Mental Health Legislation and Mental Capacity Act Committee Meeting

Tue 26 July 2022, 10:00 - 12:30

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 26 April 2022

Ceri Phillips

4 Draft MHLMCA Minutes 26.04.22MD.NF.CP.pdf (13 pages)

5.
Action Log from the meeting held on 26 April 2022

Ceri Phillips

5 Action Log Mental Health CommitteeMD(1).pdf (2 pages)

6.
Chair’s Action taken since last meeting

Ceri Phillips

7.
Any Other Urgent Business Agreed with the Chair

Ceri Phillips

8.
Mental Capacity Act

8.1.
Mental Capacity Act Monitoring Report

Jason Roberts

- 8.1 Mental Capacity Act MCA and DoLS Cover.pdf (5 pages)
- 8.1a January DoLS indicators.pdf (1 pages)
- 8.1b February DoLS indicators.pdf (1 pages)
- 8.1c March DoLS indicators.pdf (1 pages)
- 8.1d April DoLS indicators.pdf (1 pages)
- 8.1e May DoLS indicators.pdf (1 pages)

8.2.
Liberty Protection Safeguards

Jason Roberts

- 8.2 Liberty Protection Safegaurds progress to implementation Paper.pdf (3 pages)

8.3.
DOLs Audit update and recommendations

Jason Roberts

- 8.3 Internal Audit Report on Deprivation of Liberty Safegaurds (DoLS).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

Hannah Evans / Daniel Crossland

- 9.1 Mental Health Act Monitoring Exception Report July 2022.pdf (8 pages)
- 9.1a Mental Health Act Monitoring Report April - June 2022.pdf (50 pages)

9.2.
HIW Mental Health Act Annual Report – Verbal Update

Hannah Evans / Daniel Crossland

10.
Mental Health Measure

10.1.
Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report

Hannah Evans / Daniel Crossland

- 10.1 Mental Health Measure July 2022 AMS and CAMHS FINAL.pdf (9 pages)

10.2.
Care and Treatment Planning Audit

Daniel Crossland

10.2 Care and Treatment Planning Audit.pdf (5 pages)

11.
Items to bring to the attention of the Committee for Noting / Information

11.1.
Sub Committee Minutes

11.1.1.
Hospital Managers Power of Discharge - 5 July 2022

Jeff Champney - Smith

11.1.1 PoD July minutes.pdf (3 pages)

11.1.2.
Mental Health Legislation and Governance Group Minutes - 7 July 2022

Robert Kidd

11.1.2 MHLGG July minutes 2022.pdf (7 pages)

11.2.
Corporate Risk Register

Nicola Foreman

11.2 MHCLC Corporate Risk Register Report - July 2022.pdf (3 pages)
11.2a - MHCLC - Detailed Corporate Risk Register May 2022.pdf (1 pages)

11.3.
Committee Effectiveness Survey Results 2021-2022

Nicola Foreman

11.3 Committee Self Effectiveness Survey MHLMCA.pdf (3 pages)
11.3a Mental Health and Capacity Legislation Committee Self Evaluation 2021-22.pdf (21 pages)

12.
Items for Approval Ratification

Policies

12.1.
Community Treatment Order policy and procedure

Hannah Evans / David Seward

12.1.1 CTO Policy Procedure Approval Cover.pdf (3 pages)
12.1.1a Community Treatment Order Policy FINAL.pdf (42 pages)
12.1.1b Community Treatment Order Procedure FINAL.pdf (25 pages)

13.
Any Other Business

Ceri Phillips

- Draft Mental Health Bill

14.
Review of the Meeting

Ceri Phillips

15.
Note the date, time and venue of the next meeting:

October 25 2022 at 10am

Via MS Teams

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 26th April 2022 – 10am
Via MS Teams

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present		
Akmal Hanuk	AH	Independent Member - Community
Sara Moseley	SM	Independent Member – Third Sector
In Attendance:		
Rebecca Aylward	RA	Director of Nursing for Professional Standards
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Nicola Foreman	NF	Director of Corporate Governance
Caroline Bird	CB	Interim Chief Operating Officer
Daniel Crossland	DC	Deputy Director of Operations - Mental Health
Charles Janczewski	CJ	UHB Chair
Robert Kidd	RK	Consultant Clinical & Forensic Psychologist
David Seward	DS	Interim Mental Health Act Manager
Catherine Wood	CW	Director of Operations – Children & Women's
Robert Kidd	RK	Consultant Clinical & Forensic Psychologist
Observers:		
Urvisha Perez	UP	Audit Wales
Caitlin Thomas	CT	Graduate Management Trainee
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Ruth Walker	RW	Executive Nurse Director
Rose Whittle	RWh	Directorate Manager – Child Health

Item No	Agenda Item	Action
MHCLC 09/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everybody to the meeting.	
MHCLC 09/04/002	**Apologies for Absence** Apologies for Absence were noted	
MHCLC 09/04/003	**Declarations of Interest** No declarations of Interest were noted.	
MHCLC 09/04/004	**Minutes of the Meeting held on 9 February 2022** The Minutes of the Meeting held on 9 February 2022 were received.	

	The Committee Resolved that: a) The minutes of the meeting held on 9 February 2022 were agreed as a true and accurate record.	
MHCLC 09/04/005	**Action Log from the meeting held on 9 February 2022** The Action Log was received. The Director of Corporate Governance (DCG) advised the Committee that the action (MHCLC 09/02/001) which related to ratifying items at the March 2022 Board had been completed and noted that the 2 policies and procedures were approved: (i) the Section 5(2) Doctors Holding Power Policy and Procedure was approved; *(ii)* The full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme was approved; (iii) the Section 5(4) Nurses' Holding Power Policy and Procedure was approved; and *(iv)* the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme was approved. **The Committee Resolved that:** a) The Action Log was noted.	
MHCLC 09/04/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHCLC 09/04/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHCLC 09/04/008	**Mental Capacity Act Monitoring Report – DoLs Monitoring Report** The Mental Capacity Act Monitoring Report – DoLs Monitoring Report was received. The Director of Nursing for Professional Standards (DNPS) advised the Committee that she would take the report as read.	

	It was noted that the Mental Capacity Act (MCA) Lead had been in post for 3 months and was prioritising MCA training, and had trained staff groups within: • HM Prison health staff, • Physiotherapy, • Critical Care, • Endoscopy, • Mental Health • North West Locality Community Nurse Leaders. The DNPS added that in preparation and utilising the funding from Welsh Government (WG) to support Liberty Protection Safeguards (LPS), 20 places had been secured along with Swansea University staff to attend Level 7 MCA training. It was noted that an external provider would deliver MCA training to 700 staff. The Consultant Clinical & Forensic Psychologist (CCFP) asked if the training being used from Swansea University could be shared with the Mental Health Clinical Board. The DNPS confirmed that the training would be shared. The UHB Chair noted that some of the information in the report did not appear to help the Mental Health Legislation and Mental Capacity Act Committee. The DNPS agreed and noted that the content within the report would be improved for the next Committee and the information would need to be presented more clearly. The CCFP asked if details of Section 49 requests could be seen within the report at the next meeting. The DNPS confirmed that the information would be added and advised the CCFP that they would meet outside of the meeting to discuss what should be presented within the report. The UHB Chair noted that training had been a longstanding issue for the Committee and expressed his thanks for raising it within the report and added that a future update on progress being made would be useful for the Committee. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	**RA/RK** **RA**
MHCLC 09/04/009	**Liberty Protection Safeguards** The Liberty Protection Safeguards information was received.	

	The DNPS advised the Committee she would take the report as read and highlighted the key aspects which included: • The consultation relating to the Welsh Government LPS draft Regulations, was launched on 17th March 2022. It was noted that the consultation would last for 16 weeks and the deadline for responses was the 7th of July 2022. It was noted that as part of the consultation there were 4 aspects of the draft Regulations that the Health Board was being asked to consult on: - Appointment of Independent Mental Capacity Advocates (IMCAs). - The Mental Capacity (Deprivation of Liberty: eligibility to carry out assessments, make determinations and carry out pre-authorisation reviews) (Wales) Regulations 2022. It was noted that these Regulations set out who could undertake assessments, make determinations and carry out pre-authorisation reviews as part of the new process. - The Mental Capacity (Deprivation of Liberty: training and criteria for approval as an Approved Mental Capacity Professional) (Wales) Regulations 2022. It was noted that these Regulations set out arrangements regarding the role and approval by local authorities of Approved Mental Capacity Professionals (AMCPs). - The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) (Wales) Regulations 2022. It was noted that these Regulations supported the monitoring and reporting of the new system and the implementation of the LPS. The DNPS advised the Committee that the Welsh Government (WG) funding strategy had been agreed. That included £8million transitional costs for the LPS in 2022/23 although it was yet to be decided how much the Health Board would receive. The UHB Chair advised the Committee that the implementation of LPS would have a wide-ranging impact on the Health Board. He also noted that the report stated the Health Board was developing an implementation plan and associated staff resources, which would be shared with the Committee. He asked when that would be received. The DNPS responded that an implementation plan could be provided at the next Committee meeting because the project lead would be in post by that time. The CCFP advised the Committee that the consultation had been “out” for a while and the reality of the long-awaited changes was beginning to affect the Mental Health Clinical Board. He asked who was leading the agenda for the Health Board so that comments could be “fed up” to the relevant areas.	**RA**

	The DPNS responded that she was the responsible person and asked for comments to be fed up to her. The Independent Member – Community (IMC) noted that the report had stated that the Regulations identified three monitoring bodies who would be responsible for monitoring and reporting on the new safeguards: • Care Inspectorate Wales (CIW), • Health Inspectorate Wales (HIW) • Her Majesty's Inspectorate for Education and Training (Estyn). He asked if Swansea University was accredited with Estyn as well as Cardiff and the Vale UHB because it would be important from the training and education perspective. The DPNS responded that she would find that out. The Independent Member – Third Sector (IMTS) asked for clarity on 2 areas within the report: • The Health Board currently had no staff resource to manage the implementation of LPS and the required complex ongoing requirements of LPS Regulations. • Who did LPS legislation affect in relation to the types of people and the numbers of people and who were the Committee seeking assurance for. The DNPS responded that a lead for LPS (at Band 8A) had been secured for a fixed term of 12 months and noted that they were waiting to see what allocation of funding the Health Board was getting from WG to put in more fixed term resources. She added that as part of the implementation plan the staff resource needed to support LPS would be identified. It was noted that the LPS legislation was applicable to everyone over the age of 16. The UHB Chair advised the Committee that the £8m from WG was only aimed at transitional costs and he wanted to know what the recurrent situation would be. He expressed concern that if the Health Board went with the bare minimum and, if after a number of years demand accelerated, that could leave the Health Board in a difficult position. He added that it would be helpful for the Board to receive assurance via the Committee on a regular basis regarding LPS together with an understanding of the impact on the recurrent cost base. The CC advised the Committee that LPS would be received as a standing item at future Committee meetings.	**RA**

	The Committee resolved that: a) The contents of the report were noted.	
MHCLC 09/04/010	**DOLs Audit update on recommendations** The DOLs Audit update on recommendations was received. The DNPS advised the Committee that the report provided an update on the Internal Audit report and noted that the audit was performed between August 2019 and October 2019. It was noted that 4 recommendations had been received which included: • Staff should attempt to ensure that all urgent assessments were undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Standards. The DNPS advised the Committee that it continued to be a challenge and had been affected by the impact of Covid19. She added that it came back to a resourcing issue and provided the Committee with an example where there was a 1.5 whole time equivalent (WTE) member of staff doing the reviews at approximately 6 per week. It was noted to meet current demand, 6 a day would be required. • The Health Board should ensure that staff were provided with the appropriate DoLs training and where areas had low compliance these areas should be targeted. It was noted that DoLs training had been affected by Covid19 with the inability to release staff for training. However there had been some pockets of training targeted at high areas that had a large number of DoLs patients. • Staff should attempt to ensure that all standard and further assessments were undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. It was noted that there had been an improvement in timeframes because the Health Board had trained up more capacity with Directors of nurses signing off on training. • The Health Board needed to ensure that they produce a plan for implementing Liberty Protection Safeguards following the Production of the Code of Practice. It was noted that the Health Board had been unable to plan for implementing LPS due to the delay of issuing the LPS draft Code of Practice and Regulations and it was also important to note that the	

	Health Board had no staff resource to manage the implementation of LPS. It was therefore essential that the resources required were clearly stated to enable a seamless transfer from DoLs and operation of LPS. The UHB Chair expressed his concern with regards to the first recommendation where the situation had not changed and asked if assurance could be provided that the Health Board was addressing, and had plans to address, the situation. The DNPS responded that the recommendation would require resource to improve and if action was required immediately, additional monies would need to be found to resource additional staff. The UHB Chair responded that a course of action would be required over a period of time and asked for the DNPS to provide a timescale at the next Committee meeting. The IMTS noted that the first recommendation was legally bound and noted that the Health Board could not be in a position where there was no plan and added that if assurance could not be provided, it would need to be referred elsewhere. The UHB Chair responded that the Management Executive Team could look at the recommendation to establish priorities in relation to budget. The CC agreed that the recommendation should be taken to ME as a matter of urgency and advised the Senior Corporate Governance Officer to add a recommendation that stated that. **The Committee resolved that:** a) The contents of the report and the assurance provided to transition recommendations as part of the implementation of the Liberty Protection Safeguards were noted. b) The timescales and budget implications for undertaking the DoLs Urgent Authorisations recommendation from Internal Audit should be received by the Management Executive Team as soon as possible.	**RA** **RW/RA**
MHCLC 09/04/011	**Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The Interim Mental Health Act Manager (IMHAM) advised the Committee that the use of the Mental Health Act had remained consistent this period with 53% of inpatients being detained under the Act at the end of quarter 4 with 53% at the end of quarter 3. He added that there had been no fundamentally defective applications but noted that there had been one legal query raised when a patient was transferred to an independent provider.	

	The IMHAM advised the Committee that he believed the application was legally compliant and that the legal advice had been obtained which had confirmed the legality of the application. It was noted that during the period, the use of Section 136 had increased and that 63.4% of individuals assessed did not require hospital admission, 51.9% were discharged with community support and 11.5% were discharged with no follow up. It was noted that overall during the period 32.7% of patients were admitted to hospital following a Section 136 assessment which was higher than the previous quarter at 30.7%. It was noted that the number of patients under the age of 18 assessed under Section 136 had decreased from 7 in the previous quarter to 6 in this quarter and that there were 4 repeat presentations recorded. The IMHAM advised the Committee that the Mental Health Review Tribunal (MHRT) had met the previous day to the Committee meeting to discuss issues and noted that a formal outcome would be received by the end of the week around the rollout of Teams for all Tribunal hearings. It was noted that in the meantime the Health Board had been authorised to request that hearings could take place via Teams at patient/professional request and that since February 2022, 4 requests for Teams hearings had been put forward to the MHRT, all of which were granted. The CC noted that a consultant psychiatrist had requested if two doctors, who had been heavily involved in a patient's care and treatment, could observe a tribunal and that such request had been rejected by a deputy president of the MHRT. He asked if that would be reversed and relevant observers would be allowed to attend tribunals. The IMHAM responded that assurance could not be provided at this time and noted that all health boards in Wales have put in letters of concern to the MHRT. The CCFP added that the issue was being addressed via a number of approaches. That included a joint letter from Schools of Nursing to the tribunal spelling out that the opportunity for trainees for a number of disciplines was required to see how the tribunal system worked. The IMHAM advised the Committee that the Mental Health Act office continued to run Mental Health Act awareness sessions including a monthly Mental Health Act training day, which was available to all staff within the Health Board as well as a Receipt and Scrutiny, Consent to Treatment and a Rights workshop.	

	The Deputy Director of Operations - Mental Health (DDOMH) thanked the IMHAM for putting in place procedures and noted that he had been really proactive in making sure the relevant changes were in place. **The Committee Resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report was noted.	
MHCLC 09/04/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received. The Interim Chief Operating Officer (ICOO) advised the Committee that the report was picked up in more detail at the Strategy & Delivery Committee. The DDOMH reminded the Committee that the Mental Health Measure was split into 4 parts and noted that Part 1 related to Primary Care referrals into the Primary Mental Health Support Service (PMHSS). It was noted that the target was 28-day referral to assessment with a compliance target of 80% for Adults. He added that referrals for Adults and Children were at an all-time high. It was noted that regarding the over-18 Part 1a performance, every referral was being seen in under 56 days and referrals were moving steadily towards overall compliance. Performance on 08/04/22 was 69% compliant. It was noted that average waiting times for assessment was 29 days on 31/03/21 which had decreased to 28 days at the time of the meeting. The DDOMH advised the Committee that clarification had been sought from WG around when the “clock starts” and noted that WG had confirmed that the clock started at the receipt of the referral, not the date of opt-in by the service user. He added that Fully Automated Booking was explored for Fridays and SMS Text Notification for Opt-In had been developed. The Director of Operations – Children & Women’s (DOCW) advised the Committee that the position within the Children and Adolescent Mental Health Service (CAMHS) was similar and that the impact of Covid19 across teams was significant.	

	She added that like the Adult Service, referrals were at an all-time high and noted that the number of referrals received in March 2022 was the highest number received in over 2 years. It was noted that the team had worked very hard and had maximised outsourcing to deliver the target of 89%. It was noted that the waiting time was currently at 21 days which was an improvement since the Committee had last received the information. The DOCW advised the Committee that compliance against Part 1B of the target had not been achieved since December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over Christmas. She added that in January 2022 the service was significantly reduced due to sickness, maternity leave and annual leave. It was noted that as part of the move towards a Joint Assessment Team model, a brief intervention pathway would be created to ensure that young people were seen within 28 days of the commencement of their treatment, following assessment. The DOCW advised the Committee that the Single Point of Access team was launched at the end of November which had helped to manage referrals through improved processes and use of consultation with referrers. It was noted that it had been a real success in balancing the referrals. The UHB Chair noted that the report contained information around reporting inaccuracies on PARIS and asked what impact that had on reporting. The DDOMH responded that the accuracy in reports from PARIS had been fairly flawed and so work had been undertaken alongside the PARIS team to ensure that the data reflected what was actually happening within the service. He added that assurance could be provided that the issues were now fixed. The UHB Chair noted that the automated booking system was only explored for Fridays and asked if would be better to have automated booking for the whole week. The DDOMH responded that the fully automated booking system was where a spreadsheet of referrals was sent to a team who immediately sent letters to patients on same day with their appointment. He added that the issue the service saw on Fridays was that most of the referrals had arrived on the Friday afternoon and were not picked up	

	until the Monday. That meant the service had lost 4 days of the target which was why Fridays had been prioritised. The ICOO added that the point raised by the UHB Chair was noted and would be escalated to the relevant digital teams. The CC thanked the DDOMH and the DOCW for what they had been able to achieve against the context of the ever-increasing demand. **The Committee Resolved that:** a) The contents of the report were noted.	**CB**
MHCLC 09/04/013	**HIW MHA Inspection Reports** The HIW MHA Inspection Reports were received. The ICOO advised the Committee that there had been one HIW inspection for wards at Hafan Y Coed: • Cedar Ward • Oak Ward • Willow Ward. It was noted that the Health Board had received the draft report but not the final version and that no improvements had been highlighted within the initial findings. The IMTS asked if it was a routine visit from the HIW. The Deputy Director of Operations - Mental Health responded that they had been expecting a visit in relation to inpatient incidents but noted that the report did not make any further recommendations and that the initial report had commended staff for their approach and quality of care towards patients. The CC concluded that the HIW report would reflect what he and others had witnessed at Hafan Y Coed and the culture there and noted that the Committee could be assured that everyone was working in the patients' best interests. **The Committee Resolved that:** a) The HIW MHA Inspection Reports were noted.	
MHCLC 09/04/014	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes: • Mental Health Act Hospital Managers Power of Discharge Sub Committee	

	The Chair of the Powers of Discharge sub-Committee advised the Committee that the sub-Committee was still concerned about care and treatment plans and noted that the CCFP had agreed for it to be taken to the next Mental Health Legislation and Governance Group. The DDOMH responded that a routine audit had been put in place of quality care and treatment planning which had been shared with the Local Authority to demonstrate what the key issues were around the care and treatment plans. • Mental Health Legislation and Governance Group (MHLGG) The CCFP advised the Committee that the MHLGG had met on 8th April 2022 and acknowledged that there were a number of changes regarding the Mental Health Act which included: • New dedicated Nurse Educational Posts which had proved very helpful in terms of them being able to cascade information from the Mental Health Act Office. • Positive attendance from Association of Mental Health Providers (AMHP) Local Authority colleagues – It was noted that the long-standing colleague, Peter Thomas (South Wales Police) had retired and a new detective sergeant would attend the MHLGG meetings. • The Mental Health Act Office had noted that the reading of rights to people needed to picked up and that there had been issues with communication to nearest relatives on Section 3 renewals. **The Committee Resolved that:** a) The Sub-Committee Meeting Minute were noted.	
MHCLC 09/04/015	**Corporate Risk Register** The Corporate Risk Register was received. The Director of Corporate Governance (DCG) advised the Committee that the Board in March 2022 had received one extreme risk linked to the Mental Health Legislation and Mental Capacity Act Committee for assurance purposes and noted that the risk remained on the register. She added that it was hoped that scheduled actions would have led to the de-escalation of the risk prior to the March Board, but noted that a combination of operational pressures and an inability to source suitable private placements meant that the risk continued to be recorded as an Extreme Risk. The DCG advised the Committee that in May 2022 the Head of Risk and Regulation would 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 and noted that they would be tracked through the Audit and Assurance Committee. **The Committee Resolved that:** a) The Corporate Risk Register risk entry linked to the Mental Health Legislation and Mental Capacity Act Committee and the work which was now progressing, was noted.	
MHCLC 09/04/016	**Policies** The Committee received 2 policies: i) Consent to Examination or Treatment under The Mental Health Act 1983 Policy & Procedure ii) Hospital Managers' Scheme of Delegation Policy & Procedure. **The Committee resolved that:** a) The Consent to Examination or Treatment under The Mental Health Act 1983 Policy & Procedure was approved. b) The Hospital Managers' Scheme of Delegation Policy & Procedure was approved.	
MHCLC 09/04/017	**Review of the Meeting**	
	To note the date, time and venue of the next meeting: July 26 2022 at 10am Via MS Teams	

ACTION LOG
MENTAL HEALTH LEGISLATION AND MENTAL CAPACITY ACT COMMITTEE – 26th APRIL 2022
(UPDATED FOR 26th JULY 2022 MEETING)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
Actions in Progress					
MHCLC 09/04/010	**DOLs Audit update on recommendations**	Staff should attempt to ensure that all urgent assessments were undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Standards – Action Plan and timescale required.	**26.07.22**	Rebecca Aylward	**COMPLETED** On July agenda
MHCLC 09/04/009	Mental Health Legislation and Mental Capacity Act Committee - **Liberty Protection Safeguards**	LPS implementation plan and associated staff resources to be shared with the Committee Rebecca Aylward to find out if Swansea University are accredited with Estyn	**26.07.22**	Rebecca Aylward	**COMPLETED** On July agenda
MHCLC 09/04/008	Mental Capacity Act Monitoring Report – DoLs Monitoring Report	The content within the report would be improved upon for the next Committee and that the information would be presented more clearly	**26.07.22**	Rebecca Aylward	**COMPLETED** On July agenda
MHCLC 09/04/008	Mental Capacity Act Monitoring Report – DoLs Monitoring Report – **MCA Training Update**	A future update on progress being made within MCA Training would be useful for the Committee.	**25.10.22**	Rebecca Aylward	**IN PROGRESS** To be brought back to the Committee in **October 2022.**
Actions referred to committees of the Board / Other					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCLC 09/04/010	**DOLs Audit update on recommendations**	The unresolved recommendation: **Timescales for undertaking DoLS Urgent Authorisations** should be taken to Management Executives as a matter of urgency	13.06.22	Ruth Walker/Rebecca Aylward	**COMPLETED** Management Executive Agenda for 13.06.22 Discussed at ME
MHCL 19/06/008 MHCL 20/02/005	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. The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee.	27.09.22	Meriel Jenny	**IN PROGRESS** Agreement not reached with LNC at present. Discussions are ongoing. This item will be reviewed by the S&D Committee and reported back to a future meeting – **Added to S&D Action Log for September**

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring**			Agenda Item no.	**8.1**
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**	Public	x	Meeting Date:	**26.07.2022**
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Interim Deputy Executive Nurse Director**				

Main Report
Background and current situation:

The purpose of this report is to provide a general update on current issues and to introduce a revised 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.

The MCA indicators provide a level of detail on number of IMCA referrals and type of IMCA referral. In preparation for the Implementation of Liberty Safeguards (LPS) the current advocacy arrangements and contracts are under review to enable the training and recruitment of IMCA's, as it is expected under LPS regulations there will be an increase in referrals.
The MCA indicators also provide Mental Capacity training compliance by staff group, as discussed at April Committee, WG funding has enabled further Estyn approved Mental Capacity Training to be provided an update has been previously provided to April Committee.

The DoLS indicators detail the number of DoLS applications received, processed, withdrawn and breaches of urgent and standard applications. January – May 2022. (Appendix 1)

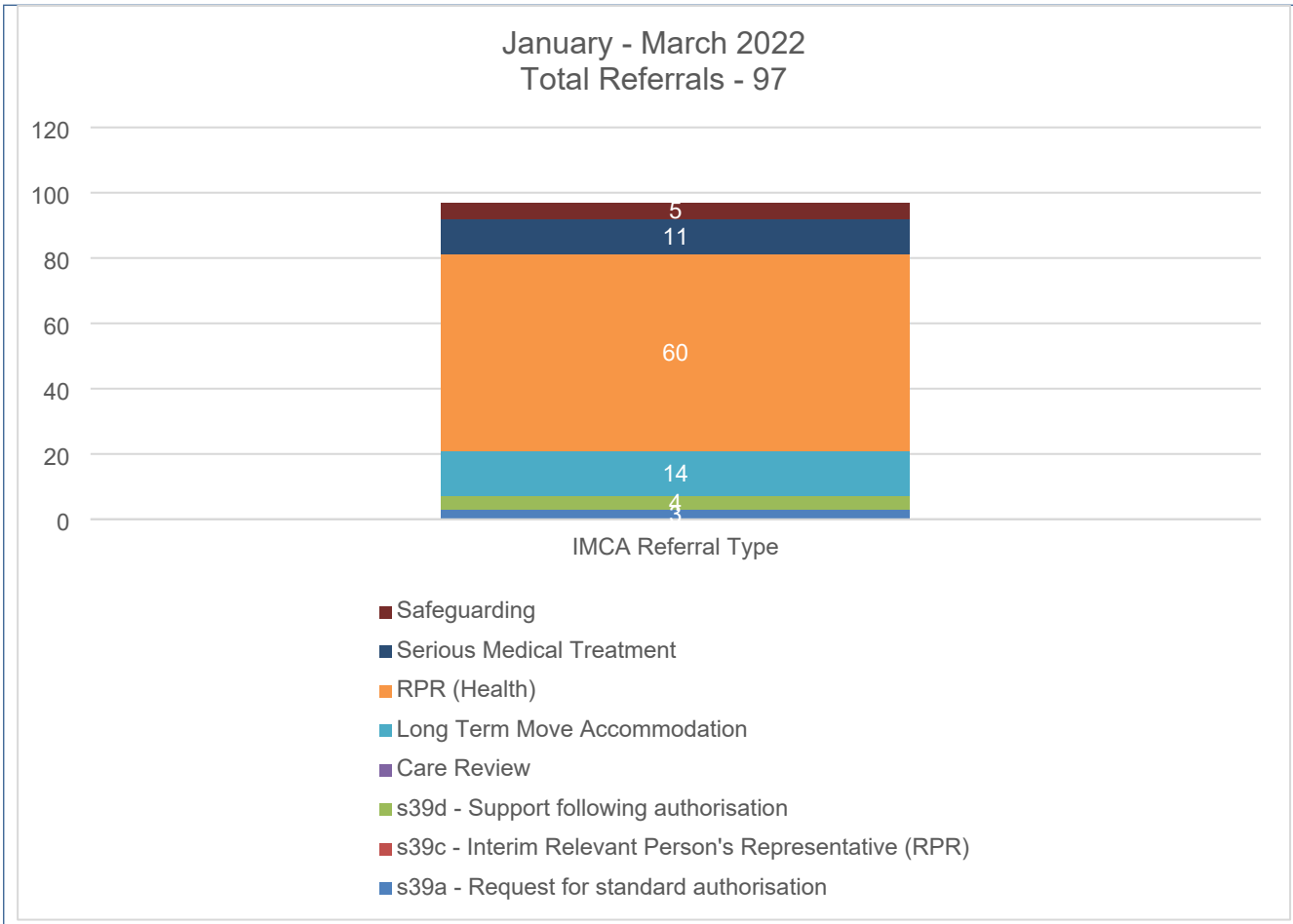
The DoLS indicators demonstrate an improving position as detailed within, Appendix 1, which provides the comparative data for January 2022 – May 2022. For the purposes of this report May 22 data has been highlighted to demonstrate clearly the current position which is broadly representative of the DoLS indicators this year to date.

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

Mental Capacity Act Monitoring actions:

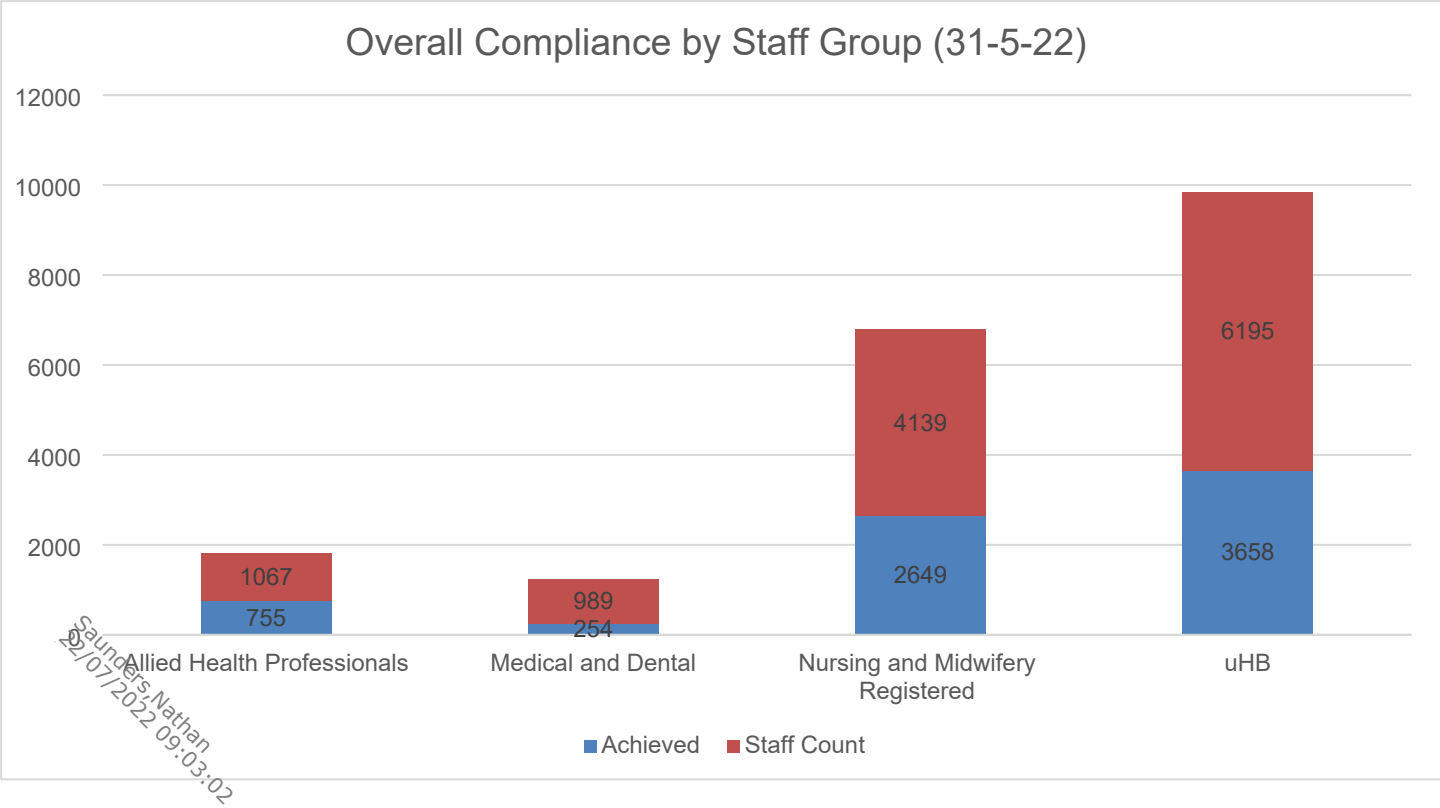
- **Mental Capacity IMCA Referral type**

The MCA Indicators demonstrate the following breakdown of IMCA referrals, data is January to March 2022 as further data is not available until August which is in line with IMCA reporting arrangements.



- **Mental Capacity Training**

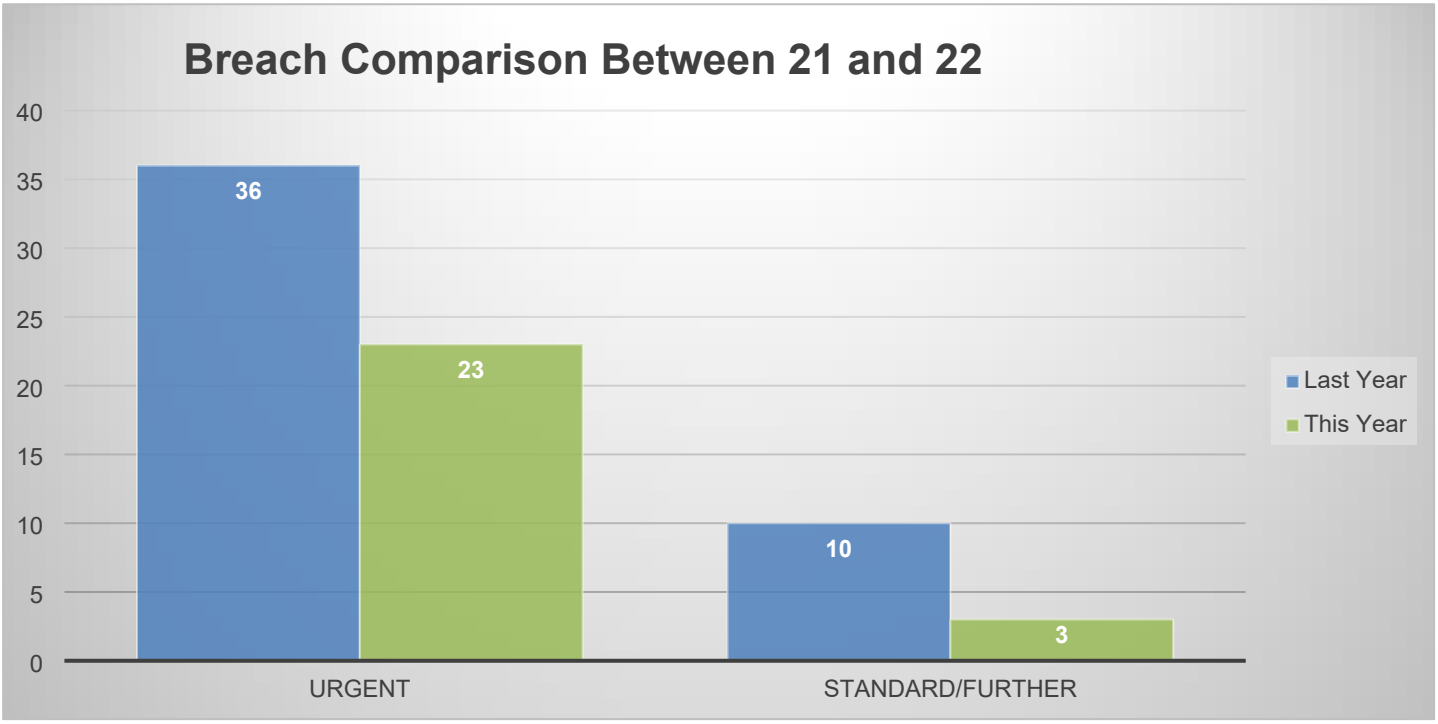
The following graph demonstrates overall Compliance by Staff group



- **Deprivation of Liberty Safeguards Monitoring actions:**

The DoLS indicators demonstrate an improving position as detailed within, Appendix 1 Which provides the comparative data for January 2022 – May 2022.

The most recent data available is May 2022 and the below graph demonstrates a comparison of breaches both urgent and standard between May 2021 and May 2022

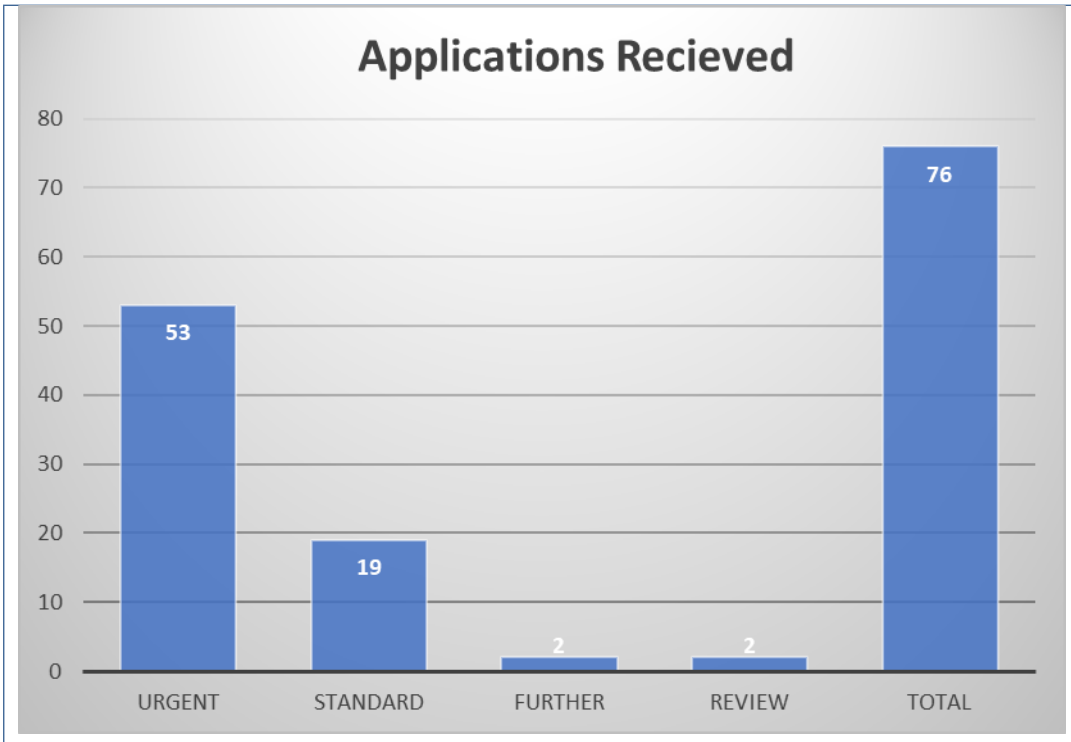


Welsh Government funding for Mental Capacity Act 2005 / Deprivation of Liberty Safeguards (DoLS) for financial year 2020/2021 enabled progress to reduce the backlog of DoLS urgent (7 days) and standard (21 days) assessments as detailed above.

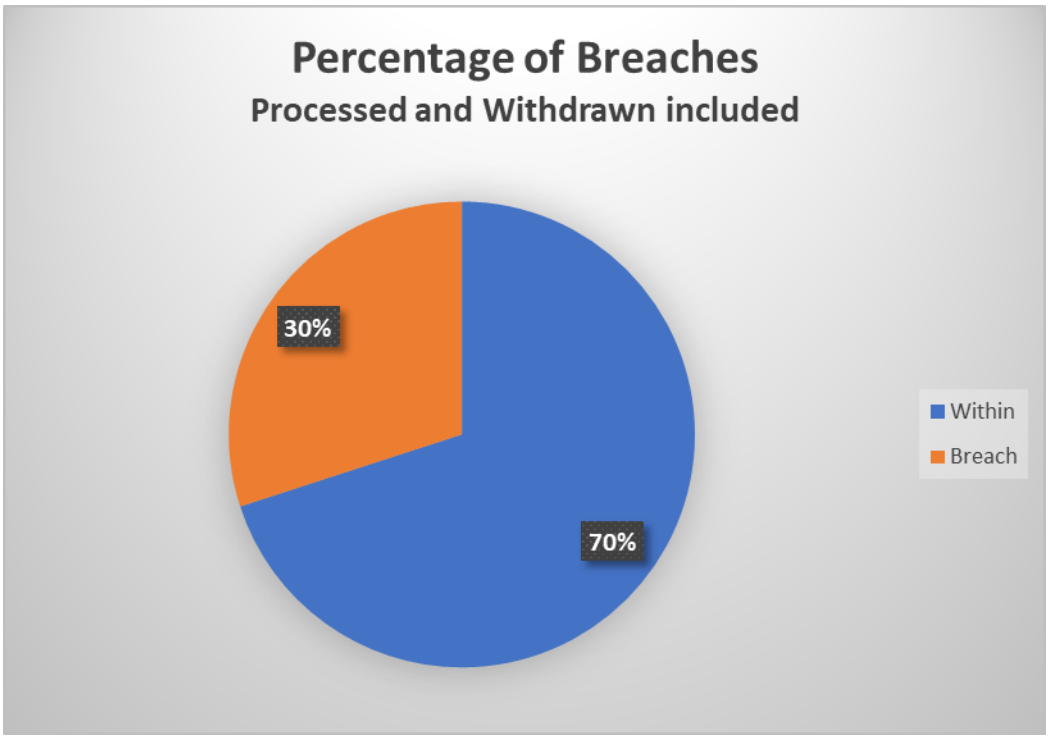
Welsh Government Funding for Mental Capacity Act 2005 / Deprivation of Liberty Safeguards (DoLS) for financial year 2022/23, will enable the recruitment to two full time Best interest assessor posts which will clear the backlog of DoLS 7 day and 21-day assessments.
The recruitment to permanent posts was approved at Management Executive on 13th June 2022

May 2022 – indicators

May indicators as below, demonstrate 76 DoLS applications were received; 53 Urgent (7 days), 19 standard (21 days), 4 reviews



The number of total breaches for May were 26 out of total number of 76 applications. Further detail is contained within Appendix 1.



Recommendation:

The Mental Health and Capacity Legislation Committee is requested to **NOTE** the contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators.

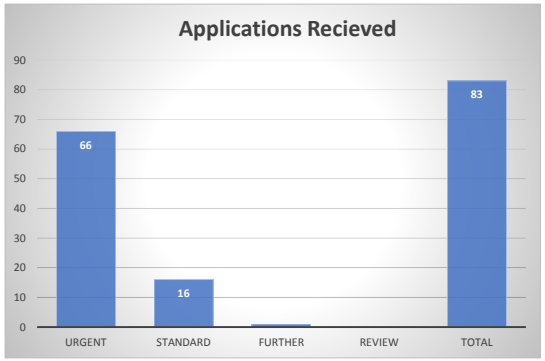
Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

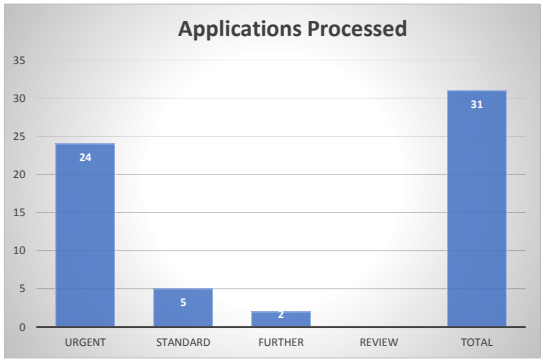
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver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

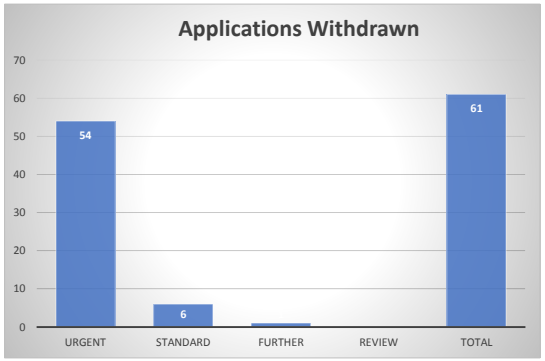
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	

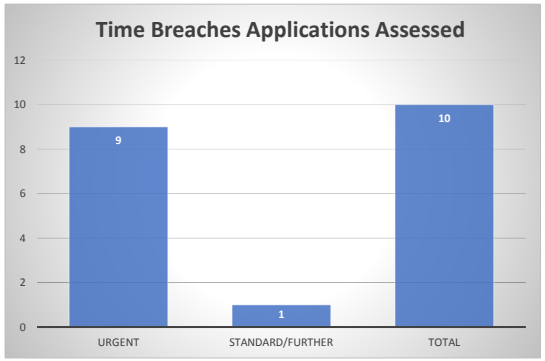
Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Risk of Non-compliance to the Mental Capacity Amendment Act 2019
Safety:
No
Financial:
No
Workforce: Yes
Risk of inability to recruit to posts
Legal: Yes
Risk of Non-compliance to the Mental 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

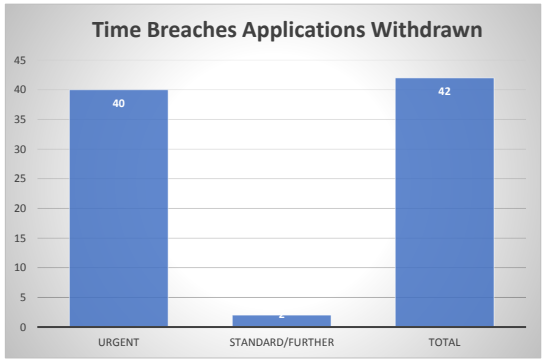
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

