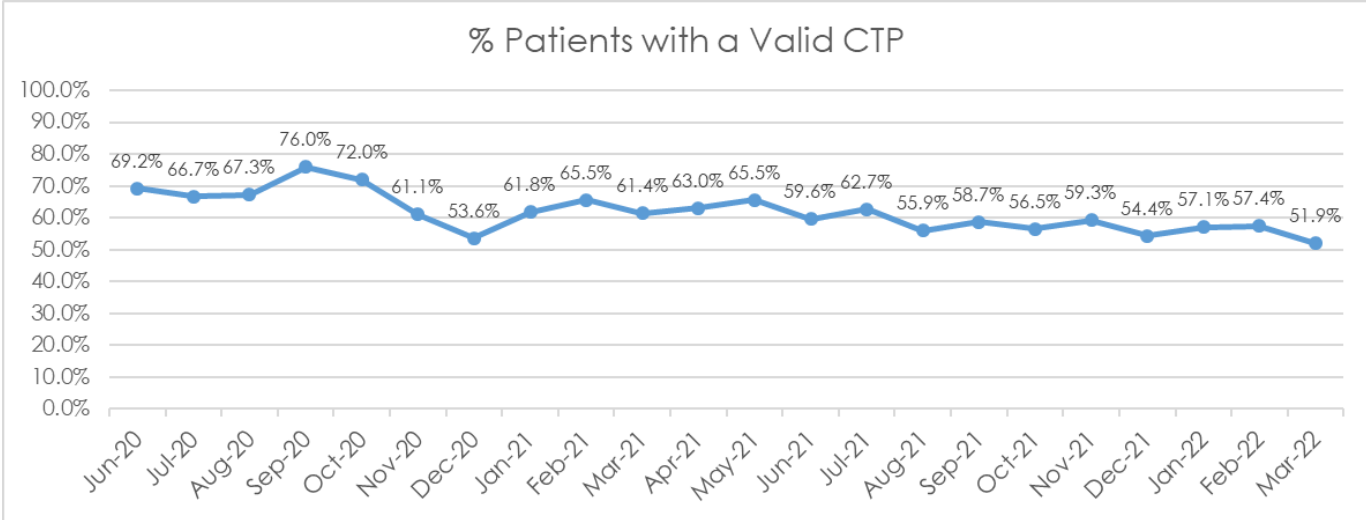
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Graph 9



Part 2 – Care and Treatment Planning (Children & Young People)

Graph 10

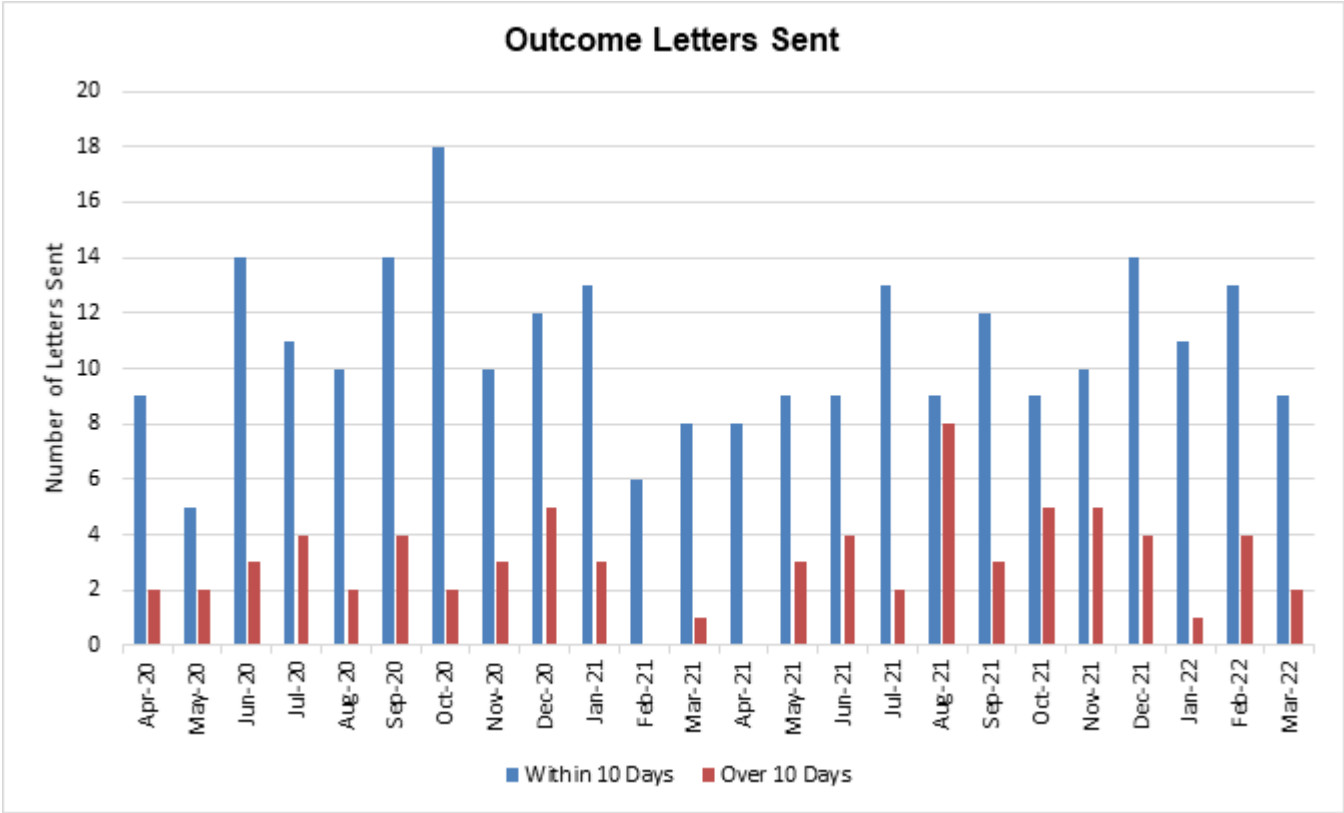


The service continues to underperform against the target, challenges to achievement have included poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable to be facilitated as a result of wider system issues e.g. social care placements not being in agreed leading to delays in completion. The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate and in a supportive multi-agency approach. Improvement in compliance remains a priority for the service.

Part 3 - Right to request an assessment by self –referral.

The target relates to service users who have self-referred, having a confirmation letter regarding the outcome of their assessment within 10 days). Graph 11 details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 11



Since changes in data capture in August 21 indicated some inaccuracies in reporting performance, the performance is improving while Part 3 referrals are rising (see Graph 11). Since data now includes any breaches post discharge where Part 3 letters were not sent, quality issues are being addressed and the numbers more accurately represent the true performance. New automated reports to teams have been set up to reduce breaches and to flag any consistent process concerns, MHCB is following this up with any areas that continue to breach towards achieving a 100% compliance rate. Performance has improved since the issue was identified in August, this month there were 2 breaches.

Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

Part 4 continues with 100% Compliance.

Advocacy Support Cymru (ASC) continue to receive referrals from the Mental Health Act Office and are also receiving phone calls/emails from existing clients on a daily basis with instruction to act, contact professionals etc.

The service continues to be compliant with the Measure. ASC have reported that Adult and MHSOP Services have been very helpful throughout the lockdown period with Advocates increasingly having

to rely on staff as they have not been able to access wards to speak with patients face to face, also working with non-instructed patients the majority are unable to talk with over the phone. The Mental Health Act Office have been proactive and creative in facilitating hearings remotely, to ensure patients legal rights are upheld.

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:

Part 1:

Ongoing monitoring and recruitment in support of Part 1a. Longer term funding through transformational programmes will be required to support compliance with Tier 1a and 1b targets in Adult. Longer term demand analysis post covid and anticipated impact of 111 'Press 2' will need to be explored.

It is recommended that Fully Automated Booking is explored for Fridays and SMS Text Notification for Opt-In are developed. Both will not be operational at least until June due to staff availability within the PARIS team.

Target return anticipated as between April and May 2022. This has been conveyed to the Deputy Minister, trajectories indicate we are on target to deliver this and mitigate any reputational risks.

Part 2:

Increase co-production in the development of Care and Treatment Plans. Auditing care plans using Delivery Unit tool on 3 monthly basis. Admin team developing a Microsoft Forms audit tool to monitor for quality of CTPs.

Part 3:

Continue to flag any performance issues to teams locally for improvement.

Part 4:

100% compliance, no further actions.

Recommendation:

The Committee is requested to:

- a) NOTE the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment: <i>Please state yes or no for each category. If yes please provide further details.</i>	
Risk: Yes/No	
Safety: Yes/No	
No	
Financial: Yes/No	
No	
Workforce: Yes/No	
No	
Legal: Yes/No	
No	
Reputational: Yes/No	
Yes	
Socio Economic: Yes/No	
No	
Equality and Health: Yes/No	
Yes	
Decarbonisation: Yes/No	
n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL
MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON
April 5th 2022 VIA Teams

Present:

Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer Vice Chair, Pod Group
Alex Nute - PoD member
Carol Thomas- PoD member
Mike Lewis - PoD member
Sarah Vetter - PoD member
Sharon Dixon - PoD member
Mair Rawle - PoD member
Peter Kelly - PoD member
Mary Williams – PoD member
Wendy Hewitt-Sayer - PoD member
Dr John Copley - PoD member
John Owen - PoD member
Alan Parker - PoD member

In attendance:

David Seward – Interim Mental Health Act Manager
Morgan Bellamy – Acting Deputy Mental Health Act Manager
Georgia Walsh – Assistant Mental Health Act Administrator
Nicola Jones – Assistant Mental Health Act Administrator

Apologies:

Amanda Morgan - PoD member

1. Welcome and Introductions

The meeting was held via Teams and the Chair welcomed all to the meeting.

2. New Members and Independent Members

There were no new members.

3. Apologies

Apologies were received and noted. Alan Parker thanked members for their support over recent months. It was noted that Teresa Goss had retired from the group. The Chair formally thanked Teresa for her contribution over many years. It was agreed to organise a social event and buy a present for her. The social fund is currently low. The Chair asked for contributions towards the fund. He agreed to send out his bank details again. **Action – Chair.**

4. Members points for open discussion

Clozapine on a CTO – this had been raised at a hearing by the IMHA because of the requirement for blood tests for monitoring levels in patents. If the condition of the CTO included compliance with clozapine medication then, de facto, there was a requirement to submit to blood and other physical tests. If the patient fails to submit to the physical tests,

they are liable to recall. As such the advocate saw this as a reduction of an individual's human rights and a restriction of liberty. After discussion the Chair agree to take this to the next Mental Health Legislation and Governance Group and report back to the Panel. **Action – Chair.**

- **Paper Reviews** – although more common in England this hasn't been accepted practise in Wales and is contrary to guidance in the Code of Practise. Only in exceptional cases will this be considered and then, only with the agreement of the nearest relative. If panel members feel a paper review would have sufficed then the issue is to be raised in the post hearing review. **Action – All.**

5. Minutes of Meeting held on 4th January 2022

These were agreed as an accurate record of the meeting.

6 Matters Arising

- **CTP/RA** – the Chair advised that he has repeatedly raised the issue and would do so again at the next meeting on 8th April. It was an issue that was a priority for the Mental Health Legislation and Governance Group (MHLGG). The Chair and Vice-Chair will do a 6 month audit of CTP's that have been flagged by panels as needing review. They will report back at the next meeting. If a panel has issues with the CTP that requires a response this needs to be raised in the recommendations. It was not sufficient just to tick the box in the minutes. **Action - Chair/Vice Chair and MHA Manager.**
 - **Late Minutes** – the Chair thanked everyone for actioning this from the last meeting. Minutes are being delivered on time.
 - **Feedback on annual reviews** – these were nearly completed and the Chair thanked everyone who had taken time to complete the self-review. The Chair will report back more fully at the next meeting. At his review with the Vice-Chair of the Health Board, he had reported that he had been impressed by the conduct of the hearings that he had observed and was satisfied that patient were treated respectfully and had an honest hearing. **Action – Chair, PoD.**
 - **Protocol for virtual hearings** – The Chair informed the meeting as to the background to this and advised that the protocol had been amended and issued to members following the last meeting. **Action - MHA Manager.**
 - **Feedback after hearings** – this needed to be completed even if the panel felt that everything worked well. One member raised an issue that had arisen from some training they had attended. It had been suggested that all matters raised at a hearing, including any recommendations/compliments should be made available to the patient and in fact that there was a High Court Judgement to that effect. Mary Williams to provide details to the MHA Manager who will investigate further. **Action - Mary Williams PoD member and MHA Manager.**
 - **Working with interpreters and people with communication difficulties** – The Chair had circulated some information on this subject to PoD members. Members asked to confirm the date it was sent. Also, the Chair had spoken with Samira Salter who would be pleased to come and talk to us. Agreed that members would look at the information provided to see if it was sufficient and to let the Chair know if they felt a talk from Samir would enhance this learning. **Action – Chair and PoD members.**
- ECT** – the training was being run after the business meeting for those who had been unable to attend the first session.

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7 Operational Issues

- **Face to face hearings** – there was a general discussion regarding a return to face to face meetings. The Chair will discuss with each PoD member at their annual review. So far there has been a range of views. For now, hearings will remain via Teams. Although patients are asked their views after every hearing there is a low response rate. The MHA office reviewed patient attendance over a six-month period at face to face hearings versus virtual hearings and more patients had attended when the Hearing was virtual. However, each patient is different and it will be important to take into account patients and professionals views when deciding how hearings will be conducted in the future. Chair to discuss at the Mental Health Legislation and Governance Group. **Action – Chair.**
- **Acoustics in hearings** – this is a particular problem when there is more than one person in the room making it sometimes difficult to see and hear the patient. This most commonly occurs when the ward office is used. When joining the meeting the ward should restrict the number of people attending to two – the nurse and patient. There are facilities in the MHA office for the RC or Social Worker to join the meeting if necessary. Members also raised the issue of meetings starting late usually because of the ward staff. It was noted that there were currently staff shortages that sometimes made it difficult to release the nurse for the hearing. MHA Manager agreed to raise with the Senior Nurses. **Action - MHA Manager.**

8 Lessons Learnt

There were no particular issues for the meeting.

9 MHA Activity Monitoring Reports

Activity reports were provided for the periods October to December 2021 and January to March 2022 for both Hospital Managers and Tribunals. There was nothing of note to discuss.

10. Concerns/compliments from Power of Discharge group Hearings

These were noted and discussed.

11. Committee and Sub-Committee Feedback

The Chair informed the group that there was nothing to report. He had not attended the last Mental Health Legislation and Governance Group due to an administrative error. The next Mental Health Legislation and Governance Group is on the 8th April 2022. Minutes of the previous meetings were included in the papers for this meeting.

