

MENTAL HEALTH CAPACITY LEGISLATION COMMITTEE
09.30am - 12pm – 6th FEBRUARY 2018
CORPORATE MEETING ROOM, HEADQUARTERS
UNIVERSITY HOSPITAL OF WALES

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Cardiff and Vale
University Health Board



MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday February 6th at 09.30hrs
Corporate Meeting Room, Headquarters, UHW

AGENDA

PATIENT STORY – Mental Health Act		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral <i>Chair</i>
2	Apologies for Absence	Oral <i>Chair</i>
3	Declarations of Interest	Oral <i>Chair</i>
4	Minutes of the Mental Health and Capacity Legislation meeting held on 29 th November 2017	<i>Chair</i>
5	Action Log Review	<i>Chair</i>
6	Any Other Urgent Business Agreed with the Chair	<i>Chair</i>
MENTAL CAPACITY ACT		
7 (10 min)	Deprivation of Liberty Safeguard Monitoring Report	<i>A Cole</i>
8 (10 min)	Mental Capacity Act Monitoring Report – SBAR a) Appendix 1 b) Appendix 2	<i>Medical Director</i>
MENTAL HEALTH ACT		
9 (10 min)	Mental Health Act Exception Report	<i>I Wile</i>
HEALTHCARE INSPECTORATE WALES		
10	a) HIW Annual Report – SBAR b) Report	<i>Ian Wile (verbal)</i>
11 (15 min)	MHA Inspection Reports (as received)	<i>Ian Wile (verbal)</i>

MENTAL HEALTH MEASURE		
12 (10 min)	Mental Health Measure Monitoring Report a) Progress on Care and Treatment Plans (verbal update)	<i>Ian Wile</i>
COMMITTEE GOVERNANCE		
13 (15min)	Committee Work Plan	<i>Board Secretary</i>
14 (15 min)	Terms of Reference	<i>Chair</i>
PART 2:	ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website	
15	a)Hospital Managers Power of Discharge sub-Committee Minutes b) PoD recommendations	<i>Chair, PoD sub-Committee</i>
16	Review of the Meeting	<i>Oral Chair</i>
	To note the date, time and venue of the next meeting:- 26 th June 2018	

**UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 3 PM ON TUESDAY 29TH NOVEMBER 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

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Present:

Charles Janczewski
Eileen Brandreth
Sara Moseley

MHCLC Chair and Vice Chair, Cardiff and Vale UHB
Independent Member and MHCLC Vice Chair
Independent Member

In attendance:

Steve Curry
Dr Graham Shortland
Ian Wile
Sunni Webb
Dr Jenny Hunt
Julia Barrell
Lucy Phelps
Amanda Morgan
Jeff Champney-Smith

Chief Operating Officer (Lead Executive for mental health)
Medical Director (part) (Lead Executive for mental capacity)
Director of Operations, Mental Health
Mental Health Act Manager
Clinical Psychologist
Mental Capacity Act Manager
Service User Representative
Service User Representative
Chair, Hospital Managers Power of Discharge
Sub-Committee

Apologies

Kay Jeynes
Jayne Tottle
Peter Welsh

Director of Nursing, PCIC
Mental Health Clinical Board Nurse
Director of Corporate Governance

Secretariat:

Helen Bricknell

MHCLC 16/102 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/103 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/104 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

**MHCLC 16/105 MINUTES OF THE PREVIOUS MEETING OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION
COMMITTEE HELD ON 29TH NOVEMBER 2016 & 9TH
MAY 2017**

The minutes (29/11/2016) were **RECEIVED** and **CONFIRMED** as a true and accurate record following the amendment to minute MHCLC 16/068:

The monthly Quality and Safety meetings report on all usage of the MCA, no audit has been undertaken from the Community Child Health Directorate. An audit will be undertaken during 2017 with the Audit Clinical Lead, however no clinical incidents in Child Health had been reported.

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record for 9th May 2017.

16/088 Minutes had conflated the Mental Capacity Act and DoLS report.

MHCLC 16/106 ACTION LOG REVIEW

To check the dates logged against the Actions on the log and up-date where necessary.

16/028: Section 136 Partnership Arrangements a verbal update on the Action will be given in part of the meeting.

16/052: This item will become redundant off the Action Log as working towards a smoking ban. The purchasing of E Cigarettes will be looked into further to ensure Human Rights are not compromised. An oral update will be given at the next Committee meeting.

16/052: The Benefits Realization report has not been finalised by Welsh Government. Upon completion it will be disseminated throughout the Committee.

16/050: The MHA Exception report is still outstanding. Police have not shared any data currently. National data can be accessed for

Black Minority Ethnicity, this can be embedded in the IMTP plan and a service report for another Committee or Operational meeting.

16/046: To triangulate, capture data and outcome of such material including staff compliance with MCA training. To receive **ASSURANCE** from the Committee, Chief Operating Officer to discuss with Clinical Boards outside of the meeting by proxy measures of training and dissemination across the Health Board to raise these figures.

The Committee **RECEIVED** and **NOTED** the Action Log.

Introduction to Independent Member Sara Moseley who joined the meeting.

MHCLC 16/107 ANY OTHER URGENT BUSINESS AGREED WITH THE CHAIR.

There was no other urgent business.

MHCLC 16/108 DEPRIVATION OF LIBERTY SAFEGUARDS MONITORING REPORT

The report was delivered by the Medical Director and provided by A Cole from Vale of Glamorgan Social Services.

The paper is for information purposes. There are significant increases in DOLS applications within the UHB. This is causing both financial strain and difficulty for Executive Directors in signing off the authorizations.. For the local authorities, concern continues as there are delays in the system on completion of assessment within care homes.

There will be an internal audit on DoLS in the New Year. The previous internal audit gave limited assurance because there was no plan to manage the outstanding assessments. Discussion to be had outside of the Committee on the continuing pressures caused by DoLS.

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/109 MENTAL CAPACITY ACT MONITORING REPORT – SBAR

The Mental Capacity Act Manager delivered a brief overview of how she tries to triangulate both internal and external information to build up a picture of the use of the Mental Capacity Act within the UHB

The Chair opened up for discussion:

- It was explained that it is difficult to capture information on the use of the Mental Capacity Act, as this can only be uncovered by scrutinizing patient records. Unlike the Mental Health Act, there are no statutory forms that have to be completed. Clinical Boards need to perform regular audits in order to find out whether clinicians are complying with the Act. There is risk currently within the UHB as not conforming within high standards.
- Statistical evidence can be gathered, again triangulation of information could be proved useful, compliance needs to be measured within the UHB and discussions to be taken outside of the Committee how to progress quality data.
- Further ideas surrounding this process to be discussed at the next Committee.

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/110 DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION (DNACPR)

The Mental Capacity Act Manager delivered a brief overview of the report. Whilst there is little direct evidence from audits that the law is not being complied with regarding DNACPR decisions, there is some indirect evidence as well as considerable anecdotal information.

Unfortunately, the All-Wales standardised DNACPR audit (agreed by Welsh Government) does not directly address the question of where patients lack mental capacity to be involved in DNACPR discussions, whether family or friends were consulted.

Within the UHB there are definitely some DNACPR decision in place that have not been taken in accordance with the law. What is not clear is the extent of the problem.

ACTION: To ask the Resus Team to include a question about consultation where patient lacks capacity to be involved in discussions about CPR in the audit template.

The Committee suggested that Welsh Government be asked to consider amending the audit template to include specific questions about people who lack mental capacity to be involved in discussions around CPR.

The Committee:

- **APPROVED** the report and supported its recommendations
- **NOTED the report and supported the actions being taken;**
- The Senior Nurse, Resuscitation Service and MCA Manager will co-ordinate a Senior Medical Staff Grand Round session to cover DNACPR and the law. Guidance will be published in the Medical Directors Bulletin.
- The Medical Director, Mental Capacity Act Manager and the Resuscitation Service will recommend, in a paper to the Quality, Safety and Patient Experience Committee, that this issue is considered as part of the routine reports to that Committee by the Clinical Boards. The support of the Chair of the MHCLC in raising this issue with the Chair of the Quality, Safety and Patient Experience Committee is requested as an action.

MHCLC 16/111 RATIFICATION OF IMCA AND LPA/CAD PROCEDURES

The Mental Capacity Act Manager gave a brief summary of the Lasting Power of Attorney and Court Appointed Deputies Procedures.

The Committee **NOTED** the report.

The Committee **SUPPORTED** the report.

The Committee **APPROVED** the report.

The Committee **APPROVED** full publication of Lasting power of attorney and court appointed deputy procedure

The Mental Capacity Act Manager gave a brief summary of the Independent Mental Capacity Advocacy procedure.

The Committee **NOTED** the report.

The Committee **APPROVED** full publication of Independent Mental Capacity Advocate procedure.

MHCLC 16/112 MENTAL HEALTH ACT EXCEPTION REPORT

The Director of Operations, Mr. Ian Wile delivered the topical information around the usage of the Mental Health Act. The Director of Operations gave

credit to the Mental Health Act department as there have been no illegal detentions in accordance to the Act for the last three quarters.

The Committee **NOTED** the report.

MHCLC 16/113 UPDATE NATIONAL CORE DATA

The Director of Operations Mr. Ian Wile reported the benchmarking report had been produced by the MHA Department and is ready for dissemination. It will be circulated in due course.

The Committee **AGREED** the report to be circulated.

MHCLC 16/114 UPDATE ON HIW INSPECTION OF LINKS CMHT

The Director of Operations, Mr. Ian Wile, verbally updated around the Inspection that was undertaken in June 2017, a positive update, hand written notes were taken at the time. It was reported that:

- The Links had a patient focused team.
- There are issues surrounding the state of repair of the building.
- Service user care obtained and feedback was very positive.
- The full report will be provided when completed.

The Chair **NOTED** that there is no current report available.

MHCLC 16/115 MENTAL HEALTH MEASURE MONITORING REPORT SBAR / REPORT

The Director of Operations, Mr. Ian Wile and Chief Operating Officer, Mr. Steve Curry discussed the report submitted outlining that Mental Health Services were compliant up until the end of the reporting period, but a spike in referrals due to the high publicity from the media and royal family exposure around Mental Health. Extra resources have been input into the team due to the high demand.

- Direct access for GP via electronic access
- CAMHS took back some referrals to recover the high demand
- In September the recovery period was complete and the compliance rate is 100%.

Earlier in the year the target of 80% has now increased to 97% and the amount of rightsizing from the team due to the demand and capacity within the service has reached a high sustainable level.

The predicted rate of referrals was high and the actual level of referrals stayed in line with projection.

- The Chair asked when would the CAMHS service reach their target of 80%, this was delivered in October, and a trajectory coming close to the time. Further explanation to wait until the presentation delivered.
- Based on weekly reporting, if it is being stretched beyond capacity, the community vacancies can be filled for drafting in support staff.
- PARIS will be fully effective for CAMHS in the near future.
- Meetings are underway and issues have been identified with data capturing.
- Patients cancelling appointments rests the 28 day clock for assessments. The patient's files are currently being checked by hand. Multiple staff will be checking every month and therefore it is not sustainable long term.
- Amount of data captured by PARIS
- High Waiting List Demand
- CAMHS delivered 86% on PART 1 of the Measure, fluctuating but overall sustainable, improving trajectory.

The Chair **NOTED** the report.

MHCLC 16/116 COMPLIANCE UPDATE PART 1

The report submitted was summarized by the Director of Operations, Mr. Ian Wile. The Power of Discharge group increased concern of the lack of complete Care and Treatment Plan's and the quantitative information held within such reports for the patients best interests.

There is national concern from professional bodies, with the lack of ability to measure the Health Board patients' improving health measures. There is a tool that is being supported which is added to the Care and Treatment Plan, enabling staff to determine what is the most important thing to them over the next 6 months. This can be used as an auditable tool and a simple lever to gather further information.

QUALITY OF CARE AND TREATMENT PLANS – PART 2

The Director of Operations Mr. Ian Wile gave a brief overview on the holistic nature of the care plan, currently being reported on twice a year, improving

the position of the Care and Treatment plans and possible random auditing. The Chair opened up for comments:

- Many service users may not be aware of the measure and their care and treatment plan, have not been involved in formulating their Care and Treatment plan.
- Reviews are not an interactive process and are in excess of 12 months before a review.
- Quality of the planning is not of a high standard and the understanding of how stretched the services are.
- Being unable to find further ways to encourage help, deliver on the needs of the patient to future services for input/ help.
- The Chair of the Power of Discharge group reiterated the lack of consistency in Care and Treatment plans at meetings.

The Committee **NOTED** the report.

MHCLC 16/117 UPDATE ON SUSTAINABILITY

CAMHS presentation was delivered by Dr. Jenny Hunt. Primary Mental Health service transferred back last April with a long waiting list, aiming to reduce the list and arrive at targets. Dr. Jenny Hunt iterated there were over 60 referrals a month which impacted on the demands of the service, job plans, assessments and interventions. The targets of 80% were reached. The increase of referrals has risen to 15-20 daily.

Adult Mental Health services helped by assessing the 16-17 year olds and have now been referred back to CAMHS directly.

- Electronic referrals system
- PARIS
- Allocation of referrals
- Telephone triage for young people
- CSI have reviewed the service and provided a modeling tool for capacity

The Chair opened up for comments/ discussions, the following were raised:

- The measure particularly with children and young people can be classed as early intervention. Trying to deliver the measure has proven difficult within primary mental health services thus resources are consequently stripping demand on the service.
- The demands on the service are to be evaluated and all aspects to be taken into account on re-sizing the service, identifying professionals for the job, working upstream and in a preventative manner to enable people to enter the services at the correct time and receive the correct

referrals, appointments and the indicators surrounding the robustness of assessments.

- The unmet need has not been truly explored but the growth would be factored into the growth of demand.
- The upstream working model and the partnership arrangements are being piloted.

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ADULT PRESENTATION

The Director of Operations, Mr. Ian Wile gave a brief overview of the presentation and the involvement within the 3rd sector.

The collaboration with Mind and the Vale, ACE and outside services for social and wellbeing.

Welsh Government came out to employ bank psychiatric nurses, services around Wales are limited and are trying to employ multi-disciplinary professionals.

The Services have been compliant since September / October 2017.

The Committee **NOTED** the report.

MHCLC 16/118 PROVISIONS OF MENTAL HEALTH SUPPORT TO PRISONERS

The report was delivered by the Chief Operating Office, Mr. Steve Curry, it was decided the paper is for noting. It is being followed up with PCIC Clinical Boards and IMTP Plan going forward.

The Committee **NOTED** the paper.

MHCLC 16/119 COMMITTEE WORK PLAN

The Chair discussed that the Terms of Reference will be brought to the next meeting.

MHCLC 16/120 HOSPITAL MANAGERS' POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/121 REVIEW OF THE MEETING

The meeting was reviewed, it was noted the Chair wants this Committee to be legislative, there will on occasion have overlaps that will feed into the Committee.

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MHCLC 16/122 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 6th February 2019 in the Boardroom, Headquarters, University Hospital of Wales.

ACTION LOG FOLLOWING MHCLC MAY 2017

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
MHCLC 16/110	29.11.17	DNA CPR	To ask the Resus Team to include a question about consultation where patient lacks capacity to be involved in discussions about CPR in the audit template.	J Barrell	In progress
MHCLC 16/110	29.11.17	DNA CPR	The Senior Nurse, Resuscitation Service and MCA Manager will co-ordinate a Senior Medical Staff Grand Round session to cover DNACPR and the law. Guidance will be published in the Medical Directors Bulletin.	J Barrell / G Shortland	In progress
MHCLC 16/110	29.11.17	DNA CPR	The Medical Director, Mental Capacity Act Manager and the Resuscitation Service will recommend, in a paper to the Quality, Safety and Patient Experience Committee, that this issue is considered as part of the routine reports to that Committee by the Clinical Boards. The support of the Chair of the MHCLC in raising this issue with the Chair of the Quality, Safety and Patient Experience Committee is requested as an action	G Shortland / J Barrell / Resus Team / MHCLC Committee Chair	In progress
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
MHCLC 16/046	9.8.16	MCA Clinical Board Reports	Include Clinical Board compliance with the Mental Capacity Act and training within the performance management framework.	S Curry	COMPLETE to stay on log for monitoring purposes.

MHCLC 16.028	10.05.16	Section 136 Partnership Arrangements	Check figures for the under 18s, CAMHS absconders and children cared for on an adult ward	I Wile	Data was hard to obtain. It was believed that no children had been affected – this will be double checked. Update to be received at May 2017 meeting
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Seek ideas from volunteers and the Third Sector to enable patients to purchase cigarettes.	I Wile	Update to be received at May 2017 meeting - COMPLETE
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Bring the benefits realization report for Welsh Government to Committee after the first year.	I Wile	October 2017 – To be disseminated when COMPLETE
MHCLC 16/050	9.8.16	MHA Exception Report	Ask the Police to provide details of BME within the Section 136 figures.	I Wile	October 2017 – To report to another Committee

Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team

The Cardiff and the Vale DOLS / MCA Team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff and Vale UHB, City of Cardiff Council and Vale of Glamorgan Council, through a partnership management board consisting of senior representatives of each Supervisory Body.

The team acts on behalf of the three Supervisory Bodies in the:

- **Coordination of DoLS assessments as requested by Managing Authorities by undertaking the following assessments:**
 - Age - 18 and over
 - Mental Illness- Is medically diagnosed with a mental disorder
 - Mental Capacity - Lacks capacity for the decision to be accommodated in the hospital or care home
 - No refusals - there is no Advanced Decision previously made to refuse treatment or care, or conflict relating to this such as LPA or Deputy
 - Eligibility - This determines whether the person meets the requirements for detention under the Mental Health Act 1983;
 - Best Interests - The person needs to be deprived of liberty for reasons of health, safety and best interests.
- **Supervision and workload management of over 20 Best Interest Assessors;**
- **Advice and support to health and social care teams across the sector in relation to MCA/DoLS issues;**
- **Training for care homes and all inpatient sites across the hospitals of Cardiff and the Vale of Glamorgan areas.**

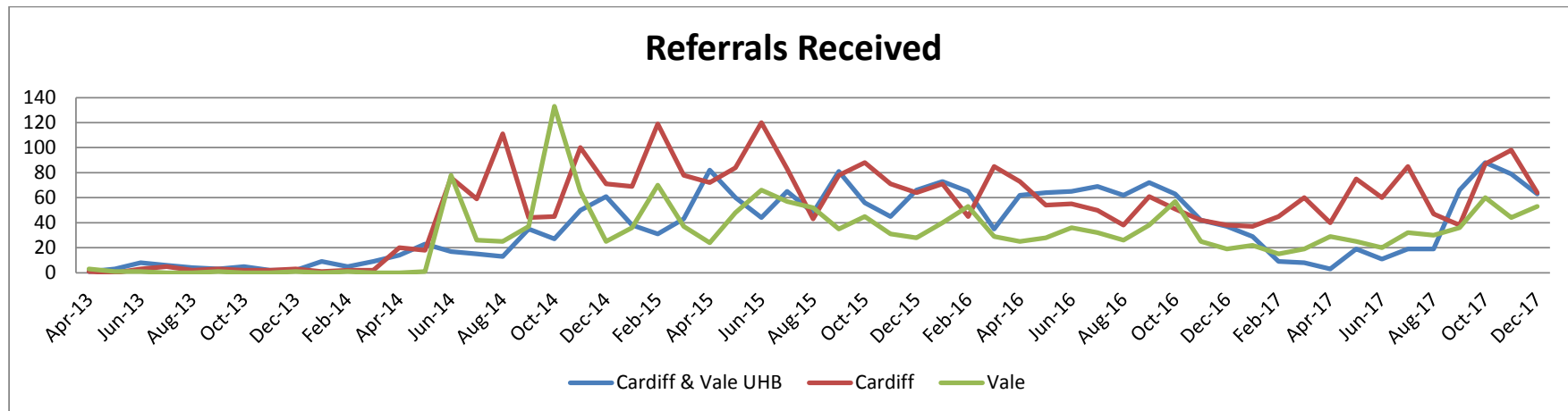
The DoLS team is based in the Vale of Glamorgan and consists of:

- 1 full time administrator
- 1 full time DOLS/MCA Coordinator (Band 7)
- 2.5 full time Best Interest Assessors

- 1.0 full time Best Interest Assessors (Cardiff Council funded)
 - Cardiff Council withdrew 1.0 FTE BIA from the team in July 2017
- 1.0 full time Best Interest Assessor (Vale of Glamorgan funded)
- 11 rota'd Best Interest Assessors

Referral rate...

The effects of the revised definition of Deprivation of Liberty following the Cheshire West Ruling continue to impact on the number of requests for Standard and Urgent Authorisations as described in the graph below. It is noticeable that in the three and a half years post Cheshire West, the number of referrals has remained high, but is stabilising leading to greater confidence in workforce planning.



Cardiff and Vale DoLS Partnership Board Report
24th January 2018

The table below shows the number of DoLS referrals per Supervisory Body over the last 4 years.

REFERRALS	2013/ 14	% of Referrals	2014/15	% of Referrals	2015/16	% of Referrals	2016/17	% of Referrals	2017/18 (until end Dec 17)	% of Referrals (until end Dec 17)
Cardiff	32	34.4%	866	49.1%	778	39.4%	882	41%	594	46%
Vale Council	6	6.4%	489	27.7%	534	27%	424	20%	329	26%
C&V UHB	55	59.1%	406	23%	661	33.5%	837	39%	367	28%
Total	93	100%	1761	100%	1973	100%	2143	100%	1290	100%

It is interesting to compare the relationship between the total number of care home beds with the total number of DoLS Authorisation requests with the total number of relevant care home beds in the area. During 2016/17 the Vale of Glamorgan received 424 DoLS Requests from 903 care home beds; 882 Requests for 2091 beds in Cardiff while we received 837 for 1711 adult hospital beds across the UHB. It is interesting to note a ratio of 1 request to 2.1 in the Vale, 1 request to 2.3 Cardiff Care Home beds is comparable to 1 to 2.0 hospital beds.

Best Interest Assessments

ASSESSMENTS	Completed Assessments 2015/16	% Completed Assessments 2015/16	Completed Assessments 2016/17	% completed assessments 2016/17	Completed Assessments 2017/18 (as of Dec 17)	% completed Assessments 2017/18 (as of Dec 17)	Outstanding Assessments
Cardiff Council	305	32.4%	409	36%	176	25%	1127
Vale Council	216	22.9%	191	17%	102	14%	612
C&V UHB	419	44.5%	522	47%	442	61%	174
Total	940		1122		720		1913

Cardiff and Vale DoLS Partnership Board Report
24th January 2018

The Welsh Government Expert Group have estimated by talking to each Supervisory Body that each DoLS Assessment takes on average one whole working day when taking into account the coordination, interview, consultation and administration for each assessment. The Cardiff and Vale DoLS Team averages 1.5 assessments per BIA, per working day.

It should be noted that the DoLS Team is not able to meet the statutory timescales (21 day) for Standard Authorisation Requests. We are currently one year behind timescale, but this is slowly reducing. The team is able to meet statutory timescales for Urgent Authorisation Requests which primarily are made from hospital wards. The Partnership Board has accepted that Urgent Requests need to be prioritised, the Operational Manager along with the DoLS Co-Ordinator has reviewed the Prioritisation Matrix and continue to use this in prioritising workload.

DoLS Authorisations

The Authorisation of completed DoLS assessments is an essential and important part of safeguarding vulnerable people. The Code is clear that the Authorisation must be undertaken by a senior manager independent of the provision of the care. The Partnership Board is asked to note that:

- Cardiff Council have recruited a MHA/MCA Lead to act as main Authoriser which has seen a significant reduction in the number of assessments awaiting authorisation (previously outstanding numbers were 76 March 2017; 63 Sept 2017)
- C&V UHB are reviewing their Authoriser protocol;
- Vale of Glamorgan will continue with OM and HoS Authorisation

AUTHORISATIONS	Outstanding Authorisations on 24 Jan 2018
Cardiff Council	1
Vale Council	1
C&V UHB	55

Cardiff and Vale DoLS Partnership Board Report
24th January 2018

Section 12 Doctors

Currently each and every DoLS Assessment requires a mental health and eligibility assessment by a Section 12 (MHA83) medical examiner at a cost of £182. The cost per Supervisory Body is indicated in the table.

The LPS scheme, although requires a medical assessment, the independent reviewer is able to make use of existing medical assessments rather than commissioning a stand-alone assessment. This represents a significant saving over the resource heavy DoLS process.

Use of Section 12 Doctors	Total number of occasions Sec 12 doctor used (2016/17)	Total Cost (£)
Cardiff Council	409	£74,454.36
Vale Council	191	£34,769.64
C&V UHB	522	£100,486.08

RPR/IMCA Reviews

The role of the IMCA/Relevant Persons Representative in protecting the rights of people deprived of their liberty cannot be overstated. *AJ vs A Local Authority* [2015] reminded supervisory Bodies of the duty to nominate a paid RPR (IMCA) where the SB is not satisfied that the relevant person has a representative to appropriately maintain contact, represent and support him or her. The table shows the number of referrals for a paid RPRs per authority and the number of reviews requested by RPRs.

Relevant Persons Representative in 2016/17	Total Number of IMCA referrals	Total Number of Reviews requested
Cardiff Council	312	5
Vale Council	139	5
C&V UHB	?	6

Partnership Agreement

Further to a recent Vale of Glamorgan internal Audit, a formal partnership agreement has been proposed, utilising Vale of Glamorgan template setting out the following:

- Function of Partnership Board
- Confirmation of Vale of Glamorgan as lead provider
- Confirmation of Funding agreement
- Resolution of complaints
- Quality Assurance
- Information Sharing Protocol

Cardiff and Vale Partnership Funding

FUNDING	Current Funding Equation	Funding Outturn 2015/16	Actual Funding %	% of Referrals	Funding based on Referrals	% Completed Assessments 2016/17	Funding Based on Comp Ass
Cardiff Council	40.74% (+1BIA)	£155,000*	52.9%	41%	£119,940	36%	£105,313
Vale Council	14.65% (+1BIA)	£60,829	20.7%	20%	£58,507	17%	£49,731
C&V UHB	44.61%	£76,708	26.2.0%	39%	£114,089	47%	£137,492
	100%	£292,537	100%	100%	£292,537	100%	£292,537

*including additional BIA at £45k

Assuming, that the Cardiff and Vale DoLS Team undertook assessments according to the actual funding percentages paid into the Team: Cardiff Council had 184 fewer completed assessments than paid for, Vale had 41 fewer than paid for while the UHB had 228 more than paid for.

	Actual Funding % 2016/17	No. of assessments according to funding %	Difference between allocation and actual
Cardiff Council	52.9%	593	-184
Vale Council	20.7%	232	-41
C&V UHB	26.2%	294	+228

Cardiff and Vale DoLS Partnership Board Report
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Assuming the DoLS Team completes 800 to 1000 assessments during 2017/18, and the actual funding proportion as at 16/17 (17/18 figures not available at time of writing): the number of completed assessments funded per Authority is shown in the table opposite.

	Actual Funding % 2016/17	Number of funded assessments at 800 per year	Number of Assessments at 1000 per year
Cardiff Council	52.9%	424	529
Vale Council	20.7%	166	207
C&V UHB	26.2%	210	262

2017/2018 so far...

The table below shows the number of completed assessments undertaken in the first 3 quarters of 2017/18. At the end of August 2017, the Team had already completed the number of funded assessments for the UHB. Any further DoLS assessments completed by the Cardiff and Vale DoLS Team for the UHB Supervisory Body have been entirely funded by Cardiff and Vale of Glamorgan Councils. However, in January 2017 the UHB agreed an additional amount of £7,000 until the end of this financial year, bringing the overall year end contribution to £83,708.

It is evident that the original funding contributions within the partnership has continued to be disproportionate to the output of assessments completed for each party. There are ongoing discussions from the UHB in terms of ongoing additional funding and it is anticipated that this will be secured for 2018/19.

The next Board report will provide a year-end final figure for all referrals received; number of assessments completed and comparative data analysis for the % completed against the funding contribution.

2017/18	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Total
Cardiff Council	22	19	24	10	16	20	13	18	16	158
Vale Council	8	12	3	15	5	12	12	12	7	86
C&V UHB	40	57	54	55	55	21	44	49	42	472

Issues to consider

The Cardiff and Vale DoLS Partnership Board is asked to note and consider:

Best Interest Assessors capacity/resource

- Ongoing risk associated with the number of outstanding DoLS Authorisation requests.

DoLS Team Funding

- The UHB might wish to consider increasing funding to the DoLS Team to ensure continued compliance with the safeguards
- Renegotiating the DoLS funding equation or revising funding arrangements

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider – this needs to be agreed and signed off
 - Information Sharing Protocol - this needs to be agreed and signed off
-

Natasha James

Operational Manager, Safeguarding & Service Outcomes

Vale of Glamorgan Council

MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT	
Name of Meeting:	Mental Health and Capacity Legislation Committee
Date of Meeting:	6 th February 2018
Executive Lead: Medical Director	
Author: Mental Capacity Act Manager – tel: 029 2074 3652	
Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together..."	
Financial impact: No direct impact of this report, but the failure to comply with MCA could lead to costly complaints and litigation	
Quality, Safety, Patient Experience impact: Adherence to MCA will mean that vulnerable patients will receive the treatment and care they need, in line with their best interests.	
Health and Care Standard Number 4.2	
CRAF Reference Number 8.1.3	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The foundations for MCA to become embedded in clinical practice are in place (e.g. training in a variety of formats), but the limited uptake of training by clinical staff (especially doctors) and the issues encountered by the IMCA service show that there is still a way to go before MCA is properly understood and complied with

The Committee is asked to:

- **AGREE** this report and support the Medical Director to improve the uptake of MCA training by doctors.

SITUATION

The Mental Health and Capacity Legislation Committee has agreed that regular reports, providing information about the UHB's use of the Mental Capacity Act 2005 (MCA), should be tabled.

It is important to note that this information does not provide direct assurance about compliance with MCA: rather, it provides an indication of awareness of and use of MCA throughout the UHB.

Demonstrating compliance with MCA can only be done by scrutinising patients' notes. It is clear that work needs to continue with MCA to embed this in clinical practice within the UHB.

BACKGROUND

The Mental Capacity Act 2005 (MCA) came into force mainly in October 2007 – over a decade ago. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for authorizing deprivation of liberty when adult, mentally disordered, incapacitated people are deprived of their liberty in hospitals or care homes (DoLS)

People, aged 16 years and over, who have impaired decision-making abilities may present in any of the services that the UHB provides.

It is not possible to state how many people with impaired decision-making abilities are patients of the UHB, but the likelihood is that it is a significant minority. Nor is it possible to know how many decisions UHB staff are making on behalf of people who cannot take those decisions for themselves.

Failure to comply with MCA could lead to the following –

- Patients refusing treatment that they need and their refusal being taken at face value, with no assessment of their capacity to make the decision being made. This could (and does) result in serious harm to vulnerable patients
- Patients not receiving care and treatment tailored to their individual circumstances
- Patients being kept unnecessarily in hospital, because staff are either ignorant of the MCA decision-making process or are not confident in using it
- Healthcare professionals and the UHB being sued, prosecuted, complained about and being reported to professional bodies
- Adverse inspection reports and publicity for the UHB

In order to assist UHB staff with understanding and using MCA, the following are in place -

Training (mandatory)

- A module of the EIDO consent e-learning course (not linked with the electronic staff record (ESR))
- Face-to-face teaching from the MCA Manager including Monthly UHB wide sessions at various locations, “Mandatory May and November” training and Senior Medical Induction
- Bespoke training on request
- The All-Wales MCA e-learning course is available for use on ESR

Information and advice

The MCA Manager provides information and advice to UHB staff on all aspects of MCA. There is also a “Mental Capacity” page on the intranet.

Policies and procedures

A number of policies and procedures are in place to support UHB staff in implementing MCA. The MCA Manager also tries to ensure that other policies adequately and accurately reflect MCA where appropriate.

Additional information

Use of MCA within the UHB

Appendix 1 sets out information that indicates the use of MCA within the UHB.

Independent Mental Capacity Advocacy

See also the report (Appendix 2) provided by Advocacy Support Cymru (ASC) – the statutory advocacy provider.