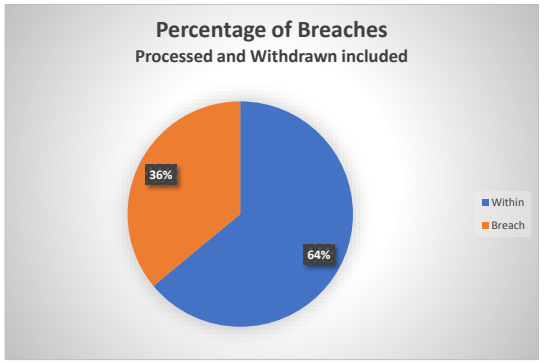


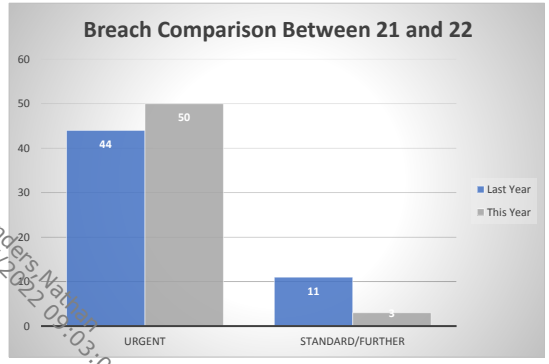


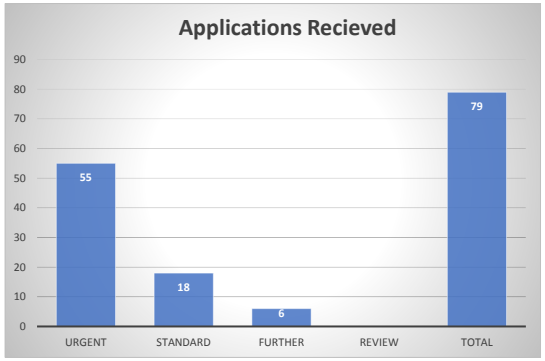


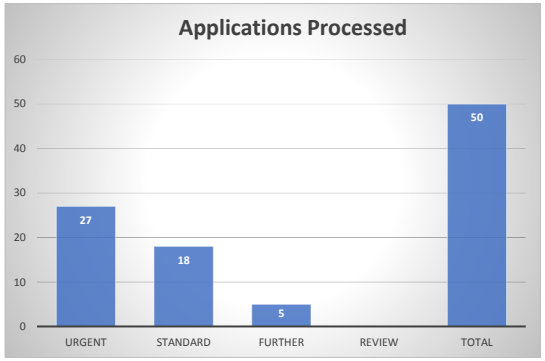


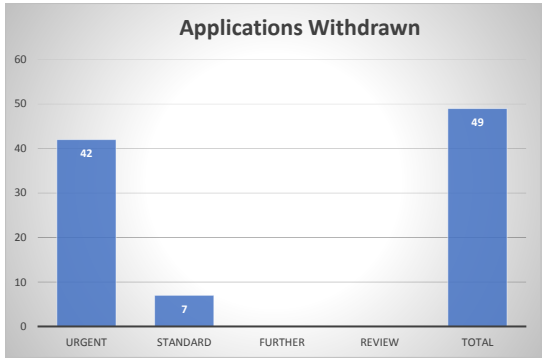


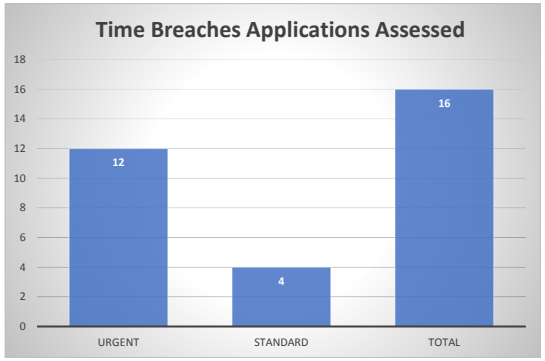


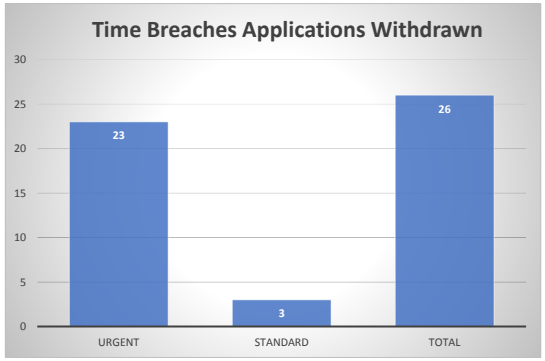


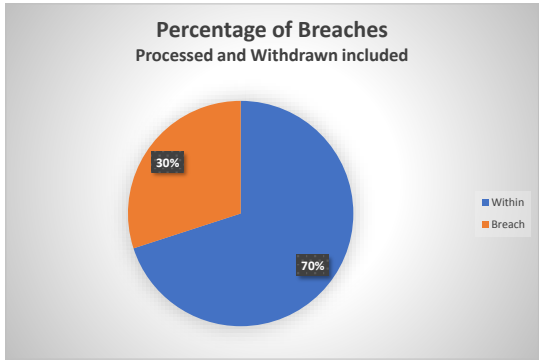


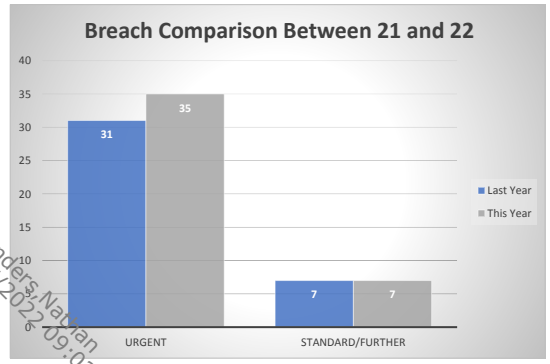


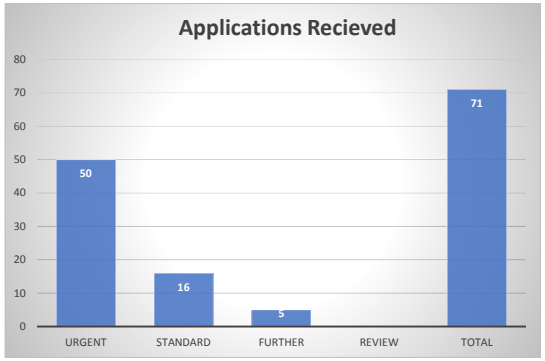


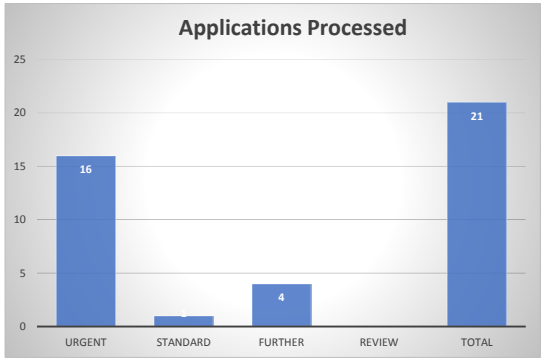


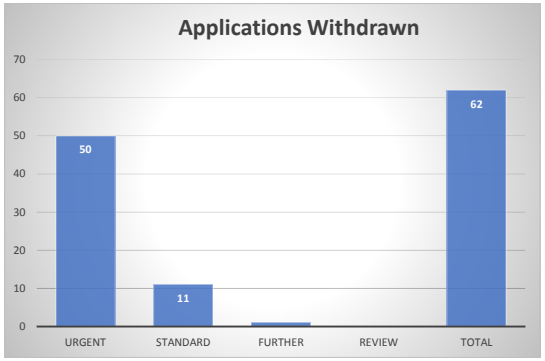


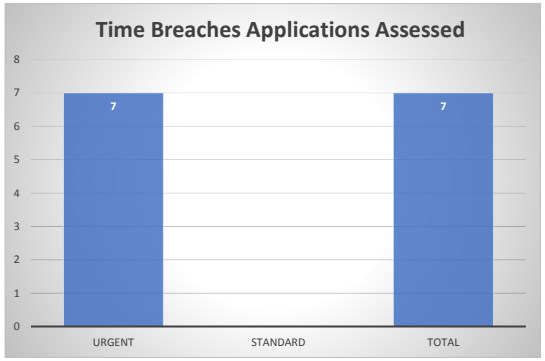


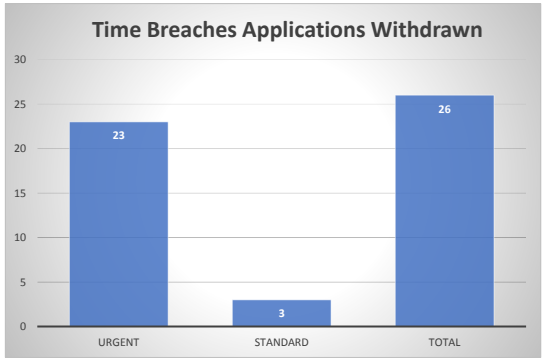


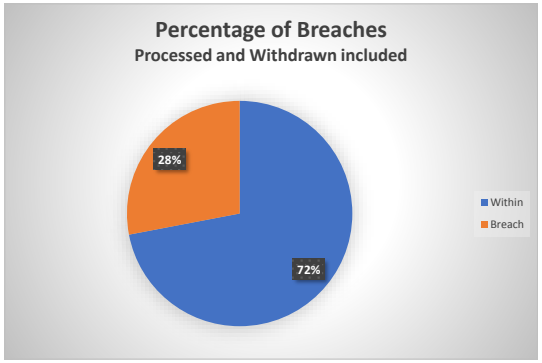


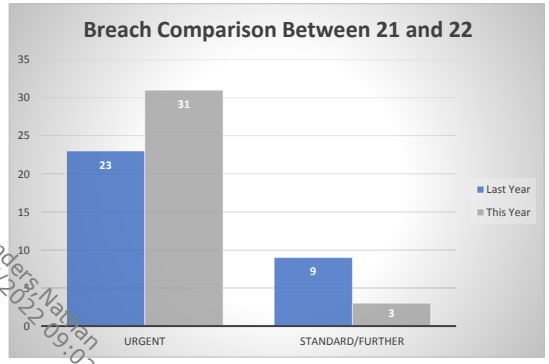


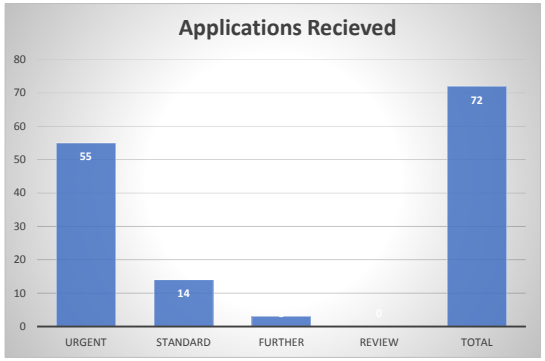


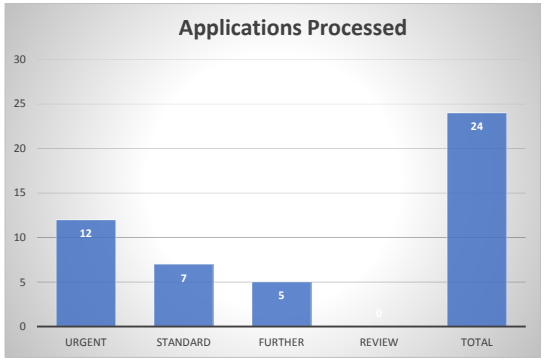


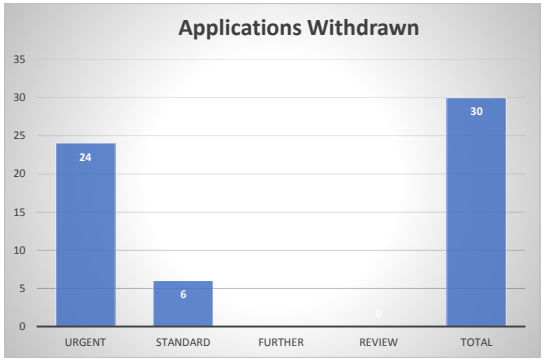


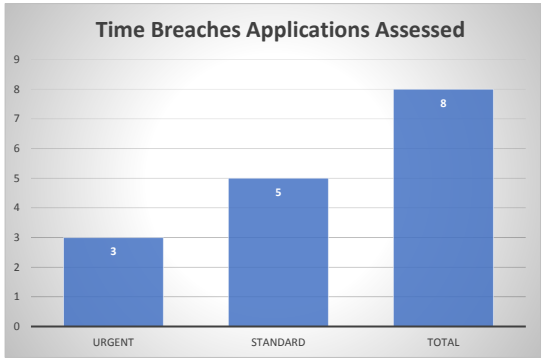


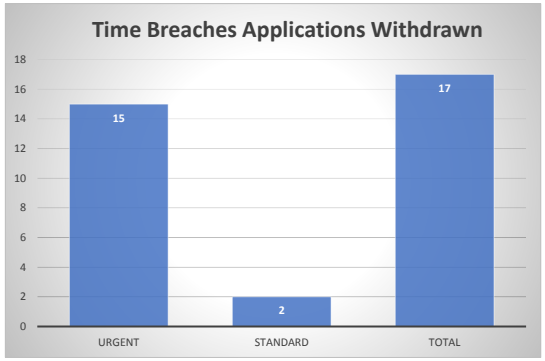


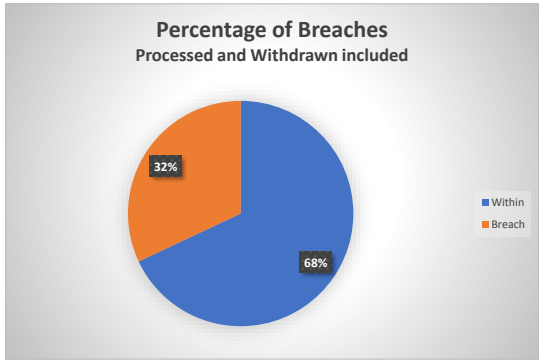


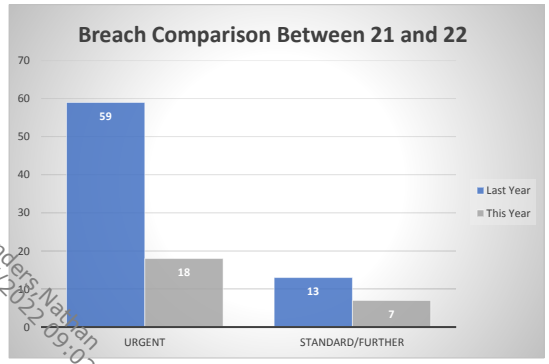


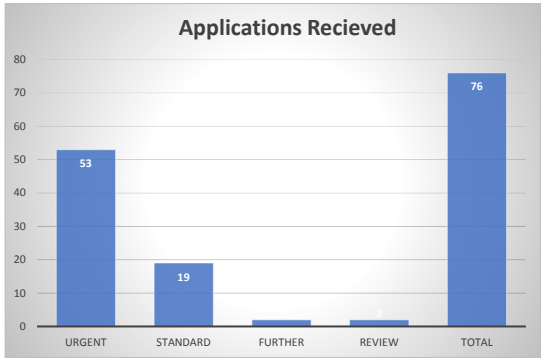


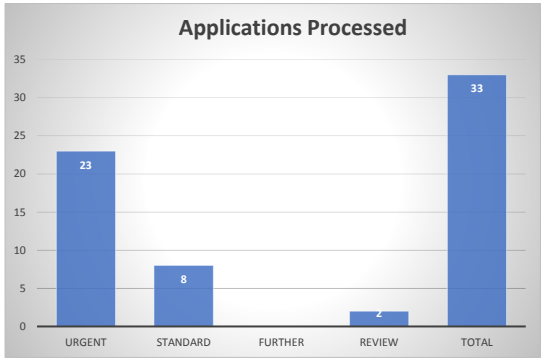


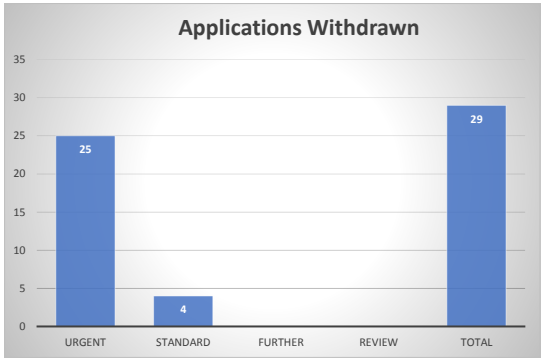


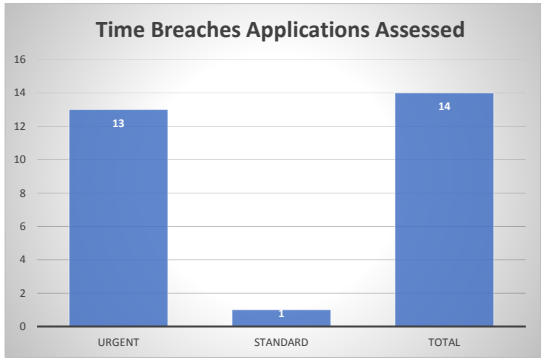


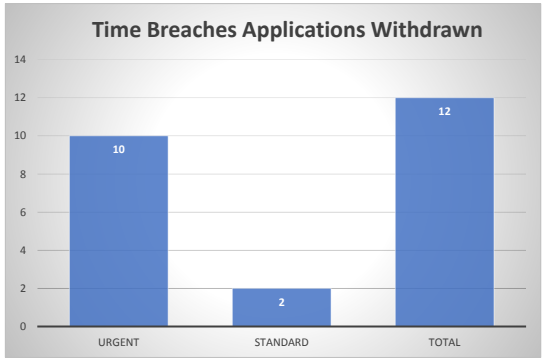


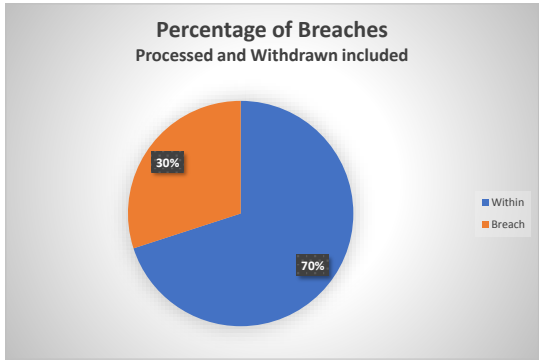


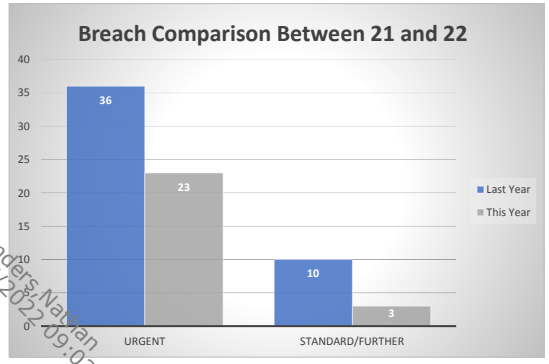












Report Title:	**Liberty Protection Safeguards progress to implementation**			Agenda Item no.	**8.2**
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**	Public	x	Meeting Date:	**26.07.2022**
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Interim Deputy Executive Nurse Director**				

Main Report
Background and current situation:

Background and current situation:
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 Liberty Protection Safeguards (LPS).

The Consultation Welsh Government LPS draft Regulations, was launched on 17th March 2022. The consultation deadline for responses has been extended to end 15th July 2022.
The 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

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.
Under the LPS, the UHB will become the Responsible Body for authorizing the arrangements that amount to a deprivation of liberty. This will significantly impact on health professionals and managers across our acute and community hospitals, mental health, learning disabilities services, nursing/care homes caring for patients in receipt of CHC funding and in independent hospitals within the Cardiff & Vale UHB geographical area. LPS will apply to all patients over the age of 16 years, 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. Work is currently being undertaken to predict the increase in cases under the LPS, likely 200 – 400 per year.

Cardiff & Vale UHB preparedness is in line with neighboring Health Boards across Wales. WG are advising against training and to launch UHB implementation until the Regulations have been finalized, this is likely to be early autumn 2022. WG plan to provide standardized training materials and it is currently anticipated that these will be released in early 2023.

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

In preparation for the LPS launch of final regulations, our LPS Project Lead is liaising with Clinical Boards to ensure Cardiff & Vale provides an informed response to the LPS draft regulations consultation and is linking closely with WG and Health Boards to ensure consistency of practice and preparedness.

Welsh Government are releasing phased funding to support LPS preparedness and implementation;

Phase 1: Mental Capacity Act: Preparation for Liberty Protection Safeguards WG funding of £106k**,** has enabled the recruitment of admin support and 2 Best Interest assessors. The recruitment of Best interest assessors will enable the back log of Deprivation of Liberty Safeguards to be cleared, support training and theses roles will evolve into the new Approved Mental Capacity Professionals (AMCP) which will be new roles employed by HB to support LPS. The recruitment to permanent posts was agreed at Management Executive 13th June 22.

Phase 2: Mental Capacity Act: Preparation for Liberty Protection Safeguards WG funding of £160k for workforce planning, Development of data capability and training needs.
£306k is available for spending on additional IMCA services.
This funding bid and UHB requirements is required by August 1st 2022.

WG have committed to future phase funding 2023/2024 and 2024/2025, however there is a financial risk to the UHB as permanent funding will be required to support Liberty protection Safeguard arrangements.

Recommendation:

The Mental Health and Capacity Legislation Committee is requested to **NOTE** the contents of the report and the current progress to implementation of 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 *Please tick as relevant*									
Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	

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
Risk of Welsh Government Funding of posts is non-recurrent post implementation.

Workforce: Yes
Risk of inability to recruit to posts
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
22/07/2022 09:03:02

Report Title:	**Internal Audit Report on Deprivation of Liberty Safeguards (DoLS) UPDATE**			Agenda Item no.	**8.3**
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**	Public	x	Meeting Date:	**26.07.2022**
		Private			
Status *(please tick one only)*:	Assurance x	Approval		Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Interim Deputy Executive Nurse Director**				

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 Safegaurds, which was undertaken during August – October 2019, (Appendix 1).

The Mental Health Legislation and Mental Capacity Act Committee requested further assurance and urgent actions to complete the outstanding recommendations presented to the Committee on 26th April 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, all of the recommendations are complete.

Recommendations 1&3: Improvement of timescales for undertaking DoLS urgent authorisations (high priority) and standard authorisations (low priority)
Action taken:
Welsh Government Funding for Mental Capacity Act 2005 / Deprivation of Liberty Safeguards (DoLS) for financial year 2022/23, will enable the recruitment of two full time Best interest assessor posts which will clear the backlog of DoLS standard (7 day) and urgent (21-day) authorisations
The recruitment to permanent posts was approved at Management Executive on 13th June 2022

Recommendations 2: Medium priority Deprivation of Liberty training
Action taken:
DoLS awareness training is now provided within mandatory safeguarding training. Individual areas have received targeted training.
The focus of future training is Mental Capacity assessments in preparation for transition to Liberty Protection Safeguards.

Recommendation 4: Produce Implementation plan for implementation of Liberty Protection Safeguards
Action taken:
Liberty Protection Safeguards Draft Code of Practice and Regulations consultation commenced on 17th March 2022 and closed on 14th July 2022. The Health Board will be unable to produce an implementation plan until the Code of Practice is final. However, the Health Board has received Welsh Government Phase 1 & 2 funding to support the preparation for Liberty Protection Safeguards
This funding has been used to strengthen Mental Capacity training and to recruit an LPS Project Lead, two Best Interest Assessors and an administration support. This is the first stage of

implementation and is aligned to Welsh Government expectations at this stage of transition from Deprivation of Liberty Safeguards to Liberty Protection safeguards.

Recommendation:

The Mental Health and Capacity Legislation Committee is requested to **NOTE** the contents of the report and the assurance provided to the completion of the recommendations and transition 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
Please tick as relevant

Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	

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: No

Workforce: Yes
Risk of inability to recruit to posts
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:

Deprivation of Liberties Safeguards (DoLS)

Final Internal Audit Report

Cardiff and Vale UHB

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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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

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:

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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.

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).

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**

Finding 1 - Timescales for undertaking DOLs Urgent Authorisations (Operating effectiveness)	Risk
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. Below are our findings: • 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.	Patients may be unlawfully deprived of their liberties
Recommendation	**Priority level**
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.	**High**
Management Response	**Responsible Officer/ Deadline**
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.	To be confirmed / October 2020

Finding 2 - DOLs Training (Operating effectiveness)	Risk
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. 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. 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.	Non- compliance with DOLs due to lack of processes / awareness
Recommendation	**Priority level**
The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted.	**Medium**

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
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. For the three standard DOLs authorisation requests the following was noted: • 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. • The average time taken was therefore 37 days. For the two further DoLS authorisation requests the following was noted:	Patients may be unlawfully deprived of their liberties

• 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. 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.	
Recommendation	**Priority level**
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.	**Low**
Management Response	**Responsible Officer/ Deadline**
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.	To be confirmed / October 2020

Finding 4 - Liberty Protection Safeguards (Operating effectiveness)	Risk
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. 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.	The Health Board is unaware of issues relating to DOLs compliance
Recommendation	**Priority level**
The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.	**Low**
Management Response	**Responsible Officer/ Deadline**
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.	To be confirmed / October 2020

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.

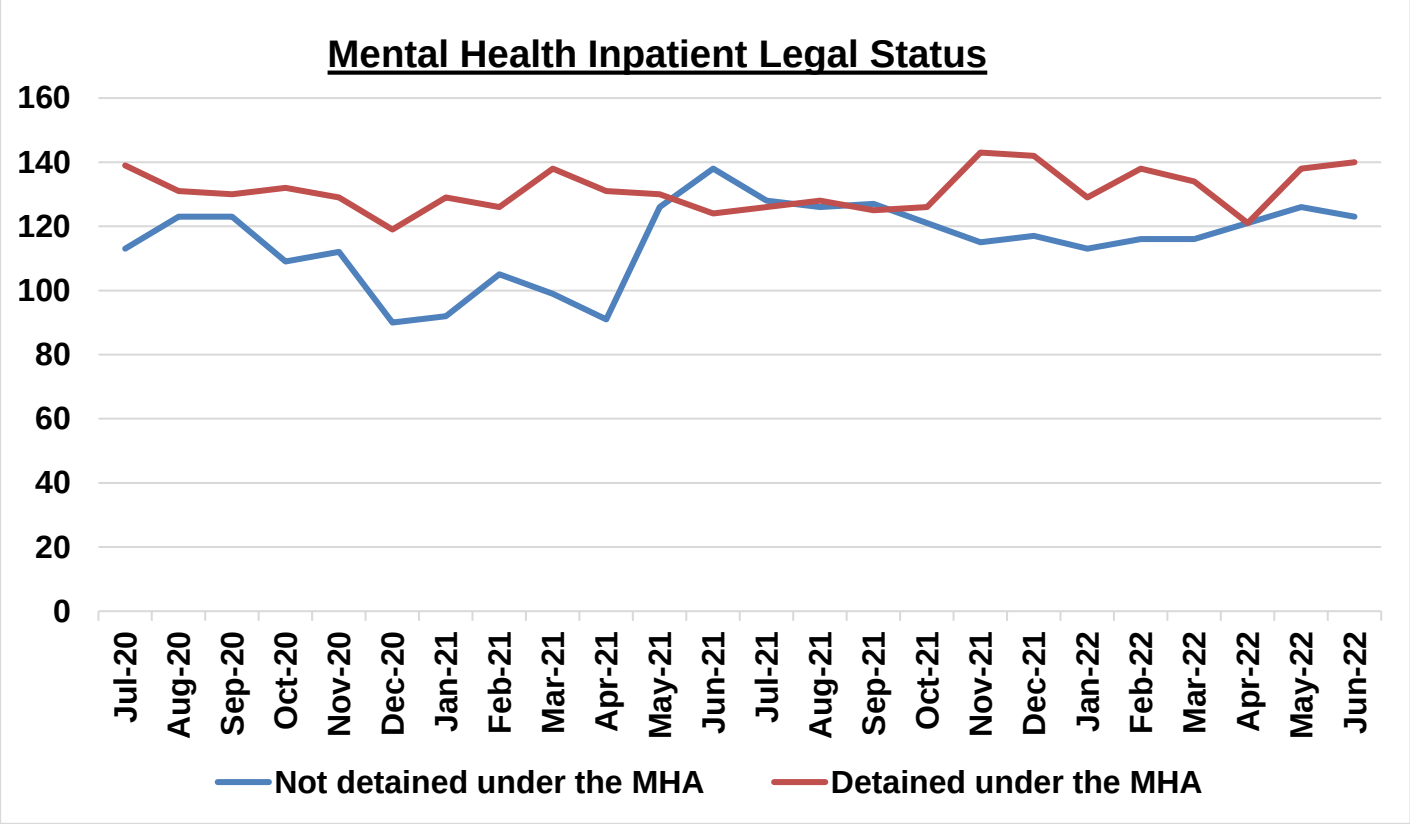
Report Title:	Mental Health Act Monitoring Exception Report				Agenda Item no.	9.1	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X		Meeting Date:	26 July 2022	
		Private					
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Interim Chief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

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 MHA



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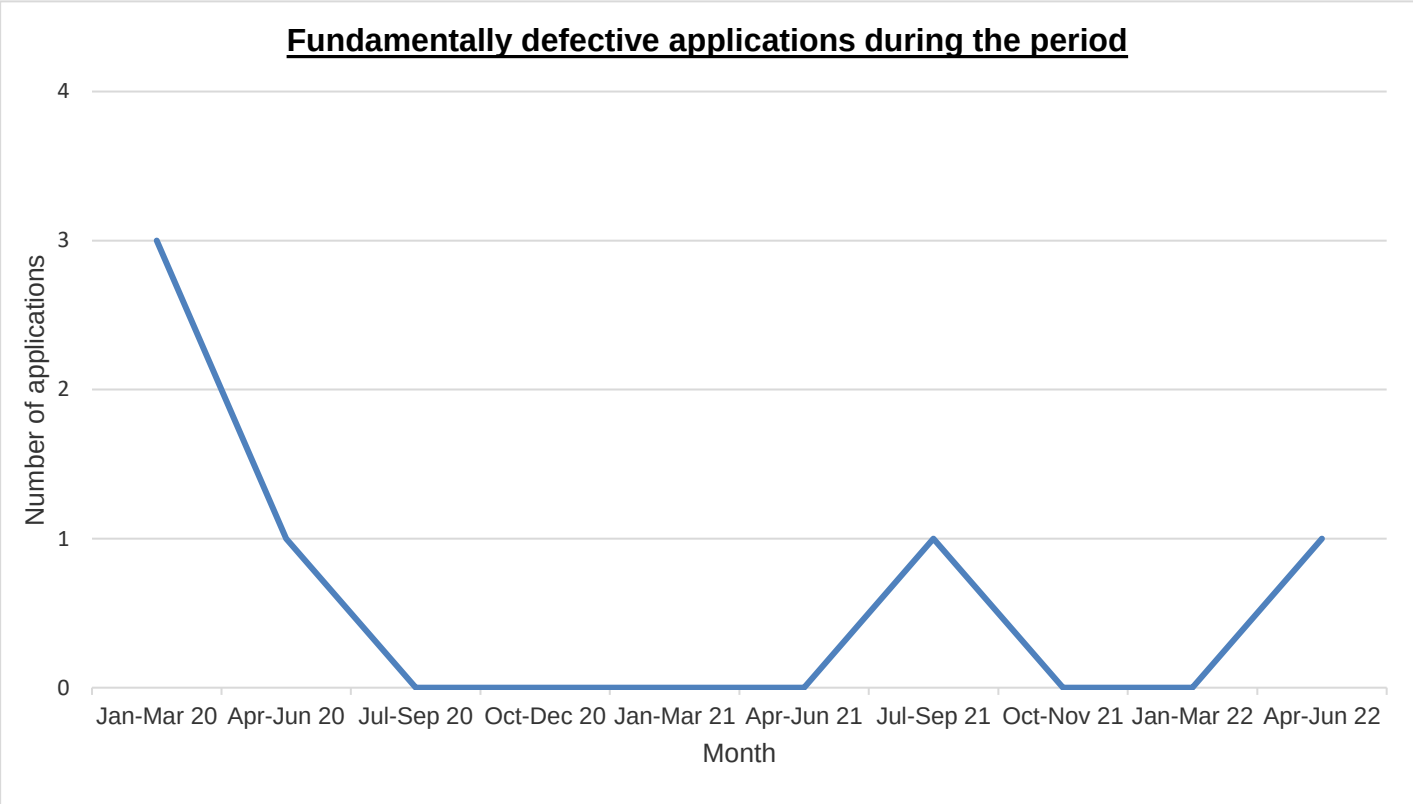
22/07/2022 09:03:02

Fundamentally defective applications



During the quarter there was 1 fundamentally defective section 2 application.

P was detained under section 2 on 08/04/2022 in A7 North, UHW. The AMHP gave the papers to nursing staff on the ward as the patient was awaiting transfer to Hafan Y Coed. A receipt wasn't completed by the AMHP nor did the AMHP send an e-mail informing the MHA office of the detention. The papers weren't sent to the MHA office or the shift coordinator therefore, the papers weren't formally accepted by a person authorised to receive them on behalf of the hospital managers. The patient didn't end up being transferred to Hafan Y Coed.
We were only made aware of the detention when the Responsible Clinician discharged the patient from section 2 and sent us the discharge form.
Based on previous legal advice sought from Richard Jones, the patient was 'liable to be detained' based on the application the AMHP had completed but because the papers weren't formally accepted, they were fundamentally defective and the patient was held without authority.

Lapsed Detention

During the quarter 1 section 5(2) lapsed.

The 5(2) was applied on a Saturday and EDT were informed. They advised to wait for day services to pick it up on Monday. The patient's Responsible Clinician completed a medical recommendation for section 2 on the Monday and the Monday AMHP manager was aware of the section 5(2) and its expiry date/time but due to not having enough AMHP's to complete the MHA assessment that day, it was to be rolled over to the Tuesday to be completed.
Unfortunately, the AMHP manager didn't pass over the details to the Tuesday AMHP manager so this wasn't picked up until Tuesday afternoon and the 5(2) had already expired. A MHA assessment was held later that afternoon and the patient was subsequently detained under section 2.

Invalid use of the MHA

During the quarter there were 2 inappropriate uses of section 5(2).

In both situations the 5(2)'s were applied in order to transport a patient, who was refusing, to a different hospital with Cardiff & Vale. A 5(2) cannot be used to transfer a patient to a different hospital as the 5(2) would automatically lapse once the patient left the original hospital. After investigating both cases, it was decided that these were invalid uses of section 5(2). The doctors who completed the 5(2)'s were advised of the error and given advice on the appropriate uses of a section 5(2).

After these incidents the MHA office created a 5(2) poster informing clinicians what powers they have in relation to transfers and medical treatment while a patient is on a 5(2). This has been cascaded throughout Mental Health.

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.*

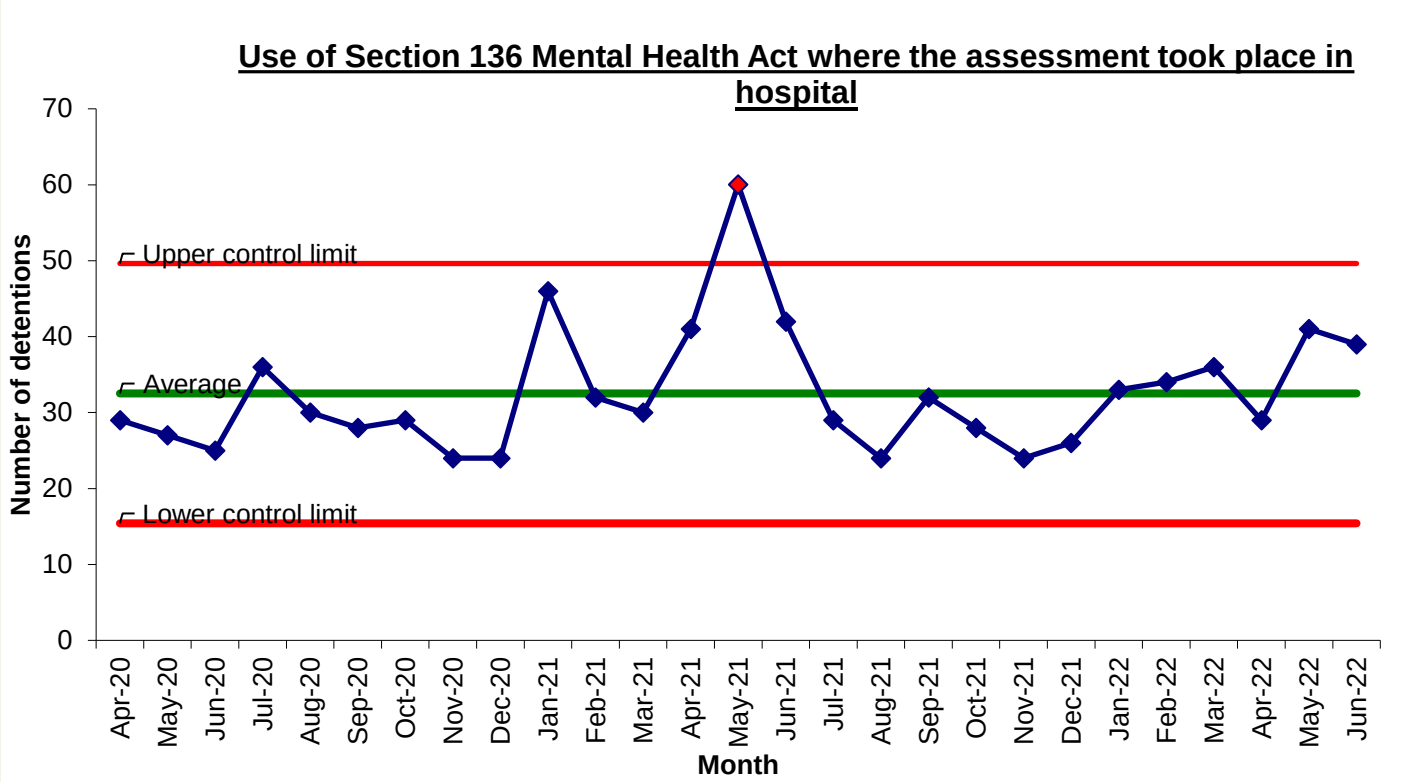
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

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

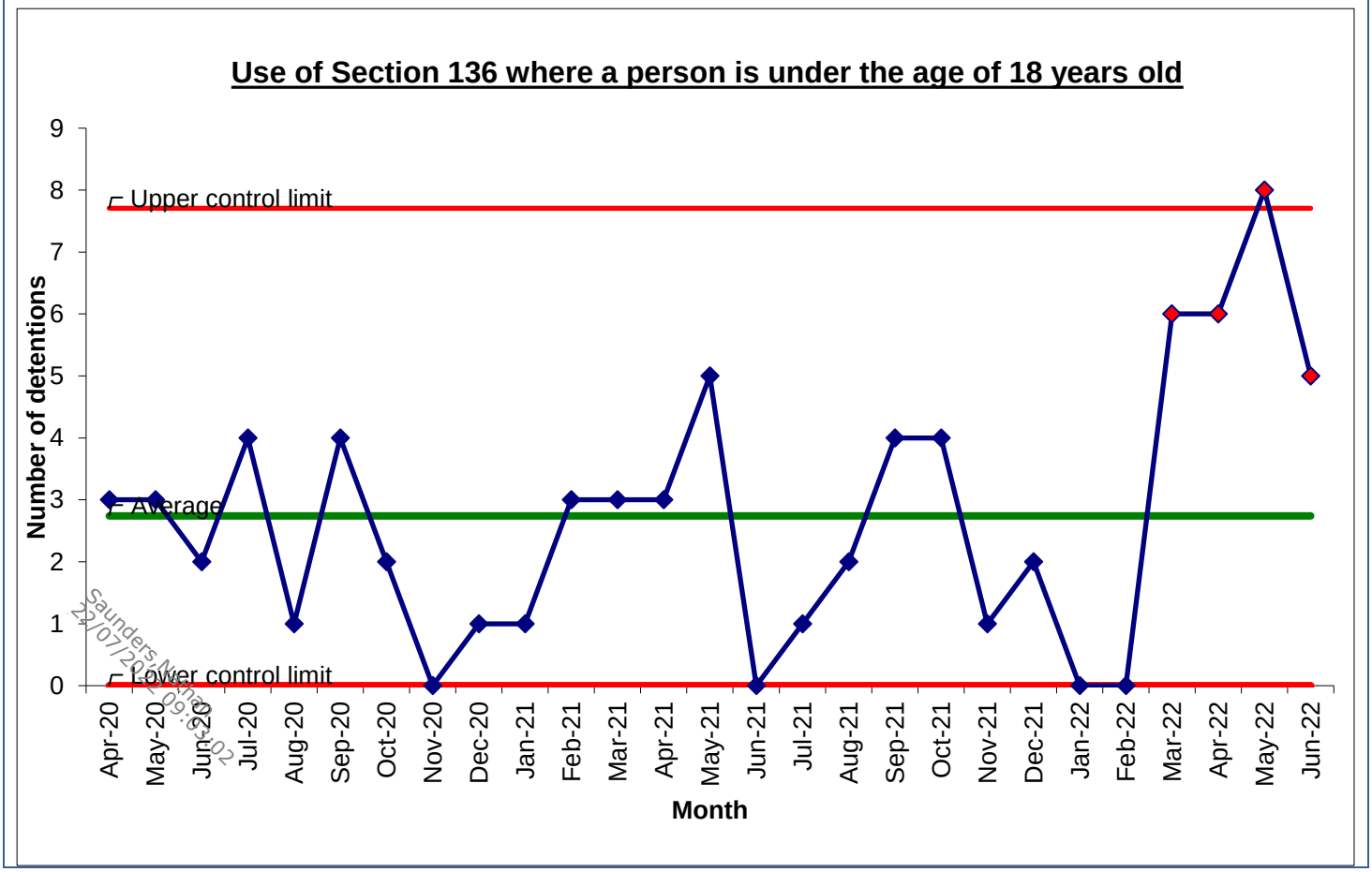
It was noted that 71.5% of individuals assessed were not admitted to hospital, with 43.1% being discharged with community support and 28.4% were discharged with no follow up. Overall during the period 28.5% of patients were admitted to hospital following a 136 assessment which is lower than the previous quarter at 32.7%. During the period 1 patient didn't have an assessment because the 24-hour time had lapsed and no extension had been requested.

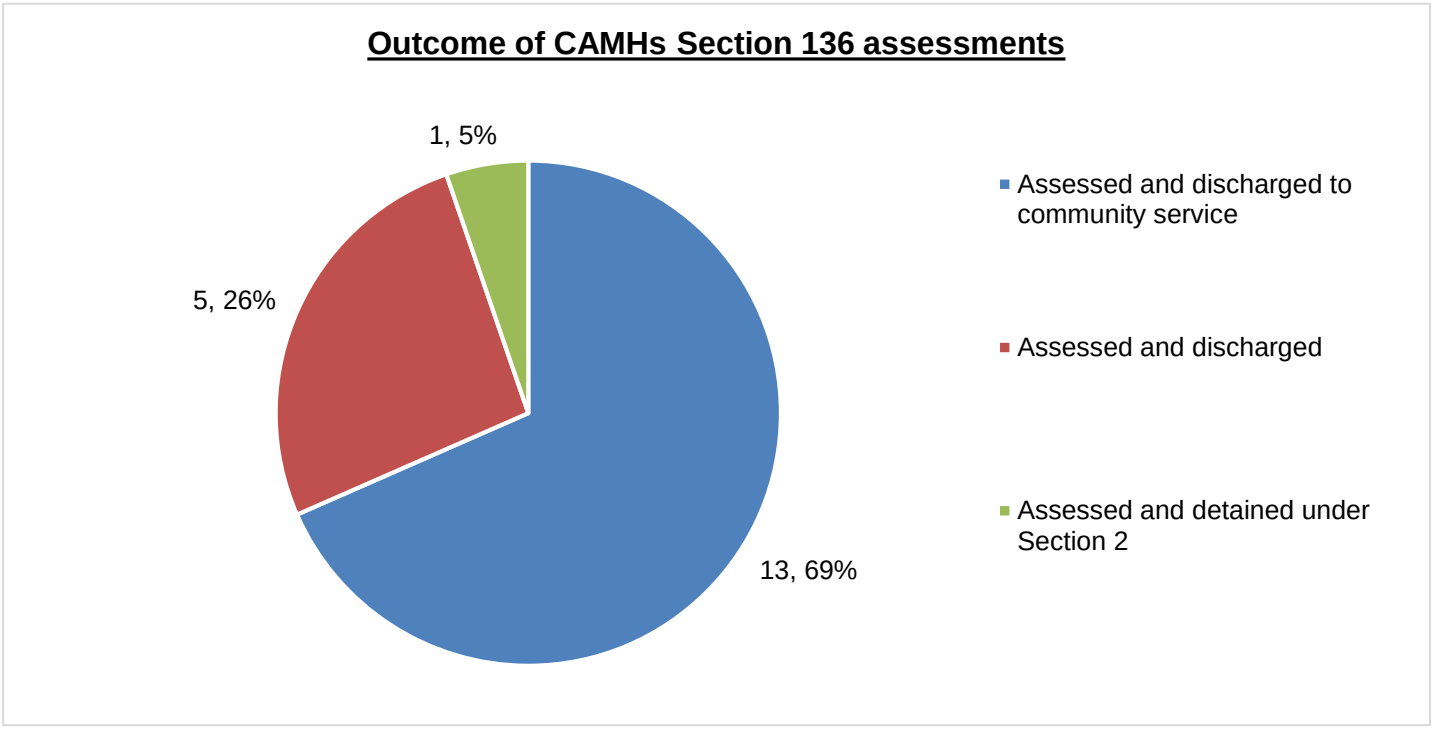
Period	% not admitted to hospital
April – June 2022	71.5%
January – March 2022	63.4%
October – December 2021	68.0%
July – September 2021	74.1%
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%
April – June 2020	70.4%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has increased from 6 in the previous quarter to 19 in this quarter. There were 9 repeat presentations for one patient and 4 for another patient.





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

The Operations Manager at the Tribunal has left and I am waiting to hear of his replacement. There has been no official update from the Tribunal regarding the rollout of Teams as standard for all hearings. However, the majority of new hearings are being listed via Teams rather than teleconference. Nothing has been communicated to the Health Boards that this will be standard going forward.

I have raised the issue again with the Business Manager and await an official decision.

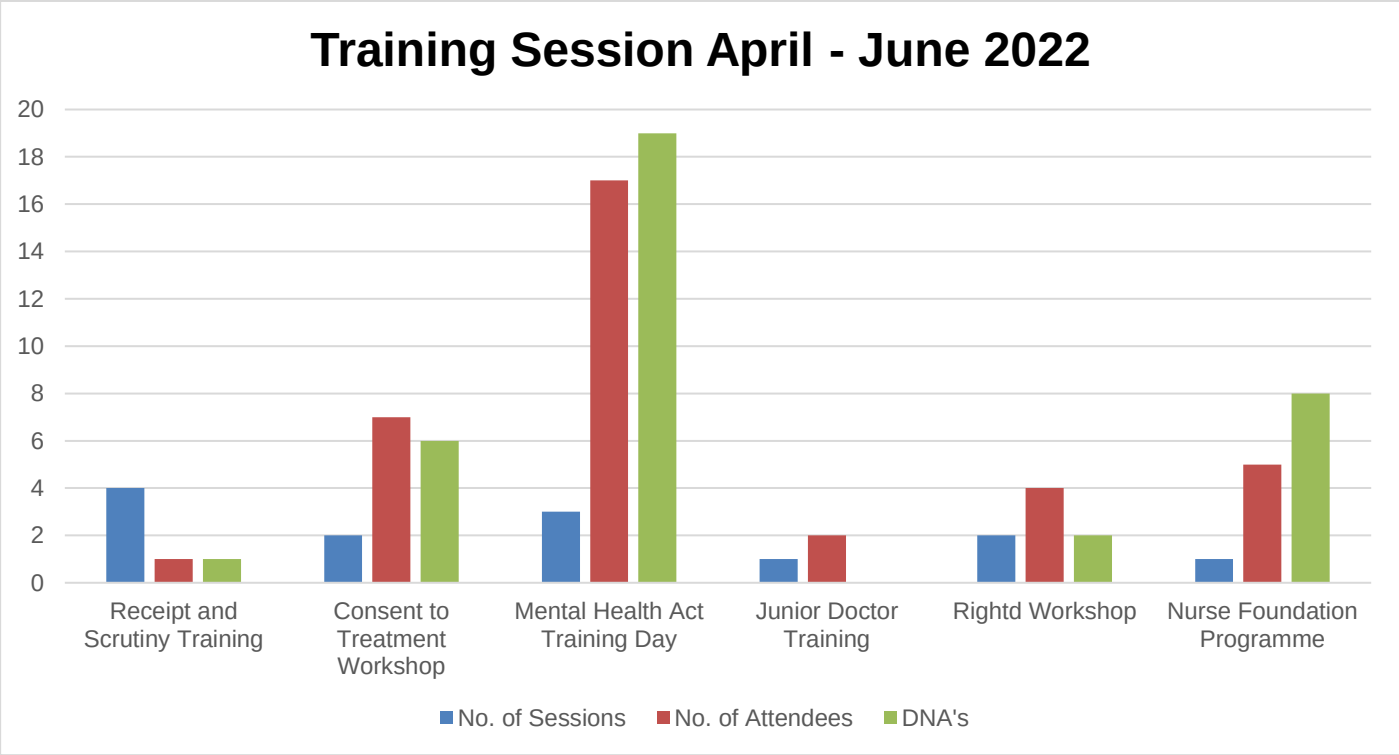
	No. of Tribunals	Teleconference	Teams
April	33	94%	6%
May	17	82%	18%
June	32	75%	25%
July	15	66%	33%
August	13	30%	69%

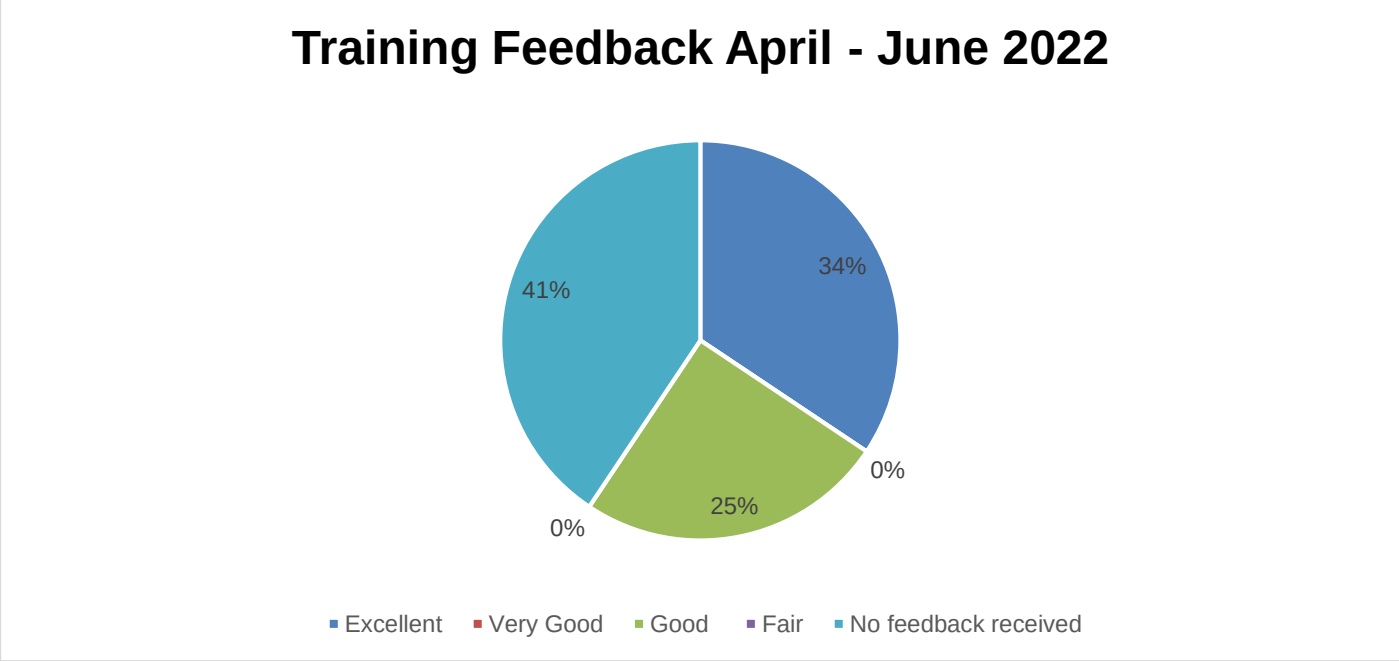
Mental Health Review Tribunal for Wales (MHRT) - Observers

I am waiting for an update from the Operations Managers at MHRT once a replacement has been appointed. I haven't had any requests to observe hearings from nurses or doctors, nor have I been aware of any requests being rejected by the MHRT.

Development Sessions

The MHA office continues to run MHA awareness sessions including a monthly MHA training day, which is available to all staff within the Health Board, Receipt and Scrutiny, Consent to Treatment and a Rights workshop. Also, we continue to support the Nurse Foundation Programme and Junior Doctor's Inductions with MHA training.





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

Fundamentally defective applications
Continue to ensure effective communication between the Local Authority and the UHB and promote MHA training across the UHB.

Lapsed Detention
Continue to ensure effective communication between the Local Authority and the UHB and to attend quarterly Local Authority meetings in order to discuss any concerns.

Invalid use of the MHA
Continue to ensure effective communication between all areas and promote MHA training across the UHB.

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 the majority of hearings via Teams video conference.

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 MHA are available and easily accessible. This will be provided by creating a MHA 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:

Report to the

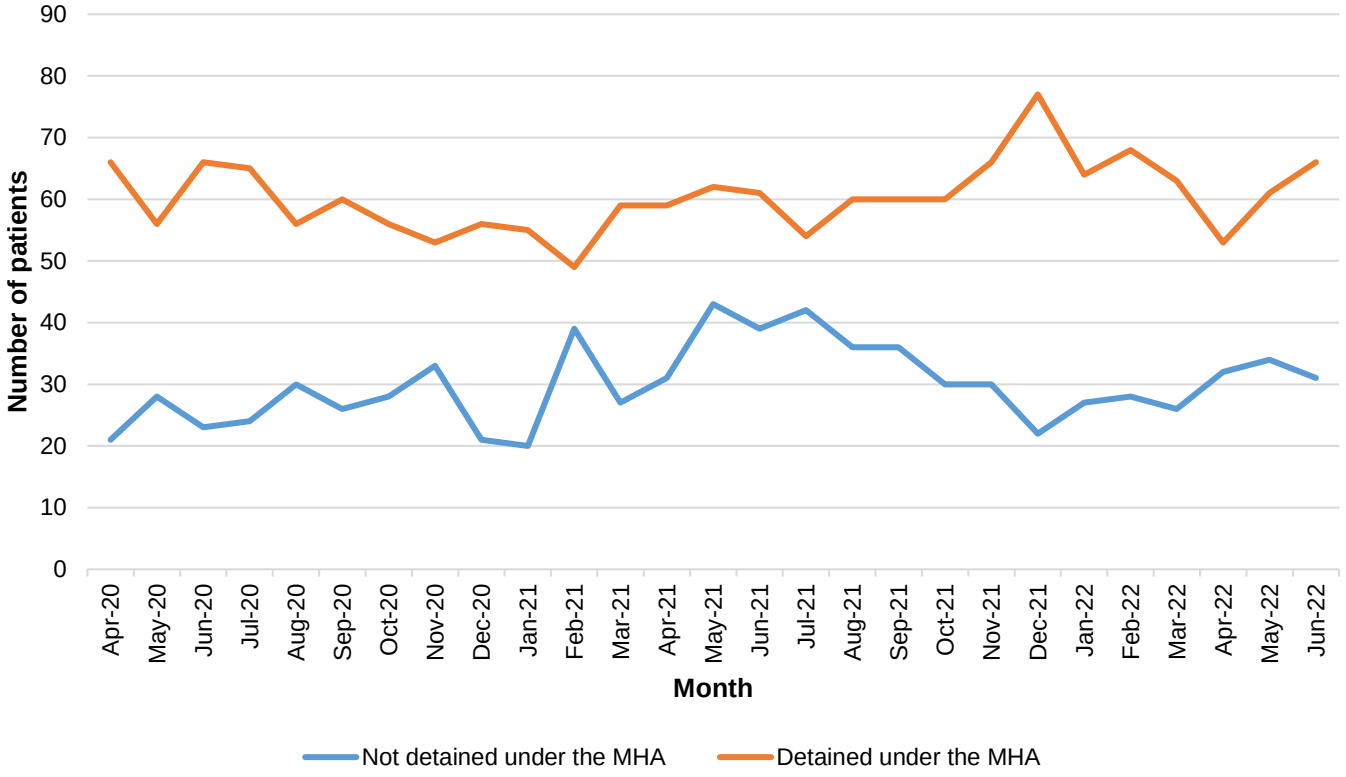
Mental Health Legislation and Mental Capacity Act Committee

