

Agenda attachments

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COMMITTEE GOVERNANCE

6.1

Self Assessment of Effectiveness

Nicola Foreman

6.1 Committee Effectiveness Review - covering report.docx

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ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE FOR INFORMATION

7.1

Annual All Wales Benchmarking Report

7.1 Draft Annual All Wales Benchmarking Report 2018-19.docx

7.2

HIW Mental Health Inspection Reports

7.3

Inheritance Report for Children and Adolescent Mental Health Service (CAMHS)

7.3 CAMHS.docx

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Hospital Managers Power of Discharge

7.4.1

Sub Committee Minutes

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7.5

Review of the Meeting

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TO NOTE THE DATE, TIME AND VENUE OF THE NEXT MEETING:

Tuesday, 22 October 2019, Woodlands House, Heath, Cardiff CF14 4TT

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday, 4 June 2019
Corporate Meeting Room, Woodlands House, Heath, Cardiff

AGENDA

1.	Preliminaries	
1.1	Welcome & Introductions	Charles Janczewski
1.2	Apologies for Absence	Charles Janczewski
1.3	Declarations of Interest	Charles Janczewski
1.4	Minutes of the Committee Meeting held on 12 February 2019	Charles Janczewski
1.5	Action Log	Charles Janczewski
1.6	Chairs Action taken since last meeting	Charles Janczewski
1.7	Any Other Urgent Business Agreed with the Chair	Charles Janczewski
2.	PATIENT STORY	
2.1		Dr Jane Hancock
3.	Mental Capacity Act	
3.1	Mental Capacity Act Monitoring Report	Peter Durning
3.2	Deprivation of Liberty Safeguards (DoLs) Update Report	Peter Durning
4.	Mental Health Act	
4.1	Mental Health Act Monitoring Exception Report	Ian Wile
4.2	Section 136 Partnership Arrangements	Ian Wile
4.3	Feedback on Mental Health Legislation Group	Robert Kidd
4.4	Policies for Ratification	Ian Wile
5.	Mental Health Measure	
5.1	Mental Health Measure Monitoring Report	Ian Wile
5.2	Delivery Unit Action Plan in Response to Care and Treatment Plan	Ian Wile
6.	Committee Governance	
6.1	Self-Assessment of Effectiveness	Nicola Foreman
7.	Items to bring to the attention of the Board/Committee for Information	
7.1	Annual All Wales Benchmarking Report	Ian Wile
7.2	HIW Mental Health Inspection Reports	Ian Wile
7.3	Inheritance Report for Children and Adolescent Mental Health Service (CAMHS)	Steve Curry
7.4	Hospital Managers Power of Discharge <ul style="list-style-type: none"> Sub-Committee Minutes 	Jeff Champney – Smith
7.5	Review of the Meeting	Charles Janczewski
8.	To note the date, time and venue of the next meeting: Tuesday, 22 October 2019, Corporate Meeting Room,	

	Woodlands House, Heath, Cardiff	
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**UNCONFIRMED MINUTES OF MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
ON 12th FEBRUARY 2019
CORPORATE MEETING ROOM, HQ**

Present:

Charles Janczewski	CJ	Vice Chair
Eileen Brandreth	EB	Independent Member – ICT
Sara Moseley	SM	Independent Member – Third Sector

In Attendance:

Julia Barrell	JB	Mental Capacity Act Manager
Steve Curry	SC	Chief Operating Officer
Nicole Foreman	NF	Director of Corporate Governance
Jane Hancock	JH	Service User Representative
Jenny Hunt	JH	Clinical Psychologist
Kay Jaynes	KJ	Director of Nursing, PCIC
Robert Kidd	RK	Consultant Psychiatrist
Dr Graham Shortland	GS	Medical Director
Katie Simpson	KS	Project Manager for CAMHS Repatriation
J C Smith	JS	Mental Health Act Hospital Manager
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Director of Operations, Mental Health

Secretariat:

HB	Helen Bricknell
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Apologies:

Amanda Morgan	AM	Service User Representative
Lucy Phelps	LP	Service User Representative
Annie Proctor	AP	Clinical Board Director – Mental Health
Jane Tottle	JT	Mental Health Clinical Board Nurse

MH19/02/001	WELCOME AND INTRODUCTIONS	ACTION
	The Chair welcomed everyone to the meeting.	
MH19/02/002	APOLOGIES FOR ABSENCE	
	Apologies for absence were noted.	
MH19/02/003	DECLARATIONS OF INTEREST	
	The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski stated that he is Chair of the WHSSC Quality and Patient Safety Committee and Sarah Moseley informed the Committee that she was the Director of MIND Cymru.	
MH19/02/004	MINUTES OF THE COMMITTEE MEETING HELD ON 23rd OCTOBER 2018	
	Resolved – that:	

- (a) The Committee agreed the minutes of the meeting held on 23 October 2018

MH19/02/005 ACTION LOG FOLLOWING THE LAST MEETING

The Committee received the Action Log from the October meeting.

Resolved that:

The Committee Members reviewed the action log for the meeting held in October 2018.

MH19/02/006 ANY OTHER URGENT BUSINESS

There was no other business to raise

MH19/02/007 DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) MENTAL CAPACITY ACT 2005

Dr Graham Shortland, Medical Director introduced the report. The following comments were made:

- The key issues remain the same as previously.
- There were significant waiting times and urgent referrals were being given priority
- Blake Morgan, Solicitors, would be delivering training to staff who would be undertaking the DoLS signatory role on the 6th and 7th March 2019.
- 15 reviews were not undertaken for Learning Disability clients who would be jointly funded within the community. The results were not shown with the reviews which had not taken place since 2016 due to constraints within the team. Regarding the Court of Protection applications – Independent Mental Capacity Assessments and Best Interest Assessments, these needed to be submitted as soon as they were completed and this had been raised with the Local Authority. The high demand on requests for COP and DoLS was having an impact on the timeliness of assessments. The Local Authority had put an action plan in place and every effort was being made to expedite the process.

Resolved – that:

- (a) The Committee noted the report.

MH19/02/008 MENTAL CAPACITY ACT (MCA) UPDATE REPORT

The above report was presented to the Committee and the following comments were made:

- The Learning, Education and Development (LED) Department had not provided the MCA training figures.
- The LED Department had stated that they would be able to produce the training statistics for the next meeting.
- It was agreed that MCA information should be explicitly included in the Healthcare Standards assessments that Clinical Boards

JB/MD

undertake. The Medical Director would liaise with the Assistant Director of Nursing, Patient Safety, about this.

- Monitoring and triangulation includes the monitoring of incident reports and training around the Mental Capacity Act. If a more detailed audit were undertaken on patients' notes would the correct recording of the Mental Capacity Act be documented in how it was considered, mentioned or used.
- Jane Hancock, Service User Representative mentioned that conversations could be recorded with patients in order to demonstrate that MCA was being followed. However, it was agreed that this would be a large piece of work to undertake.
- Kay Jeynes, Director of Nursing PCIC mentioned that the audit cycle was important as it flags up opportunities for training.
- The uptake by Drs of MCA training needs to increase. The potential consequences of non-compliance were raised and it was agreed that this needed to be discussed outside of the meeting.

Resolved – that:

- (a) The Committee noted and approved the continuing arrangements for the DoLS service.

MH19/02/009 MENTAL CAPACITY ACT REPORT

Resolved – that:

- (b) The Committee noted the MCA report.

MH19/02/010 MENTAL HEALTH ACT MONITORING REPORT

The Director of Operations, Ian Wile introduced the report and presented an overview of the exception report, highlighting the following:

- Section 135 Legislation. There was no further direction from Richard Jones on the start time of Section 136.
- Section 136 Legislation – Patients were distressed when admitted on section 136 and not being signposted to other pathways within Mental Health services when the section starts. The Health Board had been advised to adhere to the Code of Practice and not the Statutory Guidance but was still awaiting a response from Welsh Government on what their position was.
- Sara Moseley, Independent Member Third Sector declared an interest with Mental Health Crisis Care and South Wales Mental Health and Criminal Justice Partnership Board. The Partnership Board had tried to implement work around the Section 136 matter and has not been successful therefore it continued to be escalated.
- Trends on activity would be reported on in the next Mental Health Act Report for the Committee.

Resolved – that:

(a) The Committee noted the report

MH19/02/011 MENTAL HEALTH BENCHMARKING REPORT (RCP)

The Director of Operations, Ian Wile introduced the above report and the following was noted:

- For each quarter the information gets reported to Ian Wile, Director of Operations Mental Health for the purpose of performance reporting
- It was noted that Part 2 was currently compliant.

Resolved – that:

a) The Committee noted the national benchmarking information

MH19/02/012 NATIONAL REVIEW OF MENTAL HEALTH ACT 1983

The Director of Operations, Ian Wile introduced the report and informed members that 154 recommendations had been made.

Resolved – that:

(a) The Committee noted the report

MH19/02/013 HOSPITAL MANAGER'S HEARINGS AND OBSERVATIONS

A verbal update was provided by the Mental Health Act Manager, Sunni Webb and highlighted the following:

- Seven Mental Health Act Hospital Manager's hearings were observed and it was noted that effective communication was delivered at all times during the course of the hearings.

Resolved – that:

(a) The Committee noted the update

MH19/02/014 MENTAL HEALTH MEASURE MONITORING REPORT

The Director of Operations, Ian Wile provided a report on the above. The following comments were made:

- The Delivery Unit audit of the last year part 2 was poor across Wales, and Cardiff was no exception. An action plan has been developed with the DU which will be monitored through the 90 day review cycle with them.
- Part 1b was out of compliance for a number of months due to a fault with reporting. This had now been corrected to show C&V had never been out of compliance with this Tier 1 target.

Resolved – that:

(a) The MHCLC Committee were asked to note the report

MH19/02/015

PART 2 MENTAL HEALTH MEASURE CARE AND TREATMENT PLANS

The Director of Operations, Ian Wile presented the above report. The following comments were made:

- An action plan was in place due to the need for the issues to be addressed.
- Care Aims model - The standards needed to be re-audited.
- Care and Treatment Plan training was carried out in January and it was queried if the timetable should be rolled out further.

Resolved – that:

- (a) The Committee noted the report

MH19/02/016

TIER 2 CAMHS UPDATE

Project Manager for CAMHS Repatriation, Katie Simpson provided an update:

- The Committee asked to see CAMHS benchmarking information
- For adult services a senior Band 7 post has been appointed to lead a program of work to reduce Average Length of stay and the problems to patients associated with that.
- There was low compliance on Care and Treatment Plans of 53% in CAMHS
- It was 6 weeks to transfer day and a single Point of Access had been mapped out
- There had been no risks identified at the time of transfer and all steps had been taken to ensure a safe transition for patients.
- The Health Board recognised that there were risks currently around non-compliance of waiting time targets and more understanding around the KAPPA model was required.
- After 1st April a large amount of vacancies would become available and it was important that this was recognised and how the recruitment to these roles would be managed within the Organisation.
- Mental Health Measure Part 1 of the scheme is being updated around the single point of access.
- Part 2 Compliance lies within the specialist CAMHS service and the service are doing work around achieving the targets.
- Current performance target for referrals is 28 days and it was reported that we are currently treating approximately 65% of these.
- Target Date for the services to be open was the 1st April 2019.
- Eileen Brandreth, mentioned that we should ensure that the caseloads/referral figures are correct so that the team are aware of the level expected.
- The age of Children to transfer into Adult services is 17½ years of age.

IW

Resolved – that:

<p>MH19/02/017</p>	<p>(a) The Committee noted the update</p> <p>MENTAL HEALTH OPERATIONAL GROUP</p> <p>Dr Robert Kidd provided a verbal update:</p> <ul style="list-style-type: none"> • If the Chair meets with the Minister a mention of Section 136 status would be helpful as would input from Welsh Government. • A new poster had been approved relating to Section 136 and it could be placed in the A& E Department. • Section 135 warrant that allows entry into a persons' home and the process of obtaining a warrant. • Section 136 forms would be going electronic in the near future. • It was mentioned that other Forums can cascade information down to the Mental Health Operational Group for further discussion. • AMHP forum has been invited to share any operational issues with them so items can be dealt with together. <p>Resolved – that:</p> <p>(a) The Committee noted the update</p>	
<p>MH19/02/018</p>	<p>CONTROLLED DOCUMENTS TO BE APPROVED</p> <p>The Director of Operations, Ian Wile introduced:</p> <ul style="list-style-type: none"> • Patient Rights Information to Detained/Community Patients under Mental Health Act, 1983 Policy • Patient Rights Information to Detained/Community Patients Mental Health Act, 1983 Procedure • Admission to Hospital under Part II of the Mental Health Act, 1983 Policy • Application for admission to hospital under Part II of the Mental Health Act, 1983 Procedure • Review of Detention and Community Treatment Order, Mental Health Act 1983 Policy • Review of Detention and Community Treatment Order, Mental Health Act 1983 Procedure <p>Resolved – that:</p> <p>(a) The Committee approved the documents</p>	
<p>MH19/02/019</p>	<p>Self-Assessment</p> <ul style="list-style-type: none"> • Self-assessments needed to be rolled out to every member of the Committee for them to complete. • Results would then be reported back to a future meeting of the Committee. 	<p>NF</p>

Resolved – that:

- (a) The Committee approved the process for self-assessment.

MH19/02/020

Annual Report 2018/19

The Annual Report was introduced by the Director of Corporate Governance. The report provided detail of the work of the Committee for the past 12 months.

Resolved – that:

- The Committee recommended approval of the Annual Report to the Board.

MH19/02/021

Terms of Reference Review

The Director of Corporate Governance introduced the report stating it was good governance and in line with Standing Orders that Terms of Reference should be revised annually.**Resolved – that:**

- (a) The Committee recommended approval of the Terms of Reference by the Board.

MH19/02/022

Work Plan 2019/20

The Director of Corporate Governance introduced the report which provided a plan for 2019/20 for the Committee.

Resolved – that:

- (a) The Committee recommended approval of the work plan from the Board.

MH19/02/023

ITEMS TO BRING TO THE ATTENTION OF OTHER BOARD/COMMITTEE:

INSPECTION/REGULATION COMPLIANCE HIW REPORT

The Director of Operations, Ian Wile gave a verbal update:

- This item to be brought to the next meeting.

Resolved – that:

- (a) The Committee agreed the updates

MH19/02/024

HOSPITAL MANAGERS POWER OF DISCHARGE

The Chair of the Power of Discharge Group, Jeff Champney-Smith

introduced:

- Sub-Committee Minutes
- Terms of Reference

Resolved – that:

- (a) The MHCLC Committee agreed the Sub-Committee minutes and Terms of Reference

MH19/02/025 REVIEW OF THE MEETING

There was nothing to report

MH19/02/026 DATE OF THE NEXT MEETING:

Tuesday June 4th 2019 at 10am, Corporate Meeting Room,
Headquarters

ACTION LOG
FOLLOWING MHCLC COMMITTEE MEETING
FEBRUARY 2019

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MH: 19/02/016	Tier 2 CAMHS Update	For a CAMHS benchmarking report to be brought to a future meeting		I Wile	Complete – verbal report on the day
Actions In Progress					
MHCLC 18/31	Hospital Managers Power of Discharge Sub Committee Minutes	Dr R Kidd to report back on the Correct Completion of Care and Treatment Plans from the MHLAG Group.	23.10.2018	R Kidd	Raised in Directorate Quality & Safety meetings and link to wider quality of care planning initiative with IW
MH: 19/02/008	Health and Care Standards - Mental Capacity Act Training	Clinical Boards - Health and Care Standards - Mental Capacity Act Training. Medical Director to discuss at next meeting	04.06.2019	J Barrell / Medical Director	Will be carried forward to October meeting
MH:19/09/016	Tier 2 CAMHS Update	The Committee asked for Benchmarking information	04.06.2019	I Wile	Verbal update at June Committee
MH: 19/02/019	Self-Assessment	Results to be reported to a future meeting	04.06.19	N Foreman	On agenda for June meeting
Actions referred to committees of the Board					

Report Title:	MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT							
Meeting:	Mental Health and Capacity Legislation Committee				Meeting Date:	4/6/19		
Status:	For Discussion		For Assurance		For Approval		For Information	✓
Lead Executive:	Medical Director							
Report Author (Title):	Mental Capacity Act Manager							

SITUATION

The Mental Health and Capacity Legislation Committee has asked for information about the use of MCA, in order to retain awareness of this issue.

REPORT

BACKGROUND

The Mental Capacity Act 2005 (MCA) has been in force for over 11 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers people aged 16 years and over with 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)

Patients who have impaired decision-making abilities may present in any of the services that the UHB provides. 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
- 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 using MCA, the following are in place -

Training (mandatory)

- Face-to-face teaching from the MCA Manager including monthly UHB wide sessions at various locations, "Mandatory May and November" training, Senior Medical Induction and Nurse Foundation Programme
- 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

Welsh Govt - consideration of the MCA training requirements for clinicians, all-Wales data on training, etc will be discussed at a future all-Wales MCA meeting.

Court of Protection – the UHB made an application to the court regarding providing eye surgery to a patient who was objecting to it.

Specialist Services Clinical Board completed an audit of mental capacity assessments across almost all of its directorates. The results were patchy. There were some examples of well documented mental capacity assessments, but other examples where the assessments were poor.

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.

ASSESSMENT

Whilst there are individual clinicians and service areas that have developed an understanding of MCA and comply with it, the position is not uniform across the UHB: there is still a way to go until MCA is embedded in clinical practice. This is also confirmed by Advocacy Support Cymru, the statutory IMCA provider.

ASSURANCE is provided by:

This information does not provide direct assurance about compliance with MCA, which can only be done by scrutinising patients’ notes.

The report of the MCA Manager (appendix one) and IMCA report (appendix two) provide some evidence of adherence to the MCA but only Limited Assurance.