12. Training

The All Wales Hospital Managers Event is scheduled for 11th May 2022. Any topics for inclusion in the conference to be sent to MHA Manager. The focus will be on difficult issues i.e. non-capacious patients/rights of relatives/displacement of the nearest relative. **Action - MHA Manager and PoD members.**

13. A.O.B

- **Risk Assessment** – risk assessment should be reviewed prior to a hearing. The MHA office request the latest risk assessment from the nursing staff. If a panel feels the risk assessment

hasn't been updated and they aren't satisfied by verbal updates from the professional they can adjourn the hearing. **Action – PoD members.**

- **Invite to hearing** – a member raised concerns that Teams invites for hearings were sent to over 20 people in some instances. The MHA Manager explained that all nurses on a ward are sent the invite as the office don't know in advance who would be attending. After discussion the Chair agreed to pick up the issue with the individual panel member. **Action – Chair.**

As there was no more any other business the Chair closed the meeting. He thanked members for the continuing support in what are challenging times.

Date and time of next meetings

5th July 2022

4th October 2022

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04/14/2022 13:09:00



Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 08 April 2022 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
David Seward	Interim Mental Health Act Manager
Bianca Simpson Lepore	Interim Deputy Mental Health Act Manager
Mary Lawrence	Consultant representative, Adult
Louise Gibbons	South Wales Police representative
Jeff Champney-Smith	Chair, Power of Discharge Group
Callista Hettiarachichi	CAMHs representative
Katherine Lewis	Consultant social worker DOLS/ AMHP
Lynda Woodley	Operational Manager, Vale of Glamorgan
Chloe Evans	Mental Capacity Act Manager
Tara Robinson	Interim Deputy Director of Nursing (Mental Health)
Alex Allegretto	Independent Mental Health Advocacy Manager
Andrea Sullivan	Senior Nurse for Quality, Safety & Education

Apologies

Daniel Crossland	Director of Operations, Mental Health Clinical Board
Ceri Phillips	Vice Chair, Cardiff and Vale UHB
Phillip Ball	Senior Nurse, Cardiff North West Locality
Rachel Rushforth	Senior Nurse for Quality, Safety & Education
Ceri Lovell	Team leader CAMHs crisis liaison team
Jane Jones	Consultant representative, CAMHs
Mark Doherty	Interim Director of Nursing (Mental Health)

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1 Welcome and Introductions

The chair welcomed members and those in attendance.

2 Apologies for absence

Apologies were accepted and noted.

3 Minutes of meeting held on 06 January 2022

Not discussed at length at this meeting, however the chair did ask anyone whether they had any points to be amended from the previous minutes. It was agreed any points to be amended should be emailed to the minute taker after the meeting.

4 MHA Activity

The use of Section 135 warrants and the use of Section 4 have both reduced since the last quarter. It was confirmed that approved mental health professionals are careful to only use Section 4 when it is absolutely necessary. The escalation of risk at delaying admission is always considered.

The number of errors on detention papers made by shift coordinators has increased. It was suggested this is possibly due to new shift coordinators starting and the uptake of the training offered decreasing. There was discussion as to whether shift coordinator training could be tagged onto other training so that shift coordinators training can be used most efficiently. The Senior Nurse for Education, Quality and Safety will discuss this proposal with the MHA Manager and Senior Nurse managing shift coordinators to see whether this is feasible going forward.

Action- MHA Manager to liaise with Senior Nurse for Education, Quality & Safety.

The number of people detained has stayed relatively stable and we have had no fundamentally defective detentions this quarter.

The exception reports for both February and April 2022 were discussed. The incidence of a private provider querying the validity of a patient's renewal was mentioned but it was confirmed that following legal advice the renewal was valid.

The number of Section 136's has increased again this quarter and there have been four instances of Section 136's lapsing due to the assessments taking place outside of the 24-hour time limit and no extension having been requested. These all happened when the patient went to A&E as a first place of safety. There are various rationale for these occurrences but it was agreed that communication between SWP and Health Board staff needs to be improved. The police are recording these as adverse incidents but at present we aren't receiving any further communication following this. It was agreed that work would be done to allow the Health Board to receive this feedback.

Action – Mental Health Lead, SWP to share adverse outcomes with the Chair.

The CAMHs representative confirmed that management plans are being put in place for repeat presentations of CAMHs patients at A&E.

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The use of Microsoft Teams for Mental Health Review Tribunals was discussed. Hearings can be held via teams at the request of either the patient or the professionals involved and so far, all of the requests made have been granted. We have requested feedback from patients about their experience of holding an MHRT via teams but at present this hasn't been forthcoming. Once feedback has been gained we will hopefully be able to put a case forward as to how well this is going. Holding Tribunals via Teams is not a standard as of yet but it is hoped that we will have an update regarding this shortly.

The observation of Mental Health Review Tribunals by student nurses/doctors etc is also being progressed. An internal process has been put in place to allow the MHA Manager to monitor how many requests we receive; how many are accepted and how many are declined. The aim is that once requests are received we can put a case forward to ask the Tribunal to review their position on this matter.

The MHA office provide regular development sessions including the receipt and scrutiny work shop, consent to treatment and a newly created rights workshop. It was picked up during a recent HIW visit that rights are not being read regularly enough despite ward staff being prompted via PARIS on a daily basis. The MHA Manager has liaised with the Locality Managers recently to escalate this matter and ensure improvements are made going forward. The CAMHs representative queried how people detained on non-mental health wards are read their rights. It was confirmed that the MHA office do provide as much guidance as possible to nurses on general wards do comply with the Act. This issue needs to continue to be raised to Locality Managers.

Action – MHA Manager will liaise with Interim Deputy Director of Nursing re: audit of rights.

The MHA office continues to take part in the AMHP training in conjunction with Swansea University. The MHA office also delivers the nurse foundation training programme when asked to do so.

The MHA office is endeavouring to increase the awareness of the training that is available to staff so as to hopefully reduce the numbers of errors and miscommunication between staff. The MHA Manager agreed to liaise with the Senior Nurse for Education, Quality & Safety to see what more can be done.

Action- MHA Manager to liaise with Senior Nurse for Education, Quality & Safety.

5 Matters Arising

There is no update with regard to the use of attend anywhere software for SOAD consultations. The MHA Manager will raise this at the MHA Administrators Forum and the Chair of the MHLGG meeting will discuss this further at the upcoming AC/Section 12 doctors meeting held by Betsi Cadwaladr HB.

There is no update regarding the recording of repeat Section 136's. It remains on the Digital Lead's agenda.

The situation regarding transport has improved but there remains an issue with secure transport at times. The reserve transport provider we use is based in Birmingham which causes logistical issues. A list has been chased from procurement and will be shared in due course.

The MHA Manager is waiting on further clarification regarding who would be most appropriate to scrutinise consent to treatment certificates received in the MHA office.

The shortage of Section 12 doctors was highlighted by the Chair of the meeting and he confirmed that Dr Neil Jones is continuing to pursue this matter with the PCIC Clinical Board and is supporting training and those who may qualify for Section 12 approval status. One of the AMHPs present informed us that the main issues are for the EDT team and overnight assessments. The lack of availability at these times impacts upon day time services as assessments may be delayed. This is in particular in relation to Section 136's. The Operational Manager for the Vale queried whether any information was held about how many Section 12 doctors there should be per head of population or how many Section 12 doctors the HB may lose in the next five years. Unfortunately, this kind of information would be difficult to clarify. One of the consultant representatives felt that some doctors may not be seeking reapproval as the process for this has become very laborious. She felt that retention of staff may be improved if they were supported more through this process than at present.

Action- Chair of the group to discuss this matter with relevant colleagues and escalate as appropriate.

The use of electronic forms for voluntary assessments needs to be reiterated within both the SWP and the Health Board as at present the MHA office do receive forms but we are unaware of whether forms are being completed for every assessment. The chair of the meeting would like to look at the demographics of the people being brought in for voluntary assessments. It was agreed that the use of voluntary assessments should be looked at in more detail following the meeting.

Action- Chair to look into the use of voluntary assessments in more depth.

Conveyancing being entered onto the new DATIX forms and who has responsibility for this is yet to be decided but the aim of this is to ensure any issues that come up are recorded properly and consistently across the localities. The Operational Manager for the Vale will take this back to her locality. It was agreed that the conveyancing issues need to be discussed more robustly each quarter to allow them to gain more of an airing more widely.

Action – OM for Vale to discuss in locality meetings and bring data to next meeting.

The MHA Manager and the Mental Health Lead for SWP need to arrange a meeting to put the Section 136 flow chart together.

Action- MHA Manager and Mental Health Lead for SWP to create Section 136 flow chart.

The duties placed on the Health Board by Section 140 of the MHA were discussed. The consultant representative explained the position the HB has agreed to take if it known that someone will be discharged the next day however there is still no agreed pathway for people that aren't anticipated to be discharged imminently. At present each instance needs to be escalated to the silver on call when no bed is available for someone that needs to be detained. The Operational Manager for the Vale was under the impression that a pathway for this kind of instance would be agreed and that perhaps a miscommunication has resulted in one not coming to fruition. She felt that there was no optimal solution but that the one that has been agreed so far is better than leaving vulnerable people potentially at risk. The Consultant AMHP for Cardiff voiced her concern that AMHPs have often felt unsupported whilst out in the community with vulnerable patients who by the very nature of their need to be detained cannot be safely managed in the community. There seems to be a lack of clarity as to whose role it is to manage risks in these situations and the role each professional play in ensuring someone's safety. Although this quite fraught issue has been discussed before it is hoped that the Interim Deputy Director of Nursing's participation in this meeting may get this agenda item progressed more quickly than has previously been seen.

Action – Chair to escalate to Director of Nursing and Director of Operations.

There was some confusion regarding the agreement between CAMHs and Adult services for young people detained in Hafan Y Coed. Dr Jane Jones' position is that if the young person is known to the KIT team then Dr Callista Hettiarachichi will take on RC responsibilities, if the young person is not previously known to KIT/CAMHs then the adult acute crisis consultant (Dr Oruganti/Dr Seruis) for their area would retain RC responsibility but with close communication form a CAMHs consultant. This stance was queried by the consultant representative. It was agreed this will be looked into further to ensure everyone's understanding of the situation is the same.

Action- Consultant representative to clarify agreement re: RC responsibility for young people detained at HYC.

Section 117 discharges and the knowledge of how this should be undertaken according to the Health Boards procedure was discussed. The Consultant AMHP for Cardiff felt that teams that don't directly contain social workers may not have the same level of understanding of their responsibility as ones that do contain Local Authority workers. CAMHs was highlighted as a team that may not have the required level of understanding and the CAMHs representative confirmed that they do have trouble ensuring children's services understand their responsibilities under Section 117 of the Act. The representative has stated that on occasions this has stopped the successful and timely discharge of Section 117. The Operational Manager for the Vale feels that more training for children's services is very important and hopes to put something in place for this. The CAMHs representative also feels there is a knowledge gap in Health Board employees as the incidents of young people being detained under the Act has risen over the last couple of years and knowledge of responsibility may not have caught up with this.

Action- Chair to investigate Section 117 training for CAMHs services in conjunction with Local Authorities.

The Operational Manager for the Vale raised the integral issue of ensuring patients are always involved with there 117 review meetings. Decision making needs to be recorded in full and if the decision is to discharge this needs to be very clearly documented and decided with the patient.

The problem of not discharging patients from the wards bed state when they are transferred out has now been resolved. Patients are now being taken off the bed state when requested by the MHA office.

6 Feedback on operational issues and incidents:

The change in Welsh Government guidance has not changed the Health Boards processes for assessments, using remote hearings etc.

There are ongoing problems in ensuring the smooth execution of Section 135(1) warrants. The Consultant AMHP for Cardiff highlighted the problems AMHPs have experienced in using the 101 service and that issues have taken days to be resolved sometimes. A process was briefly sent out by the police to try and help resolve this but unfortunately this process has since been retracted and will need to go through further consultation before being issued again. SWP would prefer to use a pilot of their process before issuing it more widely. An instance of SWP being re-routed at last minute was explained. This was costly in terms of doctors, AMHPs and the patient's wellbeing. There does also seem to be a need for further training for police officers on the execution of Section 135 warrants. The MHA office have also received several unsigned warrants which have then not be retrospectively signed. The police representative confirmed she would be working on these problems.

There is no update regarding digital signatures. It remains on the Digital Lead's agenda.

The MHA Manager reminded those present of the importance of arranging Section 3 MHA assessments in good time of the Section 2 expiring. Leaving assessments until the 28th day of the assessment section can put extra pressure on the professionals involved in the assessment and has over the last couple of quarters caused some issues regarding nearest relatives objecting to a Section 3 but services not having time to go to court to extend the Section 2. The consultant representative will reiterate this point at the MAC meeting. The stretches on services by patients being placed out of area was also briefly discussed. We need clarification of who is managing the process of keeping track of OoA patients.

7 Feedback

The Consultant AMHP for Cardiff informed the group of a recent instance where a patient was tasered by SWP and the confusion regarding the police process that needed to follow after this. The patient needed to have an ECG but it wasn't clear whether this had to be at A&E, Hafan Y Coed or could have been held in the main

UHL site. The SWP representative confirmed she would look into this and inform the group of her findings.

Advocacy Support Cymru has recently lost two IMHA's so are currently undergoing a recruitment drive. The Advocacy Manager informed the group that increasing Covid rates have impacted how often IMHA's can visit wards. One complaint was mentioned whereby a patient said they weren't helped to appeal their section. The advocacy service are having to rely on ward staff to ensure rights are being read as necessary and sections are being appealed where appropriate. He did confirm that any issues should be raised to him to look into.

The consultant representative queried whether any movement has been made as to whether the medical member for the Mental Health Review Tribunal will be examining the patient going forward, even if only remotely. At present the members are relying on the patient's case notes and reports prior to the hearing itself. An update will be chased up from the Tribunals Operational Manager.

Action- MHA Manager to chase up response from Tribunals re: examining patients prior to Tribunals.

8 Power of Discharge Group comments, compliments and feedback

Care and treatment plans are still the PoD groups biggest concern. The Chair of the PoD group would appreciate having this agenda item brought forward at the next meeting so as to allow more time for the Power of Discharge groups issues to be discussed. The Chair of the meeting agreed that the order of the next meeting should be changed so that this item is discussed nearer the start.

Action- Change the agenda to allow for PoD issues re: CTP to be discussed nearer to the start of the next meeting.

The Power of Discharge group have also started to pick up on more issues surrounding the involvement and support offered to nearest relatives to be involved with the patients care.

At a recent hearing the conditions of a patient's CTO were discussed and whether the need for physical monitoring, i.e. bloods being taken while on Clozapine, constituted a de facto extra condition placed on the patient. The chair of the PoD group would be interested to know other clinicians' opinions regarding this.

Psychology input at acute ward level was also highlighted. This is an issue across the board but as psychology input was identified as an appropriate treatment for a patient it has been mentioned by the PoD group. The Chair of the group confirmed that access to inpatient psychological services is very limited but on the agenda for any future development plans.