on the use of The Mental Health Act, 1983

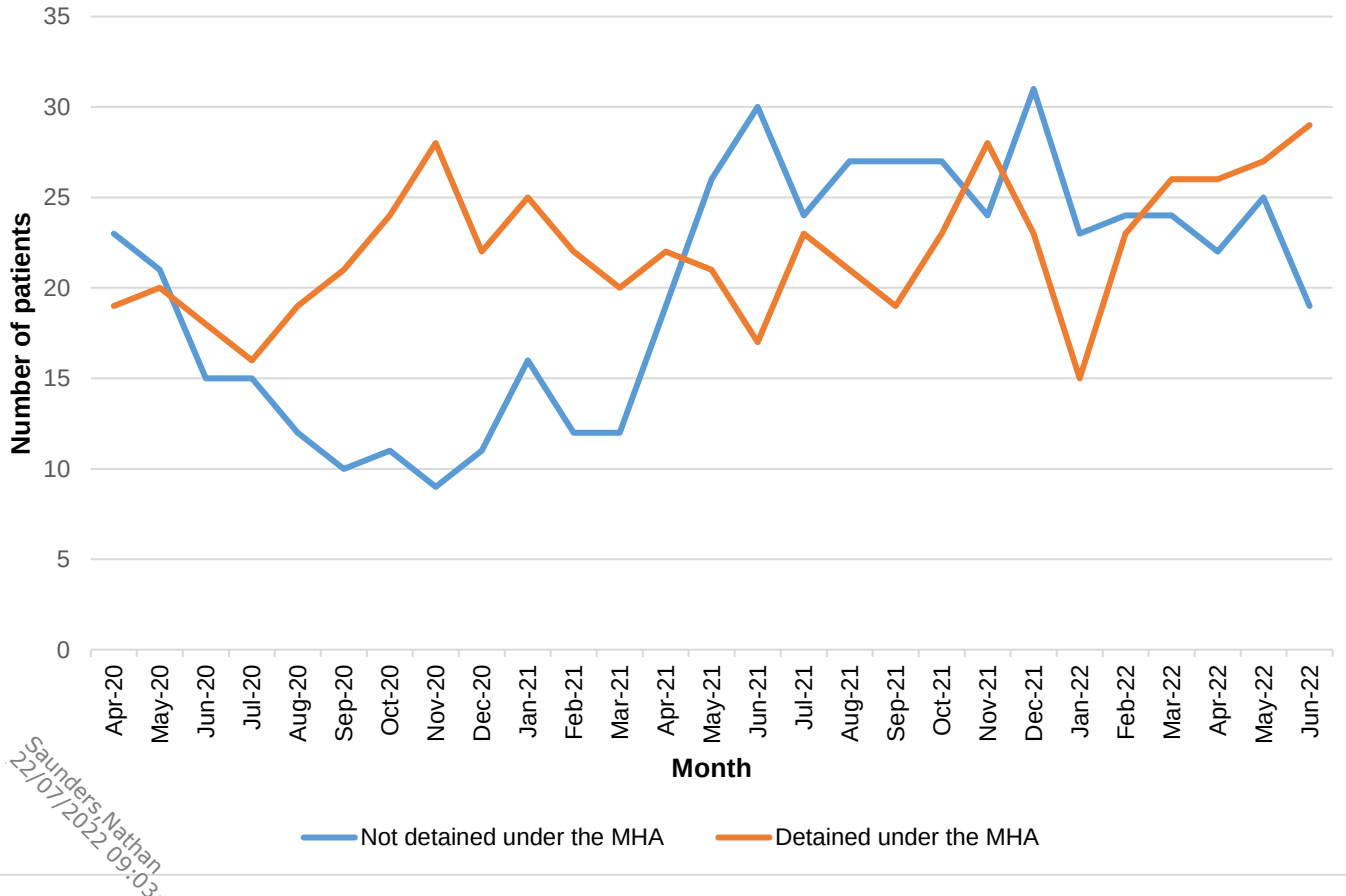
April- June 2022

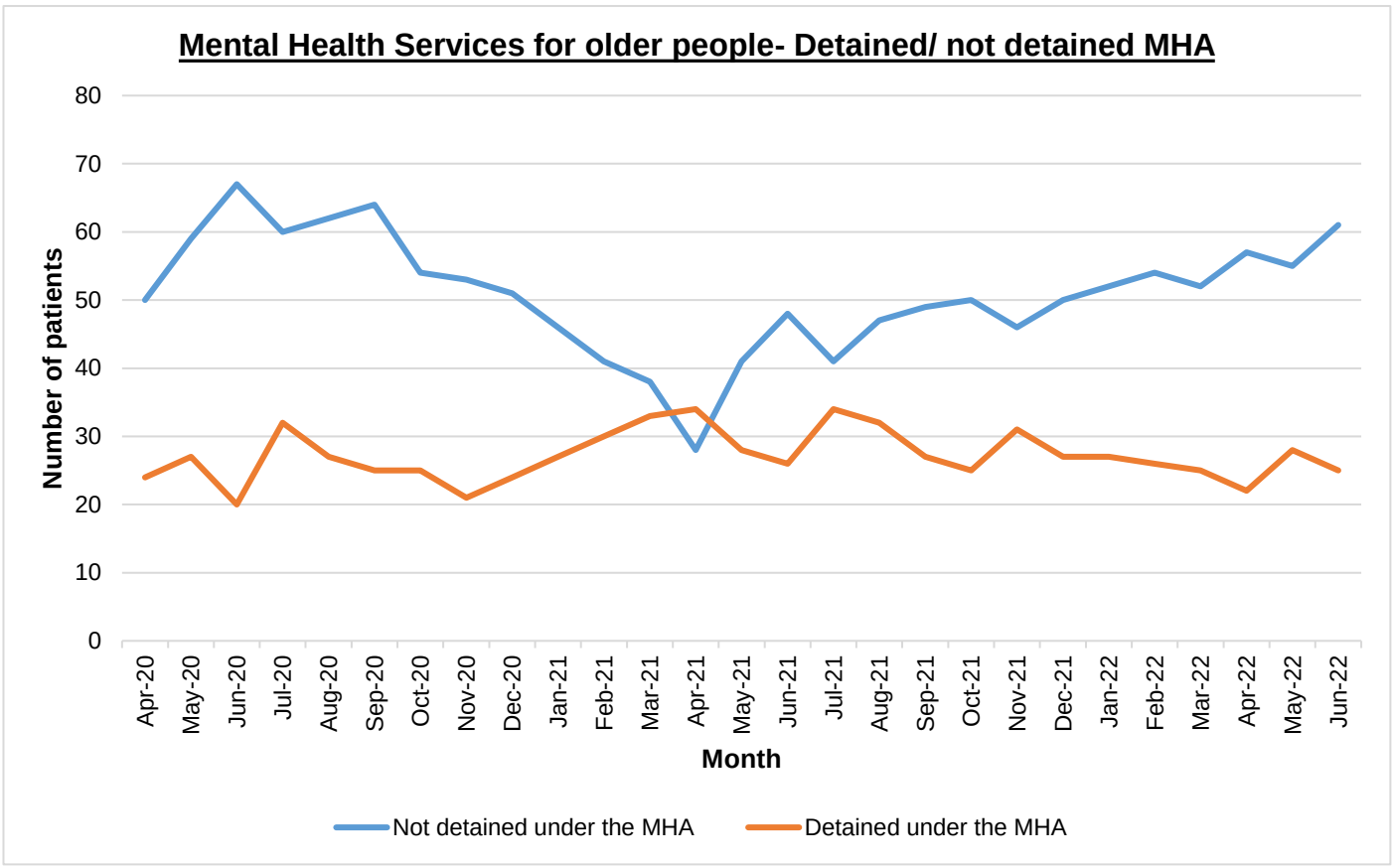
Contents **Page**

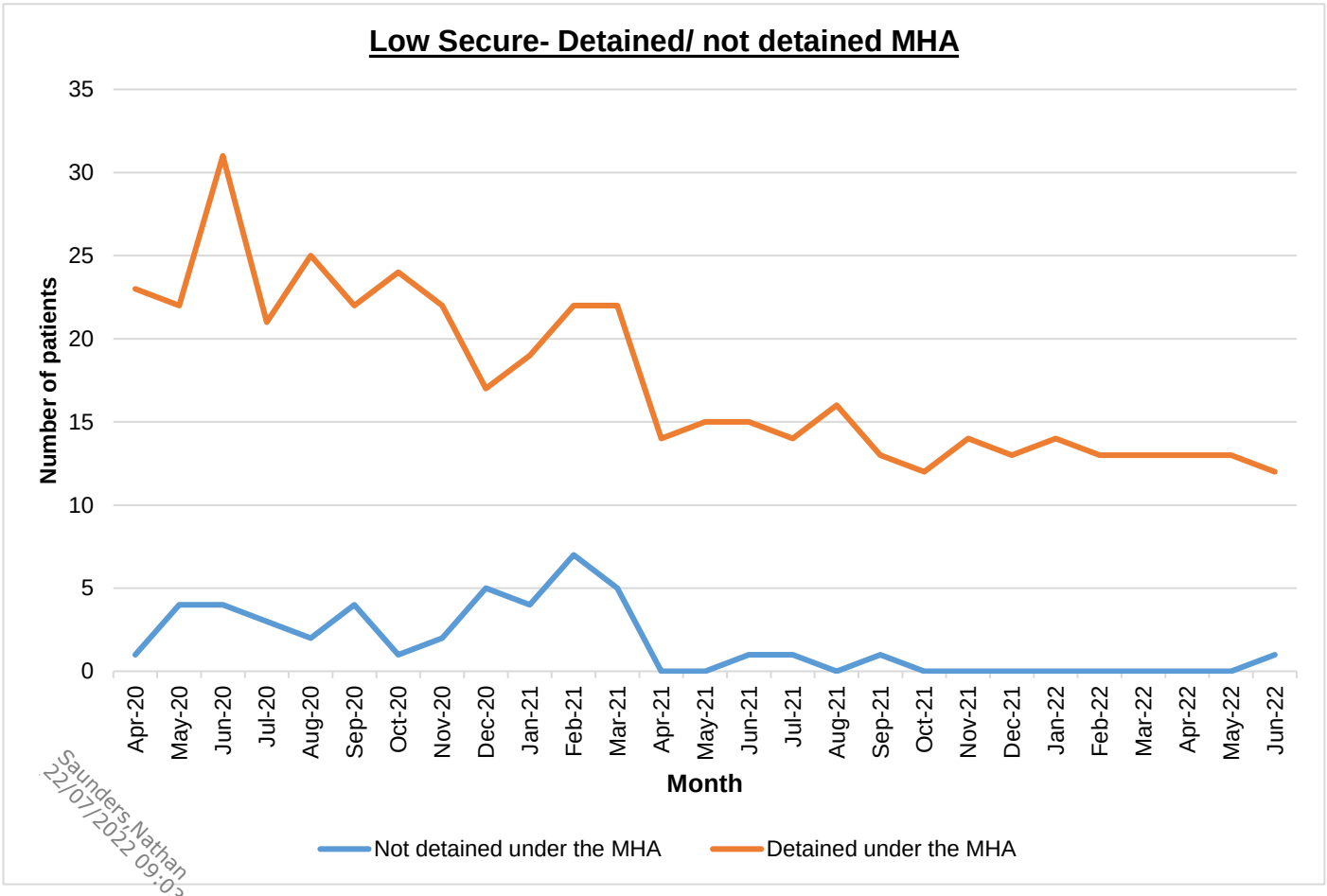
Adult Acute- Detained/ Not detained MHA

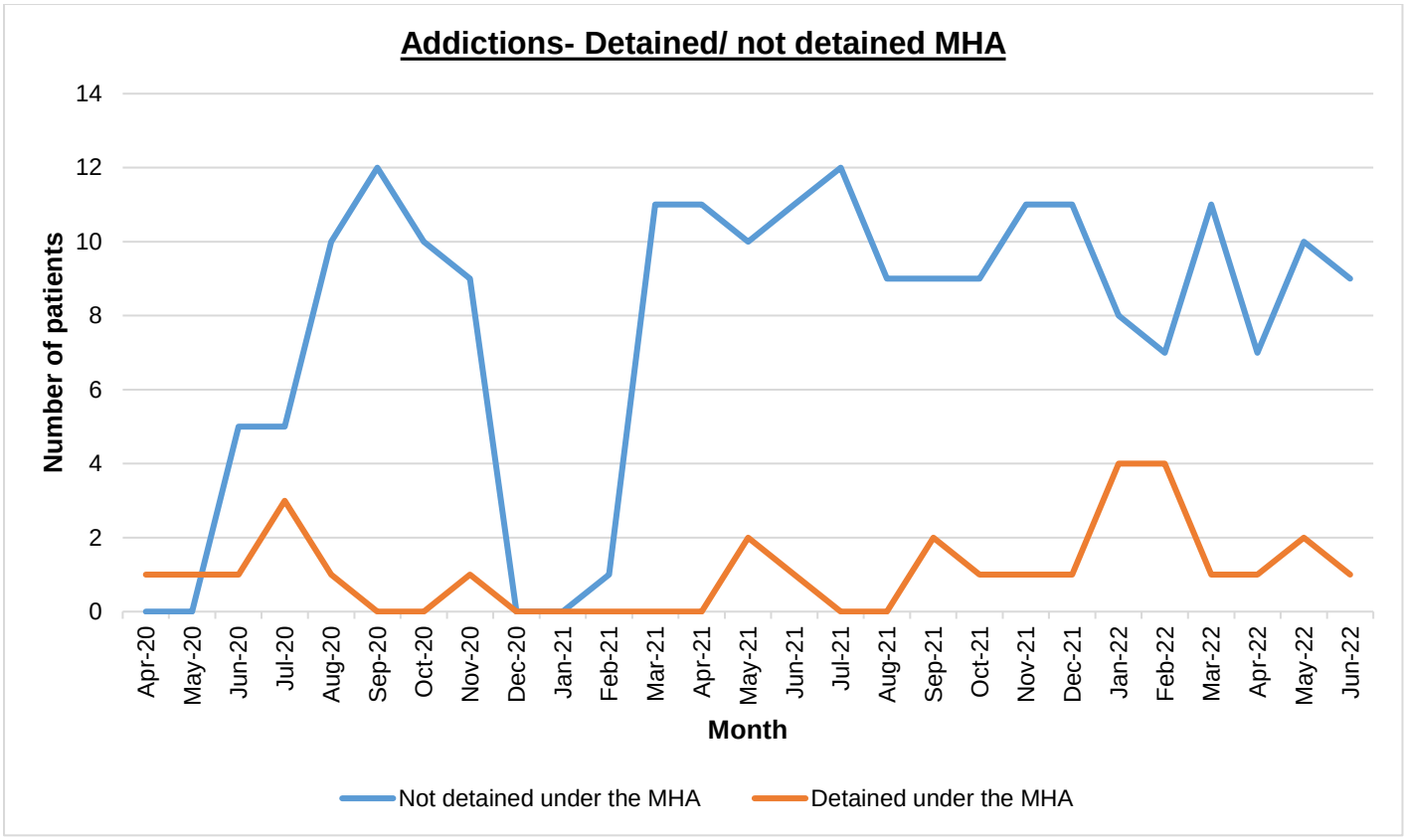


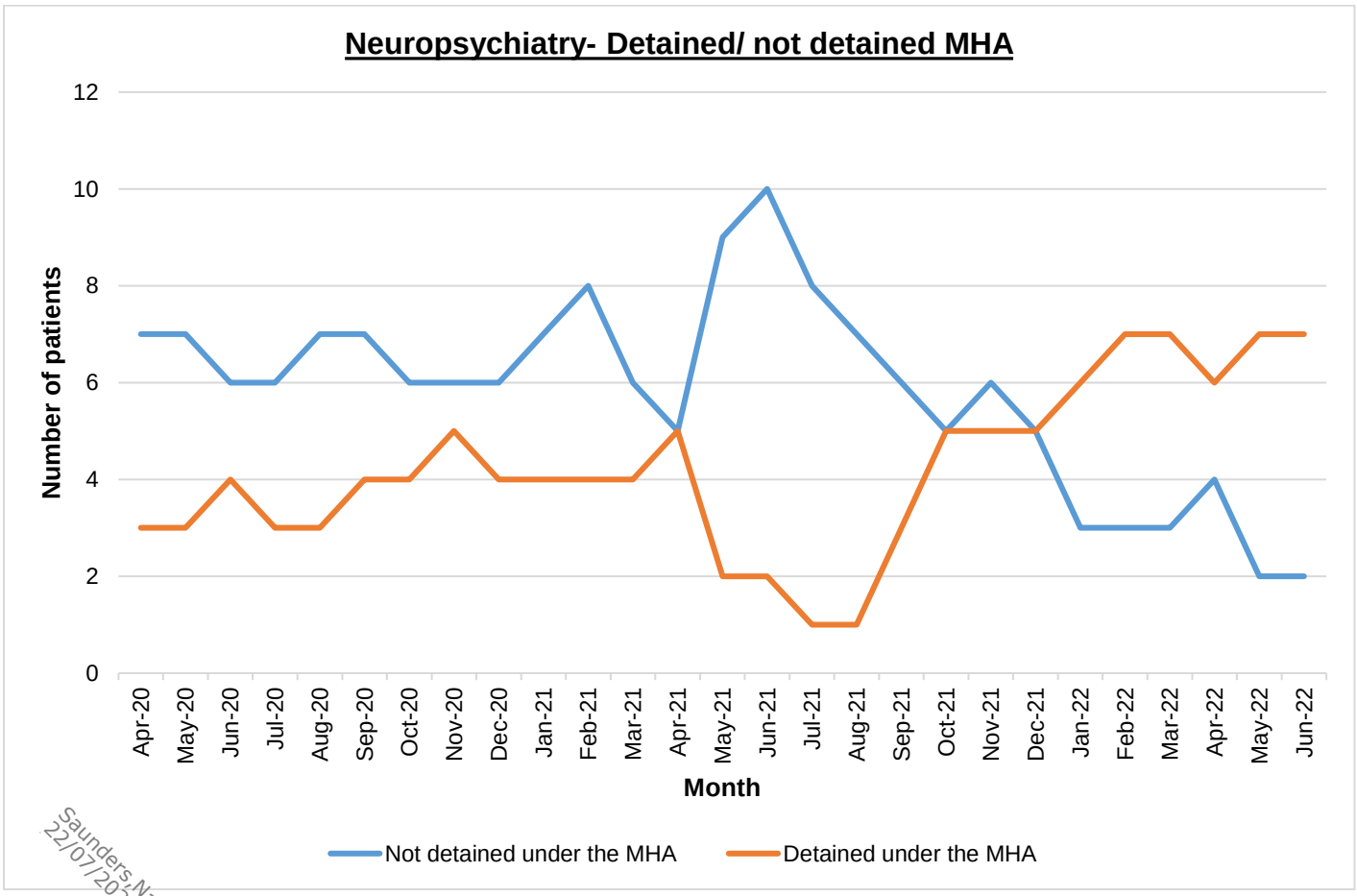
Rehabilitation- Detained/ not detained MHA







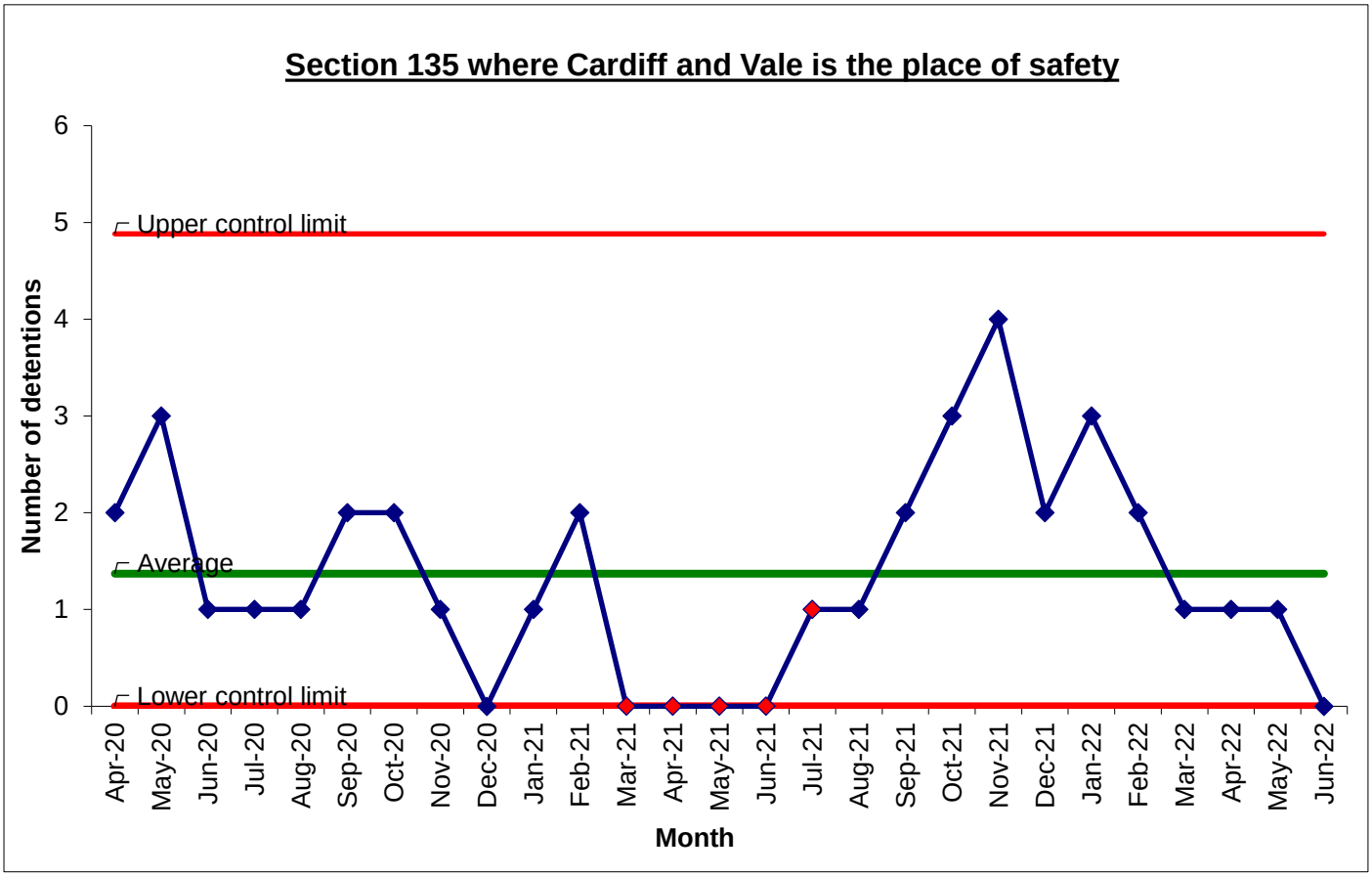




Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used twice. One patient was detained under Section 2 and one patient was detained under Section 3.

During the period Section 135(2) powers were not used.



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;-

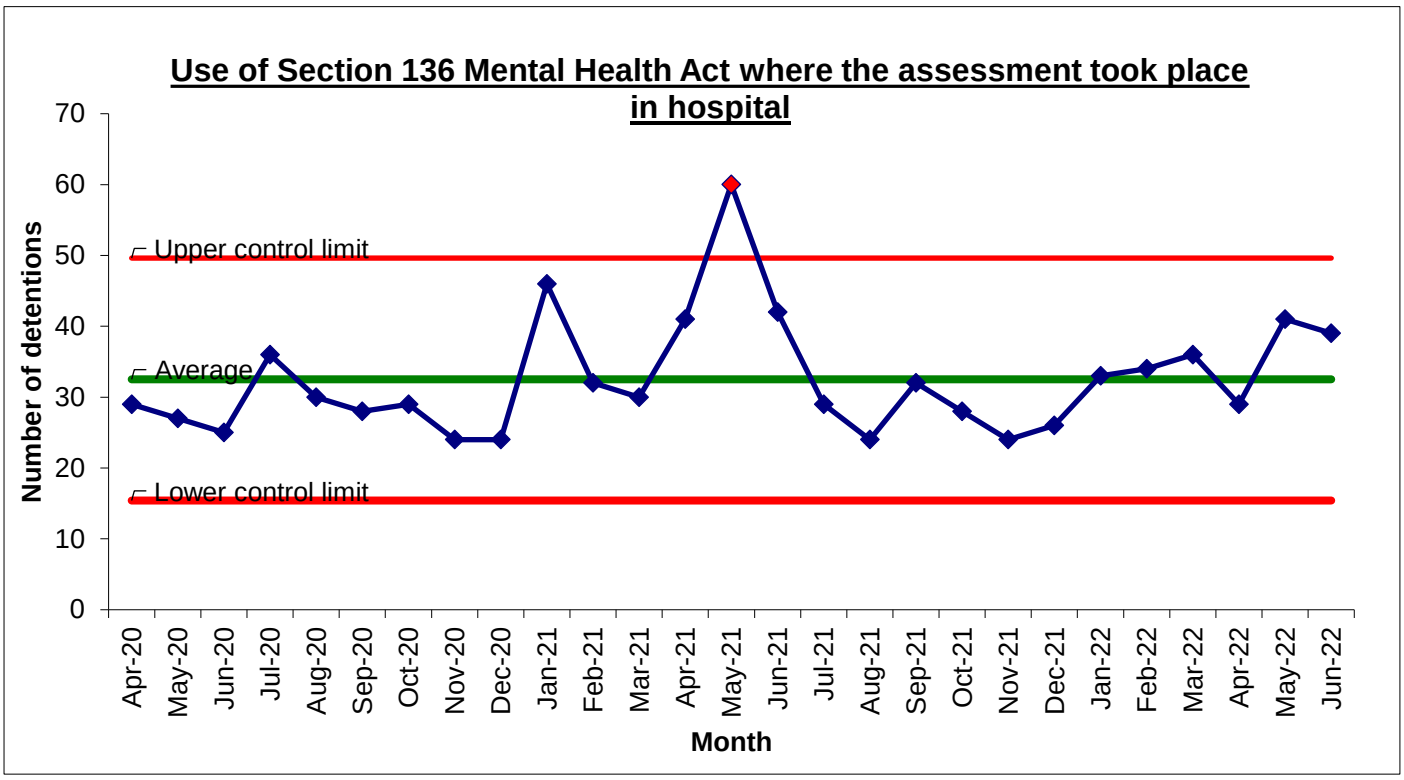
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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.

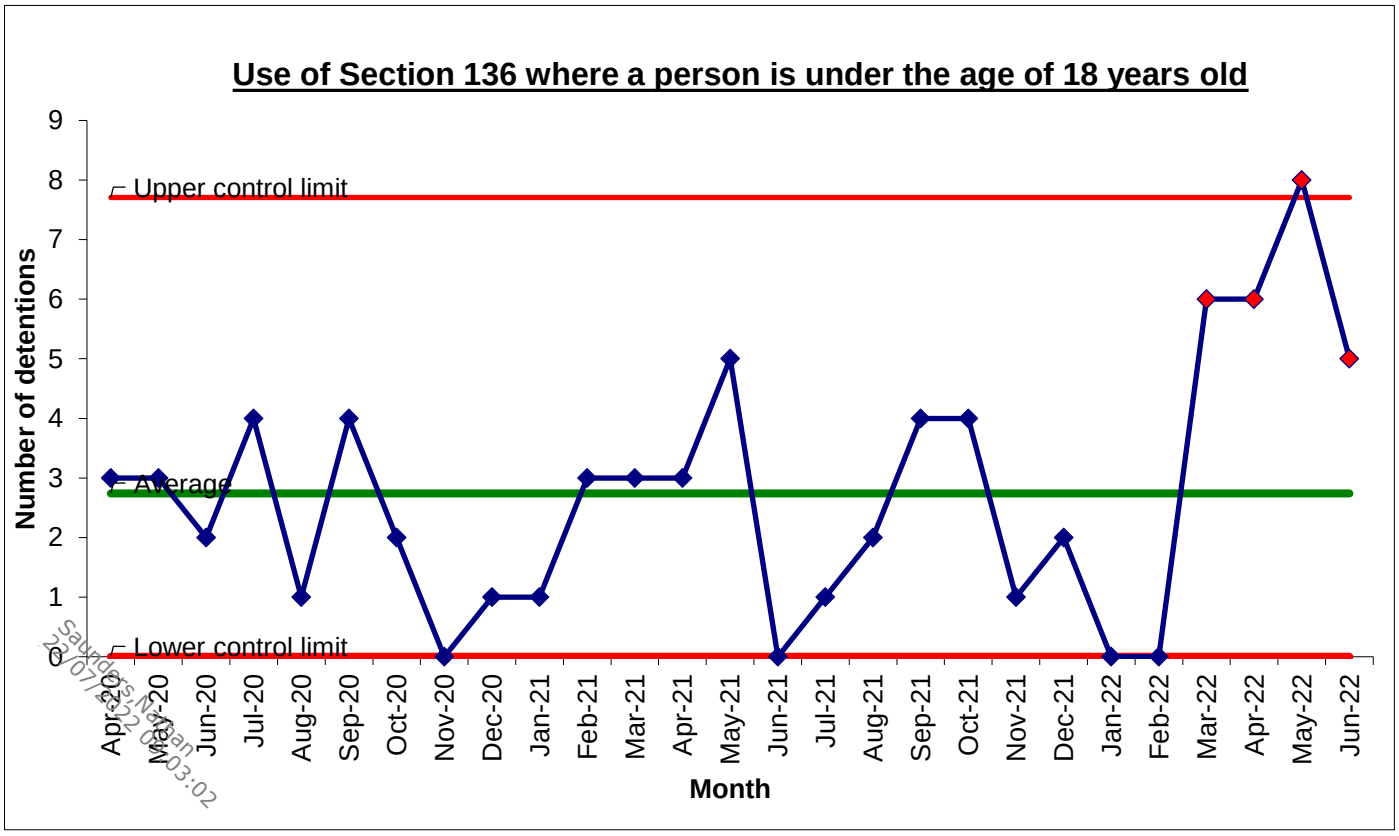
For this period we have seen eight people for a Voluntary Assessment and two were brought into hospital under the Mental Capacity Act.

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

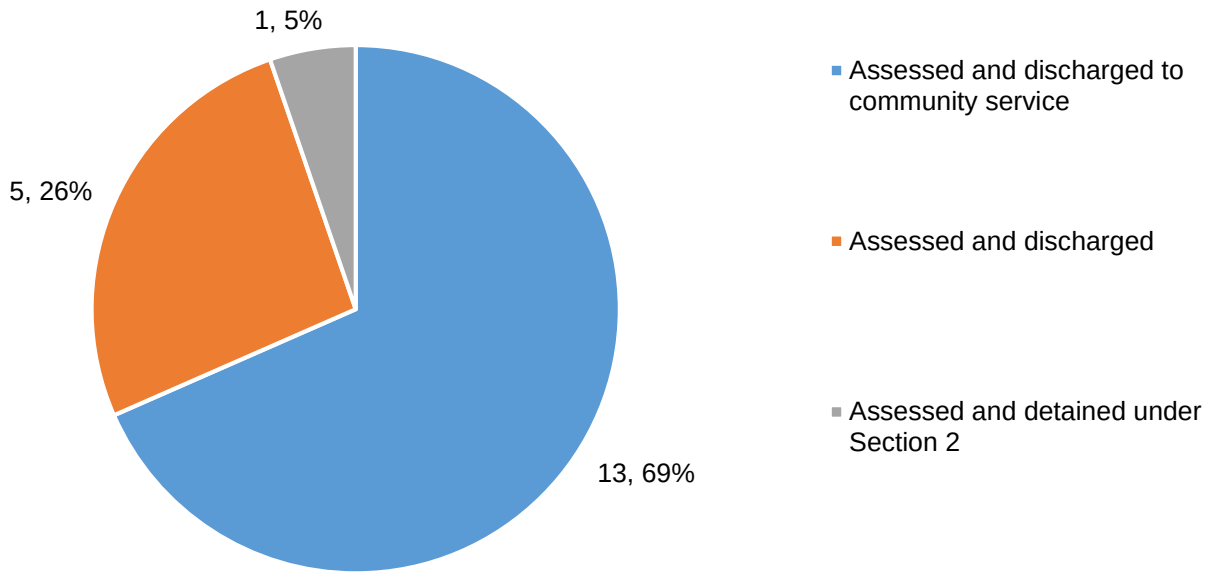
During the period a total of 109 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



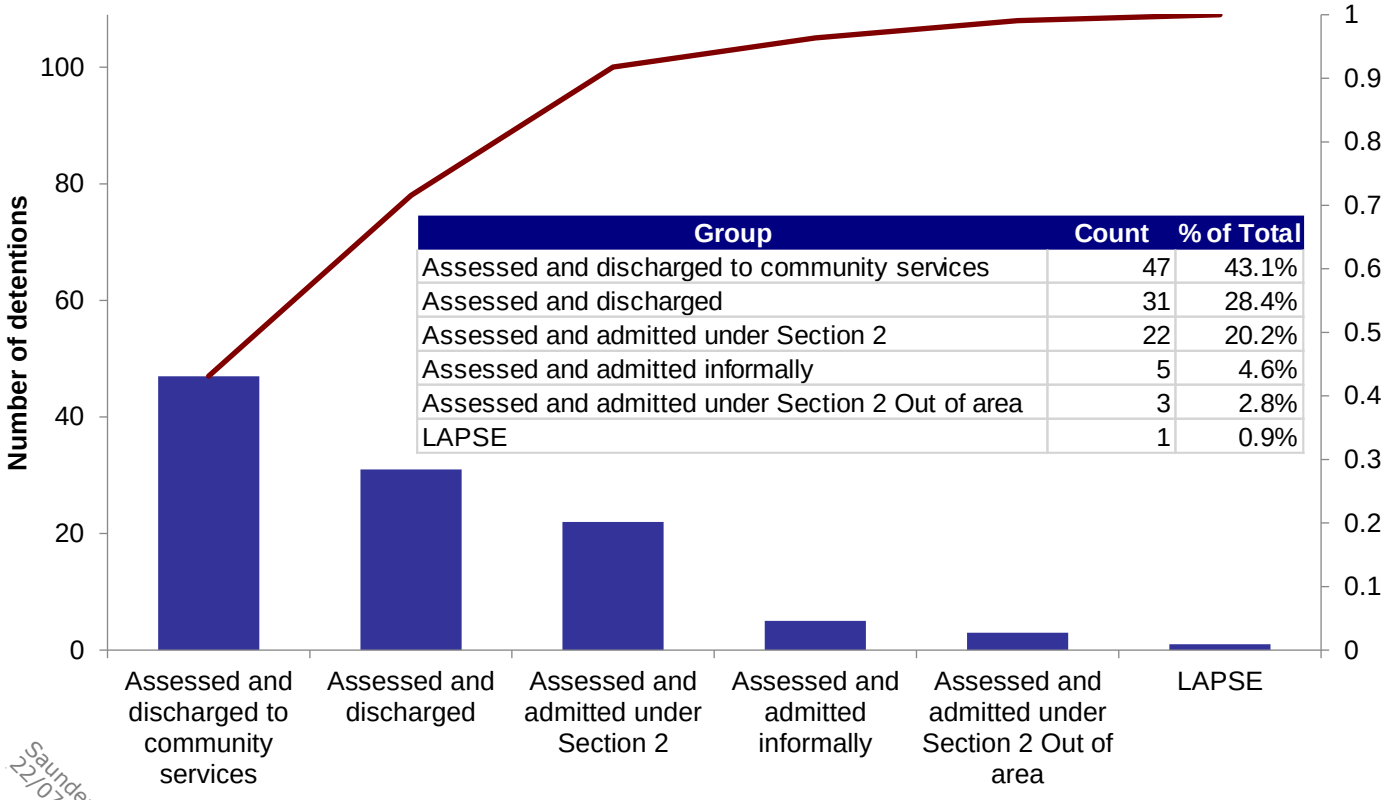
Nineteen of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. This is extracted below;-



Outcome of CAMHs Section 136 assessments



Outcome of Section 136 assessments which took place in hospital during the period April- June 2022



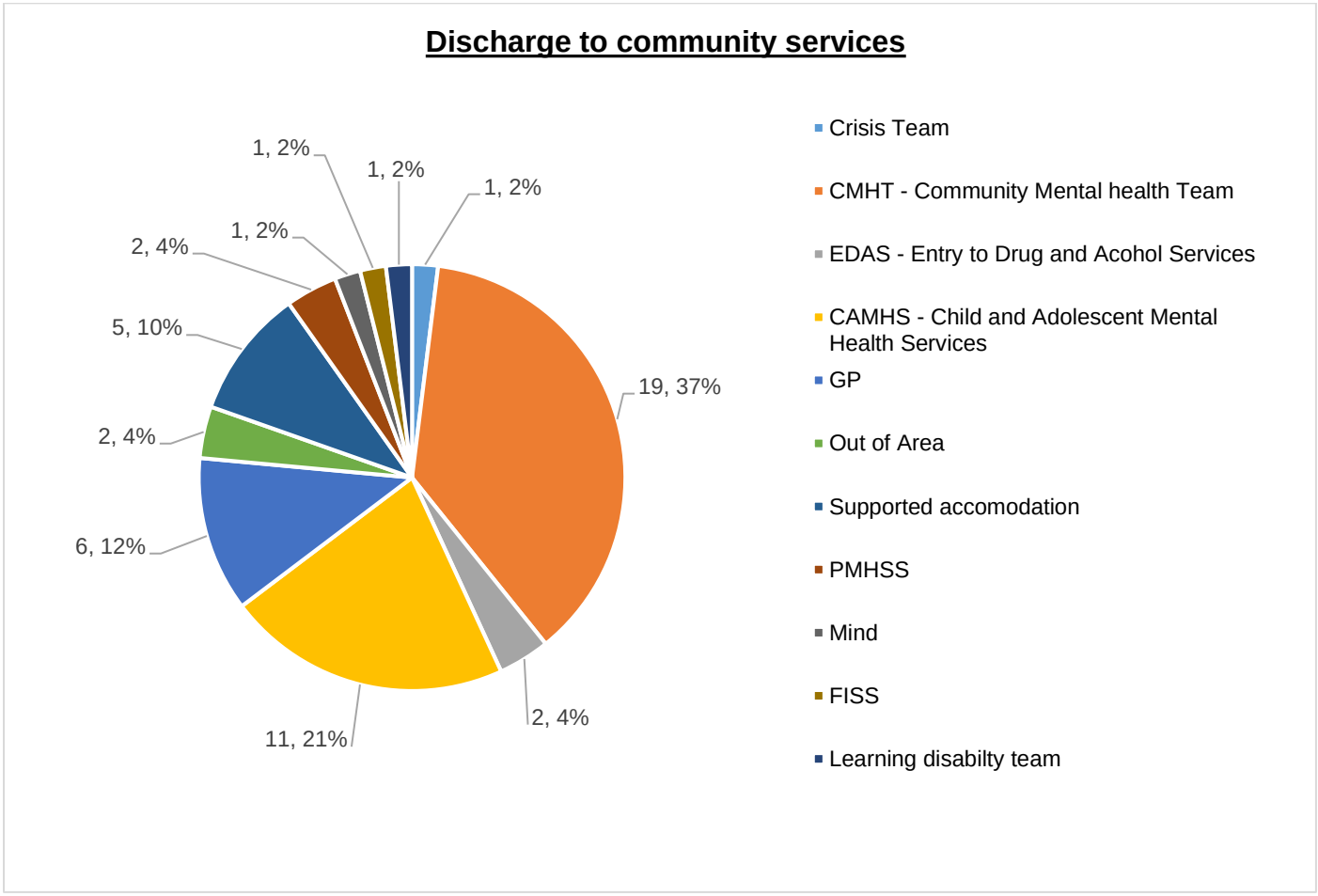
Group	Count	% of Total
Assessed and discharged to community services	47	43.1%
Assessed and discharged	31	28.4%
Assessed and admitted under Section 2	22	20.2%
Assessed and admitted informally	5	4.6%
Assessed and admitted under Section 2 Out of area	3	2.8%
LAPSE	1	0.9%

The pareto chart highlights that 71.5% 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.

- One detention LAPSED as the patient was not assessed within the 24 hour period.
- Nine of the CAMHs assessments were on the same patient.

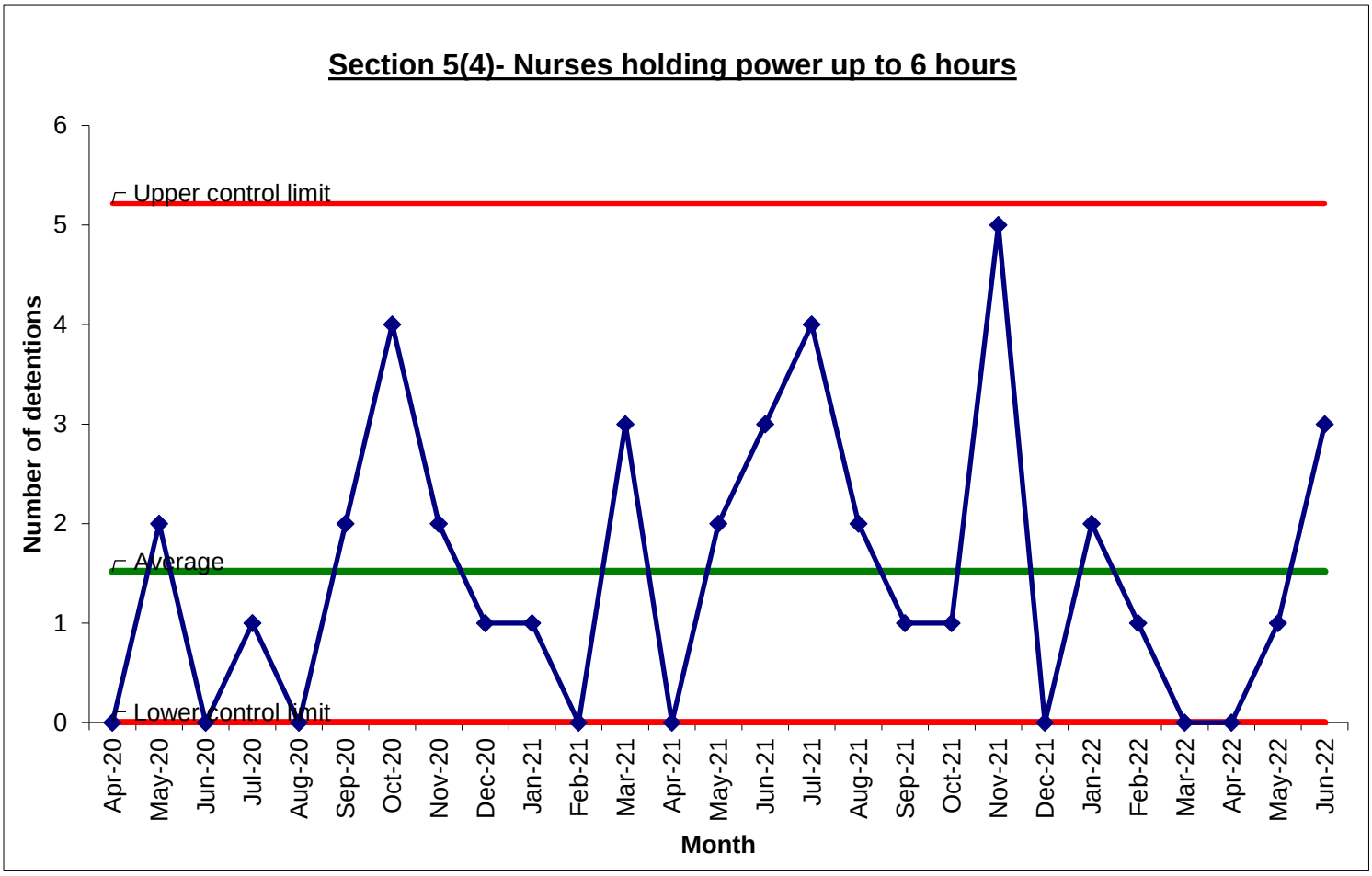
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

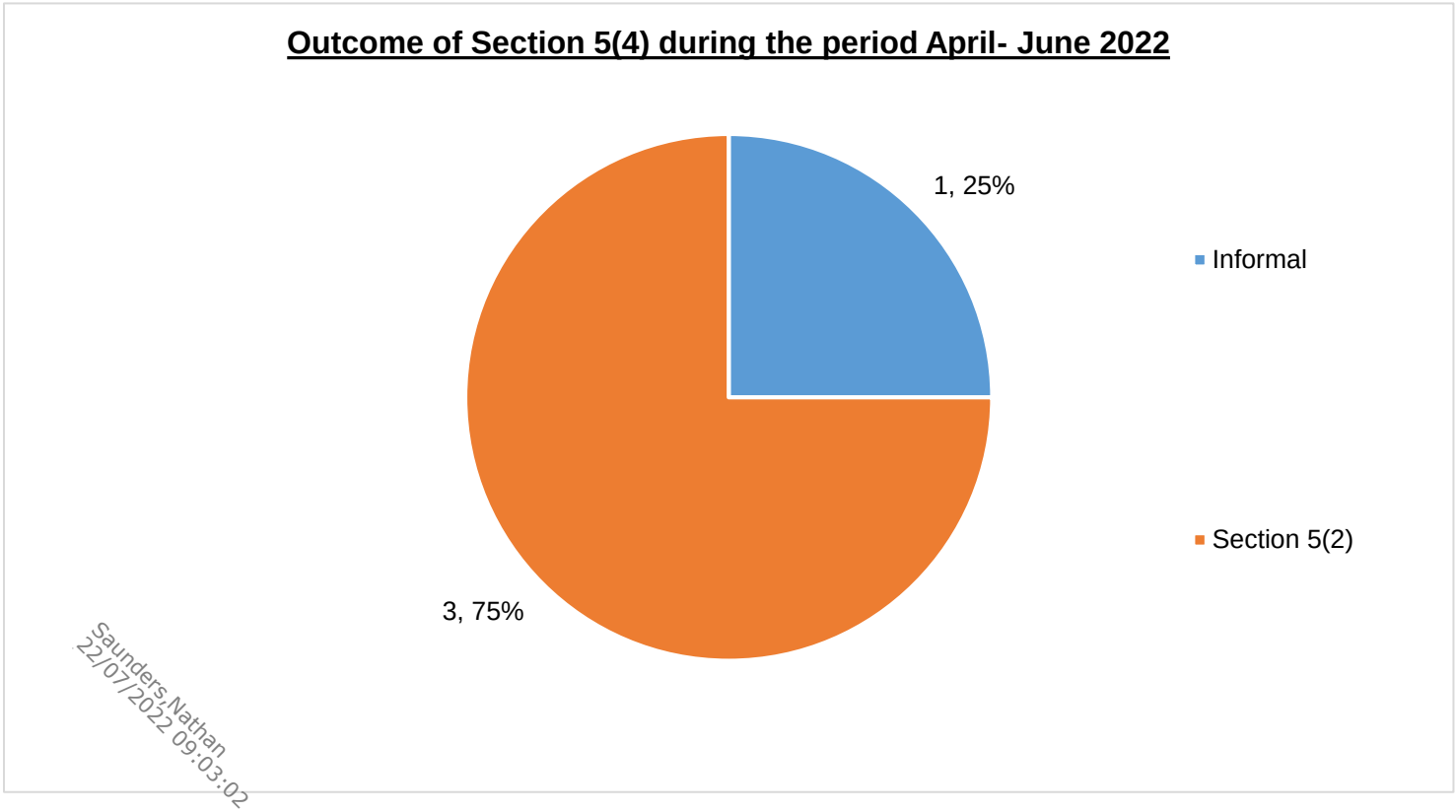


Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

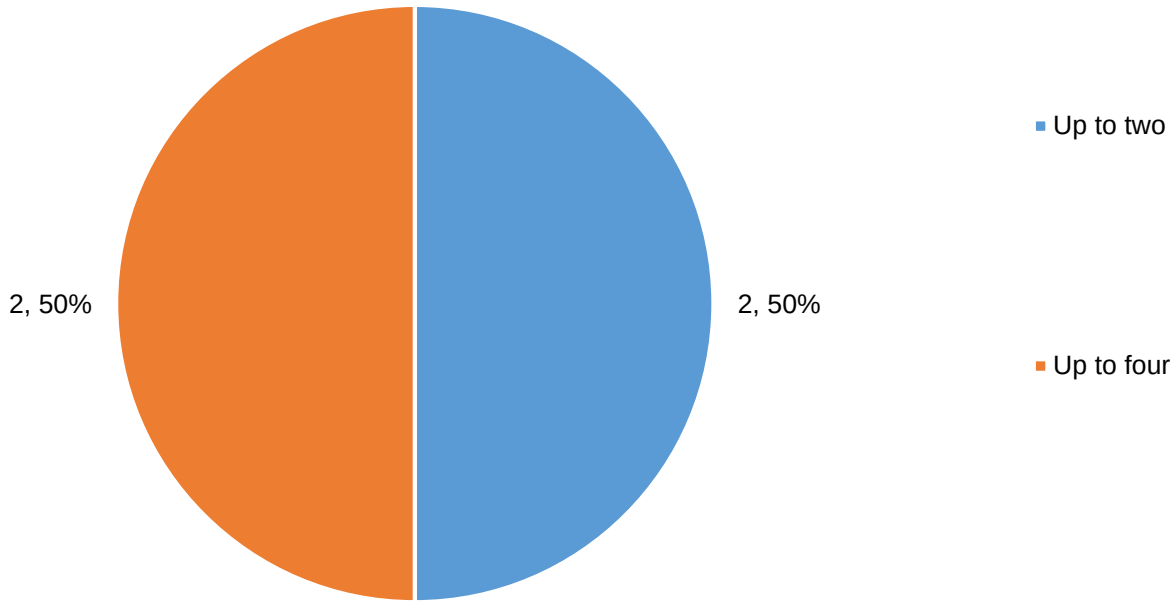
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

Section 5(4) - Nurses Holding Power

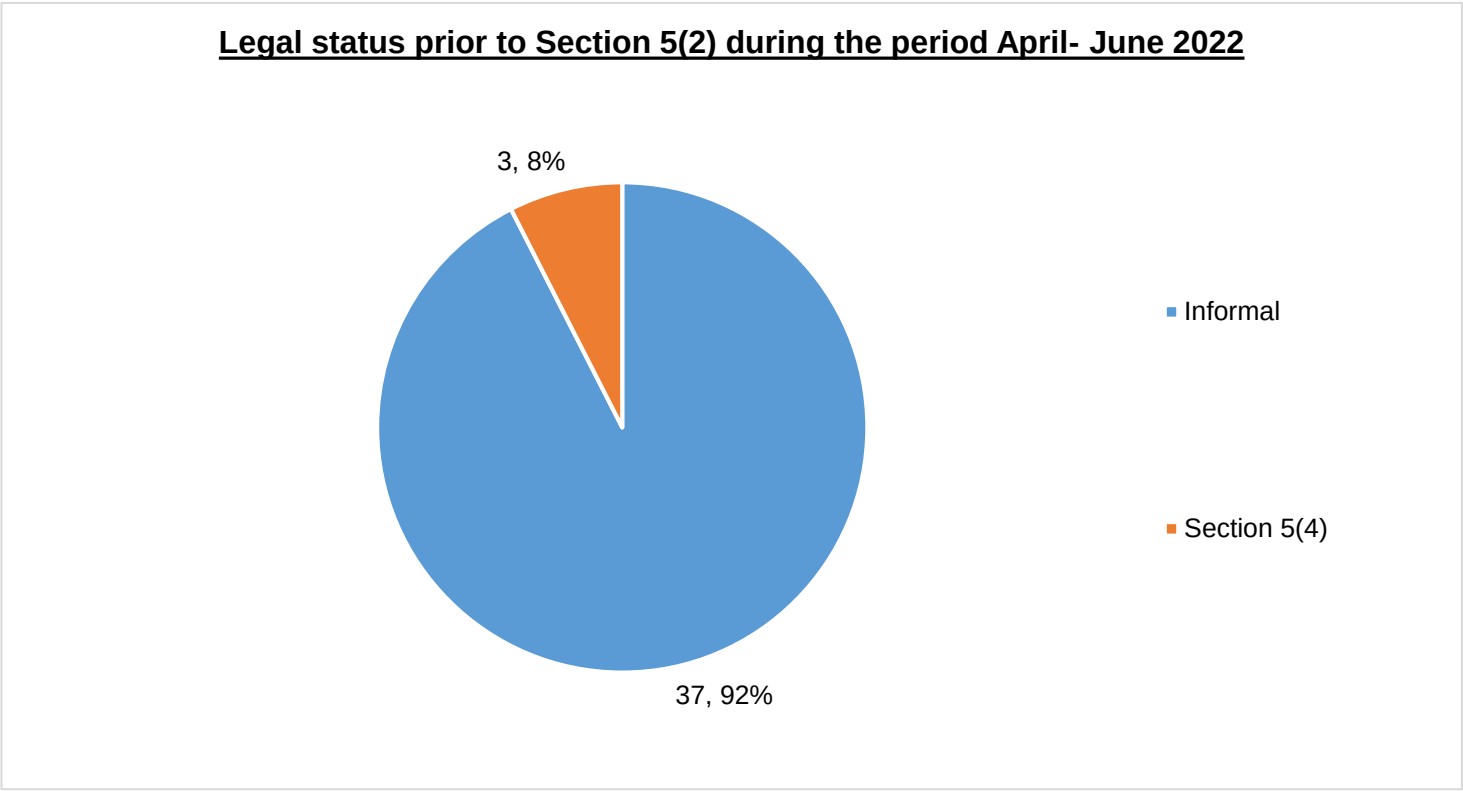


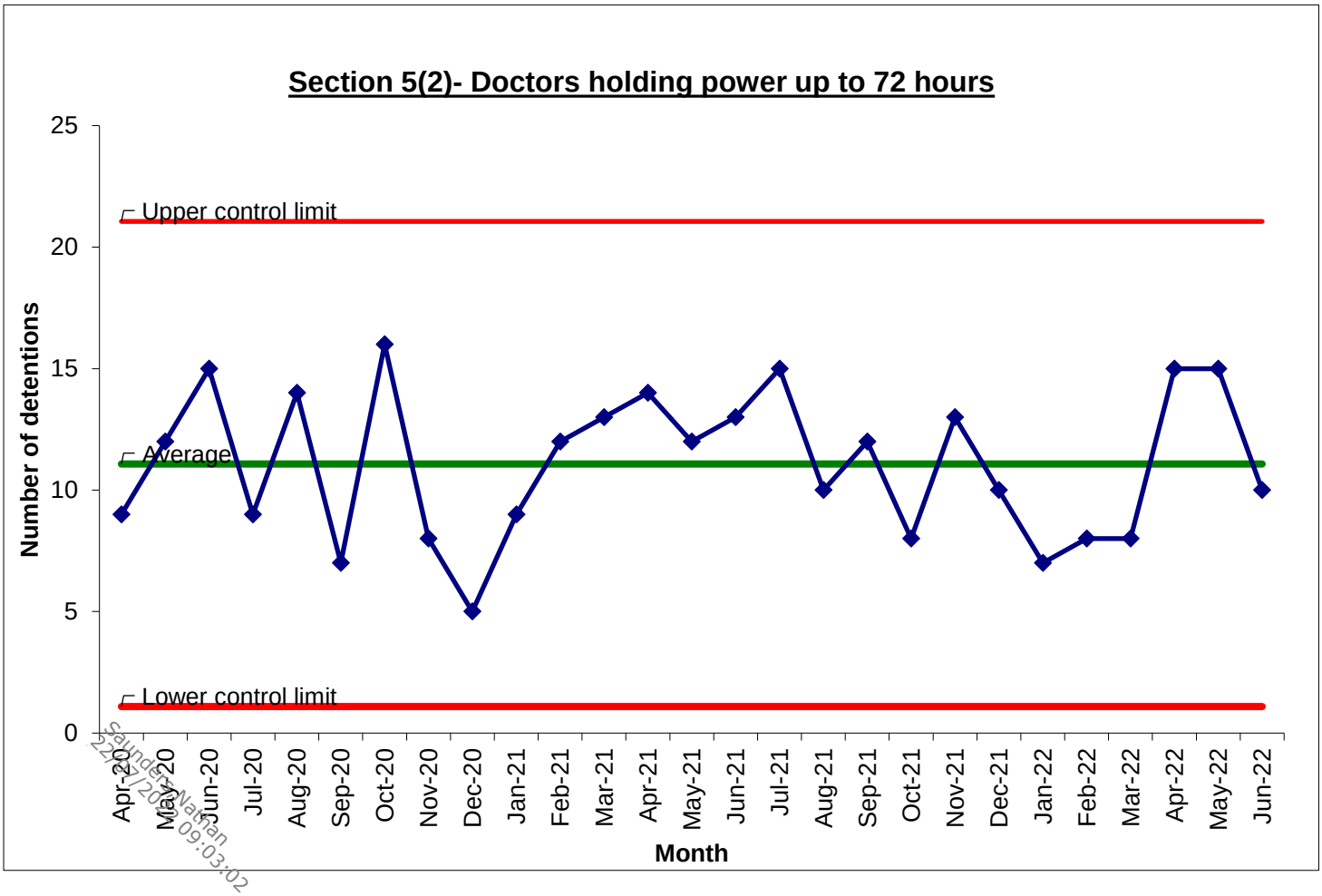


Number of hours patients were detained under Section 5(4) during the period April- June 2022

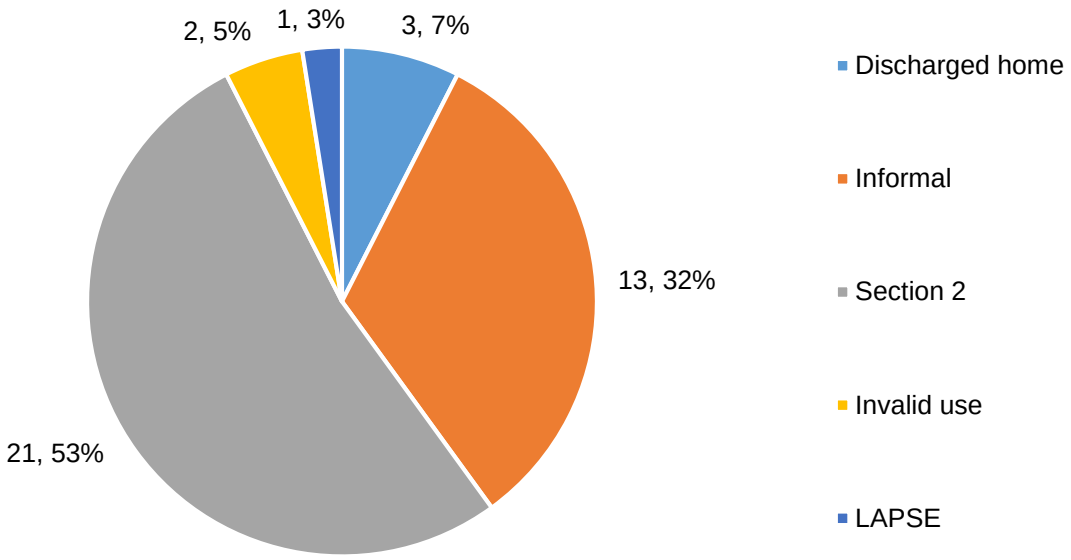


Section 5(2) - Doctors holding power

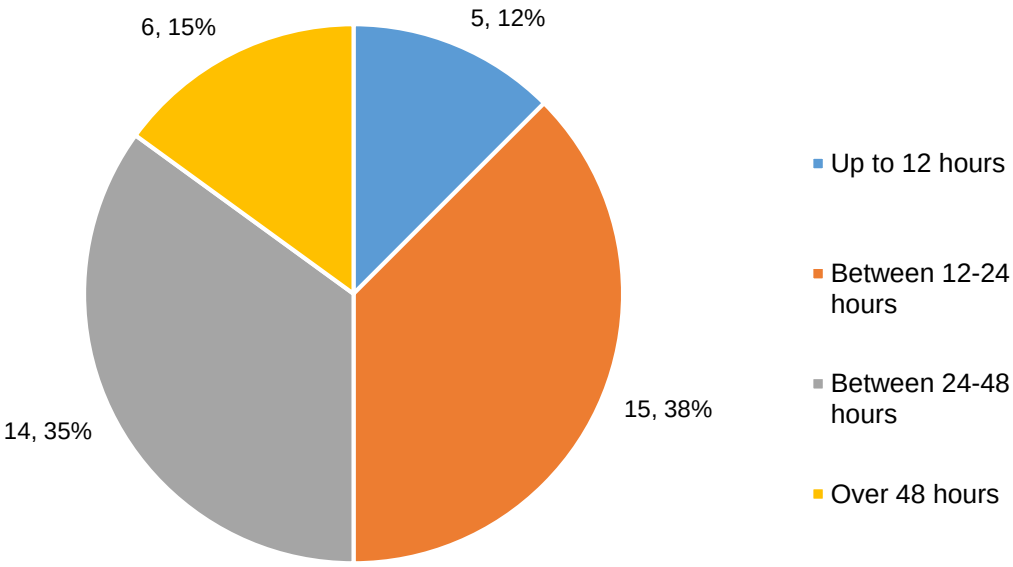




Outcome of Section 5(2) during the period April- June 2022



Number of hours patients were detained under Section 5(2) MHA during the period April- June 2022



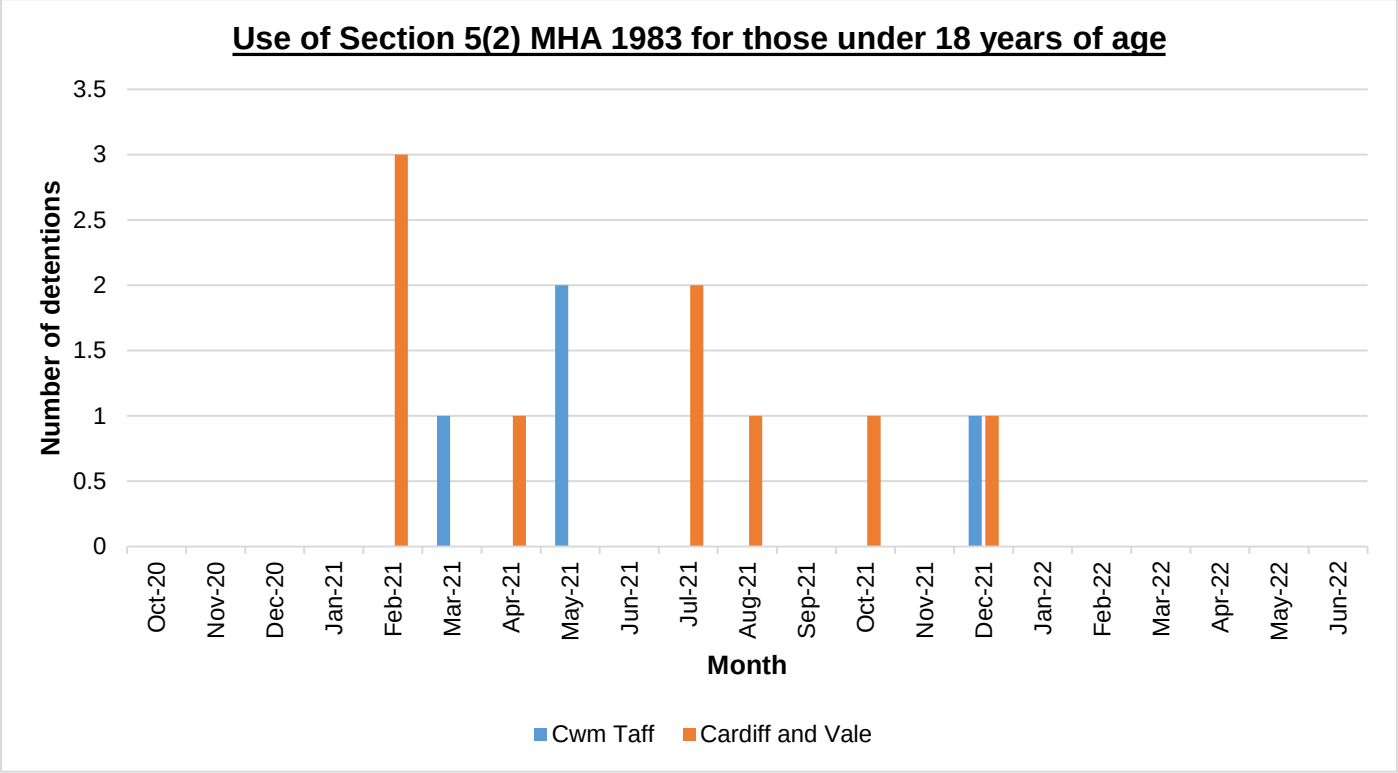
DURING THE PERIOD THERE WERE TWO INSTANCES OF AN INVALID USE OF SECTION 5(2).