RECOMMENDATION

The Committee is asked to:

- Note this report

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click [here](#) for more information

Prevention		Long term		Integration	✓	Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	<p>Yes / No / Not Applicable</p> <p>If "yes" please provide copy of the assessment. This will be linked to the report when published.</p>								



Mental Health & Capacity Legislation Committee**MENTAL CAPACITY ACT ISSUES AND INFORMATION****June 2019**

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/1/18 - 31/3/18	23
1/4/18 – 30/6/18	24
1/7/18 – 30/9/18	15
1/10/18 – 31/12/18	31
1/1/19 – 31/3/19	30

There are no obvious themes or trends to the queries. Some are straightforward, whilst others are complex, including obtaining legal advice and applying to court.

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

Referrals from the UHB to IMCA are as follows:

Decision/Issue	April – June 18	July – Sept 2018	Oct – Dec 2018	Jan – March 2019

Accommodation	12	22	15	16
Adult Safeguarding	2	1	1	4
Care Review	1	2	4	1
Serious Med T/ment	3	9	8	7
DoLS s.39A	0	0	1	0
DoLS s.39C	0	0	0	0
DoLS s. 39D	8	3	11	8
DoLS RPR	42	28	60	30
TOTAL	68	65	100	66

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

3) Healthcare Inspectorate Wales (HIW) reports

There were no inspection reports about UHB services published by HIW in the period January – March 2019.

4) Complaints from patients/carers

No complaints concerning or related to MCA issues during this period have been brought to the attention of the MCA Manager. However, it is very likely that there are complaints in this period which include MCA issues.

5) 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 period October to December 2018 includes

2 cases that were upheld or partially upheld against Cardiff and Vale UHB. MCA issues do not appear to be a factor in any of the cases.

6) Staff MCA training as at 30th April 2019

The following table gives the numbers and percentages of clinical staff who are up to date with their mandatory MCA training. MCA training can be undertaken by completing the all-Wales MCA Level 2 e-learning course on ESR, or by face-to-face training provided by the MCA Manager.

The compliance figures are disappointing and seem to have deteriorated, despite the Medical Director requiring, in writing, that Clinical Board Directors and Nurses produce action plans to address low compliance, particularly amongst doctors. He also included an article in his September 2018 Bulletin regarding the importance of MCA training.

CLINICAL BOARD	Prof Group	No. required to undertake training	No. who have undertaken training	Compliance %
Children & Women				
	Allied Health Profs	116	54	46.55
	Nursing & Midwif	1115	390	34.98
	Medical & Dental	229	17	7.42
CD&T				
	Allied Health Profs	689	204	29.61
	Nursing & Midwif	129	61	58.82
	Medical & Dental	104	13	12.5
Medicine				
	Allied Health Profs	4	0	0
	Nursing & Midwif	785	243	30.96

	Medical & Dental	248	26	10.48
Mental Health				
	Allied Health Profs	31	11	35.48
	Nursing & Midwif	505	171	33.86
	Medical & Dental	74	4	5.41
PCIC				
	Allied Health Profs	83	22	26.51
	Nursing & Midwif	374	135	36.1
	Medical & Dental	73	5	6.85
Specialist				
	Allied Health Profs	40	14	35.0
	Nursing & Midwif	860	238	27.67
	Medical & Dental	230	17	7.39
Surgery				
	Allied Health Profs	17	10	58.82
	Nursing & Midwif	453	136	30.02
	Medical & Dental	469	22	4.69

APPENDIX 2

Mental Health and Capacity Legislation Committee

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

Cardiff and Vale University Health Board

IMCA referrals

Total number of referrals received from January 2019 – March 2019 – 66 Referrals

- Serious Medical Treatment – 7
- Long Term Move of Accommodation – 16
- Safeguarding Vulnerable Adults – 4
- Care Review – 1
- RPR – 30
- IMCA 39d – 8
- IMCA 39C – 0
- IMCA 39a – 0

Service issues/Areas of concern

- General lack of understanding and acknowledgement from professionals across the health board in relation to IMCA role – Awareness raising sessions continue to take place upon request.
- General lack of understanding and acknowledgement from professionals across the health board in relation to Court of Protection processes and requirements
 - Professionals have a distinct lack of knowledge around moving a patient against their will when there is no authority in place to do so.
 - Reluctance from professionals to instigate Court of Protection proceedings when the patient is objecting to the proposed move.
- General lack of Safeguarding and Care Review referrals.
- Issues around DoLS – IMCA team receiving DoLS authorisations/RPR referrals when they have been active for weeks (leaves little time to act)
- 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 and protesting to the Best Interests outcome.

- The IMCA team have recently received a number of referrals that are very short notice or where a decision has already been made.

Report Title:	Deprivation of Liberty Safeguards (DoLS) – Mental Capacity Act 2005					
Meeting:	Mental Health and Capacity Legislation Committee			Meeting Date:	4th June 2019	
Status:	For Discussion		For Assurance		For Approval	For Information X
Lead Executive:	Medical Director					
Report Author (Title):	Medical Director					

SITUATION

The Mental Health and Capacity Legislation Committee had agreed that regular reports, providing information about the UHB's compliance with DoLS should be tabled.

Depriving a patient of their liberty where there is no court order or DoLS authorization in place (and the patient cannot be detained under the Mental Health Act 1983) is unlawful and the UHB could be sued for this.

REPORT

BACKGROUND

The Deprivation of Liberty Safeguards, an amendment to the Mental Capacity Act 2005, came into force on 1st April 2009. DoLS provide a means by which a mentally disordered, incapacitated, adult can lawfully be deprived of their liberty in hospital, if it is in the best interests of the person and there is no less restrictive way of caring for them.

As of 1st April 2009, the UHB and Cardiff and Vale of Glamorgan Local Authorities formed a partnership to provide a DoLS service across the three organisations delivered by a DoLS team. A Partnership Review Board meets on a three monthly basis with senior officials from each organisation.

Since the "Cheshire West" Supreme Court ruling in 2014, the number of applications for DoLS authorization has increased very considerably, although now appears to be stabilizing.

The DoLS Team co-ordinates the six assessments that have to be undertaken in order to establish whether a deprivation of liberty is occurring and whether the patient meets the criteria for a DoLS authorization to be granted.

ASSESSMENT

Please see appendix 1 for details of the Deprivation of Liberty Safeguards Team's Partnership Report for the year April 2018 to March 2019. Broadly, activity remains similar to the previous year and remains consistent with the significant increase seen following the "Cheshire West" Supreme Court ruling in 2014, although the number of applications appears to be stabilizing.

Assurance for the UHB is provided by the fact that the Partnership Board continues to give priority to Urgent Authorisations, which are predominantly from Cardiff and Vale UHB. There is a priority tool matrix which continues to be used by the DoLS Co-ordinator to determine priority and workflow management.

There remains an on-going risk of outstanding DoLS Authorisation requests, but this is a greater risk for Local Council partners, as the assessments for Urgent Authorisations are given priority. There remains a financial risk in re-negotiation of the DoLS funding equation. Mitigation against this is on-going work by the Partnership Board to look at the processes and functions being undertaken with the DoLS team to consider efficiency savings where support or resource is required.

Internal Audit's DoLS Follow-up Audit has been deferred until quarter 4, 2019/20 to allow the process regarding the new DoLS signatories to bed in.

Blake Morgan, LLP, Solicitors, have provided bespoke training to senior UHB staff to enable them to become signatories for DoLS authorizations. A paper setting out the signatories will be submitted to a UHB Board meeting for ratification.

Since the last MHCL meeting, the Mental Capacity Amendment Bill has been enacted. This will replace DoLS with a new system, to be known as Liberty Protection Safeguards (LPS). It is likely that LPS will come into force in the first half of 2020.

ASSURANCE is provided by:

- Regular review of the DoLS service by a tri-partite Partnership Review Board
- Mitigation of risk with priority given to Urgent assessments which are predominantly from Cardiff and Vale UHB

RECOMMENDATION

The Committee is asked to:

- **APPROVE and NOTE** the continuing arrangements for the provision of a DoLS service.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time				10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives					
Five Ways of Working (Sustainable Development Principles) considered <i>Please tick as relevant, click here for more information</i>									
Prevention		Long term		Integration		Collaboration	✓	Involvement	
Equality and Health Impact Assessment Completed:		Yes / No / Not Applicable If “yes” please provide copy of the assessment. This will be linked to the report when published.							



Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team Summary Report April 2018 – March 2019

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

This report is an end of year performance and financial report for the period April 2018 – March 2019.

N.B: Full year financial information is not yet available to be included in this report due to end year processes currently being undertaken. This report will be updated to reflect final figures, when available,

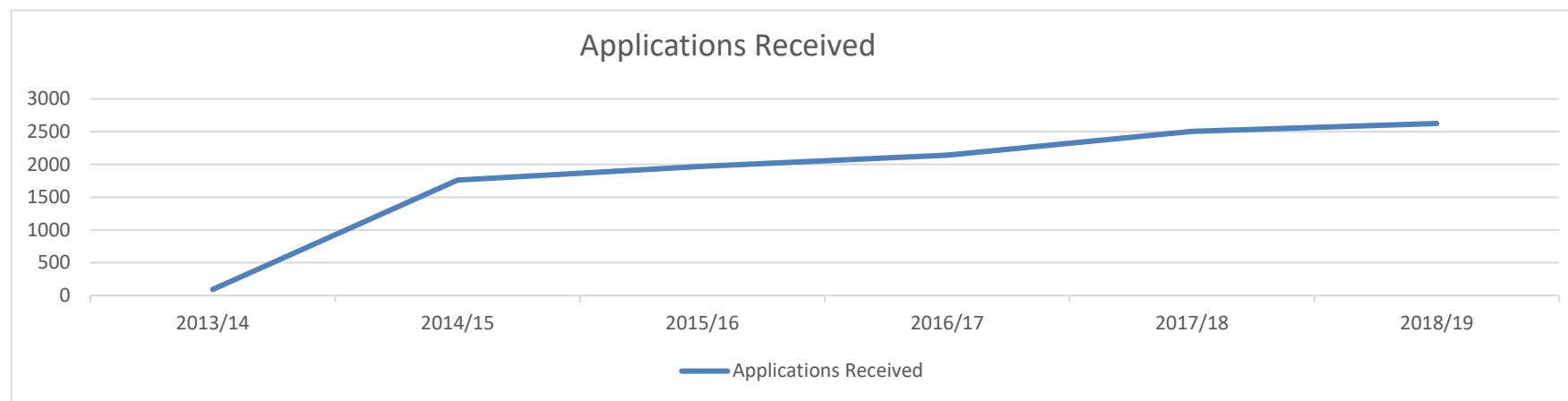
1. DoLS Requests

The table below shows the number of DoLS requests by type, per Supervisory Body during this period.

Received
Cardiff
Cardiff & UHB
Vale of Glamorgan
Total

Standard	Further	Urgent	Review	Total
801	162	111	8	1082
224	67	679	9	979
425	90	43	6	564
1450	319	833	23	2625

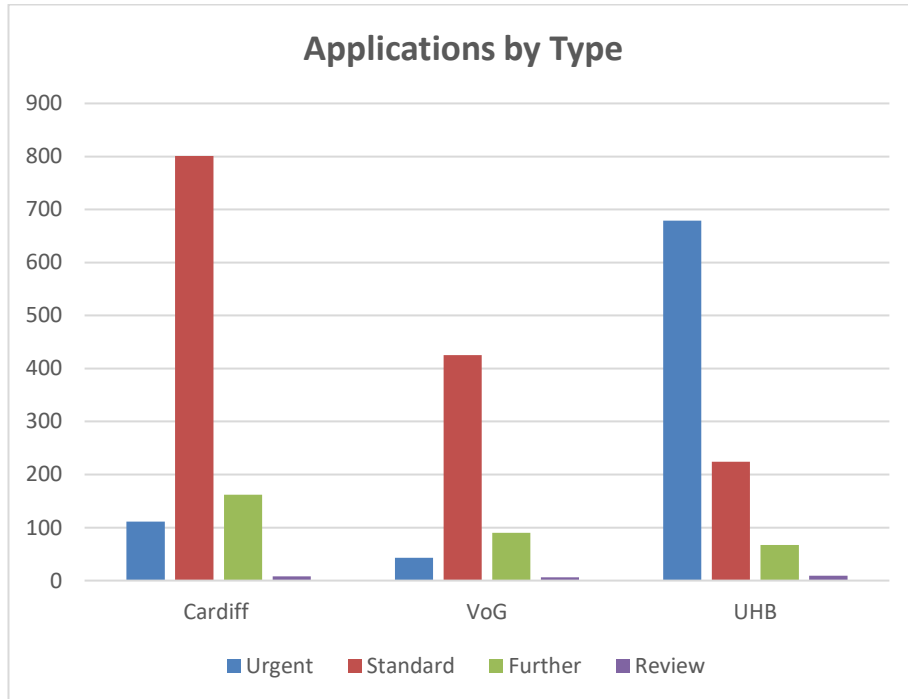
The number of requests being received has continued to increase as shown below, however, there does not appear to be significant increases year on year:



The table below demonstrates the percentage split of requests being received by each supervisory body:

Applications	2014/15		2015/16		2016/17		2017/18		2018/19	
Cardiff	866	49%	778	40%	882	41%	1012	40%	1082	41%
Vale Council	489	28%	534	27%	424	20%	458	18%	564	22%
C&V UHB	406	23%	661	33%	837	39%	1036	42%	979	37%
Total	1761		1973		2143		2506		2625	

2. APPLICATIONS BY TYPE



As the chart shows, the largest proportion of applications being made on behalf of Cardiff Council and Vale Council are standard applications. With the applications being made on behalf of the health board being Urgent Requests.

As demonstrated in the figures the UHB have a significantly higher number of urgent requests. The team work hard to meet the 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 DoLS co-ordinator continues to use the prioritisation matrix in order that we can respond in a timely manner to requests which have the highest priority.

	Urgent	Standard	Further	Review
Cardiff	111	801	162	8
UHB	679	224	67	9
VoG	43	425	90	6
Total	733	1450	319	23

3. WITHDRAWN APPLICATIONS

Applications are withdrawn for a variety of reasons, it is the responsibility of the managing authority to inform the DOLs Team that the assessment request is no longer required. Work is ongoing with the DOLs co-ordinator and Managing Authorities to ensure they are consistently advising us of withdrawn applications. There are a number of administrative processes associated with withdrawn applications and the code requires that processes are followed following these.

The following table shows the number of requests that have been withdrawn by type/supervisory body (2018/19) :

	Urgent	Standard	Further	Part 8 Review	Total
Cardiff Council	24	91	19	0	134
Vale of Glamorgan	9	90	6	1	106
C&V UHB	252	124	31	0	407
Total					647

When considering these figures, it has highlighted a significant amount of resource being associated with withdrawn applications and there is a need to understand this further and attempt to address any practice or driver issues for the large numbers being withdrawn, particularly in relation to the health urgent applications. As highlighted in the previous paragraph there is an administrative process attached to withdrawn applications and this could be reduced if we are able to identify any current issues with this process.

4. Applications Completed

The tables below show the number of applications by type completed on behalf of each Supervisory Body:

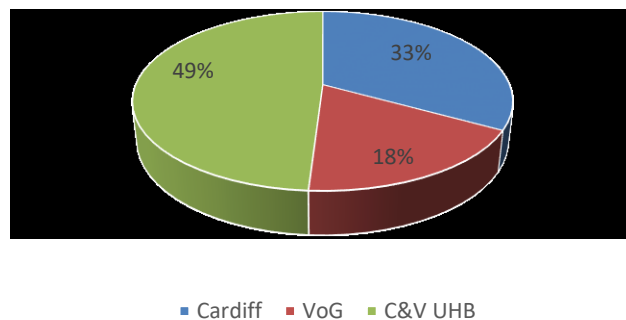
Completed
Cardiff
Cardiff & UHB
Vale of Glamorgan
Total

Urgent	Standard	Further Review	Total	
81	160	66	8	315
411	33	20	5	469
35	105	29	6	175
				959

The above demonstrates that the largest proportion of applications being completed continue to be urgent applications on behalf of Cardiff & Vale UHB.

The charts below show the percentage split of the work completed on behalf of each supervisory body.

Applications Completed



Partnership Funding

The current output focusing purely on the number of authorisations of Deprivations of Liberty continue to exceed the agreed partnership funding contributions, which are as follows:

- Cardiff Council 40.74% plus 1 BIA post @ £45,000
- Vale of Glamorgan Council 14.65% plus 1 BIA post @ £45,000
- Cardiff & Vale UHB 44.61% with additional contribution of £7,000 in 2017/18

It should be noted that ongoing work is being undertaken within the team in terms of workflow and although the split is still not exact this has become more in line with funding agreements.

5. OUTSTANDING APPLICATIONS

There remains high numbers of applications that have been received and not been assessed. Numbers are provided below, however, there needs to be a significant amount of data cleansing to take place by the DoLS Co-Ordinator and Administrator, so caution should be applied to the overall figures. It is anticipated that including this information in this report will provide some level of oversight. This will be built upon in future reports. The table details overall numbers for outstanding applications in a year.

	Standard Applications
2015	44
2016	139
2017	308
2018	770
2019	296

Financial Summary

End of year processes end on 12th April 2019. Following this we will provide an addendum to this report to include end of year financial summary.

Natasha James
Operational Manager, Safeguarding & Service Outcomes
April 2019

REPORT TITLE:	MENTAL HEALTH ACT MONITORING							
MEETING:	Mental Health & Capacity Legislation Committee				MEETING DATE:	12 February 2019		
STATUS:	For Discussion	X	For Assurance	x	For Approval	x	For Information	x
LEAD EXECUTIVE:	Chief Operating Officer							
REPORT AUTHOR (TITLE):	Mental Health Clinical Board Director of Operations							
PURPOSE OF REPORT:								

SITUATION:

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

There have been no exceptions during this period.

REPORT:

BACKGROUND, ASSESSMENT AND ASSURANCE

Detention without authority

During the period there have been no breaches. The number of patients detained without authority has been eradicated since the period July – September 2018. There have been no incidents whereby a person has been detained without authority during the period.

Section 136

Guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983 has been issued by Welsh Government since amendments were made to s.136 by the Policing and Crime Act 2017.

The amendments made reduced the detention period from 72 hours to 24 hours which could be extended under certain circumstances to a maximum of 36 hours. The detention period commenced when the person arrived at the designated place of safety.