Clinical Board MCA Leads

The following updates have been provided by the MCA Leads –

PCIC CB

- Covert Medication guidelines for the UHB, primary care and care homes developed. Scoping exercise underway to determine numbers of patients in care homes in one area who are being given covert medication. Training on the use of the guidelines in train for GPs. MCA central to this issue, so the guidelines will help to embed MCA within practice
- An audit of mental capacity assessments is being undertaken in District Nursing

Surgery CB

- Mental capacity assessments will be included in a LocSSIP (Local Safety Standards for Invasive Procedures) that is being developed for trauma procedures carried out in either in-patient wards or in outpatients

Specialist Services CB

- The CB's Directorates will be undertaking mental capacity assessment audits by the end of January

Dental CB

- An audit of mental capacity assessments is being carried out for special care dentistry patients requiring dental general anaesthesia in SSSU, UHW

CD&T CB

No update received

Women and Children CB

No information received

Medicine CB

Working with Cardiac re issues to do with replacing pacemaker batteries, etc, when patient very frail. Will be trying to implement advance care planning, so the views of the patient can be captured about battery replacement at the time the pacemaker is installed.

Mental Health CB

No information received.

ASSESSMENT AND ASSURANCE

It is clear that MCA is still not embedded in clinical practice and further education and raising of awareness is required. In particular training strategies for greater uptake of training for doctors needs to be explored.

APPENDIX 1

Mental Health & Capacity Legislation Committee
MENTAL CAPACITY ACT ISSUES AND INFORMATION
 February 2018

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/1/16 – 31/3/16	24
1/4/16 – 30/6/16	18
1/7/16 – 30/9/16	23
1/10/16 – 31/12/16	26
1/1/17 – 31/3/17	30
1/4/17 – 30/6/17	28
1/7/17 – 30/9/17	36
1/10/17 – 31/12/17	19

There are no obvious themes or trends to the queries. Some are straightforward, whilst others are complex.

This is an example of a simple query – How do staff make a referral to the IMCA service?

This is an example of something more complex – Can the attorney of a personal welfare Lasting Power of Attorney block the discharge from hospital of a patient who lacks mental capacity to decide about where she should be?

2) Monitoring reports from the Independent Mental Capacity Advocacy (IMCA) service

Referrals from the UHB to IMCA are as follows:

Decision/Issue	Oct–Dec 16	Jan-Mar 17	Apr – Jun 17	July – Sept 17
Accommodation	10	16	18	15
POVA Safeguarding	0	2	2	3
Care Review	2	6	1	2
Serious Med T/ment	6	4	5	6
DoLS s.39A	0	1	4	1
DoLS s.39C	1	0	0	0
DoLS s. 39D	4	7	5	9
DoLS RPR	74	76	82	83
TOTAL	97	112	117	119

For further information, please see the IMCA service report (Appendix 2)

The very high use of IMCA as the patient's Relevant Person's Representative under DoLS – by far the largest proportion of the referrals - continues to cause serious workload pressures for the IMCA service.

3) Healthcare Inspectorate Wales (HIW) reports

1 inspection report, published between the beginning of July and the end of December 2017, were found on HIW's website –

Noah's Ark Children's Hospital – whilst it was made clear in their report that the Children's Hospital caters for young people aged over 16, to whom the Mental Capacity Act may apply, there was no mention of MCA in HIW's report.

5) Complaints from patients/carers

2 complaints concerning or related to MCA issues during the period July – December 2017 have been brought to the attention of the MCA Manager. However, it is very likely that there are other complaints in this period which include MCA issues.

- Complaint from a relative about the refusal by staff to share medical information about a patient who temporarily lacked mental capacity to agree or not to the sharing of the information. However, in the past when his capacity was unimpaired, he had made it clear to staff that he did not want his medical information shared with his relatives
- Dispute about whether a patient had mental capacity to decide about discharge destination from hospital

6) Public Services Ombudsman for Wales reports - <http://www.ombudsman-wales.org.uk/en/publications/The-Ombudsmans-Casebook.aspx>

The Ombudsman's Case Book for the periods July - September 2017 includes 2 cases that were upheld against Cardiff and Vale UHB. MCA issues were not explicitly mentioned in either case, although it is possible that in one of the cases the patient may have had impaired decision-making.

7) Other – e.g. serious incidents

Common issues are falls and the development of pressure sores. Between July and December, there were at least 3 serious incidents involving patients who had cognitive impairments.

8) Staff training

CLINICAL BOARD	Prof Group	% trained to end of Oct 2017	% trained to end of Nov 2017	% trained to end of Dec 2017	
Children & Women					
	Allied Health Profs	8.33	25	33.3	
	Nursing & Midwifery	42.44	47.47	50	
	Medical and Dental	4.2	10.79	11.37	
CD&T					
	Allied Health Profs	64.69	70.19	71.64	
	Nursing & Midwifery	64.58	70.83	70.21	
	Medical and Dental	16.67	20.59	22.33	
Dental					
	Allied Health Profs	100	100	100	
	Nursing & Midwifery	81.82	90.91	90.91	
	Medical and Dental	62.02	65.89	64.84	
Medicine					
	Allied Health Profs	0	0	0	
	Nursing & Midwifery	42.04	55.02	55.02	
	Medical and Dental	6.5	7.29	7.29	
Mental Health					
	Allied Health Profs	68.75	81.25	78.79	
	Nursing & Midwifery	44.62	49.05	51.25	

	Medical and Dental	15.38	17.95	23.08	
PCIC					
	Allied Health Profs	76.83	79.27	79.27	
	Nursing & Midwifery	39.14	45.53	45.53	
	Medical and Dental	7.89	10	10	
Specialist					
	Allied Health Profs	36.84	40.48	47.62	
	Nursing & Midwifery	38.28	46.59	49.47	
	Medical and Dental	9.05	10.51	11.74	
Surgery					
	Allied Health Profs	8.33	25	33.33	
	Nursing & Midwifery	42.44	47.47	50	
	Medical and Dental	4.21	10.82	11.40	

These figures do not include the EIDO online consent training course, which includes a module on mental capacity. It is not clear what impact the inclusion of the EIDO course would have on these figures. However, it is very concerning that the doctors appear to continue to have a low uptake of training. The Medical Director will be looking at the question of Mandatory training in doctors generally and MCA training.

Clinicians must not provide treatment and care to patients outside of the legal framework that covers these issues - in general, patients can only be treated/cared for with valid consent, or through Mental Capacity Act 2005 or Mental Health Act 1983.

It is essential that all clinicians have a good basic understanding of MCA and comply with it. If they do not, they are not protected from being sued or prosecuted in connection with the care or treatment they have provided. They are also unlikely to have a defence to complaints made against them either to the UHB or to their professional body.



APPENDIX 2

Mental Health and Capacity Legislation Committee February 2018

Provision of South East Wales Independent Mental Capacity Advocacy (IMCA)

Service issues/Areas of concern - Cardiff and Vale Health Board

- The IMCA team are experiencing an increasing number of DoLS referrals that are being sent either as the authorisation is about to expire or when P has already been discharged from hospital. We have noticed that the referrals from the DoLS team are arriving in the post in bulk, rather than as and when they are completed. For example, we recently received 13 referrals from the DoLS team via the post. Therefore, referrals that are waiting to be sent to us eat into valuable time of the authorisation period for us to support the client.
- General lack of POVA and Care Review referrals.
- IMCAs are repeatedly explaining to professionals the purpose of the Best Interests process, explaining in detail about the "least restrictive" principle and why the patient should be central to the process. IMCAs also question staff about the legal authority (or lack of it) they are using in order to impose a decision on a client who is objecting to the Best Interests outcome.
- IMCAs have encountered some professionals who have displayed confusion around capacity assessments and the fact that they should be issue specific. Some professionals/health staff appear to be of the understanding that capacity is general, and not issue specific. There have also been cases where IMCAs have been informed that someone lacks capacity, but there is no formal capacity assessment on file/been completed.
- General lack of understanding and acknowledgement from professionals re. IMCA role.
- The IMCA team have recently received a number of referrals that are very short notice, or where a decision has already been made, Serious Medical Treatment has already taken place, or a Best Interests Meeting is due to take place the following day.
- The IMCA team have recently encountered other advocacy and paid RPR service who have been advocating for clients when an IMCA referral should have been made.
- IMCA was appointed for P regarding a move of accommodation decision. P was clear in her views that she did not want to reside in a care home, despite a decision made by the MDT that concluded it was in her best interests to reside in a residential setting. IMCA asked if P could have the opportunity to visit a placement so that she would be more informed on the decision making process, however the IMCA was informed that this would not be possible for reasons that are unclear. The IMCA also produced a report questioning what authority was going to be used to facilitate the move. Following the report being sent, the IMCA was informed that the social worker involved was no longer acting on the case, and a new social worker was to be allocated. The next time the IMCA contacted the ward for an update he was informed that P was going to be placed at a care home the following day, which had been facilitated by the new

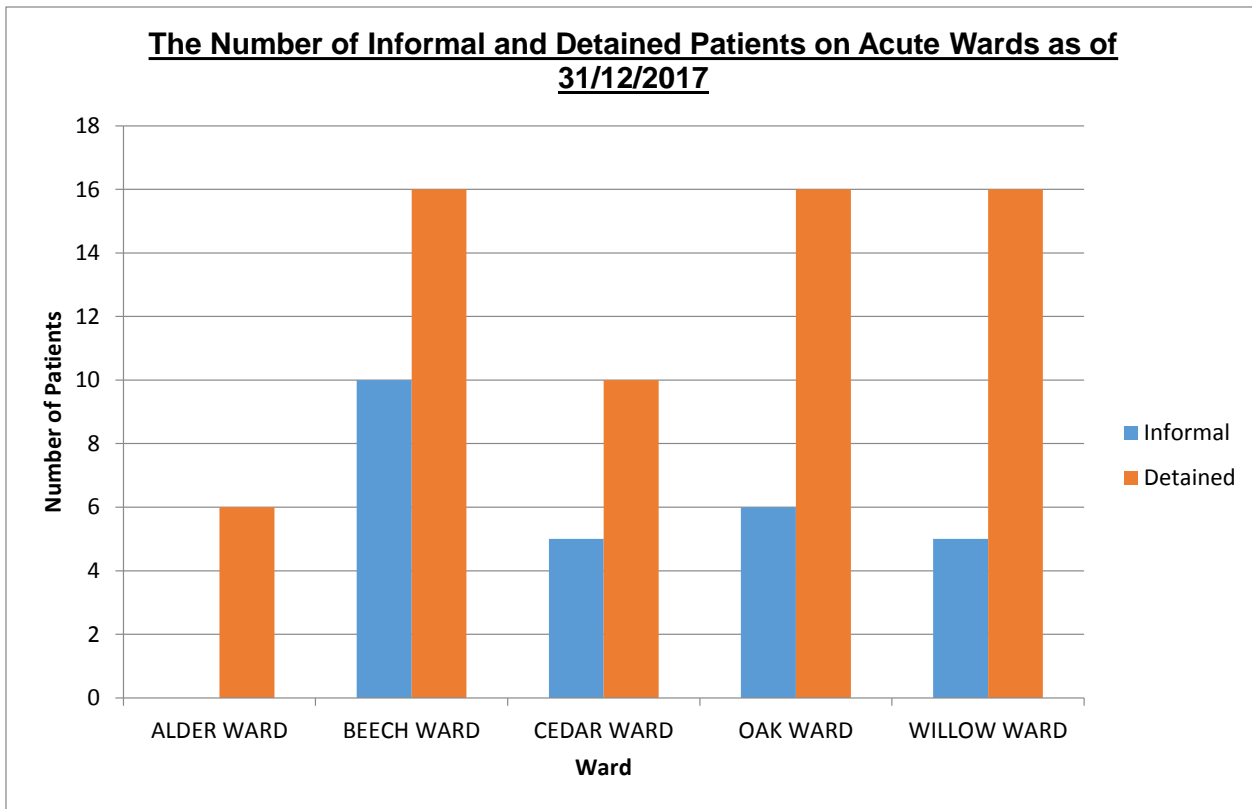
social worker. The IMCA had not had any contact from the newly appointed social worker, and it is not clear as to whether they have read the IMCA report. It is also unclear as to what authority they had used to move this P to a care home against her wishes. Despite clarifying with the ward that they had made an application to the DoLS team, no valid authorisation was in place on the ward at the time when she moved.

- IMCA was appointed as RPR for P. However, on receiving the DoLS authorisation the Form 3 Best Interest Assessment contained little to no information about the P's background history or indeed what P's wishes and views were around the deprivation of liberty. The information provided was poor and may require a review.
- IMCA was appointed as the RPR for P, who is protesting and objecting to being on the ward and would like to return to his home. His standard authorisation is only in place for a duration of 8 weeks (03/09/2017 – 04/11/2017). However, ASC only received the authorisation for P on 10/10/2017. This means that opportunities to support P were cut in half, and there is not enough time to adequately support P to instruct a solicitor and receive legal aid funding.
- IMCA was appointed for P who had sustained a head injury and as a result had very complex support needs. For example, due to him climbing out of bed and falling, P was nursed on a mattress on the floor. There was also a language barrier which the staff on the ward were not able to resolve. IMCA visited P on the ward with an interpreter, however he was still not able to communicate his needs appropriately.
In the time that IMCA has been appointed, we have been waiting for a decision maker to be appointed, however this has still not happened. P remains as a patient in UHW with no plans regarding discharge, despite being medically stable. IMCA has raised this with the IDS team and has been waiting for updates for several weeks. The appointed IMCA was also acting as the P's RPR, however his standard authorisation expired, and despite ensuring another application for a further authorisation was made, the DoLS team have still not carried out an assessment. IMCA has contacted the DoLS team who have stated that this gentleman is on their priority list, but has remained on that list throughout the Christmas period.
- IMCA currently acting as the RPR for P, who has previously expressed an objection to being on the ward and has requested to return home. IMCA met with P and discussed her current situation on the ward. P stated that she was comfortable and safe on the ward; she also did not express a wish to return home. IMCA discussed the option of residing in care home setting, however she explained that she was nervous about the idea, but was willing to consider it. IMCA contacted the social worker in the IDS team. IMCA was informed that P's family and MDT had already agreed it was in P's best interest to reside in a care home and that placements were being identified. IMCA explained to the social worker that P had previously expressed an objection to this, and asked what measure would be taken in the event of P refusing to move to a care home. The social worker told the IMCA that she would be moved "in her best interests" and did not appear to understand that a legal framework would need to be in place (i.e. a welfare decision in the Court of Protection to resolve the dispute). IMCA is continuing to represent P, and act as an independent safeguard throughout her discharge.
- IMCA appointed for P regarding a move of accommodation decision. IMCA attended a Best Interest Meeting during which it emerged that a DNAR had been placed on P in the absence of any consultation having taken place with an IMCA. The IMCA highlighted the fact that best practice had not been followed to which the Doctor conceded that although he acknowledged that a discussion should ideally have taken place, such discussion would not have resulted in a legally binding decision being reached.

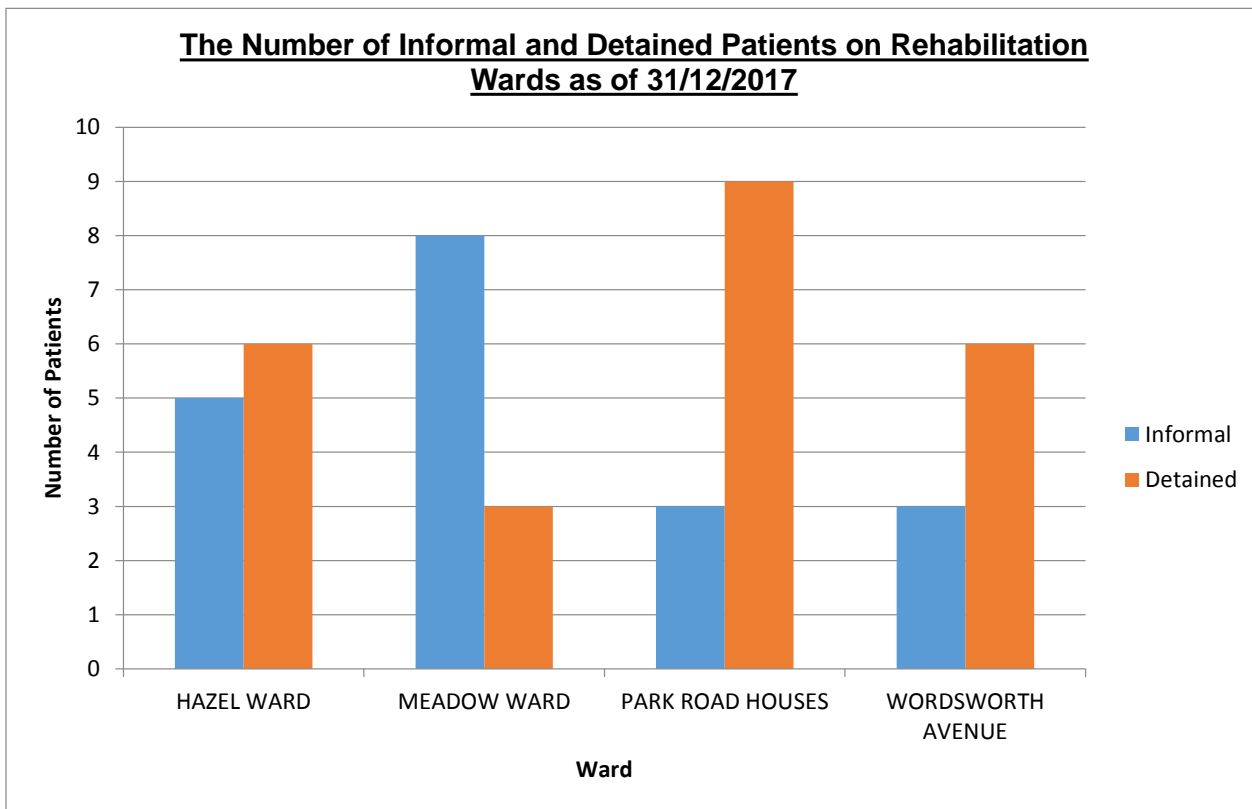


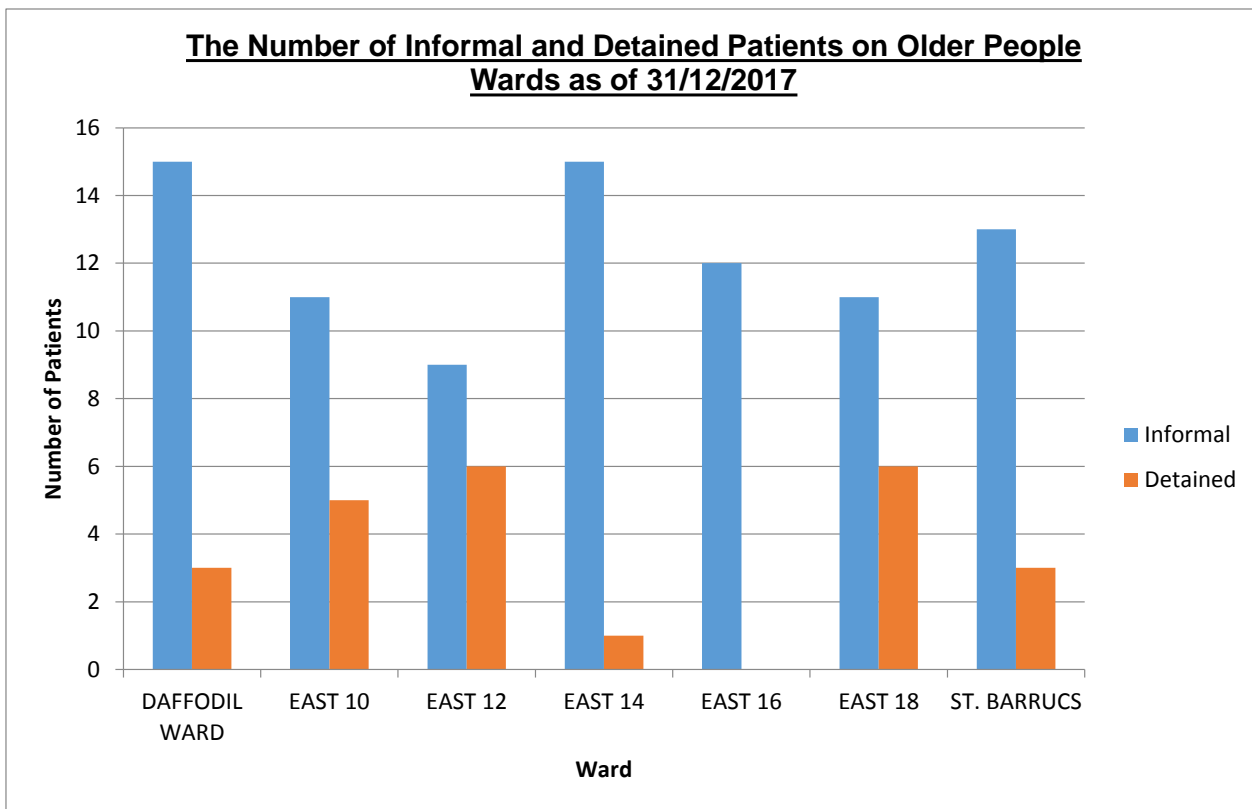
**Report to the
Mental Health and Capacity Legislation Committee
on the use of The Mental Health Act, 1983**

October - December 2017

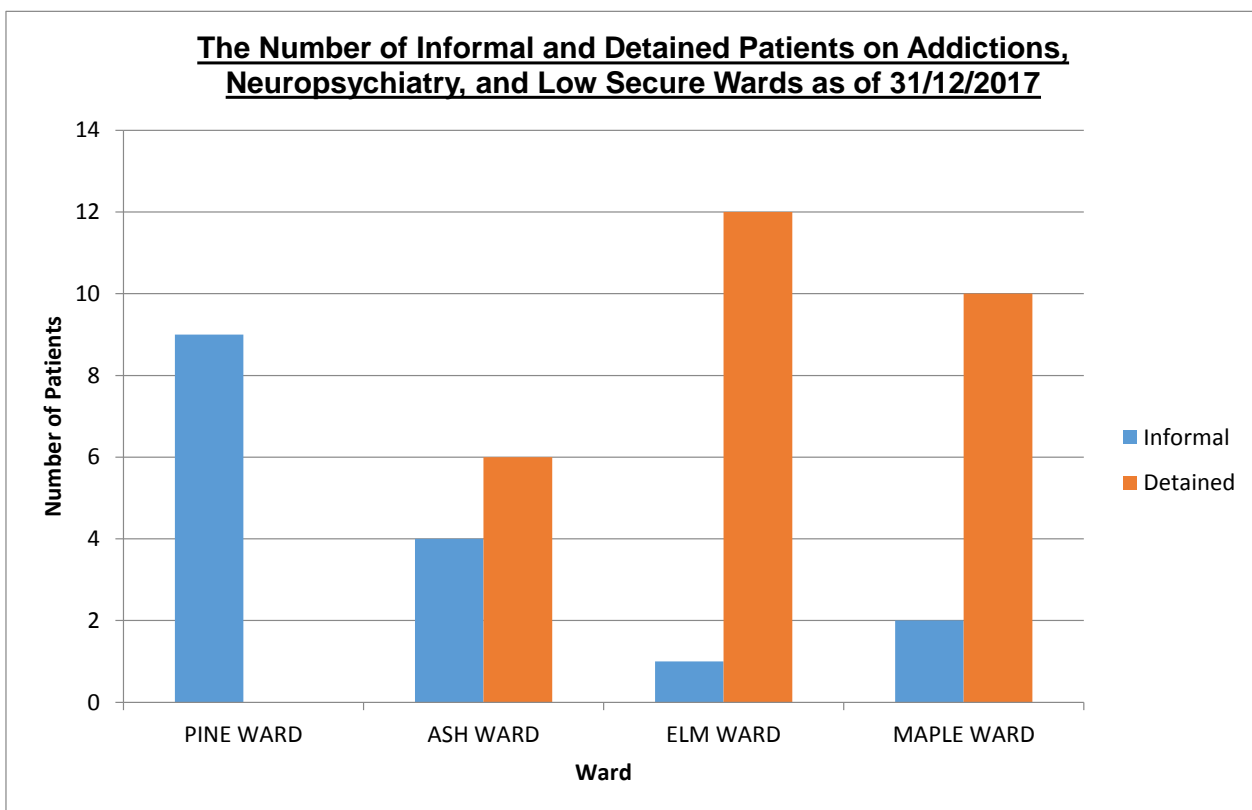


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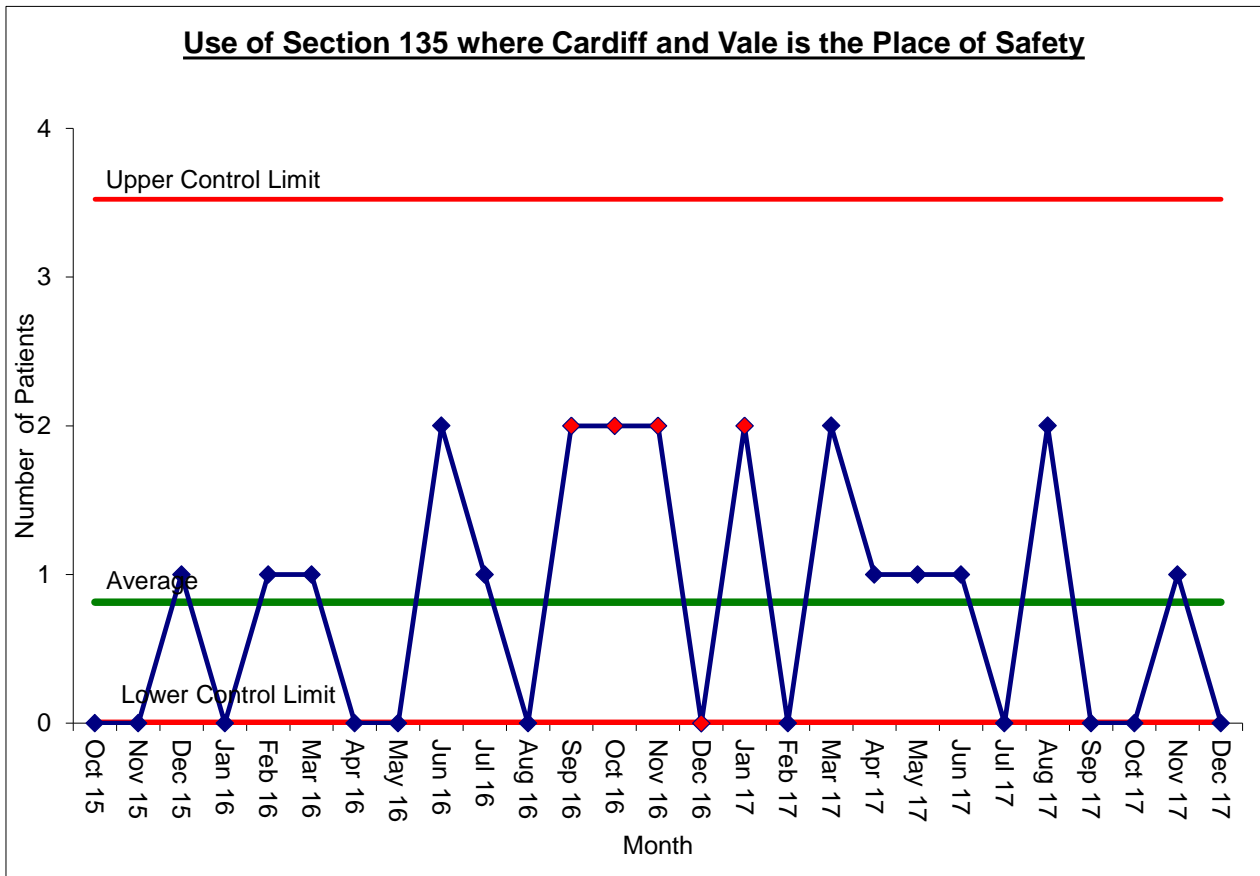


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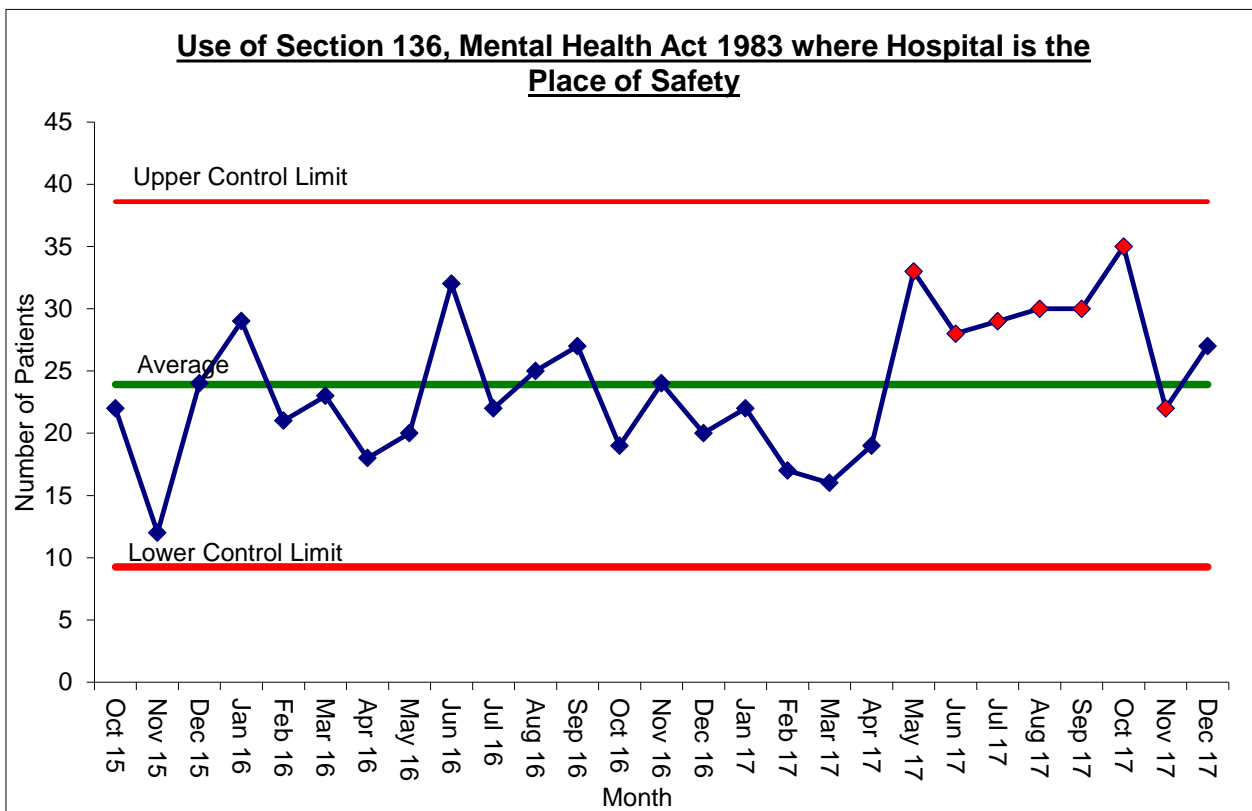


Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on one occasion. The patient was subsequently detained under Section 2.