DURING THE PERIOD ONE SECTION 5(2) LAPSED DUE TO THE PATIENT NOT BEING ASSESSED WITHIN THE 72 HOUR PERIOD.

CAMHS Commissioned Inpatient Data

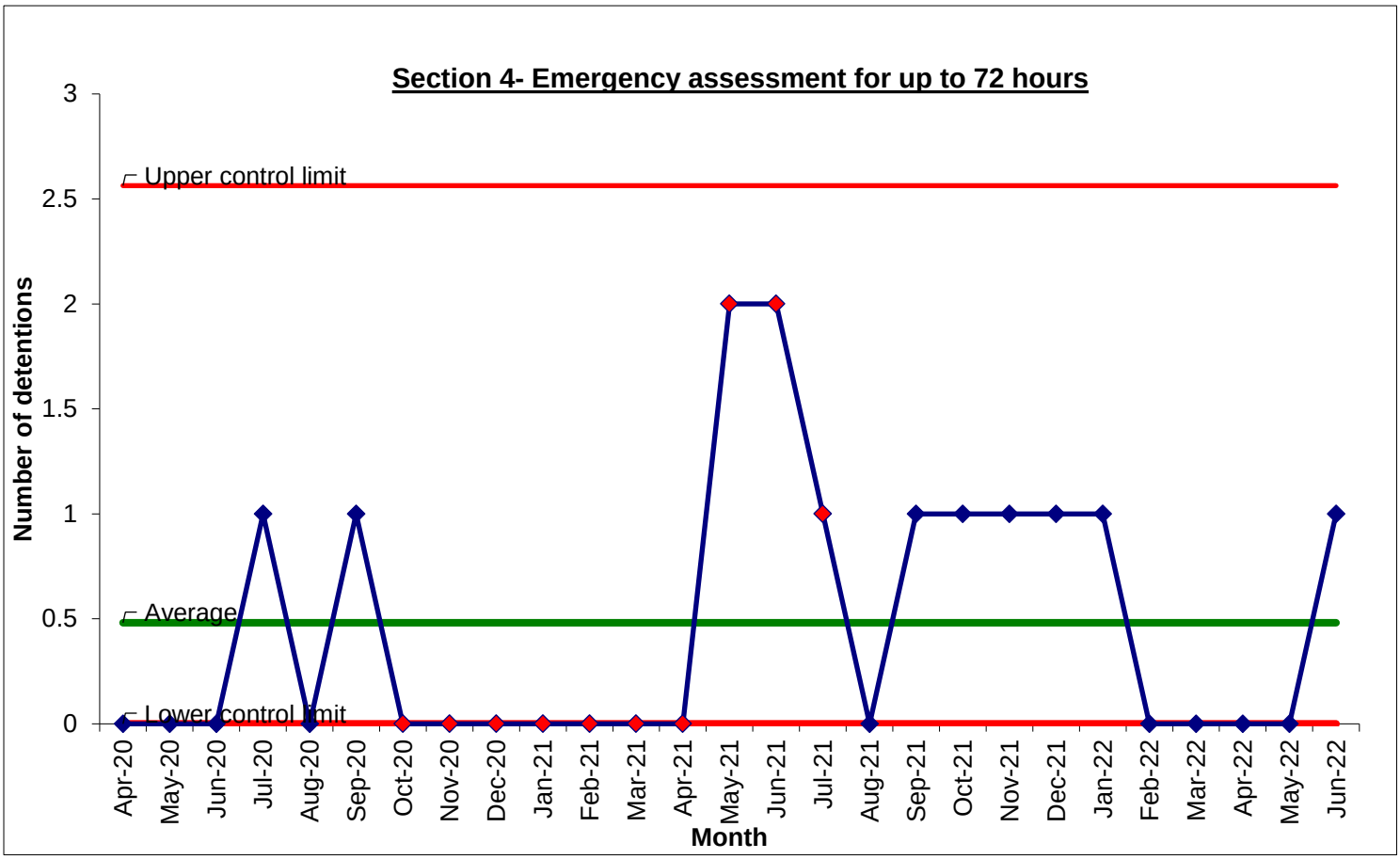
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During the period their 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.



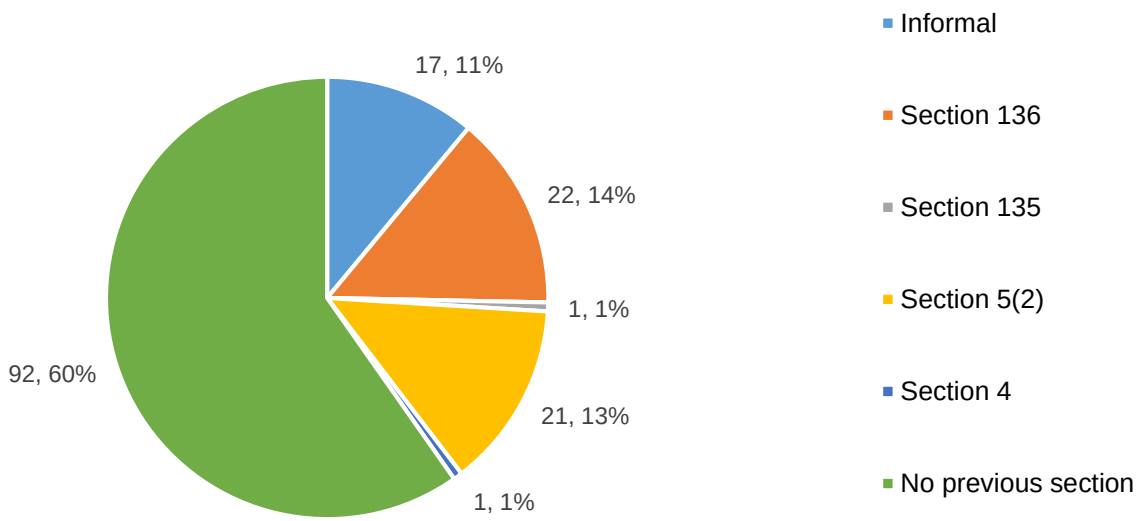
Section 4 - Admission for Assessment in Cases of Emergency

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.

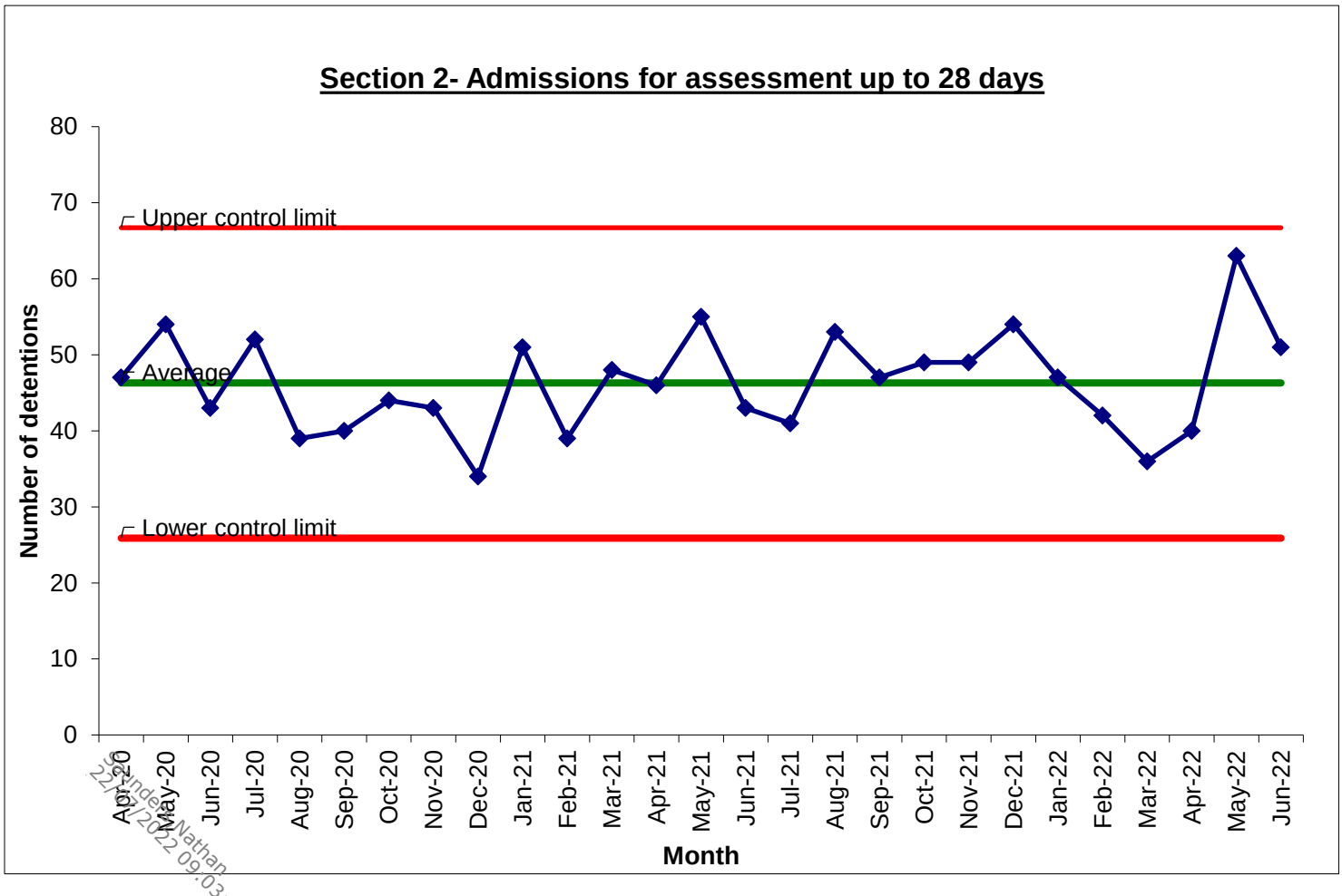


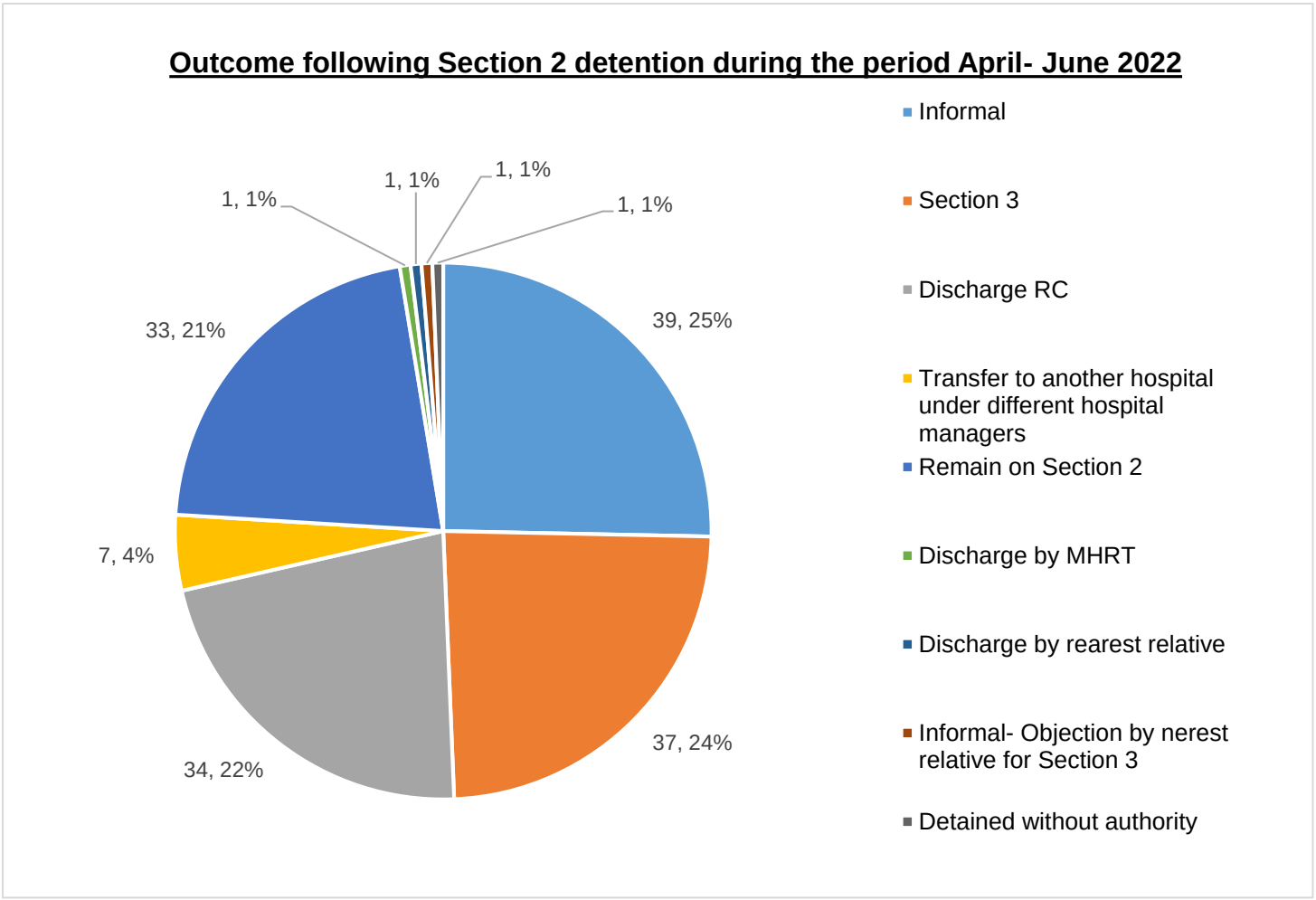
Section 2 – Admission for Assessment

Legal status prior to Section 2 during the period April- June 2022



Section 2- Admissions for assessment up to 28 days



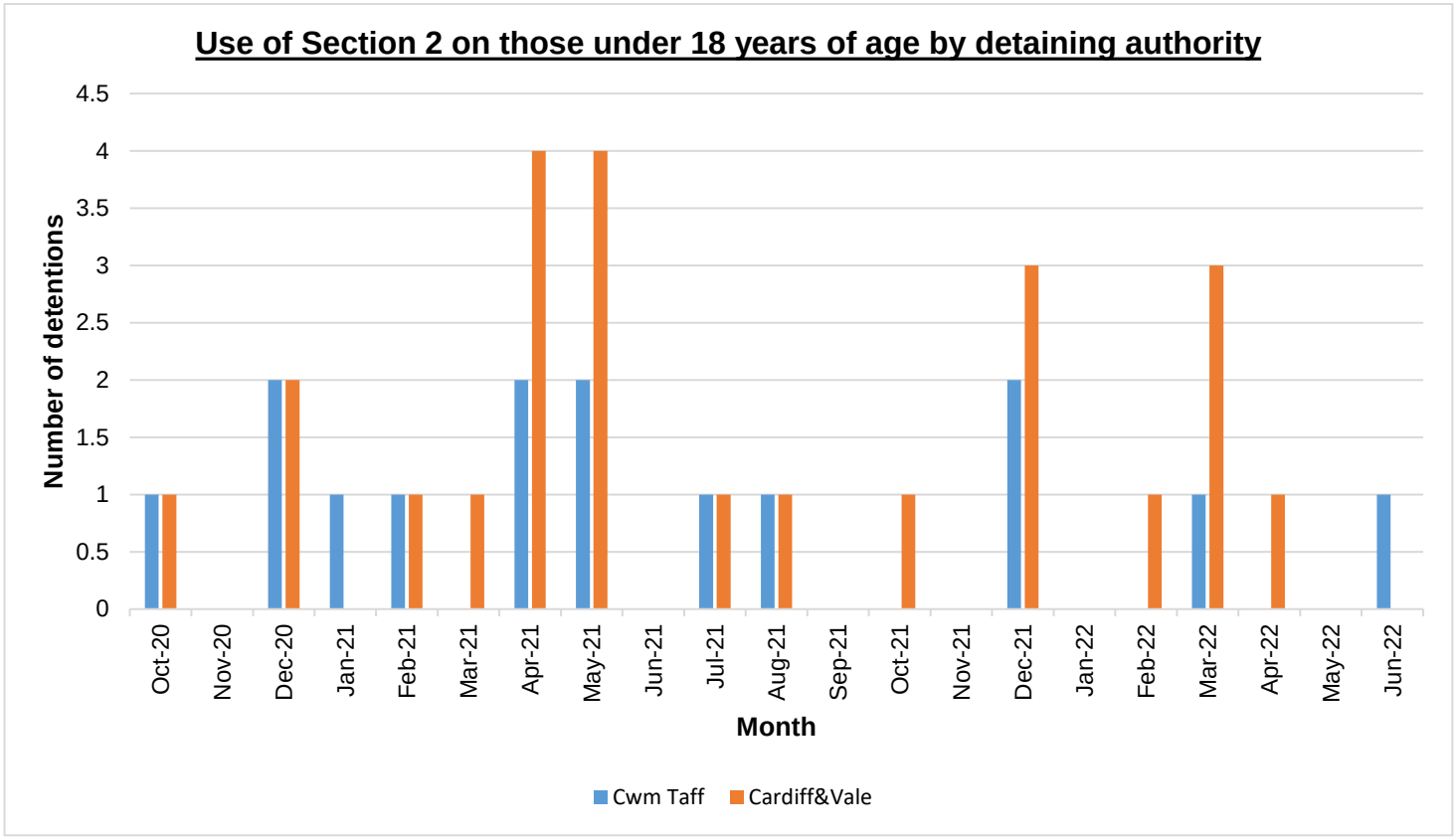


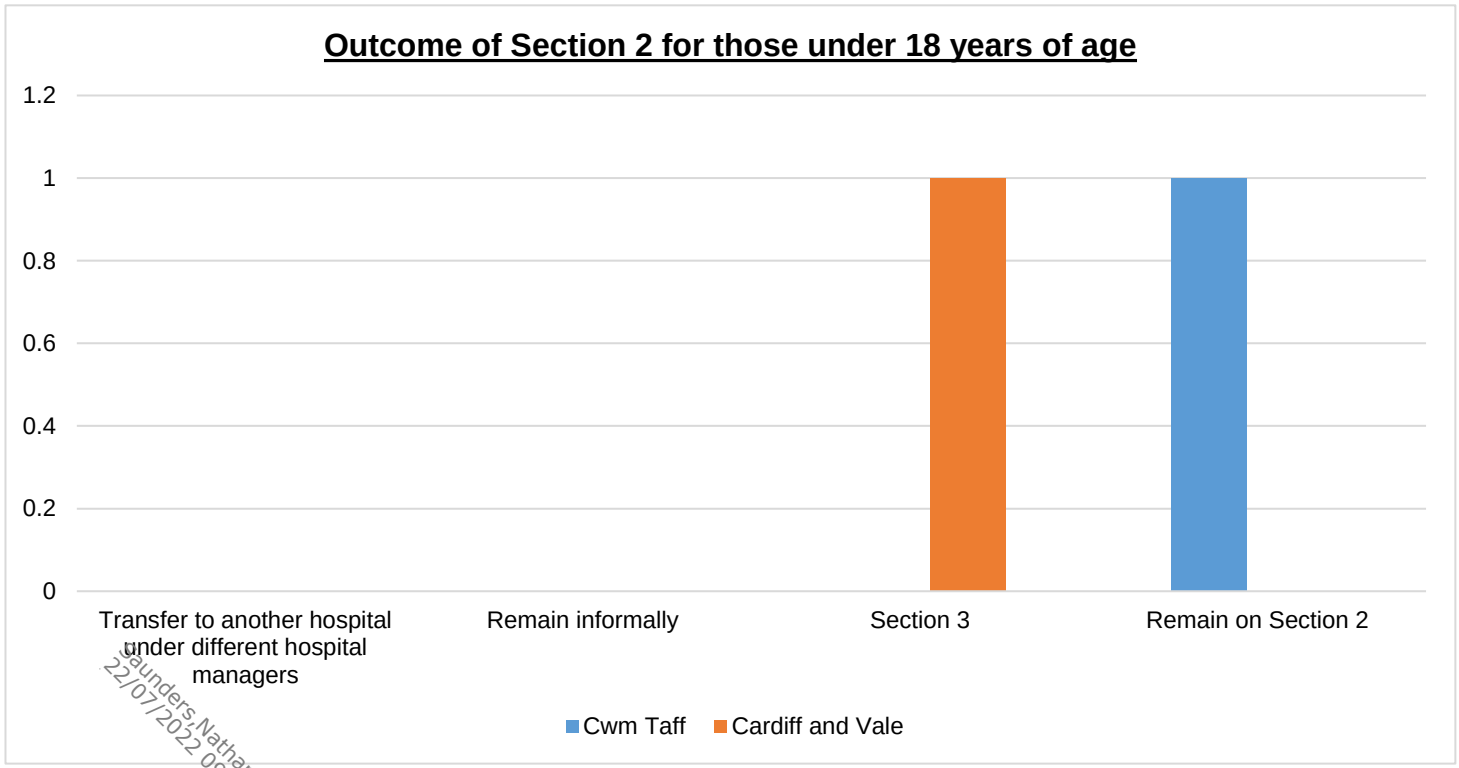
DURING THE PERIOD THEIR WAS ONCE INSTANCE OF A PATIENT BEING DETAINED UNDER SECTION 2 WITHOUT AUTHORITY DUE TO THE DETENTION PAPERS NOT HAVING BEEN ACCEPTED BY THE HOSPITAL MANAGERS IN THE NECESSARY TIME FRAME

CAMHS Commissioned Inpatient Data

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

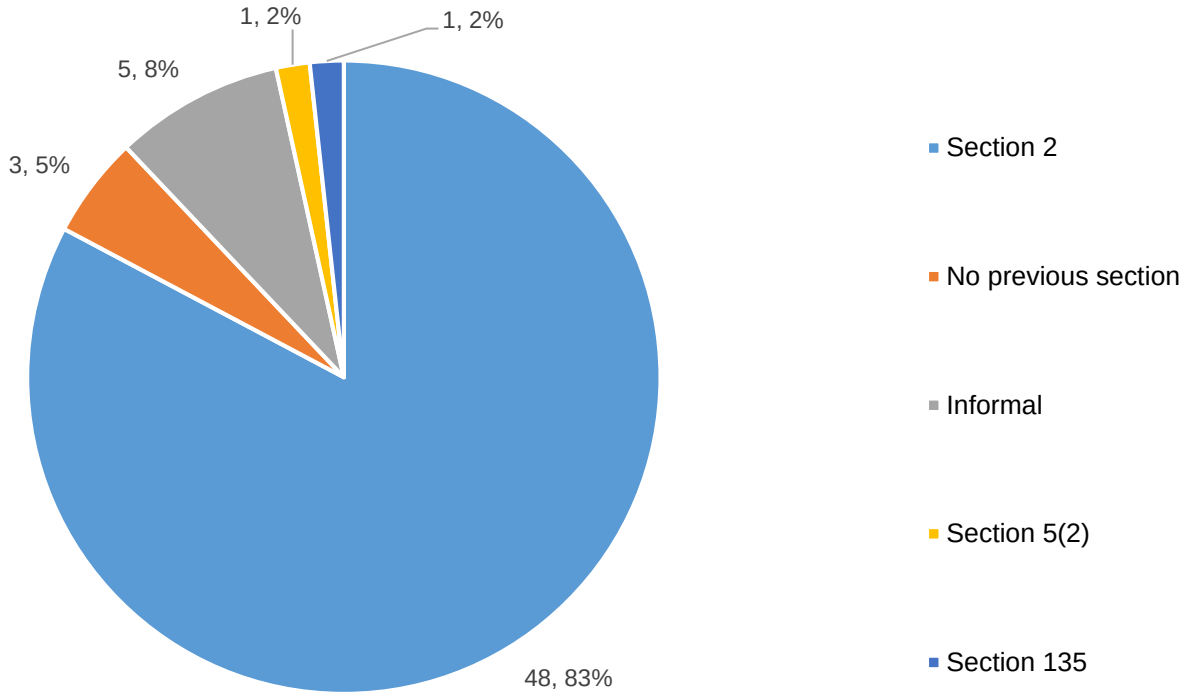
Included in the above data are those under 18 years of age. This is extracted below;-



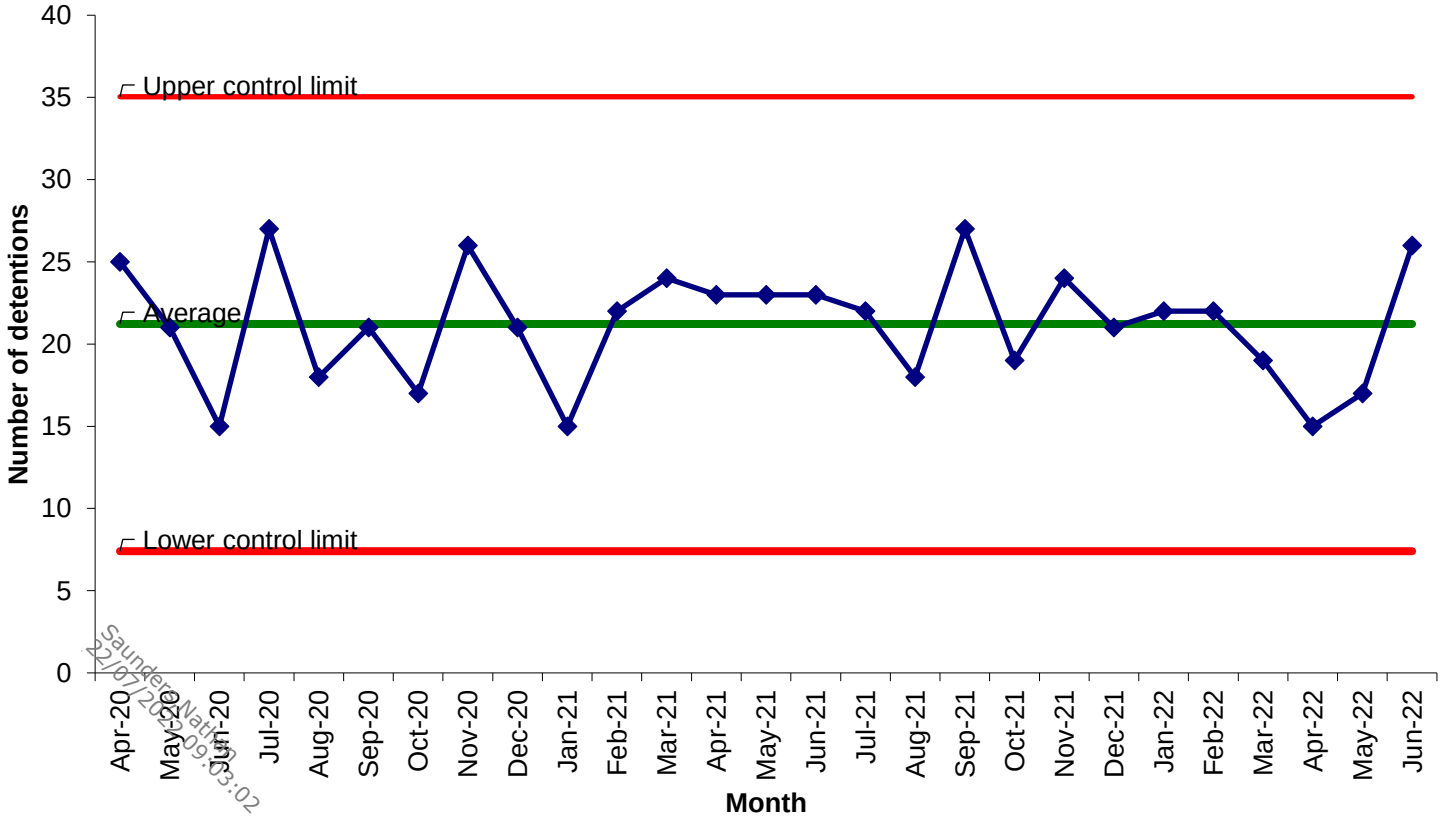


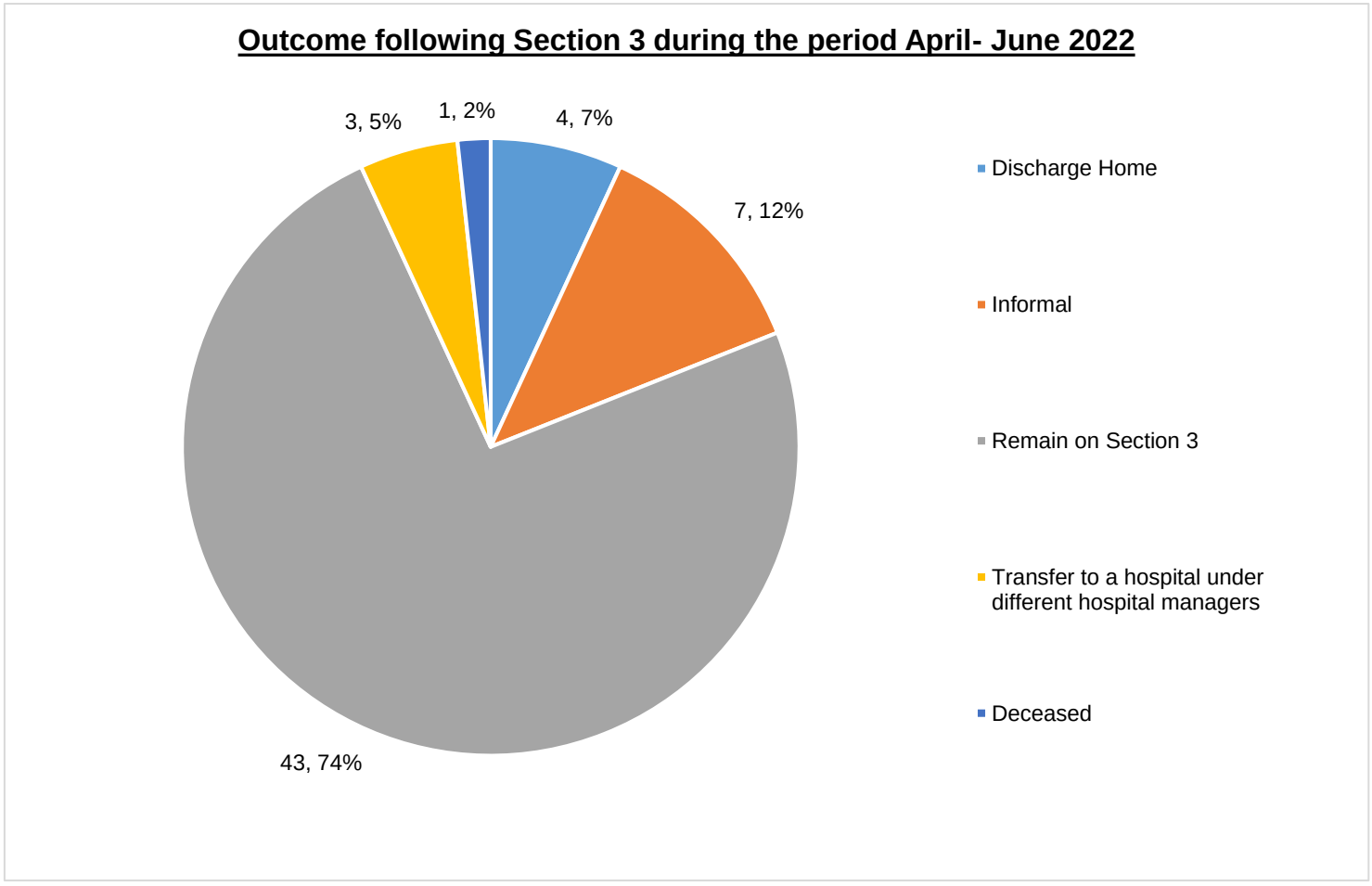
Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period April- June 2022



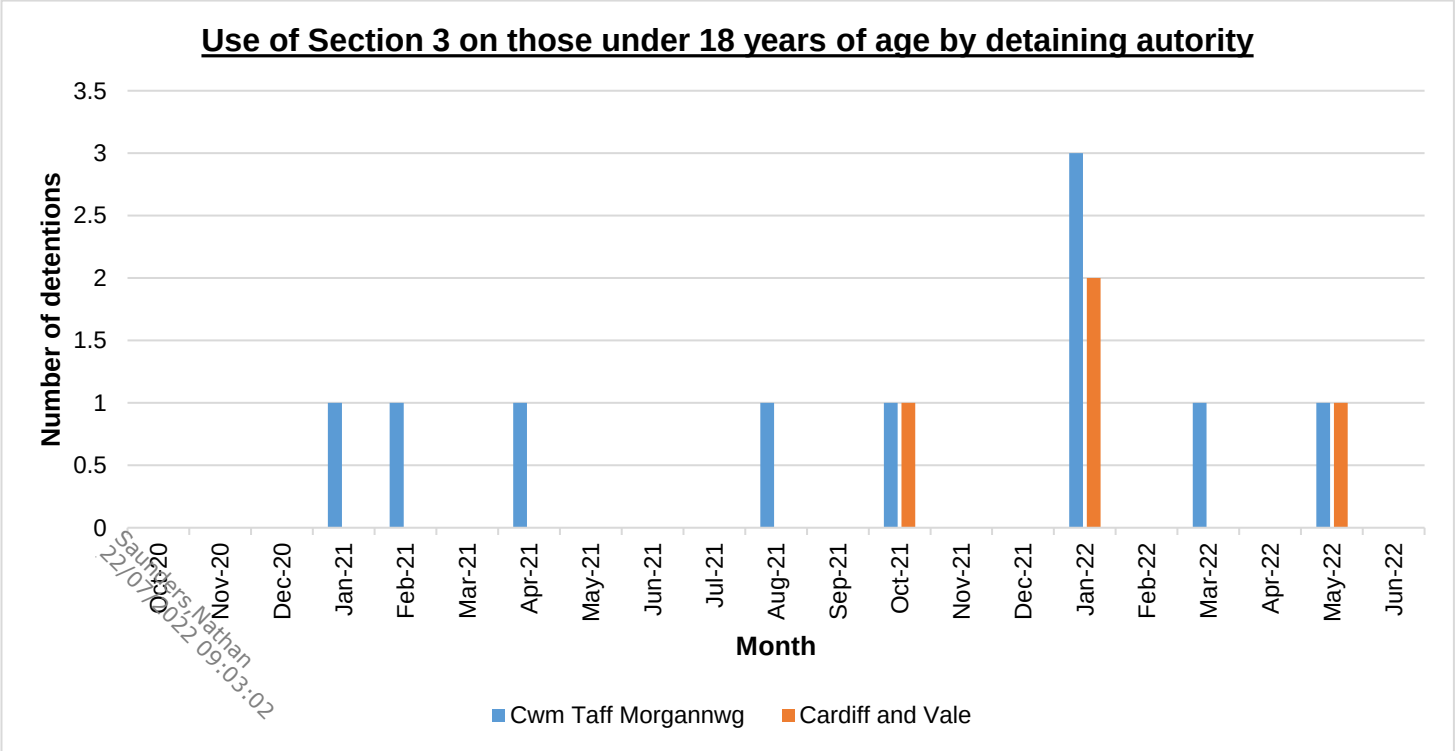
Section 3- Admission for treatment



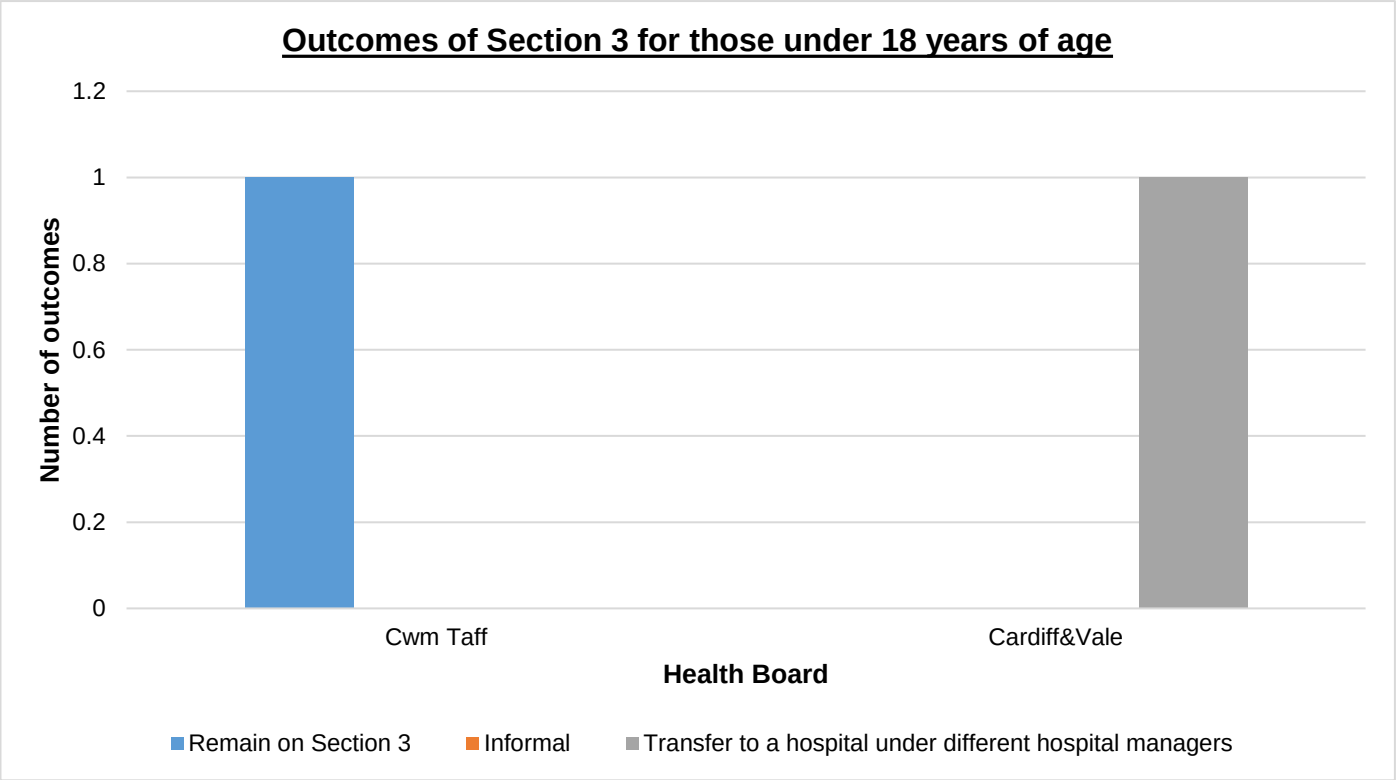


CAMHS Commissioned Inpatient Data

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



The above data would include those under 18 years of age.

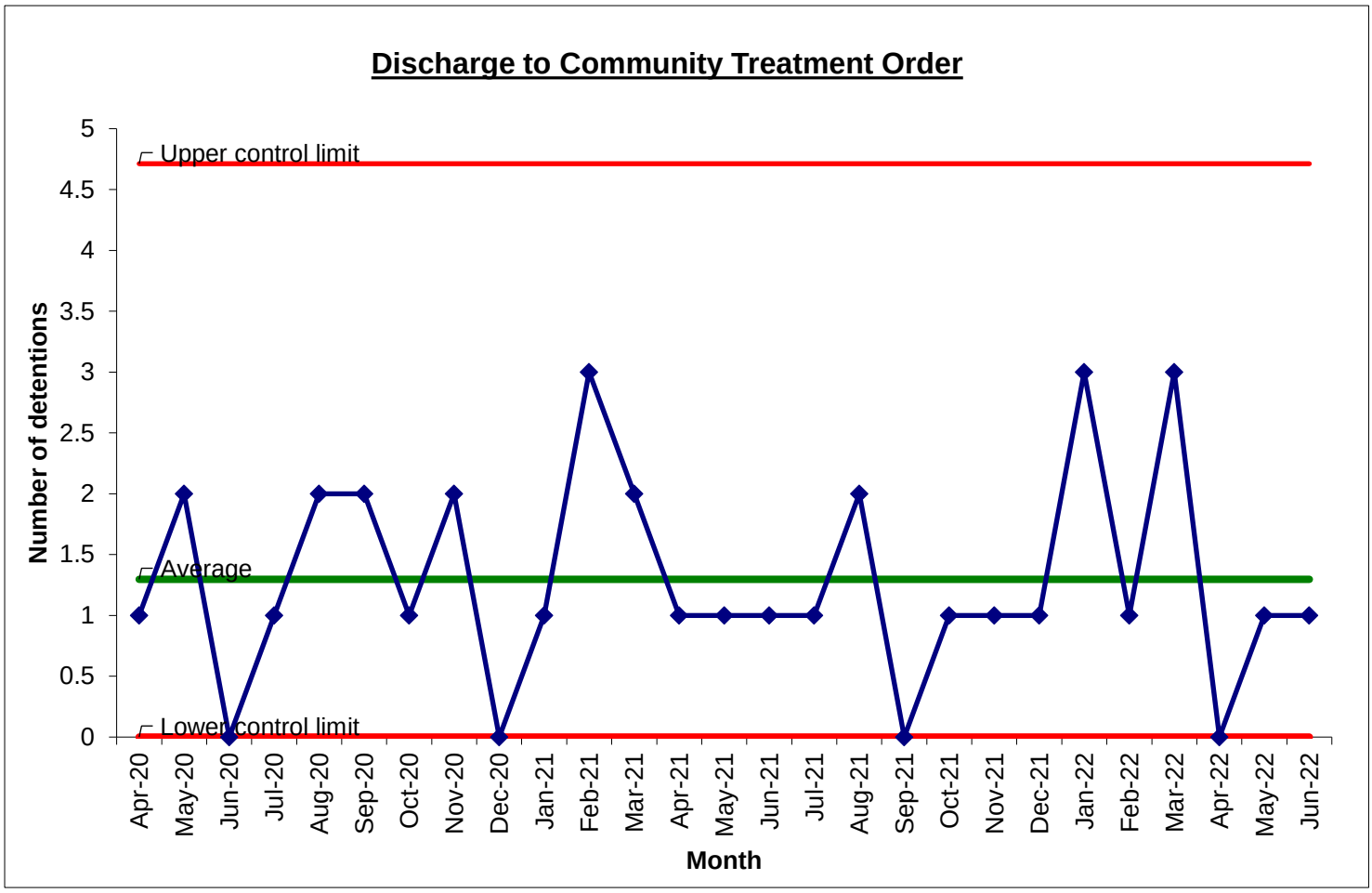


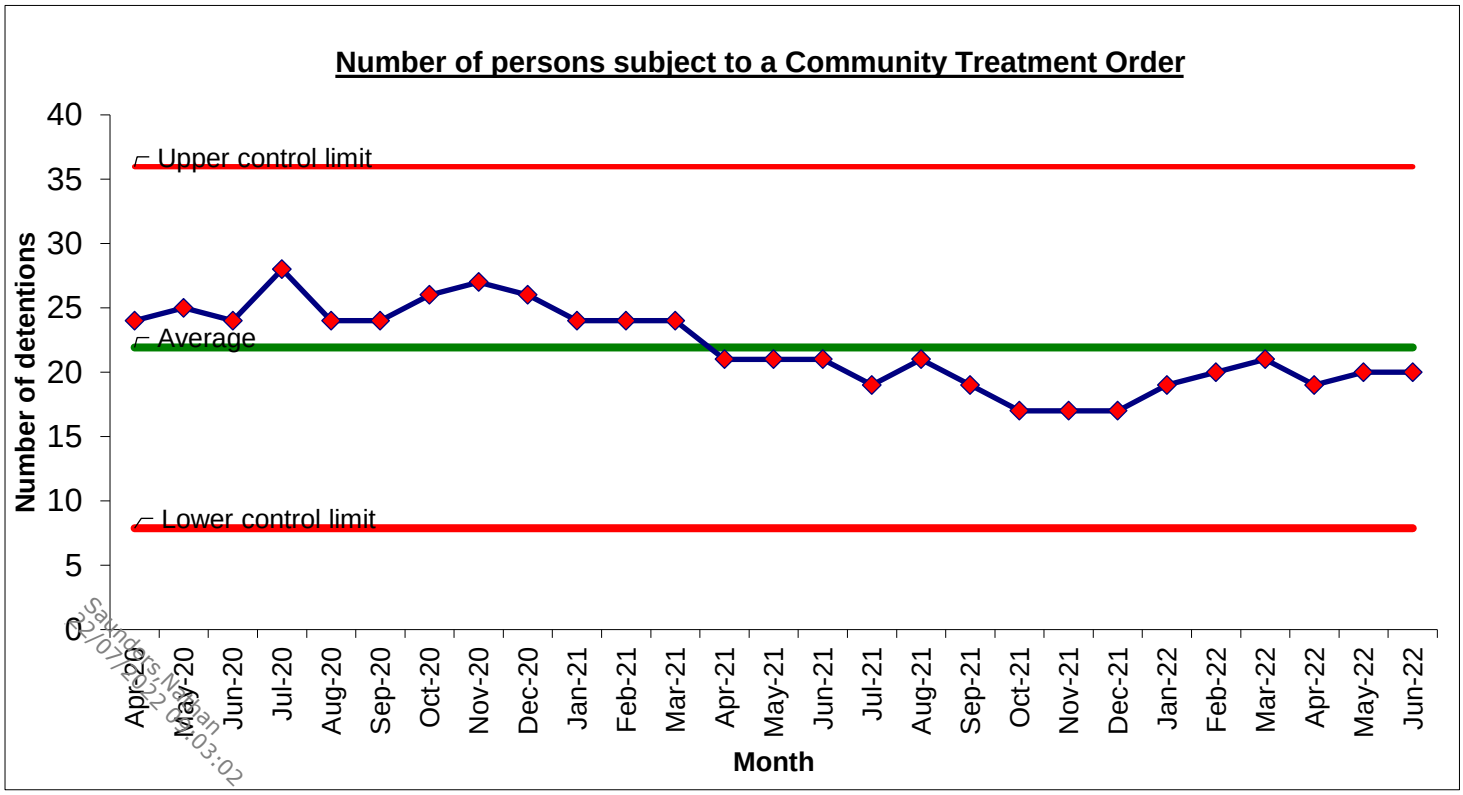
Two of the detentions listed are in relation to the same patient as they appear on both Health Boards figures.

Community Treatment Order

During the period April- June 2022 two patients were discharged to Community Treatment Order.

As at 30th June 2022, 20 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 used once. The patient's CTO was subsequently revoked.