This non statutory guidance suggests a contrary approach is taken to that in the Code of Practice for Wales in relation to patients taken to A&E.¹

A detailed consideration of this issue is contained in the Mental Health Act Manual, Richard Jones, twenty - first edition, 1-1366, 606/607.

Legal advice has been obtained and is clear that practitioners should follow the guidance contained in the Code of Practice for Wales, 16.46². Furthermore *“an element of uncertainty about the correct legal position does not constitute a “cogent reason” for departing from the Code of Practice (see the Munjaz case), the approach that should be adopted practitioners in Wales while awaiting clarification by the courts is clear.*

It is worthy of note that some NHS Trust in England follow the guidance in the Code of Practice for Wales.”

Cardiff and Vale UHB's designated PoS is Hafan Y Coed, UHL. There is no dispute that A&E could of course be a place of safety but only in exceptional circumstances, when it is deemed suitable. This will be dictated by health staffs that are in a position to agree on behalf of the management not by the police.

The Mental Health Act Manager has requested clarification on the position of Welsh Government from the Mental Health Legislation Manager on behalf of this Committee. The Mental Health Legislation Manager has confirmed that further legal advice has been commissioned to enable WG to be in a position to provide further communications once received.

This issue has now also been escalated to the Chair, Cardiff and Vale University Health Board for further consideration.

Hospital Managers

Section 23 of the Mental Health Act 1983 (the Act) gives hospital managers the power to discharge most detained patients and all patients subject to a community treatment order (CTO).

This power is delegated to a hospital managers' discharge panel which comprises of independent persons not employed by Cardiff and Vale University health Board. Hospital managers are drawn from members of the Power of Discharge Group.

Members appointed to consider exercising the power of discharge should fully comprehend the role they are to perform and receive adequate and appropriate training to ensure they:

- understand the Act and other relevant legislation
- understand the associated Codes of Practice
- understand risk assessment and risk management reports
- are able to reach sound judgments and properly record their decisions

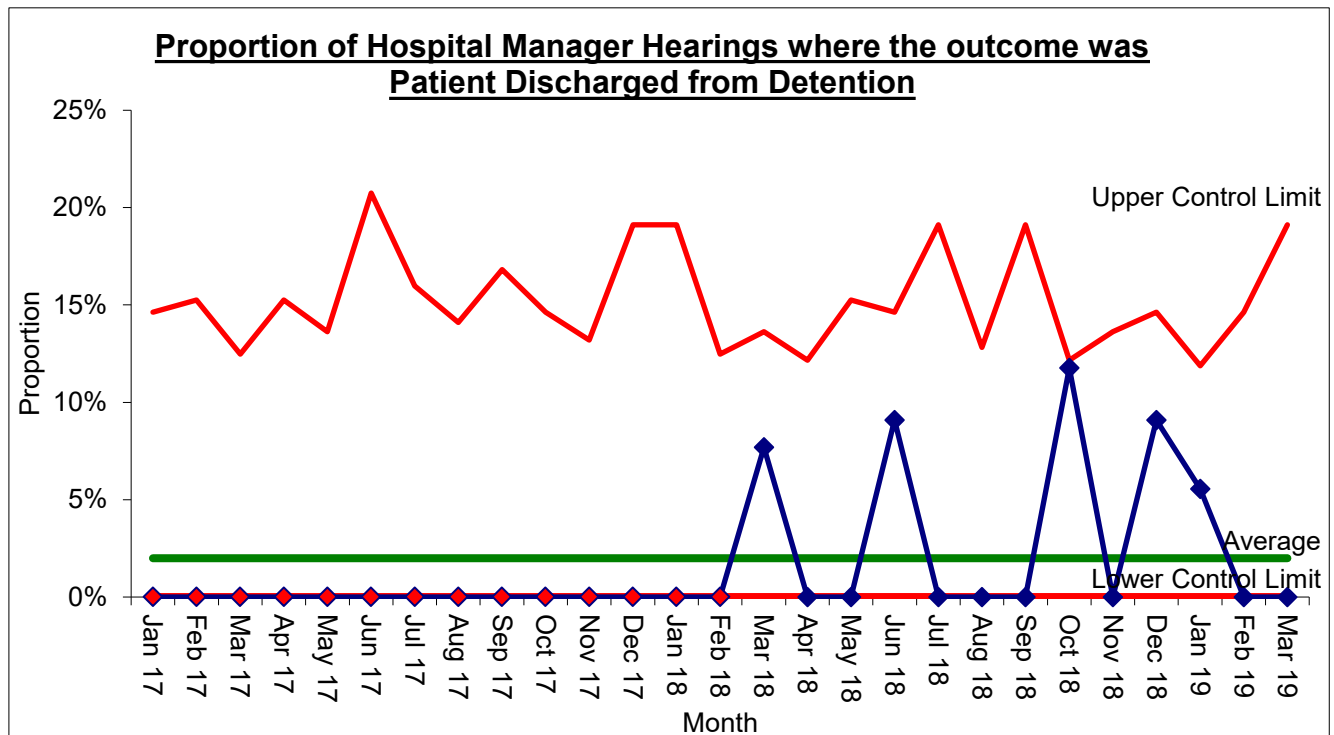
¹ *“If a person is subject to a section 135 or 136 is taken first to an Emergency Department of a hospital for treatment of an illness or injury (before being removed to another place of safety) the detention period begins at the point when the person arrived at the Emergency Department (because a hospital is a place of safety).”*

² *“If in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person under section 136, for the emergency medical assessment or treatment of their physical health this should not be treated as admission to a place of safety. Detention under section 136 will begin when the person is taken to the appropriate place of safety for the assessment of their mental health.”*

Welsh Government has agreed to fund an all Wales hospital managers training event annually since the event which took place in November 2018 was so well received. The Mental Health Act Manager is currently making arrangements for the next event to take place on 17 September 2019.

The Mental Health Act Manager continues to ensure that the Power of Discharge Group are provided with sufficient training. A decision making/writing workshop took place on 22 May 2019.

During the period one patient has been discharged from detention by the hospital managers.



The Director of Operations, Mental Health and Mental Health Act Manager have observed five hearings during the period to provide assurance that panel members are communicating effectively with patients under often particularly challenging circumstances. All members observed have displayed appropriate skills and behavior as a panel member, good knowledge of law and procedure and sound judgment and decision making.

Policies and Procedures

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 is monitored.

The Mental Health Act 1983 Code of Practice for Wales, Revised 2016 sets out a non exhaustive list of recommended policies organised into categories and referenced to the relevant chapters.

All policies should be developed to ensure that the care and treatment patients receive is in line with the guiding principles.

The All Wales Mental Health Act Policy Group was established in 2017 to ensure that policies, procedures and guidance are developed in line with the Mental Health Act 1983, Code of Practice for Wales, Revised 2016. The Group will meet annually to review the Mental Health Act policies/procedures.

A review of the section 117 and receipt of applications for detention under the MHA policies/procedures is currently being undertaken.

The Head of Operations and Delivery, Mental Health Clinical Board and the Mental Health Act Manager continue to work with Mental Health Act Leads from other Health Boards to agree and collate core data so that reliable and valid information can be routinely compared from each Health Board.

ASSURANCE is provided by:

- **Mental Health Clinical Board Director of Operations**

The Board is asked to:

Support the approach taken by the Mental Health Clinical Board ensure compliance with the MHA.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click [here](#) for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
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EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:

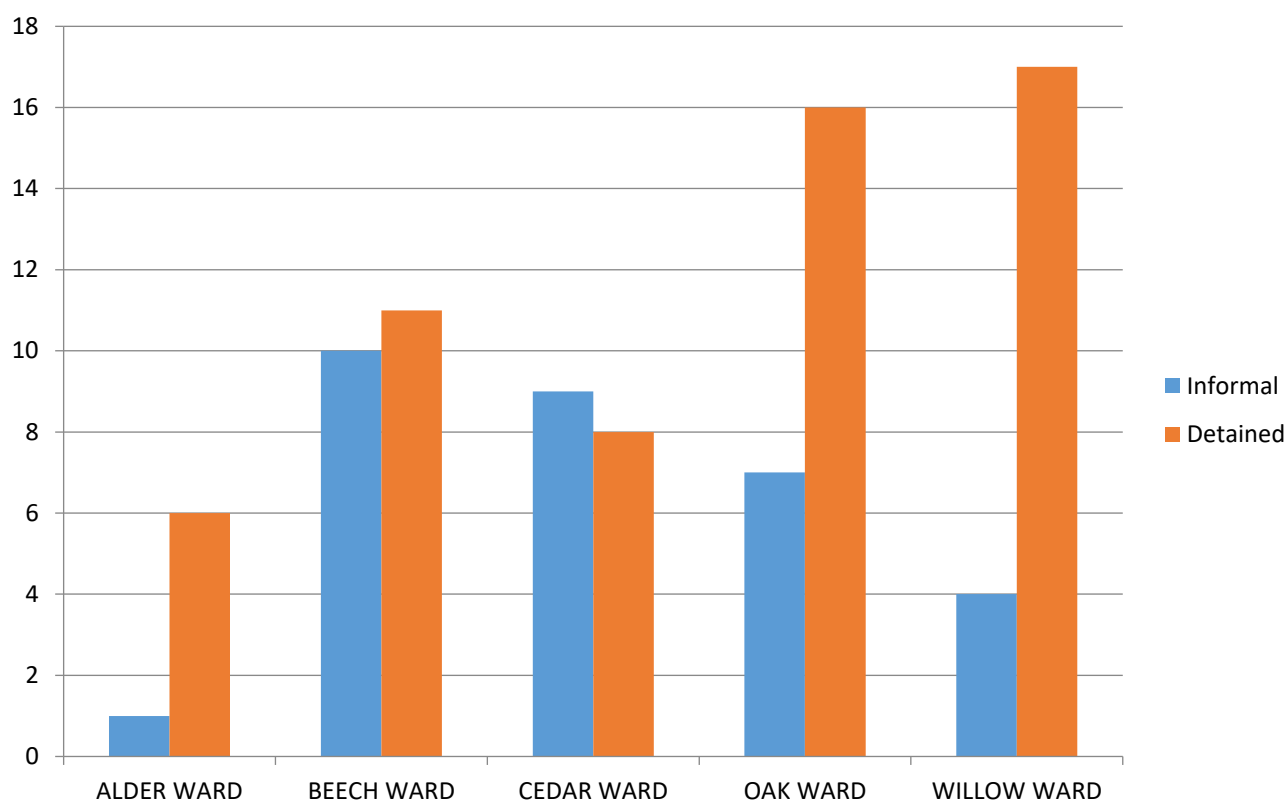
No



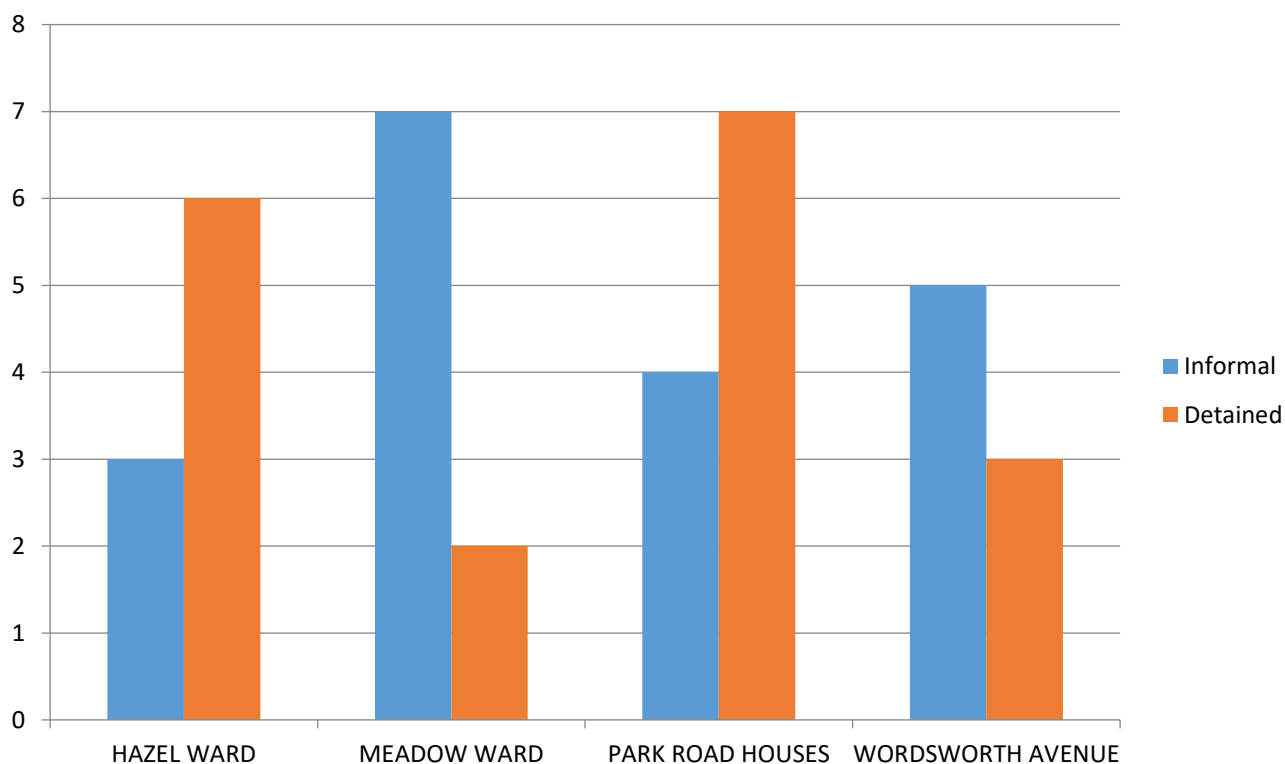
**Report to the
Mental Health and Capacity Legislation Committee
on the use of The Mental Health Act, 1983**

January – March 2019

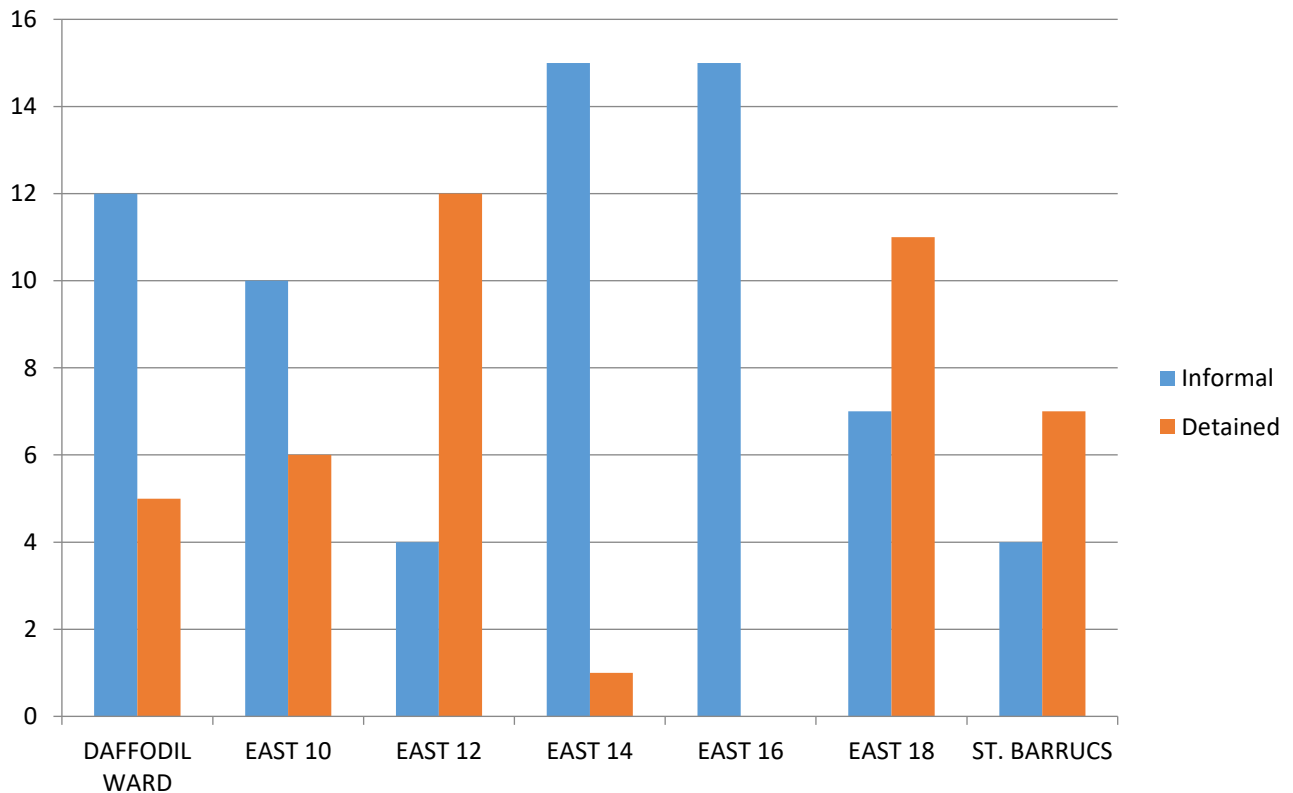
The Number of Informal and Detained Patients on Acute Wards as of 31/03/2019