9 External reviews

Earlier in the year there was a HIW inspection on some of our wards. We haven't received the report yet but it is hoped this will be received by the next meeting.

10 Interface MHA/MCA/DOLS

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08th April 2022

The DoLs consultation is open until 07/07/2022. The Chair of the meeting felt that it will be useful to correlate the findings of this group. The Operational Manager for the Vale confirmed she would share the Vale's response once she has it. The MCA Manager will be investigating who is most appropriate to gain the opinions of from a Health Board perspective. Thoughts on the DoLs consultation should be collated on a new LPS Teams channel that the chair of the group will create.

Action – Chair to create an LPS Teams channel.

11 Quality indicators and audit activities

Some of the issues raised today can be discretely audited- involvement of nearest relatives, rights being read, timely MHA assessment.

Action- Chair to investigate discretely auditing rights being read, nearest relative involvement and other issues discussed at the meeting.

Any other business

None to note.

Date of future meetings

07 July 2022

06 October 2022

Saunders, Nathan
04/14/2022 13:09:00

Report Title:	Corporate Risk Register			Agenda Item no.	11.3
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	26.04.2022
		Private	<input type="checkbox"/>		
Status (please tick one only):	Assurance <input type="checkbox"/>	Approval <input type="checkbox"/>	Information <input checked="" type="checkbox"/>		
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				
Main Report					
Background and current situation:					
<p>The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ('the Policy') were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.</p> <p>Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.</p> <p>Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to Mental Health Capacity and Legislation Committee are attached at Appendix A for further scrutiny and to provide assurance to the committee that relevant risks are being appropriately recorded, managed and escalated.</p>					
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:					
<p>The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.</p> <p>This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.</p> <p>Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board.</p> <p>At the March 2022 Board meeting 1 Extreme Risk reported to the Board was linked to the Mental Health Capacity and Legislation Committee for assurance purposes. The risks reported is summarised as follows:</p>					

Risk Description Summary	Risk Score (1 to 25)
Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	20

This risk has remained on the Clinical Board risk register following a review in February 2022. Whilst it was hoped that scheduled actions would lead to the de-escalation of the risk prior to the March Board meeting a combination of operational pressures and an inability to source suitable private placements have meant that the risk continues to be recorded as an Extreme Risk.

The Risk and Regulation team will continue to work with the Mental Health Clinical Board (and other areas) to further integrate the Health Board's Risk Management policies and procedures to ensure that those entries detailed on the Register provide an accurate indication of the risks that the Health Board is dealing with operationally.

In May 2022 the Head of Risk and Regulation will meet with the Mental Health Clinical Board to review the advisory recommendations of a recent Internal Audit report to support the implementation of recommendations made, in so far as they relate to the management of risk. It is hoped that this process will assist with the ongoing development of the Mental Health Clinical Board Risk Register and the further embedding of the Health Board's Risk Management policies and procedures.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The provision of Risk Management training and support that the Head of Risk and Regulation and his team continue to deliver to Clinical Boards and Corporate Directorates.

Recommendation:

The Board / Committee are requested to:

NOTE the Corporate Risk Register risk entry linked to the Mental Health Capacity and Legislation Committee and the work which is now progressing.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x
Impact Assessment: Please state yes or no for each category. If yes please provide further details.									
Risk: Yes/No									
N/A									
Safety: Yes/No									
N/A									
Financial: Yes/No									
N/A									
Workforce: Yes/No									
N/A									
Legal: Yes/No									
N/A									
Reputational: Yes/No									
N/A									
Socio Economic: Yes/No									
N/A									
Equality and Health: Yes/No									
N/A									
Decarbonisation: Yes/No									
N/A									
Approval/Scrutiny Route:									
Committee/Group/Exec					Date:				
N/A									

Saunders,Nathan
04/14/2022 13:09:00

Report Title:	Consent to Examination or Treatment under The Mental Health Act 1983 Policy & Procedure			Agenda Item no.	12.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	26 th April 2022
		Private			
Status <i>(please tick one only):</i>	Assurance		Approval	X	Information
Lead Executive:	Interim Chief Operating Officer				
Report Author (Title):	Mental Health Act Manager – David Seward				
Main Report					
Background and current situation:					
<p>It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non-exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.</p> <p>The Consent to Examination or Treatment under the Mental Health Act 1983 Policy and Procedure sets out the requirements for provisions of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients' subject to Part 4 and 4A.</p> <p>This document provides clear guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p>					
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:					
<p>The current policy and procedure have been created to ensure statutory requirements under the Mental Health Act 1983 are met.</p> <p>This includes key issues such as:</p> <ul style="list-style-type: none"> • When a detained patient can be treated with or without their consent • What is capacity and consent • What does medical treatment include • How to authorise medication under the Mental Health Act <p>This policy and procedure will ensure that the Health Board remains compliant with their statutory duty to treat patients under the Mental Health Act.</p> <p>Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows: -</p> <ul style="list-style-type: none"> • The document was added to the Policy Consultation pages on the intranet between 8th December 2021 and 7th January 2022; • The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group; 					

- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager and the Principal Health Promotion Specialist.

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Consent to Examination or Treatment under the Mental Health Act 1983 Policy and Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Committee is requested to:

- a) **APPROVE** the Consent to Examination or Treatment under the Mental Health Act 1983 Policy and Procedure; and
- b) **APPROVE** the full publication of the Consent to Examination or Treatment under the Mental Health Act 1983 Policy and Procedure in accordance with the UHB Publication Scheme

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

Yes – detail provided in the report regarding safely treating patients detained under the Mental Health Act

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No	
Yes – detail provided in the report regarding compliance with the Mental Health Act	
Reputational: Yes/No	
No	
Socio Economic: Yes/No	
No	
Equality and Health: Yes/No	
No	
Decarbonisation: Yes/No	
No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
04/14/2022 13:09:00

Reference Number: UHB 491 Version Number: 1	Date of Next Review: 24.02.202 Previous Trust/LHB Reference Number:
<p align="center">CONSENT TO EXAMINATION OR TREATMENT UNDER THE MENTAL HEALTH ACT 1983</p>	
<p>Policy Statement</p> <p>To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when prescribing and administering medication for mental disorder under the Consent to Treatment Provisions of the Mental Health Act 1983.</p> <p>Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering authorising treatment. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p> <p>The Responsible Clinician must be fully aware of the diverse needs of the patient when considering authorising treatment and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.</p>	
<p>Policy Commitment</p> <p>To set out the requirements for Consent to Treatment provisions of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patient's subject to Part 4 and 4A.</p> <p>We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 (as amended by the MHA 2007).</p>	

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Supporting Procedures and Written Control Documents

This Policy and the Consent to Examination or Treatment Under the Mental Health Act 1983 Procedure describe the following with regard to the use of consent to treatment provisions:

- The purpose of consent to treatment, Part 4 and 4A provisions
- The process for treating a capacious or non-capacious patient.
- The duties of the practitioners and agencies involved in the management of patients' subject to consent to treatment provisions

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales)) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy applies to all of our staff in any inpatient setting where a person is detained in hospital or who is subject to a community treatment order (CTO) under the Mental Health Act.

Approved clinicians have specific powers and duties under the Act. These include the authority to treat patients with or without their consent. Therefore, they must ensure all legal criteria and statutory forms are completed.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
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Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures	Health Systems Management Board

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written to explain how this policy will be implemented	
Accountable Executive or Clinical Board Director	Chief Operating Officer
<p style="text-align: center;"><u>Disclaimer</u></p> <p style="text-align: center;">If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the <u>Governance Directorate.</u></p>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1			<i>New policy/procedure</i>

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Equality & Health Impact Assessment for

CONSENT TO EXAMINATION OR TREATMENT UNDER THE MENTAL HEALTH ACT 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Consent to Examination or Treatment under the Mental Health Act 1983 Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Acting Mental Health Act Manager 029 21824746 David.Sewar@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	<p>The aim of this policy is to improve knowledge and ensure approved clinicians and staff are aware of their individual and collective responsibilities and the legal framework in which patients can be treated for their mental disorder under the Mental Health Act.</p> <p>Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>Ensure that statutory requirements under the Mental Health Act 1983 are met.</p> <p>Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering authorising treatment. This will ensure that considerations are given as to whether the objectives can be met in a</p>

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		less restrictive way.
4.	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>Related policies/information - Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010</p> <p>Stakeholders - Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services.</p> <p>Age - 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health)</p> <p>Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016).</p> <p>Younger adults are susceptible to mental health issues, with 6.2% of</p>

¹ <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>
<http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

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	<p>16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey.</p> <p>The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p>
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		<p>Disability - Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind “Our Communities, Our Mental Health)</p> <p>Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people</p> <p>The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure.</p> <p>Gender - There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women</p>
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	<p>compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p>
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	<p>This policy will apply regardless of gender.</p> <p>Gender Reassignment - Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, “Our Communities, Our Mental Health”) This policy will apply regardless of whether patients have transitioned or not.</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People</p> <p>Human Rights - The proposed policy promotes human rights in ensuring that all patients are detained lawfully.</p> <p>Pregnancy and Maternity - Mental health problems affect between 10</p>
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	<p>and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children.</p> <p>Within the Mind report the following issues are also identified as contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, “Our Communities, Our Mental Health”)</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016</p> <p>Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%.</p> <p>According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times.</p>
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	<p>This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there will need to be consideration against appropriate medication for pregnant women. Wards will have completed risk assessments in relation to staff.</p> <p>Race/ Ethnicity or nationality – A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation ‘Mind’, the admission rate for ‘other black’ groups is six times higher than average, suggesting discrimination within the mental health system.</p> <p>Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts. Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”)</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p>
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	<p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors' misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity.</p> <p>The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p> <p>A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh.</p>
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	<p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p>Religion or Belief - Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”).</p> <p>There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health.</p>
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	<p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p>Sexual Orientation - Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”).</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBTQ+ patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p>
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	<p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p>Welsh Language - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p>Welsh Language and its use in Cardiff & Vale of Glamorgan - The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups.</p> <p>When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%.</p> <p>In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers.</p> <p>As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.</p>
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The impact of mental ill health on employment rates - A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)⁸. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).

Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For

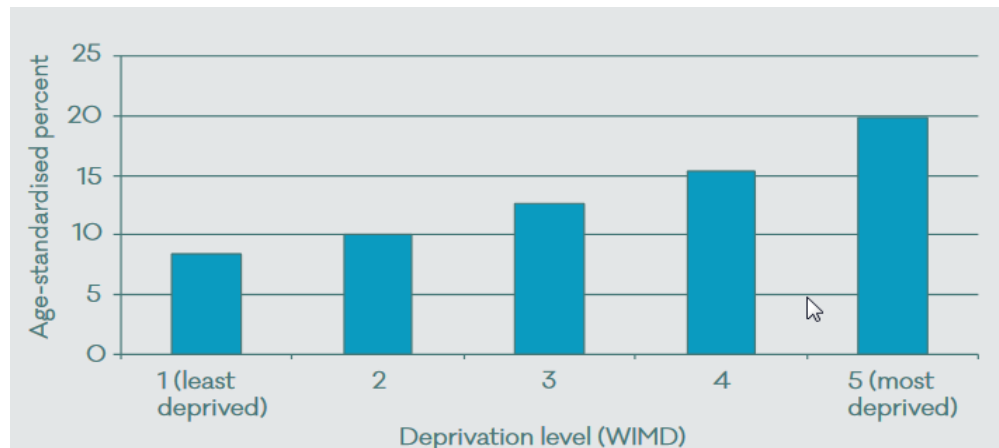
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	<p>those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).</p> <p>People according to where they live</p>
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Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with

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	<p>the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits.</p> <p>Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the <i>distribution</i> of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty.</p> <p>Both health-damaging behaviours and violence, for example, may be</p>
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	<p>survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression.</p> <p>It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).³ However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' also influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004).</p> <p>This policy will apply regardless of where a person lives.</p> <p>(From: http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf</p>
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		<p>Homeless - Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity.</p> <p>Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights.</p> <p>Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health.</p> <p>Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.</p>
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	<p>It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common</p> <p>This policy will apply regardless of where a person lives.</p> <p>Asylum Seekers - Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_asylum_seeker_health.pdf</p> <p>Prisoners - 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms</p>
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	<p>indicative of psychosis. The rate among the general public is about 4%.</p> <p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.</p> <p>49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression.</p> <p>46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide.</p> <p>http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</p> <p>Information in relation to multiple protected characteristics - Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that there are higher incidences of mental health issues among certain protected groups.</p> <p>Mind's report "Our Communities, Our Mental Health" identified the</p>
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		<p>following contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.</p> <p>These risk factors may be present in any protected group.</p>
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>The policy addresses administrative issues and responsibilities including the direct care and treatment of patients. Decisions made have an impact on the clinical pathways of patients.</p> <p>This policy applies to all of our staff in any inpatient setting where a person is detained in hospital or who is subject to a community treatment order (CTO) under the Mental Health Act. Hospital managers must ensure that approved clinicians are competent and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.</p>

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: <ul style="list-style-type: none"> • under 18; • between 18 and 65; and • over 65 	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive	A key duty is that the approved clinician must be fully aware of the diverse needs of the patient when considering authorising treatment and must take them in to account at all	Under Policy Statement

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conditions, long-term medical conditions such as diabetes	impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment	There is potential for a positive impact in that there is an awareness of this protected characteristic and	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to</i>	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	staff have to take into account the diverse needs of the individual patient.	<i>staff</i>	
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBTQ+ communities and access to health care services as noted elsewhere within the EHIA.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No impact anticipated. However, staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However, staff have to take into account the diverse needs of the individual patient.	A key duty is that the approved clinician must be fully aware of the diverse needs of the patient when considering authorising treatment and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

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		understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However, staff have to take into account the diverse needs of the individual patient.		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	.		
6.8 People who are attracted to other people of: <ul style="list-style-type: none"> the opposite sex (heterosexual); the same sex (lesbian or gay); both sexes (bisexual) 	We know from evidence that there are potential negative issues in terms of these protected characteristics. However, staff have to take into account the diverse needs of the individual patient.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of	There is the potential for a negative impact. However, staff have to take into account the diverse needs of the individual patient.	A key duty is that the approved clinician must be fully aware of the diverse needs of the patient when considering authorising treatment and must take them in to account at all	Under Policy Statement Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
vibrant culture and thriving Welsh language		times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless,	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However,	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
people who are unable to work due to ill-health	<p>staff have to take into account the diverse needs of the individual patient.</p> <p>Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.</p>		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However, staff have to take into account the diverse	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	needs of the individual patient.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	<p>Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.</p> <p>No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is</p>	A key duty is that the approved clinician must be fully aware of the diverse needs of the patient when considering authorising treatment and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	recognised that there are sometimes poorer mental health issues due to their circumstances and that their consequences for their mental health. However, staff have to take into account the diverse needs of the individual patient.	include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However, staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of	No impact identified at this	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate</p> <p>Well-being Goal – A globally responsible Wales</p>	<p>time, though it is recognised that macro-economic, environmental and sustainability factors social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.</p>		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	<p>This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect.</p> <p>A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:-</p> <p>Consent to examination or treatment policy equality impact assessment - Google search</p>
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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately if appropriate to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and when required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- <ul style="list-style-type: none"> Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> continues unchanged as there are no significant negative impacts adjusts to account for the negative impacts continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. Have your strategy, policy, plan, procedure and/or service proposal approved Publish your report of this impact assessment Monitor and review 	No significant negative Impact. The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A