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



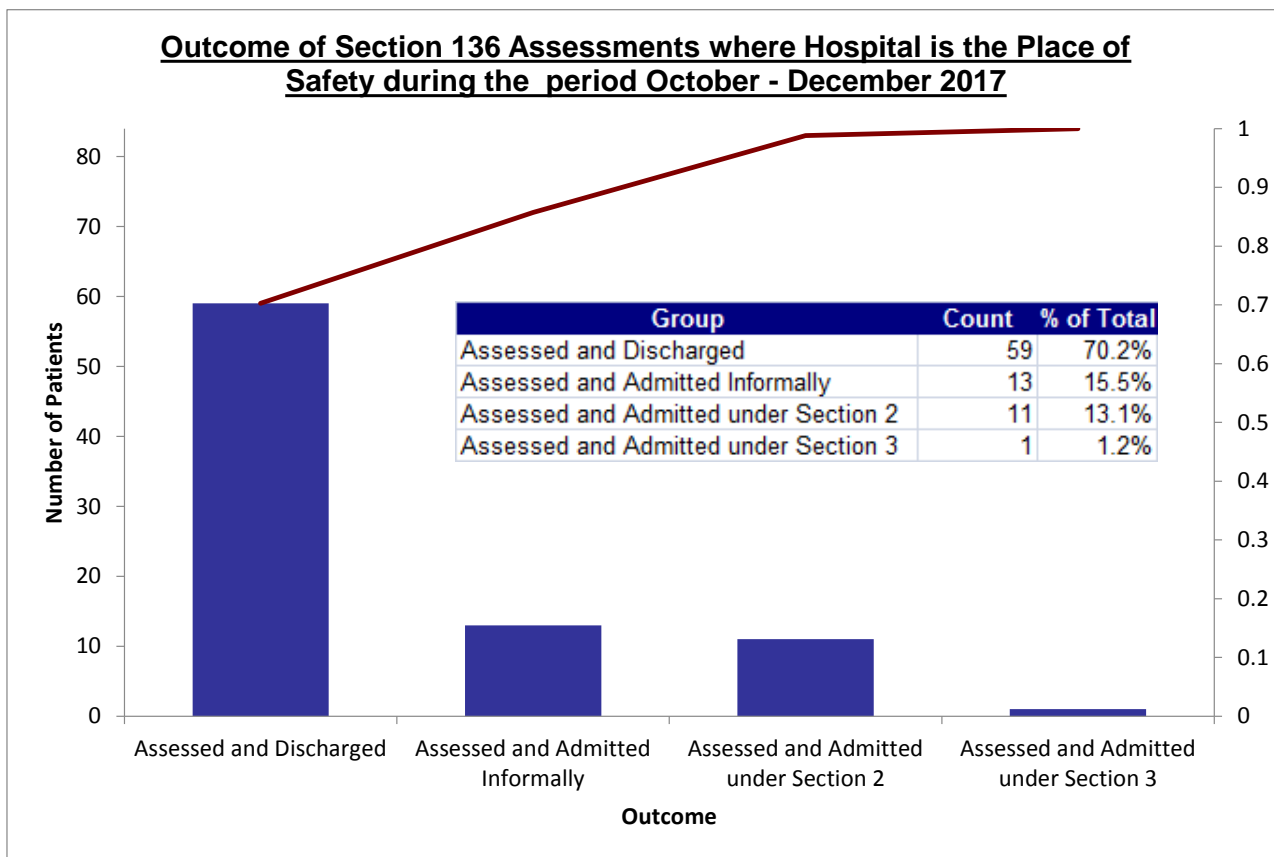
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During the period a total of 84 assessments were initiated by Section 136 powers where the MHA assessment took place in a hospital as the place of safety.

CAMHS

One of these assessments was carried out on a patient under the age of 18. The outcome was as follows:

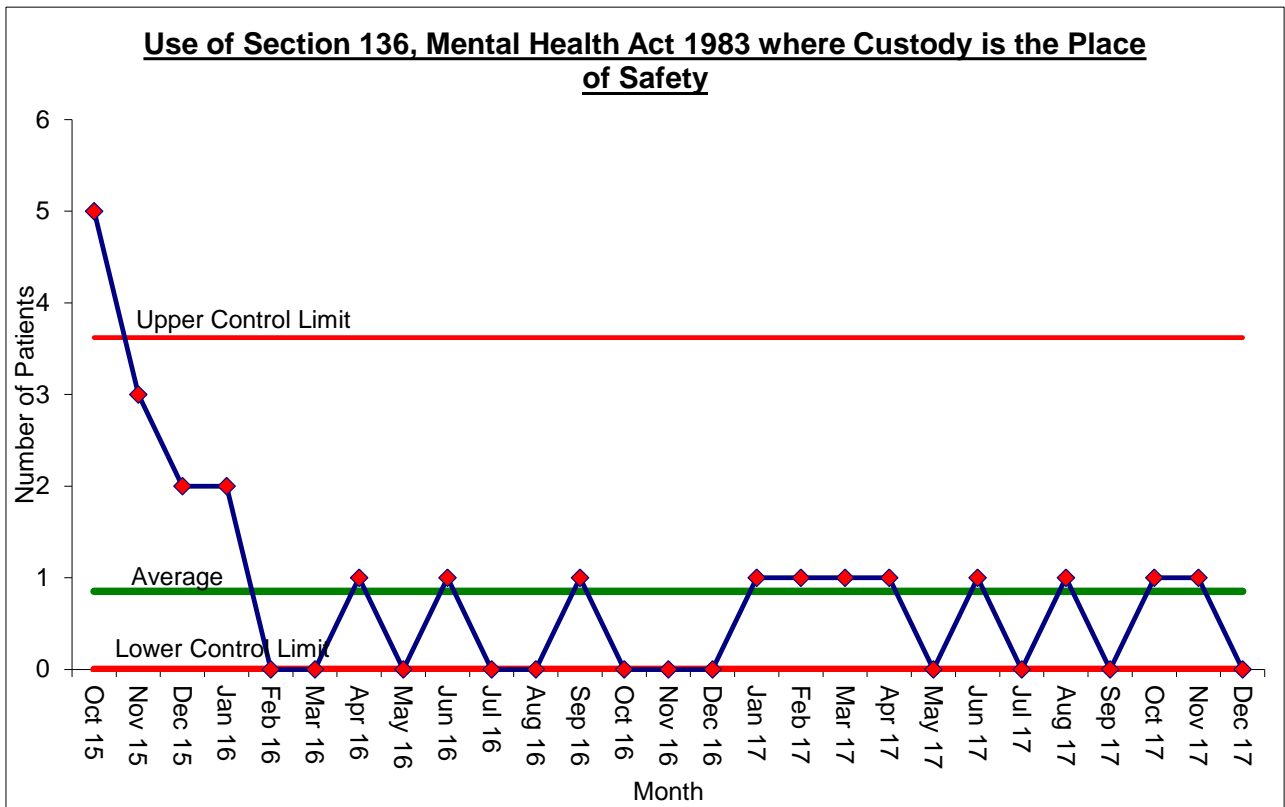
- Discharged to community services



The pareto chart highlights that 70.2% of individuals assessed in hospital under 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.

- One of the patients was admitted informally to a different Health Board

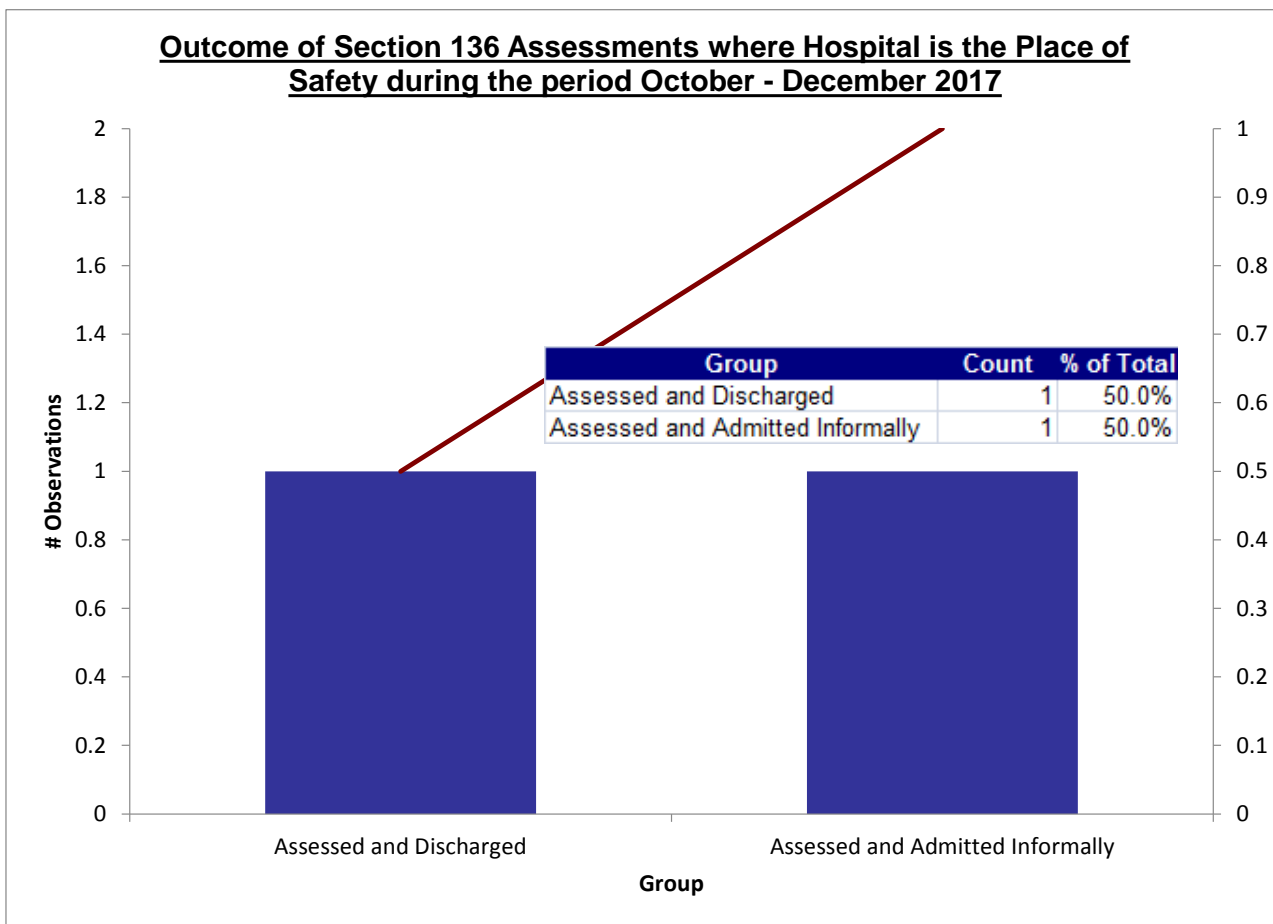
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within the police station



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During the period a total of two assessments were initiated by Section 136 powers where MHA assessment took place in Cardiff Bay Custody Suite for the following reasons;

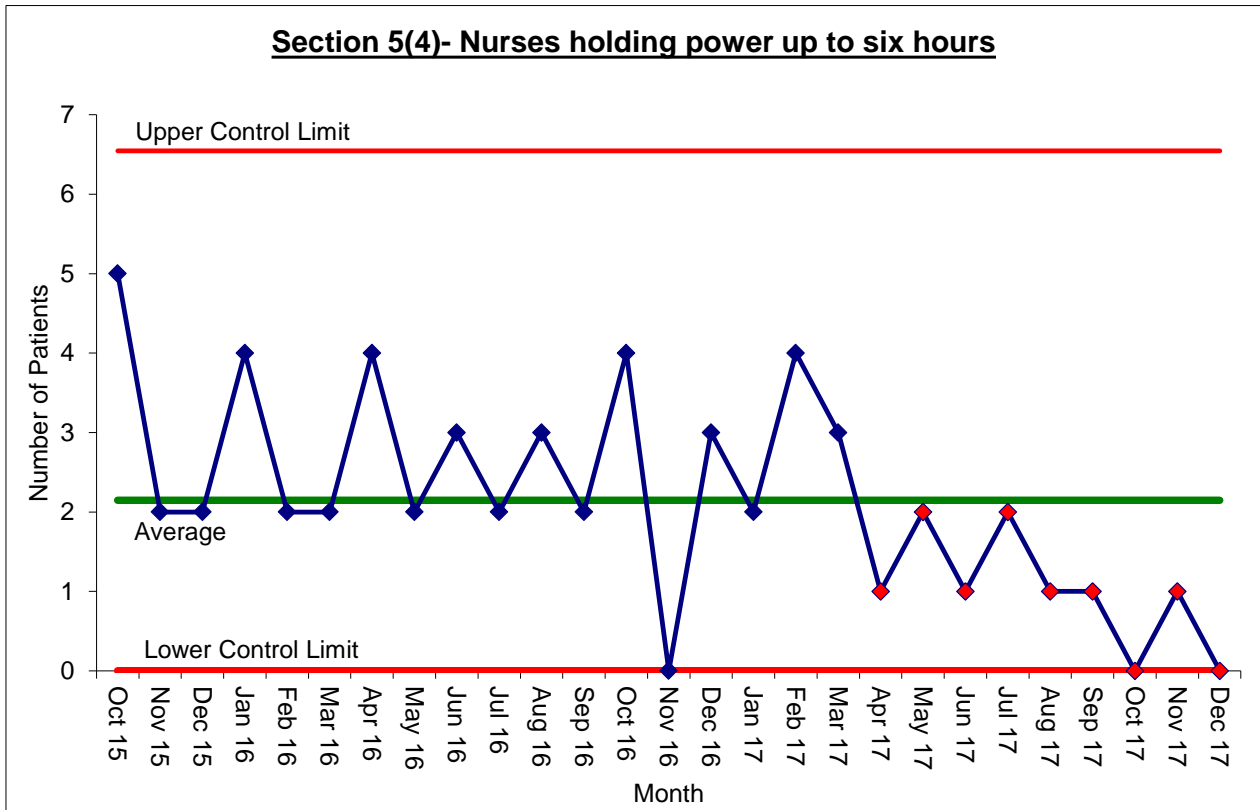
- Unmanageable risk of violence x 2



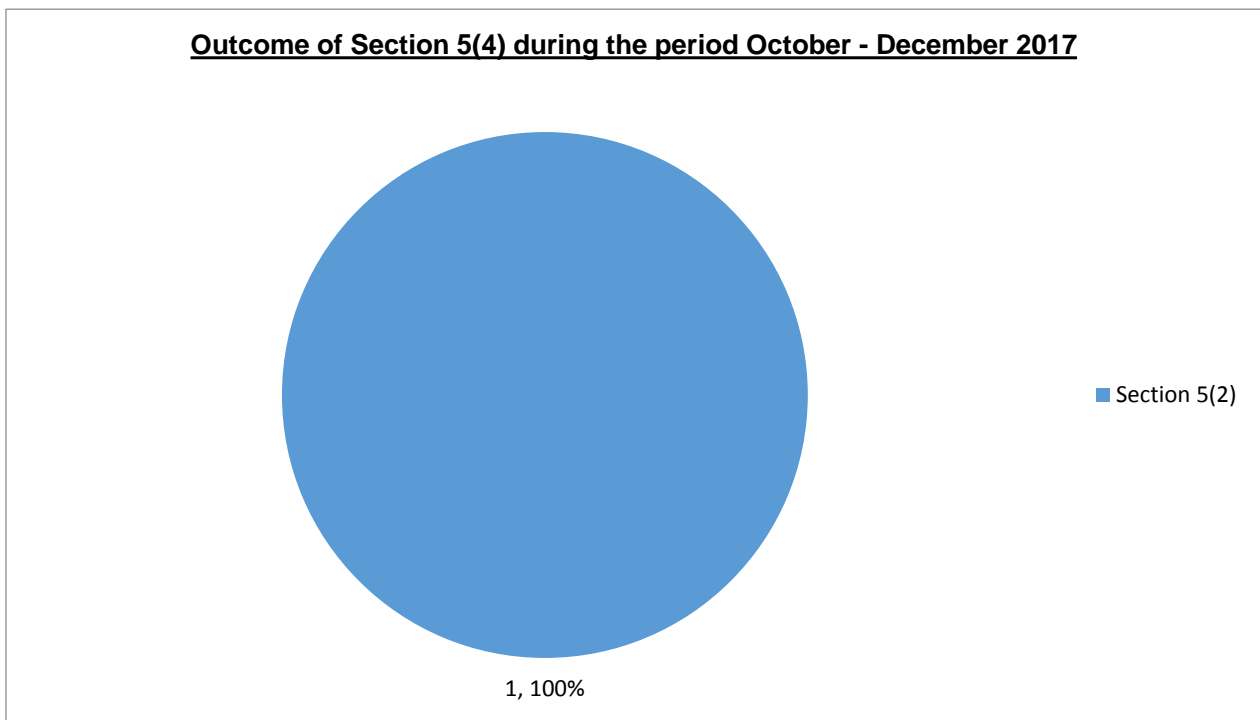
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The pareto chart highlights that 50% of individuals assessed in custody under 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.

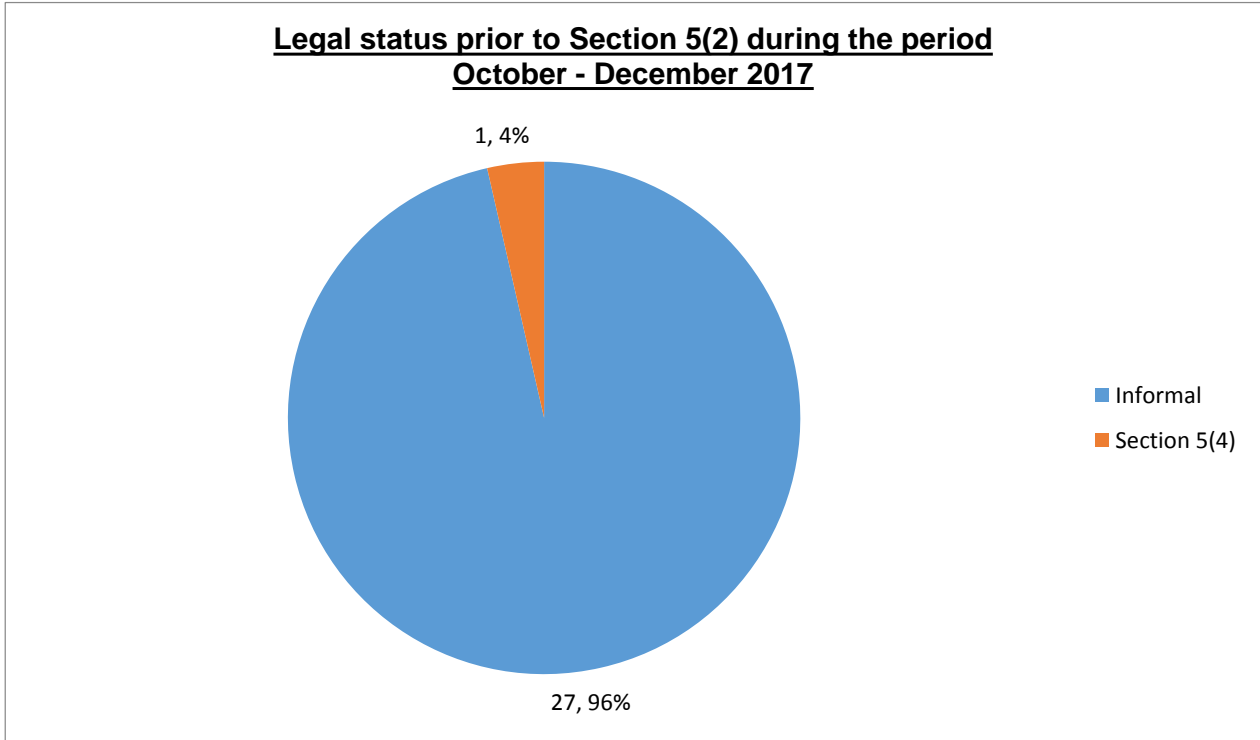
Section 5(4) Nurses Holding Power



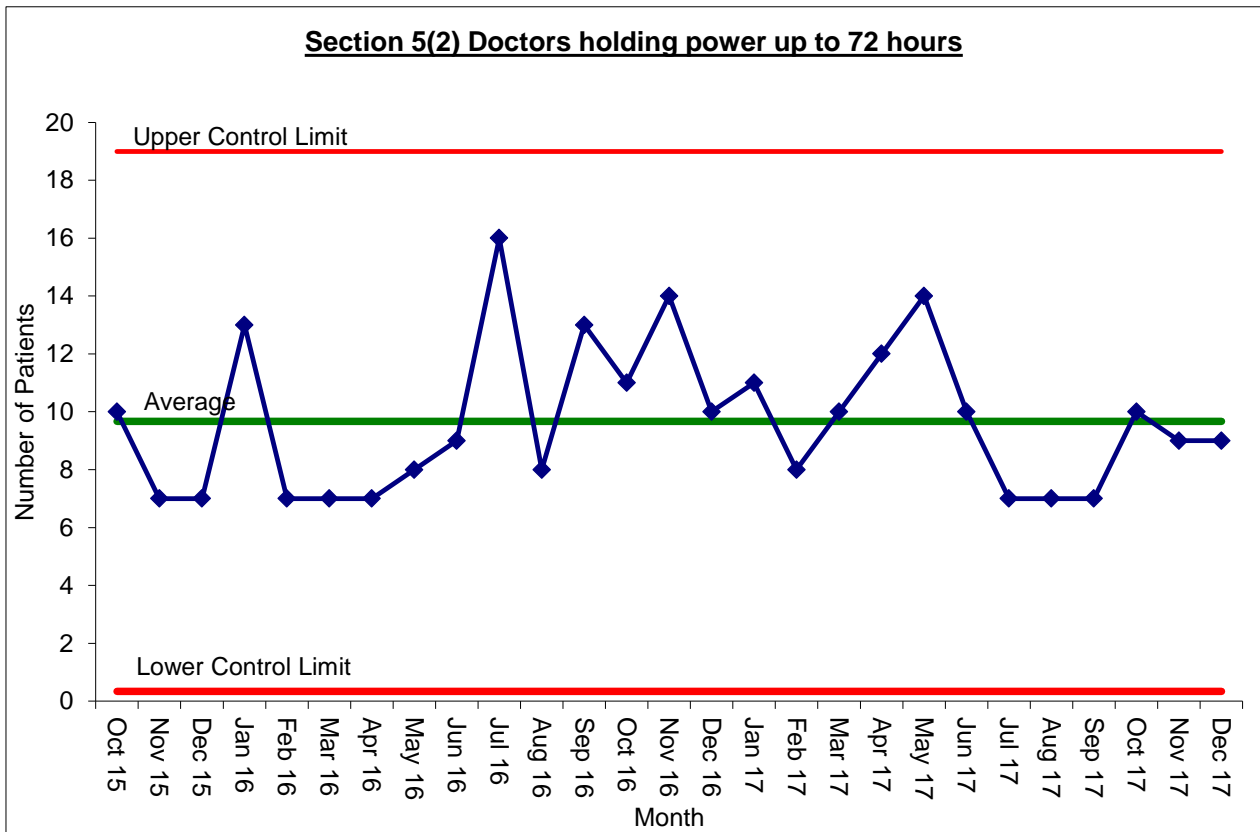
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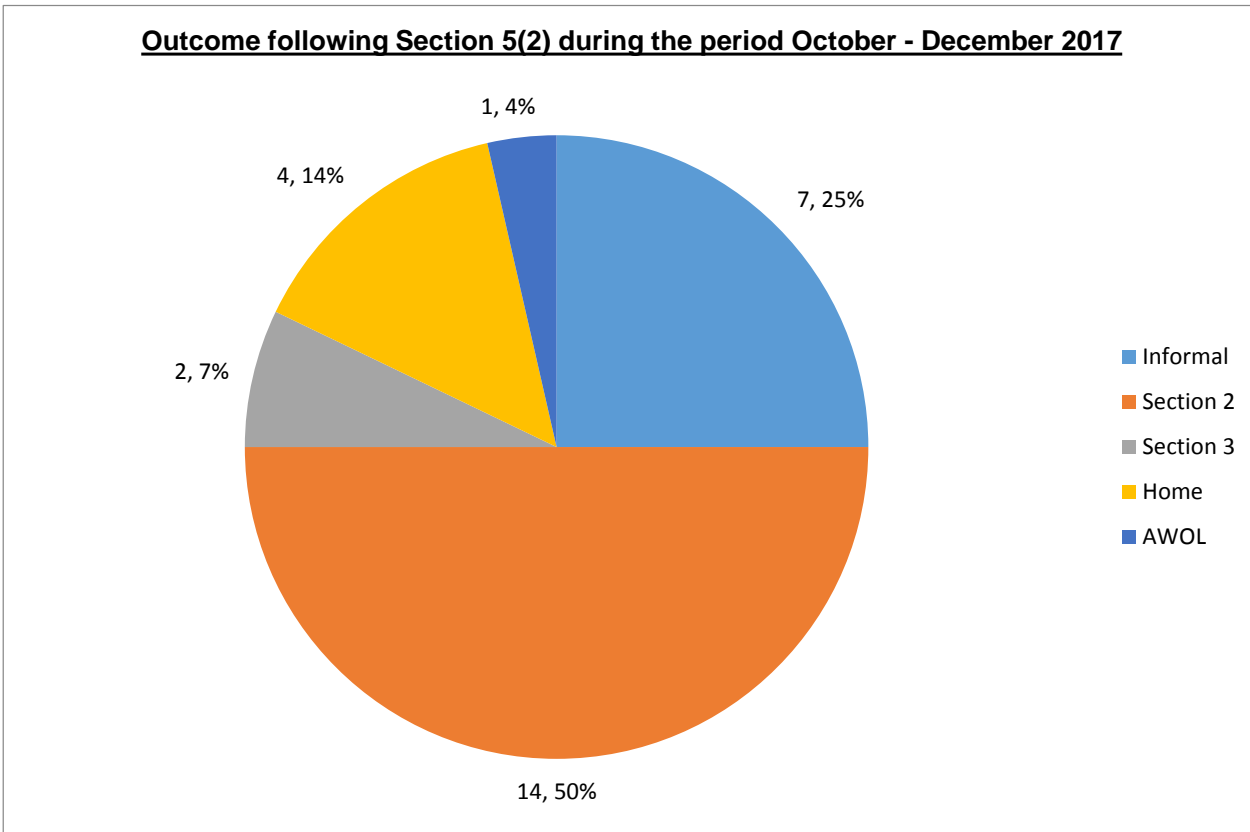


Section 5(2) Doctors holding power

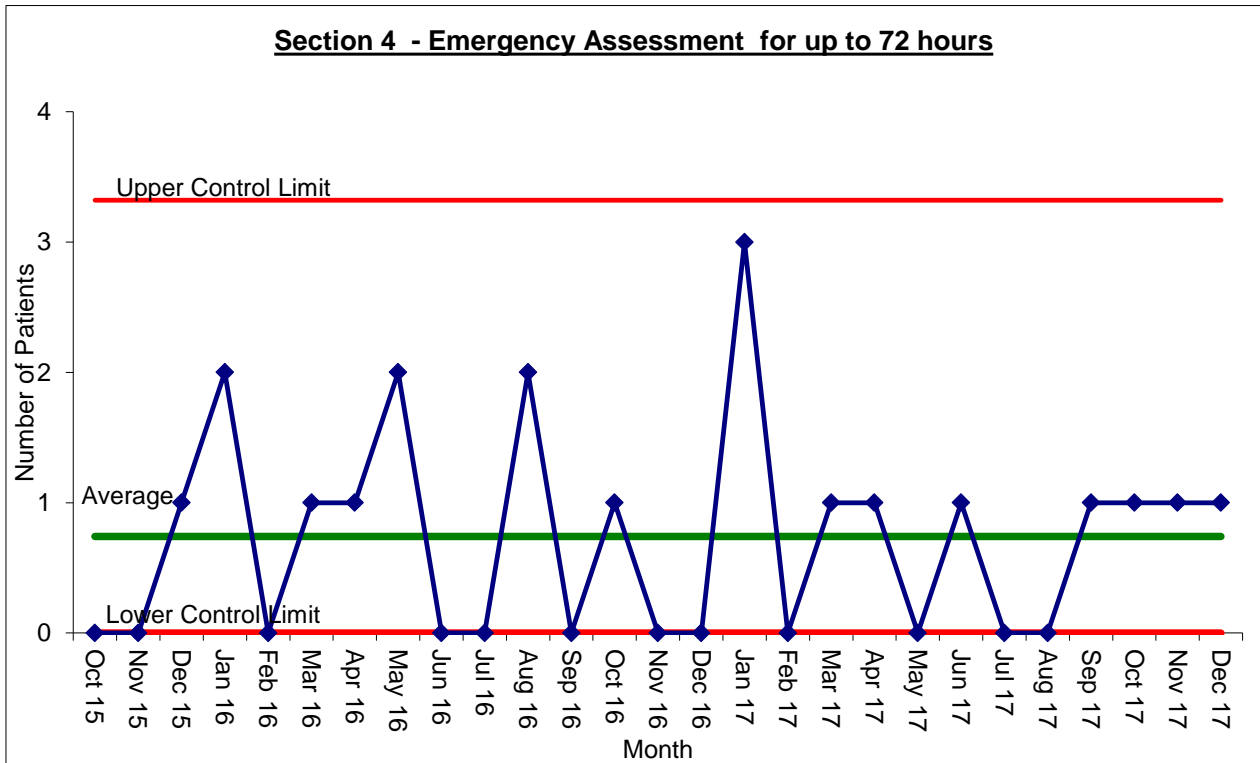


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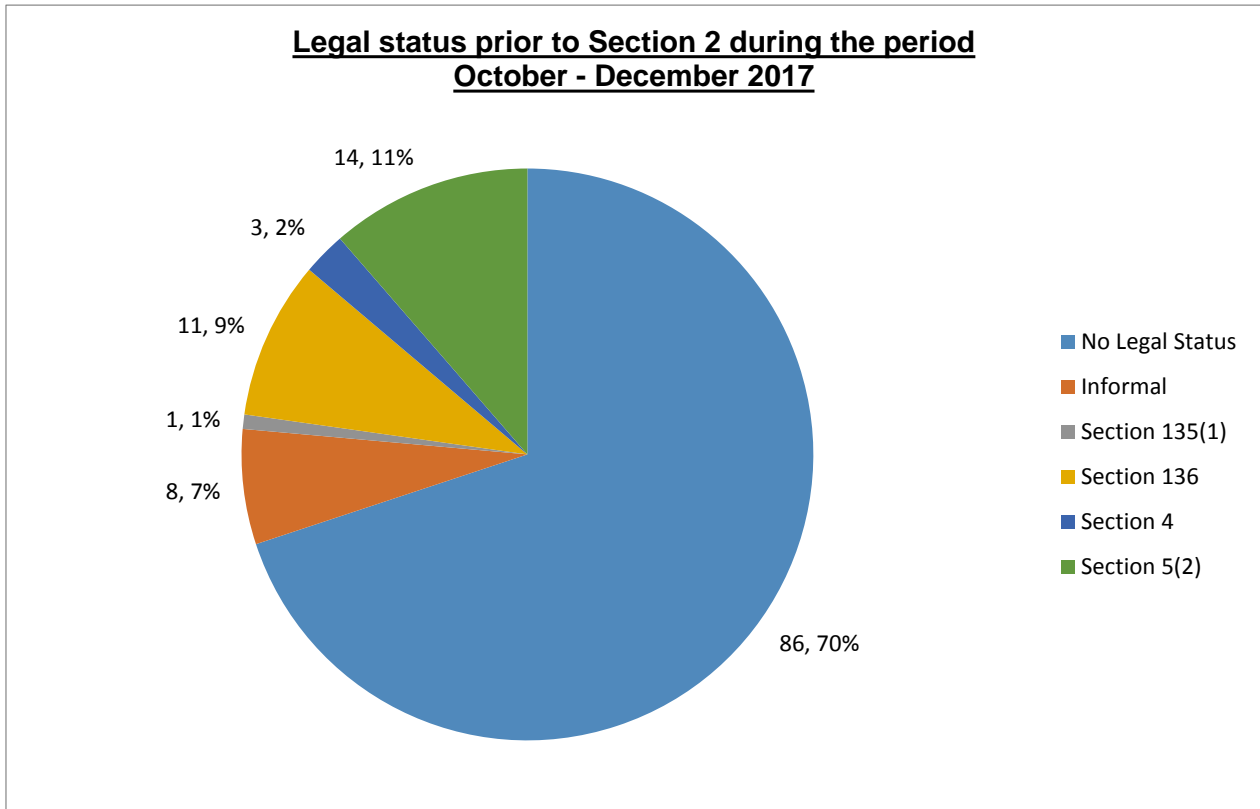
Section 4- Admission for Assessment in Cases of Emergency