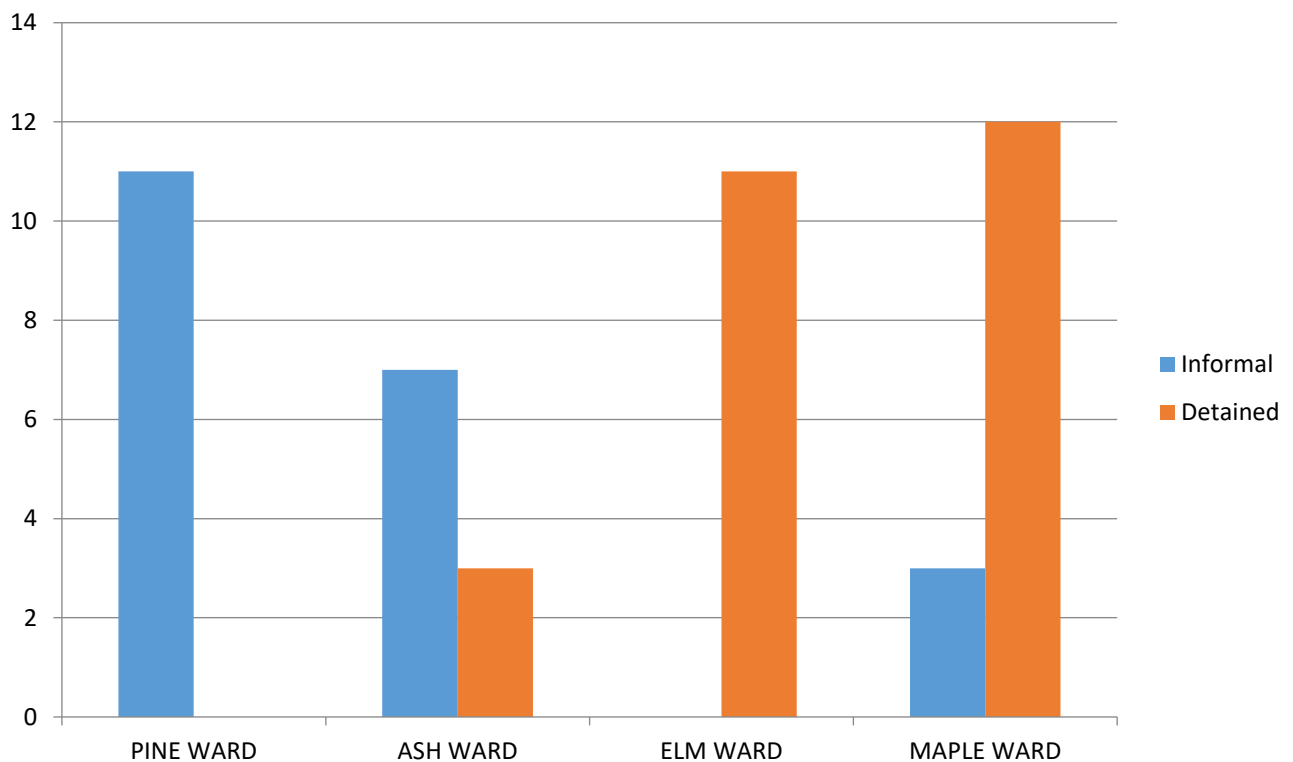
The Number of Informal and Detained Patients on Rehabilitation Wards as of 31/03/2019



**The Number of Informal and Detained Patients on Older People
Wards as of 31/03/2019**

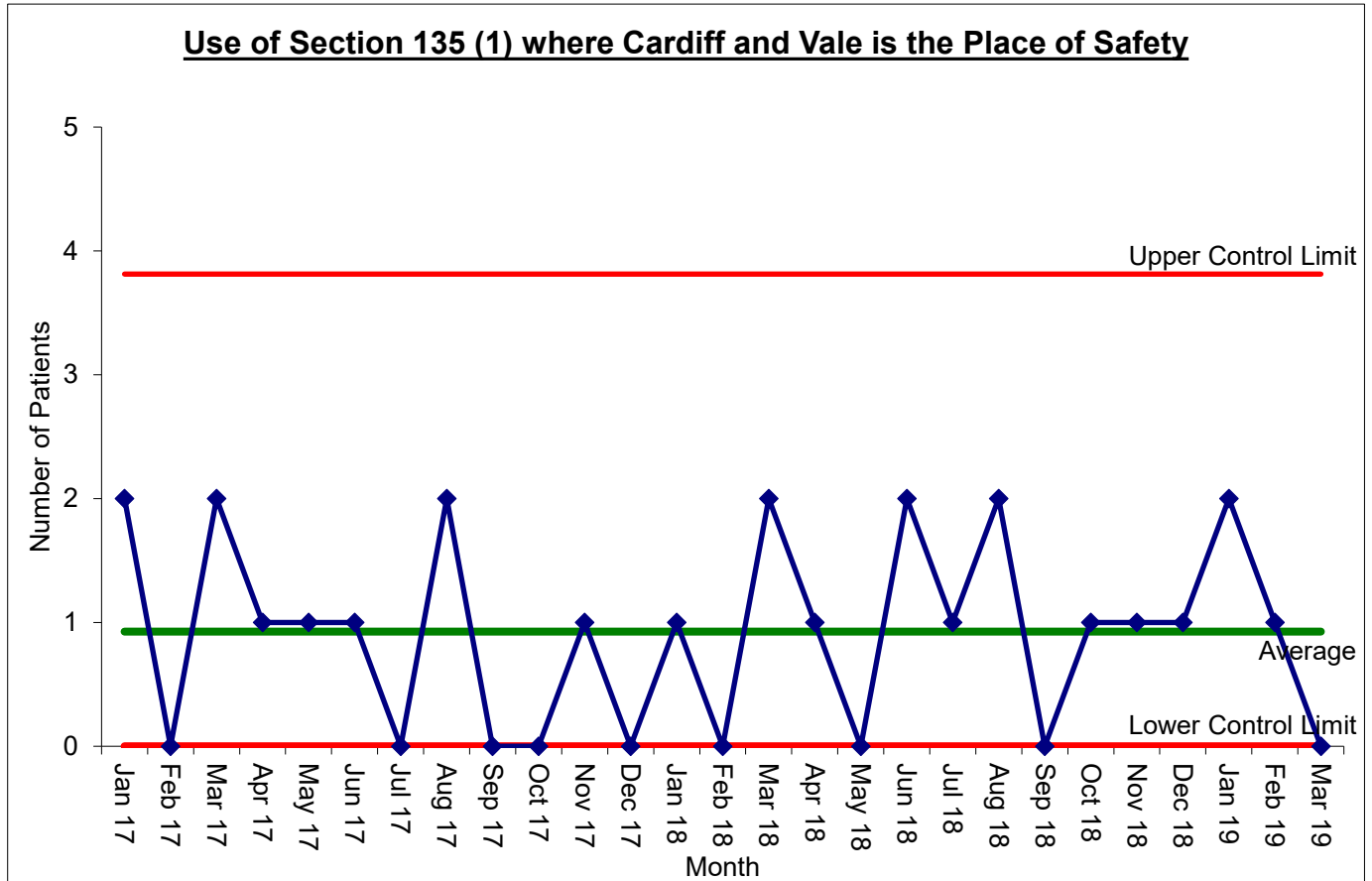


**The Number of Informal and Detained Patients on Addictions,
Neuropsychiatry, and Low Secure Wards as of 31/03/2019**

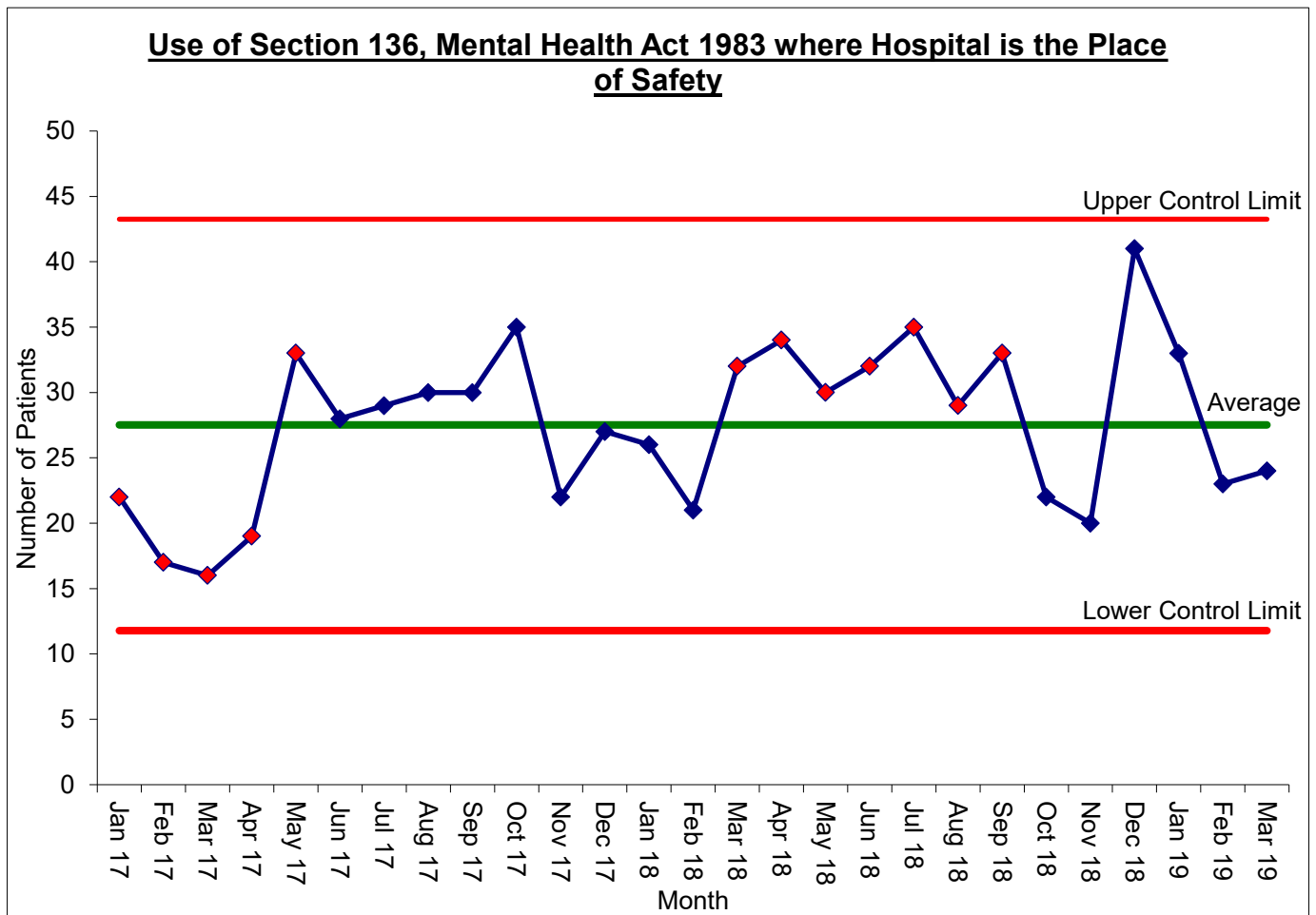


Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on three occasions. Two of these patients were subsequently detained under Section 2 whilst the third was subsequently detained under Section 3.



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



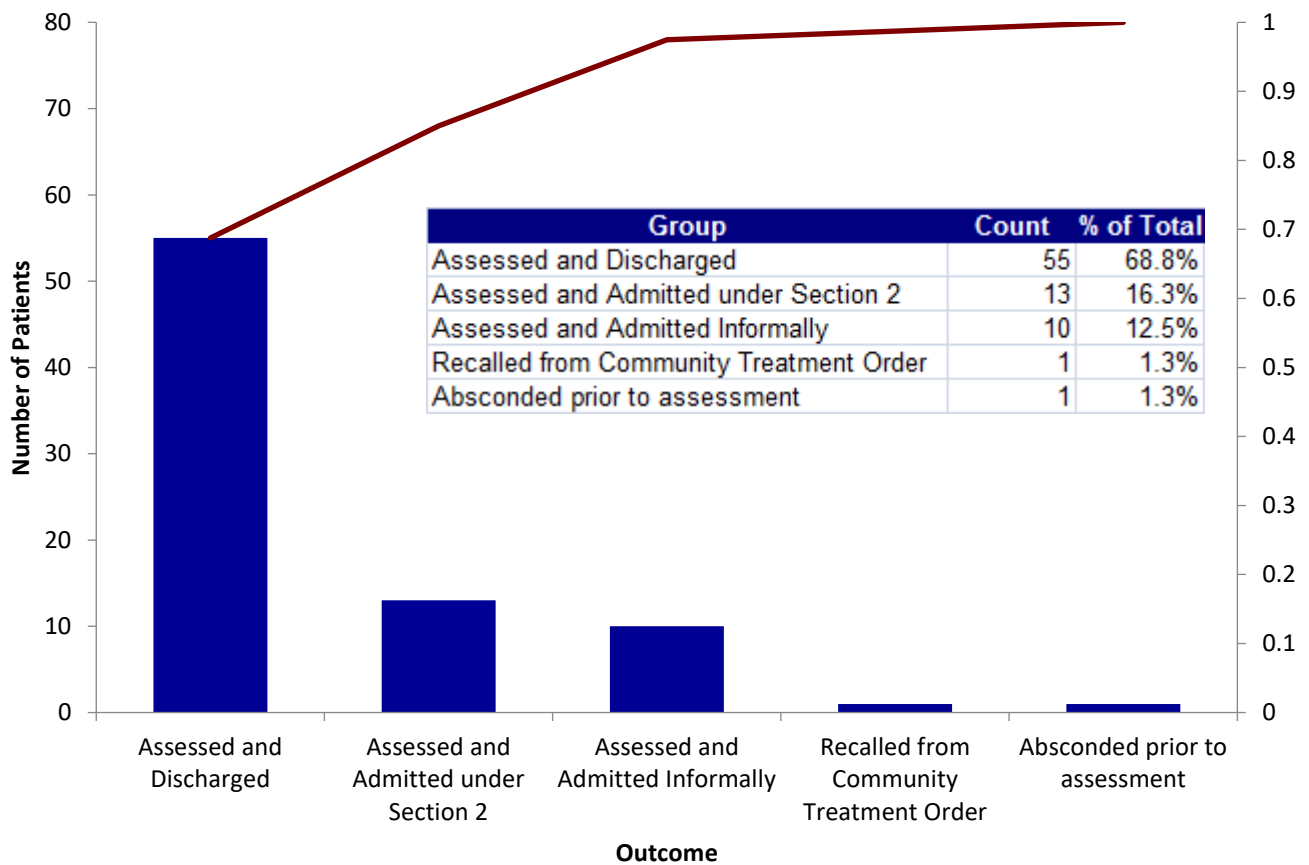
During the period a total of 79 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

CAMHS

Two of these assessments were carried out on patients under the age of 18. The outcomes were as follows:

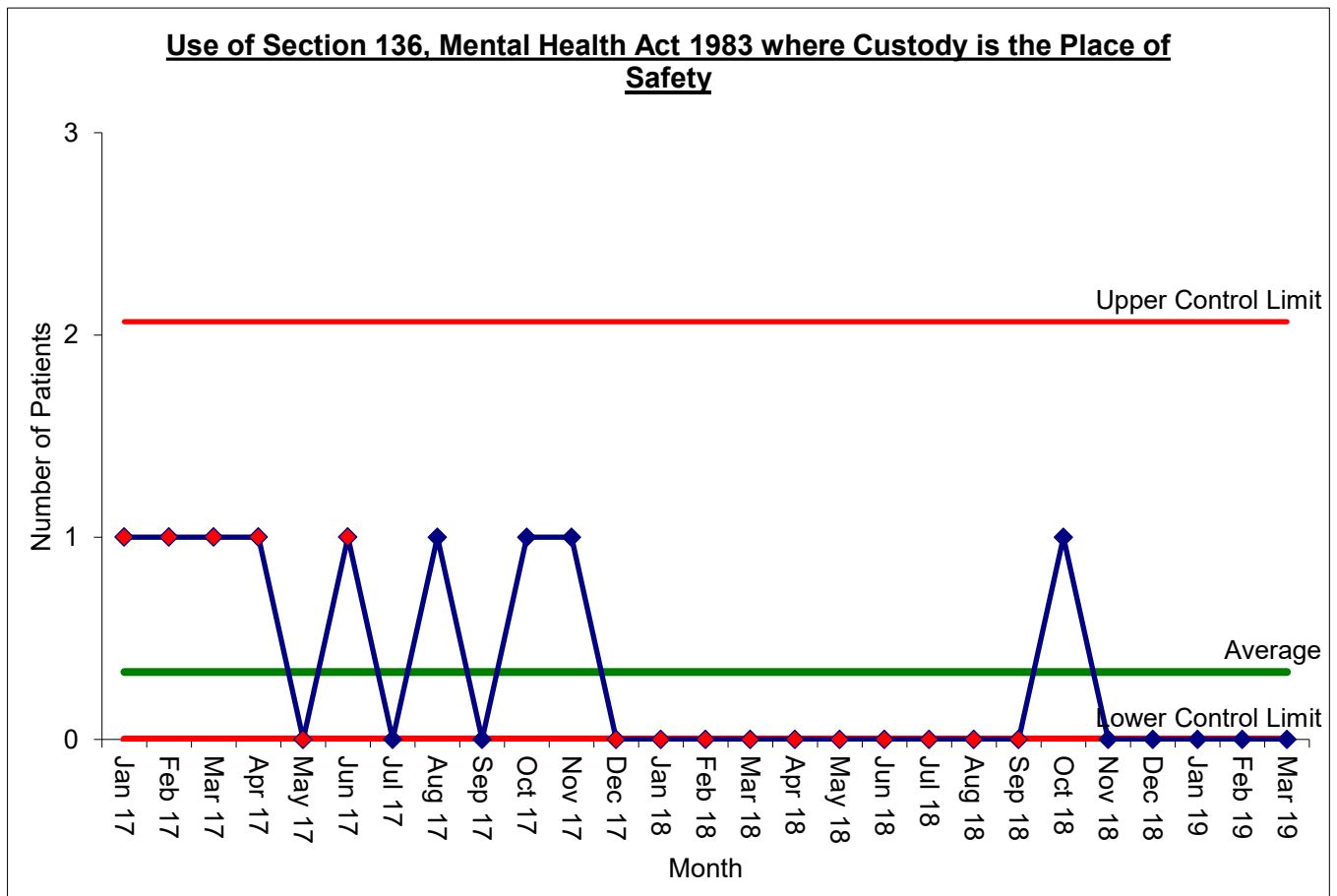
- One discharged to CAMHS community services
- One discharged from Section 136 with no follow-up care and support needed

Outcome of Section 136 Assessments where Hospital is the Place of Safety during the period January - March 2019



The pareto chart highlights that 68.8% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.