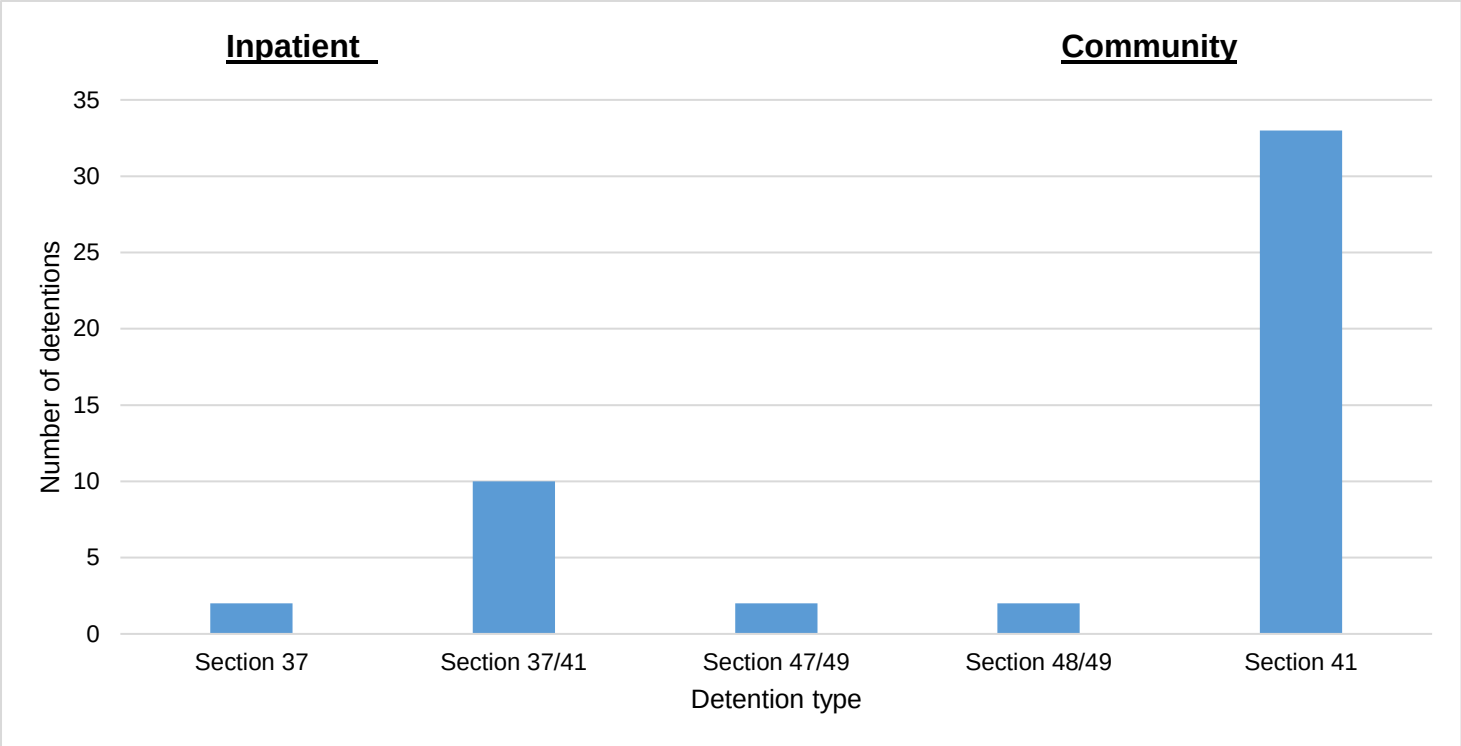
CAMHS Commissioned Inpatient Data

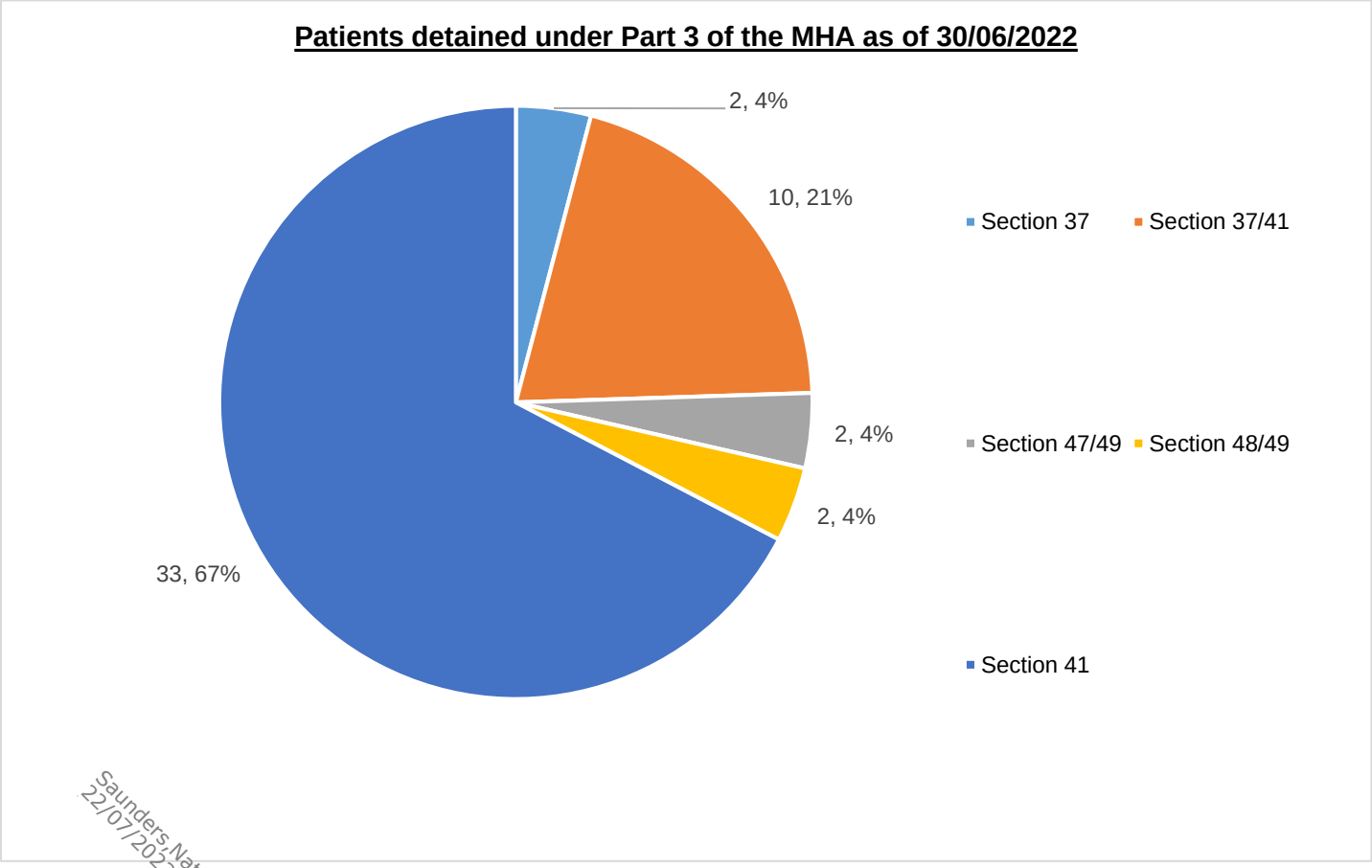
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

Part 3 of the Mental Health Act 1983

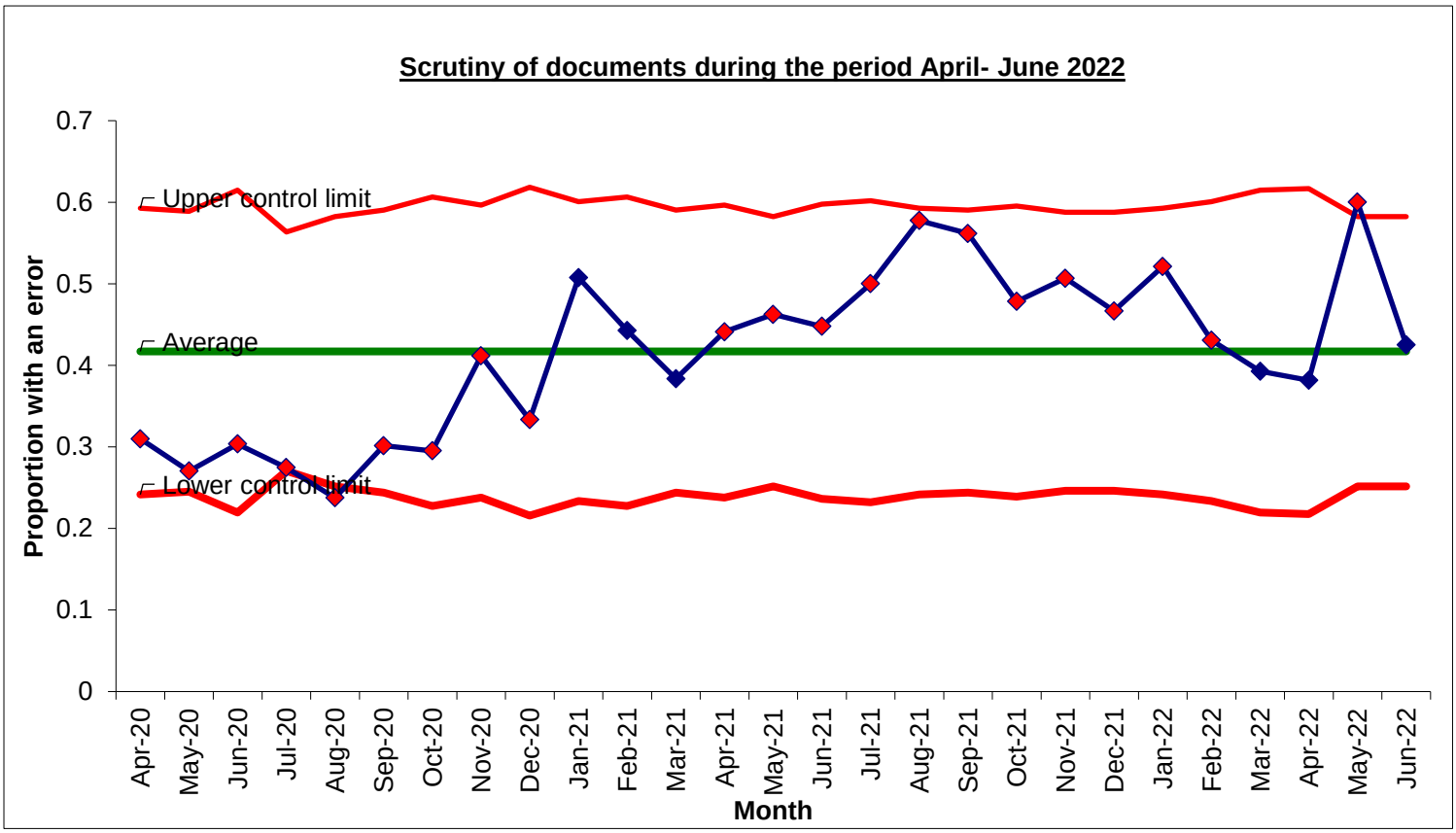
The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 30th June 2022.





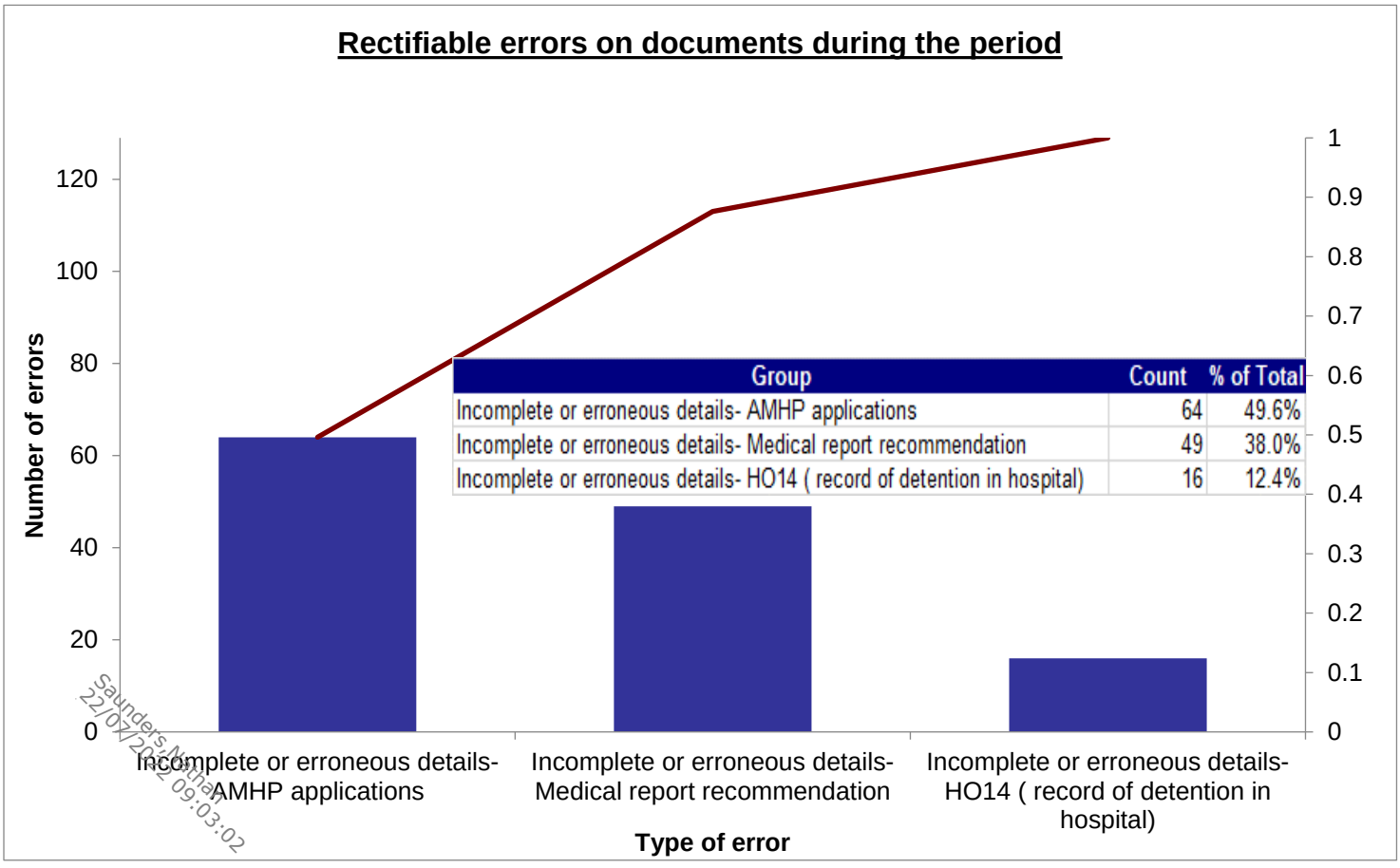
Saunders,Nathan
22/07/2022 09:03:02

Scrutiny of documents during the period

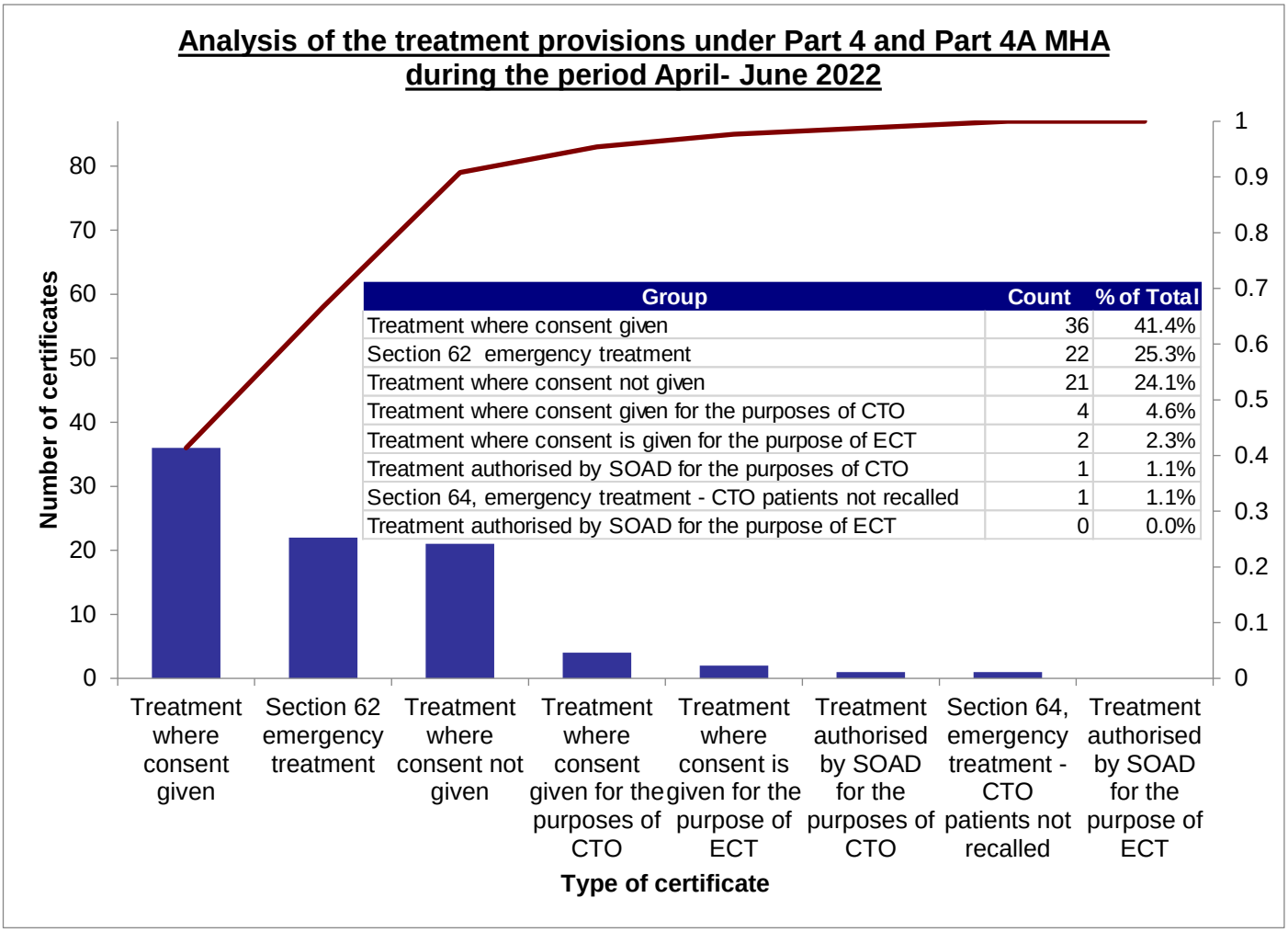


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.

Rectifiable errors on documents during the period



Consent to Treatment



Group	Count	% of Total
Treatment where consent given	36	41.4%
Section 62 emergency treatment	22	25.3%
Treatment where consent not given	21	24.1%
Treatment where consent given for the purposes of CTO	4	4.6%
Treatment where consent is given for the purpose of ECT	2	2.3%
Treatment authorised by SOAD for the purposes of CTO	1	1.1%
Section 64, emergency treatment - CTO patients not recalled	1	1.1%
Treatment authorised by SOAD for the purpose of ECT	0	0.0%

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.

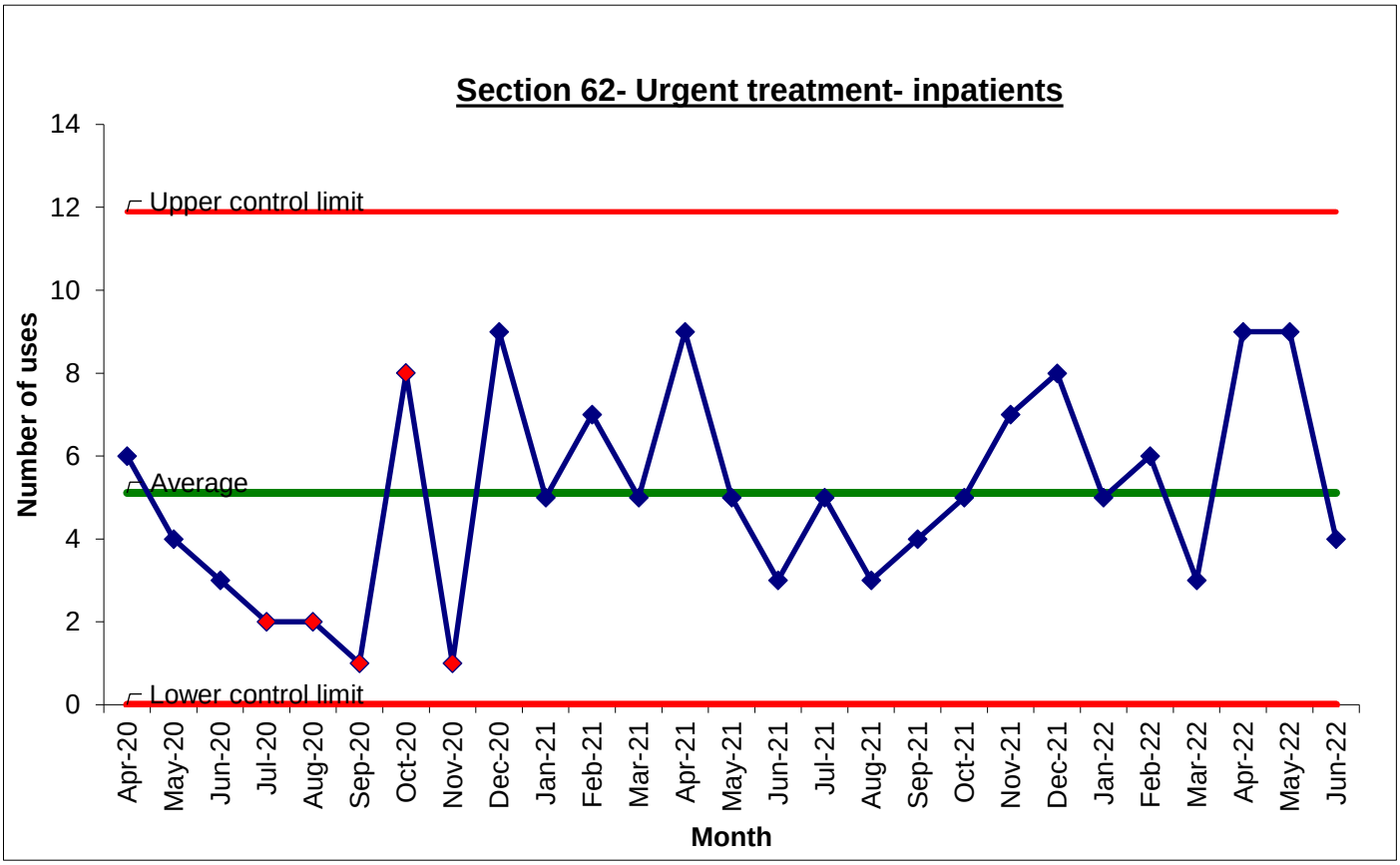
Urgent treatment is defined as treatment that is:

- 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.

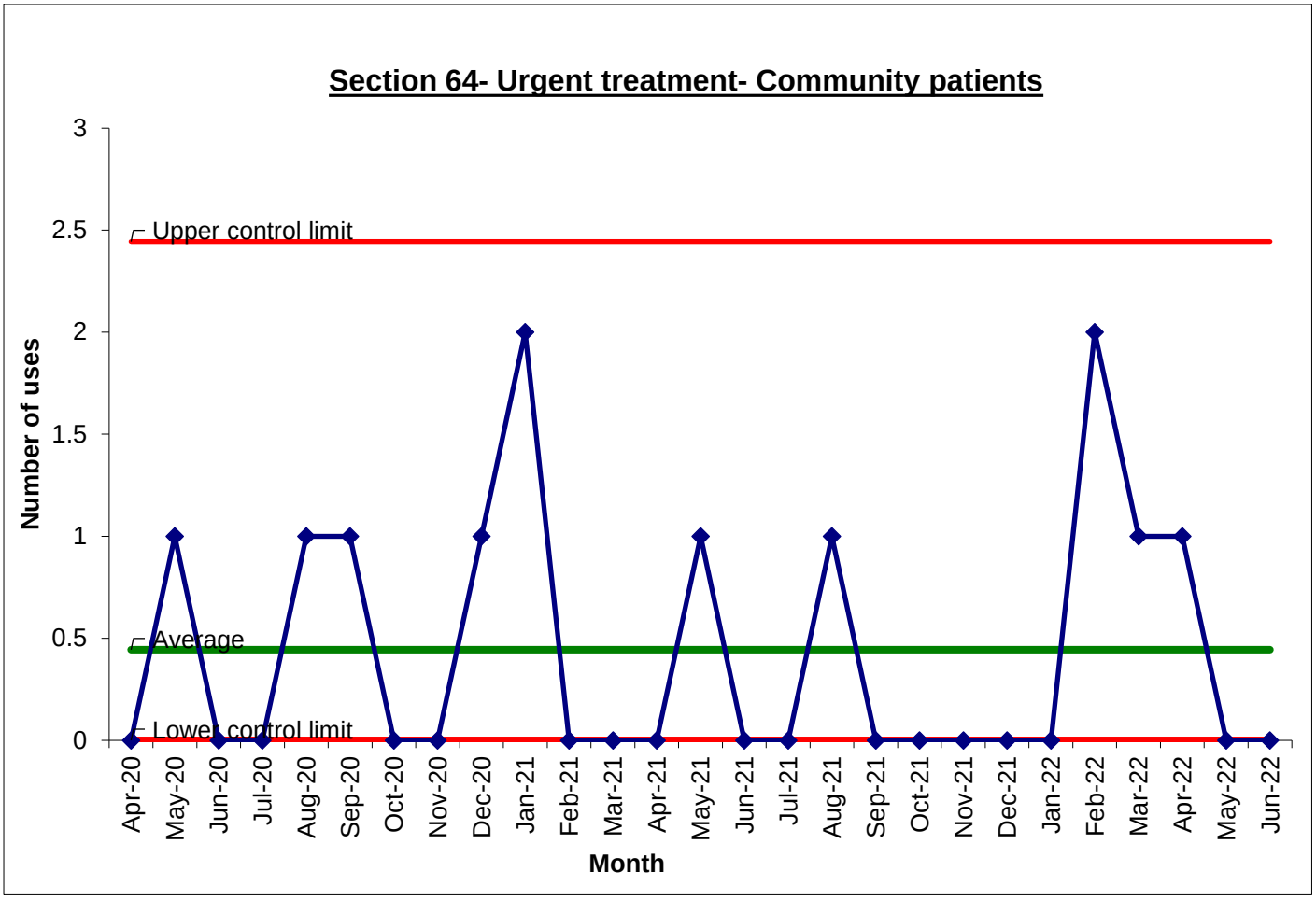
Urgent treatment can be used in any of the following instances:

- 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 twenty two occasions for the following reasons:

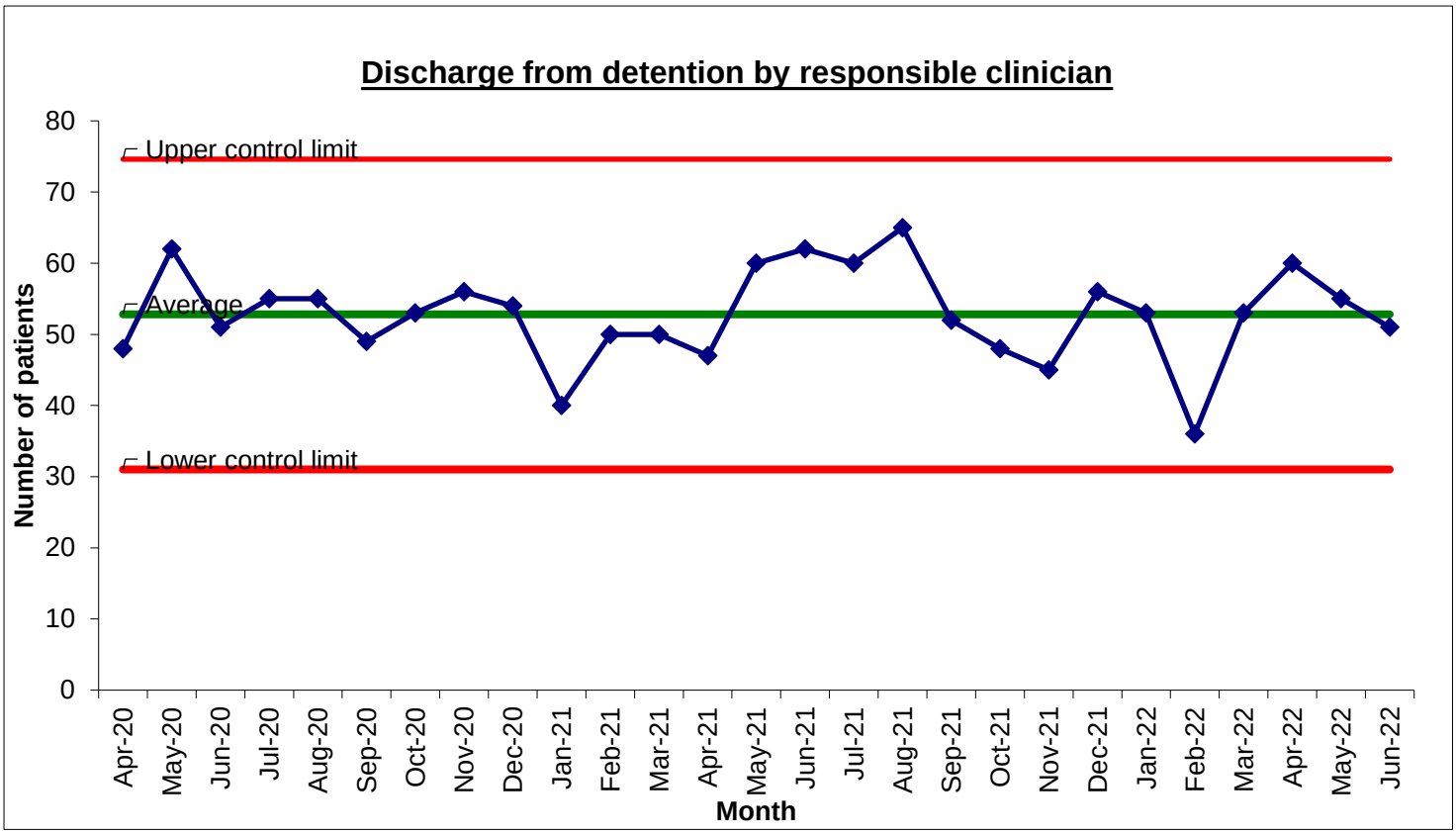
- Pending SOAD – 3 month rule x 10
- Change of capacity to consent x 5
- Change of medication x 2
- Consent withdrawn x 4
- Transfer in with no consent x 1

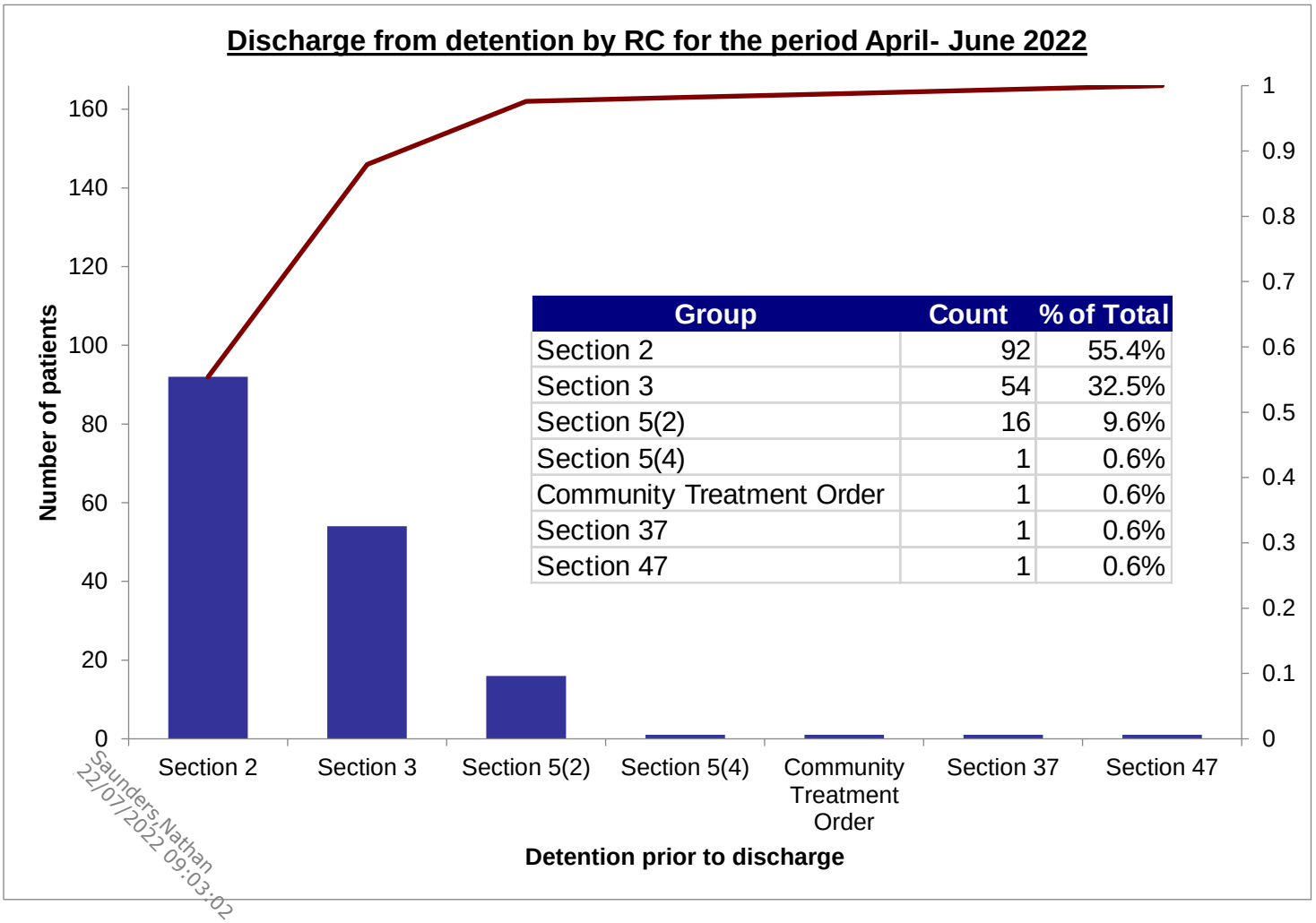


The above chart highlights that Section 64 was used once during the period for the following reason:

- One month rule awaiting SOAD x1

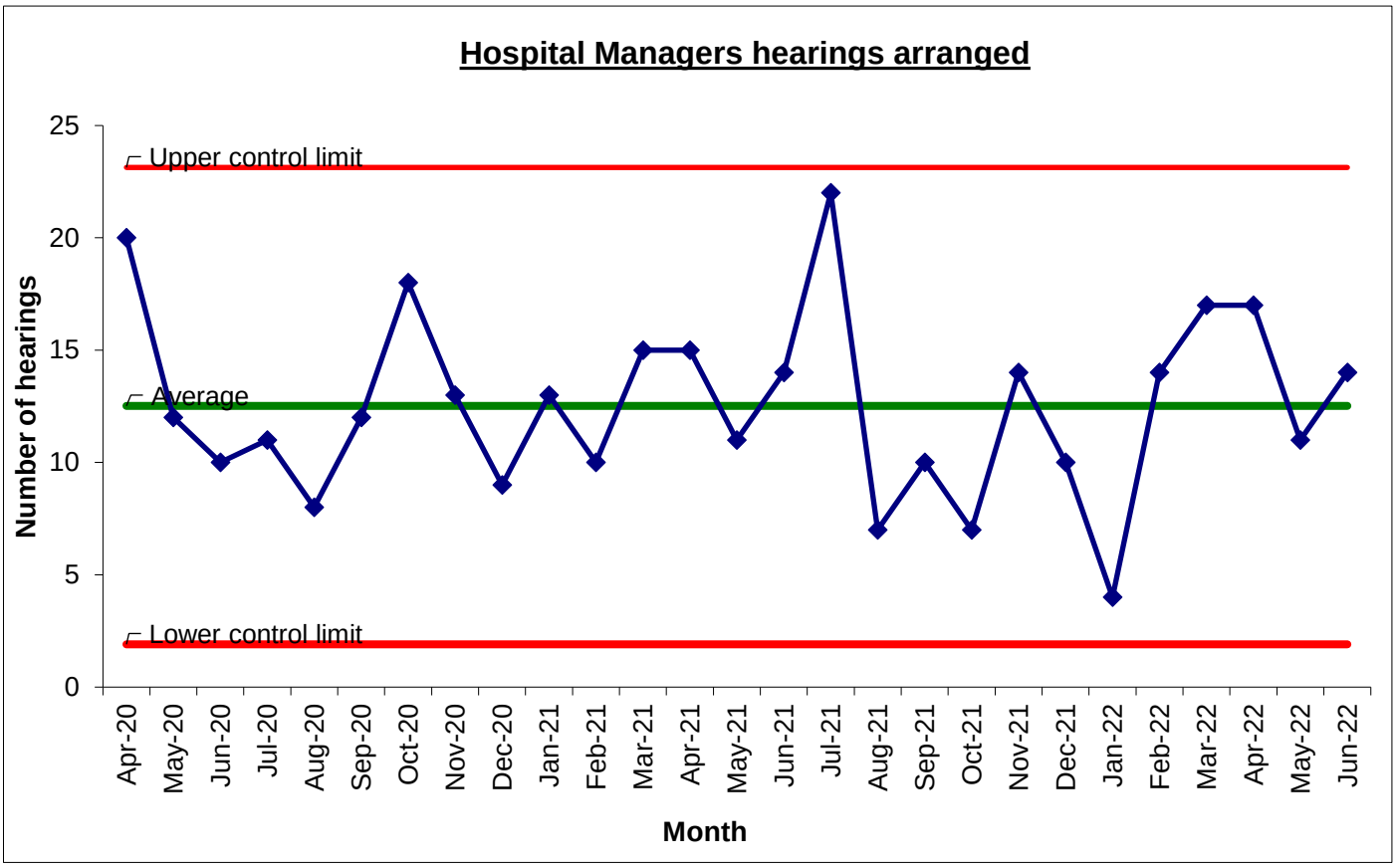
Discharge

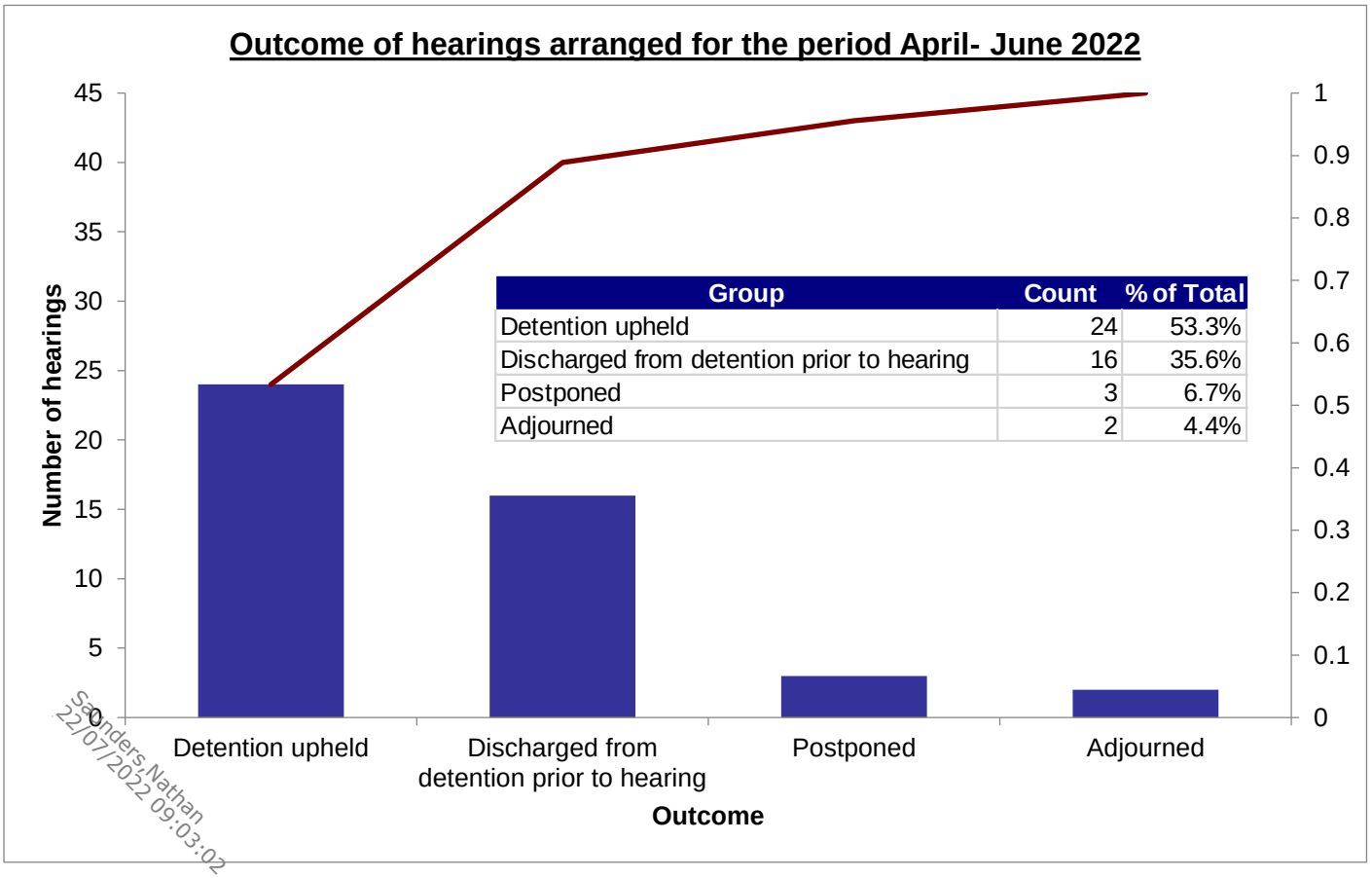




Group	Count	% of Total
Section 2	92	55.4%
Section 3	54	32.5%
Section 5(2)	16	9.6%
Section 5(4)	1	0.6%
Community Treatment Order	1	0.6%
Section 37	1	0.6%
Section 47	1	0.6%

Hospital Managers – Power of Discharge





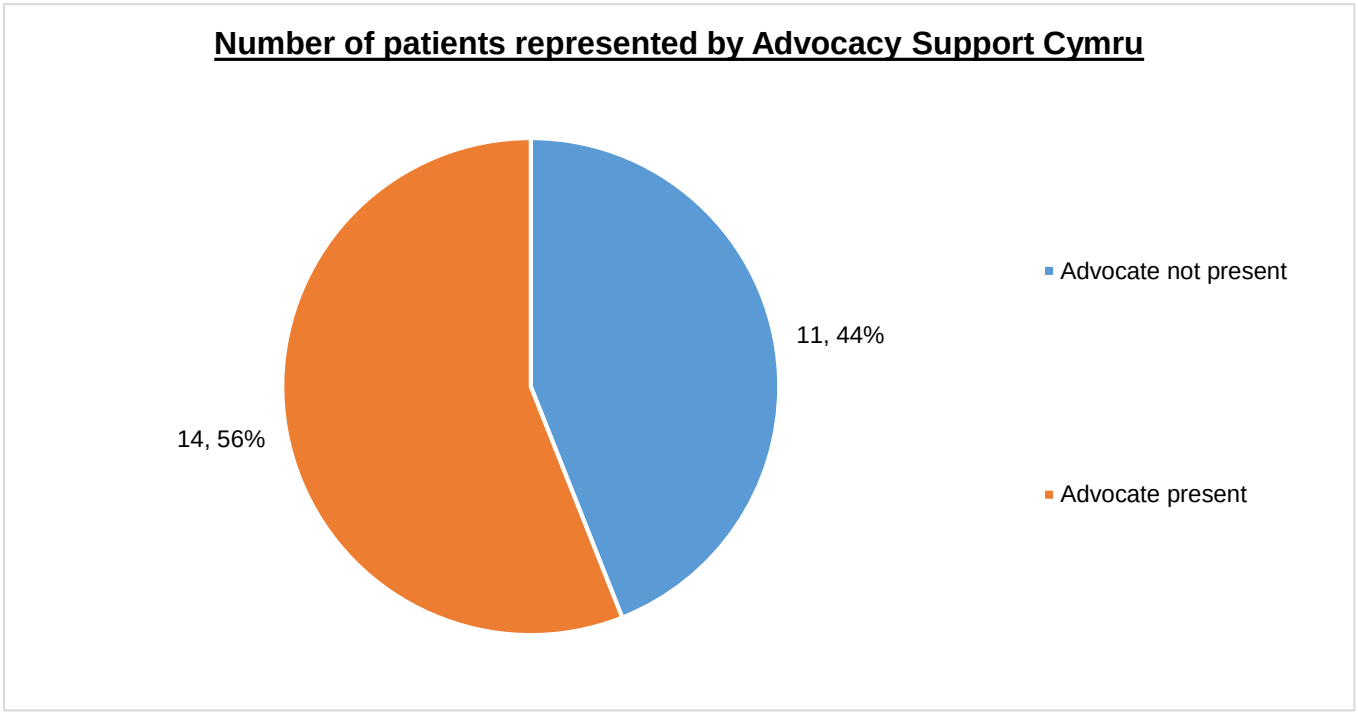
Group	Count	% of Total
Detention upheld	24	53.3%
Discharged from detention prior to hearing	16	35.6%
Postponed	3	6.7%
Adjourned	2	4.4%

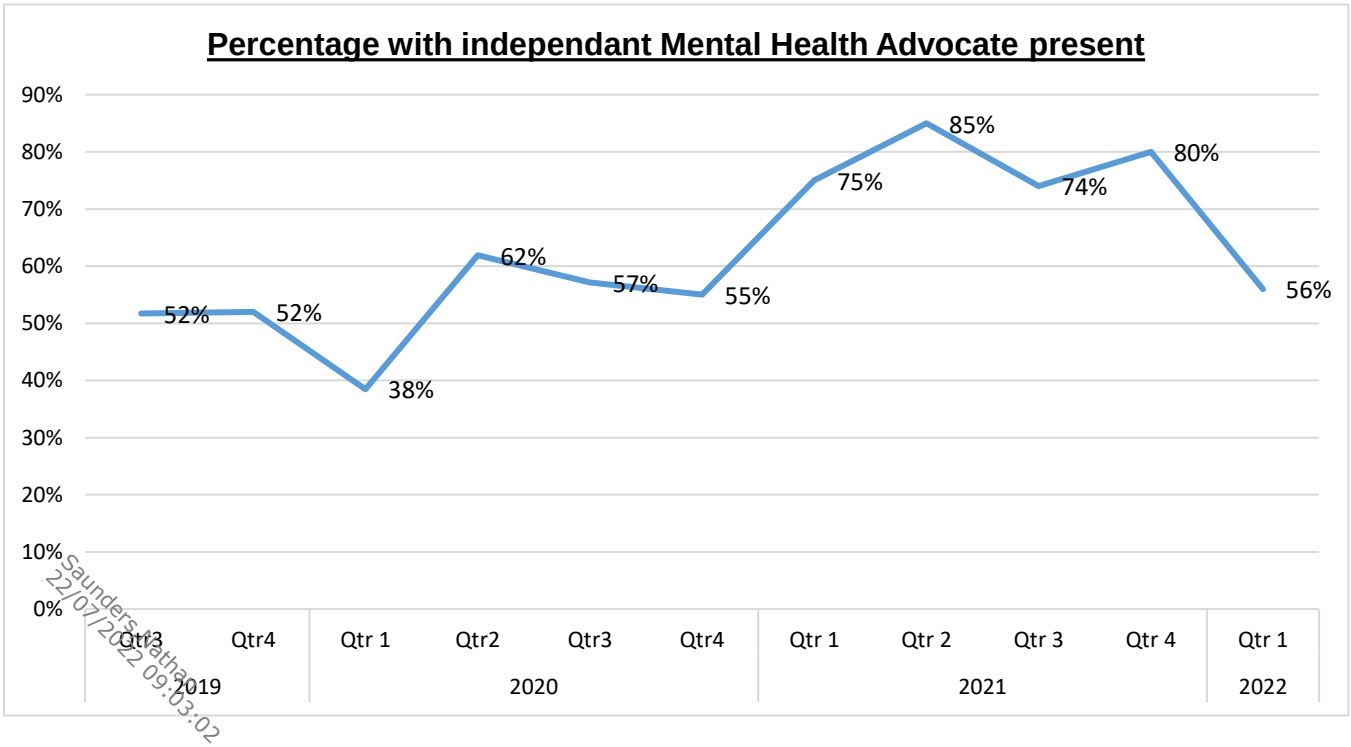
Three hearings were postponed for the following reasons:

- Renewal document not completed in time
- Reports not submitted in sufficient time
- Responsible clinician availability

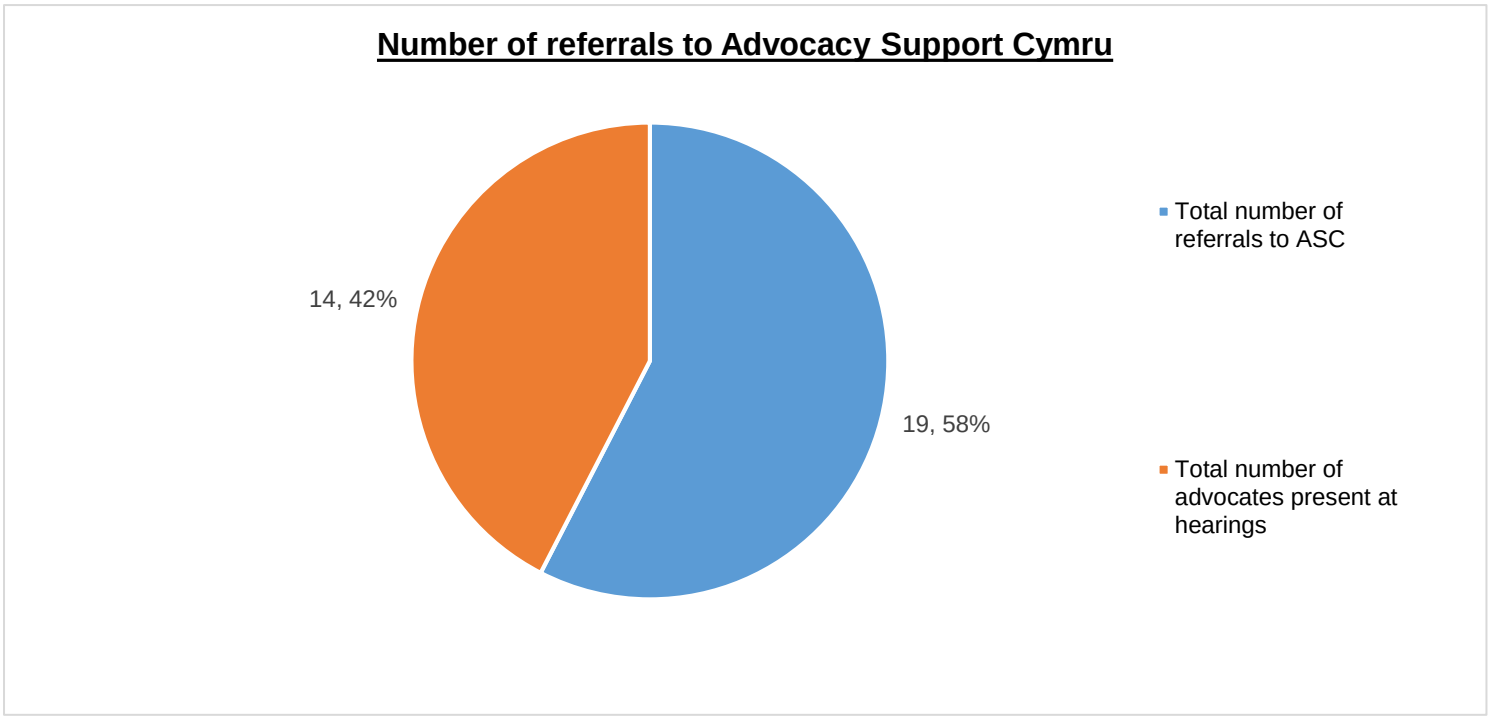
Two hearings were adjourned for the following reasons:

- Patient wanted to attend but was on leave
- Letter from patient not disclosed to panel prior to hearing



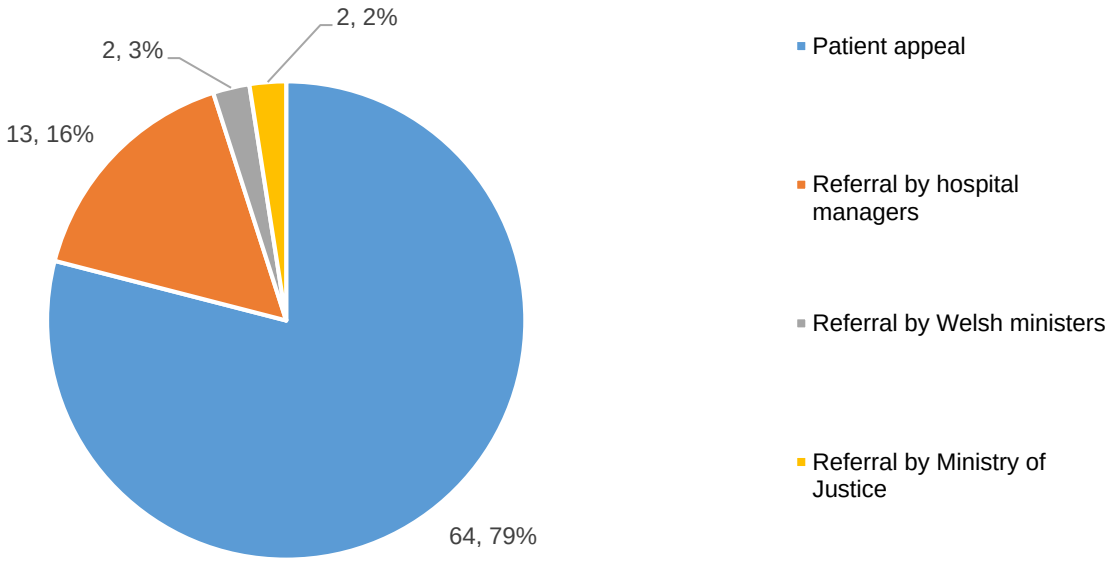


During the period the Mental Health Act Office made nineteen referrals to Advocacy Support Cymru where the patient was deemed not to have capacity to make this decision. Five of the hearings were either postponed/cancelled and therefore weren't attended by an advocate.