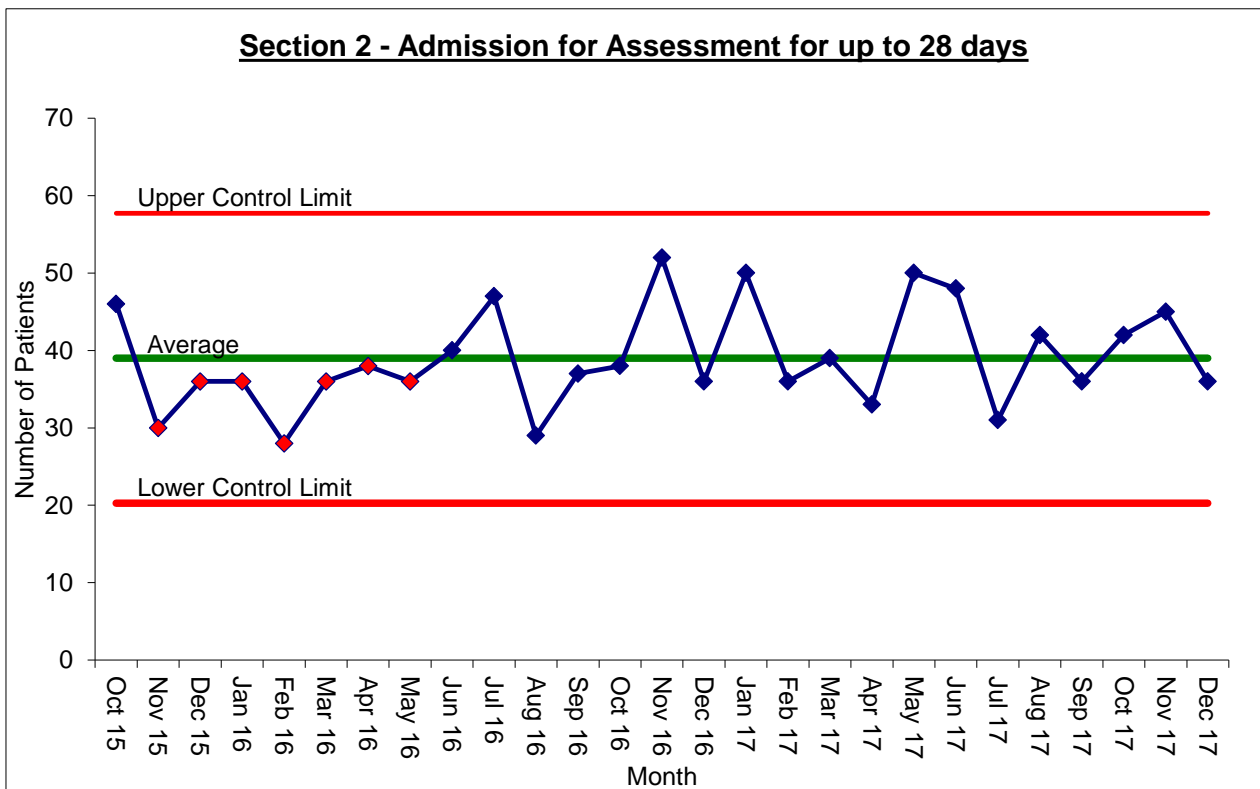
Section 4 was used on three occasions and subsequently converted to Section 2 during the period for the following reasons:

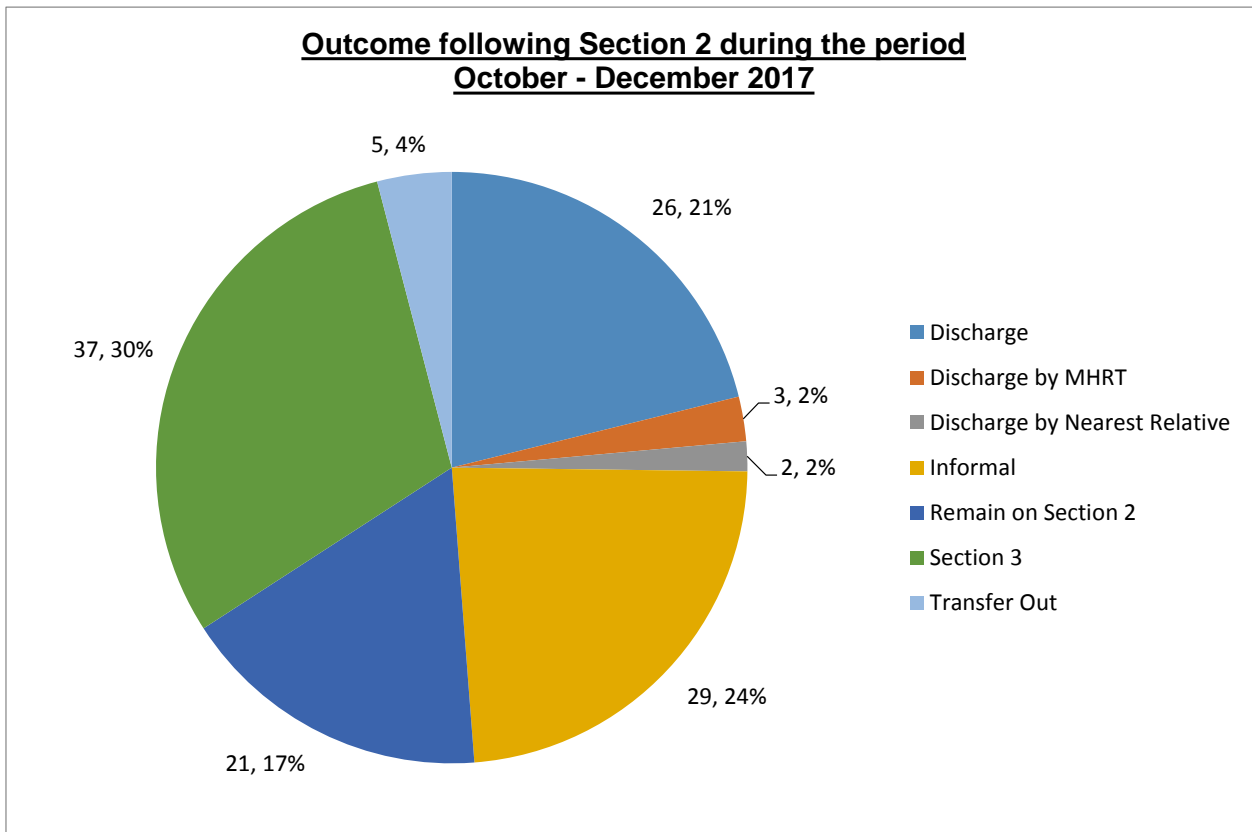
- Potential immediate risk to themselves and others. No section 12 Doctor available.

Section 2- Admission for Assessment

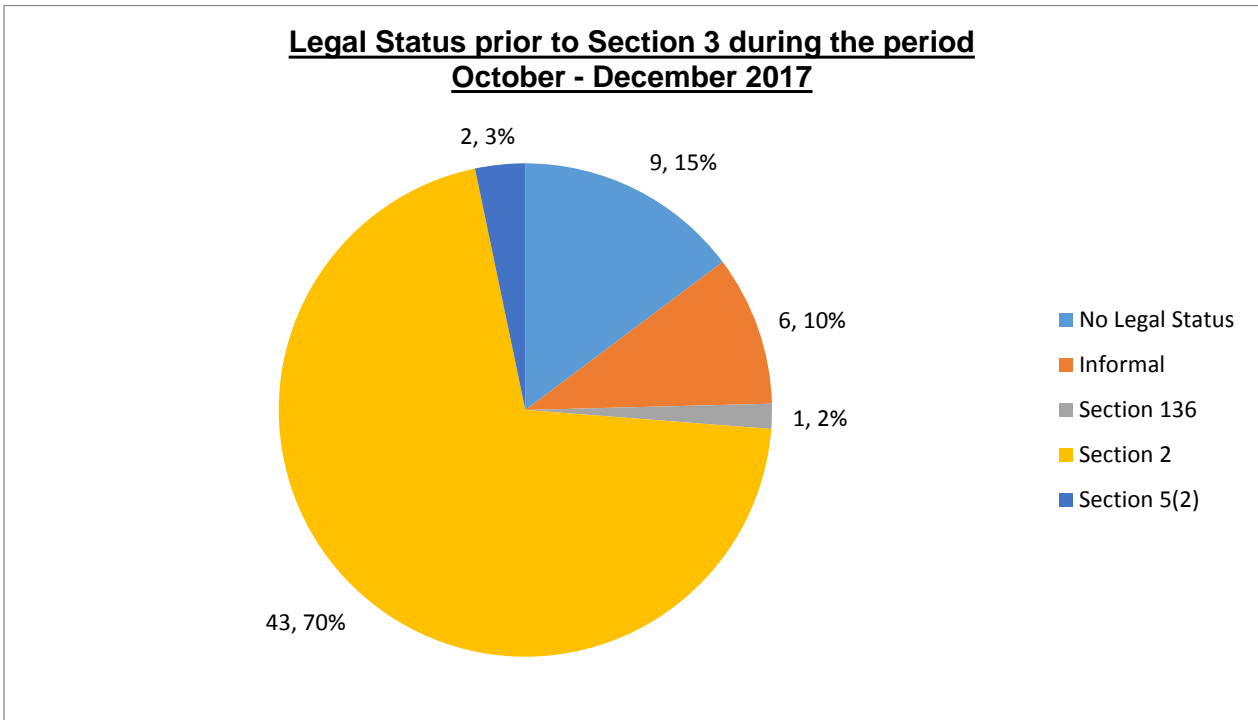


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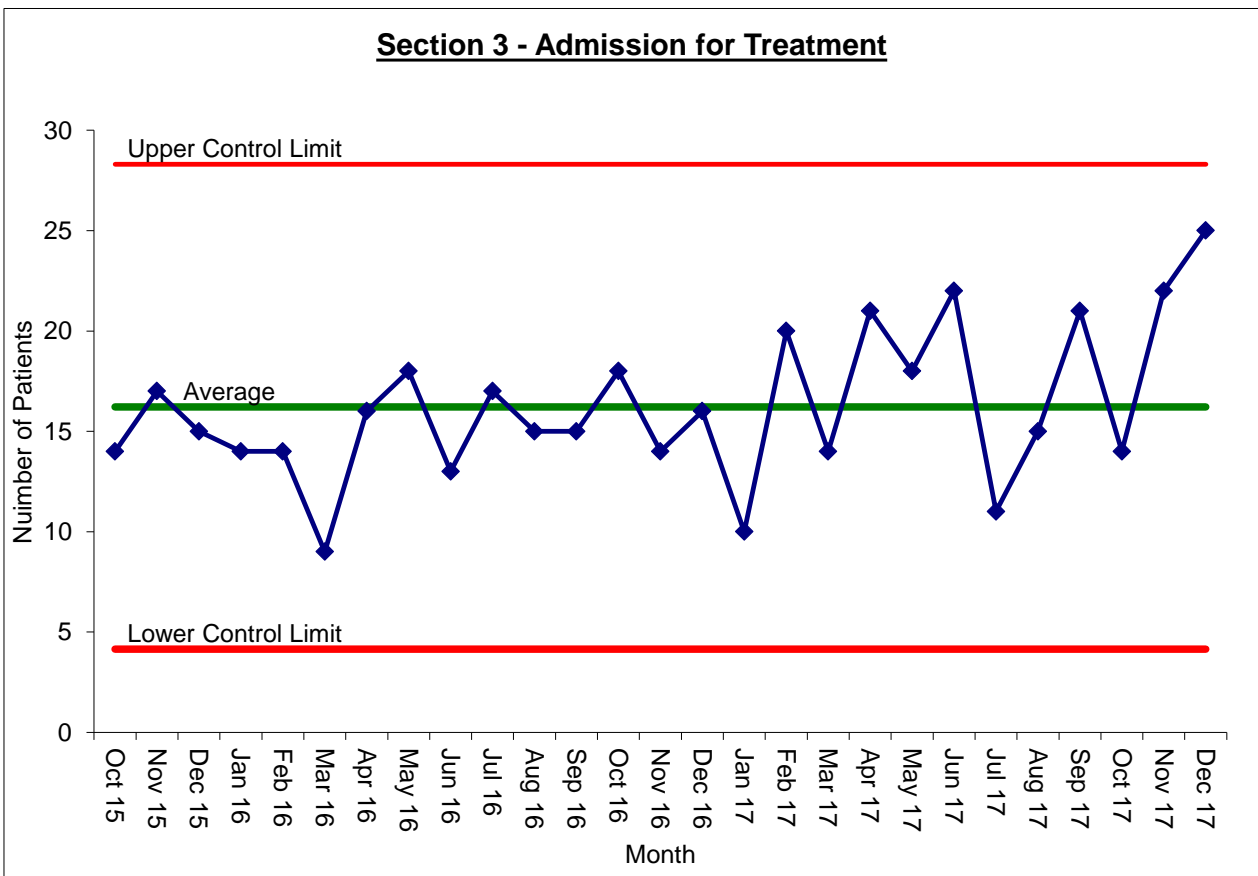


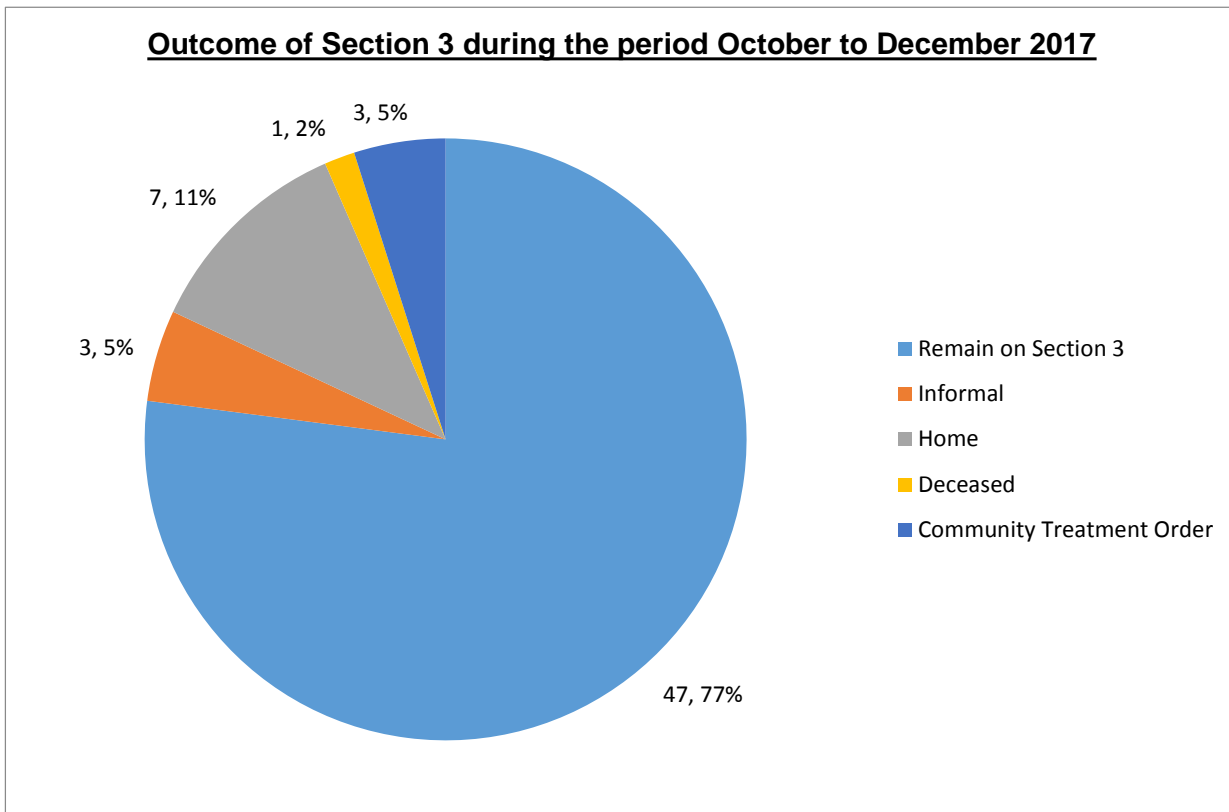


Section 3- Admission for Treatment



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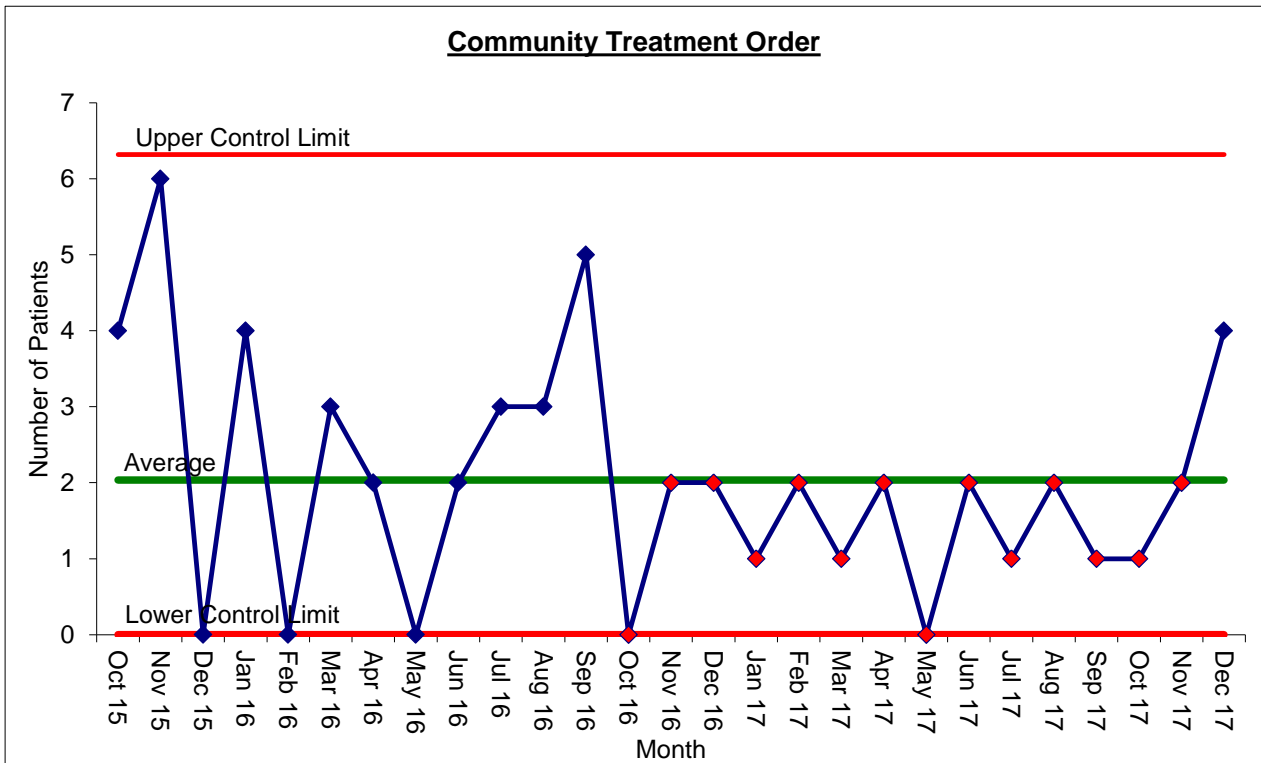




Community Treatment Order

During the period October - December 2017, seven patients were discharged to Community Treatment Order.

As at 31st December 2017, 34 patients were subject to a Community Treatment Order (CTO).

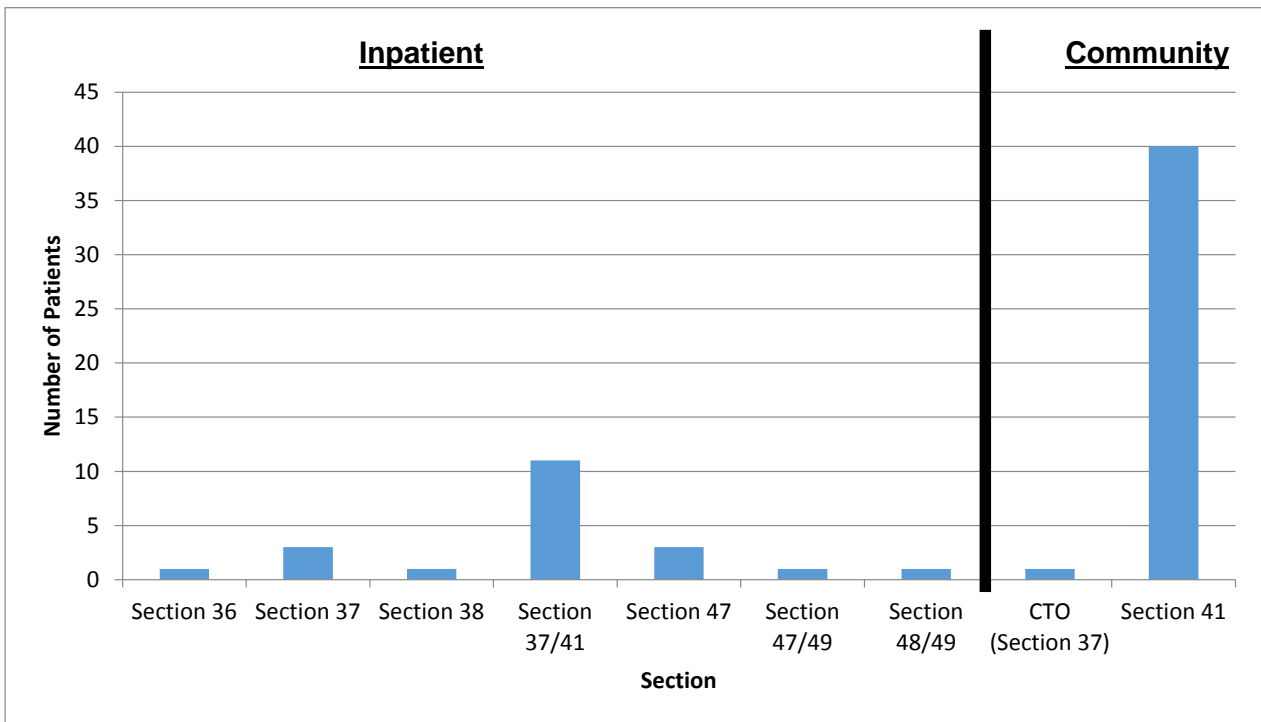


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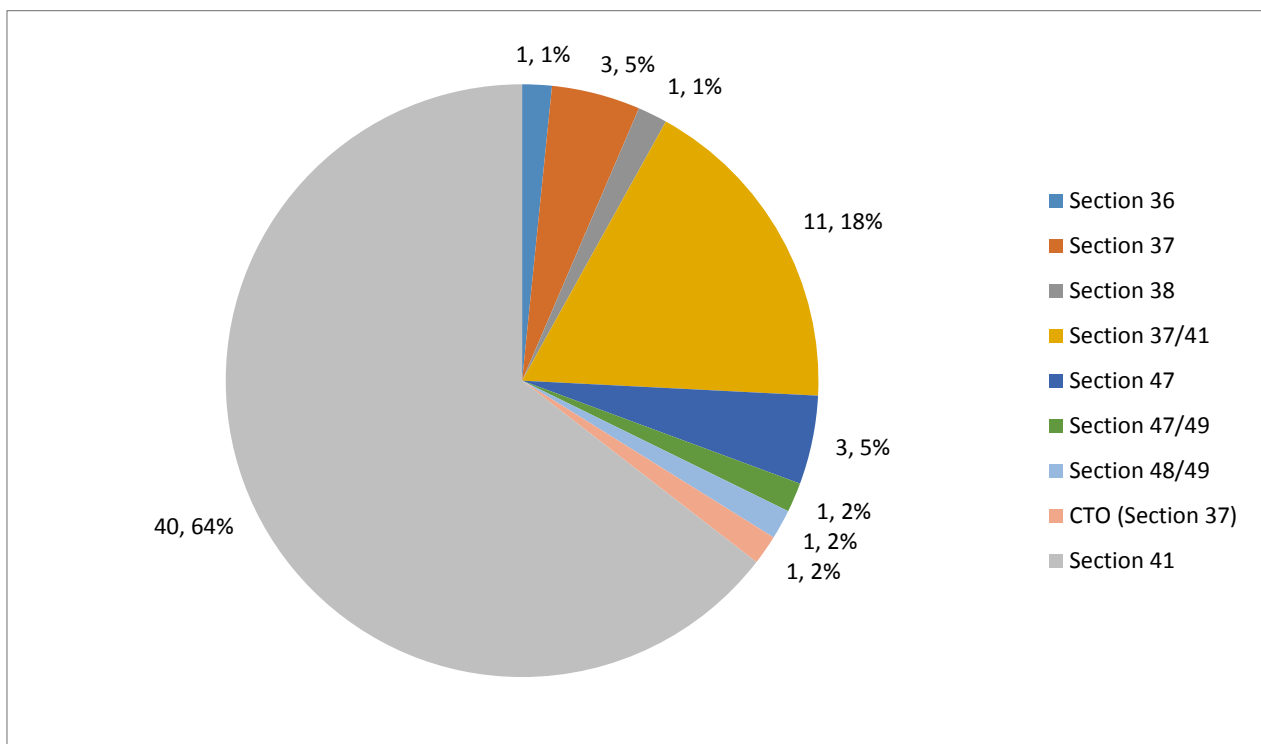
Recall of a community patient under Section 17E

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

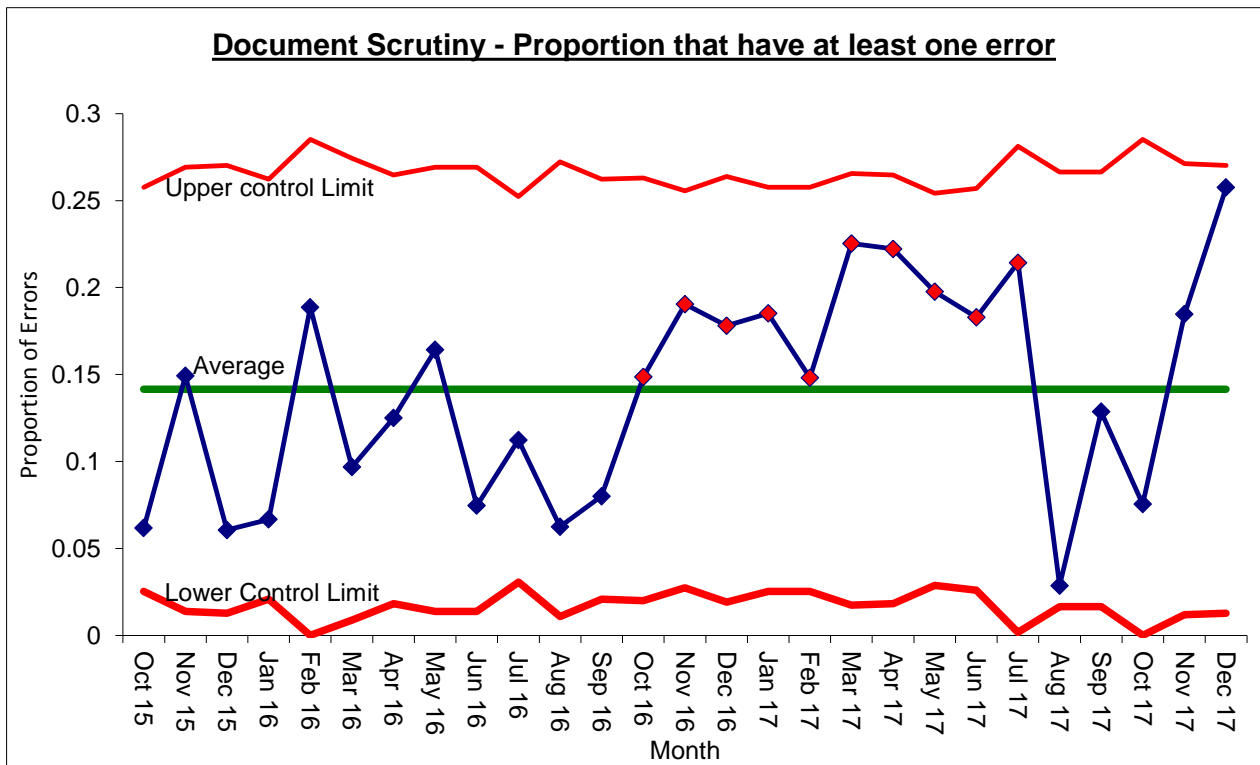
Part 3 of the Mental Health Act 1983
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/ Conditional Discharge in the community as at 31st December 2017.



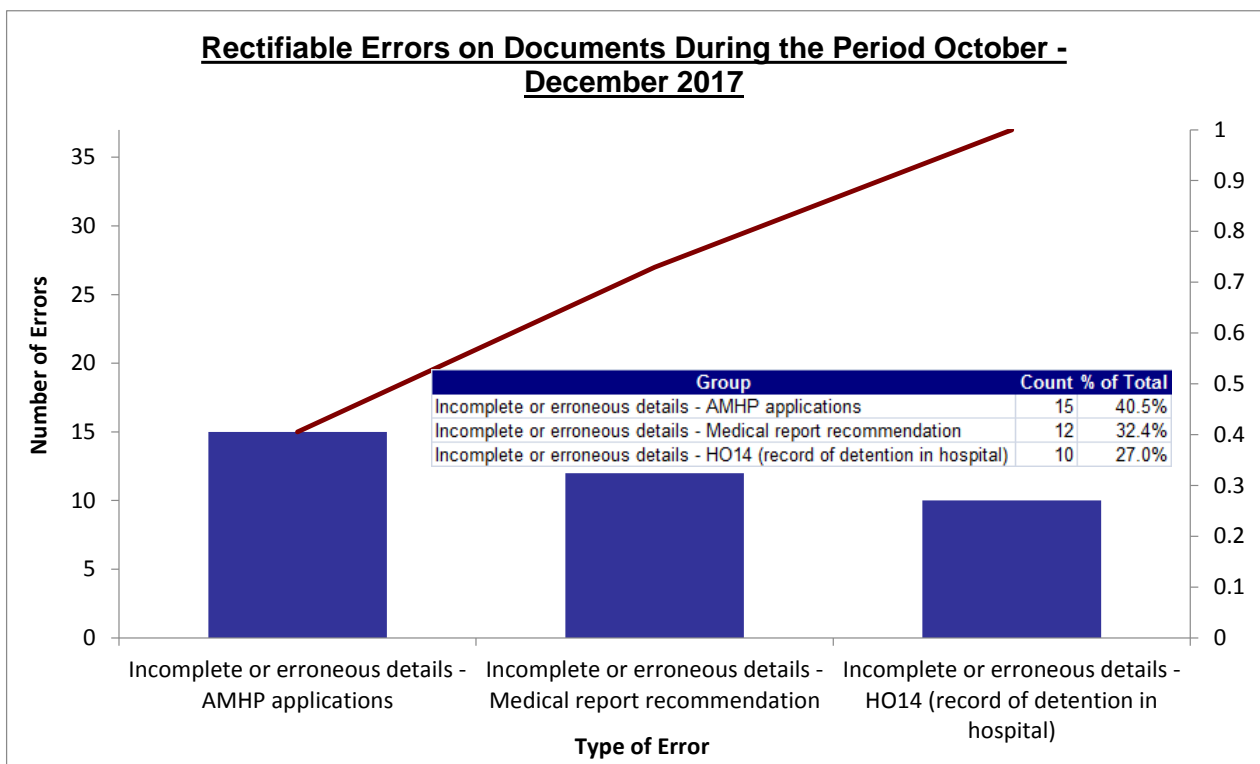
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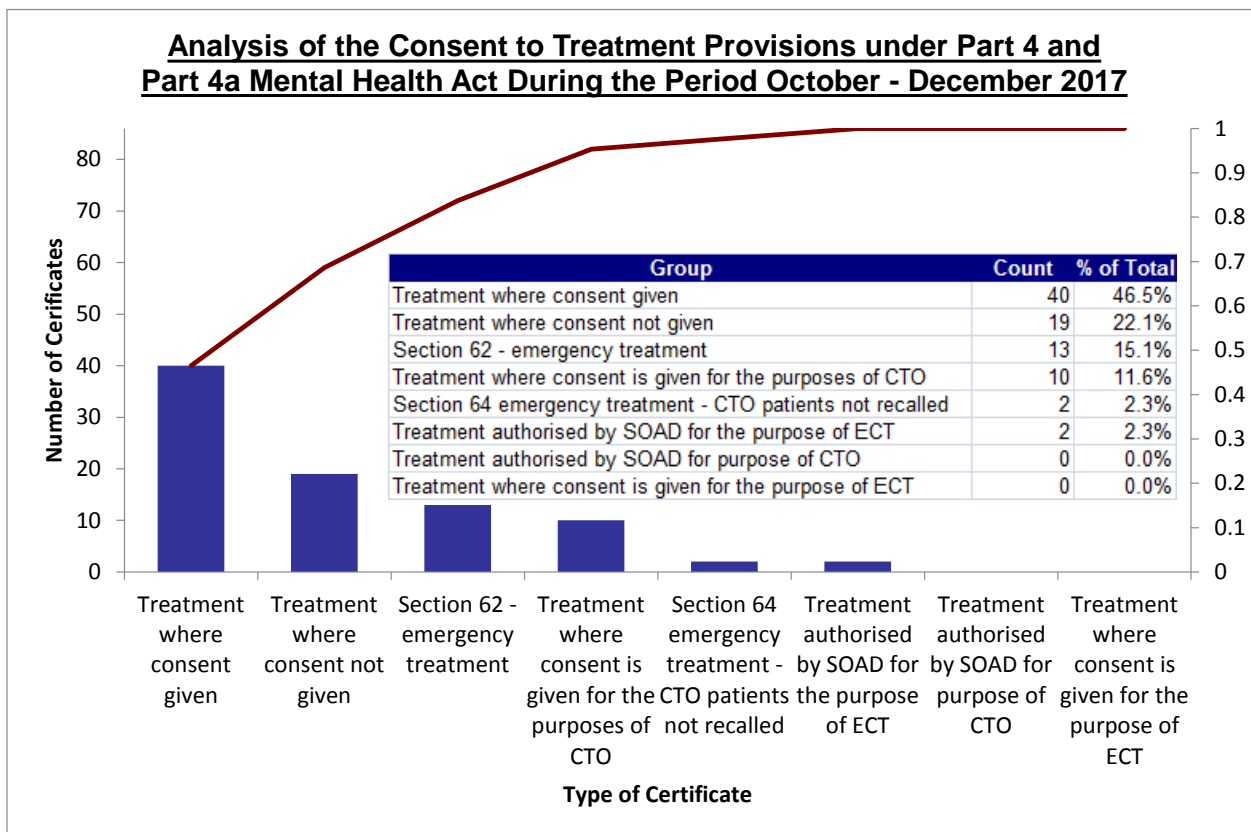
Scrutiny of documents during the period



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 narrower limit.