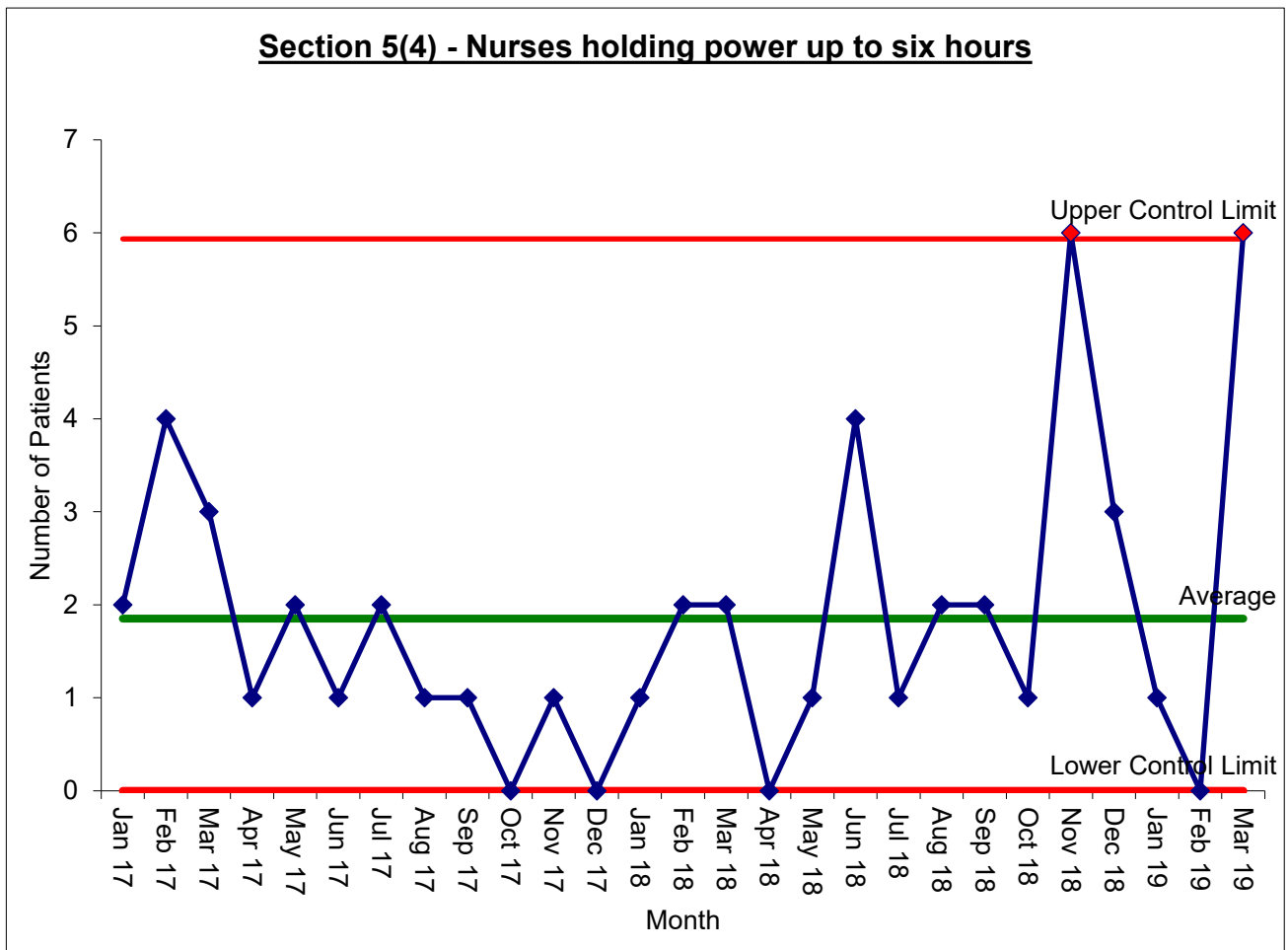
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station



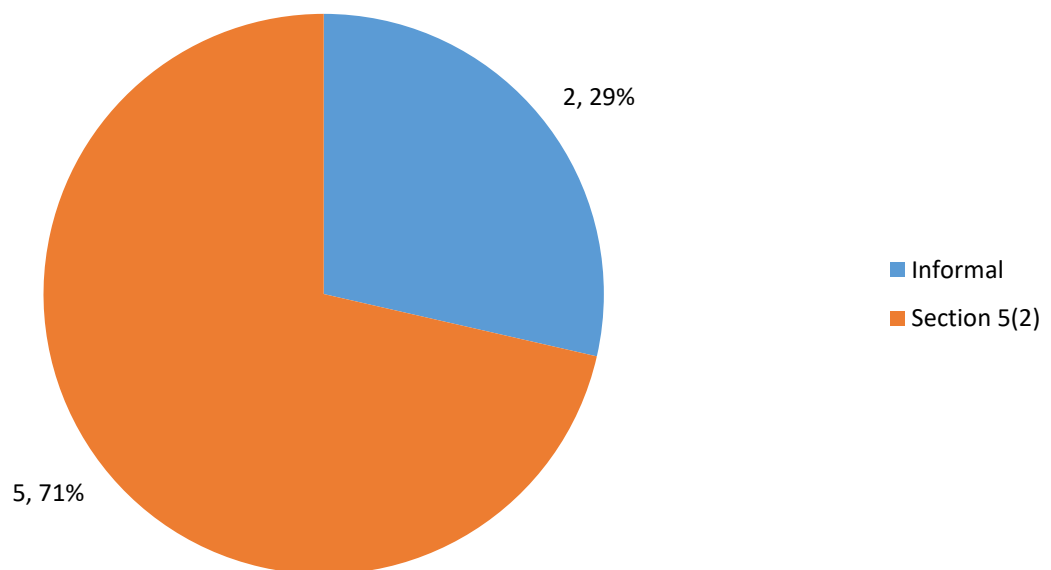
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite. .

Section 5(4) - Nurses Holding Power

Section 5(4) - Nurses holding power up to six hours

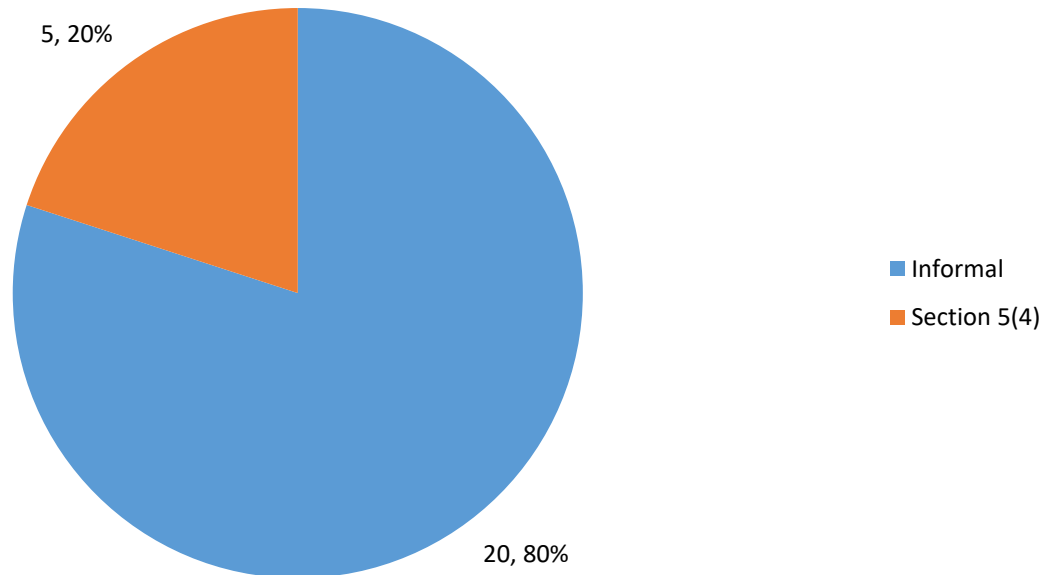


Outcome of Section 5(4) during the period January - March 2019

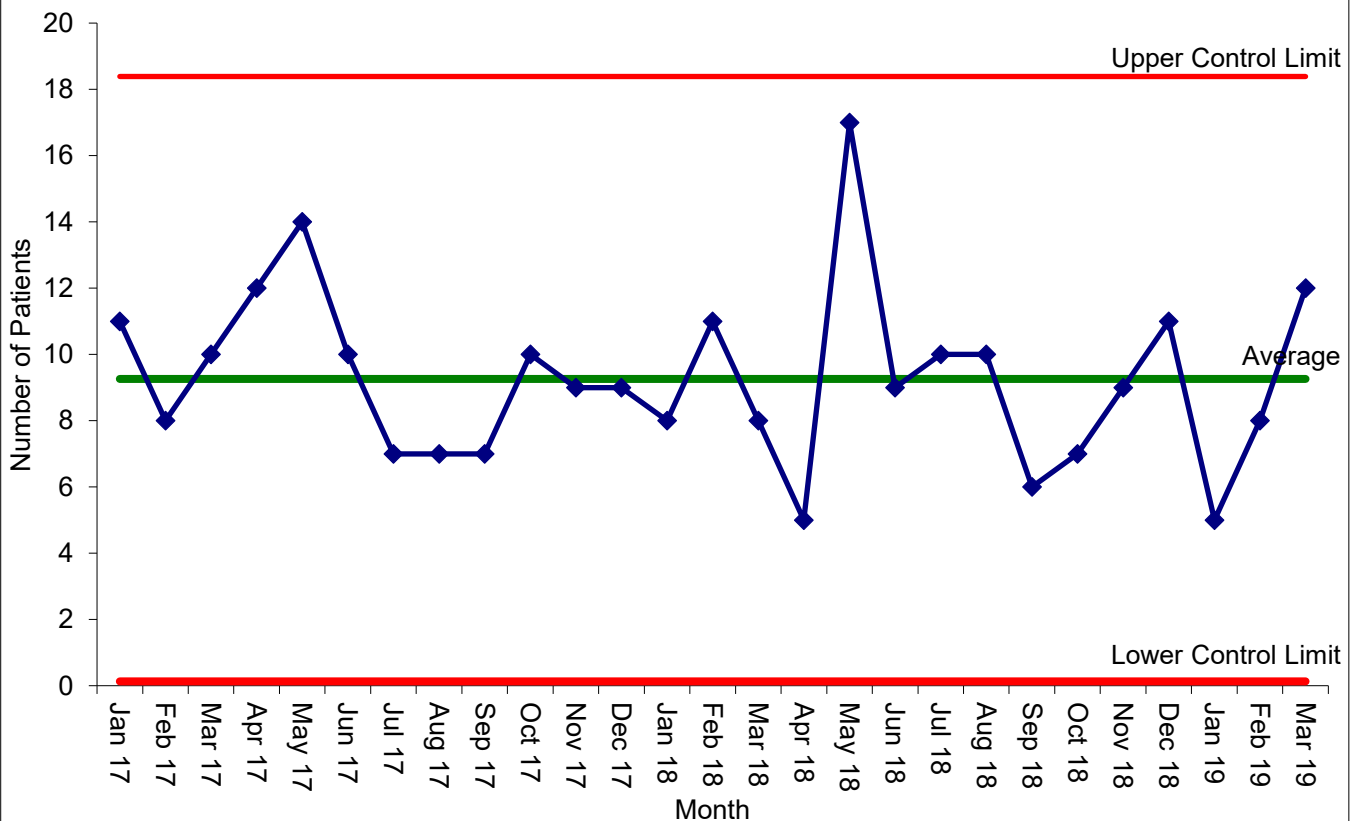


Section 5(2) - Doctors holding power

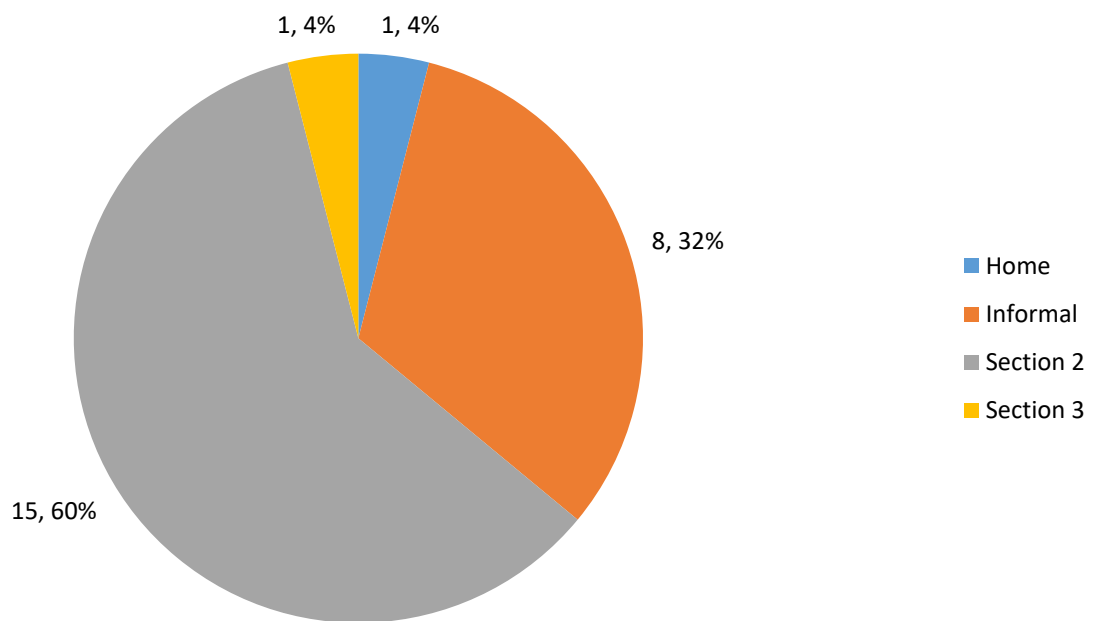
Legal Status prior to Section 5(2) during the period January - March 2019



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

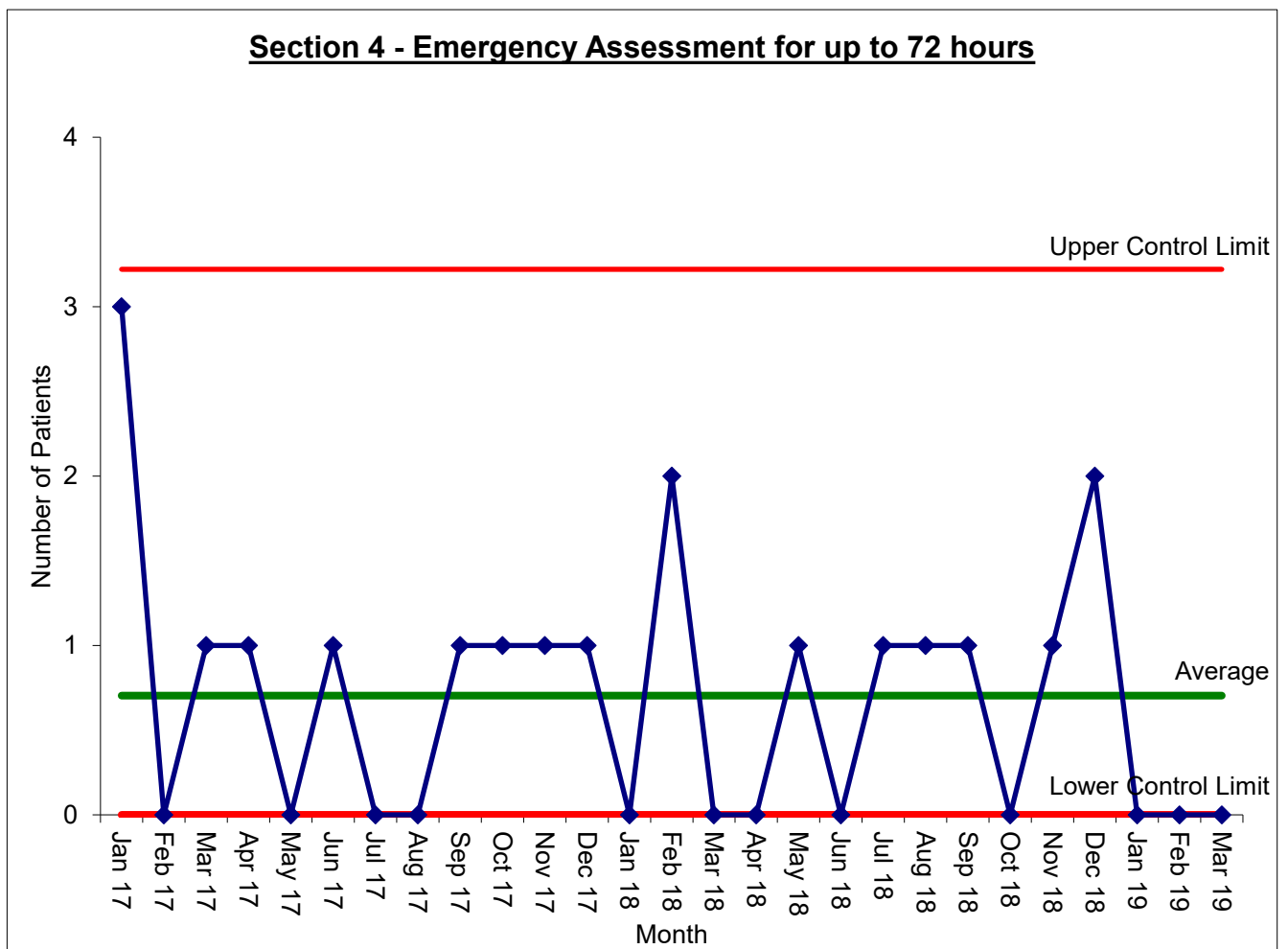


Outcome following Section 5(2) during the period January - March
2019



Section 4 - Admission for Assessment in Cases of Emergency

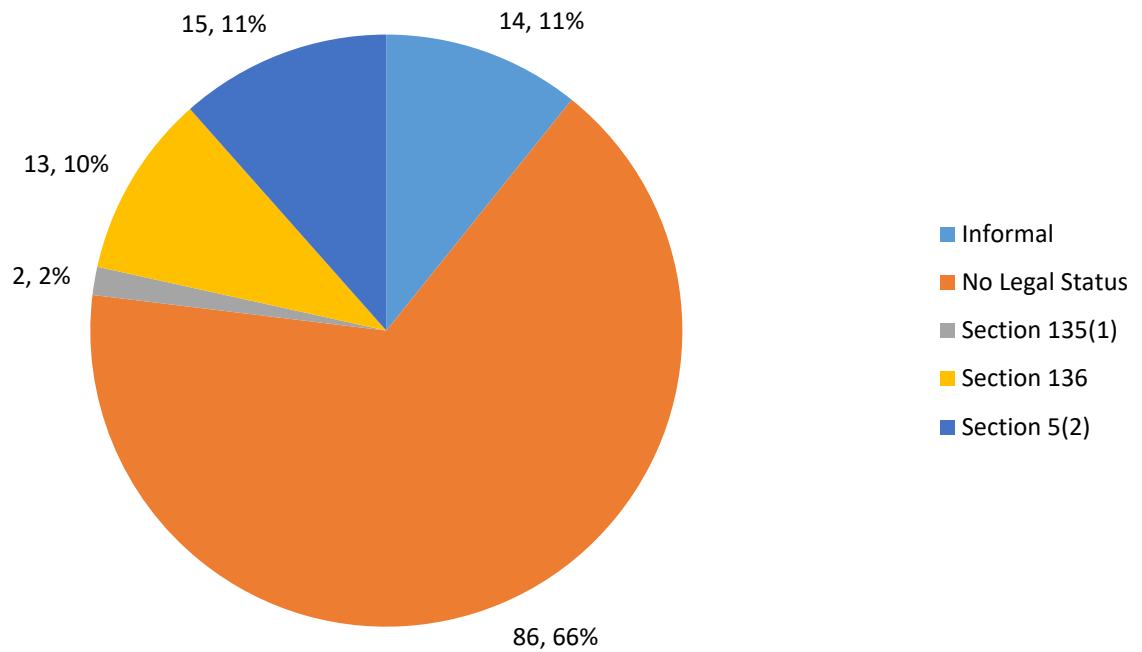
Section 4 - Emergency Assessment for up to 72 hours