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	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board	Reference Number: <i>UHB 491</i> Version Number: 1 Date of Next Review: 24.02.2025 Previous Trust/LHB Reference Number <i>N/A</i>
<p align="center">CONSENT TO EXAMINATION OR TREATMENT UNDER THE MENTAL HEALTH ACT 1983</p>		
Introduction and Aim		
This policy has been developed in line with the Mental Health Act (MHA) 1983, the Human Rights Act 1998, the MHA Regulations 2008 and the MHA Code of Practice for Wales.		
Objectives		
This policy is required to ensure that decisions made by approved clinicians and other health professionals under the Consent to Treatment Provisions (Part 4 & Part 4A) of the Mental Health Act are in line with the legal and good practice framework.		
Scope		
This policy is applicable to all employees who are prescribing and administering medication for mental disorder under The Mental Health Act 1983.		
Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.	
Documents to read alongside this Procedure	<ul style="list-style-type: none"> • Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health Act 1983, Code of Practice for Wales Revised 2016 • Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales) regulations 2008 • The Human Rights Act 1998 (and the European Convention on Human Rights) 	
Approved by	Mental Health Act Policy Group Mental Health Clinical Board Quality & Safety Committee	

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Accountable Executive or Clinical Board Director	<i>Mental Health Clinical Board</i>
Author(s)	<i>Mental Health Act Manager</i>
<p style="text-align: center;"><u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the <u>Governance Directorate</u>.</p>	

Summary of reviews/amendments			
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1. Introduction

- 1.1. Part 4 of the Mental Health Act 1983 applies to patients who are detained in law or are “liable to be detained” (i.e. those granted leave under section 17 of the Act). This also includes patients who have been recalled to hospital from Community Treatment Order’s.
- 1.2. Part 4A of the Mental Health Act 1983 sets out different rules for treatment of patients on a Community Treatment Order who has not been recalled to hospital by their responsible clinician.
- 1.3. In the Act ‘medical treatment’ includes nursing, psychological interventions and specialist mental health habilitation, rehabilitation and care.
- 1.4. The Act defines medical treatment for mental disorders as medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.
- 1.5. This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder, e.g. treating wounds self-inflicted as a result of mental disorder. The Act doesn’t authorise medical treatment for physical health problems.
- 1.6. Some treatments given to detained patients can be given without their consent: for example, treatment with medication for the first three months of detention. Other treatment, including treatment with medication after three months, requires the patient’s consent or a second opinion.
- 1.7. The requirement for consent and/or a second opinion can be summarised as follows:
 - Section 57 requires a patient’s consent and a second opinion, e.g. psychosurgery and the surgical implantation of hormones for the reduction of the male sex drive.
 - Section 58 and 58A requires the patient’s consent or a second opinion, e.g. treatment with medication beyond the three-month period and treatment for ECT (Electroconvulsive Therapy) at any time.
- 1.8. Patients who do not come within the scope of Part 4 can be treated for both mental and physical disorders under common law rules if they are mentally capable of consenting to the treatment, and under the Mental Capacity Act 2005 if they are mentally incapable of making a decision relating to the treatment in question and the treatment is in their best interests.

2. Procedure Statement

- 2.1. The procedure relates to Part 4 and 4A (Consent to Treatment Provisions) associated with the Mental Health Act 1983. The purpose of this procedure is to clarify what treatment can be imposed on patients who are liable to be detained under the Act, which includes patients subject to a Community Treatment Order. The Code identifies standards of practice that should be met

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when carrying out responsibilities under the Act. The Code is not legally enforceable but it is a statutory document and failure to follow it could be referred to in legal proceedings.

3. Scope

3.1. The aim of this procedure is to improve knowledge and ensure that staff are aware of their responsibilities and the legal framework in which patients can be treated for their mental disorder under the Act.

3.2. This document sets out to:

- Ensure staff are aware of their responsibilities and requirements as per the Code.
- Ensure staff protect patient's rights.
- Ensure staff protect themselves and the UHB from legal liability.

3.3. In order to achieve this, the following must be established:

- Effective communication processes must be provided to ensure compliance and adherence to this procedure.
- Ensure arrangements are in place for enforcing and monitoring the use of the procedure.
- Provide adequate training and support to staff delegated to undertake the task.

3.4. Approved clinicians have specific powers and duties under the Act. These include the authority to treat patients with or without their consent. Therefore, they must ensure all legal criteria and statutory forms are completed.

3.5. The MHA 1983 includes patient safeguards which must be met for the protection of the patient and for the protection of the UHB and delegated staff who are responsible for ensuring compliance with the Act.

4. Patients to whom Part 4 does not apply

4.1. Part 4 applies to all forms of medical treatment for mental disorder. Patients who are not subject to these provisions are those patients detained under sections 4, 5(2) or 5(4), 35, 135, 136, or by virtue of a direction for their detention in a place of safety under section 37(4) or 45A(5), and also includes restricted patients conditionally discharged under section 42(2) or section 73 and 74. In addition to these groups, Part 4 does not apply to patients on guardianship.

4.2. These patients can only be treated if they have capacity and are consenting or in accordance with the Mental Capacity Act (MCA) 2005 if they lack capacity to make decisions in relation to their medical treatment.

5. Approved clinician in charge of treatment

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- 5.1. Part 4 & 4A of the Act refers to the “approved clinician or person in charge of the treatment”, where the treatment in question is a form of treatment to which section 58 or 58A applies. In the majority of cases the approved clinician will be the patient’s responsible clinician, but where, for example, the RC is not qualified to make decisions about a particular treatment (if the RC is not a doctor or a nurse prescriber) then another appropriately qualified professional will be in charge of that treatment, with the RC continuing to retain overall responsibility for the patient’s case.

6. What is capacity and consent?

- 6.1. The Act frequently requires healthcare professionals to determine whether a patient has the capacity to consent to a particular form of medical treatment, and if so, whether the patient does in fact consent.
- Capacity – Capacity to consent is variable in people with mental disorder. A person lacks capacity in relation to a matter if, at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. The impairment or disturbance does not have to be permanent. A person may also lack capacity to make a decision about one issue but not about others.
 - Consent - Consent is the voluntary and continuing permission of the patient to receive a particular treatment, and is based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not ‘consent’.

7. Medication – the ‘3 month rule’

- 7.1. Under the Act treatment for mental disorder can be given to detained patients, either with or without their consent. This period lasts for the first three months minus a day and starts from the first day on which any form of medication for mental disorder was first administered whilst the patient was detained under the Act. This only applies to sections to which Part 4 provisions apply. This is often referred to as the “3 month rule”.
- 7.2. In CAV we calculate the ‘3 month rule’ date from the beginning of the first section the patient has been detained under which Part 4 provisions apply, e.g.

Patient admitted informally on 01/05/2021
 Patient detained under section 5(2) on 10/05/2021
 Patient detained under section 2 on 11/05/2021
 Patient detained under section 3 on 03/06/2021

The ‘3 month rule’ start date for the above example would be 11/05/2021, when the patient is detained under section 2 as a patient isn’t detained if they are informal and section 5(2) doesn’t come under Part 4 provisions. The end of the ‘3 month rule’ would be 10/08/2021. After this time, we would need a certificate as listed below.

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7.3. There can only be one three-month period for such treatment in any continuous period of detention, including when one period of detention is immediately followed by another. A fresh period will only begin if there is a break in the patient's detention without becoming a Community Treatment Order patient, or in the case of a restricted patient, if they had been conditionally discharged.

7.4. After the "3 month rule", further treatment will need the patient's consent and authorisation by or under the direction of the approved clinician in charge of the patient's treatment, or in the absence of the patient's consent or capacity under the authorisation of a second opinion appointed doctor (SOAD).

7.5. The certificate requirement does not apply to a patient any time during the first 1 month, beginning on the day on which a Community Treatment Order was made, for any section 58 & 58A treatment.

8. **Section 58 – Medication for mental disorder requiring consent or a second opinion**

8.1. Section 58 is concerned with the administration of medication to detained patients beyond the period of three months.

8.2. Before the three-month period ends, approved clinicians will have received automated daily PARIS reports informing them of the upcoming '3 month rule' end date for their patients. The Mental Health Act Office will also inform approved clinicians of this date. It is then the approved clinician's responsibility to ensure all the relevant forms listed in 22.3 below are received in good time of this end date.

8.3. The approved clinician should personally confirm the patient's capacity and seek the patient's consent to the administration of medication. The approved clinician must either complete a [Record of Capacity to Consent form](#) if the patient has capacity and consents or refuses to consent. If the patient lacks capacity, then a [Mental Capacity Assessment](#) needs to be completed on PARIS under clinical information. In both cases a [Consent to Treatment memo](#) will be required.

8.4. Treatment to which section 58 applies cannot be given unless:

- The approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and properly does so by completing form [CO2](#); or
- A SOAD certifies that the treatment is appropriate, and either that the patient does not have the capacity to consent or the patient has the capacity to consent but has refused to do so by completing form CO3.

8.5. On the issued certificates the approved clinician and SOAD should indicate all mental health drugs proposed, including medication given "as required" and those prescribed for side effects. The drugs must be recorded by name or by classes of drug as described in the British National Formulary (BNF or eBNF). If drugs are specified by class, the certificate should state clearly the number

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of drugs authorised in each class, and whether any drugs within the class are excluded. The BNF maximum dosage and the route of administration should be clearly indicated for each drug or category of drug proposed. This can exceed the dosages listed in the BNF but this will need to be clearly stated on the certificate, e.g. 200% max dosage and a case note provided.

8.6. A Section 58 certificate ceases to apply to a treatment if:

- The patient withdraws consent, or loses the capacity to consent to it;
- There is a change in the drug or dose that isn't covered by the existing certificate.
- There is a permanent change of the approved clinician in charge of the treatment;
- The patient is no longer detained under the Mental Health Act;

In the first two categories only, the approved clinician will need to complete a new form [CO2](#) or an [Electronic SOAD Request form](#) depending on the patient's capacity/consent status along with the documentation stated in 22.3 and 22.4 below. An [Urgent Treatment form - section 62/62A](#) may also be appropriate.

In the third category the approved clinician can complete a [Review of Treatment \(Section 61\) form](#) or a new [CO2](#) as stated in 11.4 and 11.5 below.

Once a certificate ceases to apply, the Mental Health Act Office will mark it 'treatment no longer authorised' on the original certificate and PARIS. Ward staff are to ensure all certificates marked 'treatment no longer authorised' are removed from the patient's medication file.

8.7 A CO2 and CO3 can run concurrently if the approved clinician has assessed the patient and confirmed their capacity/consent status. In these instances the approved clinician will need to provide detailed case notes.

9. Section 58A – Electro-Convulsive Therapy (ECT)

9.1. Section 58A applies to ECT and to medication administered as part of ECT. Treatment given under this section may only be given to the patient if:

- The approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and properly does so by completing form [CO4](#); or
- A SOAD has certified that the patient does not have the capacity to consent and that it is appropriate for the treatment to be given by completing form CO6.

9.2. This section applies to adult detained patients, apart from those who are subject to Community Treatment Orders and to all patients under the age of 18 (whether or not they are detained). The key differences from section 58 are that:

- Patients who have the capacity to consent to treatment may not be given treatment under section 58A unless they consent.
- No patient aged under 18 can be given treatment under section 58A unless a SOAD has certified that the treatment is appropriate.

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- There is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT).

- 9.3. A patient who lacks capacity to consent may only be given treatment for ECT if it is certified by a SOAD that the patient is “not capable of understanding the nature, purpose and likely effects of the treatment” and that it is appropriate for the treatment to be given.
- 9.4. If the patient’s capacity changes after receiving ECT treatment, the approved clinician will be required to complete the relevant form along with local documents stated in 9.5 below. A [CO4](#)/CO6 cannot run concurrently for ECT.
- 9.5. In all cases form [CO4](#)/CO6 certificate must clearly indicate the maximum number of ECT treatments it approves, which is 12 and any medication that may be given relating to the administration of ECT. Each certificate must also state whether the treatment is unilateral or bilateral.
- 9.6. The approved clinician must complete a [Record of Capacity to Consent form](#) if the patient has capacity and consents. If the patient lacks capacity, then a [Mental Capacity Assessment](#) needs to be completed on PARIS under clinical information. In both cases a [Consent to Treatment memo](#) will be required.

10. Section 60 - Withdrawal of consent

- 10.1. Section 60 provides for a patient to withdraw their consent to treatment or to a plan of treatment. The withdrawal of consent can be made in writing, verbally or through the patient’s behaviour, e.g. physically resisting the administration of the treatment. On the withdrawal of consent, the remainder of the treatment must be considered as a separate treatment.
- 10.2. If a mentally capable patient who has consented to a section 58 or 58A treatment loses their capacity to consent, the patient is to be treated as having withdrawn their consent to the treatment.
- 10.3. If a section 58 or 58A treatment is being given to a mentally incapable patient but, before the treatment has been completed, the patient becomes mentally capable of consenting to the treatment, the remainder of the treatment is to be treated as a separate form of treatment for the purposes of certification under those sections. Fresh consent for the further administration of treatment will then be required.
- 10.4. The patient’s withdrawal of consent and explanation given to the patient in light of that withdrawal of consent must be clearly documented in the patient’s health record.

11. Section 61 – Review of treatment

- 11.1. The Act does not give any specific timeframes of when certificates are to be reviewed. This section provides for the regular review by Healthcare Inspectorate Wales of treatment which is being given under Part 4 & 4A of the Act.

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- 11.2. In CAV best practice is for approved clinicians to review all patients' treatment at yearly intervals for patients detained in hospital and those subject to a Community Treatment Order.
- 11.3. Approved clinicians will receive automated daily PARIS reports informing them when reviews are due for their patients. The Mental Health Act Office will also inform approved clinicians when a review is due.
- 11.4. If the patient has a SOAD certificate (CO3/CO7) in place and the treatment authorised is still appropriate, a new SOAD request will not be needed and treatment can continue using the original SOAD certificate (CO3/CO7) as long as the approved clinician completes a [Review of Treatment \(Section 61\) form](#) along with either a [Record of Capacity to Consent form](#) if the patient refuses to consent or a [Mental Capacity Assessment](#) on PARIS under clinical information if the patient lacks capacity. In both cases a [Consent to Treatment memo](#) will be required.
- 11.5. If the patient has a [CO2/CO8](#) in place, the approved clinician must complete a new certificate authorising treatment if the patient still has capacity and is consenting along with a [Record of Capacity to Consent form](#) and a [Consent to Treatment memo](#).