Consent to Treatment



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.

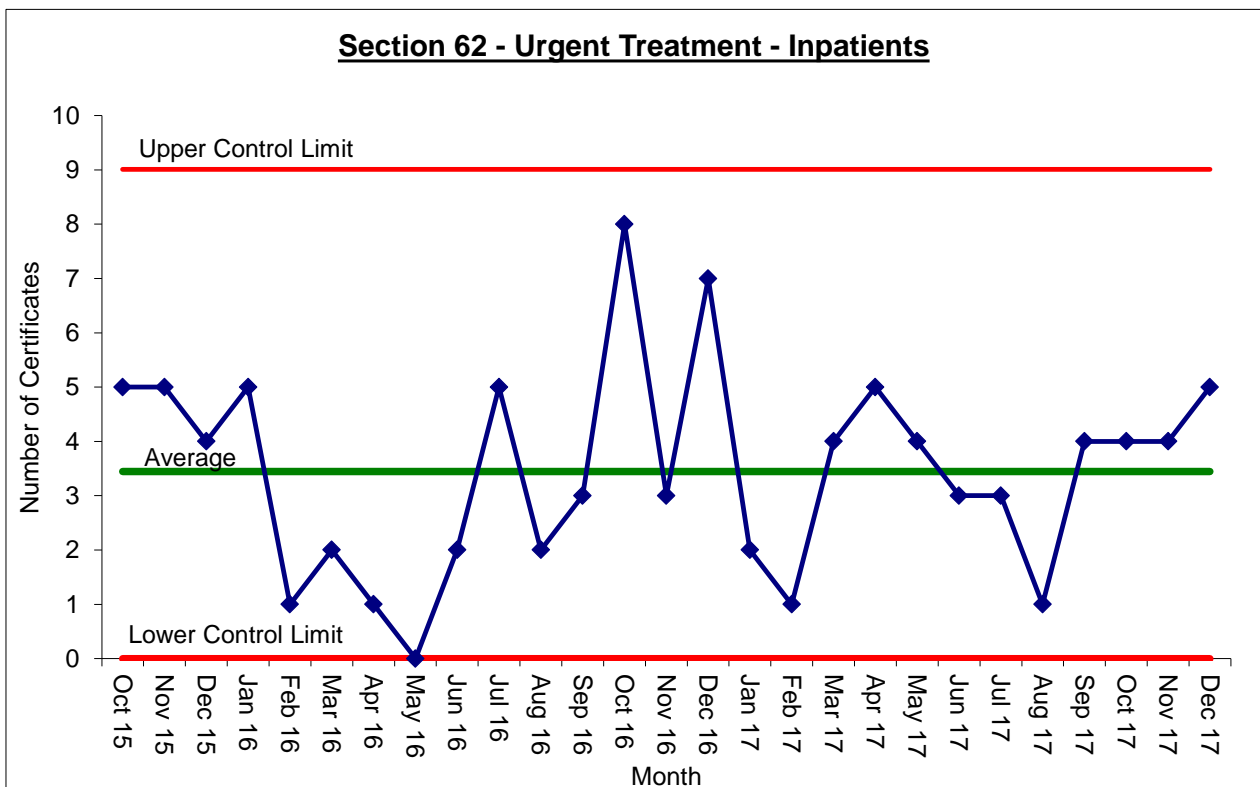
Urgent treatment is defined as treatment that is:

- 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.

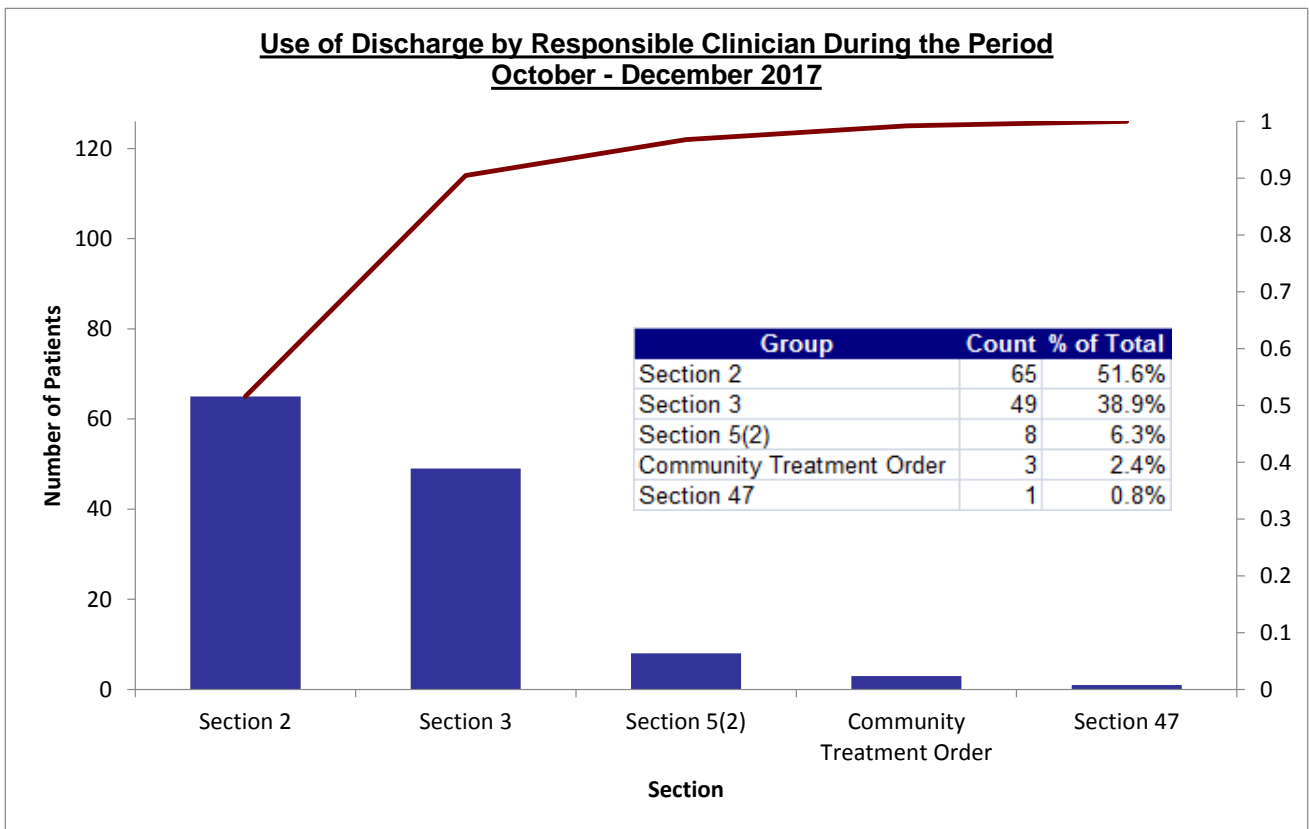
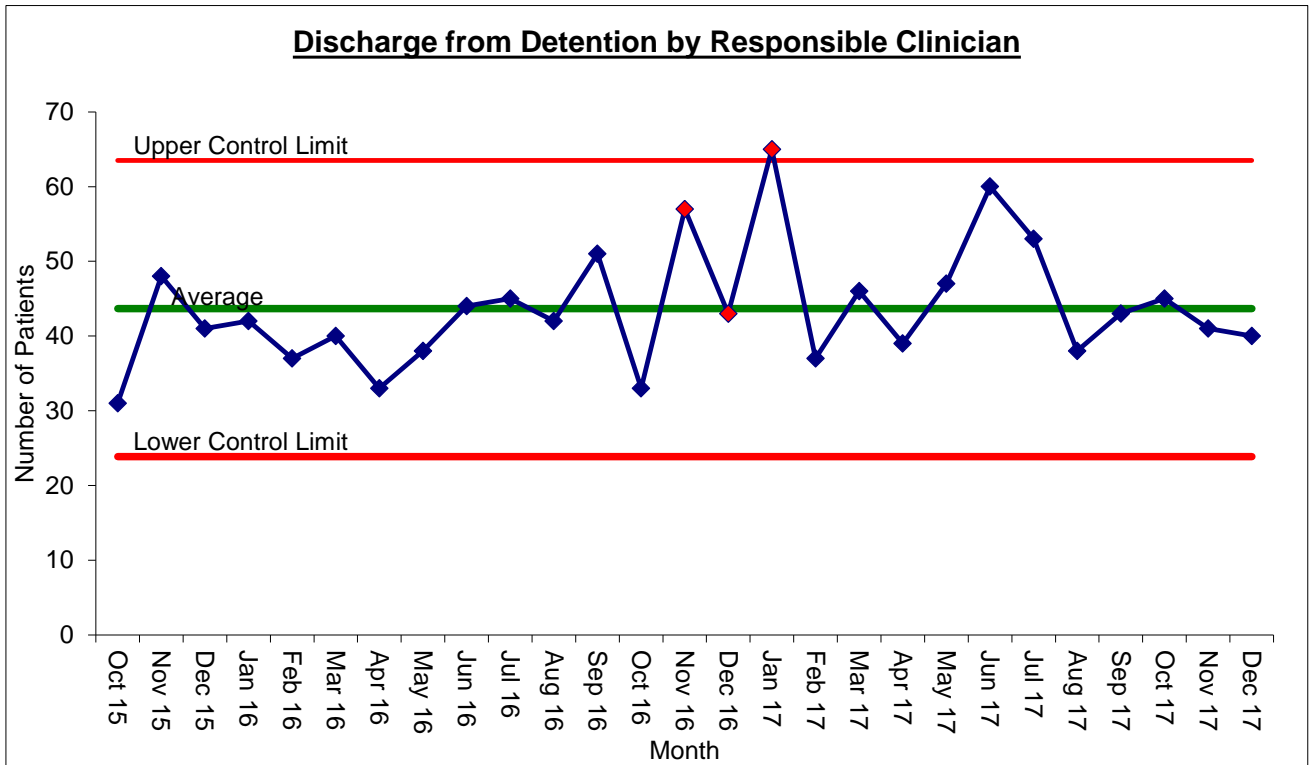


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The above chart highlights that Section 62 was used on thirteen occasions for the following reasons:

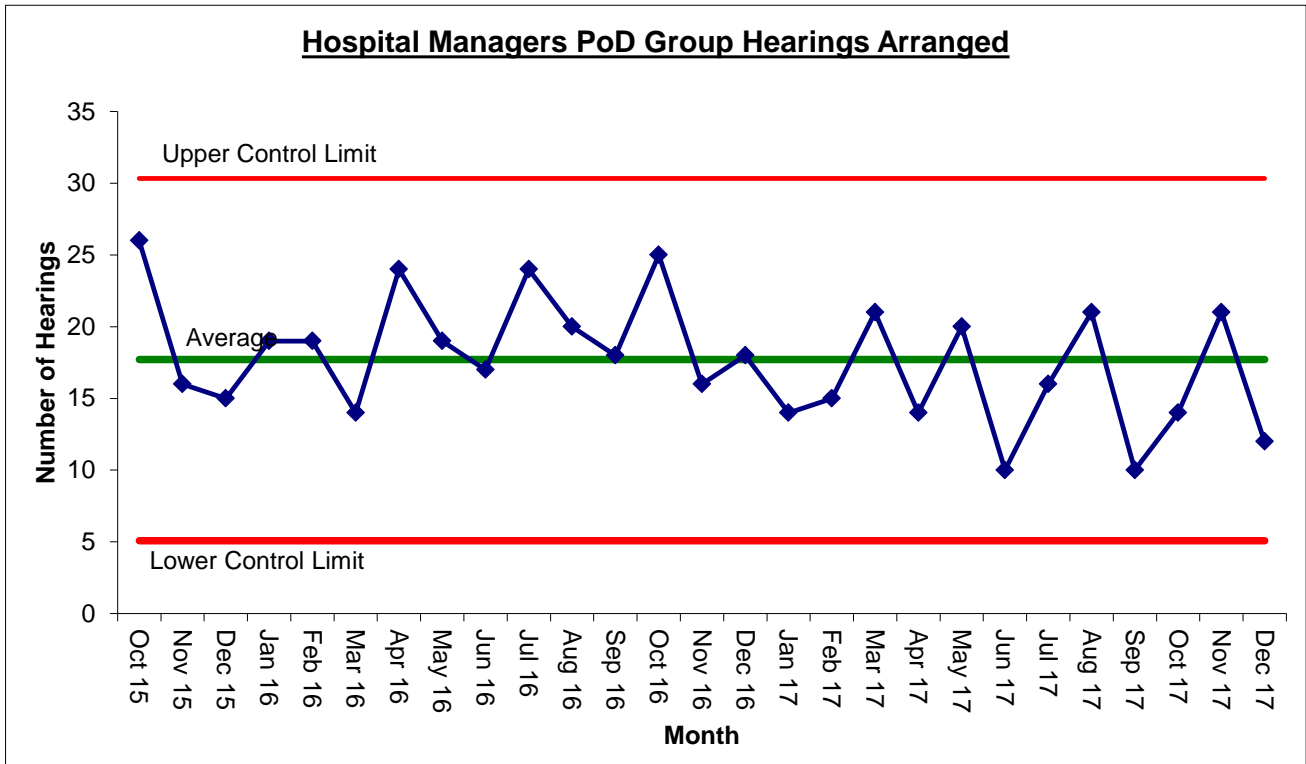
- 3 month rule x 12
- Awaiting Consent – change of medication

Discharge



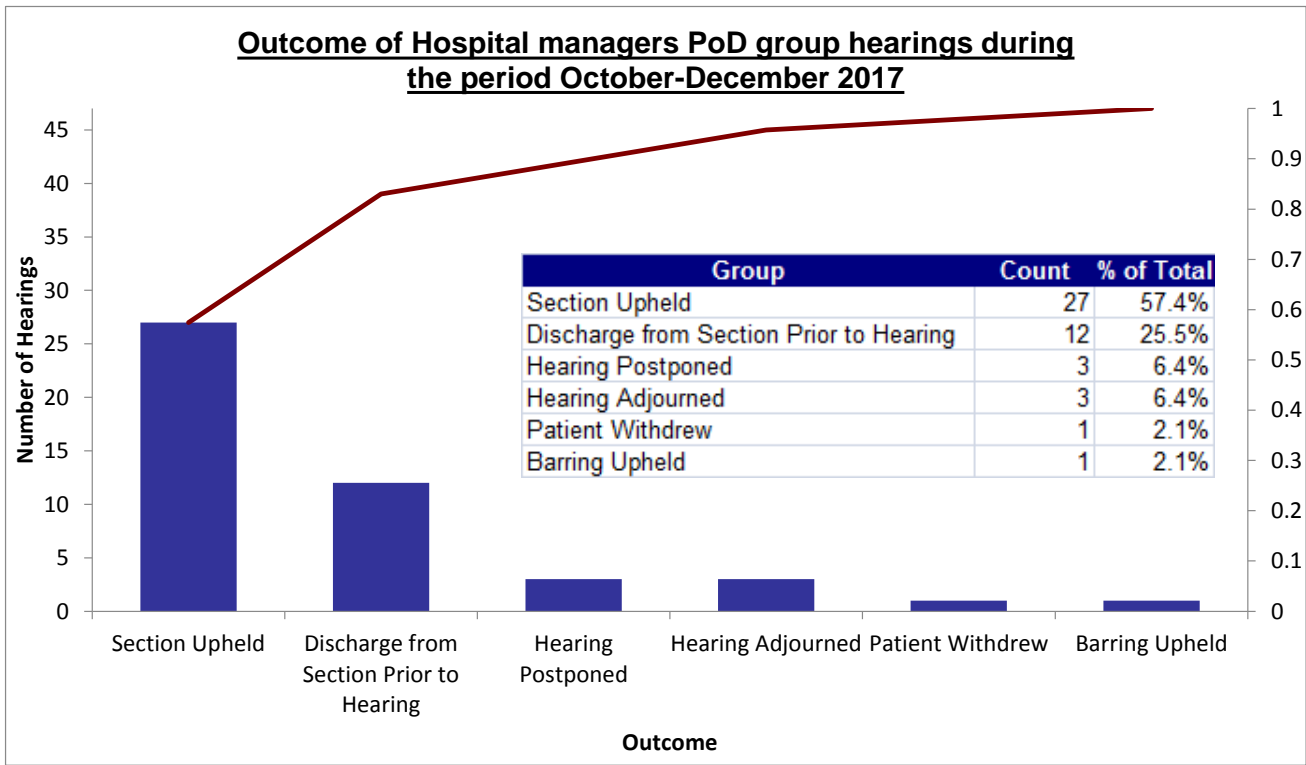
Hospital Managers- Power of Discharge

Hospital Managers PoD Group Hearings Arranged



9

Outcome of Hospital managers PoD group hearings during the period October-December 2017

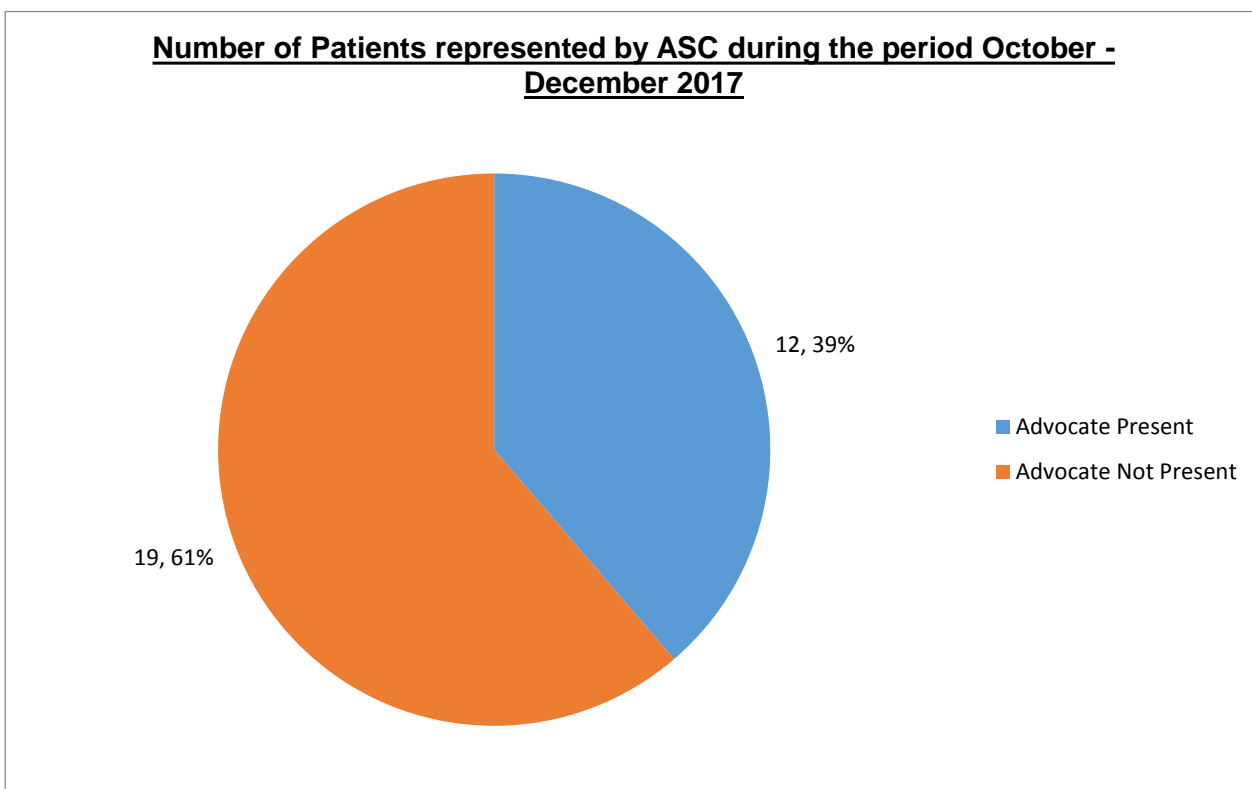


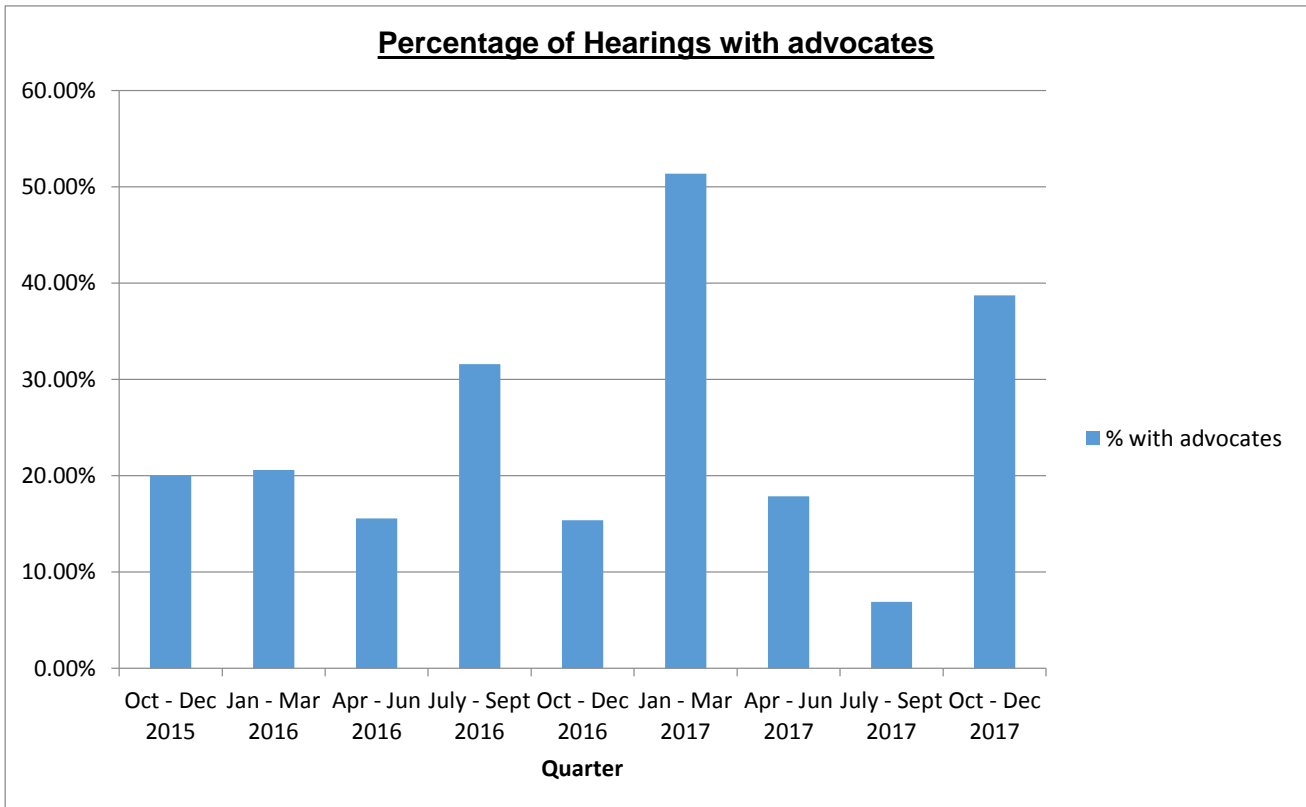
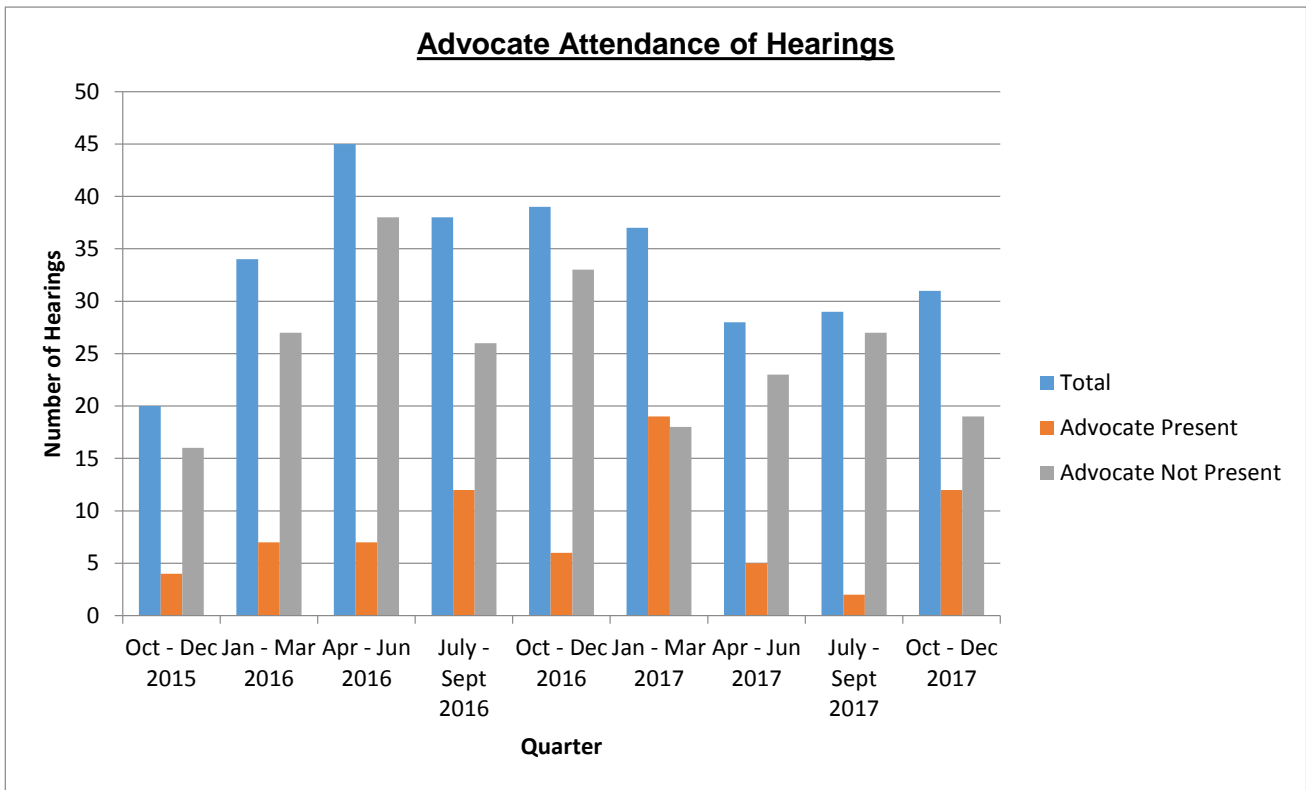
Three hearings were adjourned for the following reasons:

- More information required as Social Worker didn't know patient
- Patient didn't want to go ahead as her Care Coordinator couldn't attend
- Responsible Clinician unavailable due to sickness and the RC report required updating

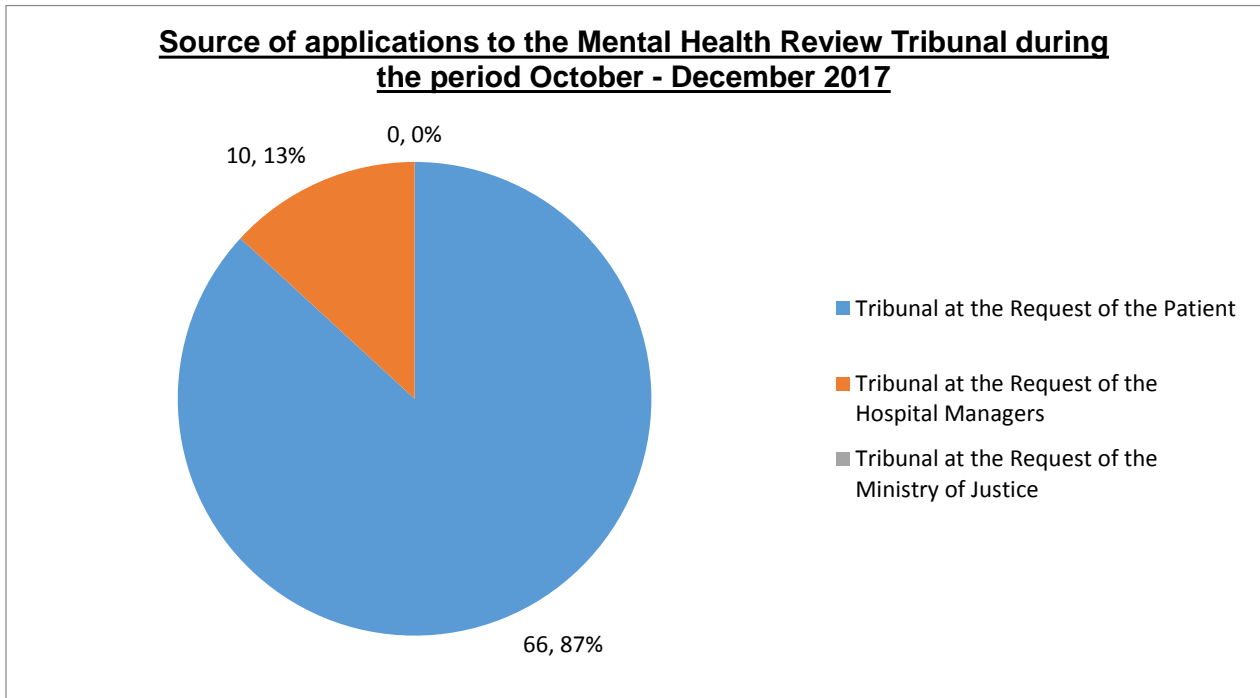
Three hearings were postponed for the following reasons:

- RC unable to attend – double booked
- Visit from patients son clashed and patient wanted to attend the Hearing
- Care Coordinator could not attend – short notice due to Hearing being re-arranged