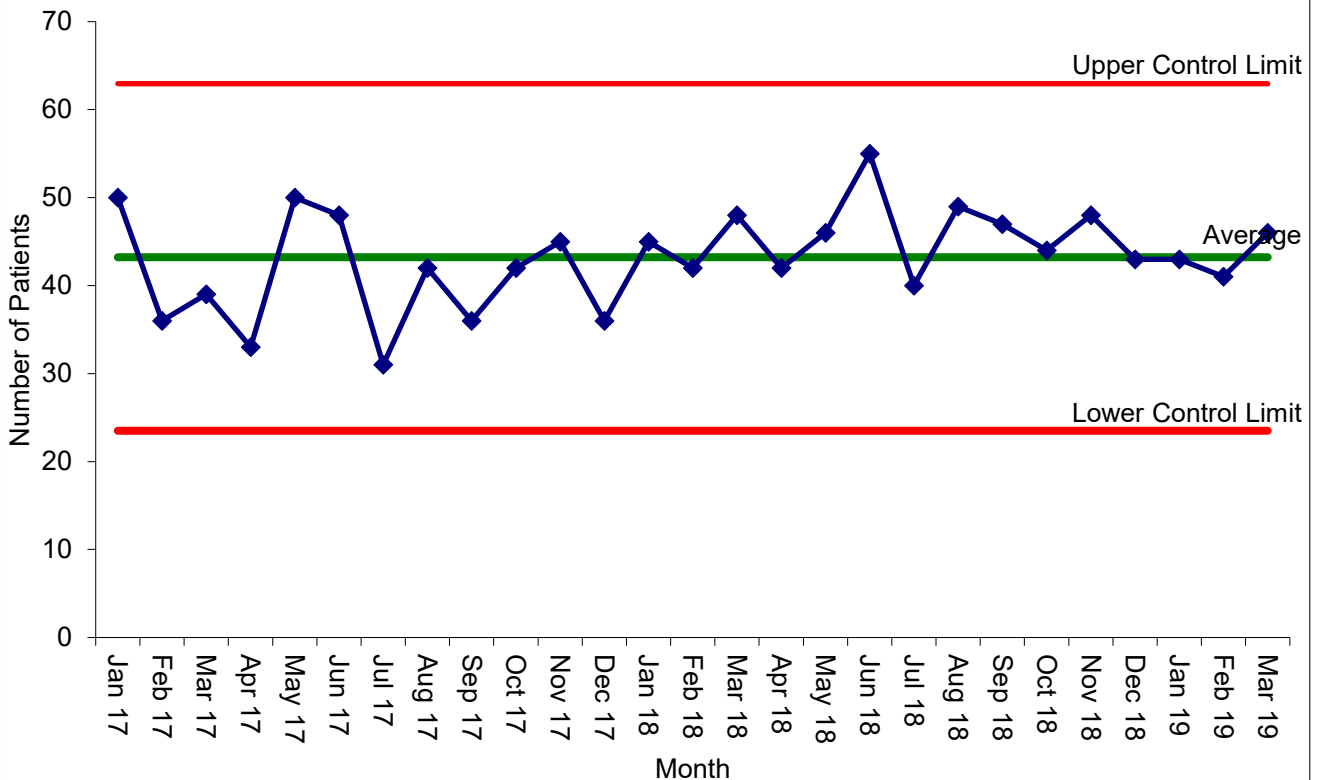
Section 4 was not used during the period.

Section 2 – Admission for Assessment

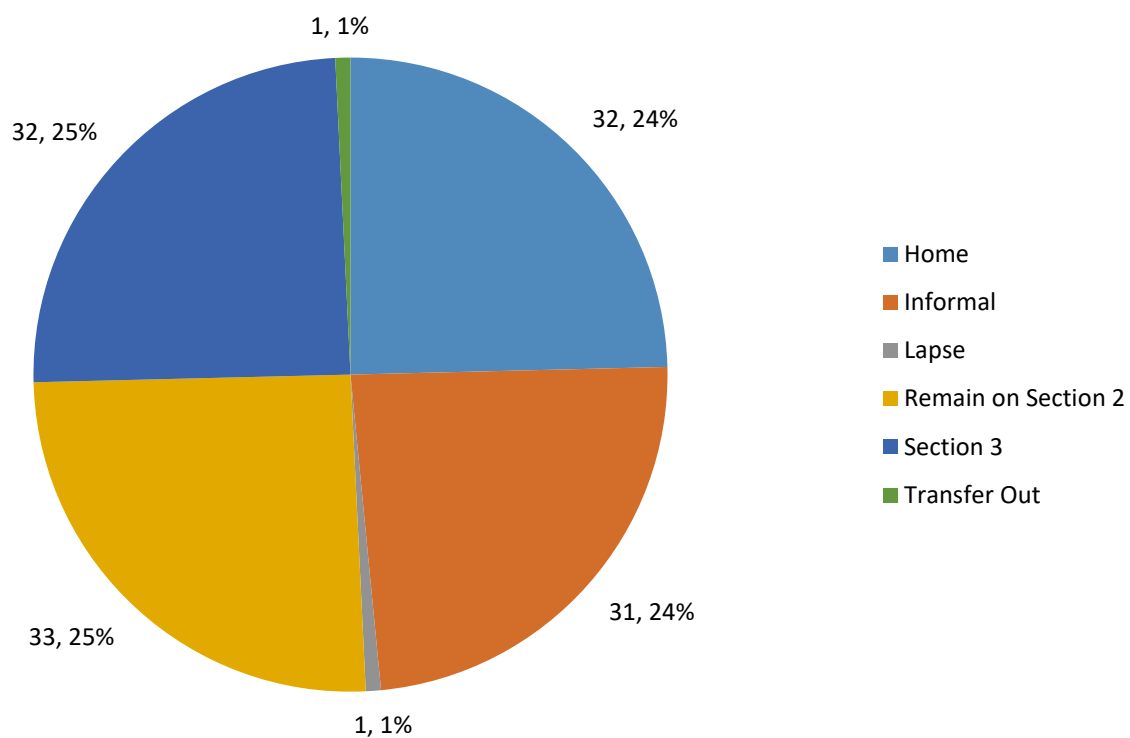
Legal status prior to Section 2 during the period January - March 2019



Section 2 - Admission for Assessment for up to 28 days



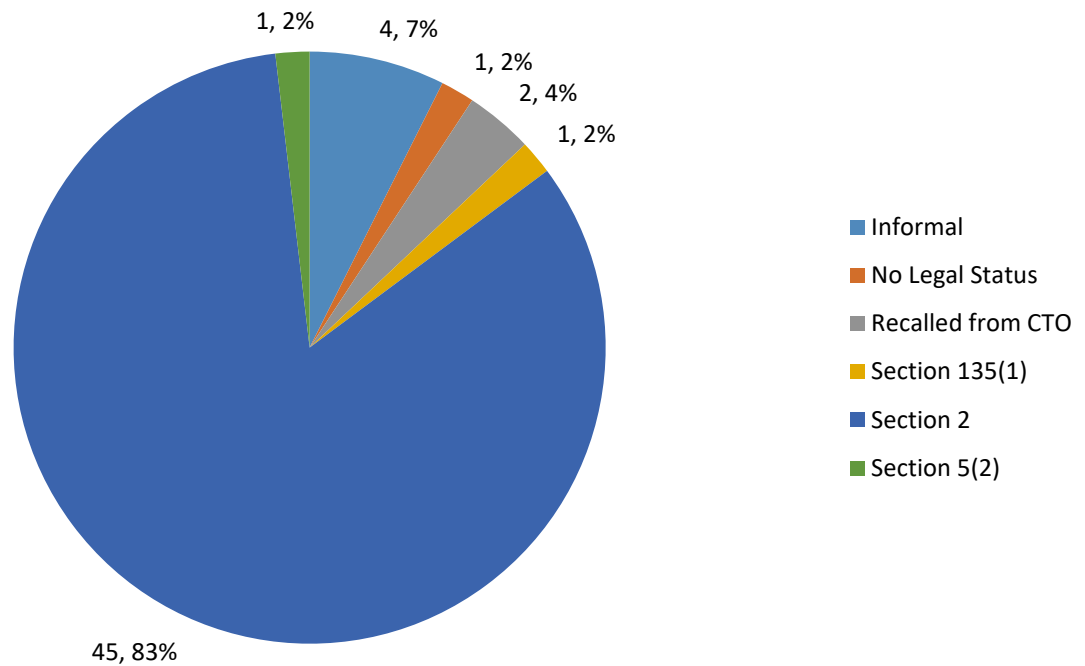
**Outcome following Section 2 during the period January - March
2019 as of 31/03/2019**



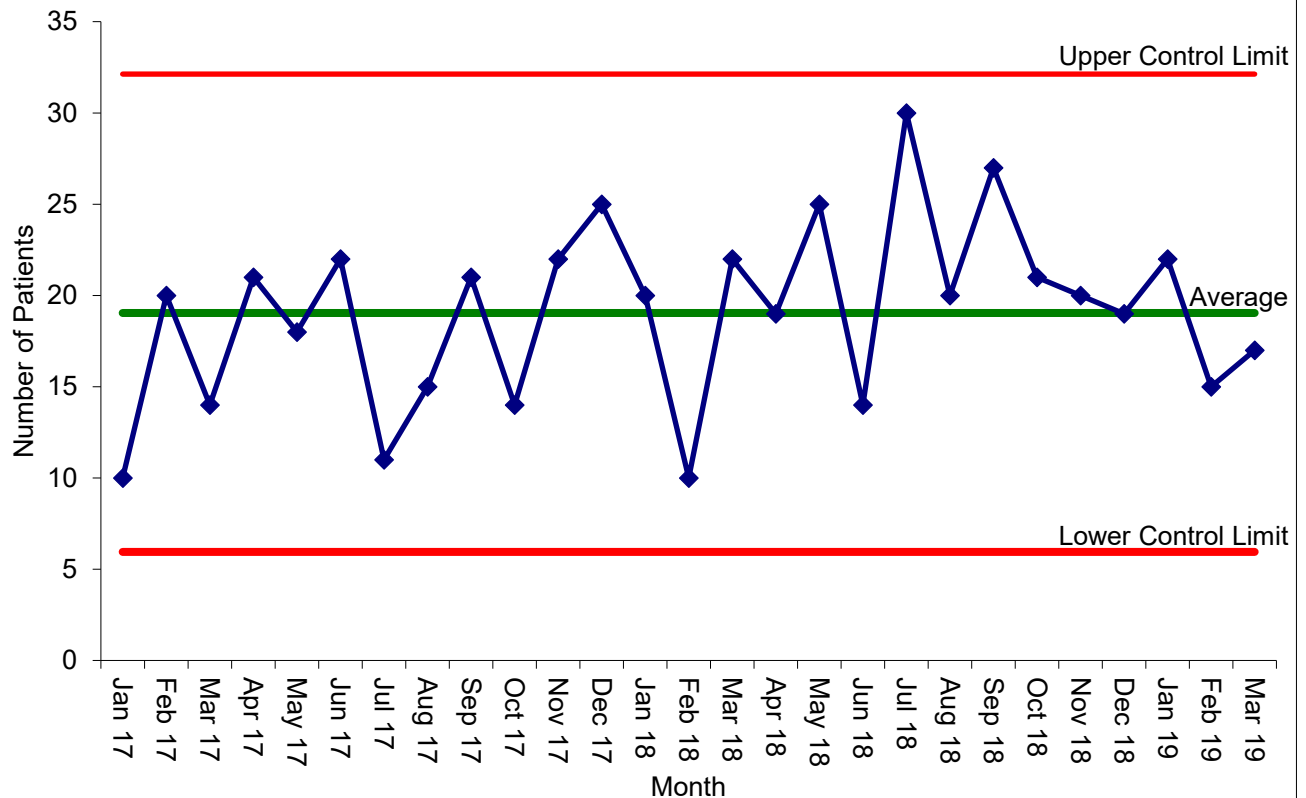
One patient subject to Section 2 lapsed and remained in hospital. An application was made for Section 3 but the AMHP did not agree.

Section 3 – Admission for Treatment

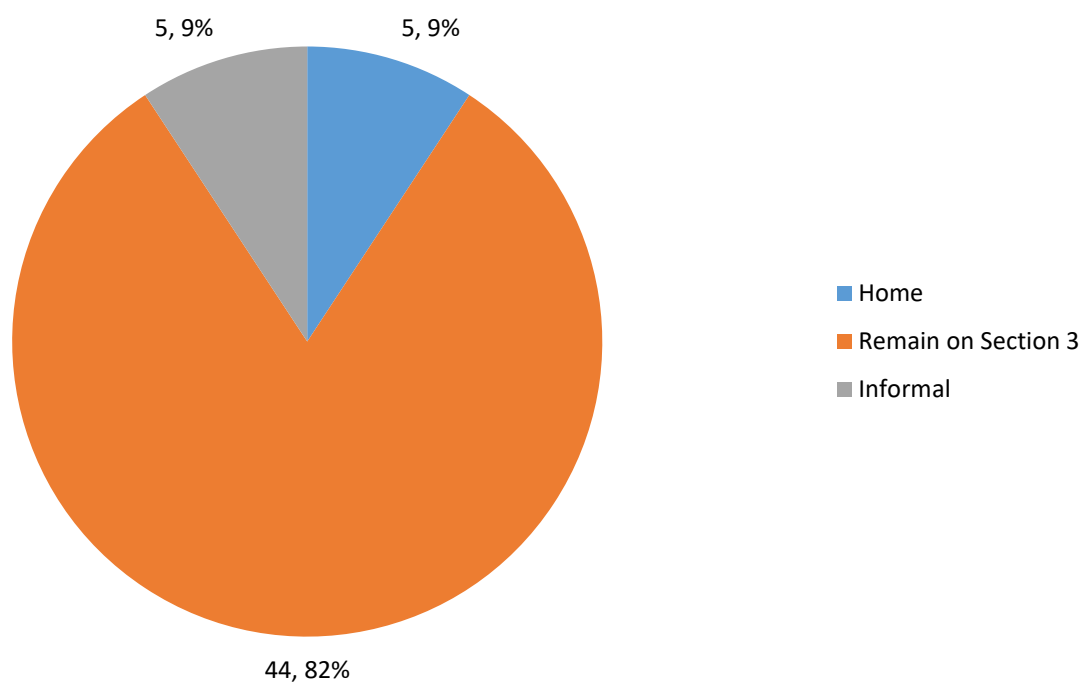
Legal Status prior to Section 3 during the period January - March 2019