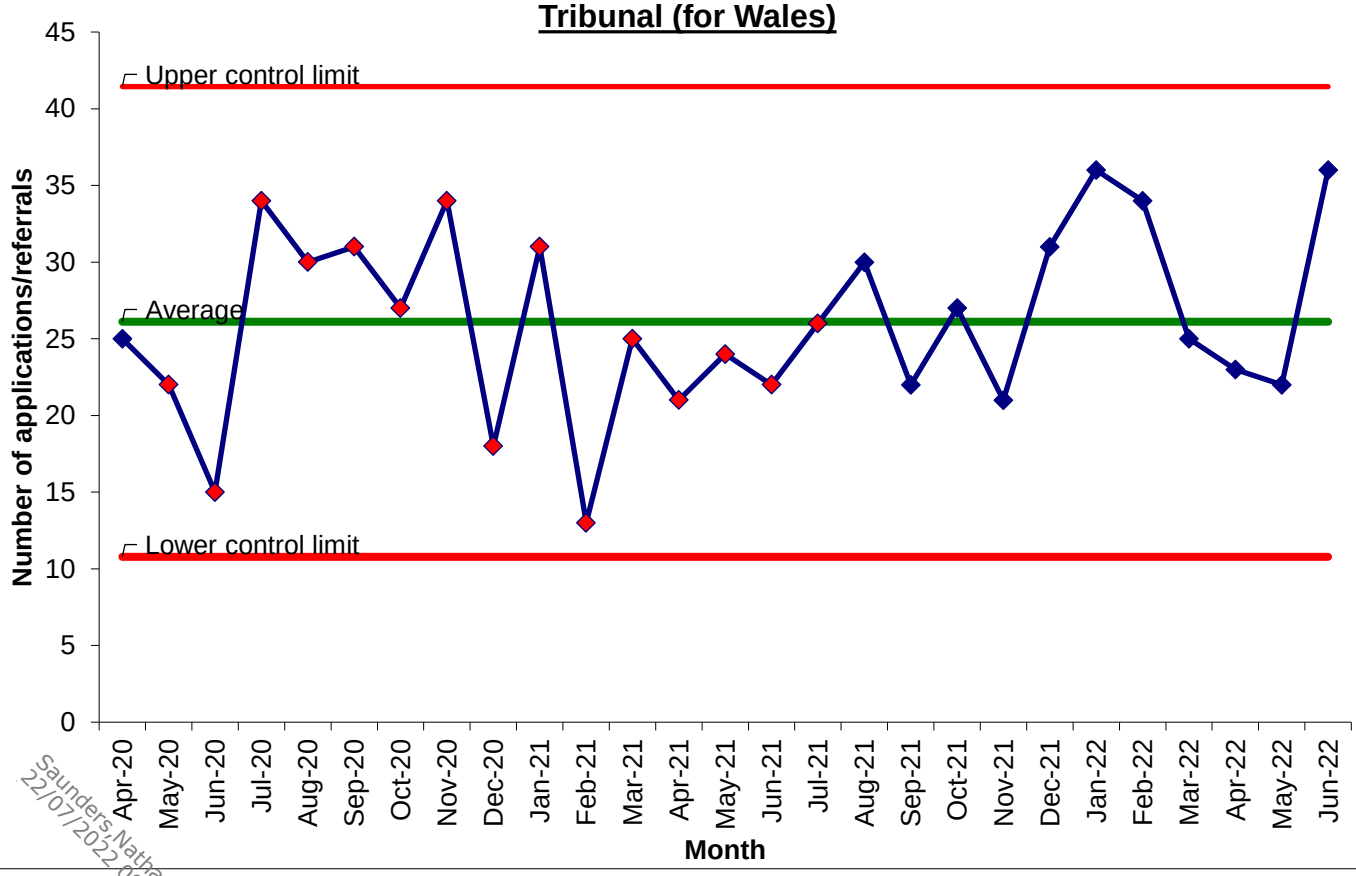


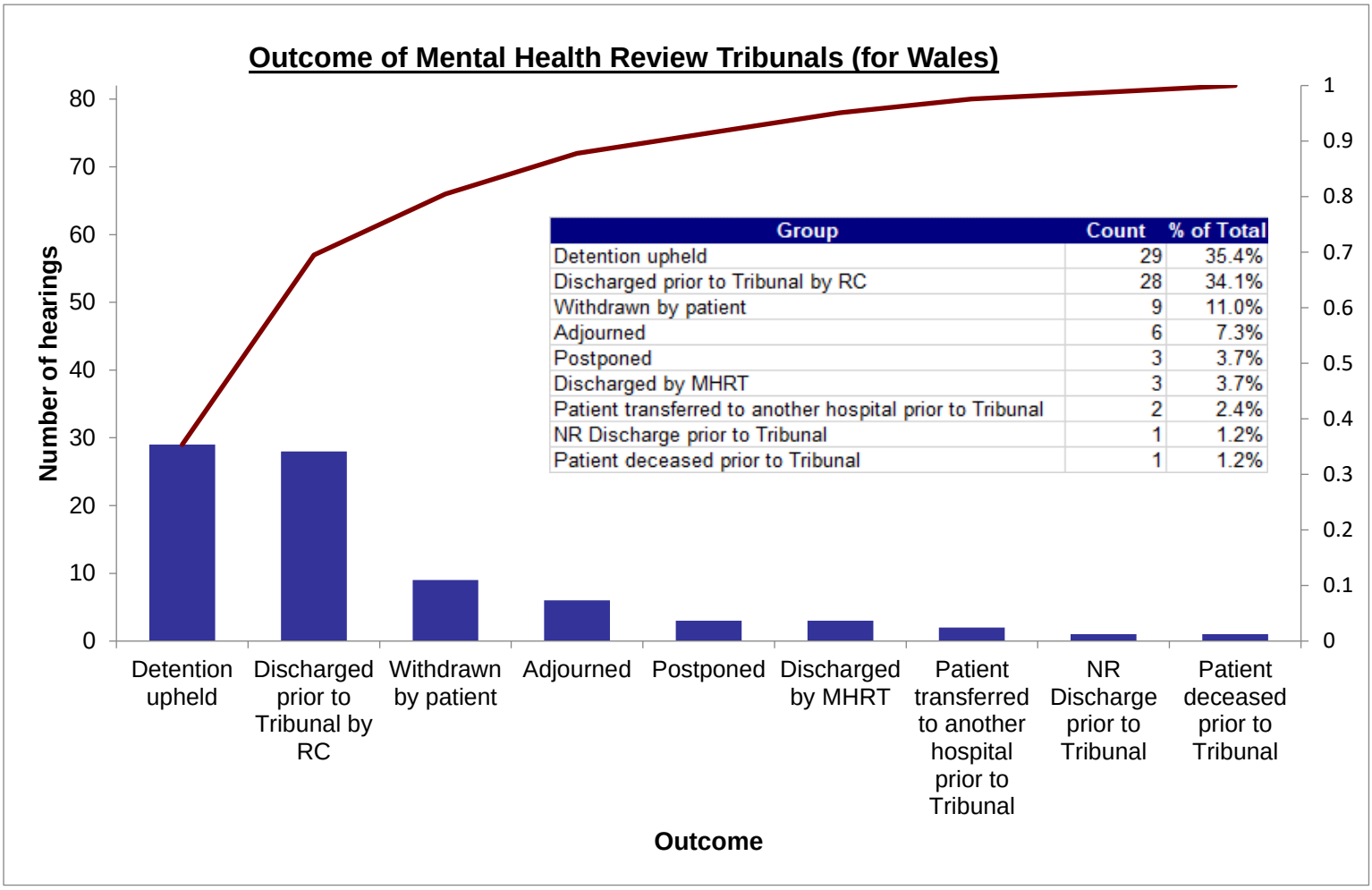
Mental Health Review Tribunal (MHRT) for Wales

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



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





Group	Count	% of Total
Detention upheld	29	35.4%
Discharged prior to Tribunal by RC	28	34.1%
Withdrawn by patient	9	11.0%
Adjourned	6	7.3%
Postponed	3	3.7%
Discharged by MHRT	3	3.7%
Patient transferred to another hospital prior to Tribunal	2	2.4%
NR Discharge prior to Tribunal	1	1.2%
Patient deceased prior to Tribunal	1	1.2%

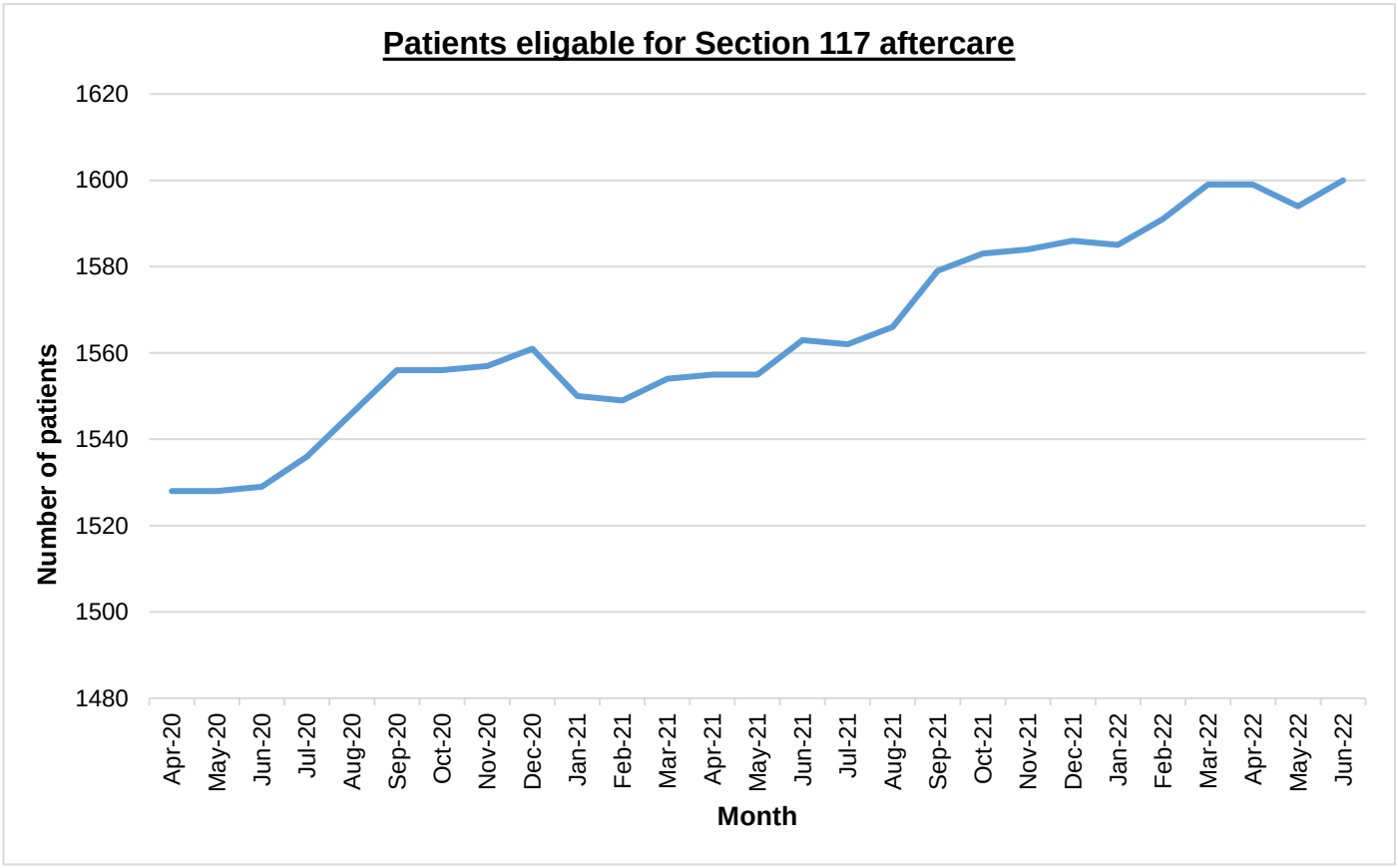
Six hearings were adjourned for the following reasons:

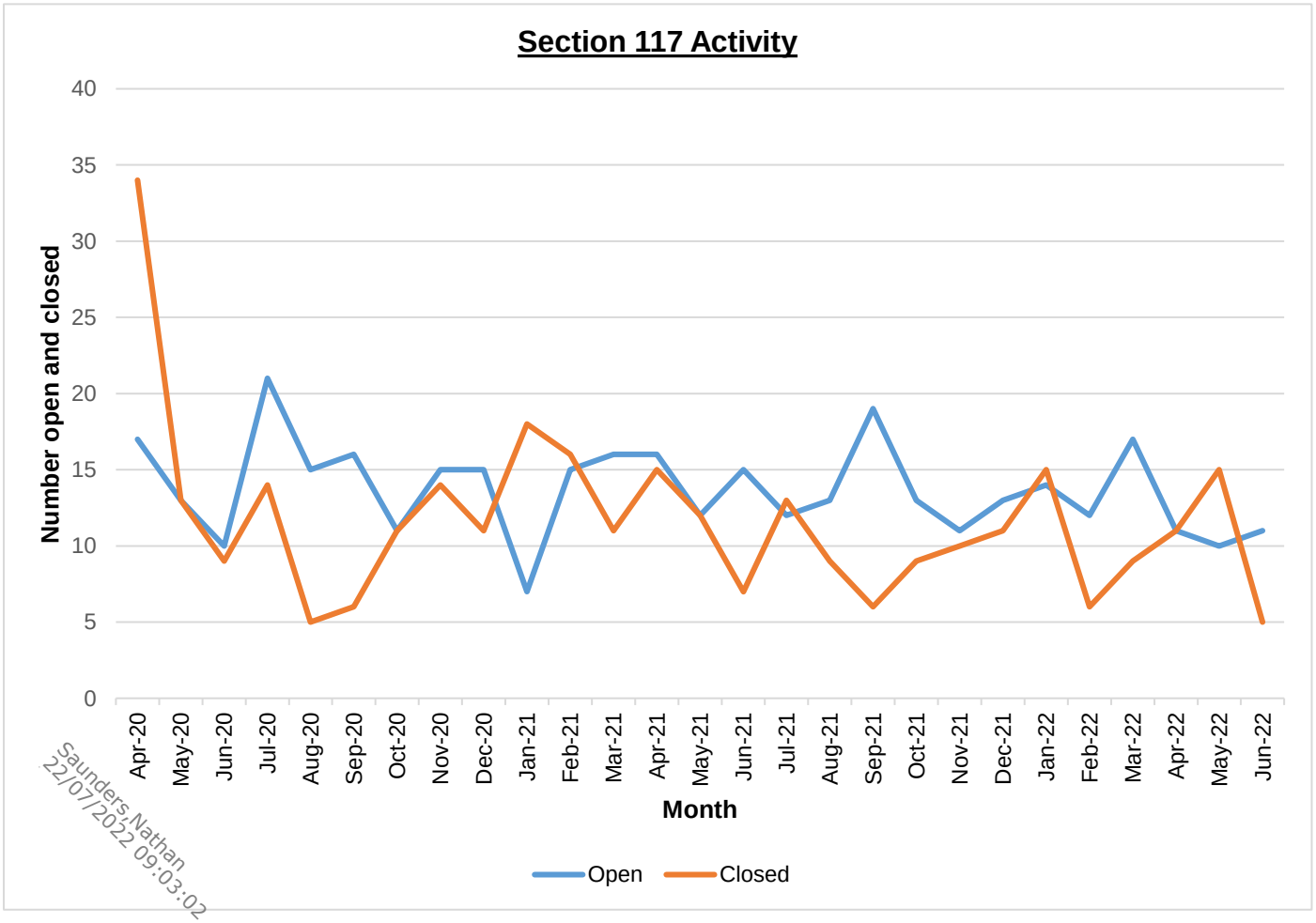
- More information needed in reports x4
- Ward not equipped for Video conference trial x 1
- Patient had not had access to reports via solicitor

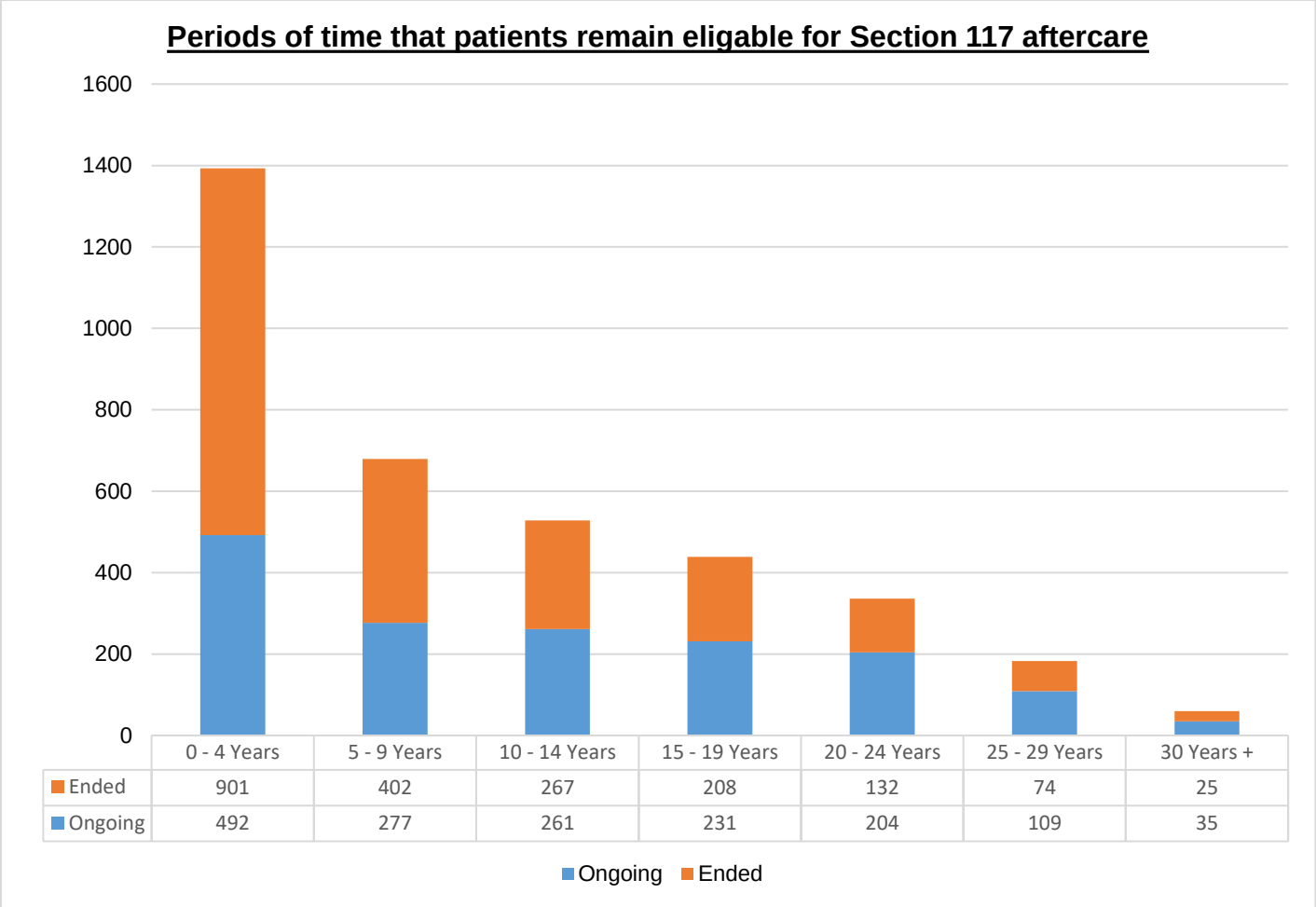
Three hearings were postponed for the following reasons:

- Updated reports needed x 1
- Availability of responsible clinician x 2

Section 117 Aftercare







Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- fourteen 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:

    - Three to return to their home area
    - one to CAMHS
    - Six to a private PICU bed
    - Three to a specialist placement
    - One to a medium secure bed

- One patient detained under Part 3 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Mangers for the following reasons:

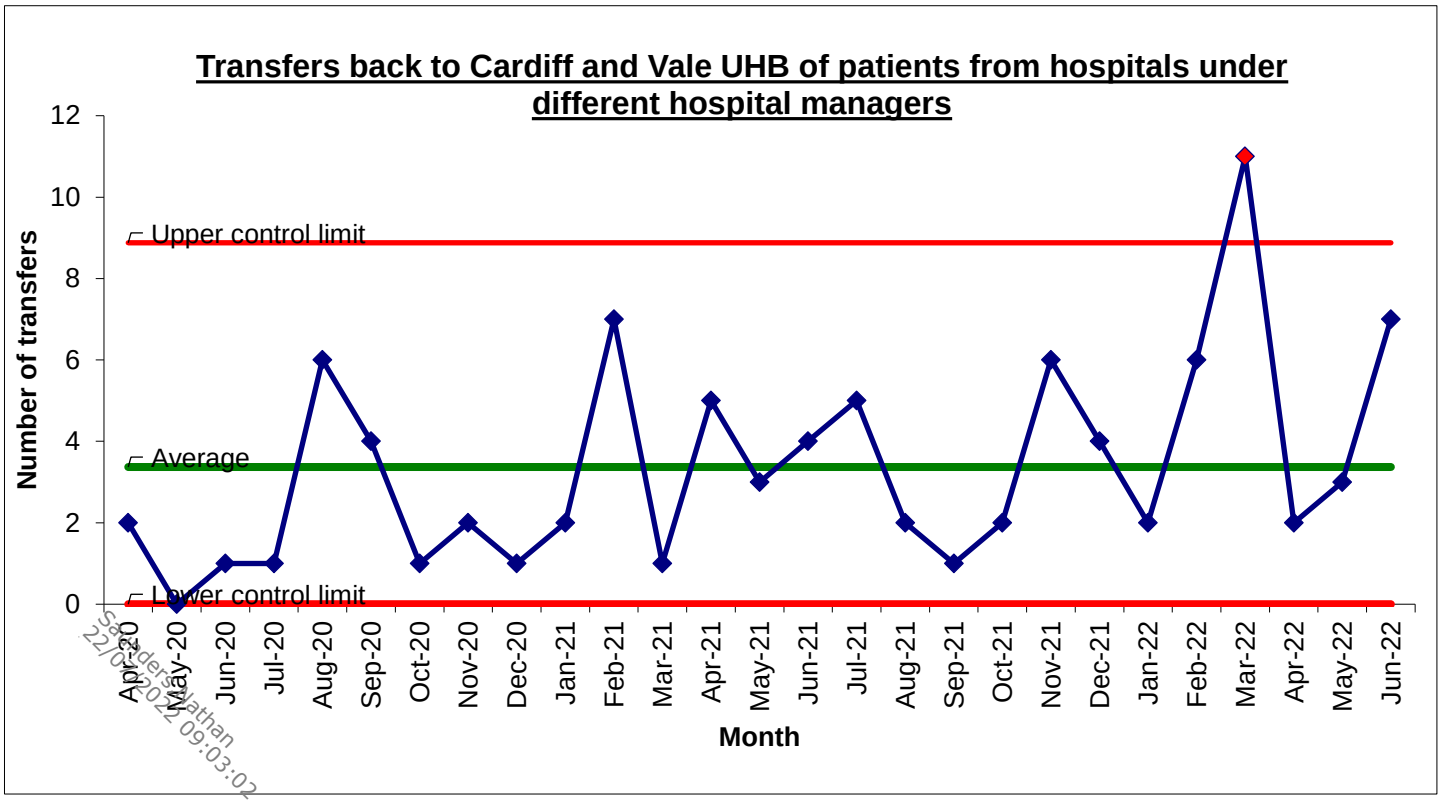
    - To a medium secure bed

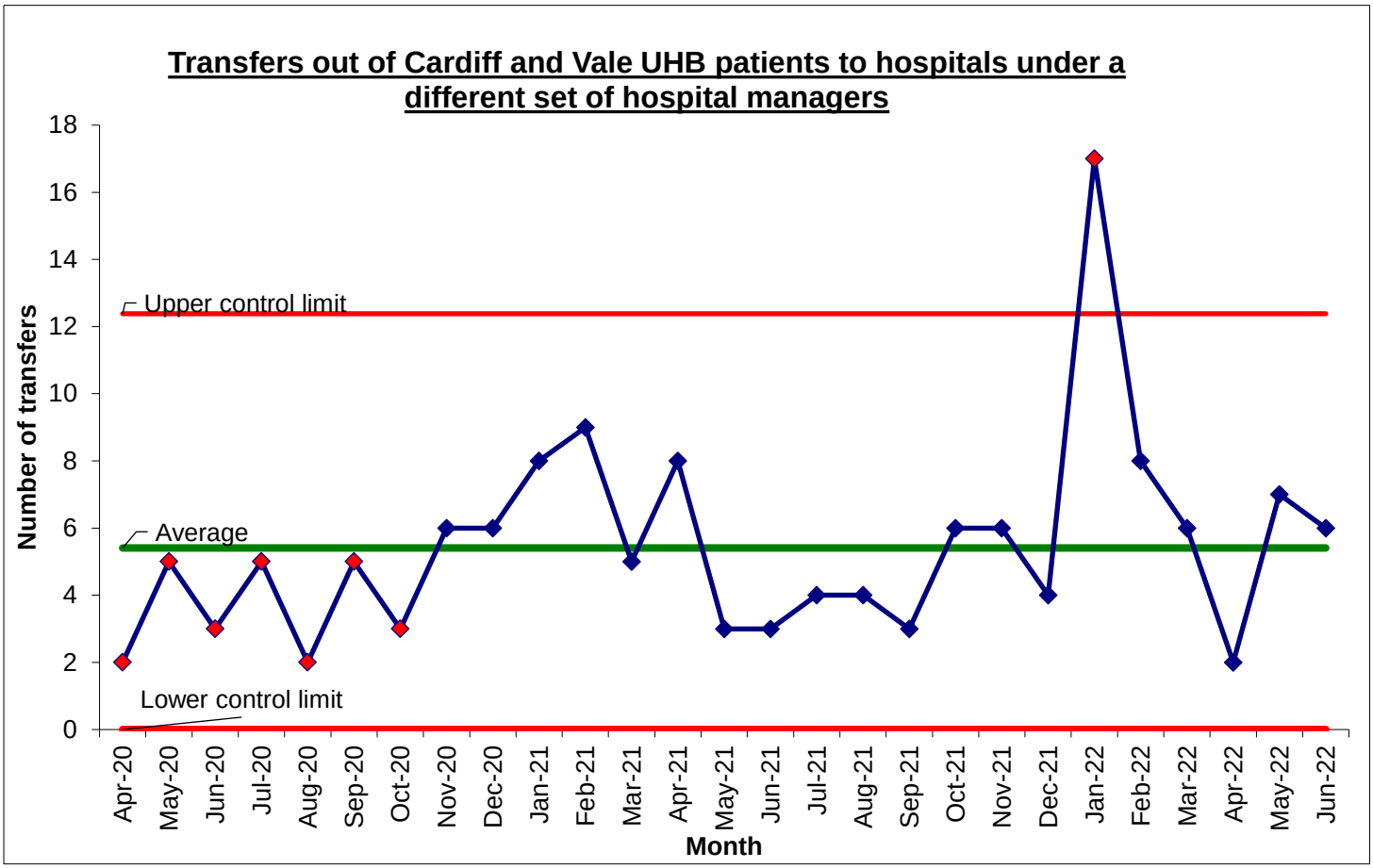
Eleven patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- Ten from PICU beds
- One from an out of area bed

One 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:

- Step down from medium secure





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

April- June 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 two deaths of detained patients.

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

	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.
Part 2 of the Mental Health Act 1983	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. 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.
Section 5(4)	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. 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). 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.
Section 5(2)	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. 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

	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.
Section 4	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. 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. 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: • 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. 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. 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.

Section 2	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. 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. 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. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. 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: • 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 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.

	Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	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. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
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)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • 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

	people from prison to detention in hospital for treatment for mental disorder. 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.
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	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. 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

	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	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: • 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.
	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. 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. If the patient lacks capacity to consent SOAD authorisation is required.
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)

Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • 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.
Section 23	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. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). 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.

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.

Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2				Agenda Item no.	**10.1**
Meeting:	Mental Health Legislation and Mental Capacity Act Committee		Public	X	Meeting Date:	26th July 2022
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	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.):

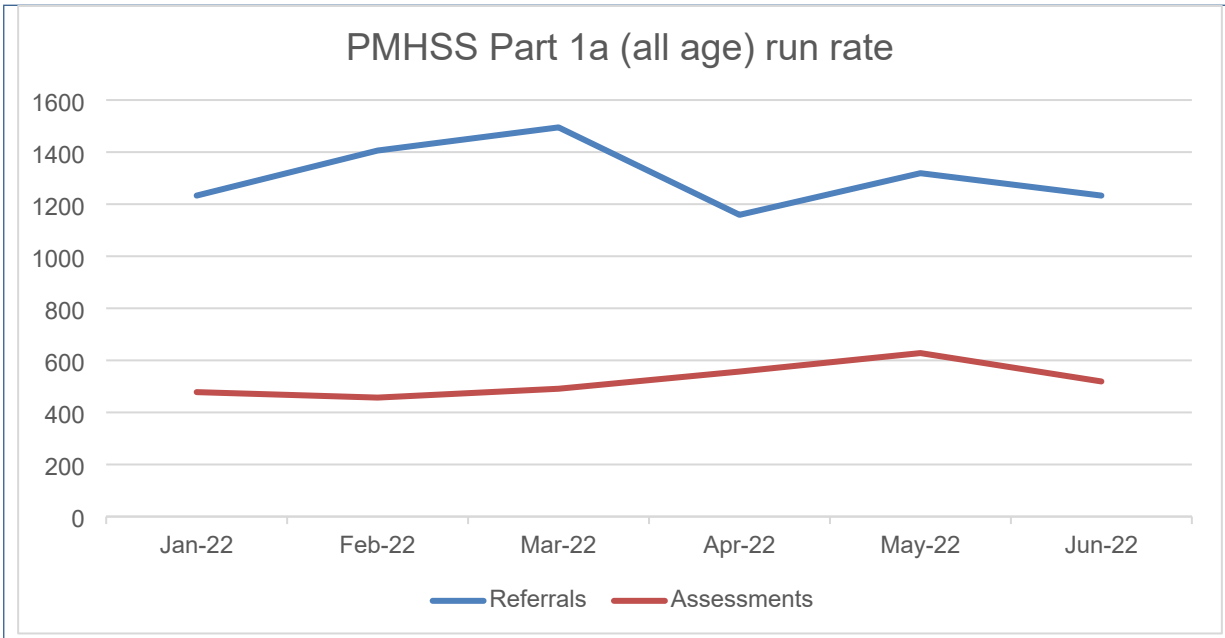
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1: PMHSS

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

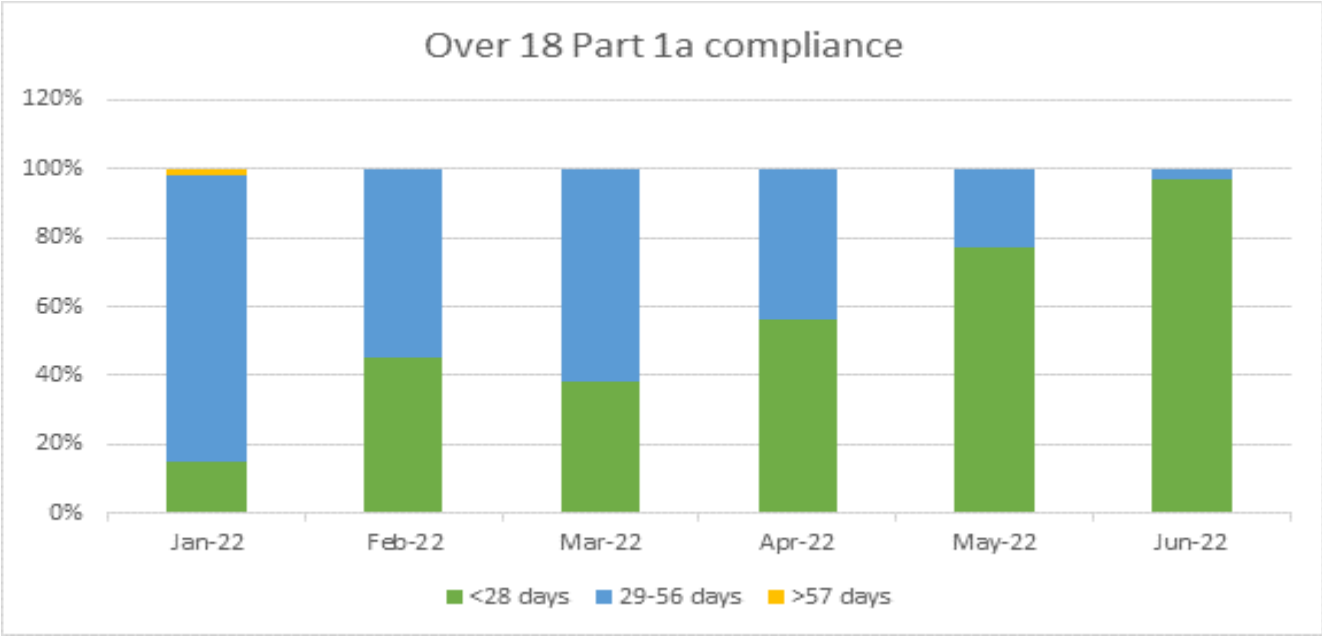
Referrals into the service aligned with the forecast of a seasonally less active period – we received 3711 referrals overall. This is an 8.8% increase on last year's Q1 referrals (all age). The service is at full clinical recruitment and sickness absence has decreased; this allows for ongoing high levels of assessment activity – PMHSS assessed 1704 in Q1 (graph 1).

Graph 1



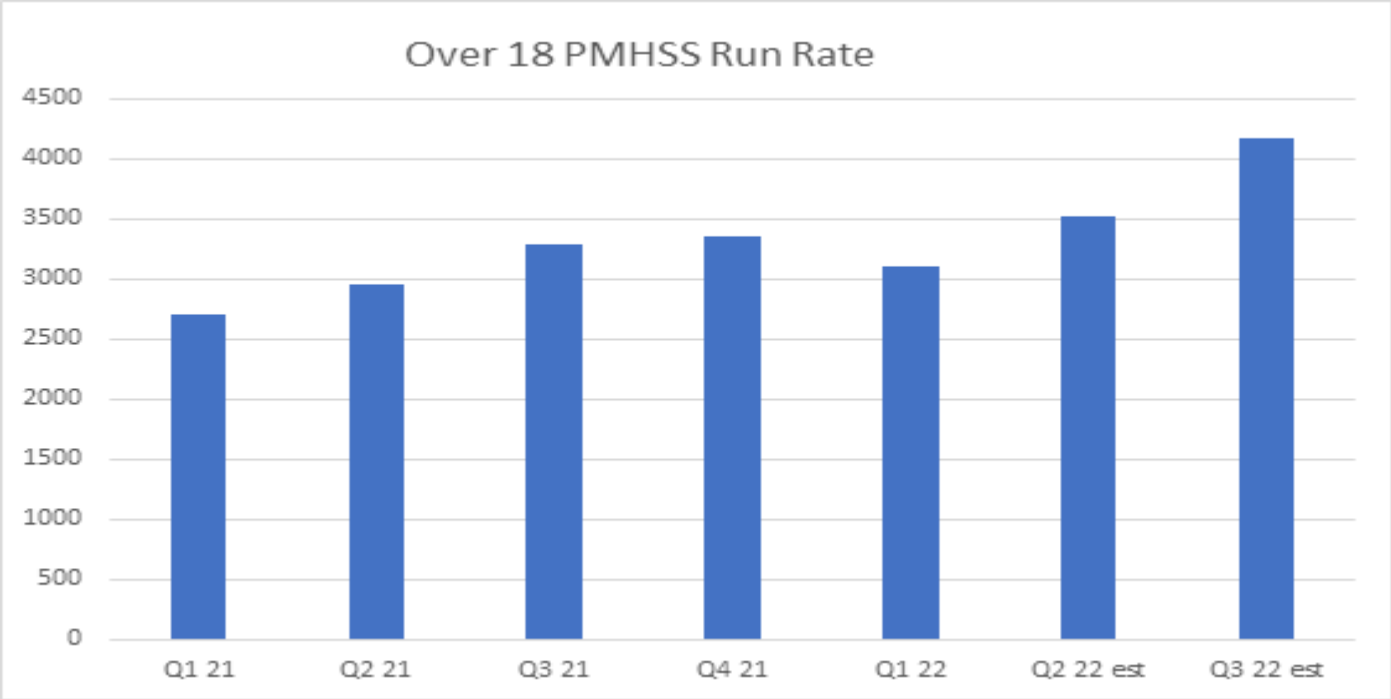
This activity meant that the service attained Part 1a compliance in June 2022 (graph 2). The overall numbers waiting for assessment has dropped further from 360 on 31/03/2022 to 166 on 30/06/2022. Average wait time for assessment has dropped from 16 days on 31/03/22 to 9 days on 30/06/2022. The service reported 95% compliance in June 2022. Early indications are for a similar Q2 then Q3/Q4 having very high levels of activity. We forecast continuing to meet target.

Graph 2



The year 2021-2022 overall saw a 30% increase of referrals into Part One Services – PMHSS forecast ongoing high rates of referral into the service and anticipate a new peak in referrals in Q3 of 2022-2023 (Graph 3)

Graph 3



Actions to maintain compliance

- Investment into Tier 0 providers to deliver Tier 0 interventions (Stress Control and ACTion for Living) at scale to reduce referrals into PMHSS- following tender process groups are starting again in Vale, we have been informed by third sector partner that groups in Cardiff will restart in August.
- Develop automated opt in letter and immediate text message prompt for all referrals into PMHSS – in process

Counselling waiting times remain low, and current referrals to PMHSS are booked in at 9 days.

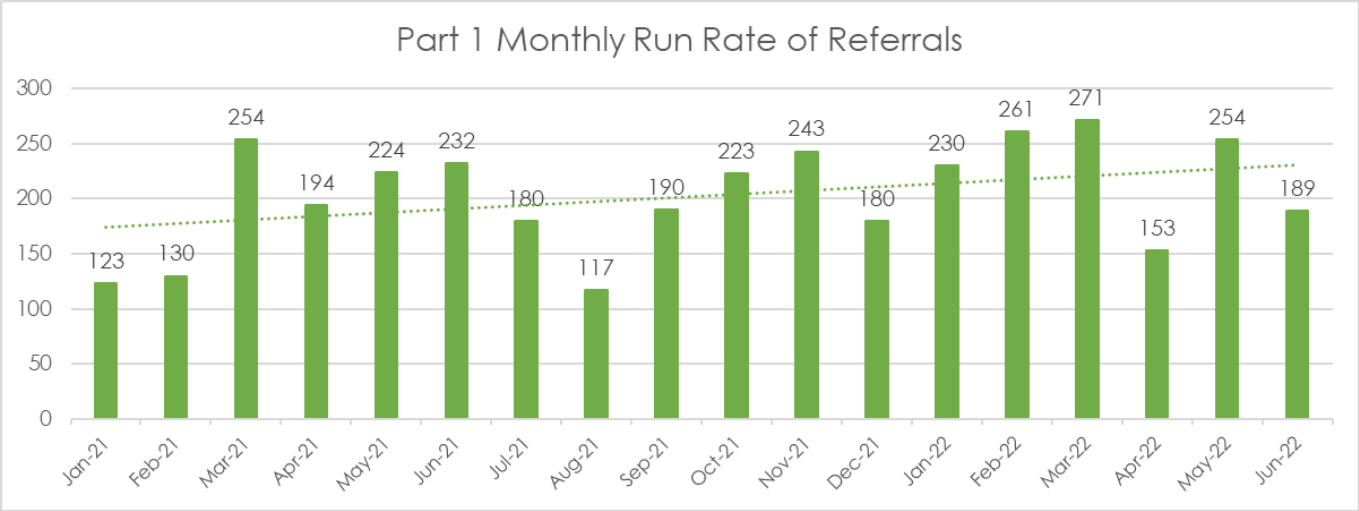
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

Compliance against the Part 1A target has not been achieved since March 2022 due to a number of operational issues. We have recently seen a significant increase in referrals in comparison with 2021 levels and unfortunately, within the core service, capacity has been reduced by long term sickness. In addition, our partner Healios who we have been working with to deliver a waiting list initiative, are also facing reduced capacity due to significant vacancy within the organisation.

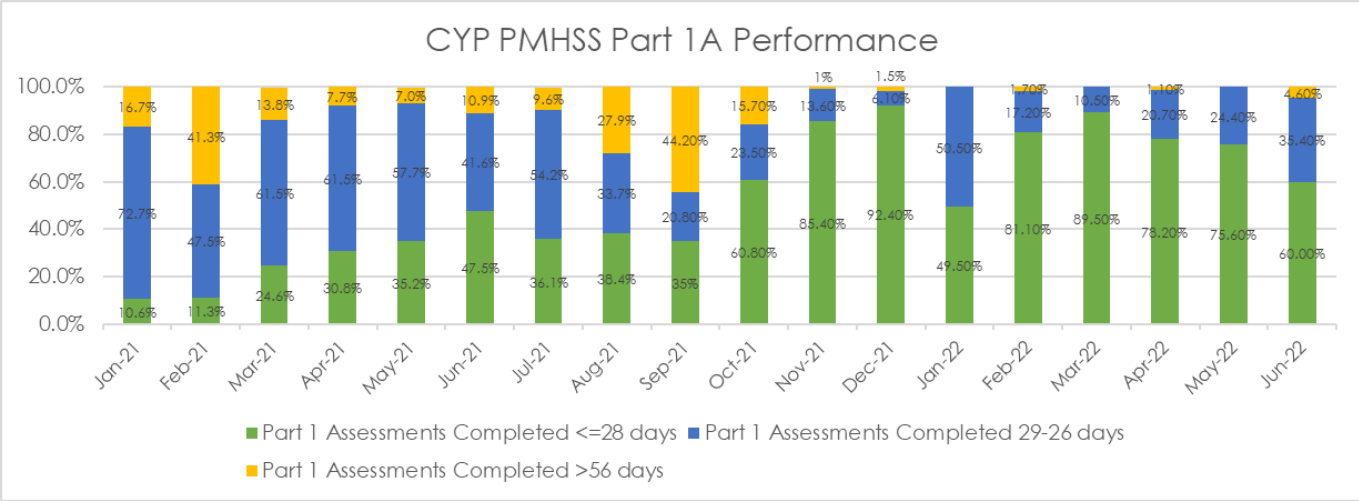
Since March 2021, the volume of referrals has increased and have remained significantly higher than pre-Covid levels. As expected, the service has seen a decrease in referrals over school holiday periods.

The average wait for assessment is currently 25 days but we are anticipating that this will increase over the next few weeks until the service mobilises an impending waiting list initiative.

Graph 4



Graph 5



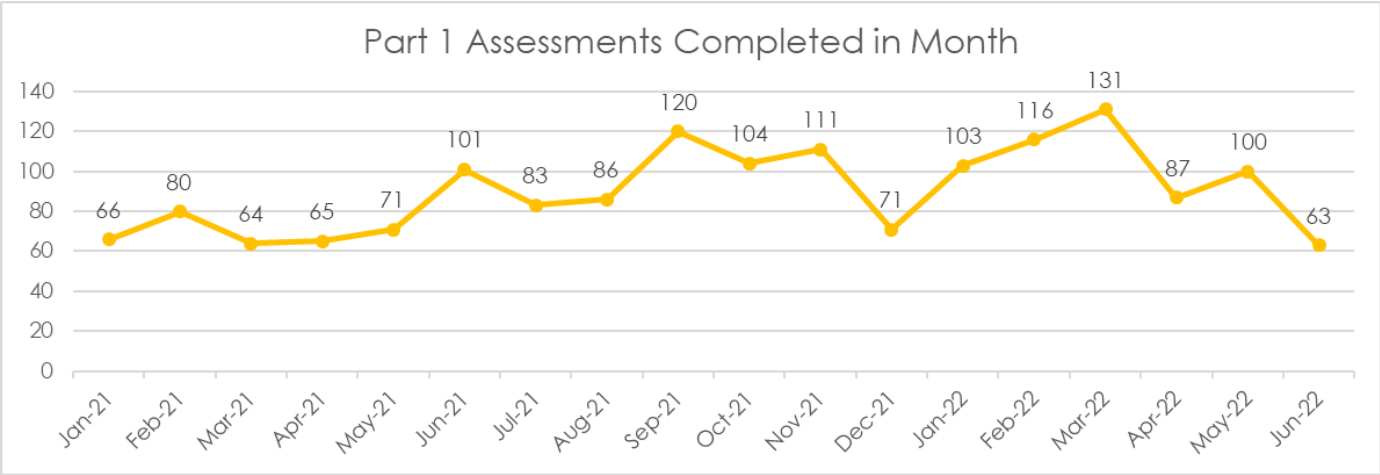
Capacity has been a challenge for the team, with a mixture of short and long-term sickness, the team has been operating on approximately 66% capacity since the beginning of December 2020. There is currently a significant recruitment drive with the development of new services as a result of COVID recovery 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 operational from the beginning of quarter 3 in 2022.

To ensure that this new service model is in the best position to commence in October, we are currently planning a waiting list initiative across what was both Primary Mental Health and CAMHS internal and external waiting lists. The service hopes to significantly reduce these waiting lists as much as possible through the use of agency staff.

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.

Graph 6



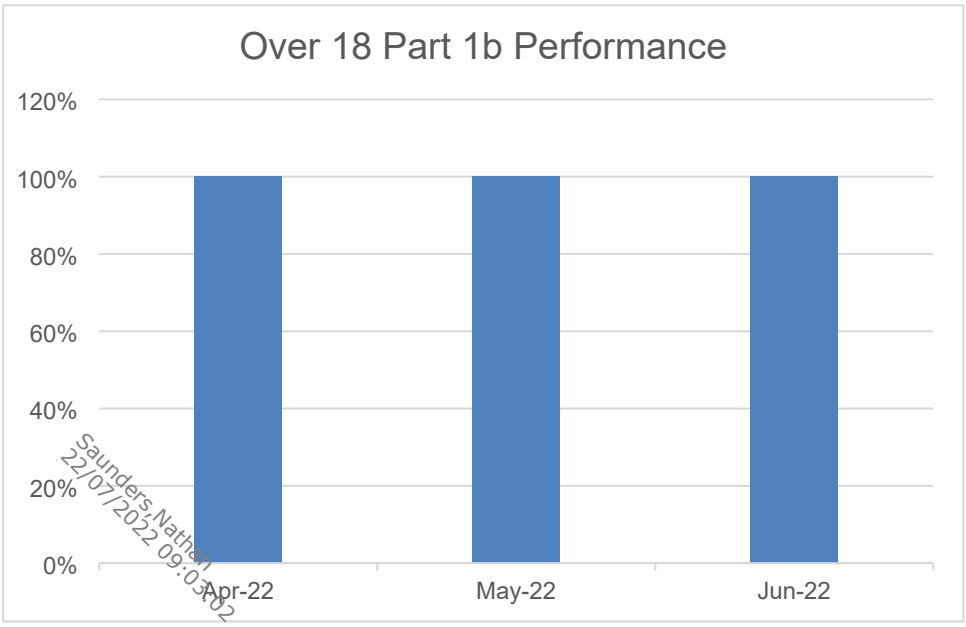
Actions to improve compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of partnership working with Healios to deliver Part 1 assessments and the use of agency staff to deliver a new waiting list initiative.
- 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.
- Recruit to remaining vacancy within the service.

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

PMHSS continues compliance with Part 1b performance target (See Graph 7). Overall a range of interventions for around 100 participants are running this reporting period.

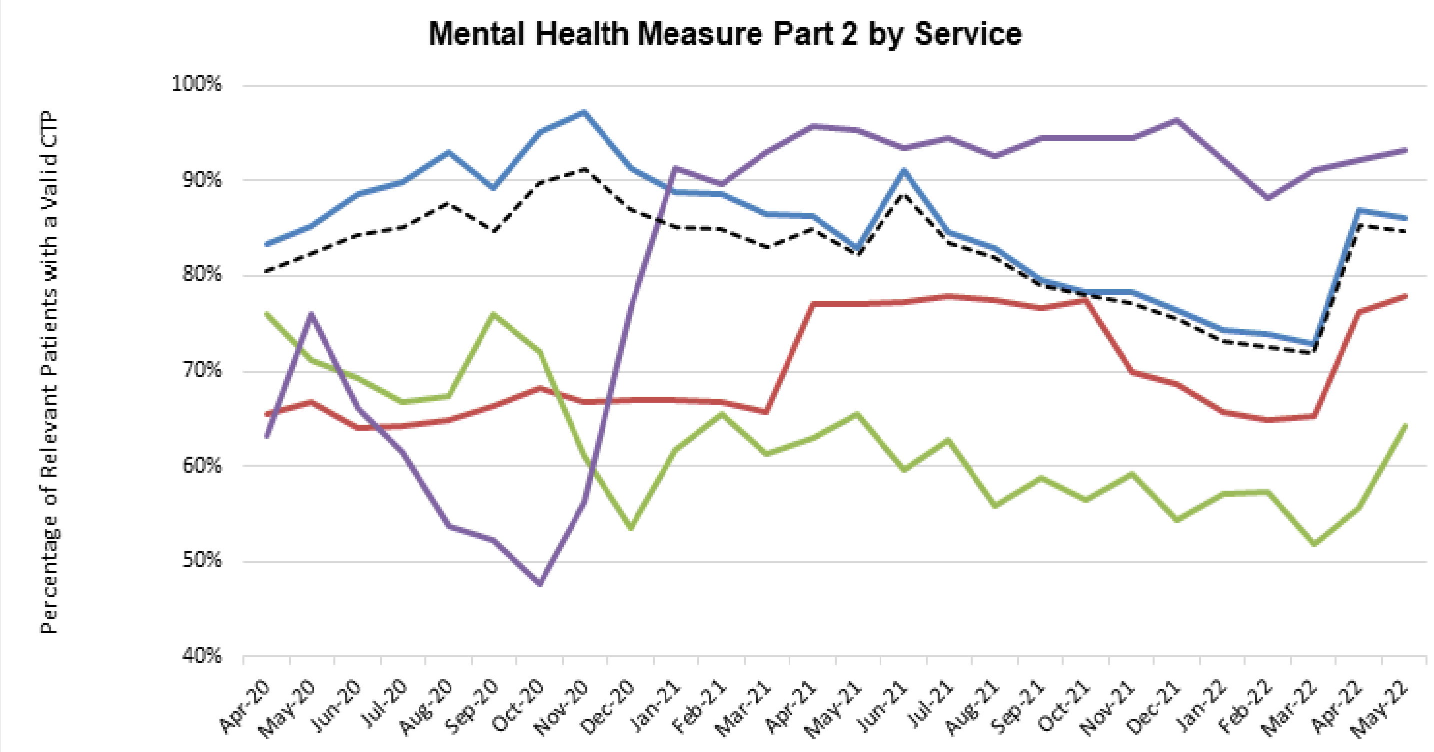
Graph 7



<u>Part 2 – Care and Treatment Planning (over 18)</u>

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

Graph 8



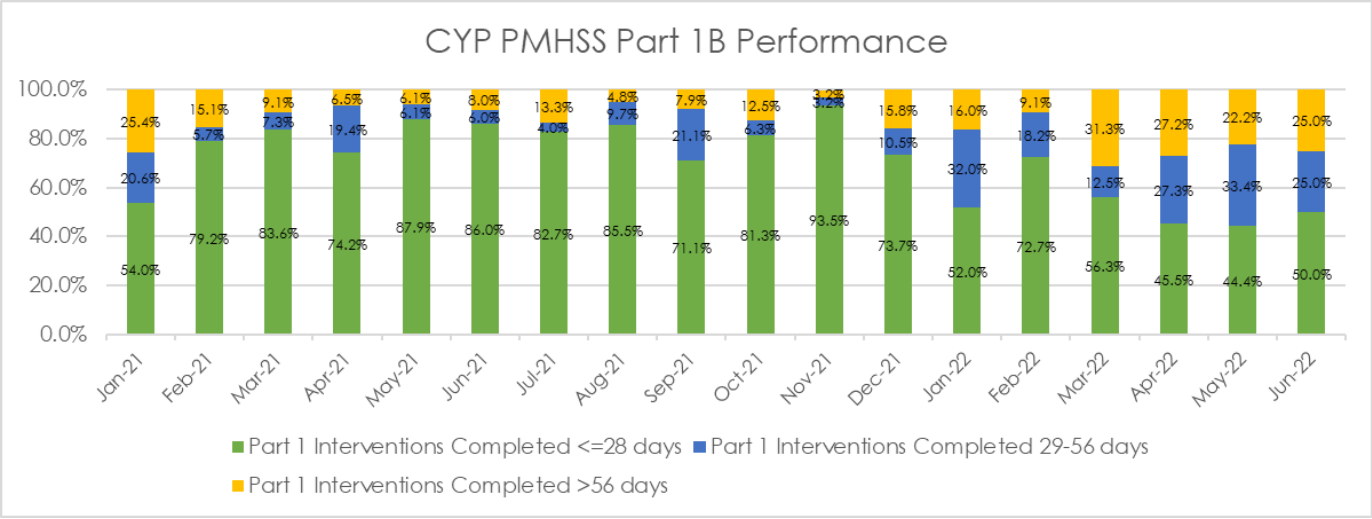
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Adult	83.4	85.2	88.5	89.8	93.0	89.2	95.0	97.2	91.4	88.7	88.5	86.4	86.3	83.0	91.0	84.5	83.0	79.6	78.2	78.2	76.4	74.3	73.9	72.8	87.0	86.1
MHSOP	65.5	66.7	64.0	64.3	64.8	66.3	68.2	66.7	66.9	66.9	66.7	65.7	77.0	77.1	77.3	77.9	77.4	76.6	77.5	69.8	68.7	65.6	64.8	65.2	76.3	77.9
CAMHS	76.0	71.2	69.2	66.7	67.3	76.0	72.0	61.1	53.6	61.8	65.5	61.4	63.0	65.5	59.6	62.7	55.9	58.7	56.5	59.3	54.4	57.1	57.4	51.9	55.6	64.2
LD	63.2	75.9	66.2	61.5	53.8	52.3	47.7	56.3	76.6	91.4	89.7	93.0	95.7	95.3	93.4	94.4	92.6	94.5	94.5	94.5	96.3	92.2	88.3	91.2	92.2	93.2
Total for UHB	80.5	82.3	84.3	85.1	87.6	84.8	89.7	91.3	86.9	85.1	84.9	83.1	84.9	82.2	88.7	83.4	81.9	79.1	77.9	77.1	75.4	73.2	72.6	71.8	85.3	84.8

The Adult data is showing an artificial decline over time. Upon investigating this was found to be a difference in the way the data extract identifies patients who are new to secondary services compared with patients who have been discharged/transferred out. The figure for new patients includes all referrals, whilst the discharged/transferred out figures only included those patients who had been accepted into the service. The disparity is that patients assessed and deemed unsuitable for secondary services have been included in the new patient data, but excluded in the discharged/transferred out data. This means that the compliance artificially appears to be decreasing over the year, only for it to recover back to where expected when the new submission year document is completed, as the number of patients in receipt of services is taken from the last day of the previous submission year – the 31st March.
This is the second priority for our PARIS team to repair.

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 school holiday periods. 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.

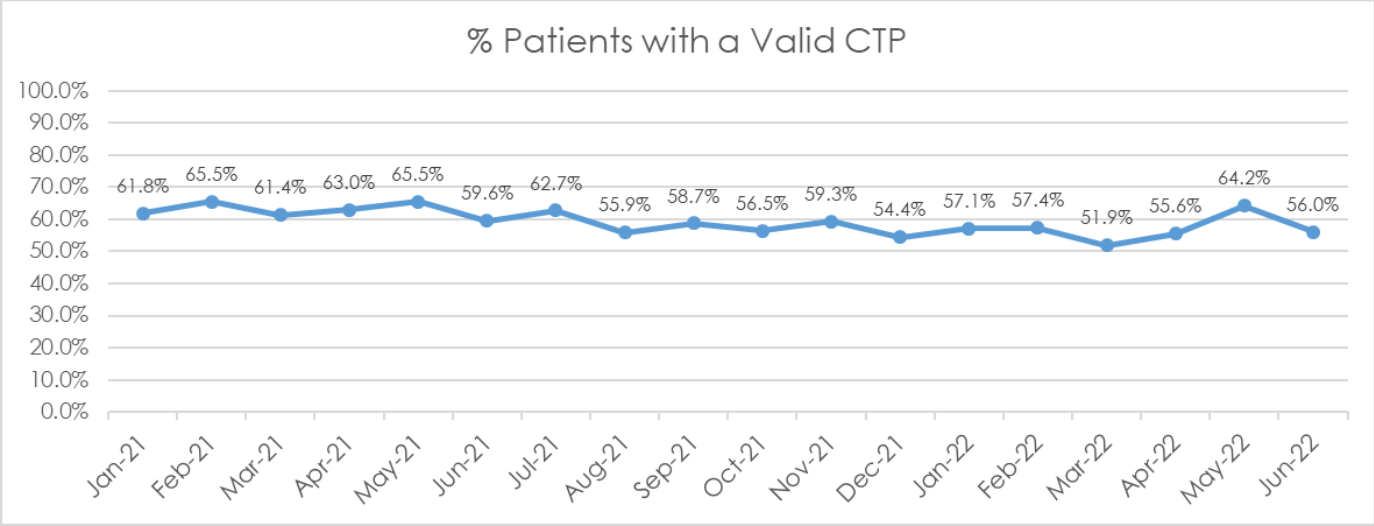
Graph 9



There will be a focus on internal waiting lists as part of the next waiting list initiative with dedicated capacity allocated to tackle this demand. Therefore, the service should start making progress towards achieving compliance with the Part 1B target over the coming months.