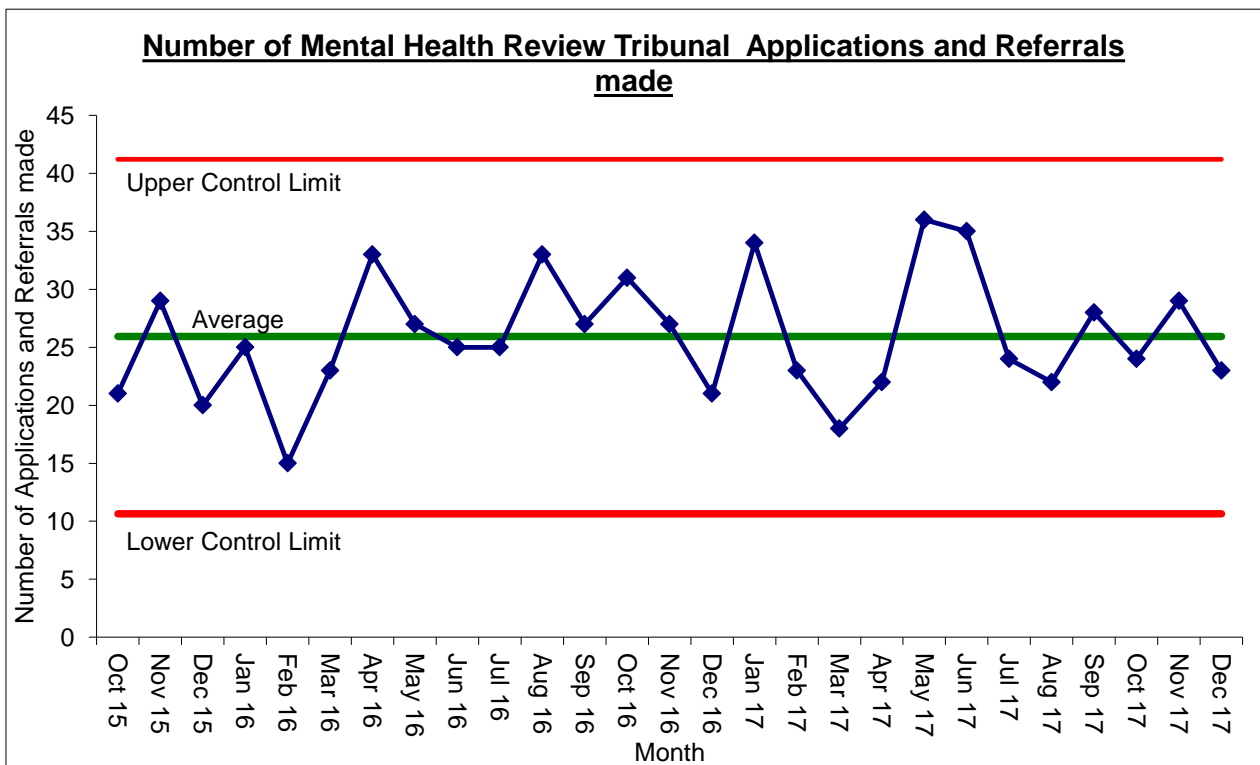


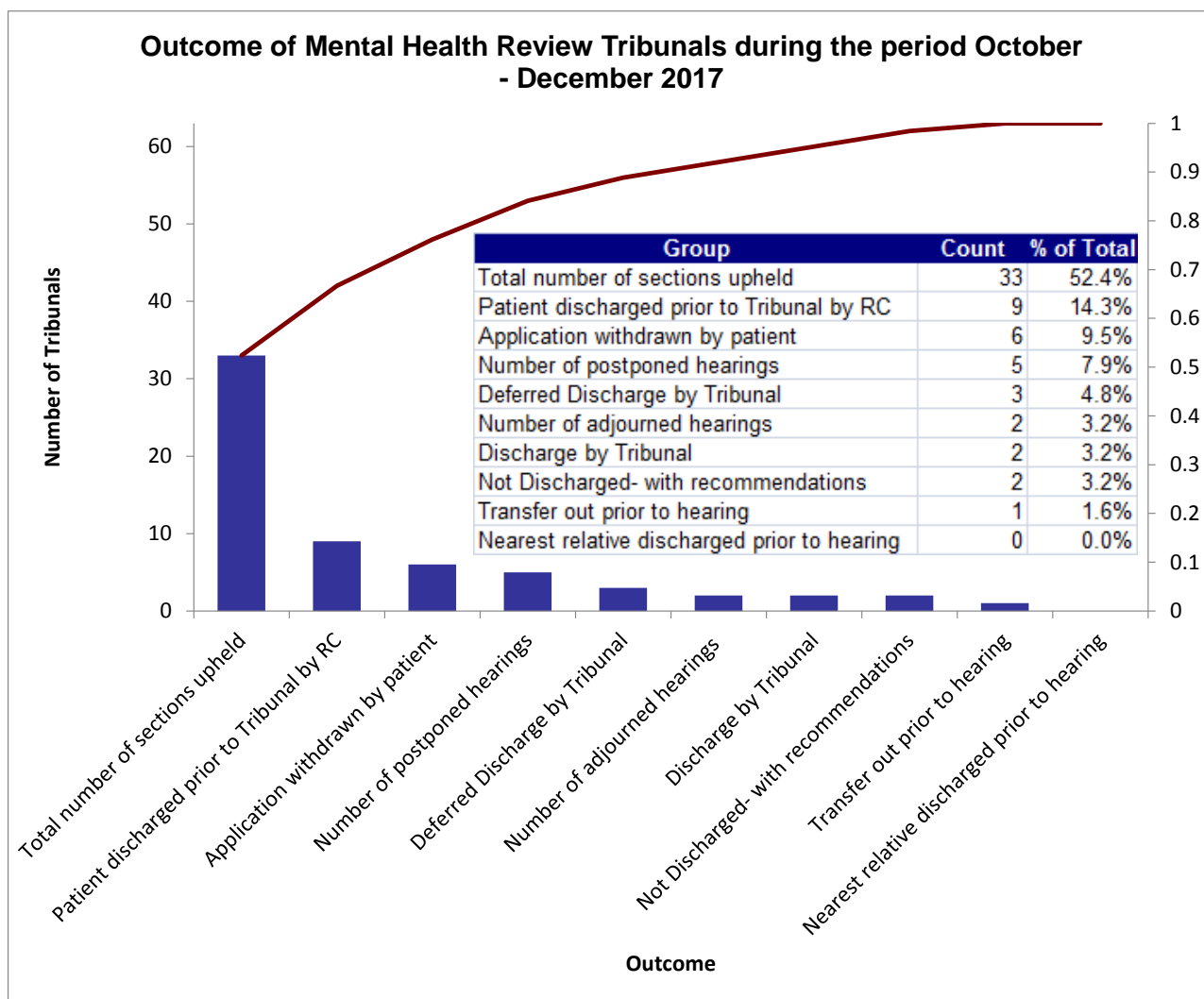


Mental Health Review Tribunal (MHRT) for Wales



9





Two hearings were adjourned during the period for the following reasons:

- Awaiting assessment by Low Secure Forensic team
- Patient changed mind and decided they wanted a solicitor to represent them

Five hearings were postponed for the following reasons:

- Patient AWOL
- Fluctuating capacity - Tribunal office appointed solicitor who needed time to build a case
- More information required from Victim Liaison
- Postponed due to clash with complex care meeting
- Patient transferred in from out of area, Responsible Clinician had not been able to meet the patient prior to Tribunal

Summary of other Mental Health Act Activity which took place during the period October - December 2017

Exclusion of visitors

During the period the Exclusion of Visitors Procedure was not implemented.

Section 19 transfers to and from Cardiff and Vale UHB

Four patients detained under Part 2 of the Mental Health Act were transferred back to their locality health board from Cardiff and Vale UHB to a hospital under a different set of Managers.

One patient was transferred out to a specialist Perinatal Unit under a different set of Managers.

Eleven patients detained under Part 2 of the Mental Health Act were transferred back to Cardiff and Vale UHB as their locality health board from a hospital under a different set of Managers.

Death of detained patients

During the period there has been one death of a detained patient. This was reported to Healthcare Inspectorate Wales.

Section 117

Section 117 continues to be monitored by the MHA Department. As at 31st December 2017 Cardiff and Vale UHB maintain responsibility for 1580 patients eligible to section 117 after care.

During this period Cardiff and Vale UHB updated the 117 register to include a further 39 and discharged 10.

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

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

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

	<p>made.</p> <p>The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.</p>
<p>Section 2</p>	<p>Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales.</p> <p>If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met.</p> <p>The purpose of the section is limited to the assessment of a patient’s condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate.</p> <p>Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made.</p> <p>The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative:</p> <ul style="list-style-type: none"> • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship.

	<ul style="list-style-type: none"> The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest <p>This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of.</p> <p>Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.</p>
Section 3	<p>Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal.</p> <p>Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.</p>
Supervised Community Treatment (SCT)	<p>Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. SCT 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.</p>
Community Treatment Order (CTO)	<p>Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto SCT.</p>
Section 17E (recall of a community patient to hospital)	<p>Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances:</p> <ul style="list-style-type: none"> Where the RC decides that the person needs to

	<p>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.</p> <ul style="list-style-type: none"> • 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 SCT 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	<p>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.</p> <p>Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.</p>
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal

	disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	<p>Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice.</p> <p>Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.</p>
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.

Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	<p>Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options:</p> <ul style="list-style-type: none"> • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for supervised Community Treatment (SCT).
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	<p>Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion.</p> <p>If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally</p>

	<p>concerned with the medical treatment of the patient for mental disorder.</p> <p>If the patient lacks capacity to consent SOAD authorisation is required.</p>
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent treatment	<p>Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is:</p> <ul style="list-style-type: none"> • To save the patient’s life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference

	<p>necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.</p>
Section 23	<p>Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication.</p> <p>Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders.</p> <p>The Secretary of State for Justice has powers to discharge restricted patients under section 42(2).</p> <p>If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or SCT is due to expire.</p>
Section 117	<p>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 SCT patients and conditionally discharged patients as well as those who have been absolutely discharged.</p>

National HIW Report Review and Action Plan

Executive Lead : Chief Operating officer
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well : Mental Health Priority – Avoiding Harm Waste and Variation
Financial impact : NA
Quality, Safety, Patient Experience impact : NA
Health and Care Standard Number - 2.1 & 6.2 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: NA

RECOMMENDATION

The Mental Health Legislation Committee is asked to:

- **CONSIDER and APPROVE the approach taken by the Mental Health Clinical Board**

SITUATION

Health Inspectorate Wales publishes an annual report on the use of the Mental Health Act in Wales. The 2017 report 'Monitoring the Use of the Mental Health Act in 2015-16' is now available from the Welsh Government website www.hiw.org.uk. This report considers this publication and the implications for Cardiff and Vale services.

BACKGROUND

The publication itself does not identify where there are practice concerns within particular mental health organizations, therefore, the mental health act manager in Cardiff and Vale review the report for general concerns, compared that to our own assessment of local issues from previous experience and local HIW reports and highlighted areas for further action

ASSESSMENT

Mental Health Act Visits did not highlight any consistent failings regarding the administration of the Act in Wales in both the NHS and independent sector.

Concern Raised in HIW Report	Suggested Actions
<p>1. Adequate records:</p> <p>1.1 Lack of copies of key documents such as AMHP reports on patients files.</p> <p>1.2 Lack of documented information, within the patients notes, that the statutory consultees had discussed the patient with the SOAD.</p> <p>1.3 Some records were disorganized and difficult to audit even where the appropriate documentation was available.</p>	<p>1.1, 1.2 & 1.3 These areas have not been identified as issues within Cardiff and Vale. No complaints have been received from any SOADs and no issues have been identified through local audit.</p>
<p>2. Consent obtained and assessments of capacity undertaken:</p> <p>2.1 The documented assessment of capacity was difficult to determine when patient records were examined. This is unacceptable given this key area for effective patient care.</p>	<p>2.1 See Action plan for capacity legislation</p>
<p>3. Section 132 – patients rights</p> <p>3.1 Good evidence that patients’ rights were explained to them at the time of initial or renewal of detention under the MHA. However, on many hospital wards we could see insufficient evidence that the patients’ rights were explained to them on a frequent and consistent basis.</p>	<p>3.1 The MHAT (Mental Health Act team) monitor to ensure patients rights are explained frequently. This is not considered to be an issue in C&V through HIW feedback reports and local audit.</p>

<p>4. S17 leave:</p> <p>4.1 Availability of staff to facilitate therapeutic activities and section 17 leave.</p> <p>4.2 A number of expired S17 leave forms left on patients' files that were not clearly identified as expired. This could lead to confusion as to which forms identifying the conditions of the leave are currently in use</p> <p>4.3 Lack of essential information on S17 leave available on individual patient files, eg: Ministry of Justice paperwork for patients detained under S37.</p>	<p>4.1 – The clinical board occasionally receives complaints from patients on locked wards requiring staff time to go off wards for leave where leave is escorted by one or more staff. Demand for this type of service user opportunity will always be greater than capacity, although in general most day to day leave is accommodated through the ward teams. Staffing levels and skill mix of ward staff in Cardiff and Vale is typical of the UK through benchmarking. To reduce boredom on wards, activity nurses are employees for all clinical areas, who provide and coordinate activities. There are efforts to develop psychological interventions where appropriate.</p> <p>4.2 & 4.3 – With electronic patient records, the likelihood of this is reduced. This has not been identified as an issue through local audit in C&V or fed back following HIW inspections</p>
<p>3. The Second Opinion Appointed Doctor Service:</p> <p>3.1 Patients' unavailable for the SOAD to undertake an assessment due to the patient being on section 17 leave or community patients failing to attend.</p> <p>3.2 Responsible Clinician and statutory consultee unavailable to discuss the</p>	<p>3.1 & 3.2 - These areas have not been identified as issues within Cardiff and Vale. No complaints have been received from any SOADs and no issues have been identified through local audit.</p>

<p>proposed treatment with the SOAD.</p> <p>The Mental Health Clinical Board generally has a responsibility for making sure arrangements are in place to facilitate a SOAD visit.</p>	
<p>3. Care and Treatment Plan:</p> <p>3.1 There were significant issues with patients care and treatment plans and risk assessments. Many plans and risk assessments were out of date and did not reflect the present situation. Some patients had risks identified that were not effectively documented along with a strategy for dealing with them. The lack of effective documented evaluation was also an area of concern.</p> <p>3.2 Lack of detail within individual patient care plans did not assure HIW Inspectors that adequate physical healthcare was being effectively delivered, alongside care for patients' mental health.</p>	<p>3.1 The Mental Health Clinical Board is currently devising an in depth CTP audit tool for implementation within its community services and considering how to effectively use this as an outcomes tool which supports the therapeutic relationship with the patient.</p> <p>3.2 Service User records are systematically audited for quality and content by the Mental Health Clinical Board with monthly submissions to the Welsh Government related to CTP quality to ensure there is a holistic care plan. Areas for development are fed back to teams with training. The MHCBC has an award winning GP rota in and out of hours to support the physical health care needs of patients.</p>



Annual Report 2015-16

Mental Health Hospitals,
Learning Disability and
Mental Health Act Inspections

October 2017

10.1

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

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
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CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Fax: 0300 062 8387
Website: www.hiw.org.uk

10.1

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Appendix A

1 Executive Summary

Introduction

Our mental health and learning disability inspections include both independent hospitals and mental health hospitals and community services provided by the NHS. Inspections and follow-up visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services throughout Wales. The inspections also fulfil our responsibility to monitor parts of the Mental Health Measure (2010) by reviewing individual patient care and treatment plans to ensure that patients have a Care Co-ordinator appointed and patients have a comprehensive mental health and physical health assessment. In addition, Part 4 states that every in-patient must have access to an independent mental health advocate and this is another area that HIW monitors.

Our reports provide more context to our visits and enable readers to have more in depth information regarding the setting, our findings, our recommendations and next steps. We ask all hospitals to provide an action plan outlining how and when they will achieve the requirements and/or recommendations and we monitor progress accordingly. All our reports, action plans and updated action plans are published on our website.

Our work

During 2015-16 we conducted 12 inspections of independent establishments and 4 inspections of NHS providers as well as 7 follow-up visits. We also undertook 59 Mental Health Act monitoring ward visits covering 30 hospitals, most of which were undertaken as part of our inspection programme.

In addition, for the first time we started a programme of review for the patients that were subject to Community Treatment Orders (CTO's). We undertook these visits to 3 Health Boards namely; Cwm Taf, Cardiff and the Vale and Aneurin Bevan.

During the inspection year we have issued 8 immediate assurance letters requiring a quicker assurance to some of the more urgent findings from our visits. In addition, in relation to the independent hospitals, a total of 2 non-compliance notices have been sent: this is the first stage of our enforcement process.

What we found

Inspections of mental health services

Throughout our mental health and learning disability inspection visits we have noted a number of areas of noteworthy practice, including:

- the positive rapport between patients and staff, despite staff dealing with very challenging patients;
- we observed an increase in NHS hospitals working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), Star Wards and Safewards, this is to be commended;
- multi disciplinary team working including community based staff across NHS is generally effective and, particularly in private providers, staff felt that the opinions of all professional disciplines that attended the meetings were valued and listened to;
- the level of psychology and occupational therapy input across the independent sector is noteworthy; and
- the openness of staff and patients to engage with the inspection process across both NHS and independent hospitals is generally very good.

However, we also identified a number of concerning themes for the NHS and independent hospitals during our inspections relating to delivery of physical healthcare, availability of sufficient staff with the right skills and knowledge, a lack of robust care and treatment plans, the need to keep essential policies and procedures under review.

Other specific themes identified within the NHS included: a lack of available beds, difficulties accessing psychology and occupational therapy, the need for consistent training in a variety of areas, a lack of a clear admission criteria or its disregard, and the need for robust staff supervision. Maintenance was also a significant issues with 80% of hospitals visited needing maintenance, refurbishment and replacement of equipment and furniture.

Additional issues specific for independent hospitals included a lack of documentation in relation to the responsible Individual visits and inadequate supervision records.

Monitoring the Use of the Mental Health Act

Our Mental Health Act visits did not highlight any consistent failings regarding the administration of the Act in Wales in both the NHS and independent sector.

For the first time during 2015-16 we commenced a programme of monitoring the implementation of the Act for patients in the community on Community Treatment Orders (CTOs). Throughout the health boards there are a significant number of patients detained in the community on CTOs and in some health boards there are nearly as many patients detained in the community, on CTOs, as in-patients accommodated on hospital wards.

We undertook a total of 3 visits to Cwm Taf, Cardiff and the Vale, and Aneurin Bevan health boards where we held interviews and discussions with patients, relatives, advocates and a cross section of staff involved in caring for patients. In all three reviews we found good examples of multi disciplinary team working and decision making. However, we identified issues with completion of documentation including the incorrect use of language when referring to the Act. We also noted that sometimes processes and systems affected the consistency of continuity of the care being provided. In one health board we saw that this led to delays in booking transport for patients and in another health board a lack of a unified electronic system for patient information resulted in delays transferring information between the different organisations involved in caring for patients.

We continue to find that individual Mental Health Act administration teams are struggling to undertake their role in ensuring patient safeguards are upheld, i.e. appeals against detention, provision of rights monitoring, consent to treatment safeguards. This is in the main due to a lack of resources. It is imperative that health boards and independent hospitals review the role of Mental Health Administrators to ensure that they have sufficient time to effectively undertake all aspects of the role.

2 Admission of patients to mental health facilities in Wales¹

In 2015-16, the total number of admissions to mental health facilities in Wales was 9,570. This was a decrease of 192 (2 per cent) compared with 2014-15.

People who are compulsorily admitted to hospital are called 'formal' patients and people who are admitted to hospital when they are unwell without the use of compulsory powers are called 'informal' patients.

In 2015-16, 2,001 people were admitted formally to a mental health facility in Wales for assessment and/or treatment. This represents an increase of 80 (4 per cent) compared with 2014-15.

Table 1 shows a breakdown of patient admissions to mental health facilities from 2012-13 onwards. Please note that the official statistics were revised by Welsh Government in 2015, following the discovery of a data issue in one of the health boards. As a result, some of the data for 2013-14 in the table below has been revised downwards.

Table 1: Number of patient admissions to mental health facilities, 2012-13 to 2015-16

Legal status	2012-13	2013-14	2014-15	2015-16
Formal admissions	1,453	1,692	1,921	2,001
Informal admissions	8,544	8,582	7,841	7,569
All admissions	9,997	10,274	9,762	9,570

Source: Welsh Government Statistics

In 2015-16, formal admissions accounted for 18.7 per cent of all admissions to NHS mental health services and for 86.3 per cent of all admissions to independent mental health hospitals.

While the total number of admissions and informal admissions has fallen for the last three years; formal admissions have increased year on year since 2012-13.

¹ The statistics in this chapter are taken from the official statistics published annually by Welsh Government. As they can be subject to revision, for the latest statistics please refer to the statistics on the Welsh Government's website. Healthcare Inspectorate Wales will not be revising this report, or previous versions of this annual report, if the official statistics are revised.

Figures for the total admissions to NHS mental health facilities by health board and independent settings are shown in Table 2.

Table 2: Number of patient admissions to mental health facilities by setting (NHS and Independent Mental Health Hospitals), 2015-16

Local Health Board/ Independent Hospital	Number	
	Informal	Formal
Betsi Cadwaladr UHB	1,180	345
Powys Teaching HB	261	62
Hywel Dda UHB	682	220
Abertawe Bro Morgannwg UHB	2,283	247
Cwm Taf UHB	816	409
Aneurin Bevan UHB	1,384	151
Cardiff and Vale UHB	920	296
Independent Hospitals	43	271
Wales	7,569	2,001

Source: Welsh Government Statistics

For NHS providers in Wales in 2015-16, Cwm Taf University Health Board had the highest number of formal admissions, (409) and accounted for almost one in four of all NHS formal admissions (23.6 per cent). Abertawe Bro Morgannwg University Health Board had the highest number of informal admissions (2,283), which accounted for almost a third (30.3 per cent) of all informal admissions).

2.1 Use of Section 135 and 136 powers – removal of an individual to a place of safety

Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear, to be mentally disordered. Police officers may use powers of entry under Section 135 of the Act to gain access to a mentally disordered individual who is not in a public place.

If required, the police officer can remove that person to a place of safety. A place of safety may be a police cell, a hospital based facility or 'any other suitable place, the occupier of which is willing temporarily to receive the patient'

Section 136 of the Act allows police officers to detain an individual who they find in a public place who appears to be mentally disordered and is in immediate need of care or control.

Both Section 135 and Section 136 allow for an individual to be detained in a place of safety for up to 72 hours. During this time period an assessment is undertaken to determine whether hospital admission, or any other help, is required. Section 136 is used significantly more often than Section 135. Table 3 shows the number of uses of Section 135 and 136 in Wales in 2015-16.

Table 3: Completed Mental Health Act assessments in hospital under Section 135 and 136, 2015-16

	Hospital is first and only Place of Safety Detention	Hospital is subsequent Place of Safety Detention after transfer from:			Unknown	Total Assessments
		Another Hospital	Police Station	Another Place		
Section 135	44	0	0	1	0	45
Section 136	1,347	24	108	0	0	1,479

Source: Welsh Government Statistics

For the majority of completed Mental Health Act assessments in hospital under both Section 135 and 136 in 2015-16, a hospital was the first and only place of safety. However, there were 108 completed Mental Health Act assessments in hospital under Section 136 that had been transferred from a police station (seven per cent of the total for Section 136).

2.2 Community Treatment Orders

Community Treatment Orders (CTOs) were introduced in November 2008. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.

Table 4 shows the health board breakdown of people discharged from hospital under a CTO in 2015-16 and Table 5 shows the outcome of those who are subject to a CTO in 2015-16 (numbers include patients from previous years). In 2015-16, there were 216 people discharged from hospital under CTOs in Wales. Of those patients still subject to a CTO in 2015-16, there were 102 recalls to hospital, 86 revocations and 116 discharges.

Table 4: Patients discharged from hospital under Community Treatment Order (CTO), 2015-16

Local Health Board	Legal status prior to CTO		Total
	Section 3	Other sections	
Betsi Cadwaladr UHB	23	0	23
Powys Teaching HB	*	0	*
Hywel Dda UHB	27	*	*
Abertawe Bro Morgannwg UHB	44	*	*
Cwm Taf UHB	18	0	18
Aneurin Bevan UHB	32	*	*
Cardiff and Vale UHB	35	0	35
Wales (a)	206	10	216
(a) Wales totals include patient discharged from independent hospitals under supervised community treatment. * Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals. Further figures (5 or more) have also been suppressed to avoid secondary disclosure.			

Source: Welsh Government Statistics

Table 5: Community Treatment Order (CTO) patient outcome, 2015-16

Local Health Board	CTO related activity				
	Recall	Revocation	Discharge	Assignment to the hospital of a CTO patient	Assignment from the hospital of a CTOI patient
Betsi Cadwaladr UHB	12	11	30	6	9
Powys Teaching HB	0	0	*	*	0
Hywel Dda UHB	18	10	14	5	0
Abertawe Bro Morgannwg UHB	18	16	10	0	0
Cwm Taf UHB	29	20	20	0	0
Aneurin Bevan UHB	19	14	32	5	0
Cardiff and Vale UHB	*	13	*	*	22
Wales (a)	102	86	116	23	40
(a) Wales totals include patient discharged from independent hospitals under supervised community treatment. * Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals.					

Source: Welsh Government Statistics

3 What we did

3.1 Our role in regard to mental health

HIW has responsibility for the inspection of NHS services, including mental health. It also has responsibility for the registration and inspection of all independent healthcare under the Care Standards Act 2000 and the associated Regulations and the National Minimum Standards.

We do this by undertaking a programme of inspections which provide an overview of care being provided by mental health services, including, where appropriate, specific review of the care of detained patients and implementation of the mental health measure

Since 2009 HIW has also, on behalf of Welsh Ministers, been responsible for monitoring how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983. We do this by;

- Visiting detained patients in hospital settings and reviewing their care and treatment;
- Providing a registered medical practitioner to authorise and review proposed treatment in certain circumstances (the Second Opinion Appointed Doctor Service);
- Investigating complaints relating to the application of the Act; and
- Producing an annual monitoring report.

3.2 Using intelligence to focus our work

HIW uses intelligence as part of a risk-based approach to influence our work programme. Further information on our risk strategy and our use of intelligence is published on our website

<http://hiw.org.uk/about/plans/operating/?lang=en>.

One key element of the intelligence that we use to focus our mental health work comprises concerns and complaints received from third parties.

In the period 2015-2016 HIW received a total of 324 complaints and concerns via letter, email or telephone either directly or via a third party. Of these, 50 (15%) were in relation to NHS mental health settings and a further 90 (28%) related to independent mental health settings.

In this period, those concerns received related to:

Table 6: Complaints and concerns received relating to mental health services, 2015-16

	NHS	Independent
Whistleblowing	0	3
Patient abuse	4	9
Infrastructure/staffing/facilities/environment	10	32
Consent/communication/confidentiality	3	2
Treatment/Procedure	22	35
Other	11	9

Those concerns were received from a number of sources as set out below;

Table 7: Source of complaints and concerns, 2015-16

	NHS	Independent
Patient	18	32
Relative/Advocate/Other	24	32
Whistleblower	5	20
Staff	3	16

A further source of intelligence are the event notifications that we receive from independent establishments under Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011. Specifically these events are:

- Death of a patient;
- Unauthorised absence;
- Serious injury;
- Outbreak of infectious disease;
- Allegation of misconduct; and
- Deprivation of liberty.

During 2015-16, HIW received 244 notifications of patient safety incidents that occurred within an independent mental health care settings. These were broken down into the following categories:

Table 8: Regulation 30/31 notifications, 2015-16

Serious injury	139
Unauthorised absence of a patient	64
Allegation of staff misconduct	34
Death of a patient	8
Other	4

The information provided on the notifiable event forms enables HIW to assess a healthcare provider's ability to comply with the 2011 Regulations and ultimately that patients are being appropriately safeguarded.

All concerns are assessed by a case manager and recorded as intelligence. The case manager will coordinate as appropriate with relevant agencies including the police, safeguarding boards, coroner and will correspond with the setting to ensure that concerns and incidents are investigated and actions are implemented. Some concerns or incidents may trigger an HIW inspection. Where appropriate concerns at NHS settings can be escalated and action can be taken on regulatory breaches in independent settings in line with our enforcement and non-compliance processes.

3.3 Where we visited

During 2015-16 we conducted 12 inspections of independent establishments and 4 inspections of NHS providers as well as 7 follow-up visits. We also undertook 59 Mental Health Act monitoring ward visits covering 30 hospitals, most of which were undertaken as part of our inspection programme.

In addition, for the first time we started a programme of review for the patients that were subject to Community Treatment Orders (CTO's). We undertook these visits to 3 Health Boards namely; Cwm Taf, Cardiff and the Vale and Aneurin Bevan.

A full list of the health boards and independent registered providers visited is given in Appendix A.

3.4 How we inspect

Engagement of patients and significant others is at the heart of all our inspections. During our visits we engage with as many patients, visitors, relatives and staff as we can.

A range of tools enable the inspectors to examine a number of key areas that impact upon the patient experience including:

- Ward environment;
- Privacy and dignity;
- Overall well- being;
- Food and nutrition;
- Care planning and treatment;
- Medicines;
- Advocacy; and
- Consent to treatment.

Our tools are published on our website to enable easy access to promote and improve patient focused care. These documents are available to organisations, patients, staff, relatives, advocates and any individual with an interest.

The majority of our initial visits take place in the evening where we consider management and leadership amongst a number of issues. Overall our inspections usually last between two and three days. These out of hours visits give an invaluable insight into how the ward operates over a 24 hours.

10.1

4 What we found

4.1 Inspections of mental health services

4.1.1 Quality of patient experience

The experience of patients is at the heart of what we do. We use interviews with patients and questionnaire to gather as wide a range of views as possible.

Overall the feedback received from patients was variable, but we generally received positive feedback about the attitude and caring response from the Multi-Disciplinary Team (MDT). Inspectors also frequently observed a positive rapport between patients and staff, despite the sometimes challenging behaviour of some patients.

One of the recurring themes from many of the patients was boredom, with many stating that there was a lack of meaningful and engaging activities. This seemed a particular issue during weekends. In some part this lack of meaningful activity and therapy may be due to a lack of occupational therapy input which was particularly evident in NHS settings.

4.1.2 Delivery of safe and effective care

Physical health care

There were a number of concerning physical health care issues identified across both NHS and independent hospitals. Out of a total of 30 hospitals visited within 11 (36%) of these physical healthcare was an issue including; a lack of adequate weight management, no records of physical observations such as blood pressure and a lack of nutritional assessments. In addition, the documentation of wound care was poor and did not meet an adequate standard to demonstrate effective wound care was being delivered. Diabetic care plans also lacked detail including the monitoring of blood sugars and a structured approach to the managing the complexities of this condition. This lack of detail within individual patient care plans did not assure our inspectors that adequate physical healthcare was being effectively delivered, alongside care for patients' mental health.

There were also deficits in the completion of fluid balance charts for patients where there were concerns about their fluid intake. For some patients we could not be satisfied that patients were sufficiently hydrated.

Some patients had a physical health issue and no plan of care was in place to address this, some examples of conditions where there were no care plans included patients who had a diagnosed urinary tract infection.

During one of our reviews we observed that no physical health care monitoring was documented following an incident of rapid tranquillisation medication. The monitoring of vital signs is essential post rapid tranquillisation and must be conducted as set out in local policies & procedures and in line with the guidance produced by the National Institute for Health & Care Excellence (NICE)

Adequate numbers of staff

In both NHS and independent hospitals we noted a lack of sufficient numbers of staff for the required observational levels and challenging nature of patients being cared for. Out of 30 hospitals visited there were 19 (63%) where we identified shortfalls in the numbers and skill mix of staff. This has resulted in a number of issues for patients, specifically:

- Some patients being unable to take section 17 leave;
- Some ward/patient areas not being adequately observed;
- Some patients not receiving regular one to one with their named nurse; and
- Some patients being unable to undertake activities because there was not enough staff available to facilitate these.