Section 3 - Admission for Treatment



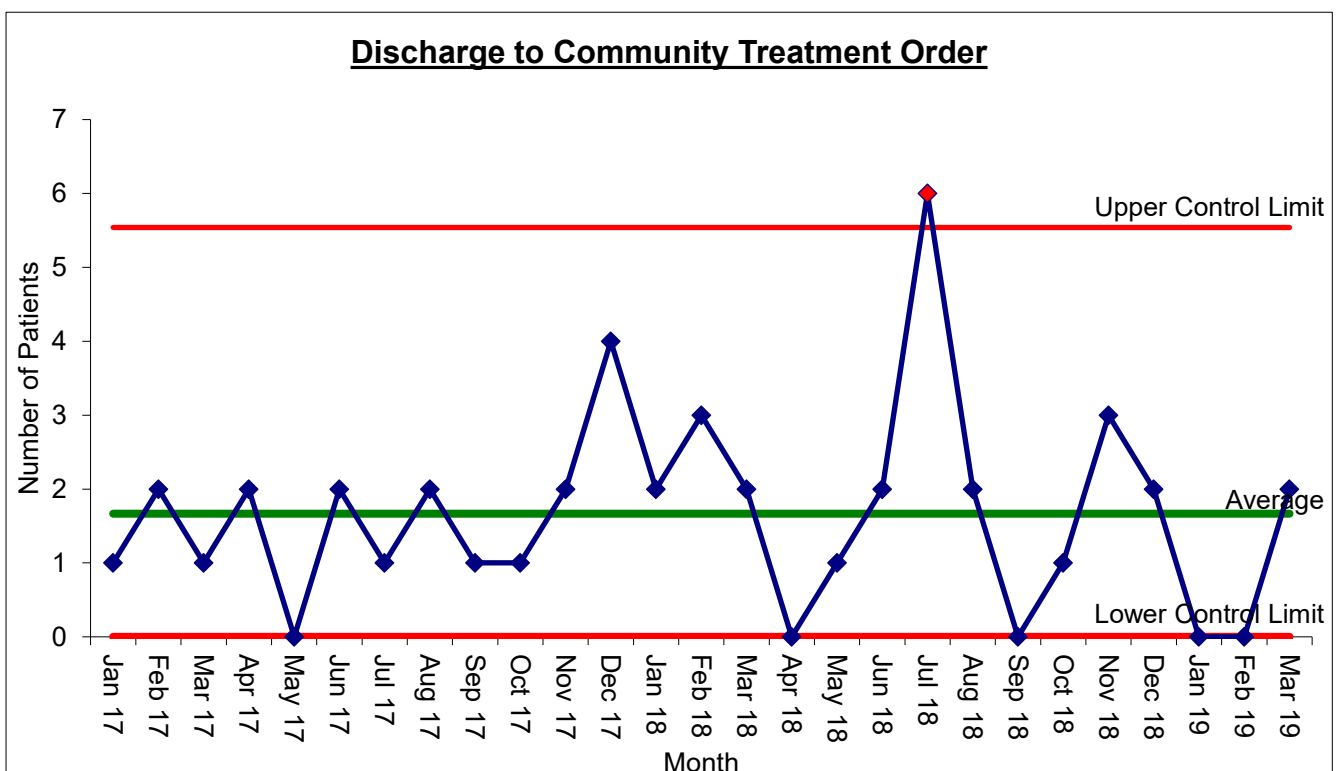
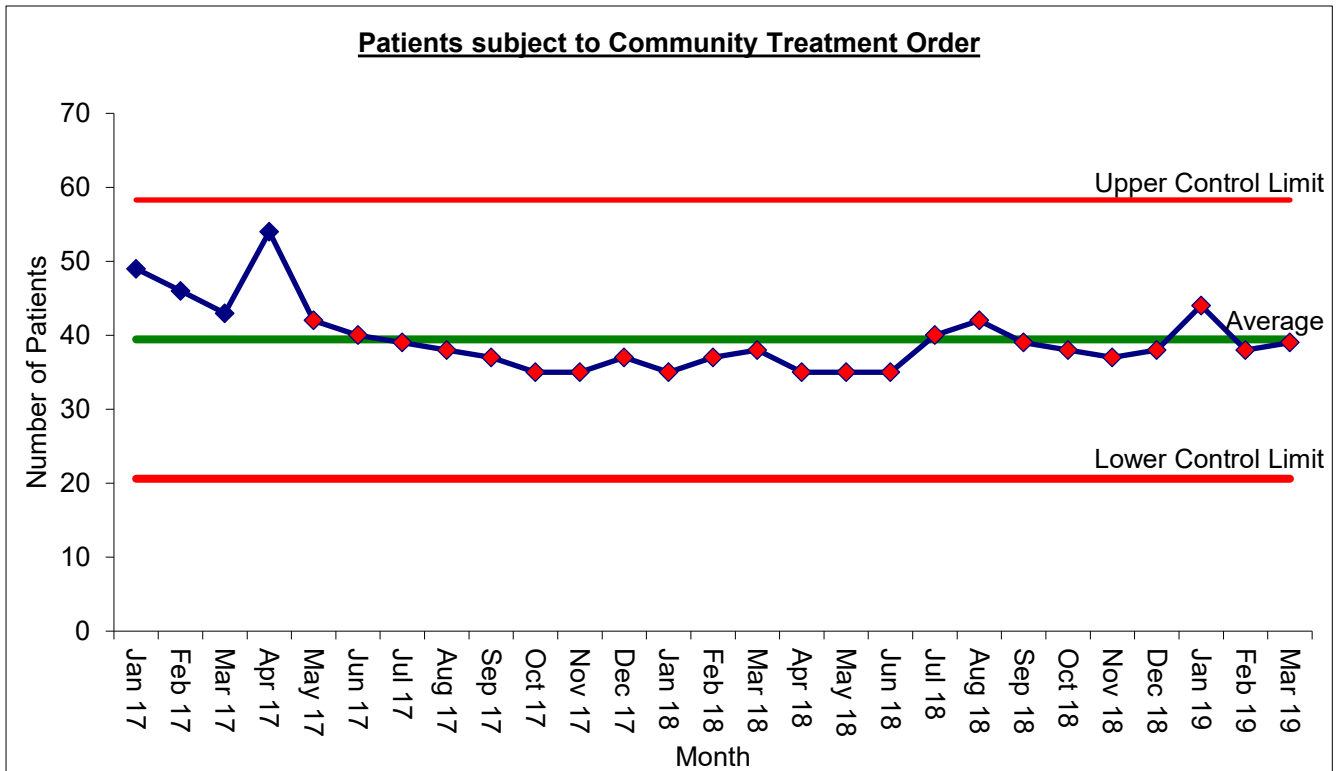
Outcome following Section 3 during the period January - March as of 31/03/2019



Community Treatment Order

During the period January – March 2019, two patients were discharged to Community Treatment Order.

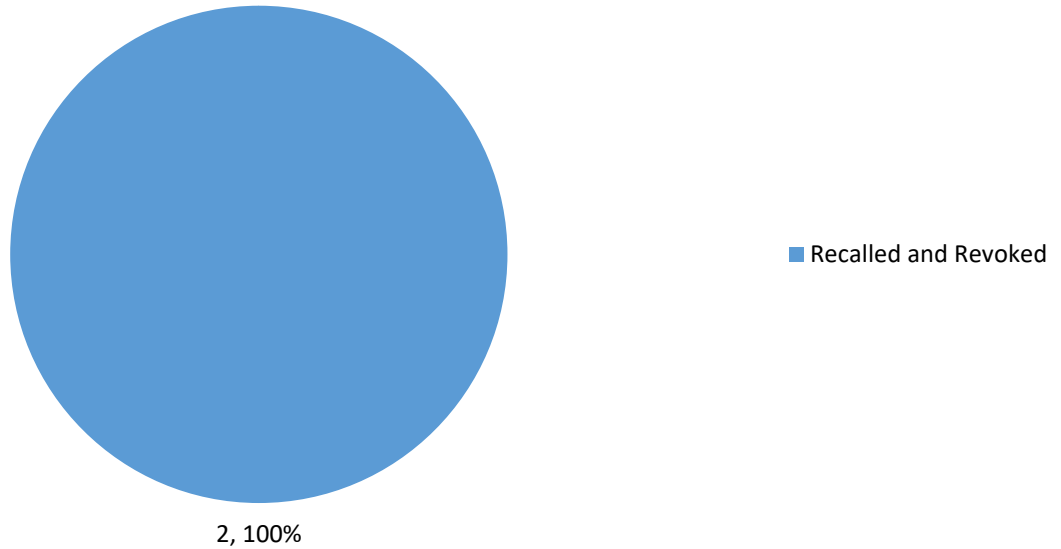
As at 31st March 2019, 35 patients were subject to a Community Treatment Order (CTO).



Recall of a community patient under Section 17E

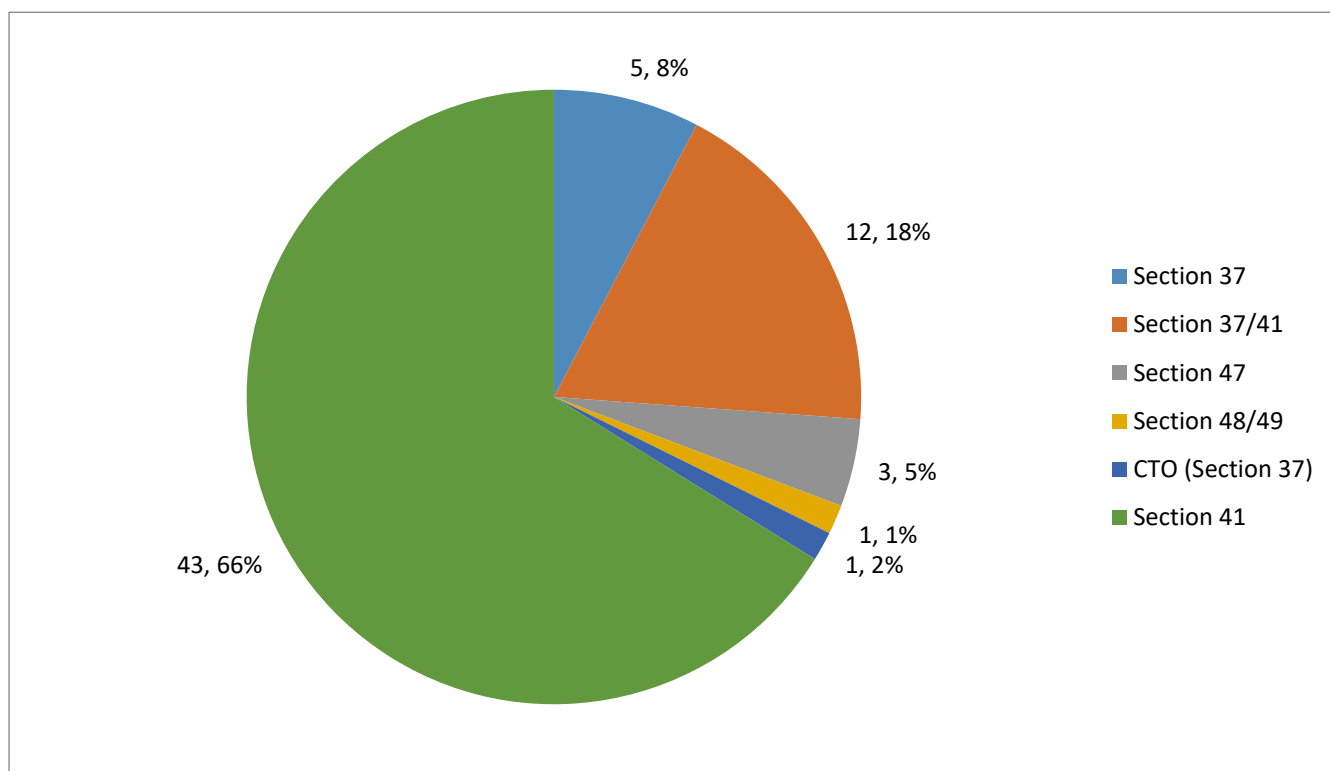
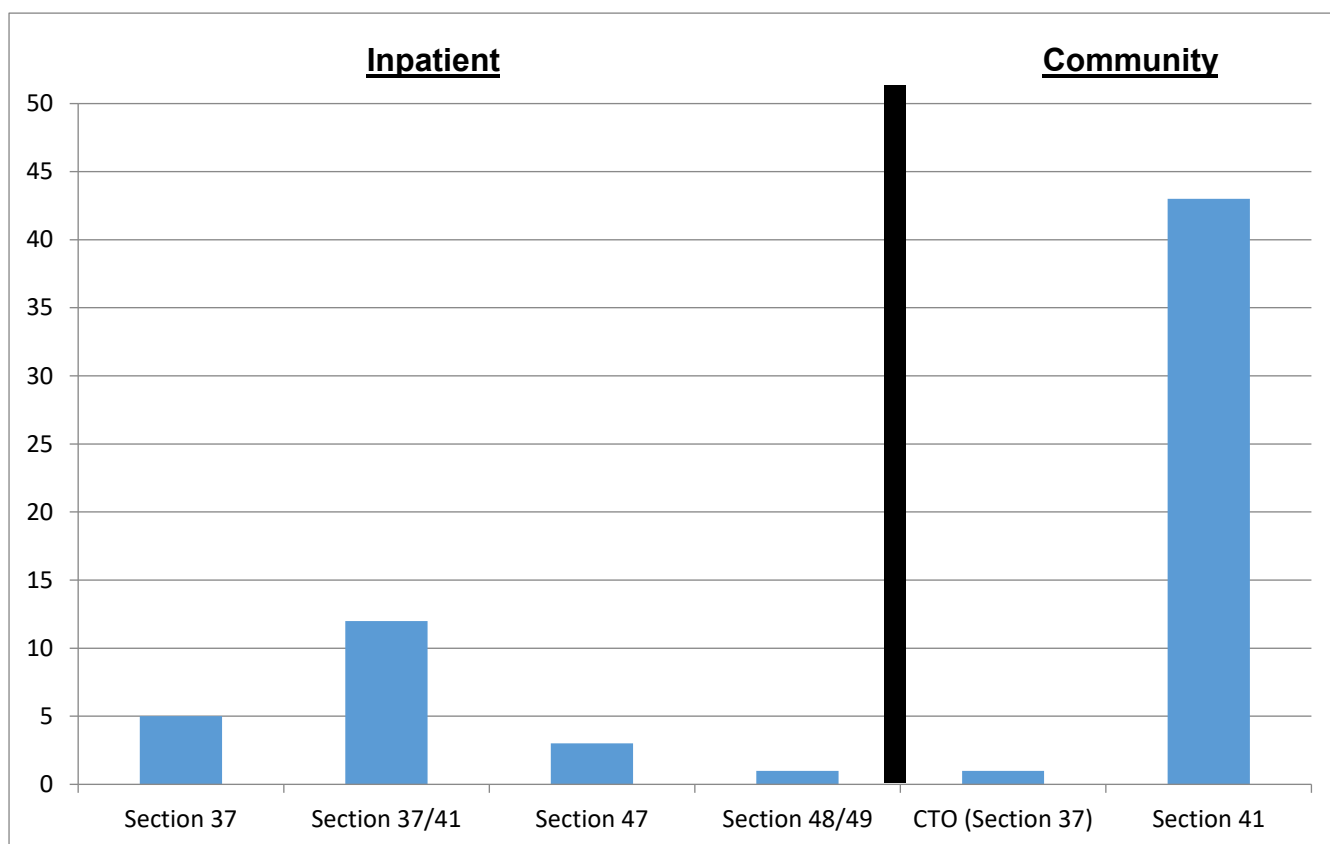
During the period, the power of recall was used on two occasions, both patients were revoked.