12. Section 62/62A & 64G – Inpatient and community urgent Treatment

- 12.1. This section provides the authorisation for treatment to be given to a patient detained in hospital (and those who have been recalled to hospital) under section 62/62A and those subject to a Community Treatment under section 64G in response to an immediate emergency. Section 58 & 58A above to not apply if the treatment in question is:
 - Immediately necessary to save the patient's life;
 - A treatment which is not irreversible, but which is immediately necessary to prevent a serious deterioration of the patient's condition;
 - A treatment which is not irreversible or hazardous, but which is immediately necessary to alleviate serious suffering by the patient; or
 - A treatment which is not irreversible or hazardous, but which is immediately necessary to prevent the patient from behaving violently or being a danger to himself or to others, and represents the minimum interference necessary to do so.

If the treatment is for ECT ((s58A) or medication administered as part of ECT), only the first two categories above apply. Only one session of ECT can be authorised on each [Urgent Treatment form - section 62/62A](#), therefore a new form will be required for each continuing session of ECT.

- 12.2. Section 62 can be used to administer medication if the patient is refusing to consent or lacks the capacity to consent. Section 62A can be used to administer ECT only if the patient lacks capacity. Section 64G can be used to administer medication only if the patient lacks capacity, there are no exceptions to this rule even in an emergency, i.e. if the patient is refusing.

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- 12.3. These are strict tests. Urgent treatment under these sections can only continue for as long as it remains immediately necessary. When it is no longer immediately necessary, the requirements of section 58 and 58A apply.
- 12.4. The use of section 62/62A & 64G is monitored by the Mental Health Act Office on behalf of the Hospital Managers to ensure they are not being used inappropriately or excessively.
- 12.5. Approved clinicians should record the use of this section on [Urgent Treatment form - section 62/62A](#) for detained patients (and those who have been recalled to hospital) and on [Urgent Treatment form - section 64G](#) for community patients (not recalled to hospital) including a case note on PARIS. When completing the urgent treatment forms, all mental health medication is to be listed along with route and dose as indicated in 8.5 above. This must be sent to the Mental Health Act Office as soon as possible in order to process.

13. Section 63 – Treatment not requiring consent

- 13.1. This section allows the consent of a patient to not be required for any medical treatment given to him for his mental disorder within the first 3 months of detention, referred to as the '3 month rule' for which section 58 and 58A above do not apply.
- 13.2. Medical treatment for the mental disorder is a range of acts ancillary to the core treatment that the patient is receiving. The treatment of a physical issue is capable of being ancillary to the core treatment if it is relieving the symptoms of the mental disorder just as much as its underlying cause. Treatment for a physical disorder will not amount to a treatment for a mental disorder where the treatment for the physical disorder is entirely unconnected with the pre-existing mental disorder.
- 13.3. There is no statutory form to complete when administering treatment under this section but approved clinicians must make detailed case notes on PARIS and inform the Mental Health Act office.

14. Section 64B/64C – Adult community patients

- 14.1. This section provides authority to treat a patient who is subject to a community treatment order, who is over the age of 16 if:
 - The approved clinician in charge of the treatment certifies that the patient has the capacity to consent and properly does so by completing form [CO8](#); or
 - A SOAD certifies that the patient does not have the capacity to consent and that the treatment is appropriate by completing form CO7.

The patient may not be given the treatment unless they consent or lack capacity. There are no exceptions to this rule even in an emergency.

- 14.2. If a community patient is recalled to hospital, they are subject to sections 58/58A in the same way as any other detained inpatient. The approved clinician may continue to treat the patient using the SOAD certificate (CO7) if they

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consider that discontinuing the treatment would cause the patient serious suffering or if the appropriate treatment is already explicitly authorised upon recall on the SOAD certificate (CO7). A new certificate will only be required if the approved clinician wants to administer new medication which isn't already authorised on the CO7 or whereby a patients [CO8](#) certificate becomes no longer authorised due to the patient no longer consenting to their treatment. In this case a [Urgent Treatment form - section 62/62A](#) will be needed.

- 14.3. A revoked community patient may continue to be treated using the SOAD certificate (CO7) if the approved clinician considers that discontinuing the treatment would cause the patient serious suffering. This only remains valid while the approved clinician is seeking to obtain a new SOAD certificate. A new certificate will only be required if the approved clinician wants to administer new medication which isn't already authorised on the CO7, in this case a [Urgent Treatment form - section 62/62A](#) will be needed. If the patient has capacity and consents to the medication a [CO2](#) will need to be completed as soon as practicable as the CO8 will no longer authorise treatment once revoked.

15. Second opinion appointed doctor (SOAD)

- 15.1. The role of the SOAD under Part 4 and 4A of the Act is to provide an additional safeguard to protect patients' rights. The SOAD will act as an individual and reach their own professional judgement on whether the proposed treatment is appropriate for the condition and patient.
- 15.2. The fact that a SOAD has authorised a particular treatment does not mean that it will be appropriate to administer that treatment. The approved clinician will remain responsible for deciding whether to administer that treatment.

16. Requesting a SOAD visit

- 16.1. The approved clinician will be notified of the upcoming '3 month rule' end date at 3 weeks and the due date by the Mental Health Act Office. They will also have had the automated daily PARIS reports informing them of the upcoming end date.
- 16.2. At this point they should assess the patient and if it is determined that a SOAD visit is needed to authorise treatment, they should complete the relevant document in 16.3 below. This should be done in good time before the end of the '3 month rule' to avoid issuing a certificate under section 62. The use of section 62 is monitored by the Mental Health Act Office on behalf of the Hospital Managers and Healthcare Inspectorate Wales to ensure that it is used appropriately and only in an urgent situation when absolutely necessary.
- 16.3. To request a SOAD visit the approved clinician will complete an [Electronic SOAD Request Form](#) stating the diagnosis and summary of history of the patient along with the proposed treatment and names of at least 3 statutory consultees that could be contacted. Best practice is for the approved clinician to inform the consultees they have been named and will potentially receive a call from a SOAD in order for them to be prepared. It is the responsibility of the

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approved clinician to send this along with copies of the patients' medication chart to the Mental Health Act Office to process.

17. Visit of the SOAD

- 17.1. Before the SOAD will issue a certificate, they will check the relevant documents and information relating to the patient. They will need to satisfy themselves that the patient's detention and Community Treatment Order papers are in order, check the patient's case notes and medication chart and they will interview the patient along with the approved clinician to ensure the proposed treatment plan is appropriate for that patient. The Mental Health Act Office will provide the case notes and current detention papers to HIW.

18. Statutory consultees

- 18.1. Before issuing a certificate approving treatment, SOAD's must consult with 2 persons (statutory consultees) who have been professionally concerned with the patient's treatment. Where section 58 or 58A applies, one of the consultees must be a nurse, the other must not be a nurse or a medical doctor. When considering issuing a Part 4A certificate, at least one of the statutory consultees must not be a medical doctor, and doesn't need to be a nurse. Neither consultees for a Part 4 and 4A certificate may be the clinician in charge of treatment or the responsible clinician.

- 18.2. The Act doesn't specify who should be named as a statutory consultee but the patients care coordinator, if they have one, may be well placed to act as a consultee or a mental health pharmacist who has been involved in a recent review of the treatment. Other consultees could include a social worker, occupational therapist, psychologist or others that are professionally registered and involved in the patients care. If a consultee doesn't feel they are able to fulfil the role, they should make this known to the approved clinician and the SOAD in good time.

- 18.3. Consultees should expect the following to be discussed with the SOAD:

- The proposed treatment and the patient's ability to consent to it;
- The statutory consultees' understanding of the past and present views and wishes of the patient;
- Other treatment options and the way in which the decision on the treatment proposal was arrived at;
- The facts of the case, the patient's progress, the views of the patient's carers;
- Where relevant, the implications of imposing treatment on a patient who does not want it and the reasons for the patient's refusal of treatment;
- Any other matter relating to the patient's care on which the "consultee" wishes to comment.

- 18.4. The Mental Health Act Office will send the named statutory consultees a [Record of Discussion form](#) that must be completed and returned as soon as

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practicable after the discussion to keep in the patients records, this is a requirement of Healthcare Inspectorate Wales.

19. The SOAD's decision

- 19.1. The SOAD must decide whether it is clinically appropriate to the patient's mental disorder for treatment to be given and its appropriateness in light of other circumstances, e.g. alternative forms of treatment, therapeutic efficacy, side effects and the patients view on the proposed treatment.
- 19.2. Once the SOAD has decided to issue the certificate they will complete the appropriate form and must provide written reasons in support of their decision, either on the form itself or separately.
- 19.3. The approved clinician is personally responsible for communicating the decision of the SOAD to the patient, unless they deem it not appropriate. In these instances they will need to record the reasons on a [Consent to Treatment memo](#). Before the memo can be completed, a [Mental Capacity Assessment](#) must be completed on PARIS under clinical information.

20. Administration of medication

- 20.1. A certificate issued by an approved clinician or by a SOAD is not an instruction to administer treatment. Those administering the treatment must still satisfy themselves that the treatment is appropriate for that particular patient.
- 20.2. It is the responsibility of the nurse administering the prescribed medication to ensure that all necessary legal requirements have been met.
- 20.3. Following the three-month period the legal authority is embodied in forms [CO2](#)/CO3, together with the medication chart. A copy of form [CO2](#)/CO3 must always be kept with the medication chart and referred to at the time that any mental health medication is administered. Only medication certified on form [CO2](#)/CO3 is authorised to be administered unless the treatment comes under the scope of section 62 above.
- 20.4. Before administering medication, the nurse should:
 - Check the medication chart for date of entry of prescription for the medication, its dose and route of administration;
 - Ensure that the three-month period has not been exceeded by;
 - Ensure that, where a patient has consented to medication beyond the three-month period, the form [CO2](#) is in place and correctly completed;
 - Ensure that, where a second opinion has been obtained, the form CO3 is in place and correctly completed;
 - Ensure the patients capacity and consent status hasn't changed.
- 20.5. If at any time the approved clinician amends the drug, route or dose on a patients medication chart, and it is not within the scope of the already authorised treatment, a new form [CO2](#)/CO3 must be completed in line with

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the legal requirements. If the approved clinician is waiting for a SOAD authorisation and they feel the treatment is immediately necessary, an [Urgent Treatment form - section 62/2A](#) can be completed if appropriate.

- 20.6. Part 4 does not apply to the treatment of physical disorders unless it can reasonably be said that the physical disorder is a symptom or underlying cause of the mental disorder (See section 63 above).
- 20.7. Any concerns regarding the legality of administering the treatment must be brought to the attention of the approved clinician in charge of the treatment and the Mental Health Act Manager/Administrators.

21. Covert Medication

- 21.1. Covert medication is the administration of medication in disguised form without the patient's knowledge or consent. This would usually involve disguising the medication in food or drink. Due to this, the patient is unknowingly taking the medication.
- 21.2. Medication given covertly can only be given to detained patients within the first 3 months of detention (3 month rule) or if authorised by a SOAD when either the patient does not have the capacity to consent or the patient has the capacity to consent but has refused to do so. The approved clinician should discuss with the SOAD the possibility of including covert medication on form CO3.
- 21.3. Before administering medication covertly, the approved clinician should consider:
 - Why it is not practicable to seek the patients consent
 - Whether, for the purposes of art.8 (2) of the ECHR, the giving of covert medication is a proportionate response to the aim of improving the patient's health or reducing the risk posed by the patient.
 - If administering covertly would it be less invasive of the patient's physical integrity.
- 21.4. Once the approved clinician has considered the above issues, it should be recorded in detail in the patient's case notes. Please see the [covert medication guidance](#) for more information.

22. Documentation

- 22.1. The correct statutory documentation must be completed in all instances when administering medication under the Act, not including medication that comes under the scope of section 63 (above) where medication can be given with or without consent for the first 3 months (3 month rule) and where the treatment of a physical issue is capable of being ancillary to the core treatment.
- 22.2. The Mental Health Act office has copies of the relevant documentation needed. The approved clinician will be prompted by the automated daily PARIS reports and the Mental Health Act Office to complete these forms. Once completed, the forms will be e-mailed to the ward or CMHT for them to

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be printed and must be kept with the patients' medication chart. Original completed documentation must always be sent to the Mental Health Act Office to check it meets the legal requirements of the Act, where it will be kept in the patients file and uploaded to PARIS.

- 22.3. In order to comply with the Code of Practice and the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 the following documentation will need to be completed:

Medication

Part 4 – detained patients			Part 4A – community patients	
Patient has the capacity and consents	Patient has capacity but refuses	Patient lacks the capacity to consent	Patient has the capacity and consents	Patient lacks the capacity to consent
CO2 – Approved clinician	CO3 – SOAD	CO3 – SOAD	CO8 – Approved clinician	CO7 - SOAD

ECT

Part 4 – detained patients	
Patient has the capacity and consents	Patient lacks the capacity to consent
CO4 – Approved clinician	CO6 - SOAD

- 22.4. In addition to the statutory forms listed above, CAV have created some local forms for both Part 4 and 4A patients:

- For a patient that has capacity to consent and properly does so or a patient that has the capacity to consent but has refused to do so, a [Record of Capacity to Consent form](#) will be completed.
- For a patient that does not have the capacity to consent a [Mental Capacity Assessment](#) will need to be completed via clinical information on PARIS.
- For all capacity/consent statuses a [Consent to Treatment memo](#) will need to be completed.

The local forms in 22.4 above will need to be completed every time a new certificate is issued by an Approved clinician or SOAD.

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23. Audit

- 23.1. The Mental Health Act Manager, Deputy Mental Health Act Manager and Mental Health Act Team Lead will monitor the progress of the implementation of the policy.
- 23.2. The Mental Health Act Office will undertake periodic audits of all Consent to Treatment certificates on wards and in CMHT's to ensure they are compliant with the Mental Health (Wales) Regulations 2008 and the Mental Health Act.
- 23.3. The UHB, Mental Health Legislation and Governance Group and Mental Health and Capacity Legislation Committee will conduct and formally review the effectiveness of the Consent to examination or treatment under the Mental Health Act 1983 policy.
- 23.4. The following indicators will be used to monitor the effectiveness of the policy:
 - Delegated staff, awareness of the policy
 - Compliance with the policy
 - Monitoring of statutory forms received by delegated members of staff
- 23.5. Audit findings will be reported quarterly to the Mental Health and Capacity Legislation Committee.