A lack of registered nurses and medical practitioners

Across both NHS and independent hospitals there was a shortage of registered nurses and medical staff. This was largely being addressed through the use of agency nurses staff and locum medical staff. Numerous issues were identified with agency nurses including the lack of a documented induction process and the availability of information to confirm that the staff had the necessary skills and knowledge to care for the patient group accommodated. Medical vacancies across some organisations were at very high levels and some strategies were being considered, particularly by health boards, to address this area.

Lack of Psychology & Occupational Therapy

We found a number of examples of a lack of psychology and occupational therapy available for patients in a number of NHS hospitals, although this was not so evident in the independent establishments. This meant that patients who were assessed as benefitting from these therapies did not receive them or there were considerable delays in their provision.

In some instances on particular wards there was no psychology or occupational therapy taking place, clearly this may well have a detrimental effect upon a patients recovery where it has been clearly documented and assessed that these distinct therapies were required.

Training

This year we have continued to identify gaps in staff training across NHS and independent hospitals. Out of 30 hospitals visited a lack of training was identified in 14 (46%). Compliance with mandatory training requirements was better in the independent sector than the NHS. Nearly all the NHS hospitals we have inspected were considered to have poor compliance in a number of training areas, including Mental Capacity Act 2005, Mental Health Act 1983, DoLS and the Mental Health Measure (2010). Clearly these deficits in the knowledge and skills of staff and have a detrimental effect upon patient care.

4.1.3 Quality of management and leadership

A Lack of Available Beds

Within the NHS we found examples of a lack of in-patient beds, this had resulted in some patients travelling many miles from home to receive care. In some hospitals temporary beds were erected in dormitory style bedroom areas with no access to a suitable nurse call system. Other examples were of patients who were on leave needing to go back to the hospital and their beds had been given to another patient and they had to go to a different hospital. Within some Health Boards there was a lack of availability of a range of service provision including low secure and services that enabled a clear pathway for patients rehabilitative care. We noted a lack of strategic planning by Health Boards who needed to address this problem.

Inadequate/lack of essential policies and procedures

In a number of our visits within both NHS and independent hospitals there was a lack of robust policies and procedures that were in line with best practice and NICE guidelines. In addition, some policies had not been reviewed for some time and had passed their proposed review date.

Lack of staff supervision

Within NHS hospitals there were examples of a lack of a supervision system for staff, some disciplines had more comprehensive and regular supervision than others but in terms of nursing staff we found examples of no documented supervision for many years.

There were supervision systems and processes in place for the majority of the independent hospitals, however, the quality, evaluation and effectiveness of the records was variable with some examples containing only a sentence or two.

Maintenance

Maintenance was a common issue with 80% of hospitals visited needing maintenance, refurbishment and replacement of equipment and furniture. This occurred across both the NHS and independent sector. Across NHS hospitals on a number of occasions the lack of response to the reporting of maintenance issues has resulted in significant deterioration of the premises. Concerns we identified included; dirty and unkempt patient areas including patient gardens and courtyards, to more significant issues including structural concerns, requiring major repairs. For a number of years there has been a lack of adequate maintenance of these hospitals and now many wards are in a state of disrepair whilst patients still remain accommodated there.

A lack of a clear admission criteria or its disregard

A particular issue identified with NHS hospitals was the lack of clear admission criteria. In addition, where a criteria existed we found examples where patients were admitted outside of that criteria to an unacceptable environment. Eg: patients admitted with advanced dementia into an acute ward of patients where some were displaying alcohol and drug detoxification.

Care and treatment plan

Within 43% of visits undertaken there were significant issues with patients care and treatment plans and risk assessments. Many plans and risk assessments were out of date and did not reflect the present situation and some patients had risks identified that were not effectively documented along with a strategy for dealing with them. The lack of effective documented evaluation was also an area of concern that was identified

4.1.4 Management issues specific to the independent sector

A Lack of Documentation for Responsible Individual (RI) visits

All independent hospitals are registered with HIW and have to comply with The Independent Health Care (Wales) Regulations 2011. Regulation 28 places a requirement on the owners of an independent hospital to visit a hospital at least every 6 months and prepare a written report on the hospital. A copy of this report must be provided to HIW, Unfortunately a number of hospitals did not have documented reports to confirm that Responsible Individual visits had taken place.

A lack of Registered Managers

It is a requirement under the Independent Health Care (Wales) Regulations 2011 that where the Registered Provider is an organisation a manager must be appointed. All the independent hospitals in Wales belong to an organisation so therefore must have a Registered Manager. The obligation to register as manager falls on the person appointed as the manager.

Unfortunately there are occasions in a significant number of hospitals where there is no Registered Manager because a manager has left and the Registered Provider is in the process of appointing another, and some who have been appointed and are completing the registration process. If a person manages an independent hospital but fails to register with HIW they commit an offence under Section 11 of the Care Standards Act. In addition, in some hospitals there is a high turnover of managers and this clearly has an impact upon the leadership at the establishment.

4.2 Monitoring the Mental Health Act, 1983 (the Act)

4.2.1 Purpose of the Mental Health Act

The Act protects individual rights of patients who are vulnerable because of their mental health. The Act allows for medical treatment to be administered to individuals who may not consent to it or have the capacity to consent. The accompanying Code of Practice for Wales has been redrafted and the revised version was published in October 2016

The majority of patients who access mental health and learning disability services in Wales are informal and this means that they will receive treatment on a voluntarily basis. However, some informal patients who are 'liable to be detained'² can be treated in hospital on a voluntary basis. A third group of patients who may require assessment or treatment can be detained against their will under the Act.

The central purpose of the Act is to ensure that both formal and informal patients receive an appropriate level of care and treatment in an environment that is conducive to their needs and promotes recovery. The key principle is based on treatment, not containment, and to balance risks to the patient and those in society. The Act provides a legal framework to allow for appropriate compulsory medical treatment to be given where it is necessary to the patient's rehabilitation.

The Act gives a range of powers and responsibilities on a number of organisations and individuals including:

- Welsh Ministers;
- Officers and staff of Health Boards, independent hospitals and social Services Departments, whether or not they work in mental health services;
- Police Officers;
- Courts;
- Advocates; and
- The relatives of individuals who maybe subject to the Act.

² 'Liable to be detained' is a phrase which refers to individuals who could lawfully be detained but who, for some reason, are not at the present time, Such reason could include, for example, their current co-operation.

The Act is used in a number of diverse environments including:

- Mental health and learning disability wards;
- General medical wards for patients of all ages;
- Other hospitals;
- Accident and Emergency departments;
- Care homes;
- Patients' own homes;
- Courts; and
- Public places.

There are distinct processes that must be adhered to when an individual is being considered for detention. These processes must also be followed when an individual has been detained with either a civil application for admission or a hospital order via the courts. The Act and Code of Practice give safeguards that intend to ensure patients are not inappropriately detained or treated.

5.2.2 How the Act is monitored in Wales

Welsh Ministers have a responsibility to ensure that the Act is lawfully and properly administered throughout Wales and must monitor how services use the Act. Ministers are also required to monitor how services discharge their powers and duties to patients detained under the Act. Patients may be detained in hospital, subject to Community Treatment Orders (CTOs), or guardianship.

This function is undertaken by HIW on behalf of Welsh Ministers who have specific duties that they are required to undertake:

- formulate an annual report;
- provide a registered medical practitioner to authorise and review proposed treatment of patients in certain circumstances;
- keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained; and
- investigate complaints relating to the application of the Act;

HIW has undertaken the role of monitoring the Act since April 2009 and this is our seventh annual report. To discharge our duties we have developed robust systems and processes to ensure that our responsibilities are met.

Mental Health Act Visits

HIW utilises the skills and experience of Mental Health Act Reviewers who visit patients who are subject to the Act in locations across Wales. These reviewers have been recruited by HIW for their skills and knowledge of the operation of the Mental Health Act. They consider how effectively Registered Providers and Health Boards discharge their powers and duties towards detained patients.

During their visits our reviewers will assess the environment, the quality and accuracy of the documentation and they will also speak with patients and staff. Their purpose is to establish whether:

- patients' privacy and dignity is being preserved;
- the Code of Practice is being met;
- the necessary policies and procedures in place;
- patients have an effective care and treatment plan that reflects their detained status; and
- patients have access to a range of professional input to ensure appropriate care and treatment including physical healthcare, psychology and occupational therapy.

In most cases these visits are carried out as part of a general inspection and our MHA reviewers will be part of a larger inspection team. However, there will also be occasions when MHA visits are undertaken as stand-alone visit.

During 2015-16 we undertook 59 MHA visits: 3 of these were to specifically monitor patients subject to CTOs. The overall findings reported earlier in this report were relevant to both formal and informal patients. Our specific monitoring of the application of the Act identified the following noteworthy areas:

- good evidence of administrative and medical audit;
- patients well supported to appeal their detention;
- well maintained detention records; and

- very positive feedback about the role of the Approved Mental Health Professionals (AMPH).

We undertook a total of 3 visits to Cwm Taf, Cardiff and the Vale, and Aneurin Bevan health boards where we held interviews and discussions with patients, relatives, advocates and a cross section of staff involved in caring for patients. In all three reviews we found good examples of multi disciplinary team working and decision making. However, we identified issues with completion of documentation including the incorrect use of language when referring to the Act. We also noted that sometimes processes and systems affected the consistency of continuity of the care being provided. In one health board we saw that this led to delays in booking transport for patients and in another health board a lack of a unified electronic system for patient information resulted in delays transferring information between the different organisations involved in caring for patients.

It should be noted that Mental Health Act Administrators have a pivotal role, within all organisations, to ensure the effective monitoring, administration and implementation of the Act. These Administrators had an increasing workload and all Health Boards and Independent Providers of Healthcare must keep this workload under review to ensure the Administrators have sufficient time to undertake this complex role

In addition our monitoring of the application of the Act identified the following areas of concern;

Are adequate records kept?

During a significant number of our visits we identified that there were issues with record keeping including:

- a lack of copies of key documents such as the AMHP reports on patient files;
- a lack of documented information, within the patients notes, that the statutory consultees had discussed the patient with the SOAD; and
- some records were disorganised and difficult to audit even where the appropriate documentation was available .

Where appropriate has consent been obtained and the assessments of capacity been undertaken?

The documented assessment of capacity was difficult to determine when we examined a number of patient records. This is unacceptable given this key area for effective patient care.

Are individuals detained under the Act aware of their rights under Section 132 of the Act?

There was good evidence that patients' rights were explained to them at the time of initial or renewal of detention under the MHA. However, on many hospital wards we could see insufficient evidence that patients' rights were explained to them on a frequent and consistent basis.

Is Section 17 leave managed appropriately?

There were a number of issues identified with the documentation of section 17 leave including:

- a number of expired forms left on patients files that were not clearly identified as expired. This could lead to confusion as to which forms identifying the conditions of the leave were currently in use; and
- lack of essential information on section 17 leave available on individual patients files, eg: Ministry of Justice paperwork for patients detained under section 37³

The Second Opinion Appointed Doctor Service (SOAD)

SOADs play an important role in safeguarding individuals who are subject under the Act and promoting their human rights. SOADs are key to ensuring proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

- Liable to be detained patients on CTOs (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients;
- Formal and informal patients who are being considered for various serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57);
- Detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58);
- Patients under 18 years of age, whether detained or informal, for whom ECT is proposed, when the patient is consenting having the competency to do so (Section 58A) ; and
- Detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A) .

³ Section 37 is a hospital order, which is an alternative to a prison sentence.

Once a SOAD request has been received by HIW we aim to ensure that the visit takes place within the following timescales:

- two working days for an ECT request;
- five working days for an inpatient medication request; and
- ten working days for a CTO request.

Our SOAD's continue to find that despite making arrangements to see a patient when they arrive the patient is not available. This clearly has an impact for the patient and their treatment. In addition there continues to be occasions when the Responsible Clinician and Statutory Consultees are unavailable to discuss the treatment with the SOAD, although there has been an improvement in the availability of clinical records/patient notes.

SOADs have a key function in the safeguarding of the rights of patients who are detained under the Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments) Individual SOADs come to their own opinion about the degree and nature of individual patients mental disorder and whether or not the patient has capacity to consent.

A SOAD must be satisfied that the patients' views and rights have been taken into consideration. If they are satisfied the SOAD will issue a statutory certificate which then provides the legal authority for treatment to be given. After careful consideration of the patient and approved clinician's views a SOAD has the right to change the proposed treatment. For example a SOAD may decide to authorise only part of the proposed treatment or limit the number of ECTs given.

In Wales during 2015-16, there were **869** requests for a visit by a SOAD, an increase from 812 in 2014-15. Since 2013-14, the number of requests has risen each year..

Of these:

- 793 requests related to the certification of medication,
- 60 requests related to the certification of ECT,
- 16 requests related to medication and ECT.

The following table provides a breakdown of requests per year:

Table 9: Requests for visits by a SOAD, 2006-07 to 2015-16

Year	Medication	ECT	Both	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869

Source: SOAD requests to HIW

6 Conclusion, Recommendations and Next Steps

This report identifies some key issues for Health Boards and for independent providers that must be addressed to give the level of service that patients suffering from a mental illness deserve. Some of the practices and issues identified within the report are unacceptable and it is important that HBs and independent providers have effective governance processes in place to identify issues and address any areas identified.

During our reviews of both NHS and private providers a number of significant issues have been identified by HIW. It is important that providers have robust governance processes in place to identify the issues themselves and take appropriate action. We were concerned to note that around a number key areas including physical healthcare, and care plans and risk assessments for patients, the provider was not aware of the deficits until they were noted by HIW.

HIW continues to work with partnership agencies, HBs and independent providers to improve the patient experience of this very vulnerable patient group.

Recommendations/requirements (requirements for Independent sector only)

Following our findings from our inspections during 2015/16 we have made the following recommendations and requirements (requirements under the regulations are for independent providers only) which the Health Boards and Independent Providers must address in order to deliver a safe and effective service to a vulnerable patient group. Such recommendations will have been included in the individual reports which have been issued to providers following each of our inspections.

Recommendation/requirement	Regulation/standard
Patient experience	
All Health Boards and Independent Providers must ensure that patients have access to a range of meaningful social and recreational activities and that they receive support to participate in these	Health and Care Standards 1.1, 6.1 and 6.2 Regulation 15 (1) (a) & (b)
Delivery of safe and effective care	
All Health Boards and Independent Providers must ensure that all the physical health care needs of patients are fully assessed and addressed	Health and Care Standards 2.2 , 4.1 and 7.1 Regulation 15 (1) (a) (b) (c) & (d)

All Health Boards and Independent Providers must ensure that all wards have adequate numbers of staff (nursing, medical, psychology and Occupational Therapy) to ensure patients needs are fully met	Health and Care Standard 7.1 Regulation 20 (1) (a)
All Health Boards and Independent Providers must ensure that ALL staff have the necessary training, knowledge and skills to effectively care and treat patients	Health and Care Standard 7.1 Regulation 20 (2) (a) & (b)
Quality of management and leadership	
The Health Boards must ensure that there are sufficient inpatient beds available for potential admissions	Health and Care Standard 2.1
The Health Board and Independent Provider must have effective management and quality assurance systems in place to ensure compliance with the regulations and standards to ensure safe and effective treatment	Health and Care Standards 3.4, 3.5 and 7.1 Regulation 19 (1) (a) & (b) and (2) (a) (b) (c) (d) & (e)
The Health Boards and Independent Providers must ensure that policies and procedures are up to date and reflect current good practice recommendations	Health and Care Standards 2.1, 2.6 and 3.1 Regulation 9 (1)
The Health Board and Independent Providers must ensure that ALL staff receive regular meaningful and documented supervision	Health and Care Standard 7.1 Regulation 20 (2) (a)
The Health Boards must ensure that a comprehensive maintenance programme is in place for ALL its hospitals to ensure that the environments of care are and remain suitable to meet the needs of the patients	Health and Care Standard
The Independent Providers must ensure that the Responsible Individuals are undertaking documented visits that cover the areas listed within Regulation 28 of the regulations	Regulation 28
The Independent Providers must ensure that the individual hospitals have a registered Manager in place	Regulation 11 (1) (a) & (b)
The Health Boards must ensure that there is a clear admission criteria and it is effectively implemented	Health and Care Standard 2.1

The Health Board and Independent Provider must ensure that each patient has a comprehensive risk assessment and care and treatment plan in place	Health and Care Standard 6.1
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Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also <i>independent mental health advocate</i> .
Accreditation for Mental Health Services (AIMS)	These are standards produced by the Royal College of psychiatrists for inpatient wards.
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	<p>A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers.</p> <p>Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.</p>
Approved Mental Health Professional	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over

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	is set out in Section 2 of the Mental Capacity Act 2005.
Care Programme Approach (CPA)	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.
CO1 form	Certificate of consent to treatment and second opinion (Section 57)
CO2 form	Certificate of consent to treatment (Section 58(3) (a))
CO3 form	Certificate of second opinion (Section 58(3) (b))
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Compulsory treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you: Particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.

Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as “sectioning” or “sectioned”
Discharge	<p>Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge.</p> <p>Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.</p>
Doctor	A registered medical practitioner.
Doctor approved under section 12 (also ‘section 12 doctor’)	<p>A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers.</p> <p>Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under Section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under Section 12</p>
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).

HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	<p>The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust or Health Board)</p> <p>Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.</p>
Hospital order	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under Section 37 of the Act.
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of

	time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as ' <i>Section 17 leave</i> '.
Liabile to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time
Local Social Services Authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental Health Act Commission (MHAC)	The independent body which was responsible for monitoring the operation of the Act. The Health and Social Care Act 2008 abolished the MHAC. Its functions in relation to Wales transferred to the Welsh Ministers who delegated them to Healthcare Inspectorate Wales (HIW).
Mental Health Review Tribunal for Wales (MHRT for Wales)	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common

	conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Ministry of Justice	Responsible for the Home Office's Mental Health caseworker section along with the public protection caseworker section.
National Institute for Health & Care Excellence (NICE)	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term ' <i>patient</i> ' should be used in practice in preference to other terms such as ' <i>service user</i> ', ' <i>client</i> ' or similar. It is simply a reflection of the terminology used in the Act itself.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under Section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the <i>Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008</i> .
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49 The order or direction will be imposed on an offender

	where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 12 doctor	See doctor approved under Section 12.
Section 37	This is an hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function,
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 132	This provides a responsibility on the hospital managers to take all responsible steps to ensure all detained patients are given information about their rights
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety

Section 136	Section 136 of the Act allows for any person to be removed to a place of safety if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; Part 1 – Primary mental health support services Part 2 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services Part 4 – Mental health advocacy
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Appendix A

Health boards and independent registered providers visited during 2015/16

Health Board	Hospital	Wards
Abertawe Bro Morgannwg University Health Board	Llwyneryr Assessment and Treatment Unit	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Hafod-y-Wennol Assessment and Treatment Unit	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Rowan House	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Cefn-yr-Afon	Ty Ogwr, Ty Garw and Ty Llynfi
Abertawe Bro Morgannwg University Health Board	Princess of Wales, Bridgend	Psychiatric Intensive Care Unit, Wards 14, 15, and 21,
Aneurin Bevan University Health Board	Llanfrecdfa Grange Assessment and treatment Unit	The hospital comprises one ward that was visited
Aneurin Bevan University Health Board	Ysbyty Aneurin Bevan	Carn yr Cefn
Aneurin Bevan University Health Board	Maindiff Court	Ty Skirrid and Lindisfarne wards
Betsi Cadwaldr University Health Board	Heddfan	Clywedog, Dyfrdwy, Gwanwyn, Hydref and Treweryn (PICU)
Betsi Cadwaldr University Health Board	Ablett	Tegid, Cynnydd and Dinas,
Betsi Cadwaldr University Health Board	Hergest	Taliesin, (PICU), Cynan and Aneurin
Cardiff and Vale University Health Board	Iorwerth Jones Centre	Coed-y-Felin and Coed-y-Nant
Cwm Taf University Health Board	Ty Llidiard Child and adolescent Unit	Enfys and Seren

Cwm Taf University Health Board	Royal Glamorgan	Admission, wards 21 & 22, Psychiatric Intensive Care Unit, Enhanced Care Area and, Seren
Cwm Taf University Health Board	Pinetree House	Aspen, Rowan and Willow wards
Hywel Dda	Tudor House	The hospital comprises one ward that was visited

Independent provider	Hospital	Wards
Cambian Healthcare Ltd	Delfryn	Delfryn House, Delfryn Lodge and Rhyd Alyn
Cambian Healthcare Ltd	St Teilo's	Hospital consists of one ward
Coed Du Hall Ltd	Coed Ddu Hall	Ash, Beech and Cedar
Craegmoor Hospitals Ltd	The Priory, Aberdare	The hospital comprises one ward that was visited
Craegmoor Hospitals Ltd	Church Village	The hospital comprises one ward and a self contained bungalow that was visited
Heatherwood Court Limited I	Heatherwood Court	Caerphilly, Cardigan, Chepstow and Caernarvon
Mental Health Care (St David's) Limited	St David's	The hospital comprises one ward that was visited
Mental Health Care (Plas Coch) Ltd	Plas Coch	Morfa and Coachhouse
Partnerships in Care Ltd	Llanarth Court	Awen, Deri, Osbern, Howell, Iddo, Treowen, Teilo and Woodlands Bungalow
Partnerships in Care Ltd	Aderyn	The hospital comprises one ward that was visited
Pastoral Cymru (Cardiff) Ltd	Ty Catrin	Sophia, Victoria, Trelai, Heath and Roath
Priory Group Ltd	Cefn Carnau	Sylfaen, Bryntirion and Derwen
Regis Healthcare Ltd	Regis Healthcare Hospital	Brenin
Rushcliffe Independent Hospitals (Aberavon) Ltd	Rushcliffe Aberavon	The hospital comprises one ward that was visited

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NB – The following hospitals listed above were visited twice during 2015/16;

- Delfryn House and Lodge
- Plas Coch
- Hergest

Mental Health Measure Monitoring Report February 2018
Name of Meeting : Mental Health and Capacity Legislation Committee Date of Meeting : 06 February 2018
Executive Lead : Chief Operating Officer
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number : 1&6
CRAF Reference Number : 8.1.2
Equality and Health Impact Assessment Completed : N/A

RECOMMENDATION

The Committee is asked to:

- **Agree the approach taken by the Mental Health Clinical Board**

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.

BACKGROUND

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.

ASSESSMENT AND ASSURANCE

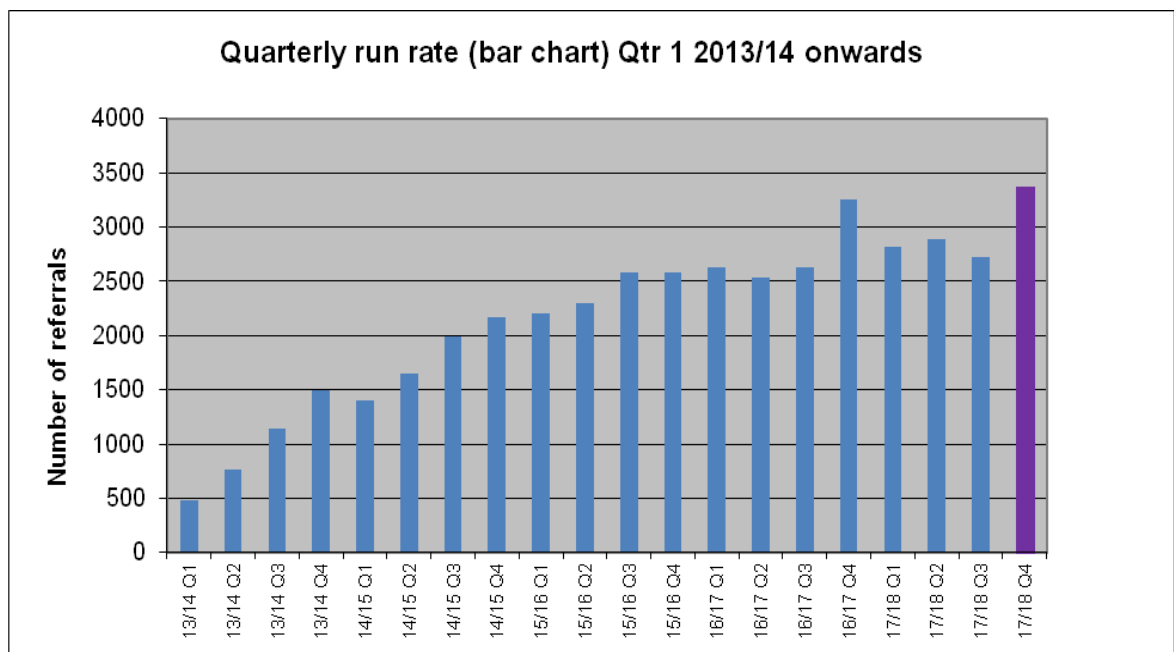
For Parts 1, 2 & 3 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

Quarter 3 of 2017/18 has seen a continued general 'plateauing' of referrals to PMHSS this financial year following the spike in referrals in Quarter 4 of 2016/17. However, estimates based on previous years referral patterns indicate a potentially very busy Quarter 4 with referral numbers for the period topping 3,000.

Figure 1 below shows the Quarterly referral run rate for PMHSS with confirmed data in blue and estimated data in purple. Estimated data is based on previous average month-on-month changes in referral rates for the previous three years.

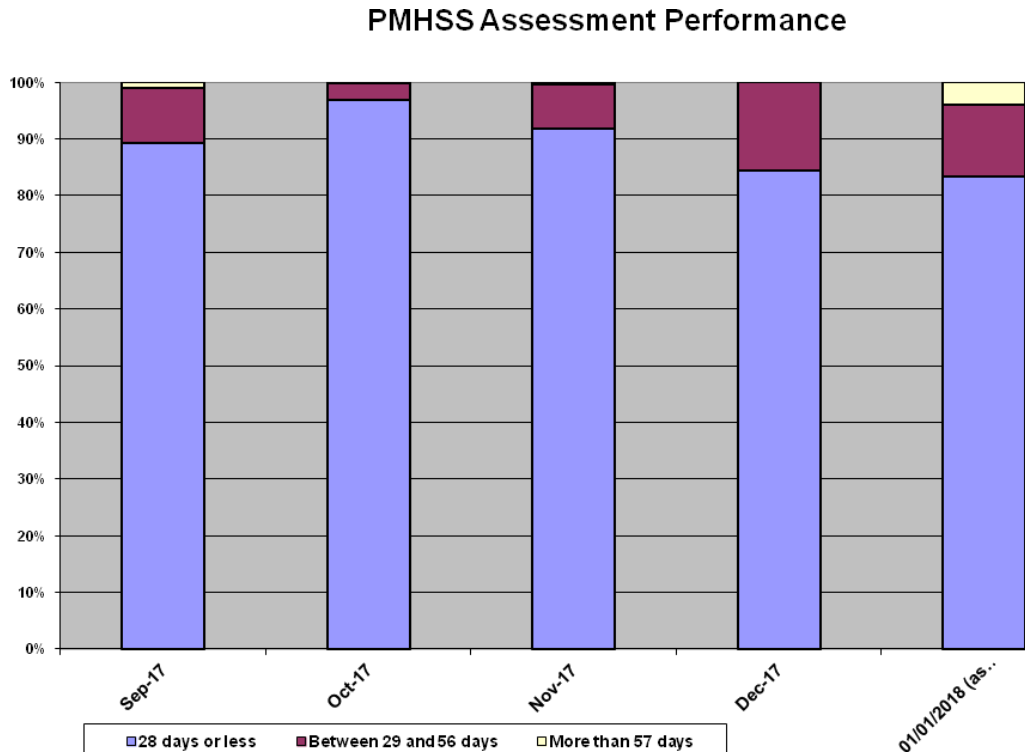
Figure 1:



As stated in the previous Monitoring Report, additional funding has afforded the service the ability to increase its capacity for Band 4 Clinical Psychology Assistant Practitioners and Band 6 PMHSS Practitioners. At time of writing all 3.5wte vacancies for the Band 4 posts are now filled with a start date of mid February set for the 0.5wte Band 6.

See Figure 2 for Tier 1 performance which despite high demand for assessment is being met ostensibly as the service is nearly at establishment with little sick leave over the reporting period.

Figure 2



Current under-18 assessment activity, i.e., that activity which is provided solely by Children & Young Persons (CYP) Primary Care Team, is below the Welsh Government target. In effect this shortfall in compliance can detrimentally affect the overall UHB summary by as much as 10%. However, work is being done with this service, particularly around IT systems and methods of reporting, to achieve and maintain compliance.

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The team is currently at 80% plus for the 28 day target of providing an intervention following completion of a Part 1 assessment.

Mitigation of risk

- PMHSS went live with a Bank staff arrangement in August '15 and have a small pool of staff to draw from. Shifts are currently on Monday and Tuesdays between 5pm and 8pm and every other Saturday between 9am and 5pm. With subsequent increases in the PMHSS substantive establishment, the service is a lot less reliant on Bank with Saturday shifts occurring only once a month, if at all, and less need for weekday evening shifts.

- The Clinical Board is currently reviewing all community vacancies for scrutiny as to whether the resource can be redirected to the PMHSS team to assist with demand, even on a temporary basis.

CYP Issues

The clinical board is currently in regular contact with CYP services regarding:

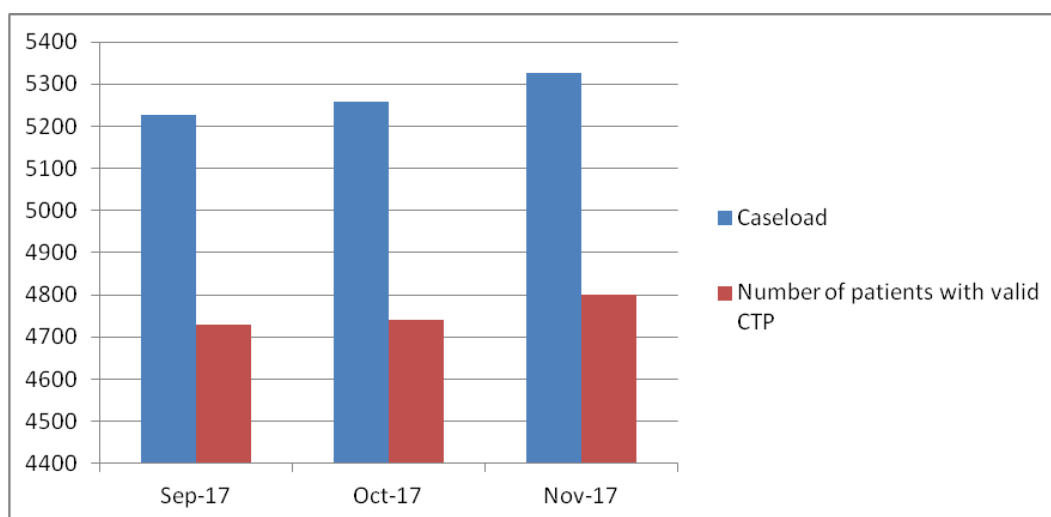
- The average referral rate for financial year 2017/18 has remained steady at 108. The previously documented discrepancy between CAMHS and C&V MHCBA activity numbers has improved since CYP went on to Paris in October '16 but still has a little way to go before being entirely reliable. Regarding the aforementioned increased funding, a proportion of that funding has gone to CYP to increase capacity.

Part 2 & 3 : Care and Treatment Planning

Care and Treatment Planning within Secondary Mental Health Services

The performance target set by Welsh Government for Part 2 is 90%. Monthly caseload variance is due to rates of referrals and discharges. The data includes Adult, Older Adult, Forensic, Learning disabilities and CAMHS services:

	Sept-17	Oct-17	Nov-17
Total number of patients in receipt of secondary MH services in C&V	5,227	5,259	5,327
90% of Service users have a valid CTP	4,730 90.5%	4,740 90.1%	4,799 90.1%



Performance Issues

Adult, Older Adult and Learning Disability are all reporting performance of 90% and above for September, October and November. Learning Disability within Cardiff West has traditionally had a disproportionately high number of relevant patients and has been reviewing the need for many to remain under the Measure. 43 patients have been discharged from their service in the last 3 months.

CAMHS are reporting that their performance just below 40% compliance for October and November. CAMHS service in Cardiff is commissioned by Cwm Taf. This issue was to be discussed in the commissioning meeting on the 4th September but there has been a decrease in compliance. The CTP compliance issue has been once again been raised to our provider of services in Cwm Taf and their Clinical Director.