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

Graph 10

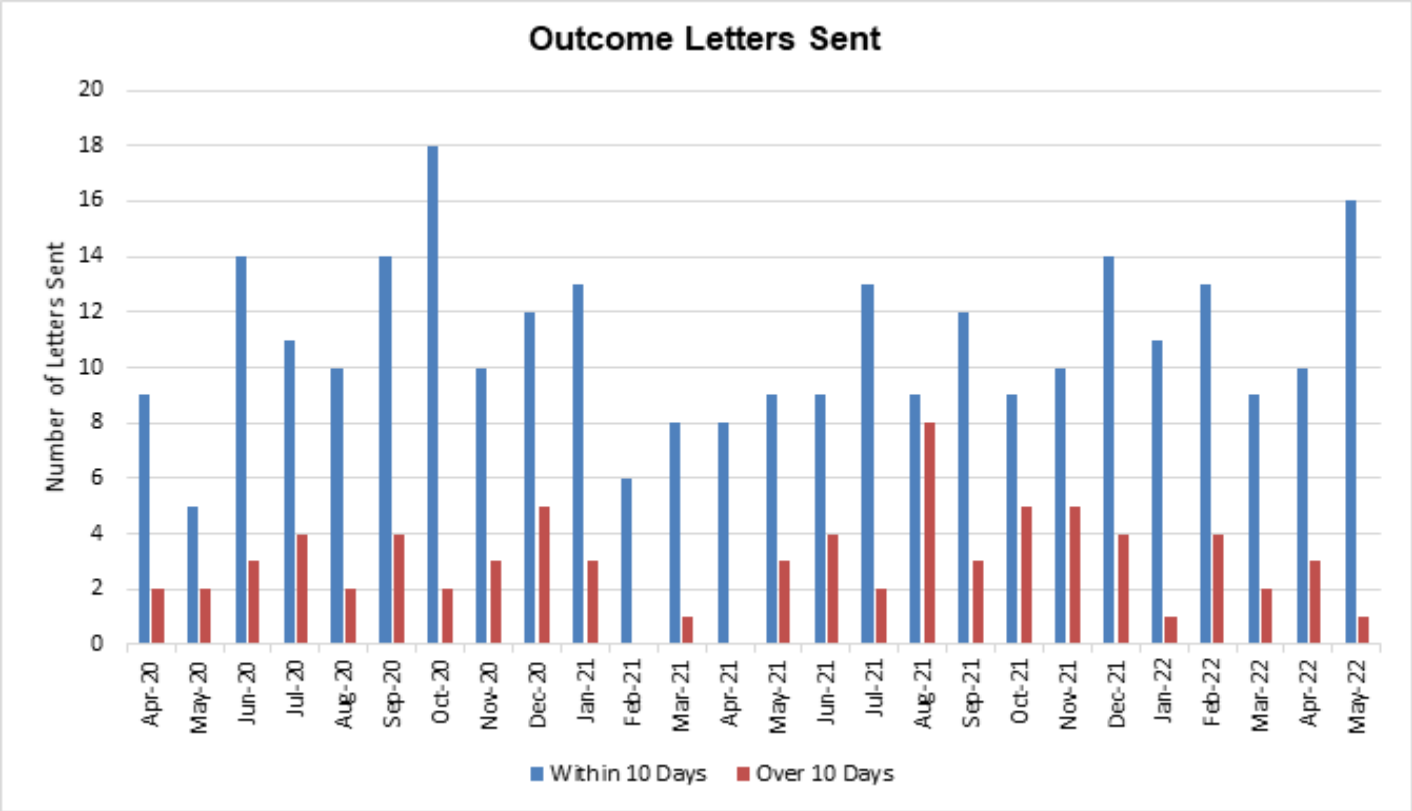


The service continues to underperform against the target, challenges to achievement have included poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable to be facilitated 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 have been addressed and the numbers more accurately represent the true performance. 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 May 2022 there was one breach which was sent at 11 days.

<u>Part 4 – Advocacy – standard to have access to an IMHA within 5 working days</u>

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:
Maintain progress and monitor trajectory.
Text Notification system is the priority development area from PARIS and is top of the list of actions for the MH PARIS team.

Part 2:

Next priority for PARIS is for the Part 2 report repair which was requested as soon as identified.

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:

To **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

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
No
Reputational: Yes/No
Yes- within report
Socio Economic: Yes/No
No
Equality and Health: Yes/No
Yes – within report
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Report Title:	Part 2 Care and Treatment Planning Audit				Agenda Item no.	10.2	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public			Meeting Date:	26/7/22	
		Private	X				
Status *(please tick one only):*	Assurance		Approval		Information		X
Lead Executive:	Chief of Operations						
Report Author (Title):	Director of Operations						

Main Report
Background and current situation:

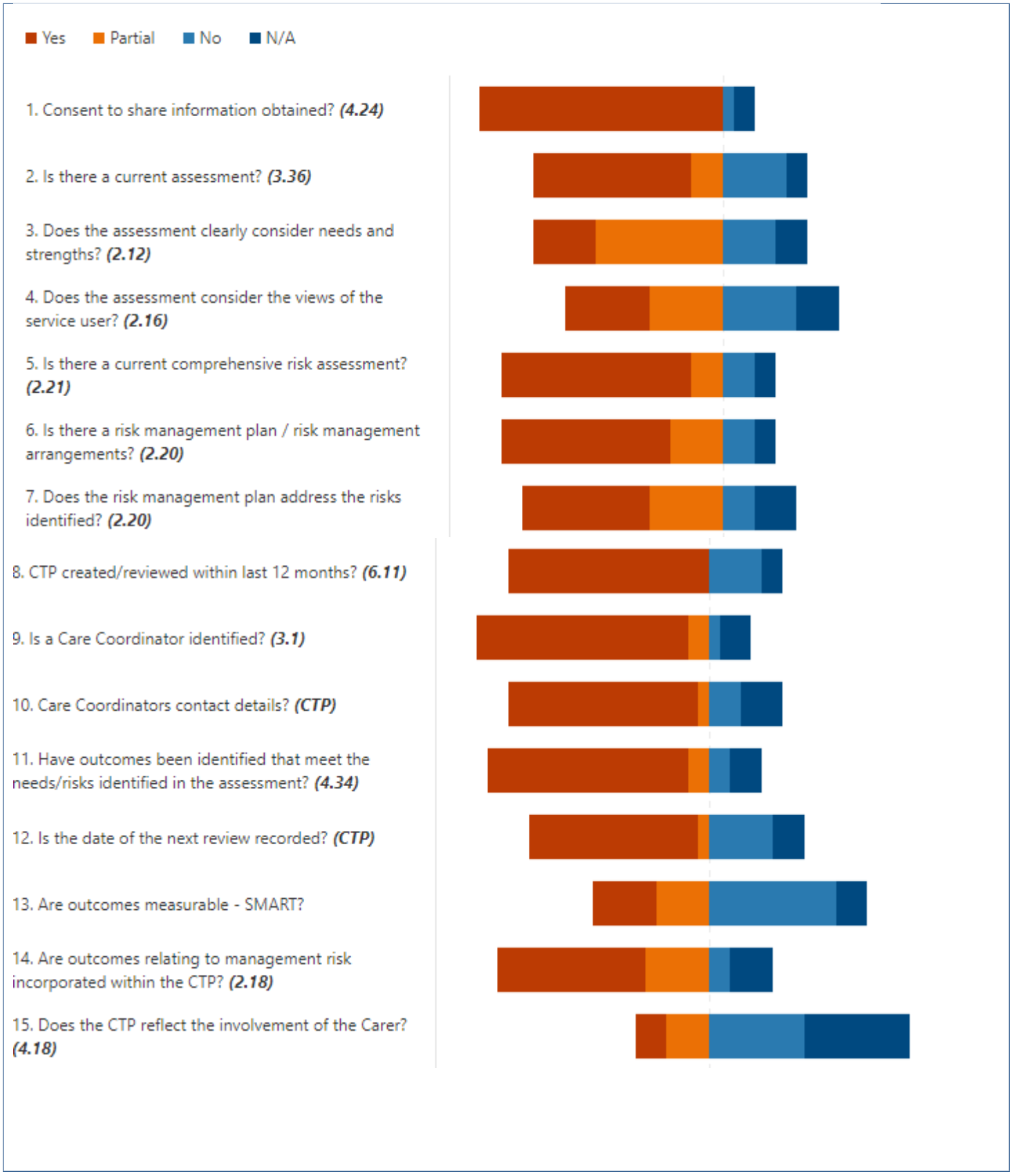
Background:
Part 2 Care and Treatment Plan (CTP) compliance measures the numbers of CTPs but not the quality. Delivery Unit audits in 2018 indicated that CTPs across Wales were of variable quality. The Delivery Unit audit tool has been repeated locally but integrated and consistent use of the tool has been time consuming and difficult to collate centrally.

This year an audit cycle using the template through Microsoft Forms has been agreed within the MHCB and the 2 Local Authorities on a quarterly basis. The first audit cycle returned audits of 26 CTPs across a range of services. Agreement to pilot and roll out further and to include submissions from the Local Authority has been agreed.

Current situation:
Themes are developing from the CTP audit that reflect the same issues from previous Delivery Unit audits. Some key areas are:

1. CTPs could be more strengths based, tending to focus on medical / diagnostic issues
2. Incorporation of service users' views on outcomes, strategies for risk / safety management could be more developed.
3. Outcome focused care with a view towards discharge is something that is not reflected in most CTPs audited.
4. Inclusion and engagement of carers / relatives / significant others in CTP planning was limited in the audit.

Data reflecting the standards from the Code of Practice from the audit is shown below:



a. Accomodation

b. Finance

c. Spiritual / Cultural / Social

d. Work and occupation

e. Medical and other treatment

f. Parenting and caring relationships

g. Education and training

h. Personal care, physical wellbeing

17. Responsible person identified for each action? ***(CTP)***

18. Are timescales specified? ***(CTP)***

19. Have relapse signatures been identified? ***(4.81-5)***

20. Has a crisis plan been identified? ***(4.81-5)***

21. Have language or communication requirements been identified? ***(4.4)***

22. Have the views of the patient been recorded? ***(4.15)***

23. Has the care plan been agreed with the patient? ***(4.16)***

24. Has the CTP been signed by the service user? ***(CTP)***

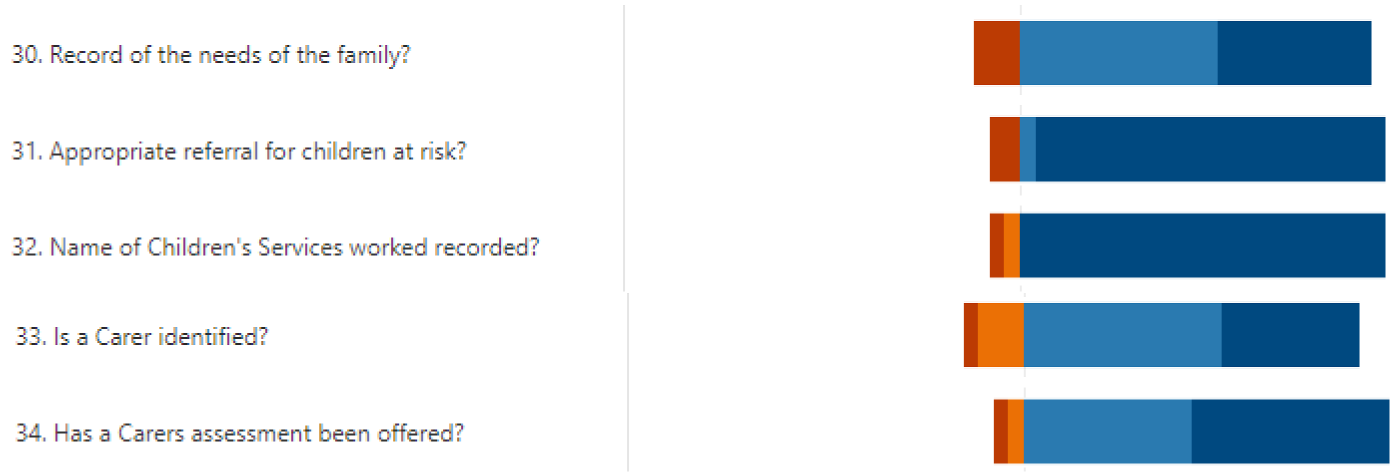
25. Has the CTP been signed by the Care Coordinator? ***(CTP)***

26. Does the Review demonstrate the views of those involved have been sought? ***(4.18)***

27. Does the Review reflect the progress for each goal/outcome in the care plan? ***(6.4)*** ***(6.9)***

28. Has discharge been discussed/documented as part of the Review?

29. Has the care plan been updated/written within 2 weeks of the review date? ***(6.16)***



Local Actions subsequent to the audit:

1. Continue the audit quarterly.
2. Local data will be shared with managers for action
3. A new Data Subgroup is being set up within the Cardiff and Vale Crisis Care Concordat Group where this data reports will be collated and any issues escalated to the National Crisis Care Concordat.
4. A range of service areas in Mental Health Clinical Board and Local Authority have undergone Care Aims training, Suicide Mitigation training, and Collaborative Conversations training all of which support outcome focused, collaborative care and safety planning. Further work is needed to engage service users in Care and Treatment Planning to develop more co-produced and outcome focused CTPs that reflect the needs of the service user and their carers more effectively.

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

This is a collaborative and integrated audit that includes responses from Local Authority and Health.

Recommendation:

The Committee is requested to:

Note the content of the audit.

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: No

No risks ensuing from this Audit which aims to improve patient safety.

Safety: Yes

At this stage the findings reflect general awareness of the challenges of integrating risk assessments into CTPs. Work is ongoing in MHCB to improve the use and effectiveness of risk assessment / safety planning. Co-produced safety planning and the tools for this were raised at the National Forum. A pilot is ongoing for co-produced safety planning in Cardiff and Vale.

Financial: No

None currently.

Workforce: Yes

Training has been provided but the impact of this will be visible in further audits.

Legal: No

N/A

Reputational: Yes

The quality of the submitted audit data may indicate that quality is variable, however there are a number of factors here that include:

1. *May be an 'in draft' CTP and therefore incomplete*
2. *May be a Local Authority CTP and not completed by Health*
3. *There may not be engagement or consent from a patient that requires a CTP under law*
4. *That some Part 2 service users do not have outcomes but cannot be discharged from Part 2.*

More audits will need to be completed to indicate where improvement is required.

Socio Economic: Yes

Discharge planning needs to be better integrated towards more outcome focused care. Co-producing CTPs is not specifically audited but early indicators suggest this is an area for improvement.

Equality and Health: No

Not enough data to indicate this at present and there are no patient demographics within the audit tool to indicate whether particular groups are affected.

Decarbonisation: No

N/A

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Saunders.Nathan
22/07/2022 09:03:02

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON July 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
Mary Williams – PoD member
Wendy Hewitt-Sayer - PoD member
John Owen - PoD member
Alan Parker - PoD member
Amanda Morgan - PoD member

In attendance:
David Seward – Mental Health Act Manager
Morgan Bellamy – Deputy Mental Health Act Manager
Georgia Walsh – Assistant Mental Health Act Administrator
Nicola Jones – Assistant Mental Health Act Administrator

Apologies:
Peter Kelly – PoD member
John Copely – PoD member
Ceri Phillips – Vice -chair Health Board

1. Welcome and Introductions
The meeting was held via Teams and the Chair welcomed all to the meeting. The Chair was pleased to confirm that David had been appointed as the Mental Health Act (MHA) Manager. He congratulated David on his appointment. It was confirmed that the other staff members in the office had been made permanent. The Chair offered congratulations on behalf of the PoD as we look forward to continue working with them in the coming year.

2. New Members and Independent Members
There were no new members.

3. Apologies
Apologies were received and noted. Both Huw Roberts and Rasphal Singh are currently not available for hearings due to recent personal difficulties. It is anticipated that they will be back by the end of the summer.

4. Members points for open discussion

- **WARRN Risk Assessment –** The MHA manager provided the group with an update. WARRN risk assessments will be replacing the current risk assessment i.e. Form 4. Staff are allowed to complete this only if they have received the required training. There have been difficulties in releasing staff to attend the training. The panel will be provided with the most up-to-date risk assessment as part of their Hearing pack. It was agreed that training will be provided to the PoD group on WARRN. **Action – MHA Manager**

5. Minutes of Meeting held on 5th April 2022
One amendment was noted. Under matters arising (item 6) **Feedback from hearings** it should read "judicial review" not "High Court Judgement". This was noted. The minutes were confirmed as an accurate record of the meeting.

6 Matters Arising

- CTP/RA – the Chair advised that he has repeatedly raised the issue at Mental Health Legislation and Governance Group (MHLGG). For the next meeting it will be higher up the agenda to allow for a fuller discussion. There had been some improvements noted although this was still hit and miss. **Action Chair PoD group**
- Feedback after hearings – The Chair had noted that quite often little if anything had been written on the feedback sheet. It was agreed that the sub- group would be reconvened to discuss and provide options going forward. **Action PoD sub-group**
- Working with interpreters and people with communication difficulties – after discussion it was felt that some training for PoD members would be helpful. This topic to be added to the list of requested training. **Action MHA manager/PoD Chair**
- Disclosure to patients – Further to discussions at the last PoD meeting and discussions today it was agreed to seek a legal opinion on whether all material completed at a Manager's Hearing needed to be disclosed to the patient. **Action MHA Manager/Chair PoD**
- Clozapine on a CTO – This has been raised at MHLGC and there has been a clear response from the Responsible Clinician following the concern raised. The Chair though needs to follow up with the advocacy service. Arising from the discussion was a request to have some further training on the Human Rights Act and the interplay with the MHA. At the request of PoD members, A. Nute agreed to consider delivering this training. **Action Chair and A. Nute**

7. Operational Issues
Acoustics in hearings – this remains a 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. The MHA manager confirmed that staff were aware of the facilities in the MHA office. There was a discussion on the use of microphones in such circumstances. The MHA manager confirmed that the ward technology does not support the use of individual microphones. The Chair reminded members that if the acoustics prevent a fair hearing they should adjourn. **Action ALL**

Email addresses and data protection – The MHA manager confirmed that TEAMS does not support "blind copy" of emails. There was a discussion regarding the possibility of having Health Board email addresses. The Chair agreed to check whether this was possible and would bring it back to the next meeting. **Action Chair**

Care and Treatment Plans (CTP) review – The Chair confirmed that he and the Vice-Chair had reviewed the revised CTPs where members had highlighted concerns. He could confirm that in all cases the CTPs had been updated. He and the Vice-Chair were continuing to monitor. **Action Chair and Vice- Chair**

8 Lessons Learnt
There were no particular issues for the meeting.

9 MHA Activity Monitoring Reports

Activity reports were provided for the periods January to March 2022 and April to June 2022 for both Hospital Managers and Tribunals. It was noted that representation by advocacy in the period January to March 2022 was at 80% although this fell in the following quarter. The number of discharges prior to hearings and Tribunals remain high. Nothing further of note.

10. Concerns/compliments from Power of Discharge group Hearings
These were noted and discussed. There was a numbering error on the April to June quarter and the MHA manager agreed to check this. There was a lengthy discussion about concern No. 7 in the April to June document. It concerned the transfer of care arrangements out of area. The response to the concern was unsatisfactory and a request was made to the MHA manager for further clarity from the social worker team leader. PoD members requested update training from a social worker to better understand some of the current issues. C. Thomas agreed to speak with the Social Worker team leader from the Hamadryad. **Action MHA Manager/ Chair/C. Thomas**
The Chair noted the increasing concerns raised regarding nearest relative. He also thanked members for complimenting the clinical teams when appropriate.

11. Committee and Sub-Committee Feedback
The Chair advised the group that the minutes of the last meeting were attached to the papers. He had raised both the issue of CTPs and psychology input but was hoping for further debate at the forthcoming meeting. **Action Chair and MHA Manager**
There is increasing concern and frustration that the Mental Health Review Tribunal for Wales will not allow observers. The matter is being taken up by the Vice-Chair of the Health Board. The President of the Mental Health Review Tribunal has written an article for in the June edition of Mental Health Law on-line. It concerns who should and should not be accessing training. MHA Manager agreed to re-send the link for Mental Health Law on-line. **Action MHA Manager**

12. Training
The All Wales Hospital Managers Event took place on the 11th May 2022.
The response to the training has been positive. MHA Manager to circulate the collated feedback from the breakout groups. **Action MHA Manager**

Other areas for training include: Interpreters/ Interface of the Human Rights Act and MHA/ Transition and funding/ Brain Injuries/WARRN. After discussion it was agreed to revisit training requirements twice a year and try to incorporate some training into the Business meeting. **Action Chair and MHA Manager**

13. A.O.B
POD recruitment – MHA Manager explained that he was looking to recruit a further 2/3 members. There is no closing date and he will interview with the Chair when people put themselves forward. **Action ALL**

Teressa's night out – this to be rearrange for September. The good news was that she was better. Chair to take the card and gift vouchers in the meantime.

Draft Mental Health Bill – MHA manager agreed to send this out to members. It details what is proposed and there is no mention of Hospital Managers. **Action MHA Manager**

Date and time of next meeting – October 4th 2022 10.00 am

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 07 July 2022 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
David Seward	Mental Health Act Manager
Bianca Simpson Lepore	Deputy Mental Health Act Manager
Morgan Bellamy	Deputy Mental Health Act Manager
Mary Lawrence	Consultant representative, Adult
Louise Gibbons	South Wales Police Representative
Jeff Champney-Smith	Chair, Power of Discharge Group
Katherine Lewis	Consultant social worker DOLS/ AMHP
Lynda Woodley	Operational Manager, Vale of Glamorgan
Alex Allegretto	Independent Mental Health Advocacy Manager
Noel Martinez Walsh	Local Authority Lead, Vale of Glamorgan
Mark Doherty	Director of Nursing (Mental Health)
Darren Shore	Lead Nurse, Adult Mental Health
Phillip Ball	Senior Nurse, Cardiff North West Locality
Marianne Seabright	Lead Nurse, MHSOP
Ceri Phillips	Vice chair Cardiff and Vale UHB
Andrea Sullivan	Senior Nurse for Quality, Safety & Education

Apologies

Ceri Lovell	Team leader CAMHs crisis liaison team
Katie Fergus	Consultant Representative, Adult
Chloe Evans	Mental Capacity Act Manager
Ruth Evans	Interim Locality Manager- Vale of Glamorgan

1 Welcome and Introductions

The chair welcomed members and those in attendance. It was noted that the Mental Capacity Act and Deprivation of Liberty Lead are not currently included in the Terms of Reference for this meeting and should be added. Those present were asked to review the terms, which were written before the recent changes in structure of services, and let the MHA Manager know of any proposals.

2 Apologies for absence

No apologies were mentioned at the meeting.

3 Minutes of meeting held on 08 April 2022

Not discussed at length at this meeting but any suggested changes should be sent to the MHA Manager.

4 MHA Activity

The Mental Health Act Monitoring and Exception reports from April- June were discussed and some changes in activity were discussed.

There has been an increase in the number of Section 136 CAMHS assessments well above what we would normally see. It was discussed that quite a few of these were due to repeat presentations of the same people. The control limits within the C charts that are produced reflect previous data and are not arbitrary so do provide meaningful data.

There was one instance of a patient of a patient having been detained without authority due to papers having not been submitted to the MHA office in the necessary time frame. It was identified that this is a training issue on behalf of both the Local Authority and the Health Board to ensure that the importance of receipting and then communicating assessments to the MHA office is understood. The AMHP lead in Cardiff reiterated that she has pressed the importance of the receipting system to her AMHPs several times.

There has also been an increase in the number of Section 5(2)s being used within the last quarter, however this number is still well within the control limits. Unfortunately, there have been two instances this quarter of Section 5(2) being used inappropriately. The MHA office have circulated a poster reminding professionals about the correct use of Section 5(2) and what it does and doesn't allow them to do in relation to treatment and transfer. One lapse of Section 5(2) also occurred due to the patient not being assessed during the 72-hour period. This is felt to be an anomalous issue which is not thought to be a training issue.

The MHA Manager informed the group that during May 2022 there were 63 Section 2 assessments, this is more in any single month than we've had since at least April 2020. The consultant representative does feel that there often are seasonal

variations in people presenting but that no discernible information can be gleaned from this one month of an increased use.

5 Matters Arising

The power of discharge group representative felt that the last couple of quarters care and treatment plans have improved in quality after a long period of being high up the PoDs agenda items. He feels they have been more consistently fully completed and completed to a better standard than the PoD group have been used to. There was some debate about who is the most appropriate person to complete inpatient CTPs and it was confirmed that passing over care coordinator responsibility is a relatively easy process.

There has been no update regarding the recording of repeat 136 presentations.

The MHA Manager confirmed that over the last quarter the majority of Tribunals have been held over Microsoft teams. There has been no official guidance or communication regarding this from the Tribunal but it is felt to be a positive change so far.

The positive impact of St Johns ambulance service was again discussed and feedback regarding their service is currently being compiled. However, there are still problems sourcing secure transport for patients who are unwilling to come into hospital once detained or are displaying aggressive behaviour. The Director of Nursing (Mental Health) confirmed that this issue was being investigated by Tara Robinson as we spoke and that alternative transport methods are being looked for. There is also a hope that the St Johns ambulance may be able to provide more assistance in this kind of instance going forward, though this is currently only in its first stages of being investigated.

The MHA Manager talked about the proposal to medically scrutinise consent to treatment certificates. We were informed that other Health Boards do get their certificates scrutinised and that this would add a layer of safeguarding to our Health Board if it could be implemented here. The MHA Manager and the Lead Nurse for Adult Mental Health agreed to discuss this further outside of this meeting but previous discussions have signalled that ward managers are likely to be the most appropriate people to undertake this task.

Action- MHA Manager/ Lead Nurse Adult Mental Health to discuss.

The shortage of Section 12 doctors will be raised at the next committee meeting in order to hopefully get this matter progressed more quickly. This has been raised nationally as well. The chair of the meeting also sits on the AC Approvals Panel and confirmed that the lead in this area is unlikely to provide their input regarding this.

The monitoring of voluntary assessments has still not come to fruition due to both the Health Board and South Wales Police being uncertain as to the data they are currently collecting and whether it can be in any way guaranteed to be a true reflection of the number of voluntary assessments. A message has been sent to the shift coordinators to remind them of the importance of getting forms completed for

voluntary assessments as well as S136s. It was agreed that the crisis team, South Wales Police and MHA office should link in with one another to try and get this matter investigated further.

Action- MHA Manager to set up meeting regarding voluntary assessments

The lead AMHP from Cardiff LA confirmed that she encourages all her AMHPs to submit E-DATIX reports for conveyance issues as a way of hoping to encourage long term improvement and as a way to track any patterns that may occur.

The Section 136 flow chart will be progressed very shortly by South Wales Police and the MHA Manager to ensure the resultant flow chart works from both the polices' and Health Boards perspectives.

Action- MHA Manager to arrange meeting regarding 136 flow chart.

The form of words regarding the Health Boards position on its Section 140 obligations is yet to be formulated. The previous Clinical Director did do some work on this but the Chair of the meeting confirmed that he has emailed several people to try and get this looked into further going forward.

The inconsistencies surrounding who will be acting as Responsible Clinician for CAMHs patients on cedar ward were discussed. The two adult consultants that work on cedar have not got the qualifications to look after CAMHs patients and are therefore not legally allowed to take on this role. Despite their being some confusion regarding this previously, it has never proved to a problem and the community CAMHS consultant has always taken the RC role for young people detained in Hafan Y Coed. The Lead Nurse for Adult Mental Health felt the length of time some young people end up being detained on adult wards warrants being looked into as this is often much longer than guidance permits.

Action- Chair to investigate action point regarding length of time CAMHs patients at HYC.

It is felt by the Chair of the group that there is only limited further pressure that can be placed on the Tribunal president around the issue on people observing Tribunals to facilitate training. It will remain as an agenda item as is felt to be an important part of training for people to know how these processes work in real life.

More work needs to be done as far as training on S117 and discharge from this aftercare provision. There are thought to be gaps in knowledge in teams that don't use the MHA 1983 regularly such as CAMHs/ patients on guardianship order. The Chair of the group has agreed to take this piece of work further.

Action- Chair to look further into S117 knowledge gaps.

6 Feedback on operational issues and incidents:

Facemasks are now required in hospital settings again but no one felt this would create any particular problems with implementing the Act. One member of the group felt that communication is definitely hindered by facemasks and informed the group

that each situation is risk assessed in regard to how strictly to follow current guidelines.

Due to time pressures there has been no update regarding digital signatures.

The prevalence of locked doors in Hafan Y Coed is also being investigated.

7 Feedback

The Lead AMHP for the Vale confirmed there hasn't been any significant changes since the last minutes and is content that the longer term and perhaps harder to resolve issues are being looked into. Thankfully this past quarter has seen a lower number on incidents.

The Lead AMHP for Cardiff raised concerns that police officers are often unwilling to support mental health professionals in instances where the patient is unwilling to attend hospital and is presenting as a danger to others. The police often take the stance that they are unwilling to attend without a warrant being obtained even though this may not always be necessary. The Mental Health Liaison Officers in the meeting have asked to be notified of adverse incidents almost straight away so that they can help resolve problems before the escalate. An escalation process also needs to be agreed so that disagreements about police intervention can be resolved in a thorough way that ensure each incidence is looked at in its own merits. The Chair informed everyone that the use of E-DATIX is being encouraged to all.

The Lead AMHP for Cardiff mentioned a recent process that has been set up in conjunction with the MHA team to hopefully capture data on all applications for Section 135 warrants. It is hoped this will allow for improvement as far as accurate data collection. The Lead AMHP also queried whether a recent process provided and then retracted by the police has had any update. The Mental Health Liaison Officer for South Wales Police advised that due to operational changes within the service they are now in a position to look into creating a new 135 process which should further help AMHP's when trying to execute a 135 warrant.

The PoD Chair informed everyone that the sub group have picked up on a more recent trend of nearest relatives being either not identified or incorrectly identified and that their involvement in some patients care seems to have diminished. The Lead AMHP in the Vale confirmed that they have also recently picked up on this trend and are providing ongoing training to AMHPs surrounding the importance of the role of the nearest relative. AMHPs have been reminded that the bar for not consulting with a nearest relative is a high one and consulting needs to be a default. The Vale team are working on resolving this matter so that it doesn't keep occurring. The system for MHA assessments in Cardiff is more complex and therefore gives rise to a more challenging method of identifying nearest relatives at the time of assessment. There are occasions whereby the AMHP who detains a person may never have involvement with them after and the case goes back to the home CMHT meaning the lack of nearest relative is perhaps being lost in translation somewhat. The Lead AMHP for Cardiff will bring this back to the AMHP managers who can feed this trend back to their teams.

The consultants meeting only highlighted the CAMHs Responsible Clinician issue which has already been discussed.

The PoD group recently discussed whether the requirement for blood tests for patients on CTO's prescribed clozapine constituted a de-facto detention. The Responsible Clinician provided a robust response to this and the managers are happy that this issue is resolved. The PoD group have also noted the increased incidence of several people using one device in one room when participating in hospital managers hearings. There has been concern that this may not provide the patient with a fair hearing and the Chair of the PoD group has encouraged its members to consider adjourning a hearing if they are unable to receive the necessary information in a proper and easy manner. There is a room available in the MHA office, which should be utilised if there are felt to potentially be technical issues with a hearing.

There was no feedback from any police meetings.

The Advocacy Lead confirmed that advocates have also noticed an improvement with care and treatment plans over the last couple of months. They have also noted an increase in referrals from all wards but in particular MHSOP. Advocates have noticed patients moving wards fairly frequently. One instance whereby a ward round was missed by an advocate due to a lack of communication regarding the change of time was mentioned. The Lead Nurse for Adult Mental Health apologised for this as this was obviously unfair on both the patient and the advocate involved. The Lead Nurse asked that incidences like this are highlighted to him so that they can be resolved quickly. The Chair of the group wants to ensure advocates are welcomed to MDTs.

8 Power of Discharge Group comments, compliments and feedback

Incomplete care plans have been a concern for the hospital managers for a number of years. Thankfully there does seem to be some improvement recently in both quality and quantity. There is still however a gap between the care that patients are receiving and that which is being recorded on their care and treatment plans. This is particularly a problem within the acute wards. The Director of Nursing (Mental Health) confirmed that the problem of incomplete/ inadequate care plans has been picked up in various other meetings as well and that this matter is being looked at as part of the drive to return Hafan Y Coed to stability after a challenging couple of years for the unit. There was concern raised that despite recent improvement there are still a worrying amount of incomplete/ inadequate care and treatment plans submitted to the PoD group. During the next quarter the Chair and Vice Chair of the PoD group will be undertaking their annual review of the PoD comments so should be able to pick up on trends over the last year or so. It was recognised that the new locality structure has facilitated the dissemination of the information from this meeting to the localities to hopefully allow issues to be resolved quicker.

9 External reviews

No external inspections are known of at present.

10 Interface MHA/MCA/DOLS

Not discussed during this meeting.

11 Quality indicators and audit activities

Not discussed during this meeting.

12 Any other business

It was suggested that looking over the draft Mental Health Bill would not be looked at during this meeting as its thought that external events may slow down its progression through Parliament.

It was briefly discussed that some work may be done on race and equalities issues in the future.

The Chair of PoD and Chair of the group recognised the confirmation of the MHA Manager being made permanent. The MHA Manager also recognised the permanent appointments of the MHA office team.

Date of future meetings

06 October 2022

12 January 2023

06 April 2023

Report Title:	Corporate Risk Register			Agenda Item no.	11.2
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	26.07.2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

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.

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.

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.

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

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.

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.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board.

At the May 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:

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

This risk has remained on the Clinical Board risk register following a review in May 2022. Whilst it was hoped that scheduled actions would lead to the de-escalation of the risk prior to this meeting the risk has been exacerbated by Covid with a number of additional contributory factors, including:

1. Delays in transfer to appropriate CAMHS units within 72 hours.
2. Increasing numbers of CAMHS admissions.
3. A lack of available beds and no external providers accepting CAMHS patients leading to delays in admission.
4. Staffing issues impacting on safety (each CAMHS patient requires 1:1 staffing).
5. Highly complex individuals with specific conditions that are unsuited to any environment in Hafan Y Coed or other facilities in the UHB.

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 met 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 engagement and the ongoing support to be provided will assist with the ongoing development of the 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 the Mental Health Clinical Board 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.

Recommendation:

The Committee is requested to:

NOTE the Corporate Risk Register risk entries linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which is now progressing with Clinical Board.

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
Ongoing risk management discussions and support provided to the Mental Health Clinical Board will strengthen the Clinical Board's risk management processes.
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
22/07/2022 09:03:02

CORPORATE RISK REGISTER MAY 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Mental Health Clinical Board	10	Aug-20	**Young People in Adult Mental Health Placement** Young people with complex needs require admission to adult mental health services as no suitable alternative available. There is a risk that the patients will be in a sub-optimal clinical environment which will adversely impact on their safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.	5	5	**25**	Additional staff allocated to the care of these patients.	5	4	**20**	Safeguarding discussions ongoing with private care providers with no realistic placement available for the forseeable future. Away day to plan alternatives to admission with C&W CB. Earmarked area in HYC post covid to allow impact of Sanctuary to be evaluated while reducing impact on Cedar ward and CAMHS patients.	5	2	**10**	Jul-22	Mental Health &Capacity Legislation Committee	Patient Safety

Report Title:	Committee Self Effectiveness Survey Results 2021- 2022			Agenda Item no.	11.4
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	26 July 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

Routine monitoring of the effectiveness of the Board and its Committees is a vital part of ensuring strong and effective governance within the Health's Board's governance structure. Under its Standing Orders (SO 10.2.1), the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Further, and where appropriate, the Board may determine that such evaluation may be independently facilitated.

The Health Board undertook an annual review of the effectiveness of its Board and its Committees in April 2022 using survey questions derived from best practice guides, including the NHS Handbook, and using the following principles:

- the need for Committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives;
- the requirement for a Committee structure that strengthens the role of the Board in strategic decision making and supports the role of non-executive directors in challenging Executive management actions;
- maximising the value of the input from non-executive directors, given their limited time commitment; and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

For the 2021-2022 self-assessment, a survey was disseminated via Survey Monkey to all Board and Committee Members and Board and Committee attendees, enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2021-2022, which relate to the Mental Health Legislation and Mental Capacity Act Committee (attached as **Appendix 1**). There were no areas identified for improvement.

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

- The survey questionnaires for the annual Board/Committee Effectiveness Surveys 2021-2022 were issued in early April 2021 and attained a positive response rate overall.

- The overall findings are positive which provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committees are effectively supporting the Board in fulfilling its role.

To ensure effective governance the Board Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in March/April 2023 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2022-2023.

Recommendation:

The Committee is requested to:

a) **NOTE** the results of the Annual Board Effectiveness Survey 2021-2022, relating to the Mental Health Legislation and Mental Capacity Act Committee.

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	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	
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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

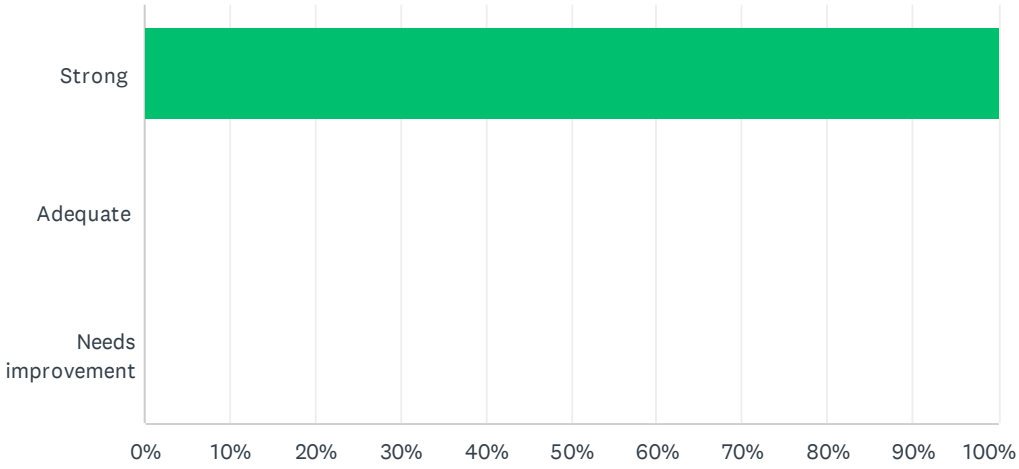
Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No

Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Audit Committee	12th May 2022

Q1 The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full Board. NHS Handbook status: 1 - must do

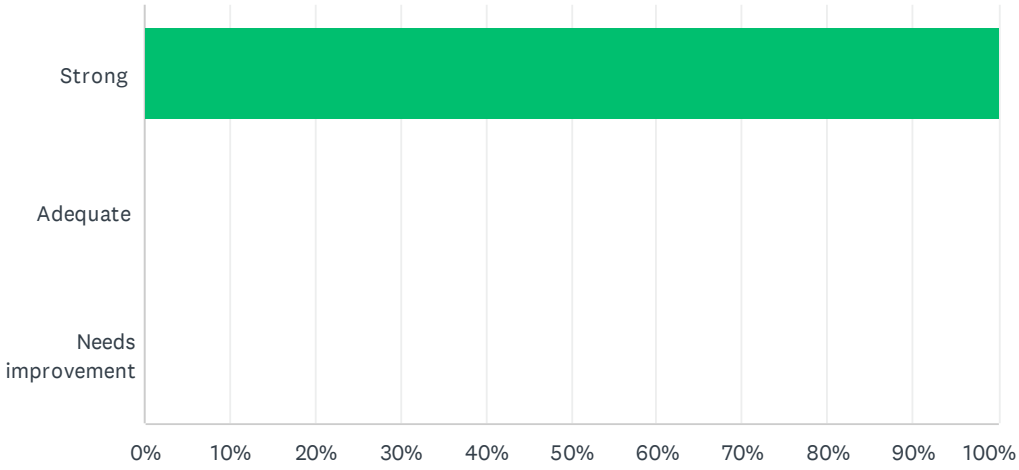
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	100.00%	4
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		4

Q2 The Board was active in its consideration of Committee composition.NHS Handbook status: 2 - should do

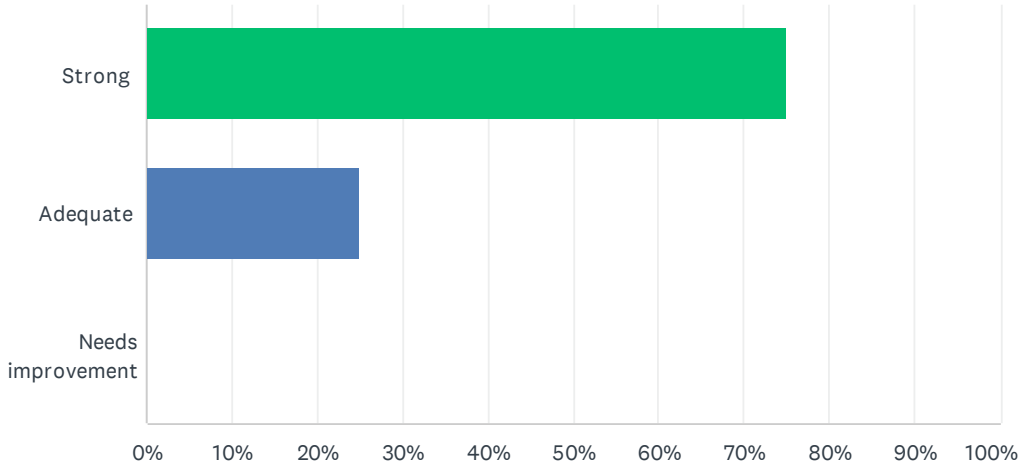
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	100.00%	4
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		4

Q3 The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

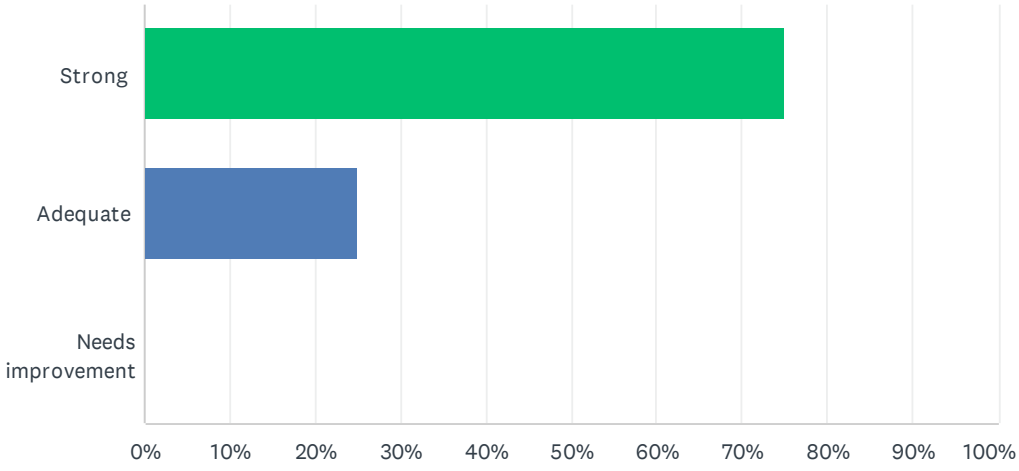
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	75.00%	3
Adequate	25.00%	1
Needs improvement	0.00%	0
TOTAL		4

Q4 The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.NHS Handbook status: 2 - should do

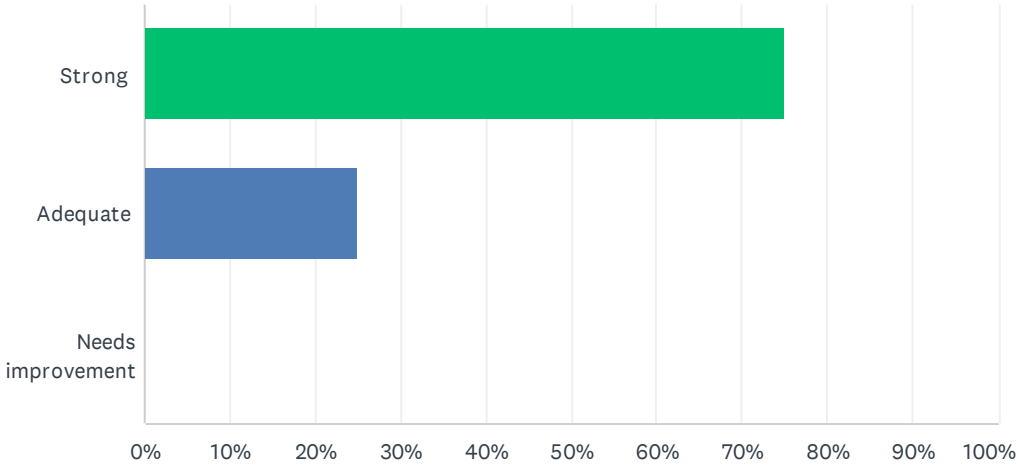
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	75.00%	3
Adequate	25.00%	1
Needs improvement	0.00%	0
TOTAL		4

Q5 Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.NHS Handbook status: 2 - should do

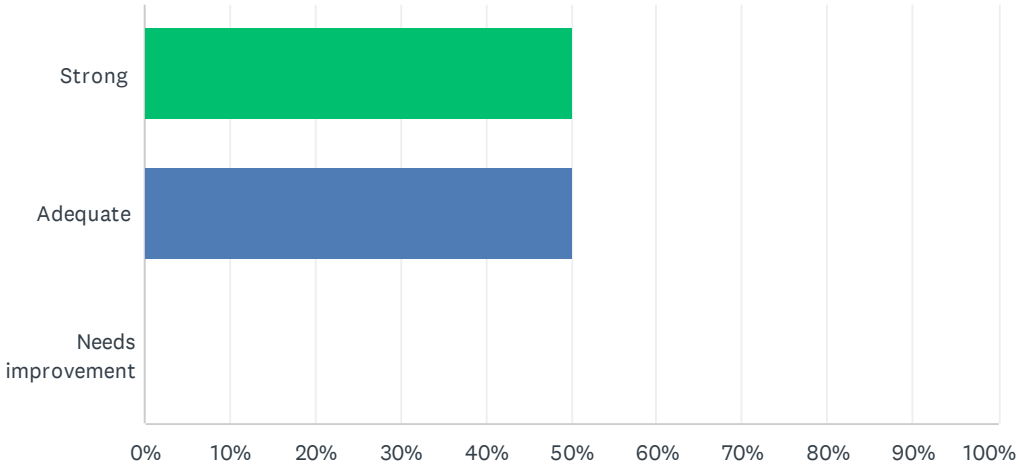
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	75.00%	3
Adequate	25.00%	1
Needs improvement	0.00%	0
TOTAL		4

Q6 Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.NHS Handbook status: 1 - must do

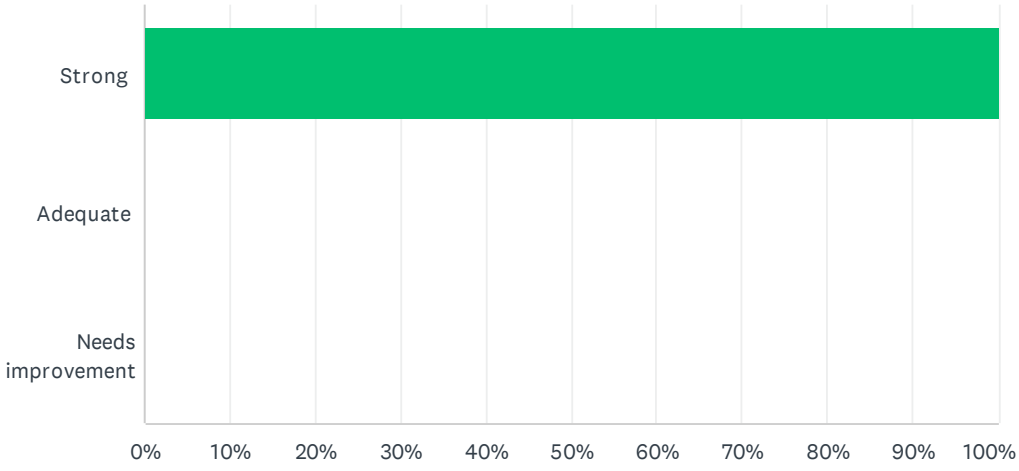
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	50.00%	2
Adequate	50.00%	2
Needs improvement	0.00%	0
TOTAL		4

Q7 The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.NHS Handbook status: 2 - should do

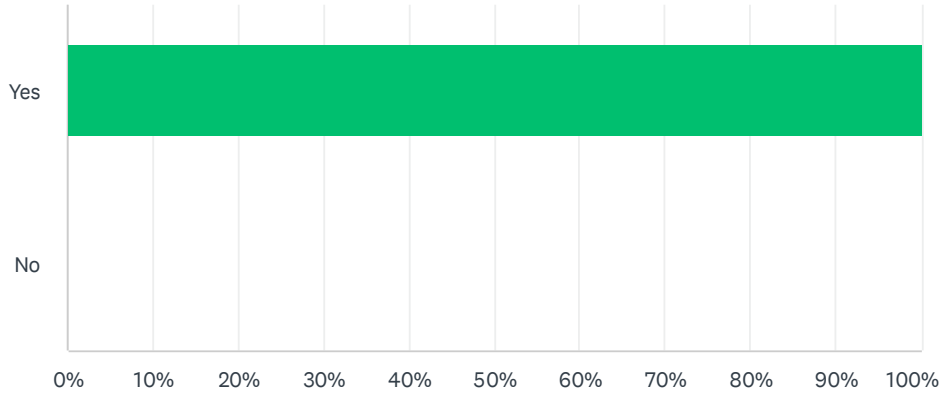
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	100.00%	4
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		4

Q8 Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?NHS Handbook status: 2 - should do

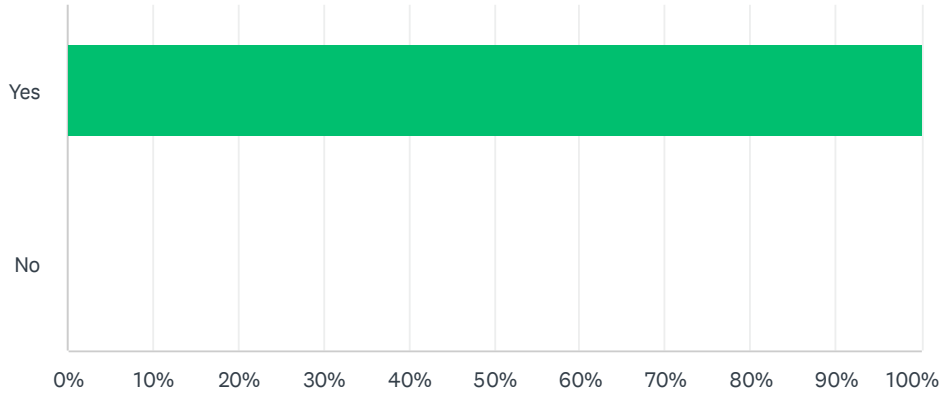
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	4
No	0.00%	0
TOTAL		4

Q9 Are changes to the committee's current and future workload discussed and approved at Board level?NHS Handbook status: 2 - should do

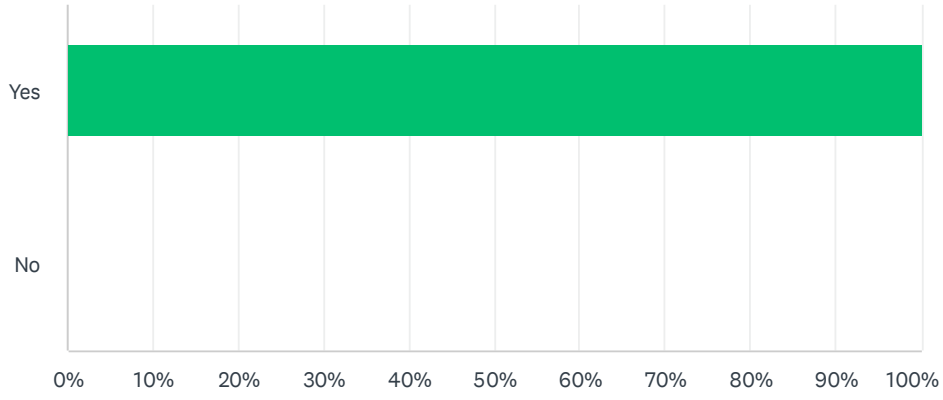
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q10 Are committee members independent of the management team?NHS Handbook status: 1 - must do

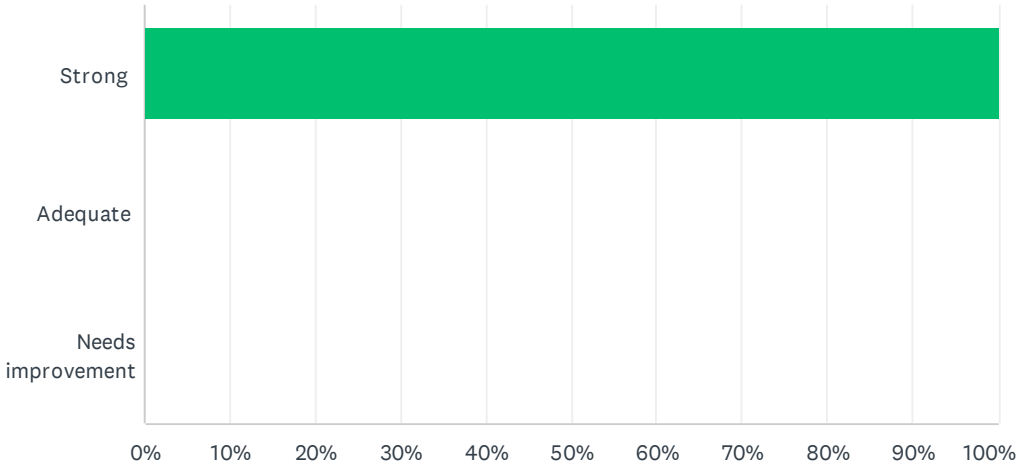
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	4
No	0.00%	0
TOTAL		4

Q11 The Committee agenda-setting process is thorough and led by the Committee Chair.NHS Handbook status: 2 - should do

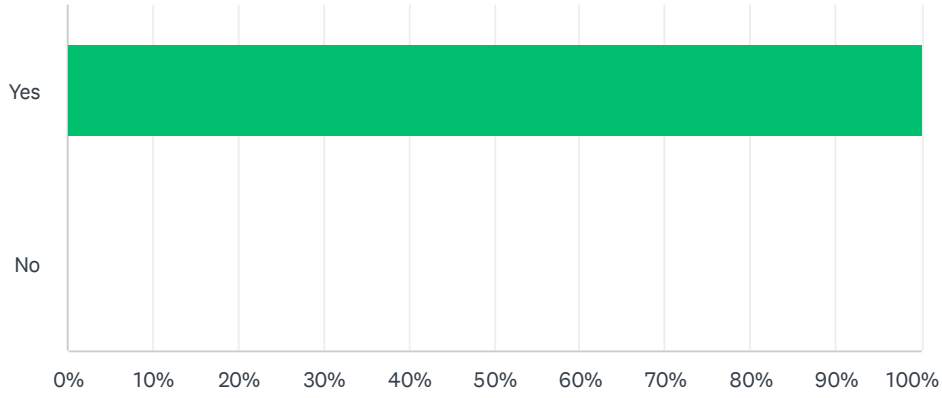
Answered: 4 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	100.00%	4
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		4

Q12 Has the Committee established a plan for the conduct of its work across the year?NHS Handbook status: 2 - should do

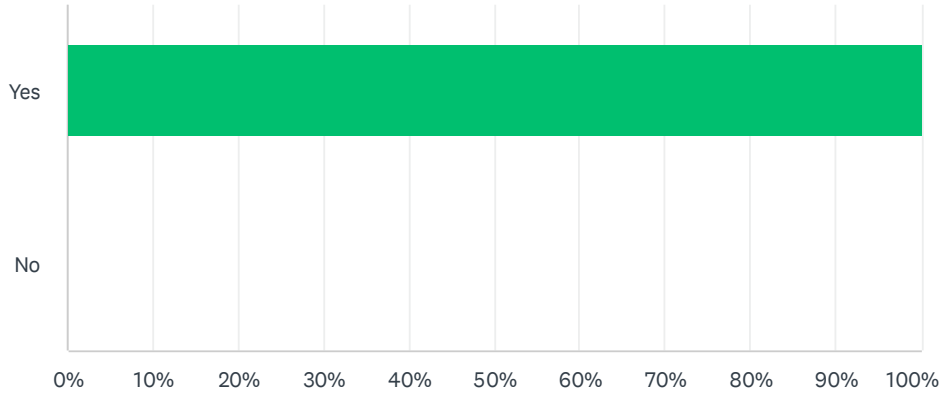
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q13 Has the committee formally considered how its work integrates with wider performance management and standards compliance?NHS Handbook status: 2 - should do

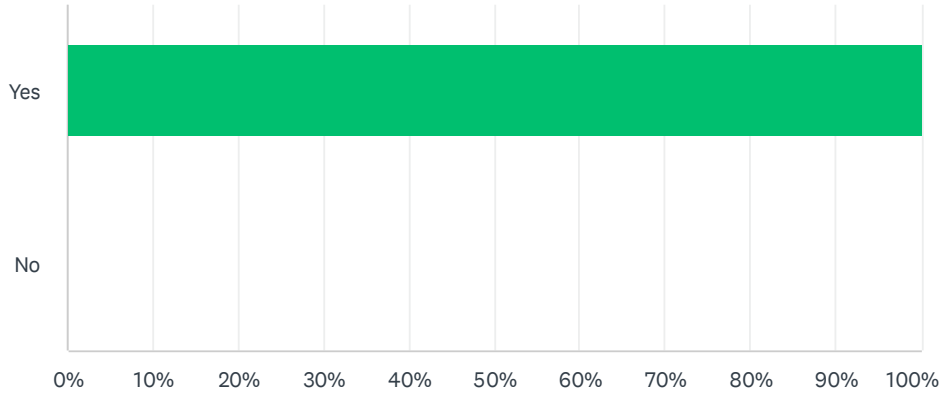
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q14 Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?NHS Handbook status: 2 - should do

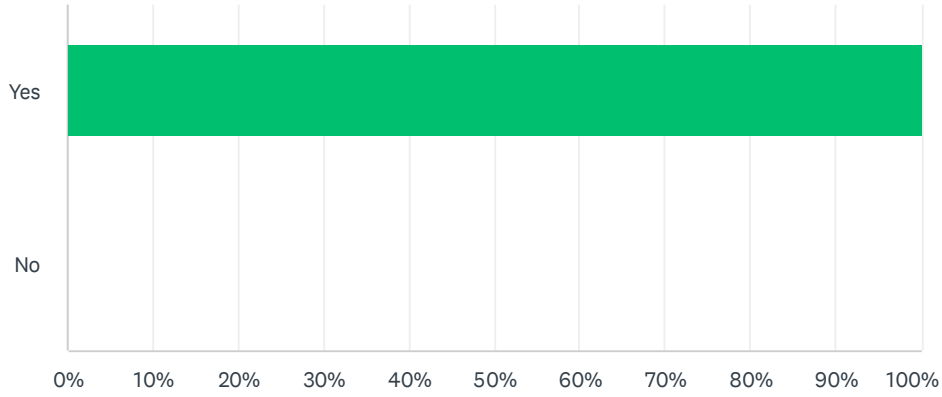
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q15 Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?NHS Handbook status: 2 - should do

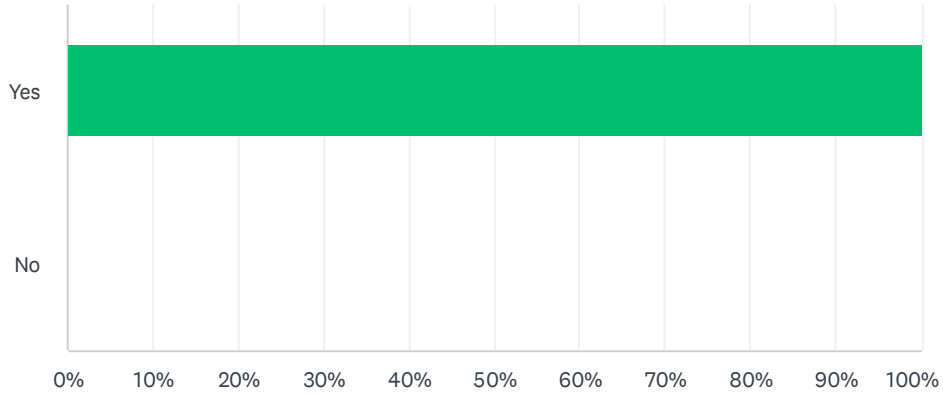
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q16 Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?NHS Handbook status: 2 - should do

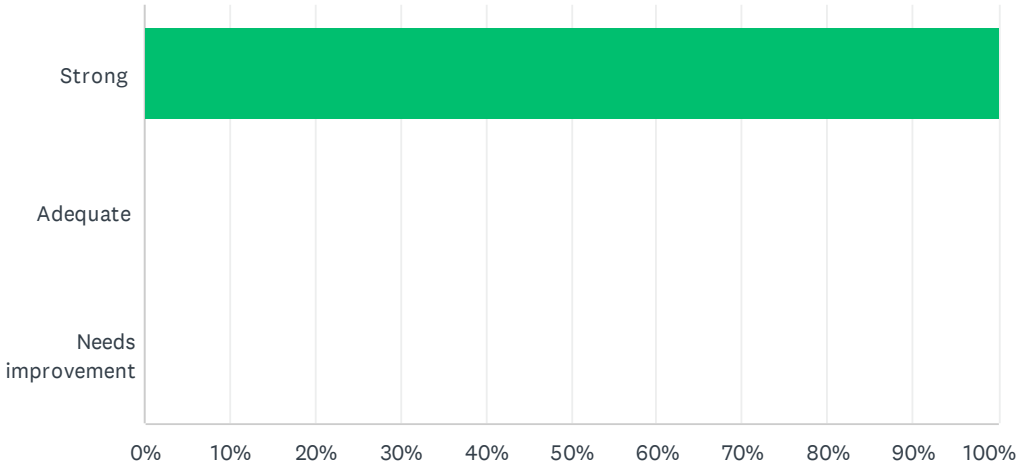
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q17 The committee's self-evaluation process is in place and effective. NHS Handbook status: 2 - should do

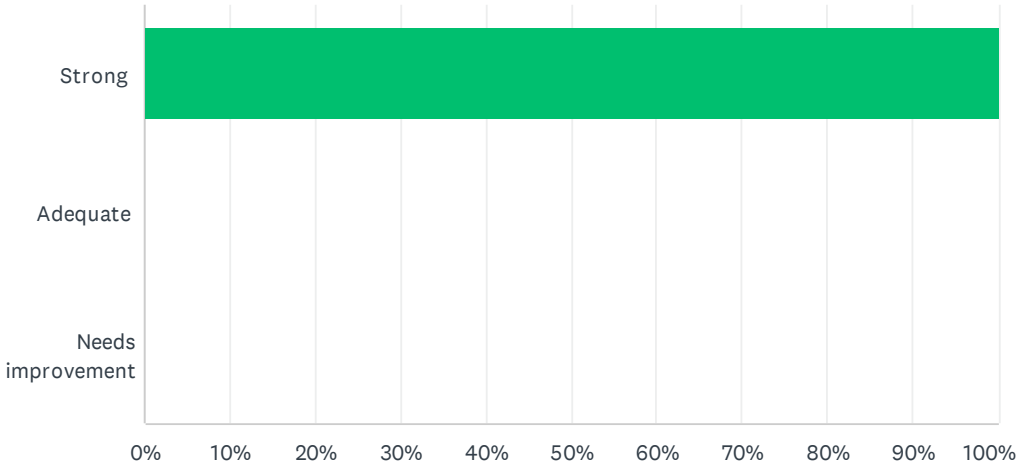
Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strong	100.00%	3
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		3

Q18 What is your overall assessment of the performance of the Committee?