24. References/Further Information

- Mental Health Act 1983, ISBN 0-10-542083-2
- Mental Health Act 2007, ISBN 978-0-10-541207-6
- Mental Health Act Manual, Richard Jones, Twenty-First Edition, ISBN 978-0-414-06789-9
- Mental Health Act 1983, Code of Practice for Wales, Revised 2016
- The Mental Health Regulations 2008
- The Human Rights Act 2005

25. Distribution

- 25.1. This policy will be made available on the UHB intranet and internet sites and be circulated to individual delegated officers and managers of delegated officers.
- 25.2. All employees within Cardiff and Vale UHB should be aware of this policy to ensure those who are prescribing and administering medication for mental disorder under The Mental Health Act 1983 are in line with the legal and good practice framework.

26. Review

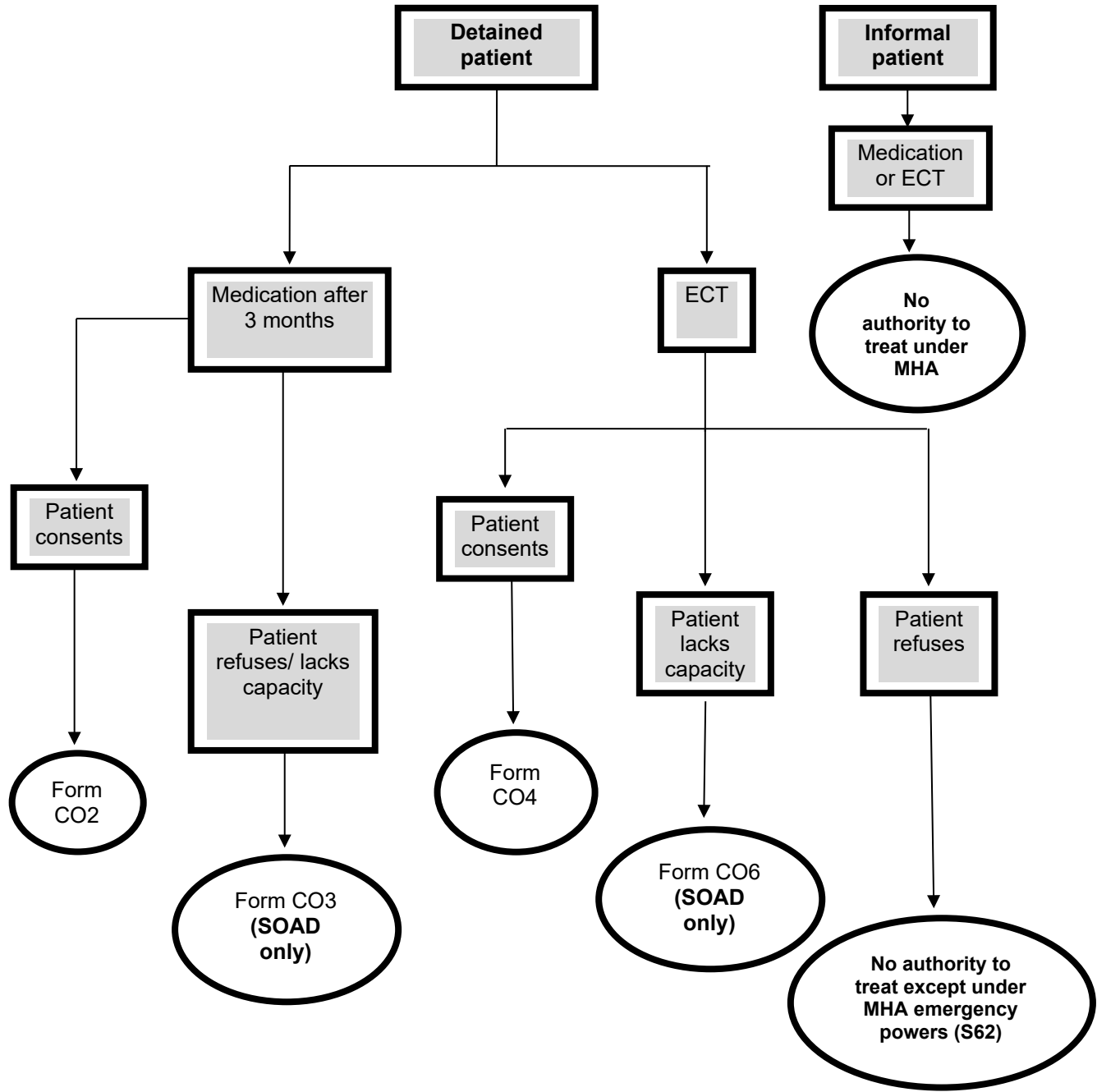
- 26.1. This policy will be reviewed in 3 years' time, or earlier if required by changes to terms and conditions of legislation.

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Appendix 1

Certification of Treatment Flowchart - Inpatients



KEY:

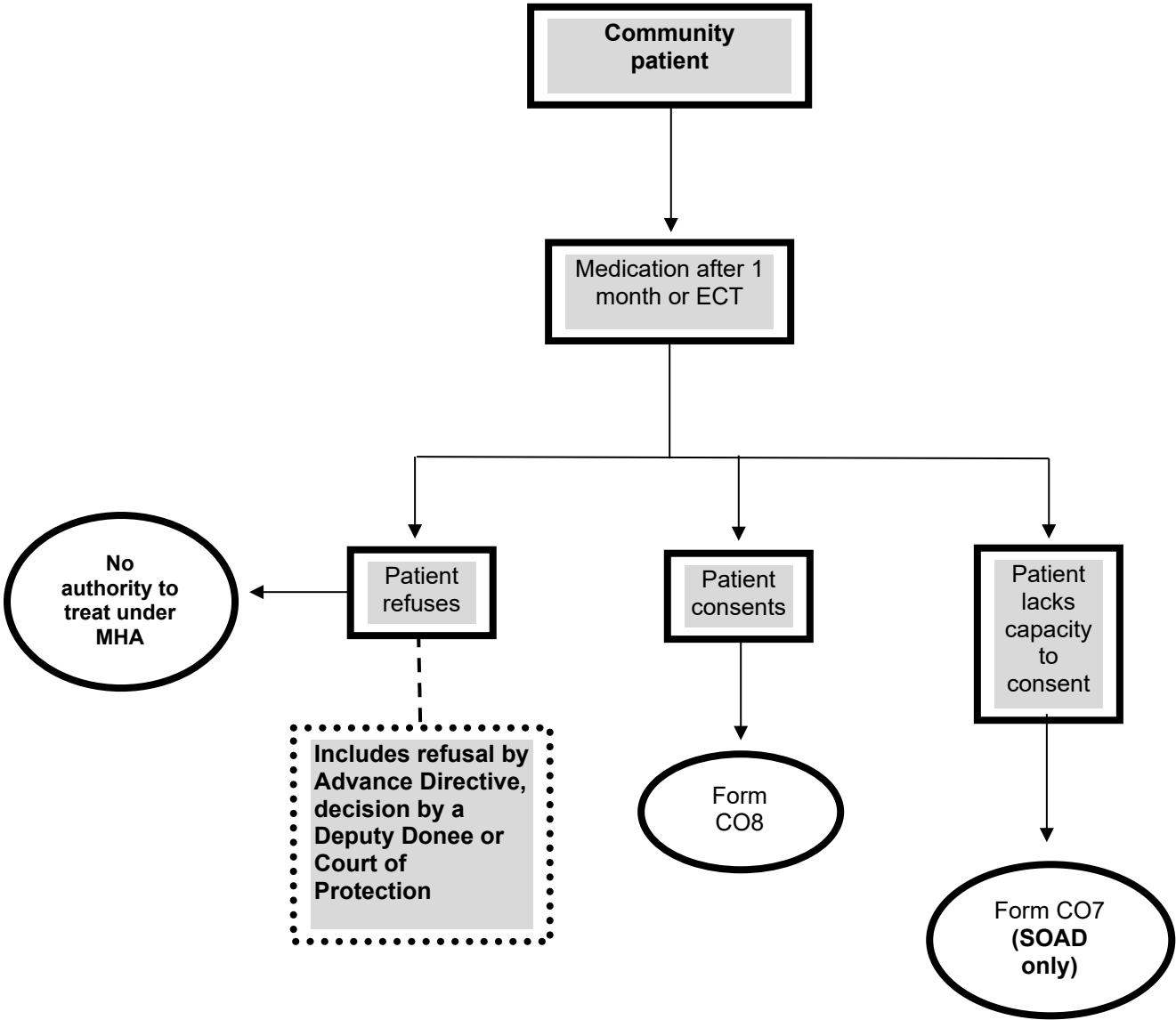
- s62 Urgent treatment
- CO2 Certificate of consent to treatment
- CO3 Certificate of second opinion
- CO4 Certificate of consent to treatment (patients at least 18 years of age)
- CO6 Certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of treatment)

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Appendix 2

Certification of Treatment Flowchart – Community



KEY:

- s64 Urgent treatment
- CO7 Certificate of appropriateness of treatment to be given to a community patient (Part 4A certificate)
- CO8 Certificate of consent to treatment for community patient (Approved clinician Part 4A certificate)

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Appendix 3

Administration of medicine for mental disorder guidance

(The guidance issued by the Care Quality Commission in England is acknowledged by Healthcare Inspectorate Wales as a measure of good practice for the administration of medication where patients detained under certain sections of the MHA 1983 are subject to Part 4 Consent to Treatment provisions under the Act.)

LEGISLATION and LEGAL DOCUMENTATION	PROCEDURAL GUIDANCE
<p>The three month rule For a period of three months from when it was first administered, medication for mental disorder may be administered in the absence of consent without the need for certification, under the direction of the approved clinician in charge of the treatment and the patient is detained under a section to which Part 4 applies: ss. 2, 3, 36, 37, 38, 47 and 48 (with or without restrictions).</p> <p>Treatment following the first three months Once the three-month period has expired:</p> <ul style="list-style-type: none"> Medication for mental disorder may be administered to a patient who has given capable consent which is recorded on statutory form CO2 either by the approved clinician in charge of the patient's treatment or a SOAD. Medication for mental disorder may be administered to a patient who is either not capable of consenting or is refusing medication as long as the giving of the medication is authorised by a SOAD and recorded on statutory form CO3. Regularly administered "as required" (PRN) medication should be included on the form CO2 or CO3. If it is not included it may only be given under s.62 urgent provisions. <p>Legal documentation</p> <ul style="list-style-type: none"> Forms CO2 and CO3 represent the legal authority to continue administering medication to patients who are subject to consent to treatment provisions under s. 58 (<i>treatment requiring consent or a second opinion</i>). It is unlawful to administer medication for mental disorder to patients detained under sections: 2, 3, 36, 37, 38, 47 and 48 (with or without restrictions) unless it is covered by a form CO2 or CO3. A copy of the current CO2 and/or CO3 must be kept with the medicine card and a second copy must be retained in the patient's record. Non-current copies of CO2/CO3 forms must not be removed from the patient record. However they must be clearly marked "VOIDED" and dated as such. The current version must always be filed securely uppermost. 	<p>Each time, before administering medication for mental disorder the nurse must:</p> <ul style="list-style-type: none"> Check the medicine card for date of entry of a prescription for the medicine, for its dose and for the route of administration. Check the date of the first administration to ensure that the three month period has not been exceeded. Where a patient has consented to medication beyond the three month period, ensure that a Form CO2 is in place and correctly completed, and that the patient still consents. Where a form CO2 is in place, check that the medication prescribed on the medicine card has been authorised by the approved clinician in charge of the patient's treatment or the SOAD Where a second opinion has been obtained, ensure that the form CO3 is in place and is correctly completed, and if the patient is certified as incapable of giving consent, that the patient remains incapacitated. Where a form CO3 is in place, check that the medication prescribed on the medicine card has been authorised by the SOAD. <p>N.B. Forms CO2 and CO3 can run concurrently where a mentally capable patient consents to some of the treatment but not to all of the treatment.</p> <p>Where a Form CO2 or CO3 has not been completed even though required, the administration of medication for mental disorder may constitute an assault. The only exception is in the case of urgent treatment where s.62, MHA 1983 may apply.</p>

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 Saunders, Nathan

Report Title:	Hospital Managers' Scheme of Delegation Policy & Procedure			Agenda Item no.	12.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	26 th April 2022
		Private			
Status (please tick one only):	Assurance	<input type="checkbox"/>	Approval	X	Information
Lead Executive:	Interim Chief Operating Officer				
Report Author (Title):	Mental Health Act Manager – David Seward				

Main Report

Background and current situation:

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non-exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Scheme of Delegation Policy sets out the requirements for provision of the scheme of delegation to the practitioners and agencies involved in the management of patient's subject to detention/liability to detention under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

This document provides clear guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act (MHA)1983 as amended by the MHA 2007.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The current policy and procedure have been updated to ensure statutory requirements under The Mental Health Act 1983 are met.

This includes:

- Removal of glossary of terms
- Updated sections for clarity
- Removal of any qualified nurse able to accept nearest relative discharge request

This policy and procedure will ensure that the Health Board, defined as the Hospital Manager's, remains compliant with all of their statutory functions under the Mental Health Act.

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows: -

- The document was added to the Policy Consultation pages on the intranet between 21st January 2022 and 18th February 2022;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;

- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager and the Principal Health Promotion Specialist.

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Hospital Managers' Scheme of Delegation Policy and Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Committee is requested to:

- a) **APPROVE** the Hospital Managers' Scheme of Delegation Policy and Procedure; and
- b) **APPROVE** the full publication of the Hospital Managers' Scheme of Delegation Policy and Procedure in accordance with the UHB Publication Scheme

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

No

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – detail provided in the report regarding compliance with the Mental Health Act

Reputational: Yes/No	
No	
Socio Economic: Yes/No	
No	
Equality and Health: Yes/No	
No	
Decarbonisation: Yes/No	
No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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04/14/2022 13:09:00

Reference Number: UHB 409 Version Number: 2	Date of Next Review: 24/02/2025 Previous Trust/LHB Reference Number: N/A
<p align="center">Hospital Managers' Scheme of Delegation Policy Mental Health Act, 1983</p>	
<p>Policy Statement</p> <p>The Health Board is responsible for ensuring that the Mental Health Act is used lawfully and fairly, in accordance with the principles of the Mental Health Act Code of Practice for Wales, including ensuring all paperwork is scrutinised for validity, that detained patients are informed of their rights, and that patients are referred to the Tribunal within the timeframes set out in the Mental Health Act. The Health Board also have various powers, to discharge patients from detention, transfer detained patients to other hospitals in accordance with regulations, as well as withholding a patient's outgoing correspondence where the law permits.</p> <p>To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their delegated functions under the Mental Health Act.</p> <p>The arrangements for authorising people to exercise delegated functions are set out in a scheme of delegation.</p> <p>People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, or belief, sex and sexual orientation and culture, or any combination of these. There must be no unlawful discrimination and reasonable adjustments must be made. Individuals' protected characteristics should be taken into account and good practice followed in all aspects of care and treatment planning and implementation.</p>	
<p>Policy Commitment</p> <p>We will set out the requirements for provision of the Scheme of Delegation to the practitioners and agencies involved in the management of patients' subject to detention/liability to detention under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).</p> <p>We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p>	

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Supporting Procedures and Written Control Documents

This Policy and the Hospital Managers' Scheme of Delegation Procedure describe the following with regard to:

- the purpose of a scheme of delegation
- informing the organisation of the arrangements for authorising people to exercise delegated functions as set out in the Scheme of Delegation
- ensuring that all staff authorised for the receipt and scrutiny of Mental Health Act documentation are aware of their responsibilities and requirements both individually and collectively in relation to the delegated duties of Hospital Managers

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to all people authorised to exercise delegated functions to be carried out day to day required by the Mental Health Act, 1983 (MHA) on behalf of Cardiff and Vale University Health Board within all Mental Health inpatient settings, community settings and general hospital settings where patients are detained under the MHA.