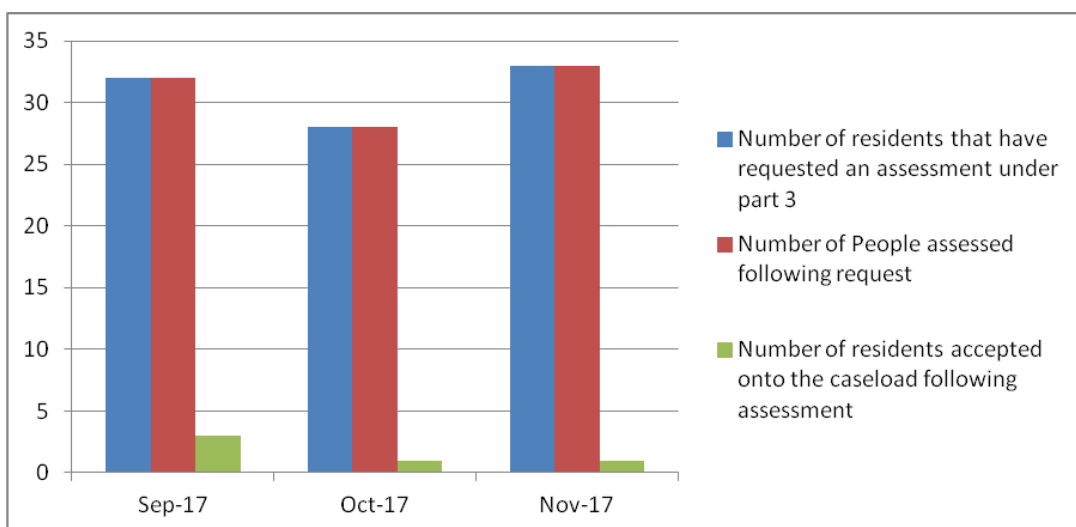
Each directorate within the Mental Health Clinical Board have been instructed to undertake their own audit, which they will feed back to the Clinical Board. The audits will relate to the quality of the care and treatment plans as well as the quantity.

Part 3

Right to request an assessment by self –referral

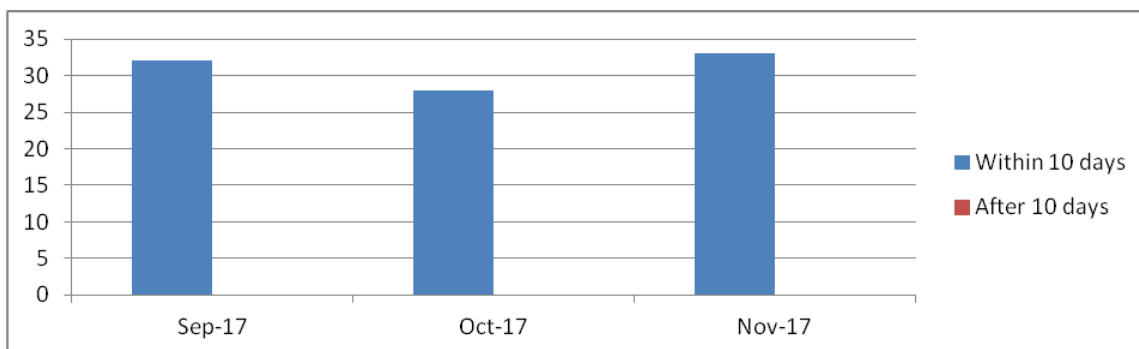
Service users who have previously received secondary mental health services and have been discharged have a right to self refer for an assessment of their mental health for up to three years following discharge.

	Sept-17	Oct-17	Nov-17
Number of residents that have requested an assessment under part 3	32	28	33
Number of People assessed following request	32	28	33
Number of residents accepted onto the caseload following assessment	3	1	1



All part three requests and outcomes are scrutinised prior to reporting. It has previously been reported that there was a high rate of DNA for self referral assessments but attendance has remained at 100% attendance over the last 3 months.

Following part 3 requests there is a requirement to issue an outcome of assessment report within ten working days. The target set out by Welsh Government for this is 100%.



Part 4 : Advocacy Services


Part 4 Inpatient Advocacy


The UHB continues to commission Advocacy Support Cymru and is 100% compliant with part 4 of the measure to provide in-patient advocacy service across the University Health Board. The quarterly return to Welsh Government for July to September 2017 demonstrated a total of 85 new patients (66 compulsory patients and 19 informal patients) over a three month period in line with reporting requirements under the “Duty to Review” for Post-Legislative Assessment of the Mental Health (Wales) Measure 2010. A total of 52 patients were discharged from Advocacy services over this period.

Community Advocacy

The Community Advocacy Service is provided by Advocacy Support Cymru which is commissioned separately by the Mental Health Clinical Board and continues to see growth across the Community setting for the months July to September 2017.

Number of qualifying compulsory patients assisted:	5
Number of qualifying informal patients assisted:	27
Number of referrals for people who could not request advocacy:	1

 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board				
Mental Health and Capacity Legislation committee Draft Work Plan 2017-18	May	Aug	Nov	Feb
Patient Story	Mental Health Measure	Mental Health Act S117	Mental Health Act	Mental Capacity Act
Clinical Board review of ensuring MCA compliance (remitted from HSMB 19.2.15)	Clinical Board MCA compliance report: Medicine / Special	Clinical Board MCA compliance report: Surgery / PCIC	Clinical Board MCA compliance report: Women & Children / Dental	Clinical Board MCA compliance report: CD&T / Mental Health
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) <i>Standing item</i>	x	x	x	x
Section 117 Compliance	x			
Section 136 Partnership arrangements	x			
Monitoring MHA impact of closure of MHSOP ward				
Monitoring MHA impact of changes to community services				x
HIW MHA Annual Report	x		x	x
HIW MHA Inspection Reports (as received)	x	x	x	x
Hospital Managers' Decision Rights	x			
Hospital Managers' Handbook	x	X		
Hospital Managers Power of Discharge sub-Committee Annual Report	x			
Hospital Managers Power of Discharge sub-Committee minutes	x	x	x	x
Mental Health Measure				
Mental Health Measure Monitoring Report	x		x	
Part 1 – Compliance update		x		
Part 2 - Quality of Care & Treatment Plans			x	
Western Vale transfer Monitoring Report	x			
Provision of Mental Health Support to Prisoners (CRAF ref 5.1.16, risk rating 12) <i>Last update October 2014</i>				
Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) <i>Risk rating 16</i>		x		x
MCA Training update	x			
DoLS Monitoring Report		x		x
Deprivation of Liberty Safeguards: Implications of Supreme Court Ruling	x	x	x	x
DoLS Audits		x		x
Consent Audits (CRAF 8.1.3) Risk rating 16	x			
Committee Governance				
Committee Work planner	x			x
Review of Effectiveness			x	
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference				x
Review of Terms of Reference				x

 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board				
Mental Health and Capacity Legislation committee Draft Work Plan 2018-19	Feb-18	Jun-18	Oct-18	Feb-19
Patient Story	Mental Capacity Act	Mental Health Act S117	Mental Health Act	Mental Health Measure
Clinical Board review of ensuring MCA compliance (remitted from HSMB 19.2.15)	Clinical Board MCA compliance report: Medicine / Special	Clinical Board MCA compliance report: Surgery / PCIC	Clinical Board MCA compliance report: Women & Children / Dental	Clinical Board MCA compliance report: CD&T / Mental Health
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) <i>Standing item</i>	x			
Section 117 Compliance				
Section 136 Partnership arrangements				
Monitoring MHA impact of closure of MHSOP ward				
HIW MHA Annual Report	x			
HIW MHA Inspection Reports (as received)	x			
Hospital Managers' Decision Rights				
Hospital Managers' Handbook				
Hospital Managers Power of Discharge sub-Committee Annual Report				
Hospital Managers Power of Discharge sub-Committee minutes	x			
Mental Health Measure				
Mental Health Measure Monitoring Report				
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Part 2 - Quality of Care & Treatment Plans				
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Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) <i>Risk rating 16</i>	x			
MCA Training update				
DoLS Monitoring Report				
DoLS Audits			x	
Consent Audits (CRAF 8.1.3) Risk rating 16				
Committee Governance				
Committee Work planner	x			
Review of Effectiveness				
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference	x			
Review of Terms of Reference	x			



Mental Health & Capacity Legislation Committee

Terms of Reference and Operating Arrangements

1. INTRODUCTION

- 1.1 The University Health Board's (UHB) Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".
- 1.2 In line with Standing Orders (and the UHB Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health & Capacity Legislation Committee**. The detailed terms of reference and operating arrangements agreed by the Board in respect of this Committee are set out below.
- 1.3 The principal remit of this Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure).

Mental Health Act

- 1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.
- 1.5 The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.
- 1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.
- 1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.
- 1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

Mental Health Measure

- 1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:
- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
 - making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
 - extending mental health advocacy provision.

Mental Capacity Act

- 1.10 The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.
- 1.11 The MCA covers three main issues –
- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
 - How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
 - The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus the scope of MCA extends beyond those patients who have a mental disorder.

2. PURPOSE

- 2.1 The purpose of the Mental Health and Capacity Legislation Committee (the Committee) is to give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Act;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice

- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

The Committee will also advise the Board of any areas of concern in relation to compliance with the MHA, the Measure and MCA.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- consider and approve relevant policies and control documents in support of the operation of Mental Health and Capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- consider any other information, reports, etc that the Committee deems appropriate.

Authority

- 3.2 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference, concentrating on the governance systems in place and indicators of their effectiveness, particularly in the management of risk. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the UHB's procurement, budgetary and other requirements.

Sub Committees

3.4 In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a sub-committee, to be known as the Power of Discharge Sub-committee. Three or more members drawn from the Sub-Committee will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to SCT.

3.5 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

Retention of Board Responsibility

3.6 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Cardiff and Vale University Health Board, as well as the Power of Discharge Group.

4. MEMBERSHIP

Members

4.1 A minimum of four (4) members, comprising:

Chair	Vice Chair of the Board
Vice Chair	Chosen from amongst the Independent Members on the Committee
Members	A minimum of two other Independent Members of the Board
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers and partners are expected to be in attendance so that the Committee can obtain appropriate assurances on compliance with mental health and mental capacity legislation across its breadth of statutory responsibilities:

- Chief Operating Officer (Lead Executive)
- Board Secretary
- Medical Director
- Clinical Board Director Mental Health
- Clinical Board Nurse Mental Health
- Head of Operations and Delivery, Mental Health Clinical Board
- Clinical Board Director (or their nominated representative) – Medicine
- Clinical Board Director (or their nominated representative) – Primary, Community and Intermediate Care
- Local Authority Associate Board Member (Director of Social Services)
- Mental Health Act Manager
- Mental Capacity Act Manager
- Representative from Hospital Managers Power of Discharge Group
- Chief Executive – IMHA service provider
- Chief Executive – IMCA service provider

4.3. By invitation:

The Committee Chair may extend invitations to attend committee meetings to others from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration.

Secretariat

4.4 The Board Secretary shall attend every meeting and the meeting will be serviced by a member of the corporate team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair (and, where appropriate, on the basis of advice from the UHB Remuneration and Terms of Service sub-committee).

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of organisational development for Committee members as part of the UHB overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

- 5.1 Two Independent Members, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

- 5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw, to facilitate open and frank discussion of particular matters.

Format of agenda

- 5.4 The agenda for the meeting will be split into three parts comprising of:
- Mental Health Act 1983;
 - Mental Health Measure (Wales) 2010;
 - and Mental Capacity Act 2005.

The proportion of time to be spent at each meeting on the respective parts will be set out in the Committee meeting planner, alternating the focus during the cycle of meetings and according to need.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.
- 6.2 The Committee is directly accountable to the UHB for its performance in exercising the functions set out in these terms of reference.
- 6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information.

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

- 6.4 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example equality and human rights, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

- 7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example the Board's Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, for example where the Committee's assurance role relates to a joint or shared responsibility.

- 7.3 The Board Secretary, on behalf of the Board shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

- 9.1 These Terms of Reference shall be reviewed biennially by the Committee with reference to the Board.



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GIG
CYMRU

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro



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Cardiff and Vale
University Health Board

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 09 JANUARY IN TRAINING ROOM TWO AT HAFAN Y COED.

Present:

Mr Jeff Champney Smith	Chair PoD Group
Mrs Elizabeth Singer	Vice Chair, PoD Group
Mrs Elaine Gorvett	PoD member
Dr John Copley	PoD member
Mr Mike Lewis	PoD member
Mrs Teresa Goss	PoD member
Mr Alan Parker	PoD member
Mrs Sarah Vetter	PoD member
Mr Simon Williams	PoD member
Mrs Wendy Hewitt-Sayer	PoD member
Mr John Owen	PoD member

In attendance:

Ms Sunni Webb	Mental Health Act Manager
Mrs Bianca Simpson-Lepore	Mental Health Act Admin Manager

Apologies:

Mrs Mair Rawle	PoD member
Mrs Patricia Hallett	PoD member
Mrs Sharon Dixon	PoD member
Mr Rashpal Singh	PoD member
Mr Peter Kelly	PoD member
Mr Huw Roberts	PoD member
Mr Tony Summers	PoD member

1 Welcome and Introductions

The Chair of the group welcomed everyone to the meeting and noted there were no guest speakers present.

2 Apologies

All apologies were received and noted

3 Members points for open discussion

Cardiff and Vale University
Local Health Board

MHA PoD Group
09 January 2018

Several PoD members voiced concerns that social workers are attending Hospital Managers hearings without any or sparse knowledge of the patient. Some PoD members commented that this seems to be happening fairly often. One case in particular was highlighted. The panel were able to continue with the hearing and make a fair decision. A comment was made to the social worker that a lack of knowledge of the patient was unsatisfactory. PoD members all agreed that a social worker without any knowledge of the patient could not provide any meaningful input. Also, it was a waste of resource. PoD members acknowledged that social workers were under huge pressure but that hopefully the situation can be improved upon.

4 Minutes of meeting held on 17th October 2017

The minutes were accepted as a true and accurate record of the previous meeting.

5 Matters Arising

The information relating to discharges prior to the hospital manager's hearings has been added to the PoD group information and it was agreed it will be discussed later in the meeting.

PoD members have noticed a drop in the numbers of comments and concerns being raised since Richard Jones' training (at which he suggested the recommendations that PoD members made needed to be worded in a less forceful manner). The Chair of the panel thought this reduction in comments may be due to PoD members getting used to new ways of working and those present agreed with this.

Mandatory fire safety training was discussed within the group. It was discussed that due to MHA office time pressure recently the proposed link and log-in details to the online fire safety had not been sent out as of yet. PoD members were informed that if they felt they needed support in completing the online training then MHA Office staff would be able to assist before or after a hearing. Members were also given the option of attending face to face training.

Breakaway training was also highlighted. The Chair of the group informed those present that an online module will be tested to see if it is appropriate for PoD members to complete. A risk assessment will also be completed. Any further updates will be communicated to the group in due course.

The MHA Admin Manager will endeavour to source panic alarm fobs for all PoD members to increase safety at hearings but PoD members were all reminded of the red strips around the meeting rooms that will automatically send for help.

The Hospital managers Power of Discharge handbook and protocol have been distributed by the Mental Health Act Manager. She has asked for all comments to be submitted to her by the end of January 2018.

Action- Source alarm fobs for hospital managers

6 MHA Activity Monitoring report- October – December 2017

PoD Activity

PoD members discussed the new graph providing details of how long before hearings patients were being discharged. Previously PoD members had postulated that the act of arranging hearings had forced professionals into considering the patients case in more detail and potentially discharging them. However, the graph provided to the PoD members contradicted this as there didn't appear to be any correlation between manager's hearings and discharges.

PoD members queried where the control lines on C Charts come from. The MHA Manager agreed to ask the MHA Coordinator to look into this.

Action- investigate Control Lines on C Charts**MHRT Activity**

The group did not note anything of significance this quarter.

7 Areas of Concerns or Complaints

As previously noted the group have noticed a decline in the numbers of comments being made following hearings. There is however still a concerning amount of comments regarding Care and Treatment plans. The group noted how important reports from appropriate professionals are - in particular care homes or support accommodation where patients reside. Those present agreed that if they did not have sufficient information to carry on they can adjourn a hearing.

8 Training

The Mental Health Act Manager informed all those present that an all Wales Hospital Managers training date was being investigated. The MHA Manager is hoping to get funding from each Health Board to cover the cost of the day. All suggestions for topics for the day should be passed to the MHA Manager. September 2018 is being proposed for the date but this will need to be further looked into.

PoD member were reminded that if no suggestions for training were brought forward then they will potentially lose the day.

9 Any other business

A review of the appraisal process is being undertaken, the MHA Manager and Chair of the PoD group will discuss this with the Mental Health Clinical Board Director of Operations to decide on the best way forward but a potential proposal is that the Chair of the PoD group undertakes all other members appraisals and the Mental Health Clinical Board Director of Operations undertakes his. One PoD member suggested an all Wales review process so that each Health Board is following the same procedure. All those present agreed this would be a positive way forward and it was noted that this should go onto the All Wales Mental Health Act Administrators Forum agenda.

The group were informed that the MHA Admin manager would be commencing maternity leave as of June 2018. They gave congratulations and compliments to her.

Subsequent to all managers hearings the MHA Office send out feedback forms. The group were informed of one specific piece of feedback that said "Those on the panel are always respectful. They are particularly good at explaining processes to patients."

Pod Members were pleased to hear this praise and the Chair of the Panel thanked PoD members for their hard work.

10 Date of future meetings to be held at 10.00hrs in the Seminar Room, First Floor, HYC, UHL:

24 April 2018

24 July 2018

30 October 2018



Attachment 5

POD Recommendations 2016/2017 Analysis

Preamble:

The analysis does not follow any particular scientific approach to content analysis, it's basically what I think. Percentages have been rounded to the nearest number, that's why, if anyone's checked, they add up to 101. Previous percentages are included in normal font in reverse date order

The analysis is only of the POD recommendations, outcomes have not been included. Sections were named by me after grouping similar recommendations together. I have used the heading titles identified in previous years. Recommendations are reproduced exactly as in the reports, a patient name has been redacted.

The number of recommendations has almost doubled from last year.

Areas of Concern (n=114)

Sample period July 2016- June 2017

Care Plans - (27, 24%, 18%, 16%, 17%)

- Care plan needs updating.
- Care Plan needs updating to reflect his current situation. There was no risk assessment included within the papers - clinical team asked to review the situation.
- Care plan needs to be updated to reflect the current situation.
- CTP not updated or signed. Ward staff suggest we have some system to have access to the intervention plan as that is the working document in use.
- CTP needs updating to become more outcome focused.
- The care plan and risk assessment needs to be reviewed.
- The care plan needs to be updated to reflect the rehabilitation plan.
- The CTP although comprehensive is out of date and would benefit from a more outcome focused approach.
- The CTP needs to be rewritten to reflect changes in treatment regime.
- The CTP is not outcome focused and needs to be rewritten to encompass goals that would enable the patient, his family and staff to monitor progress.
- The care and treatment plan needs an urgent update to reflect the current treatment programme.
- CTP was not completed and we request this be done as soon as possible.
- CTP needs updating and outcomes need to be clearer.
- The risk assessment needs to be reviewed - out of date.
- The CTP does not capture the current position of the patient neither is it outcome focused. It needs updating.
- The CTP did not reflect the current care planning and contained factual errors.
- CTP needs review with achievable and realistic outcomes that will allow the MDT to

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monitor progress.

- An up to date risk assessment needs to be provided.
- Care plan to include more achievable short term goals so the patient can see progress.
- The risk assessment and CTP are out of date and should be reviewed as soon as possible.
- The care plan needs to be updated and signed.
- The care plan was out of date and needs updating. Furthermore the professionals need to give careful consideration to the criteria even though the patient speaks positively about the CTO.
- We pointed out that the CTP was not available and the ward nurse will follow this up.
- The Care Co-ordinator confirmed that there was an up to date CTP but it was not produced at the hearing.
- The CTP is not outcome focused i.e. it does not specify the outcomes the MDT is trying to achieve, the time frames or the person responsible. The intervention plan is not personalised and has the wrong name in one instance.
- The panel recommend that the care plan is updated with the patient now that she has moved to a different ward and it is also out of date.
- The care plan needs updating to change the mention of Section 3 to CTO.

Accuracy of Reports - (17, 16%, 11%, 16%, 9%)

- Risk Assessment requires one amendment on page 4 to state the patient comes in every two weeks and not weekly.
- The panel feel certain aspects of reports need correction especially with regard to the dates given for the start of section 37.
- All the reports contained an inaccurate address for the patient and this should be altered. There were also errors in :
 - a) Nurse's report- page 5 the date of the MHA assessment is incorrect.
 - b) The doctors report- page 3 seventh paragraph refers to his admission in 2004 not 2014.
- Risk assessment- the review date is incorrect.
- The review date on the risk assessment needs to be updated.
- The patients address on the care plan is incorrect and needs updating
- There are issues with the report from social services- a lack of information during the period 05/02/2005 and 08/06/2016.
- Future reports are to acknowledge there is no evidence to support a view that he has been a risk to his mother.
- There was a query from the patients advocate on the forensic report detailing his past offences and appearances in court. Could this be checked as numbers did not tally?
- Some dates in the RC report were inaccurate and need correcting.
- Not clear from the reports whether the patient was on remand or serving a prison sentence. The HO15 need to be checked to ensure its accuracy on this point. The panel also noted that the report stated he had been convicted of GBH the professionals attending confirmed this was an error.
- The panel were frustrated that the written nursing report was called into dispute by

15.1

the deputy ward manager. We recommend that nursing reports should be agreed by the nursing team before submitting report to the panel and more importantly the patient and representative.

- It was noted that the risk assessment indicates a current risk of violent or sexual offence this is no longer the case as confirmed by team. We request an amendment to the care plan.
- There are two reports from the nursing staff- one from a previous ward and one from Hazel Ward. The earlier report needs a signature and date.
- In the RC report point 55 there are descriptions of the patient's parents which he finds upsetting and the panel find of no consequence. Consideration should be given to removing those words.
- The patient was unhappy with the inaccuracies in the report and would like this to be rectified; the list of medication is inaccurate.
- Due to the contradiction in opinion in the written reports between the Social Worker and the Clinicians the panel felt the social work report should contain more detailed evidence for not meeting the criteria for detention. The Social Work decision was reversed verbally in the meeting having initially stated in the report that she was recommending lifting of the section. The panel requests a written update be supplied immediately.

Professional Attendance/Preparation for Hearing - (7, 6%, 11%, 3%, 7%)

- The RC needs to be mindful of the importance attached to hearings starting on time.
- No social worker was in attendance.
- The panel were disappointed that the social worker did not attend and a substitute was not provided.
- The Social worker did not attend and no deputy was put in place.
- The Care co-ordinator neither attended nor submitted a report.
- Social worker was not in attendance this made the decision less robust and based on written reports without a recent update.
- It was regrettable that the Social Worker who attended was not known to the client and could not contribute other than her report. It was also regrettable that the nurse from her previous ward only attended. It would have been useful for a nurse from her present ward to be present.

Compliments - (7, 6%, 5%)

- The panel wish to congratulate the work presently and also in the past done for the patient during his stay at Conway house. The panel were pleased to hear of the good progress made by the patient during his four year stay at Conway house.
- The panel wish to congratulate the team on the progress and stability that the patient has shown over the last two years.
- The panel were pleased to note the patients continued improvement and would be keen to see a successful completion of hearing voices course. We were pleased to note that the option of an independent flat with necessary support remains on the agenda.
- The care and treatment plan were comprehensive and up to date.
- The patient has an outcome focused CTP and comprehensive risk assessment management plan.

- All panel members agree that the CTP was comprehensive and outcome focused. Also a comprehensive risk assessment and management plan were included.
- An excellent outcome focused care and treatment plan completed by the primary nurse.

Environment - (7, 6%)

- Managers were concerned by the disruption to the patients sleep due to the continuous alarms going off on the ward. The RC agrees the panel recommend a review of trust blanket policy regarding this.
- The patient was moved to a low secure ward in November due to a bed shortage on the acute ward. This had an implication on his mental wellbeing at the time. He is currently awaiting a bed in a more appropriate setting.
- The patient complains of poor sleep because his bed is uncomfortable and he says too short. We suggest that this could be taken up with the Clinical Board.
- The panel felt that the recent ward move has adversely affected the patient's mental health and a swift return to his original or a similar ward would accelerate his recovery. The patient was upset and agitated at his move and the increase in stress levels may well have contributed to his behavioural relapses. The medical team appeared to be aware of this and we would hope a solution is found in the very near future.
- The accommodation has been missing curtains since April 2016 and the washing machine on the ward remains uninstalled resulting in the patient mum returning to supply further clothes due to losses. Both of these are unacceptable and the panel wishes to be informed of a rapid resolution. The patient's mother considers air conditioning does not provide a comfortable environment. Again the panel want to be informed of progress.
- The patient is currently placed on a low secure rehabilitation ward. The clinical team do not believe that this level of security is necessary. We understand that this placement is due to shortage of beds but that is not beneficial to the patient's health. He is an elderly vulnerable individual with poor mobility currently placed with significantly younger people who he finds threatening and has nothing in common with.
- The panel were concerned to hear that the patient who has a physical illness along with a mental illness was accommodated in a windowless 2 bed room for approximately 5 months. In addition the patient's husband has the same name as her roommate's relative adding to her confusion this clearly made her condition worse. The panel considered that this treatment of patients is highly inappropriate for their mental disorder.

Ward Activity. (6, 5%, 1%, 3%, 5%)

- The patient and his mum complain he lacks things to do on the ward.
- The patient should be assisted to pursue his individual interests- namely modelling and reading. The patient's family feel that he is bored and unmotivated and that he needs practical activities suitable to his physical state to stimulate his life. To expand on one of our recommendations. It became clear that the patient was unmotivated and bored on the ward. He is not a 'thinker' but a 'doer', and finds it difficult to join groups where he has to talk. He would much rather be out walking or

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doing something practical. In fact the only positive thing he has done in months is mend his mothers' front door lock.

- It is also clear that there is nowhere for the patients to go for a walk, escorted or unescorted, except the hospital grounds, and a few other facilities for them that are practically based (Carpentry). The RC reiterated this himself, and mentioned that he was hoping that he might be able to organise transport to take people out to Cosmeston Park.
- Boredom and lack of things to do since the move from Whitchurch, is mentioned a lot by other patients as is feeling as if they are in prison. Family explained to us during the period when we saw just the patient and family that the patient has deteriorated since moving there because he is so bored.
- We realise that in the patient's case his boredom may not all be environmentally based, but to do with his illness. However the paucity of facilities is not helping the patients. I would be glad if you could take this forward.
- The patient expressed the opinion that there is little to do in terms of activity while on the ward. We hope the hospital maybe able to increase these to prevent frustration.

Financial Assistance - (6, 5%, 3%, 6%, 2%)

- The issue surrounding benefits and court of protection should be resolved ASAP.
- The panel noted that the patient has debt problems which is affecting his mental health and urge this matter to be dealt with ASAP.
- A Petty cash facility needs to be available for the patient to access during his stay on the ward.
- The proposed assessment of capacity to manage his financial affairs should be undertaken without delay.
- Under the national assist act 1947 property regulations the patients property needs to be formally visited and an inventory taken of any valuables and important papers required taken into safe keeping.
- The panel would like to see direct payments for weekend support arranged as soon as possible.

Nearest Relative - (6, 5%, 3%, 3%, 2%)

- Further consideration to be given to the patient's daughter's eligibility for financial support in her role as a carer.
- It was of concern that (*patient*) has no one at present look after her finances. With no capacity at present she is very vulnerable. Next of kin is being re-assed.
- The advocate has undertaken to investigate the issue of changing the nearest relative.
- The patient wishes to remove his son as his nearest relative.
- A change of Nearest Relative needs to be formulated with the Mental Health Act Office.
- The issue of nearest relative needs to be identified and clearly stating.

Miscellaneous - (6, 5%, 1%)

- A care coordinator should now be named.

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- The issue of access to the patient's younger child needs to be clarified.
- The communication problems with the family need monitoring for consistency.
- The panel feel that in future hearings it would be helpful for the patient if they take place in the afternoon because of his slow start in the morning.
- Good practice – face to face contact when offering to go through reports.
- It is a priority that firm regular contact is maintained between the patient and his team.

Leave - (4, 4%, 3%, and 6%)

- The panel also agree that attempts should be made to increase the patient's unescorted leave.
- The panel note the good progress made and hope that he will take advantage of additional unescorted leave and be encouraged to do so on a regular basis.
- The patient is allowed 4 hours escorted leave twice weekly but says he has not had any yet. Although nursing staff state that there are nursing shortages, failure to grant escorted leave is concerning and the panel considered that this should be expedited regularly.
- The patient also has a number of personal problems which he needs to deal with in the community.

Advice on Future Treatment/Care - (4, 4%, 14%, 10%, 17%)

- A referral for assessment for aspergers syndrome was made 18months ago and should be followed up.
- A new referral to OT and Physio was suggested.
- The panel felt that the patient would benefit with some on-going physiotherapy to assist with his mobility.
- The panel would like a review of all her medication and a chance for the patient to discuss Clozapine with her doctors.

Physical Problems - (4, 4%, 0, 1.5%, 3%)

- In order to maintain the patients physical health regular dental hygiene is required.
- The panel recommend this be instigated.
- Also a record of the patient's general physical condition would be an advantage in their knowledge of his overall condition.
- The patient to be encouraged to wear his hearing aid and if need be a new one to be considered. We recommend patient be referred to in house GP for pain relief for osteoarthritis.

Reviews etc - (4, 4%, 7%, 6%, 3%)

- The panel wish for six month discretionary review to check the progress of the treatment plan.
- The panel request a review hearing towards end of May.
- The panel recommends that the patient has a discretionary review in 3 months time with the same panel.

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- The panel wish to hold a discretionary review in a month's time to assess progress on the points made above and the patients step down discharge plans to Integra.

Discharge/Move On - (3, 3%, 9%, 10%, 13%)

- The panel wish to see a very early plan for the patient to be moved to a more appropriate placement. The panel understands that this is underway but it should be regarded as urgent due to his physical and mental needs.
- The panel would like to see funding for a move to a supported secure community placement supporting the clinical aspirations put into place as soon as possible.
- Care Co-ordinator to visit Ty Gwyn hall as soon as possible to assess her requirements as there are concerns from the family that they are not being met.

Patient requests - (3, 3%, 3%, 6%)

- Access to his medical records is important to the patient. Currently these are being checked to allow him to have full access. The chair agreed to follow this up with the MHA office.
- The panel noted that the patient has a high level of frustration about his circumstance and feel any investigations into his brain damage need to be expedited ASAP.
- The patient should be given some indication that discharge planning has begun to ease his frustration. The panel does however note that the patient has cognitive impairment and may not grasp the implications.

Patient Access to Reports - (1, 1%, 0, 3%, 5%)

- The patient did not have the opportunity to read through the papers although the AMHP did attempt to undertake this.

Length of Reports - (1, 1%, 0, 1.5%, 2%)

- The medical report was extremely limited only being received on the day of the hearing, this was somewhat improved by an excellent verbal update.

Advocacy - (1, 1%, 8%, 10%, 4%)

- The advocate indicated to the panel that he had insufficient time to prepare. The advocate stated that he was prepared to continue with the hearing. The panel agreed that more time must be given in preparation so that advocacy service can give their clients full support.

Relative's Opinions - (0, 0, 1.5%, 4%)

Missing Documents/Information - (0, 0, 1.5%, 3%)

Headings are listed above in decreasing order of number of comments. I have also read these since Richard Jones's excellent presentation on the rôle of the Hospital Manager.

There has been a significant increase the overall number of recommendations. Our main concerns continue to be the inaccuracy of CTPs and other reports. One new category emerged this year, that of environment. Lack of activity on wards has taken a sharp increase this year. Good to note we are maintaining the increase in compliments to clinical teams. Other issues are pretty self-explanatory.

In light of Professor Jones's comments, I am fairly confident that the subjects of concern are appropriate, however, in some cases we may have to consider the language we use.

Jeff Champney-Smith

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