Answered: 3 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strong	100.00%	3
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		3

Q19 Additional Comments

Answered: 0 Skipped: 4

Q20 Name

Answered: 2 Skipped: 2

Q21 Position

Answered: 2 Skipped: 2

Report Title:	Community Treatment Order Policy & Procedure			Agenda Item no.	12.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	26th July 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Mental Health Clinical Board Director of Operations				
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 Community Treatment Order Policy and Procedure sets out the requirements and criteria of a community treatment order along with the process of assessing the suitability for the use to the practitioners and agencies involved in the application and management of patient's subject to a community treatment order 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
- Amended sections throughout for clarity
- Removed paragraph that were no longer relevant due to change in processes.

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 16th March 2022 and 12th April 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 Community Treatment Order 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 Community Treatment Order Policy and Procedure; and

b) **APPROVE** the full publication of the Community Treatment Order 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

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:

Saunders,Nathan
22/07/2022 09:03:02

Reference Number: UHB 407 **Version Number:** 2	**Date of Next Review:** **Previous Trust/LHB Reference Number:** **N/A**

Community Treatment Order Policy
Mental Health Act, 1983

Policy Statement

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 considering and assessing individuals for a community treatment order (CTO).

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

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering a CTO 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.

Policy Commitment

We will set out the requirements for provision of community treatment orders under section 17A of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patient's subject to a CTO**.**

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.

Supporting Procedures and Written Control Documents

This Policy and the Community Treatment Order Procedure describe the following with regard to a CTO:

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patient's subject to a CTO

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 employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

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	Mental Health and Capacity Legislation Committee - Pending
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislations Committee
Accountable Executive or Clinical Board Director	Chief Operating Officer

Disclaimer

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.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	26/06/2018	02/07/2018	New document
2			N/A

Equality & Health Impact Assessment for

COMMUNITY TREATMENT ORDER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	COMMUNITY TREATMENT ORDER 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	The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
4.	Evidence and background information considered. For example	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental

	• population data • staff and service user's 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 Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **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. **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) 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). 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

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

		impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016: - 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. 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. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **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) 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 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. **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: - 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. 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. 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. 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. This policy will apply regardless of gender. **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. 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.

		The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* 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 **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **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. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 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%. 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. This policy will apply regardless of whether patients are pregnant at the 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. **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. 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”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. 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. 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. 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

		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. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **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"). 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

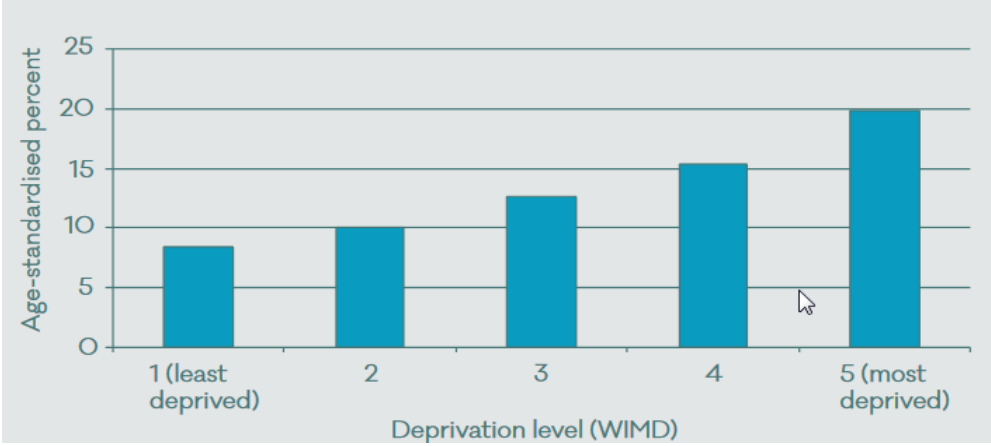
		keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of 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"). 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. 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. 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.

		The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **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. 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. **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 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.

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. 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 *distribution* 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.

		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. 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). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

		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 higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **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_aslym_seeker_health.pdf **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%.

		26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 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. 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. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **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 that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.

		These risk factors may be present in any protected group. Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital stay, improved medication adherence or patients' quality of life, and have queried whether community treatment orders are an effective alternative to standard care. Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale'. **Ethical Considerations** Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions, community treatment orders will commonly be imposed on people who have capacity. Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns) **Examples of patient experience** Participants perceived both positive and negative impacts of CTOs. The positives included affirmation of experiences with the mental health system; improved rapport with the case management and clinical team,

		increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it. (Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system – Magnus Mfoafo-McCarthy International Journal of Equity in Health Sept 2014) Findings of **NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) (DoH 2011) -** The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO. A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

		(A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales" Simon Lawton Smith for the Kings Fund Sept 2005) Community treatment orders are designed to ensure patients live in their home or supported accommodation. The power of recall under section 17E is used when a patient is not compliant with their conditions or becomes mentally unwell. They are used for patients who have frequent repeated admissions to hospital.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The Community Treatment Order Policy 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. The functions are carried out on a day to day basis.

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: • 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 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	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	Under Policy Statement

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
	characteristic and staff have to take into account the diverse needs of the individual patient.	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 **NB** Gender-reassignment is anyone who proposes to, starts, is going through 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.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

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
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			
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.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
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	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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 on maternity leave.			
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 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 they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	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.

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
		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.
6.8 People who are attracted to other people of: • 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	N/A	N/A

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
	patient.		
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 they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

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
		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 those with physical or sensory impairments.	N/A	Under Policy Statement

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
6.11 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
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

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.

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	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

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
non-prescribed drugs plus access to services that 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

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 Well-being Goal – A resilient Wales	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

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
7.5 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 macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

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
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	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.		

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	There is some concern and debate around effectives of Community Treatment Orders. Whilst some protected groups may be disproportionately represented in the numbers accessing mental health services and who may be subject to the CTO Policy, there is no evidence at this stage that any individuals or group/s will be discriminated against or adversely impacted by the policy if implemented fairly and equitably. There is some concern that Community Treatment Orders may impact adversely on the human rights of people with mental health issues who have capacity as the decision making process is risk based rather than capacity based (Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns). However, this is rebutted within the debate citing no difference between CTO and a hospital based imposed treatment regime. **https://www.google.co.uk/search?q=Impact+of+community+treatment+orders+on+protected+groups&oq=Impact+of+community+treatment+orders+on+protected+groups&gs_l=psy-ab.12...1837221.1854919.0.1857397.59.38.1.0.0.0.531.5383.0j2j4j6j3j1.16.0....0...1.1.64.psy-ab..50.0.0.gB1dGnixrkY** CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others.

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 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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o 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 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 must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the form, is carefully monitored. The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.

Reference Number: UHB 408 **Version Number:** 2	**Date of Next Review:** **Previous Trust/LHB Reference Number:** **N/A**

Community Treatment Order Procedure
Mental Health Act 1983

Introduction and Aim

This document supports the Community Treatment Order (CTO) Policy, Mental Health Act 1983.

To ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs.

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This procedure describes the following with regards to a CTO;

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patients' subject to a CTO

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

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	• The Mental Health Act 1983 (as amended by the Mental

alongside this Procedure	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 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Community Treatment Order Policy Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*
Disclaimer **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.**	

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			• *Removal of glossary of terms.* • *Amended paragraphs throughout for clarity.* • *Removed paragraphs that weren't relevant due to change in processes.*

CONTENTS

1. INTRODUCTION

This procedure sets out to describe the process of using Community Treatment Orders (CTO). Those on CTOs will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTOs.

CTOs provide a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, a CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of Community Treatment Orders (CTOs) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 ("the Code of Practice").

CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others. It is one of a range of options for mental health treatment in the community and is implemented through the making of a CTO.

3. SCOPE

This procedure is applicable to employees within All Mental Health inpatient settings, community settings and general hospital settings where patients are subject to Community Treatment Orders.

4. MATTERS FOR CONSIDERATION FOR CARE IN THE COMMUNITY

To support and deliver care in the community for a patient detained on a treatment order (e.g. Section 3), the options include:

- Section 17 leave of absence. This can be short term or for extended leave of absence;
- Section 117 aftercare;
- Transfer onto guardianship; or
- Community treatment order.

5. WHO IS ELIGIBLE FOR CTO?

To be considered for CTO a patient must be currently detained under section 3 of the Mental Health Act (MHA) or an unrestricted Part 3 patient (section 37, section 45A, section 47 or section 48). Those detained for assessment on section 2 are not eligible. Furthermore, a CTO can only be used for patients whose treatment needs have already been assessed in hospital under one of the above-mentioned detention orders and they meet the eligibility criteria.

6. ELIGIBILITY CRITERIA

The patient's treatment needs have already been fully assessed under section 3 or as an unrestricted Part 3 patient and the patient is still liable to be detained. An individual patient can be discharged onto a CTO if they satisfy the eligibility criteria, which are that:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of other persons that they should receive such treatment;
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital;
- It is necessary that the responsible clinician should be able to exercise the power under s17E(1) of the Act to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

7. RECOMMENDATIONS BY THE MENTAL HEALTH REVIEW TRIBUNAL (MHRT)

The MHRT may decide not to discharge a patient who has made such an application to them. The MHRT may decide, instead, to recommend that the RC should consider whether the patient should go onto a CTO (qualifying patients only). The RC will carry out the assessment of the patient's suitability for a CTO in the usual way.

However, it will be for the RC to decide whether or not a CTO is appropriate for that patient. The assessment may have to be carried out within a period of time as allowed for by the MHRT.

8. RISK ASSESSMENT

Whilst determining whether the criteria for a CTO is met, the RC shall consider, having regard to the patient's history of mental disorder and any other relevant factors, what risks there would be of a deterioration of the patient's condition if they were not detained in a hospital. The following must be assessed:

- Failure to follow a treatment plan;
- Patient's insight and attitude to treatment;
- The risk of patient's condition deteriorating after discharge;
- The risk of harm arising from the patient's disorder is sufficiently serious to justify the power of recall;
- The co-operation of the patient in consenting to the proposed treatment.

9. ASSESSMENT FOR CTO

The Responsible Clinician and the Approved Mental Health Professional (AMHP) will need to consider whether the objectives of a CTO could safely and effectively be achieved in a less restrictive way. If the RC grants the patient leave for 7 or more consecutive days, they have to consider a CTO. The RC will decide whether a CTO is the right option for any patient and will require the agreement of the AMHP. The RC must be satisfied that appropriate treatment is, or would be available for the CTO patient in the community. The key factor is whether the patient

can safely be treated for mental disorder in the community with the RC's power to recall the patient to hospital for treatment if necessary. The RC would also assess the risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

10. CONSULTATION

When the RC considers that a patient may be suitable for a CTO, the first step would be to consult with those involved in the care of the patient including the care coordinator and, where applicable, a different RC who will take over the responsibility for the patient in the community. Consultation is necessary when a CTO is first considered but it should also take place on any review of a CTO, when a change of condition is considered and prior to recall of a community patient unless the need for recall is too urgent.

The patient does not have to consent formally to a CTO. However, in practice patients need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

The RC must be fully aware of the diverse needs of the patient when considering a CTO 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.

11. WHO TO CONSULT

- The patient, who may be supported by a Independent Mental Health Advocate (IMHA);
- Approved Mental Health Professional (AMHP)
- The care coordinator;
- A different RC (if applicable) who will take over responsibility for the CTO patient;
- The nearest relative/carers (unless the patient objects or it is not reasonably practical)
- The multi-disciplinary team involved in the care of the patient;
- Anyone with authority to act on behalf of the patient under the MCA 2005, such as an attorney or a deputy;
- The GP; it is important for the GP to be aware that the patient is to go onto a CTO. A patient without a GP should be encouraged and helped to register with a practice; and
- Other relevant professionals.

12. WHO MAKES THE DECISION

The RC and the AMHP make the decision as to whether a CTO is the right option for the patient. They would also have considered whether there is a less restrictive way to achieve the same objectives. The RC must be satisfied that the relevant criteria are met. An AMHP must state in writing that they agree with that opinion and that it is appropriate to make the order. This will be done by completing the appropriate part of Form CP1.

13. THE ROLE OF THE APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

The AMHP must reach an independent professional view. The AMHP should ensure that they consider the patient's wider social circumstances including any cultural issues. They should also consider any support networks the patient may have, the potential impact on the patient's family, employment and educational circumstances.

If the AMHP does not agree that a CTO should be made or does not agree to the conditions, the CTO cannot proceed. It would not be appropriate for the RC to approach another AMHP in the absence of changes to the plan. Where such disagreement occurs, an alternative plan should be developed by the relevant professionals.

When an AMHP disagrees to the making of a CTO, they should make a written entry to that effect in the patient's notes on PARIS.

14. CARE AND TREATMENT PLANNING MEETING

CTO patients are entitled to aftercare services under section 117 of the Act. The care and treatment plan will reflect the needs to be met by the services from the Health Board and the Local Social Services Authority (LSSA). Such care plans, coherent with CTO, must be in line with the requirements of care and treatment planning and a care coordinator will need to be identified. Good care planning will be essential to the success of a CTO. This would include an appropriate package of treatment and support services and the identification of a care coordinator. There would be a record of the patient having an attorney if applicable and also of any advance decisions.

15. CONDITIONS

A CTO will specify the conditions to which the patient is to be subject whilst on a CTO. All CTOs must include the ''mandatory conditions'':

- A condition that the patient must make themselves available for examination when an extension of the CTO is being considered; and
- Where necessary to make themselves available for examination to allow a second opinion approved doctor (SOAD) to provide a Part 4A certificate authorising the patient's treatment in the community.

The MHA Code of Practice for Wales suggests that the RC with the agreement of the AMHP may also set other conditions that are necessary or appropriate to ensure one or more of the following purposes:

- Ensuring that the patient receives medical treatment;
- Preventing risk of harm to the patient's health or safety;
- The protection of other persons.

With the exception of the two mandatory conditions, other conditions are in themselves not enforceable. The reasons for any conditions should be explained to the patient and others and be recorded in the patient's notes on PARIS.

Where applicable the RC should take account of any representation from a victim or their family,

where the provisions of the Domestic Violence, Crime and Victims Act 2004 apply.

The conditions might include stipulating:

- Where a community patient is to live;
- The arrangements for receiving treatment in the community;
- The avoidance of the use of illegal drugs and/or alcohol where their use has led to relapse in their mental disorder.

16. COMPLETING A COMMUNITY TREATMENT ORDER

The RC is responsible for initiating the process. The patient is entitled to ask the IMHA to support them at this point. Staff should assist the patient in contacting the IMHA if requested. The decision to go ahead is a joint one by the RC and the AMHP (who may be a member of the multidisciplinary team).

- The RC completes Part 1 of the Statutory Form CP1;
- The AMHP completes Part 2 of the Form CP1;
- The RC completes Part 3 of the Form CP1;
- As soon as reasonably practical the RC shall furnish to the Mental Health Act Department (on behalf of the managers of the responsible hospital) with the duly completed Form CP1 together with an up-to-date risk assessment and care and treatment plan;
- The Mental Health Act Department will ensure that a copy of the Form CP1 is scanned onto PARIS and the original kept in the patients legal file;
- The date on which the patient is discharged on CTO shall be the date on Part 3 of the duly completed Form CP1;
- The community patient is informed of the effect of CTO by the care coordinator or Responsible Clinician and the Mental Health Act Department;
- A copy of the CP1 is sent to the patients GP

17. COMMENCEMENT OF CTO

The day on which the CTO is made is determined by the date on the duly completed Part 3 of Form CP1. Hence, that will be the date on which the patient shall be discharged onto a CTO. Similarly, for patients who are already on s17 leave, they will instead be 'transferred' onto a CTO from that date. This date may be a short period after the date on which the form is signed, to allow for arrangements to be put in place for the patient's discharge.

When the CTO is in force, the hospital managers' authority to detain is suspended and the patient becomes a 'community patient' and the community treatment order they are subject to will expire after six months, at which point the RC will decide whether to extend the CTO or discharge it.

18. DURATION OF CTO

The CTO will be in force, until:

- The community treatment period expires;

- The patient is discharged by the Responsible Clinician or Hospital Managers under s23 or under a direction by the MHRT under s72 (1)(c);
- (For Part 2 Patients) the nearest relative applies for discharge and it is not barred by the RC;
- The patient no longer satisfies all the criteria for CTO;
- The CTO is revoked under s17F.

19. COMMUNITY TREATMENT ORDER PERIOD

The community treatment period shall cease to be in force on expiry of the period of six months beginning with the day on which it was made. The day it was made is arrived at by the date on the duly completed Part 3 of Form CP1. Unless the CTO has previously ceased to be in force, it can be extended for a period of six months and thereafter for a period of one year at a time.

20. GIVING INFORMATION TO THE PATIENT

Following the decision to make the CTO, the RC should inform the patient and others consulted, verbally and in writing of:

- The decision;
- The conditions to be applied to the CTO; and
- The services which will be available for the patient in the community.

Unless the patient objects, the nearest relative should be informed where practicable of the conditions to be applied and of their right to apply for the discharge of the patient from CTO.

21. GIVING INFORMATION ABOUT THE INDEPENDENT MENTAL HEALTH ADVOCATE TO THE PATIENT

CTO Patients are qualifying patients for the purpose of accessing the services of the Independent Mental Health Advocate (IMHA). The care coordinator will give CTO patients information both orally and in writing as soon as practicable after the patient goes onto CTO about the availability of the IMHA service.

The care coordinator, as soon as practicable after a CTO is applied must complete a rights form with the patient and ensure they have a CTO information leaflet. The Mental Health Act Department will send such information to the Nearest Relative, unless the patient objects (or does not have a Nearest Relative).

22. VARIATIONS IN/SUSPENSION OF ANY CONDITIONS OF A CTO

With exception of the two mandatory conditions, the RC may vary or suspend any of the above conditions applied to a CTO. There is no requirement for the RC to obtain an AMHP's agreement before doing so. Unless there is an urgent need to vary, it would be good practice to obtain an AMHP's agreement before doing so. Any variation of the conditions by the RC shall be recorded on Form CP2. The RC may by order in writing vary the conditions of the CTO from time to time. Additionally, the RC may suspend any condition specified in the CTO. The RC may consider any failure to comply with the conditions warrant for recalling the patient, however,

failure to comply with the conditions is not in itself enough to justify the power to recall. The RC should record any decision to suspend conditions in the patient's notes on PARIS, with reasons.

As soon as practicable, the RC shall furnish to the Mental Health Act Department a duly completed Form CP2. The Mental Health Act Department will ensure that a copy is sent to the care coordinator along with any other appropriate professionals and that the information about any such changes is brought to the attention of the patient and anyone affected by the changes. The patient must understand the reasons for the changes and how to comply with them. The original Form CP2 will be filed with the Form CP1 in the patient's legal file and uploaded to PARIS.

23. CHANGE OF RESPONSIBLE CLINICIAN

In certain circumstances, the RC for an inpatient may not be the RC for a community patient. In such cases, at an early stage of planning for the CTO the RC must liaise with the different RC to take over responsibility for the patient. Hence, as part of the CTP review, on the inpatient unit both the community team and the different RC who will take over the responsibility for the CTO patient must attend such reviews. Alternatively, transfer can take place during a CTP review and the CTO patient informed accordingly.

24. MEDICAL TREATMENT FOR MENTAL DISORDER IN THE COMMUNITY (PART 4A)

The provision of medical treatment for mental disorder is governed by Part 4A of the Act. There are two types of requirements in Part 4A, namely authority and certification. In all cases, the person giving the treatment must have the authority to do so and the certificate requirement must be met for section 58 and 58A type treatment. The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for treatment under Part 4 of the Act. There is no certificate requirement for the first month (1-month rule) from when a patient is put onto a CTO, or 3 months from when the medication was first given to the patient, whichever is later. After this time, a certificate is required either by the AC in charge of the treatment or from a SOAD.

To a negligible extent, those on CTO who are under the age of 16 may have the competence to consent to the treatment. The MCA 2005 is not directly relevant. The child's own consent will provide the authority. However, the Act also requires a SOAD or the AC in charge of their treatment to certify this on a Part 4A certificate. Under 16-year olds, who do not have competence, can be treated by the AC in charge of the treatment or someone acting under the AC's direction provided certain conditions are satisfied.

CTO patients with capacity to consent cannot be treated in the community against their wishes. There are no exceptions to this rule, even in emergencies. A CTO patient will be recalled to hospital when treatment for the patient's mental disorder is clinically necessary and the patient is not consenting.

The authority to treat patients who lack capacity to consent to a treatment may come from an attorney, a deputy or the Court of Protection. The AC in charge of the treatment would be able to provide treatment to the person who lacks capacity, provided certain conditions are met (see Ch.24.17 of the Code). The only exceptions, under section 64G, will be in emergencies where

patients lack the capacity to consent to treatment which is immediately necessary to prevent harm to the patient and is a proportionate response to that harm.

25. ARRANGING FOR A SOAD VISIT

If a SOAD is required to provide treatment under Part 4A, the RC should complete an Electronic SOAD Request Form and identify the two consultees. The care coordinator is ideally placed to be one of the consultees. The consultees should be registered staff members who have been professionally concerned with the patient's medical treatment such as a doctor, CPN, OT or AMHP, but neither consultee can be the patient's RC or the AC in charge of the treatment in question.

In circumstances whereby, the care coordinator would be on leave, the RC should identify another consultee who has been professionally concerned with the patient's medical treatment to speak to the SOAD.

26. CTO PATIENT – IDENTIFYING ATTORNEY / ADVANCE DECISIONS

If the patient lacks capacity to consent to treatment, the care coordinator or RC/AC will inform the SOAD if the patient has an attorney or deputy and details of any advance decisions or any expressed views, wishes or feelings, both past and present.

27. SOAD VISIT

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 CTO papers are in order, check the patient's case notes, a recent medical report, if available, medication chart and they will interview the patient either via telephone or in person if the SOAD feels it is appropriate; and it is the duty of the Hospital Managers to find a suitable location for this interview. The SOAD will also interview the AC and the statutory consultees to ensure the proposed treatment plan is appropriate for that patient. A statutory consultee form will need to be completed as soon as possible after the discussion with the SOAD.
The Mental Health Act Department will provide the case notes and current detention papers to HIW. Once the SOAD has decided to issue a certificate it will be emailed to the Mental Health Act Departments generic inbox to process.

28. EFFECT OF CTO

The application for treatment will not cease to have effect because the patient has become a 'CTO patient'. However, whilst the patient remains on a CTO:

- The authority of the managers to detain him (section 6(2)) with regard to that application shall be suspended; and
- Any reference however expressed in this or any other legislation to patients liable to be detained or detained under this Act shall not include that patient on a CTO.
- Furthermore, whilst the patient remains on CTO, section 20 shall not apply to the patient, however, section 20A will apply.

The authority for the detention of the patient shall not expire during any period in which that

authority is suspended.

29. APPLICATION FOR DISCHARGE FROM CTO

CTO patients are entitled to request the hospital managers consider their discharge from CTO. Additionally, their nearest relative can apply for their discharge from CTO giving 72 hours' notice, unless the RC issues Form NR1 barring the discharge.

The effect of discharge is to end the CTO and the suspended liability to detention. The patient can no longer be recalled to hospital or required to stay in hospital.

30. MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

CTO patients are entitled to apply to the MHRT once during each period of detention. The hospital managers will refer them every 3 years if they haven't appealed to the MHRT within that time and when the patient has been revoked from their CTO. The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for referrals to the MHRT.

31. INFORMING CTO PATIENTS OF LOCATION OF THE MHRT HEARING

The MHRT hearings will be conducted either via teleconference or Teams and potentially face to face if appropriate. When the date of the hearing has been set, the Mental Health Act Department will inform the patients RC, social work team and community nurse, or ward nurse if the patient is informal. It is the MDT's responsibility to inform the patient of these details.

32. ACCESS TO PATIENTS' CLINICAL RECORDS

The medical member of the Tribunal may want to examine the patient before the hearing takes place. Hospital Managers must ensure that the medical member can see the patient in private and any records relating to the patient's detention or treatment will be produced for their inspection. The patient should be told of the visit in advance so that they can be available to meet the medical member. The medical member may speak to the patient via the telephone or video. The Mental Health Act Department are responsible for sending any information to the MHRT.

33. LEGAL REPRESENTATION

Patients should be informed that they are entitled to free legal advice and representation. Hospital Managers and Local Social Services Authorities should inform patients of their rights to present their own case to the Tribunal or to be represented by someone else. A list of solicitors who undertake tribunal work should be available for use by patients – this is especially important for CTO patients who may not have daily contact with professionals.

34. ATTENDANCE AT HEARINGS

It is important that the RC and other relevant staff involved in the patient's care should attend for the full hearing, as their evidence will be crucial in the decision reached by the Tribunal as to whether the patient still meets the criteria for CTO under the Act.

Patients do not need to attend the hearing but should be encouraged to do so, unless it would be detrimental to their health or wellbeing. The RC, allocated social worker, community nurse/care coordinator and other relevant staff should attend the full hearing so they are aware of all the evidence and the tribunal's decision and reasons.

35. MONITORING CTO PATIENTS

CTO should form a part of the patient's care and treatment plan, in accordance with section 8 of the Mental Health (Wales) Measure 2010 and regulations pursuant to it.

It will be important to maintain close contact with a patient on a CTO and to monitor their mental health and wellbeing. The care coordinator will normally be responsible for coordinating the care and treatment plan, working with the RC, the team responsible for the patient's care and any others with an interest. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and would include access to services provided locally. Appropriate action will need to be taken if the patient becomes unwell, engages in high risk behaviour as a result of mental disorder, or withdraws consent to treatment or begins to object to it. The reasons for a failure to comply with any condition must be considered and if necessary reviewed. The patient's compliance with the conditions will be a key indication of how the CTO is working in practice.

If the patient refuses crucial treatment, an urgent review of the situation will be needed. If suitable alternative treatment is available which would allow the CTO to continue safely and which the patient would accept, the RC should consider such treatment if this can be offered.

A failure to comply with a condition is not in itself enough to justify recall. Each case should be considered on its own merits and any actions are proportionate to the level of risk posed by the patient's non-compliance.

36. RESPONDING TO CONCERNS RAISED BY CARERS AND OTHERS

The care coordinator/community mental health team must give due weight to any concerns raised that the patient is not complying with any conditions and/or that their mental health is deteriorating. The care coordinator/community mental health team (CMHT)/out-of-hours services will deal with any such concern as an urgent referral. The practitioner concerned will access the CTO patient's records including the care plan and risk assessment.

The practitioner concerned will also obtain all the relevant details of the concerns to make a decision as to whether to meet with the person who raised the concerns and/or the CTO patient. Depending on the risk, the practitioner concerned/care coordinator will discuss the concerns with the RC/on-call consultant so that the RC/on-call consultant can decide whether to recall the CTO patient or not.

37. ADMISSION TO HOSPITAL OF CTO PATIENTS ON A VOLUNTARY BASIS

CTO patients may agree to be admitted to hospital on a voluntary basis. On such occasions the CTO patient would **not** have been recalled to hospital by their RC. CTO patients who are in hospital on a voluntary basis can be recalled if there is a need to. However, as Part 4A patients the medical treatment they may receive is governed by the rules applied to CTO patients as in Chapter 25 of the Code.

The Mental Health Act Department will send a reminder to the RC after 1 month of the patient being in hospital informally to undertake a review to determine if the patient still satisfies all the criteria for CTO, whilst the patient remains on the ward.

38. PROCEDURE FOR RECALL OF CTO PATIENTS TO HOSPITAL

The power to recall includes circumstances when the community patient is already in hospital at the time the power of recall is exercised. The RC may recall a community patient if they are of the opinion that:

- The patient requires medical treatment for his mental disorder in hospital; and
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient was not recalled to hospital for that purpose.

The notice in writing to recall a community patient to a named hospital shall be sufficient authority for the managers of that hospital to detain the patient in hospital.

All patients on a CTO have a hospital which is responsible for oversight of their case while they are in the community. The Act refers to this hospital as the "responsible hospital''. There is no special procedure to follow if the CTO patient is re-assigned to another hospital which is under the same managers.

The RC may recall a patient to a hospital other than the responsible hospital. In such instances, the RC has responsibility for coordinating the recall process, unless agreed with someone else. The power of recall will be carried out by notice in writing to the patient. The RC will complete Form CP5 to recall a community patient. Two copies of the completed Form CP5 must be taken. One copy is to be kept on the patient's records by the community mental health team, one copy must be given to the patient and the original must be faxed or scanned and e-mailed before being forwarded to the Mental Health Act Department.

It will not usually be appropriate to post a notice of recall to the CTO patient. It is important that, whenever possible, the notice should be handed to the patient personally. When the need for recall is urgent, it will be important that there is certainty as to the timing of the delivery of the notice. When such a notice of recall is handed to the patient, it is effective immediately. This may not be possible if the patient's whereabouts are unknown, or if the patient is unavailable or simply refuses to accept the notice.

Regulation 3 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 states that a notice of recall may be served by delivery to the patient's usual or last known address. Delivery of the recall notice relating to a CTO is secured by delivery in person or by pre-paid post.

SERVING THE NOTICE – WHEN NOT HANDED TO A CTO PATIENT

- If it is urgent, the notice should be delivered **by hand** to the patient's usual or last known address. The notice is then **deemed to be served** (even though it may not actually be received by the patient) on the **day after it is delivered**. That is, the day beginning immediately after midnight following delivery.
- First class post can be used. The notice is deemed to be served on the second working

day after posting. Sufficient time must be allowed, as detailed above, for the patient to receive the notice before any action is taken to ensure compliance.

Once the notice of recall is duly served the patient can be treated as absent without leave (AWOL Section 18) if that is necessary and taken and conveyed to hospital. Should the police be informed, the care coordinator would inform the police that the CTO patient has been duly recalled and is now AWOL.

There may be cases whereby the patient's whereabouts are known but access to the patient cannot be obtained. In such cases, it may be necessary to consider whether a warrant issued under section 135 (2) is needed.

39. COMMUNITY PATIENTS WHO ARE ABSENT WITHOUT LEAVE

Patients on a CTO are considered to be absent without leave (AWOL) if:

- They fail to return to hospital when they are recalled; or
- They abscond from hospital following recall.

A patient, who is AWOL, may be taken into custody by an AMHP, an officer of the staff of the responsible hospital, a constable or anyone authorised in writing by the RC or the Hospital Managers, and returned to the hospital to which they were recalled.

That may only be done before:

- The time at which the CTO is due to expire (assuming it were not to be extended); or
- The end of the six months beginning with the first day of the AWOL, if that is later.

If patients are taken into custody, or come to the hospital voluntarily, before the end of the period during which they could be taken into custody, the 72 hours for which they can be detained effectively starts again on their arrival at the hospital, even if they had already been detained for part of that period before they went AWOL.

Special arrangements apply if a patient is AWOL at any point during the week which ends on the day their CTO is due to expire, and an extension report has yet to be made. The arrangements are equivalent to those of Part 2 detained patients.

If a patient is taken into custody, or comes to the hospital voluntarily, within 28 days, an examination and the report under section 20A may be furnished to the managers to extend the CTO.

If patients are taken into custody, or come to the hospital voluntarily, after being absent for more than 28 days, their CTO expires at the end of the week starting on the day of their arrival at the hospital unless the RC furnishes a report to the managers within that time to extend the CTO using Form CP 4. The CTO may also be revoked under section 21B(4)(a).

40. POWERS IN RESPECT OF RECALLED PATIENTS

The community patient may be recalled to a hospital other than the responsible hospital.

- The recalled patient may be transferred to another hospital.
- Subject to meeting the necessary conditions and written agreement of an AMHP, the RC may by order in writing revoke the CTO.
- The RC may at any time release the patient but not after the CTO has been revoked.
- If the CTO has not been revoked or the recalled patient released at the end of 72 hours, the patient shall be released from hospital. However, a released patient remains subject to the CTO. The ‘‘holding powers’’ of section 5 may not be used to keep the patient in hospital after the end of the 72-hour period.

The period of 72 hours begins when the patient arrives at the hospital he has been recalled to and not when the notice of recall has been issued or received. Form CP6 should be completed by the Mental Health Act Department or Shift Coordinator when the patient arrives noting the date and time of arrival.

Section 5(6) makes it clear that a patient subject to CTO is not to be held on either section 5(2) or section 5(4) of the Act.

41. POWER OF RECALL TO A HOSPITAL OTHER THAN THE RESPONSIBLE HOSPITAL

The hospital managers (or a person authorised by them) from the hospital which the patient is to be transferred from must use Form TC6 to authorise the transfer to the managers of the hospital to which the patient is being transferred to.

A copy of the duly completed Form CP5 to recall the patient will be provided to the managers of the hospital to which the patient is recalled as soon as possible after it is served to the patient. This will provide sufficient authority for the managers of the named hospital to detain the patient. The legislation allows a recalled patient to be transferred to another hospital provided it is done within the 72-hour period.

A transfer between hospitals while a patient is recalled does not change the responsible hospital.

42. TRANSFER OF A RECALLED PATIENT

A CTO patient who has been duly recalled may be transferred to another hospital managed by the same hospital managers. There is only the transfer arrangement, as an internal issue, to be carried out so as not to negatively affect the continuity of care. This can only be done within the same 72-hour period. The nurse in charge of the receiving unit must know the time at which the 72 hours started and must ensure that the Form CP6 is duly completed and returned to the Mental Health Act Department.

43. TRANSFER OF A RECALLED CTO PATIENT TO A HOSPITAL UNDER DIFFERENT MANAGERS

A recalled CTO patient may also be transferred to another hospital under different managers. In such cases the transfer must be effectuated within the 72-hour period. The Mental Health Act Department or Shift Coordinator, on behalf of the Hospital Managers, must complete Part 1 of

Form TC5. Part 2 of the form must be completed by someone authorised by the managers of the receiving hospital.

When Part 2 is duly completed, a copy of the completed Form TC5 must be scanned to the Mental Health Act Department. The Mental Health Act Department must notify:

- The patient, in writing, of the name and address of the responsible hospital and the details of the hospital managers; and
- The patient's nearest relative of the name and address of the responsible hospital and the details of the hospital managers (if the patient does not object).

44. RECORDS TO BE KEPT FOR RECALLED PATIENT

The Mental Health Act Department, on behalf of the hospital managers, will keep a record of the time and date of the patient's detention as a result of the notice of recall given by the RC. The start time and date will be the time and date of the patient's arrival on the inpatient unit.

The Shift Coordinator or Mental Health Act Department must record the start date and time of the 72-hour period and also the release of the recalled patient, if the RC decides not to revoke the CTO, using Form CP6.

When completed the Form CP6 must be faxed or scanned and the original sent to the Mental Health Act Department who will keep a record of these times and dates on behalf of managers of the responsible hospital. A copy will be retained in the patient's notes.

Prior to the release, the care coordinator and anyone else involved must be informed of the CTO patient's release.

45. MEDICAL TREATMENT FOR MENTAL DISORDER – RECALLED PATIENTS

Though the CTO patient has been recalled to a hospital, the required treatment may be given on an outpatient basis when appropriate. CTO patients who have been recalled to hospital are subject to the same rules on medical treatment (with certain exceptions) as other detained patients and are subject to Part 4 of the Act.

Part 4A does not apply to the treatment of CTO patients who have been recalled to hospital, unless or until they are released from detention in hospital.

Part 4 applies to such patients instead, but with three differences.

First, treatment which would otherwise require a certificate under section 58 or 58A can be given without such a certificate if it is expressly approved instead by the patient's Part 4A certificate (if the patient has one). It is expressly approved if the SOAD states in the certificate that the treatment in question may be given to a patient who has been recalled. The certificate may contain conditions. The conditions may, for example, be different for the patient who is not recalled. However, the Part 4A certificate cannot authorise section 58A treatment for which there would be no authority under Part 4A itself.

Second, medication which would otherwise require a certificate under section 58 can be given without such a certificate if the certificate requirement in Part 4A would not yet apply to the treatment because less than one month has passed since the making of the patient's CTO. In

other words, no certificate is required for the administration of most medications to a patient who has been a CTO patient for less than a month.

Third, treatment that was already being given on the basis of a Part 4A certificate before the patient was recalled to hospital may be continued temporarily, even though it is not authorised for administration on recall on the Part 4A certificate, if the person in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. However, this exception only applies pending a new certificate being obtained.

SOADs providing Part 4A certificates need to consider what treatments (if any) to approve, should the patient be recalled to hospital.

These exceptions also apply to CTO patients whose CTOs have been revoked except that, for section 58 type treatments, continuance with medication will continue pending compliance with section 58 requirements.

Part 4A does apply to CTO patients who are in hospital, either voluntarily or when complying with a condition of their CTO without having been recalled.

HIW may at any time notify the AC in charge of the treatment in question that a Part 4A certificate will cease to apply from a certain date.

46. REVOKING A COMMUNITY TREATMENT ORDER

A CTO may only be revoked while the patient is detained in a hospital as a result of being recalled. The RC may by order revoke the CTO if:

- In their opinion the patient again needs to be admitted to hospital for medical treatment under the Act; and
- The AMHP agrees in writing with the RC and that it is appropriate to revoke the CTO.

The RC's order revoking the CTO will be in the form of a duly completed Form CP7. The RC will complete Part 1 and the AMHP will complete Part 2 of the Form CP7. Again, as soon as practicable the original Form CP7 will be sent by post to the Mental Health Act Department after first faxing or scanning a copy to them.

The Mental Health Act Department, on behalf of the hospital managers, must refer the patient's case to the MHRT as soon as practicable after the revocation of the CTO. As soon as practicable, the Mental Health Act Department will inform the care coordinator and the relevant CMHT of the revocation of the CTO.

If the AMHP does not agree that the CTO should be revoked then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will remain on a CTO. The AMHP's decision and full reasons should be recorded in the patient's notes on PARIS.

47. EFFECT OF REVOKING A COMMUNITY TREATMENT ORDER

Below is the effect of revoking the CTO in respect of the patient.

- Section 6(2) shall have effect as if the patient has never been discharged from hospital

on a CTO. The patient's detention under their original treatment order will be re-instated from the date of revocation.

- The provision of this or any other Act relating to patients being liable to be detained (or detained) in pursuance to an application for admission for treatment shall apply to the patient as was prior to the CTO being made.
- When the patient is being detained in a hospital other than the responsible hospital, the provisions of this Act will have the effect as if the application for admission for treatment were made to that other hospital and he had been admitted to that other hospital at the time when the patient was originally admitted in pursuance of that application.

In any case of a patient being revoked, section 20 shall have the effect as if the patient had been admitted to hospital in pursuance of the application for admission for treatment on the day on which the order is revoked. The detention will last for six months and the RC will be able to renew the detention order, if appropriate, two months prior to the last day of the detention order.

Where the CTO patient has been recalled to a hospital which is not the responsible hospital, the RC/Mental Health Act Department must furnish the managers of that hospital with a copy of the order.

48. MEDICAL TREATMENT FOR MENTAL DISORDER – ON REVOCATION OF A CTO

Upon revocation of the CTO, the patient would be detained on the treatment order they were on directly before the CTO was applied. As such the patient will be subject to Part 4 of the Act as far as medical treatment for mental disorder is concerned. The period of time spent receiving treatment on section 2 and section 3 and CTO will count as being continuous. In order to treat patients under Part 4 of the Act, new certificates will be needed within 1 week of the CTO being revoked.

49. DUTY TO INFORM NEAREST RELATIVE

The Mental Health Act Department on behalf of the hospital managers will inform the nearest relative that a detained patient is to be discharged from hospital, unless that patient or the relative has asked that such information should not be given. This duty applies equally where patients are to be discharged from hospital by means of a CTO.

50. EXTENSION OF COMMUNITY TREATMENT ORDER PERIOD

Within two months ending on the day on which the CTO would cease to be in force, it shall be the duty of the RC to examine the patient and, if it appears to him that the conditions are satisfied and that the AMHP has agreed in writing, the RC must furnish the managers of the responsible hospital a report on the prescribed Form CP3. However, before providing the report the RC must consult one or more other persons who have been professionally involved with the patient's medical treatment.

The report, duly furnished, would extend the CTO for the prescribed period. Unless the hospital managers discharge the patient under section 23, the care coordinator as delegated by the hospital managers would inform the community patient of the renewal.

51. CONSULTATION BY RC PRIOR TO EXTENSION OF COMMUNITY TREATMENT

ORDER PERIOD

Before furnishing the above CTO Form CP3 to the hospital managers, the RC must consult one or more other persons who have been professionally concerned with the patient's medical treatment. The RC will need to complete Part 3 of Form CP3 with details such as the name and profession of the person consulted. Ideally, it may be the care coordinator, an Occupational Therapist, a Community Psychiatric Nurse (CPN) or a chartered psychologist who has been professionally concerned with the patient's medical treatment.

52. HOW CAN A COMMUNITY PATIENT BE DISCHARGED FROM CTO?

A community patient ought to be discharged from a CTO if the patient no longer meets the criteria for CTO. Such a patient can be discharged from CTO in the following ways:

- Discharge by the RC at any time using Form CP8;
- By the hospital managers under section 23 of the Act using Form CP8;
- For Part 2 patients following application by their Nearest Relative (NR) giving 72 hours' notice;
- By the MHRT;
- Following the patient's reception under guardianship.

53. EFFECT OF EXPIRY OF A COMMUNITY TREATMENT ORDER

A patient will be absolutely discharged from CTO and liability to be recalled to hospital and the application for admission for treatment will similarly cease to have any effect when the CTO expires.

54. SAFEGUARDS FOR CTO PATIENTS

Patients on CTO will be entitled to similar safeguards to patients detained in hospital including nearest relative rights and the right to apply to an MHRT. Patients on a CTO will also have their treatment (if it involves giving medicines) reviewed and certified by a second opinion appointed doctor or an AC after three months from when medication was first given or one month from discharge from hospital onto CTO, whichever is later. CTO patients will have their case reviewed regularly and will be discharged when they no longer meet the criteria.

55. MONITORING

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

The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a CTO is appropriate.

56. TRAINING

The Health Board will provide ongoing training for staff who are involved with the care and treatment of patient's subject to Community Treatment Orders. Details of training available can be found by contacting the Mental Health Act Department or checking their intranet page on CaV Web.

57. IMPLEMENTATION

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

58. RESPONSIBILITIES

58.1 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.

58.2 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.

58.3 Community Team Managers/Service Managers

It is the responsibility of all clinical managers to:

- Ensure that this procedure is brought to the attention of all their staff, and that they understand and adhere to the guidance/procedure contained within.
- Ensure that all staff involved in the care and treatment of CTO patients have received adequate training and are competent to carry out these guidelines.

59. 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.

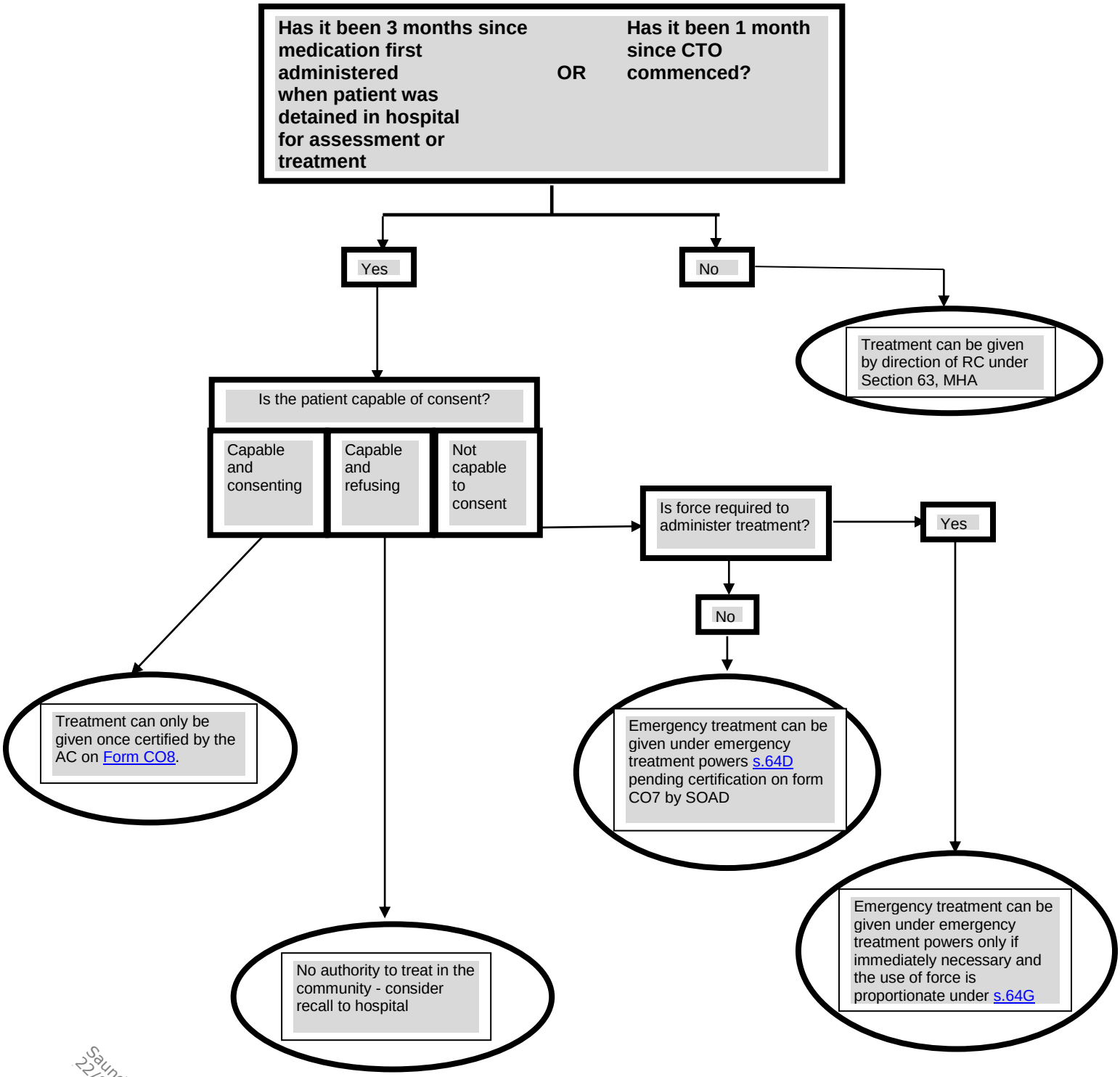
Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Domestic Violence, Crime and Victims Act 2004
Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008

60. APPENDICIES

Appendix A – Treatment with medication for patient's subject to a Community Treatment Order.

Appendix A

TREATMENT WITH MEDICATION FOR PATIENTS SUBJECT TO A COMMUNITY TREATMENT ORDER



KEY:

s.63, MHA	Treatment not requiring consent
s.64B, MHA	Adult community patients
s.64D, MHA	Adult community patients lacking capacity
s.64G, MHA	Emergency treatment for patients lacking capacity or competence
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)