Equality and Health Impact Assessment

There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive	Chief Operating Officer

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or Clinical Board Director	
<p style="text-align: center;"><u>Disclaimer</u></p> <p style="text-align: center;">If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.</p>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	26/06/2018	02/07/2018	New document
2	26/04/2022	27/04/2022	

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Equality & Health Impact Assessment for HOSPITAL MANAGERS' SCHEME OF DELEGATION POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	HOSPITAL MANAGERS' SCHEME OF DELEGATION POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Mental Health Act Manager 029 21824746 David.Seward@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	<p>This policy should ensure that all staff authorised for the receipt and scrutiny of Mental Health Act documentation are aware of their responsibilities and requirements both individually and collectively in relation to the delegated duties of Hospital Managers.</p> <p>It is the responsibility of the Mental Health Act administration team to maintain records of all original documentation and record this information on the Mental Health computerised information system</p> <p>The principle objectives of this policy are to inform the organisation the arrangements for authorising people to exercise delegated functions as set out in the scheme of delegation. Unless the Act or regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way their constitutions allows or in the case of the HB in line with NHS legislation.</p>
4.	Evidence and background information considered. For example <ul style="list-style-type: none"> population data 	Related policies/information - Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards,

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<ul style="list-style-type: none"> • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>Equality Act 2010</p> <p>Stakeholders - Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services.</p> <p>Age - 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health)</p> <p>Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016).</p> <p>Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health</p>
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¹ <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

² <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

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	<p>Foundation Fundamental Facts 2016:-</p> <p>Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey.</p> <p>The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p> <p>Disability - Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health")</p> <p>Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007)</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people</p> <p>The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure.</p> <p>Gender - There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p> <p>This policy will apply regardless of gender.</p> <p>Gender Reassignment - Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, “Our Communities, Our Mental Health”) This policy will apply regardless of whether patients have transitioned or not.</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People</p> <p>Human Rights - The proposed policy promotes human rights in</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>ensuring that all patients are detained lawfully.</p> <p>Pregnancy and Maternity - Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children.</p> <p>Within the Mind report the following issues are also identified as contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, “Our Communities, Our Mental Health”)</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016</p> <p>Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%.</p> <p>According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times.</p> <p>This policy will apply regardless of whether patients are pregnant at the</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff.</p> <p>Race/ Ethnicity or nationality – A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system.</p> <p>Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts. Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, "Our Communities, Our Mental Health")</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p> <p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>In 2009 the Department for Communities and Local Government <u>noted</u> that Gypsies and Travellers face particular difficulties accessing</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity.</p> <p>The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p> <p>A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh.</p> <p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p>Religion or Belief - Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”).</p>
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health.</p> <p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p>Sexual Orientation - Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”).</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall Unhealthy Attitudes 2015 report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey</p>
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		<p>With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p> <p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p>Welsh Language - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p>Welsh Language and its use in Cardiff & Vale of Glamorgan The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers.</p>
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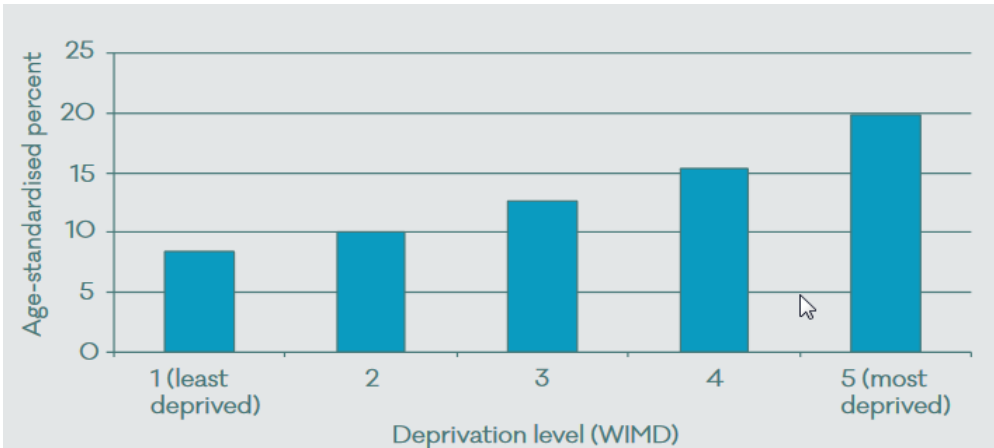
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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.</p> <p>The impact of mental ill health on employment rates</p> <p>A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder⁷. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% parttime (Meltzer et al., 2002)⁸. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).</p> <p>Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi</p>
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and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

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		<p>There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits.</p> <p>Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the <i>distribution</i> of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of</p>
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	<p>poverty.</p> <p>Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression.</p> <p>It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).³ However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' <i>a/so</i> influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004).</p> <p>This policy will apply regardless of where a person lives.</p> <p>(From: http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf </p>
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Homeless

Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity.

Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights.

Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health.

Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times

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<p>Saunders Nathan 04/14/2022 13:09:00</p>		<p>higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common</p> <p>This policy will apply regardless of where a person lives.</p> <p>Asylum Seekers Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and underdiagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_asylum_seeker_health.pdf</p> <p>Prisoners 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.</p> <p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality</p>
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		<p>disorder.</p> <p>49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression.</p> <p>46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide.</p> <p>http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</p>
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>The policy addresses administrative issues and responsibilities rather than the direct care and treatment of patients, although decisions made have an impact on the clinical pathways of patients.</p> <p>The Hospital Managers' Scheme of delegation policy applies to mental health patients admitted to inpatient mental health wards. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.</p>

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: <ul style="list-style-type: none"> • under 18; • between 18 and 65; and • over 65 	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement section.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	individual patient.	they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff</i>	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	Under Policy Statement section.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers	However staff have to take into account the diverse needs of the individual patient.	detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
belief	the individual patient. .		with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: <ul style="list-style-type: none"> the opposite sex (heterosexual); the same sex (lesbian or gay); both sexes (bisexual) 	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual patient.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which	Under Policy Statement section. Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
		they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than	N/A	Under Policy Statement section.

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Approved By: MHCLC		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	those with physical or sensory impairments.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners , though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	account the diverse needs of the individual patient.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	<p>This policy is a technical document identifying the duties under the MHA of Hospital Managers and a formal scheme of delegation of these powers to UHB officers and is a legislative requirement under Mental Health Act.</p> <p>This is an updated policy. Changes made were in line with current legislation and will not impact adversely on any protected group/s.</p> <p>A search of similar policies elsewhere indicated a positive or neutral impact on protected group/s</p> <p>https://www.google.co.uk/search?site=&source=hp&q=hospital+managers+scheme+of+delegation+mental+health+equality+impact+assessment+&oq=hospital+managers+scheme+of+delegation+mental+health+equality+impact+assessment+&gs_l=psyab.12...991.25263.0.27458.107.67.7.0.0.0.556.10945.2j2j12j11j7j1.35.0....0...1.1.64.psyab..68.24.6267...0j0i131k1j0i22i30k1j33i21k1j33i160k1.GkgOkLRlha4</p>
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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- <ul style="list-style-type: none"> Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> continues unchanged as there are no significant negative impacts adjusts to account for the negative impacts continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. Have your strategy, policy, plan, procedure and/or service proposal approved Publish your report of this impact assessment Monitor and review 	<p>No significant negative Impact.</p> <p>The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval.</p> <p>Once the policy has been approved the documentation will be placed on the intranet and internet.</p> <p>The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.</p>	N/A	N/A	<ul style="list-style-type: none"> The health board's Mental Health and Capacity Legislation Committee is responsible for providing assurance to the health board hospital managers that those functions of the Act , as which they have delegated to officers and staff are being carried out correctly; and that the wider operation of the Act in relation to the health board's area is operating properly.

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<p>Reference Number: UHB 410</p> <p>Version Number: 1</p>	<p>Date of Next Review: 24/02/2025</p> <p>Previous Trust/LHB Reference Number: N/A</p>
<p align="center">Hospital Managers' Scheme of Delegation Procedure Mental Health Act, 1983</p>	
<p>Introduction and Aim</p> <p>This document supports the Hospital Managers' Scheme of Delegation Policy, Mental Health Act, 1983.</p> <p>To ensure individuals are aware of their delegated functions under the Mental Health Act.</p> <p>To Provide clear direction and guidance to staff in relation to the arrangements for authorising people to exercise delegated functions on behalf of the Hospital Managers.</p> <p>To Ensure that statutory requirements under the Mental Health Act 1983 are met.</p>	
<p>Objectives</p> <p>The principle objectives of this Procedure are to inform the organisation of the arrangements for authorising people to exercise delegated functions as set out in the scheme of delegation. Unless the Act or regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way their constitutions allow or in the case of the Health Board, in line with NHS legislation.</p> <p>This Procedure describes the following with regard to the Hospital Managers' Scheme of Delegation:</p> <ul style="list-style-type: none"> • The purpose of a Scheme of Delegation • Who is authorised to exercise delegated functions on behalf of the Hospital Managers • Responsibilities and requirements of individuals in relation to the delegated duties of Hospital Managers 	
<p>Scope</p> <p>This procedure is applicable to all people authorised to exercise delegated functions to be carried out day to day required by the Mental Health Act, 1983 (MHA) on behalf of Cardiff and Vale University Health Board within all Mental Health inpatient settings, community settings and general hospital settings where patients are detained under the MHA.</p>	
<p>Equality and Health Impact Assessment</p>	<p>There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.</p>

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Documents to read alongside this Procedure	<ul style="list-style-type: none"> • The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 <p>All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including:</p> <p>Hospital Managers' Scheme of Delegation Policy Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure Community Treatment Order Policy Community Treatment Order Procedure</p>
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	<i>Chief Operating Officer</i>
Author(s)	<i>Mental Health Act Manager</i>
<p style="text-align: center;"><u>Disclaimer</u></p> <p>If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.</p>	

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	26/06/2018	02/07/2018	New document
2	26/04/2022	27/04/2022	Removal of glossary of terms.

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			<i>Updated sections for clarity. Removal of any qualified nurse able to accept nearest relative discharge request</i>
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1. INTRODUCTION

Associate Hospital Managers as appointed by the Health Board have the authority to detain patients under the Mental Health Act 1983 (the Act). The Health Board is defined as the 'Hospital Managers' for the purposes of the Act.

Hospital Managers have a range of responsibilities, including:

- Ensuring that patient's care and treatment complies with the Act;
- Authority to detain patients admitted under the Act; and
- Power to discharge certain patients (sec 23 of the Act) - which can only be exercised by three or more members of a committee formed for that purpose.

There are many other responsibilities and duties which are carried out on the Health Boards behalf by 'authorised officers' (staff) of our hospitals. These include receipt, scrutiny and amendment of detention documents, ensuring patients' rights are made known to them, referral for and arranging Mental Health Review Tribunals, ensuring compliance with renewal/extension, consent treatment and second opinion dates. This is not an exhaustive list as there are many other duties. These roles and responsibilities will be given in more detail below and in the scheme of delegation at **Appendix A**.

It is the hospital managers who have the authority to detain patients under the Act and have equivalent responsibilities towards patient's subject to Community Treatment Orders (CTO), where the patient was detained at the "responsible hospital" immediately before becoming subject to the Community Treatment Order (CTO), even if those patients are not being treated at one of their hospitals. The procedure provides assurance that the health board as a detaining authority has formally delegated specific statutory duties and powers to specific individuals (or groups of individuals).

The health board's Mental Health and Capacity Legislation Committee is responsible for providing assurance to the health board hospital managers that those functions of the Act, which they have delegated to officers and staff are being carried out correctly; and that the wider operation of the Act in relation to the health board's area is operating properly.

2. PROCEDURE STATEMENT

The Health Board is responsible for ensuring that the Mental Health Act is used lawfully and fairly, in accordance with the principles of the Mental Health Act Code of Practice for Wales, including ensuring all paperwork is scrutinised for validity, that detained patients are informed of their rights, and that patients are referred to the Mental Health Review Tribunal within the timeframes set out in the Mental Health Act. They also have various

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powers to discharge patients from detention, transfer detained patients to other hospitals in accordance with regulations, as well as withholding a patient's outgoing correspondence where the law permits.

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, or belief, sex and sexual orientation and culture, or any combination of these. There must be no unlawful discrimination and reasonable adjustments must be made. Individuals' protected characteristics should be taken into account and good practice followed in all aspects of care and treatment planning and implementation.

3. SCOPE

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

The scheme of delegation covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

4. THE STATUTORY FUNCTIONS OF HOSPITAL MANAGERS

The statutory functions of the hospital managers are as follows:

4.1. Receipt, Scrutiny and Recording of Documentation

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 documents 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. (Code of Practice for Wales, 35.8).

It is necessary that all detention papers undergo both administrative and medical scrutiny to ensure that they are technically correct and that the clinical reasons given are sufficient for detaining the patient under the Act. The Mental Health Act administrator will carry out the administrative scrutiny and a consultant who is not involved with the patient concerned will carry out the medical scrutiny in accordance with local practice.

The MHA Administration team provides the Mental Health and Capacity Legislation Committee with details of defective admission documents and of any subsequent action on a regular basis.

Authority for checking that detention documents are in order and receiving papers authorising a patients' detention can only be undertaken by:

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- The Mental Health Act Department
- Shift Coordinator
- Night Site Manager

All of the above staff should receive regular training and instruction in the receipt and scrutiny of admission documentation.

Section 15 of the Act describes the types of errors that may be rectified in the statutory documents. The person who signed the document in question must complete the rectification and that must take place within 14 days of the date of the Form HO14 (record of receipt of admission). Further guidance on the subject of rectification may be found in Part II of the Act.

If admission documents reveal a defect which fundamentally invalidates the application and which cannot, therefore, be rectified under section 15, the patient can no longer be detained on the basis of the application. Authority for detention can only be obtained through a new application. The hospital managers should use their power under section 23 to discharge the patient. The patient should be informed both verbally and in writing.

Responsibility for coordinating this at Cardiff and Vale UHB rests with the Mental Health Act Department

4.2. Report on hospital in-patient (section 5, MHA)

Hospital Managers should monitor the use of section 5 including:

- How quickly patients are assessed for detention and discharged from the holding power
- The attendance times of doctors and approved clinicians following the use of section 5(4)
- The proportion of cases in which applications for detention are, in fact, made following use of section 5

Hospital managers should ensure suitably qualified, experienced and competent nurses are available where there is a possibility of section 5(4) being invoked.

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department

4.3. Emergency admission (section 4, MHA)

Hospital managers should monitor the use of section 4 and ensure that second doctors are available to visit a patient within a reasonable time after being requested. This will also be monitored by Healthcare Inspectorate Wales (HIW).

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department

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4.4. Allocation of a Responsible Clinician

Every patient must have an allocated Responsible Clinician (RC). (Code of Practice for Wales, Chapter 36) The RC is the approved clinician who will have overall responsibility for the patient's care and treatment. The patient should be informed of the identity of the RC and of any change. Chapter 36 of the Code of Practice for Wales outlines the functions of RC's and approved clinicians and steps to be followed to ensure that:

- The patient's RC is the available approved clinician (AC) with the most appropriate expertise to meet the patient's main assessment and treatment needs;
- A patient's RC can be easily determined;
- Cover arrangements are in place when the RC is not available;
- There is a system for keeping the appropriateness of the RC is under review.

The allocation of the Responsible Clinician is delegated to the Clinical Team and the Clinical Director. A list of approved clinicians in Wales and those employed by the Health Board is held by Betsi Cadwaladr University Health Board.

4.5. Transfer between hospitals (section 19, MHA)

Section 19 of the Act allows hospital managers to authorise the transfer of most detained patients from one hospital to another. Decisions on transfers may be delegated to a person who could, but need not be the patient's responsible clinician. For restricted patients, the consent of the Secretary of State for Justice is also required.

The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

4.6. Transfers into/from guardianship (section 7, MHA)

Section 19 allows hospital managers to authorise the transfer of most detained patients into guardianship with the agreement of the relevant local authority. This procedure avoids the need to discharge the patient from detention and making a separate guardianship application. There should be good reasons for any transfer into guardianship and the needs and interest of the patient must be central to decision making.

The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

4.7. Transfer and assignment of responsibility for CTO patients (section 19A, MHA)

The managers of a hospital to which a CTO patient has been recalled may authorise the patient's transfer to another hospital during the 72 hour maximum period of recall. With the agreement of the hospital to which the patient is being transferred, the hospital managers may also reassign responsibility for CTO patients so that a different hospital will become the patient's responsible hospital.

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Nathan

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The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

4.8. Removal and return of patients (section 86)

Part 6 of the Act enables the transfer between the United Kingdom jurisdictions, Channel Islands or Isle of Man of detained patients (otherwise than under s.35, s.36 or s.38), patients subject to guardianship or to compulsion in the community where the patient concerned needs to remain subject to detention, guardianship or the equivalent CTO on arrival in Wales.

Following approval by Welsh Ministers this role is performed on behalf of the Hospital managers by the Mental Health Act Department.

4.9. Responsibilities under Community Treatment Order

There is a duty on the hospital managers to take steps to ensure patients understand what a CTO means for them and their rights to apply for discharge. A copy of this information must also be provided to the nearest relative, where practicable, if the patient does not object. (Code of Practice for Wales, Chapter 4)

The RC, Care Coordinator or qualified nurses will perform this role on behalf of the hospital managers.

4.10. Recall to hospital for CTO patients (section 17E)

Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form (CP6) must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure the patient's length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.

The completion of form CP6 will be undertaken by Mental Health Act Department or Shift Coordinator on behalf of the hospital managers.

4.11. Duty to provide information to patients

Section 132 and 132A of the Act require hospital managers to take such steps as are practicable to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order (CTO), understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO. (Code of Practice for Wales, Chapter 4)

Information should be given to the patient both verbally and in writing, in accessible formats, appropriate to the patient's needs, e.g. Braille, Moon, easy read and in a language the patient understands. It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information verbally.

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Patients should be given all relevant information, which includes how to make a complaint, how to access advocacy services, legal advice and the role of the Inspectorates.

Those with responsibility for the care and treatment of patients should be aware of the most effective way to communicate with each individual and their family, carers and relevant others. Everything possible should be done to overcome barriers to effective communication.

Under section 133 of the Act, the hospital managers must inform the nearest relative (as defined in section 26 of the 1983 Act) when a patient is released from detention, including a patient who is to be discharged from hospital under CTO. It need not be provided, if either the patient or nearest relative have requested that this information should not be given.

The role for ensuring that the patient and nearest relative are informed in line with the above requirements rests with the Mental Health Act Department or suitably experienced nursing staff.

4.12. Correspondence of patients

Section 134(1)(a) of the Act allows hospital managers to withhold outgoing post from detained patient if the person it is addressed to has requested in writing that they do so and the procedure to be followed in the event of the hospital managers receiving a written request for outgoing mail to be withheld.

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department.

4.13. Information about Independent Mental Health Advocates

Section 130D places a duty on hospital managers (and in certain cases RCs) to provide qualifying patients with information that advocacy services are available and how to obtain that help.

This role will be provided on behalf of the hospital managers by ward nursing staff, community staff or the Mental Health Act department in accordance with (Code of Practice for Wales 37.15)

4.14. Duty to refer cases to the Mental Health Review Tribunal for Wales (section 68, MHA)

Hospital Managers must refer a patient's case to the MHRT for Wales in the circumstances set out in section 68 of the Act below:

- Who has not exercised their right to apply (or been referred by Welsh Ministers or the hospital managers as set out in section 68;

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- Who has been transferred from guardianship under regulations under section 19 and has not applied for a tribunal;
- Who has not had an application made on his behalf by the nearest relative or by virtue of a referral by Welsh Ministers;
- If the authority for detention is renewed and the patient has not had a MHRT for more than three years, or a patient under 18 years of age, for one year; or
- On the revocation of a Community Treatment Order (CTO)

The responsibility for ensuring that systems are in place to make a reference to the MHRT for Wales within the timescales will be performed by the Mental Health Act Department on behalf of the hospital managers.

4.15. Referrals to the Mental Health Review Tribunal for Wales by Welsh Ministers

Hospital managers should consider asking Welsh Ministers to exercise their power of referral for a patient (whose rights under Article 5(4) may be at risk of being violated) to have their case considered by the MHRT for Wales (Chapter 37.40 of the Code refers).

The hospital managers should normally seek such a reference in any cases where:

- A patient's detention under section has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative
- The patient lacks the capacity to request a reference
- The patient's case has never been considered by the MHRT for Wales or a significant period has passed since it was last considered

The Mental Health Act Department will perform this duty on behalf of the hospital managers.

4.16. Renewal/Extension of authority to detain (section 20/20A, MHA)

The hospital managers should consider a report made under section 20(3) or section 20A (4) before the current period of detention or community treatment expires. If a responsible clinician does not hold a review before the period of detention or CTO expires, this should be considered a very serious matter to be urgently reviewed. The hospital managers should have processes in place to ensure that this does not happen.

The Responsible Clinician has responsibility for completing the report to renew a patient's detention or extend the CTO. The Mental Health Act Department receives the report on behalf of the hospital managers and arranges a hearing for the hospital managers to sit and consider the renewal of detention or extension of CTO.

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4.17. Report barring discharge by nearest relative (section 25, MHA)

The nearest relative may order the discharge of a patient detained under section 3, or CTO by giving 72 hours' notice to the hospital managers in writing. The person receiving the notice must note the time and date received.

The receiving of this notification of intent to discharge the patient is delegated to the Mental Health Act Department or Shift Coordinators.

The responsible clinician may within the 72-hour period furnish Form NR1 barring the discharge by the nearest relative.

The duty of informing the nearest relative in writing of the decision on behalf of the hospital managers is delegated to the Mental Health Act Department.

4.18. Duties in respect of victims

The Domestic Violence, Crime & Victims Act 2004 (DVCVA) 2004 places a number of duties on hospital managers in relation to certain patients who have committed sexual or violent crimes together with guidance on the exercise of these.

The duties include the following information is communicated to victims:

- When authority to detain a patient expires
- When the patient is discharged, including allowing the victim to make representations about discharge conditions and whether a CTO is to be made
- What conditions of discharge relate to the victim, and when these cease
- The victim's entitlement to make representations on the need for a CTO and allowing representation concerning the conditions attached to the CTO
- Any conditions on the CTO relating to the victim or their family, and any variation of the conditions
- When the CTO ceases

Responsible Clinicians will perform this role on behalf of the hospital managers.

4.19. Discharge from MHA detention and CTO (section 23, MHA)

Hospital Managers have the power to discharge certain patients from detention (section 23 of the Act) which can only be exercised by three or more members of a Committee formed for that purpose. Although the function is delegated to a Committee of three or more lay members, the Health Board remains responsible for this statutory function. A panel of three or more members drawn from the Hospital Managers Power of Discharge Sub-Committee (a Sub-Committee of the Mental Health & Capacity Legislation Committee) hear individual cases where patients or their nearest relative have applied for discharge. The panels also sit on renewal and extension hearings; these are collectively known as hospital managers reviews.

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Section 23 of the Act (the power to discharge certain patients from detention) is delegated to three or more members of the Hospital Managers Power of Discharge Sub-Committee and the Responsible Clinician.

4.20. Consent to Treatment

The hospital managers should ensure that robust procedures are in place to notify the approved clinician in charge of the patient's treatment, of the expiry of the three-month rule set by section 58 and the one-month rule for Part 4A certificates for community patients. Hospital managers should check that action has been taken.

This is delegated to the Mental Health Act Department on behalf of the hospital managers.

The same reminder system should ensure that patients are asked whether they consent to continued medication.

Responsibility for this task is delegated to the Mental Health Act Department in conjunction with qualified nursing staff and community staff.

If the patient is unwilling to consent or incapable of doing so, the approved clinician in charge of the patient's treatment must ask Healthcare Inspectorate Wales to arrange for a second opinion appointed doctor (SOAD) to visit the patient and review the proposed treatment.

When a second opinion is required, the hospital managers should ensure that the patient, statutory consultees (one of which is neither a doctor nor a nurse), and any other relevant people, are available to consult with the SOAD, and that the statutory documents are in order and readily available for inspection.

Responsibility for this is delegated to the Responsible Clinicians and Mental Health Act Department in conjunction with qualified nursing staff and community staff.

4.21. Emergency Treatment

The Hospital Managers should monitor the giving of 'urgent treatment' under section 62 and 64 of the Act. They should ensure that a form is provided for completion by the responsible clinician, or the approved clinician in charge of the patient's treatment. It must record details of:

- the proposed treatment
- why it is immediately necessary to give the treatment
- The length of time for which the treatment was or will be given.

The use of section 62 and 64 will be monitored by the Mental Health Act Department on behalf of the hospital managers.

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4.22. Hospital accommodation for children

Section 131A of the Act puts a duty on hospital managers to ensure any children receiving in-patient care for mental disorder in their hospitals are accommodated in an environment which is suitable for their age and in line with their needs. This duty will apply to children admitted informally to hospitals, as well as those detained under the Act.

The admission of children and young people onto psychiatric wards is monitored by the child and adolescent mental health services on behalf of the hospital managers.

7. TRAINING

The health board will provide ongoing training for staff that have a delegated duty under the scheme of delegation. Details of training courses available can be found on the Mental Health Act Department intranet page or by contacting the Mental Health Act Department.

8. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

9. RESPONSIBILITIES

9.1. Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

9.2. Chief Operating Officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

9.3 Designated Individuals

The procedure states which individuals are responsible for certain sections of the Mental Health Act under the Scheme of Delegation at Appendix A.

10. REVIEW

This Procedure will be reviewed every 3 years or following any changes in legislation to the Mental Health Act 1983.

11. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents

Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7

Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health

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Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

12. APPENDICES

Hospital Managers' Scheme of Delegation.

APPENDIX A: Hospital Managers' Scheme of Delegation

The arrangements for authorising decisions should be set out in a scheme of delegation approved by the resolution of the body itself. (Code of Practice for Wales, chapter 37.8)

Page	Legislative Reference	Function	Delegated to
6	Section 15	Receipt, scrutiny and recording of documentation	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Section 5	Report on hospital in-patient	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Section 4	Emergency admission (Monitoring)	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Code of Practice for Wales - Chapter 36	Allocation of Responsible Clinician	Clinical Director, Integrated Team Manager
8	Section 19	Transfer between hospitals	MHA Administration Team, Shift Coordinator, Night Site Manager, Responsible Clinician
8	Section 7	Transfers into/from guardianship	MHA Administration Team, Shift Coordinator, Night Site Manager

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Page	Legislative Reference	Function	Delegated to
8	Section 19A	Transfer and assignment of responsibility for CTO patients	MHA Administration Team, Shift Coordinator, Night Site Manager, Responsible Clinician
8	Section 86	Removal and return of patients	MHA Administration Team
9	Section 17E	Recall of CTO patient to hospital	Responsible Clinician, Mental Health Act Administration Team, Shift Coordinator, Night Site Manager
9	132, 132A and 133	Duty to provide Information to patients	MHA Administration Team, Ward Manager, Shift Coordinator, Night Site Manager, Community Staff, Responsible Clinician
9	Section 134(1)	Correspondence of patients	MHA Administration Team
9	Section 130D	Independent Mental Health Act Advocates – duty to provide information	MHA Administration Team, ward staff, community staff,
10	Section 68	Referral to MHRT for Wales	MHA Administration Team
10	Section 67	Referrals by Welsh Ministers to MHRT	MHA Administration Team
10	Section 20 and 20A	Renewal of authority to detain	MHA Administration Team
11	Section 25	Report barring discharge by nearest relative	MHA Administration Team, Ward Manager, Responsible Clinician
11	Domestic Violence, Crime & Victims Act 2004	Victims Right to be informed of discharge and conditions attached to that discharge	Responsible Clinician
11	Section 23	Discharge from MHA detention or CTO	Responsible Clinician Hospital Managers - who have the power to discharge certain patients from detention which can only be exercised by three or more members of a Committee formed for that purpose. The UHB Board remains

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Page	Legislative Reference	Function	Delegated to
			responsible for this statutory function.
11	Part IV and Part IVA Section 58 – Section 63	Consent to Treatment	MHA Administration Team, Nursing Staff, Community Staff, Approved Clinicians and Responsible Clinician
12	Section 62	Emergency Treatment (Monitoring)	MHA Administration Team, Responsible Clinician
12	Section 131A	Hospital accommodation for children and young people (Monitoring)	MHA Administration Team, CAMHS

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