Outcome of Recall to hospital from Community Treatment Order

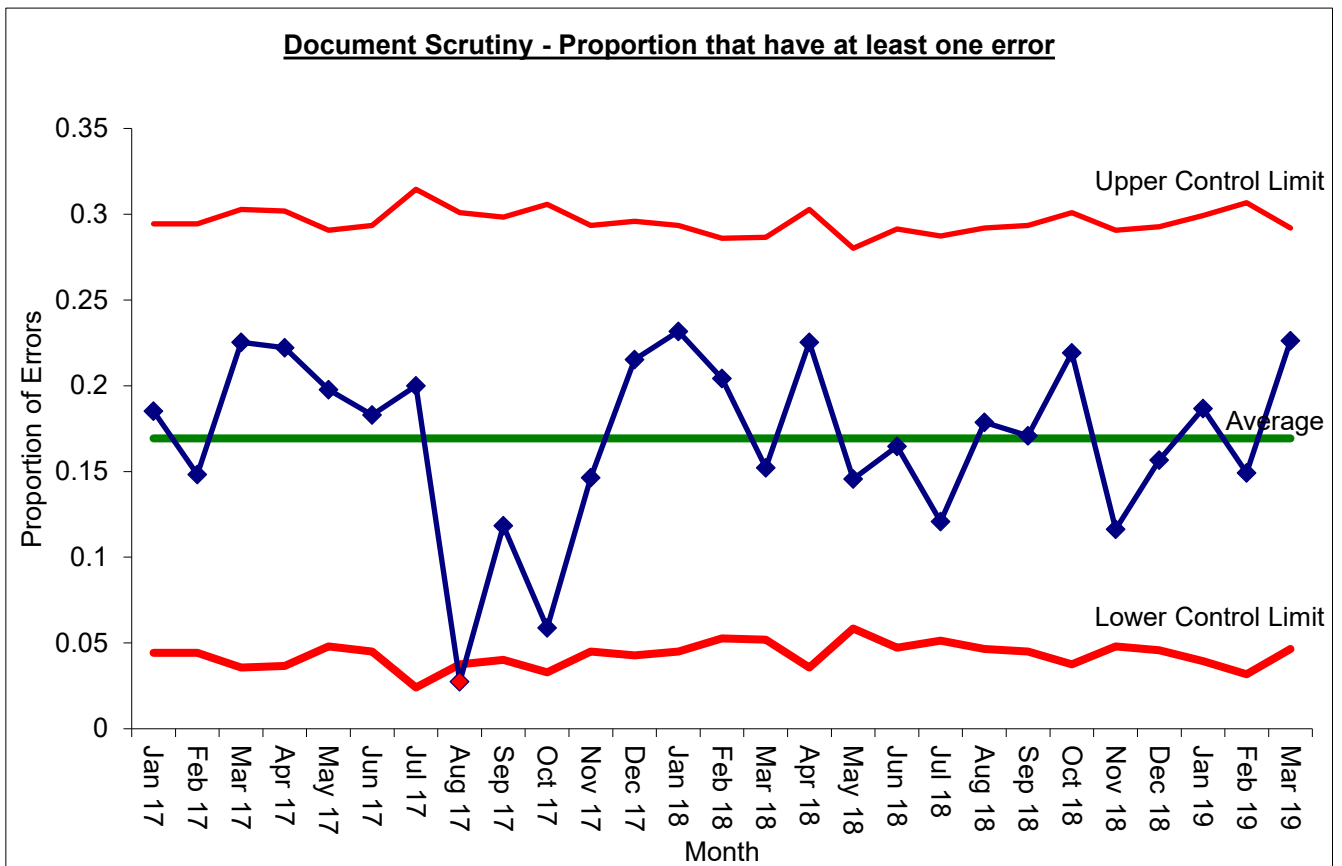


Part 3 of the Mental health Act 1983

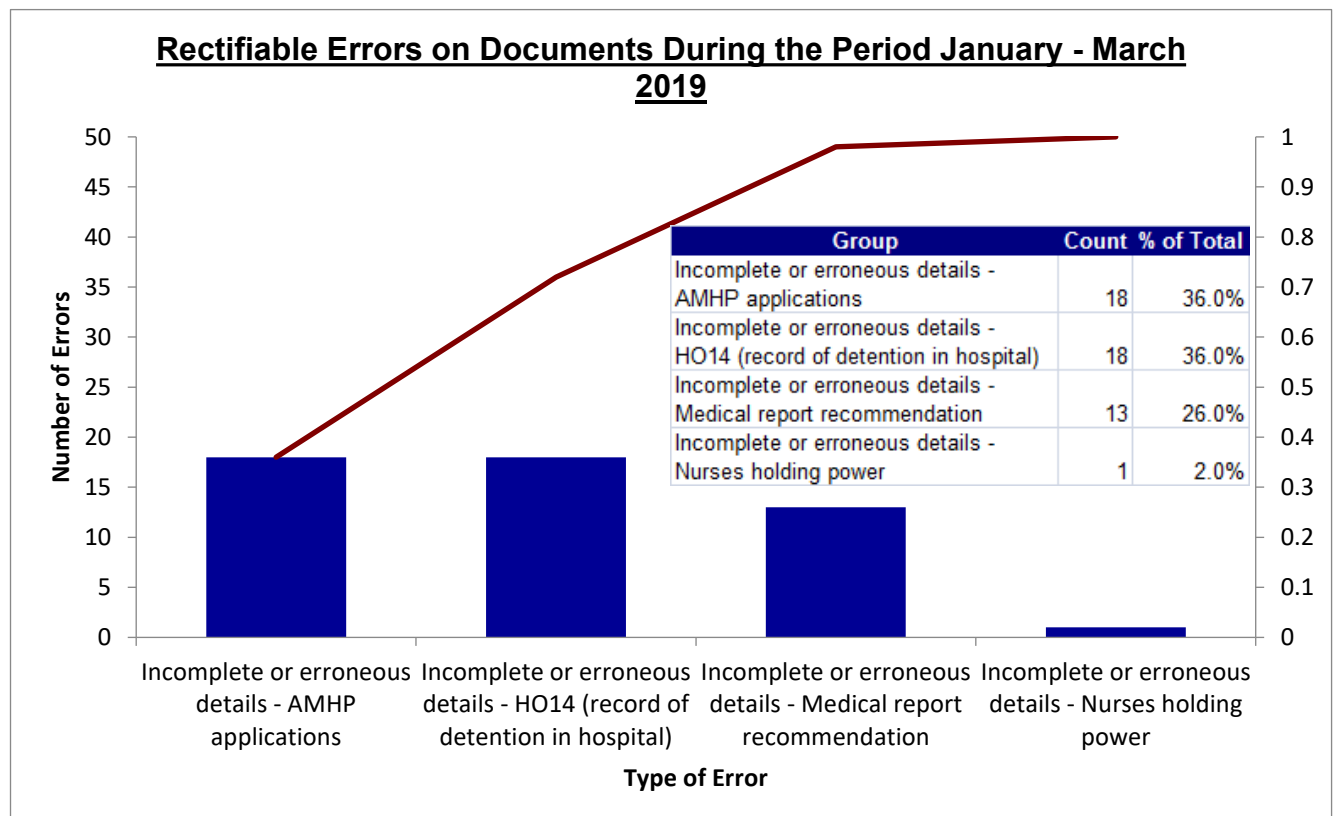
The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st March 2019



Scrutiny of documents during the period

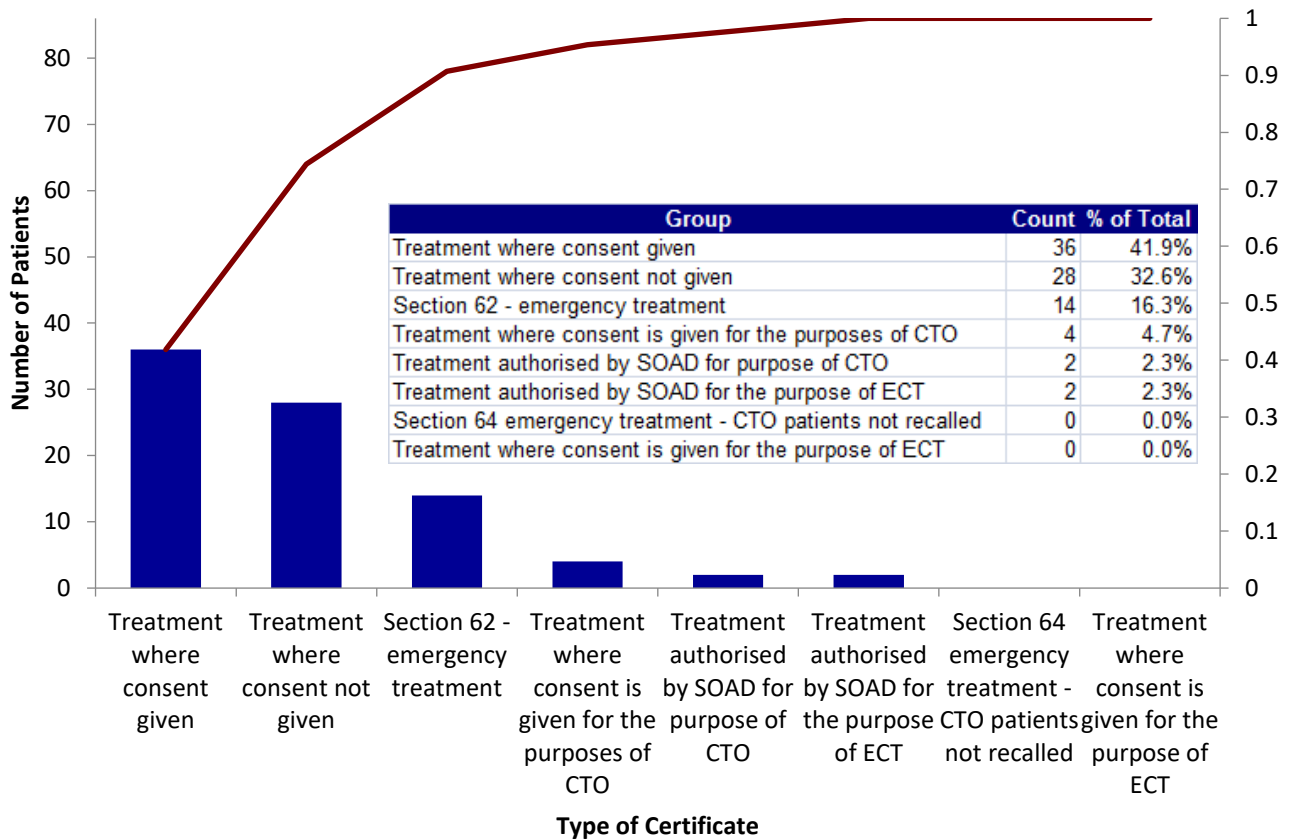


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.



Consent to Treatment

Analysis of the Treatment Provisions under Part 4 and Part 4a Mental Health Act During the period January - March 2019



Urgent treatment

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

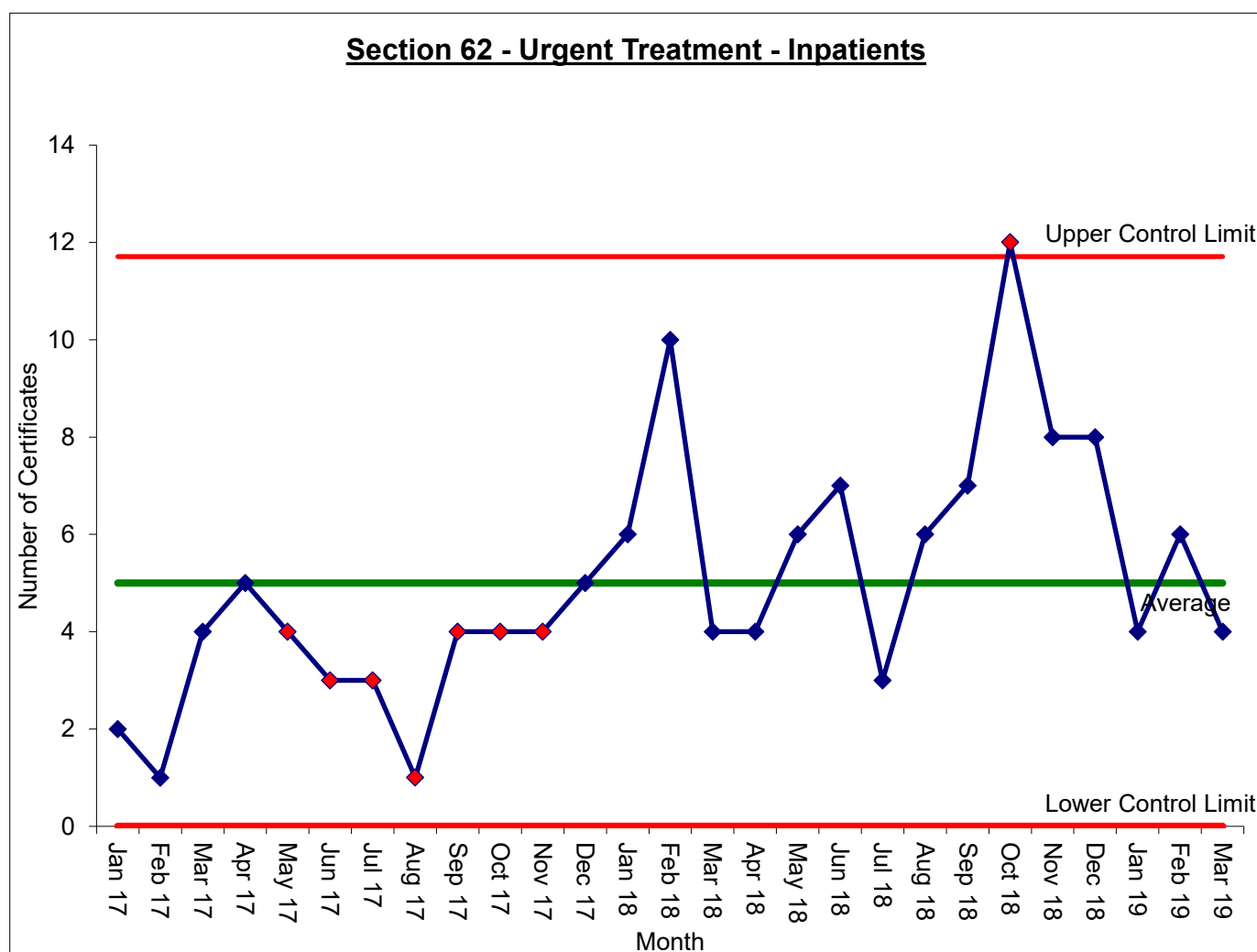
Urgent treatment is defined as treatment that is:

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

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

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

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



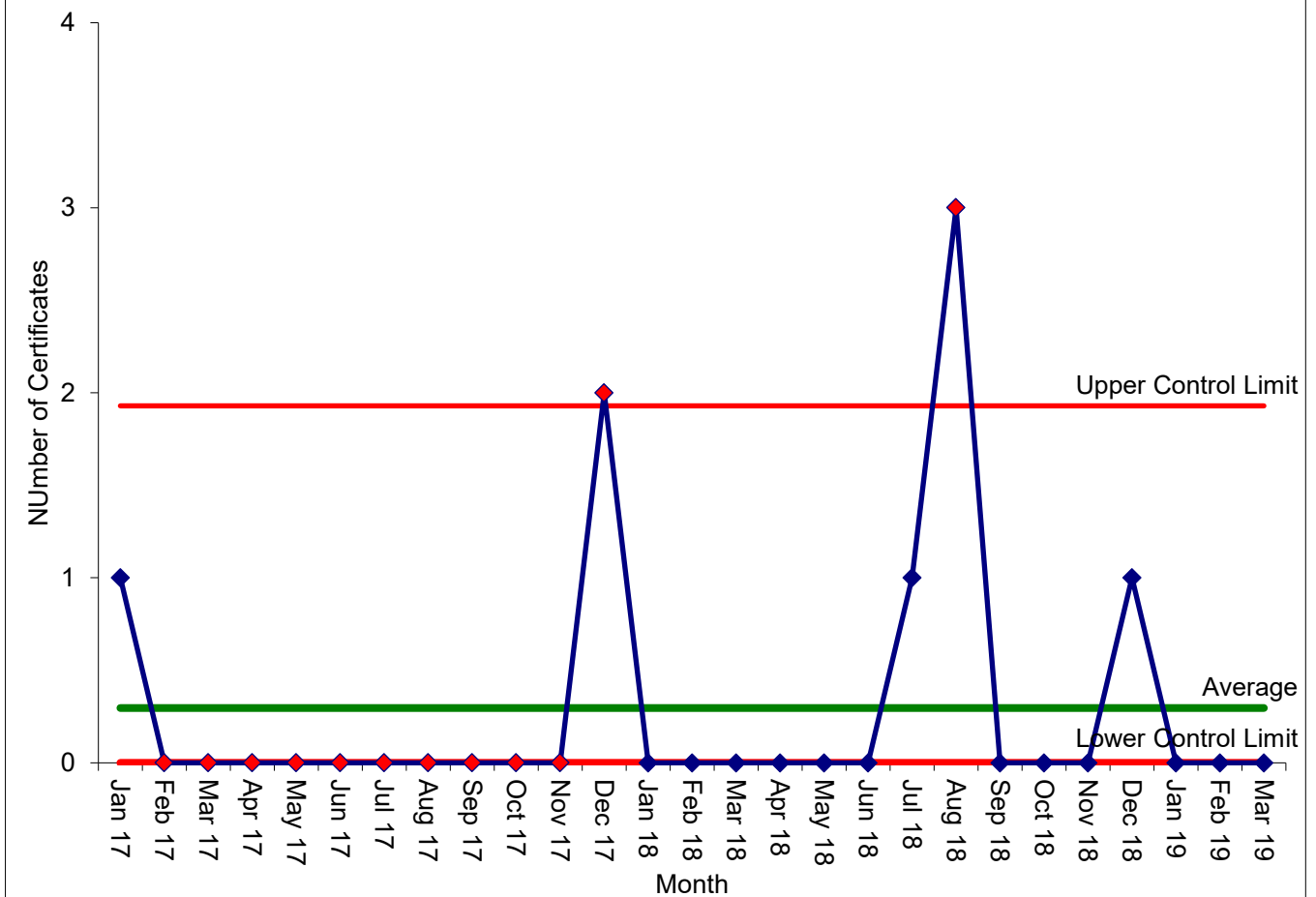
The above chart highlights that Section 62 was used on 14 occasions for the following reasons:

3 month rule x 8

Urgent medication treatment x 6

Urgent ECT treatment x 1

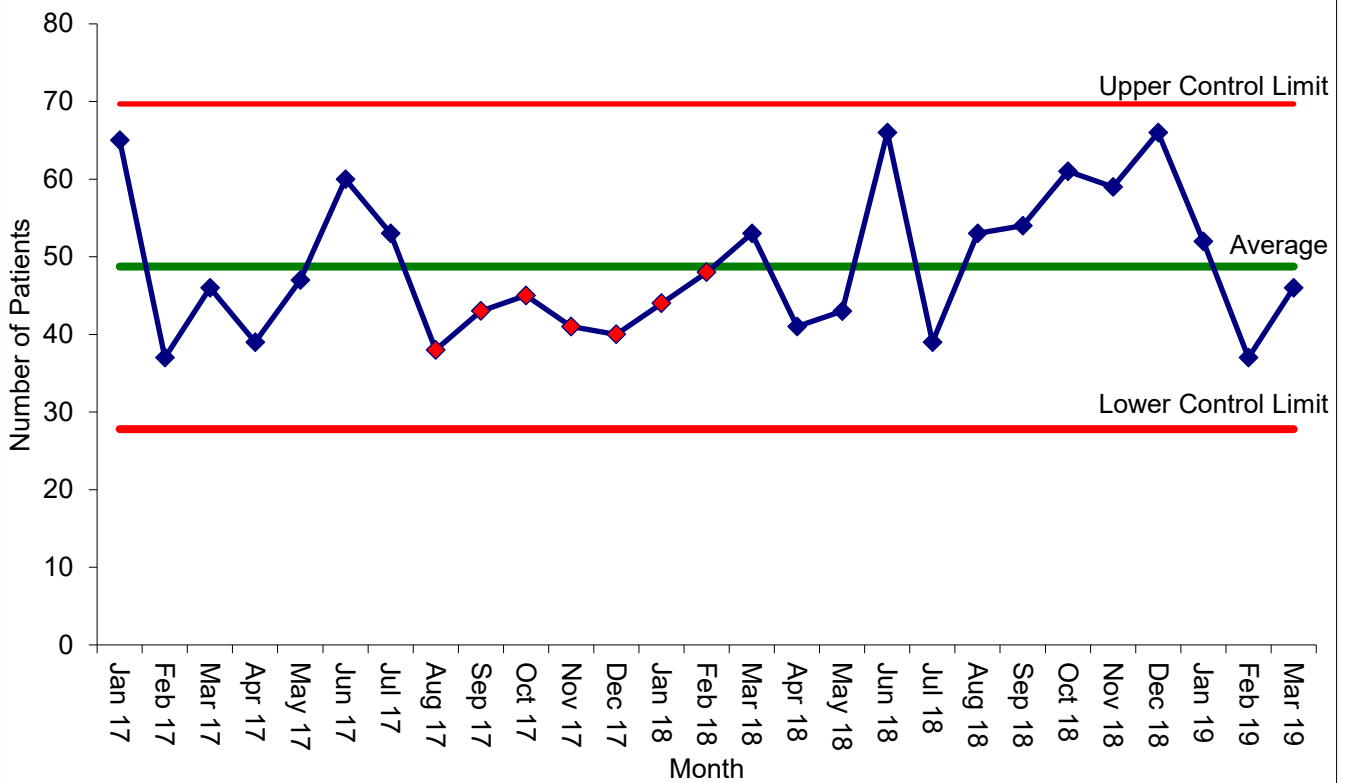
Section 64 - Urgent Treatment - Community Treatment Order



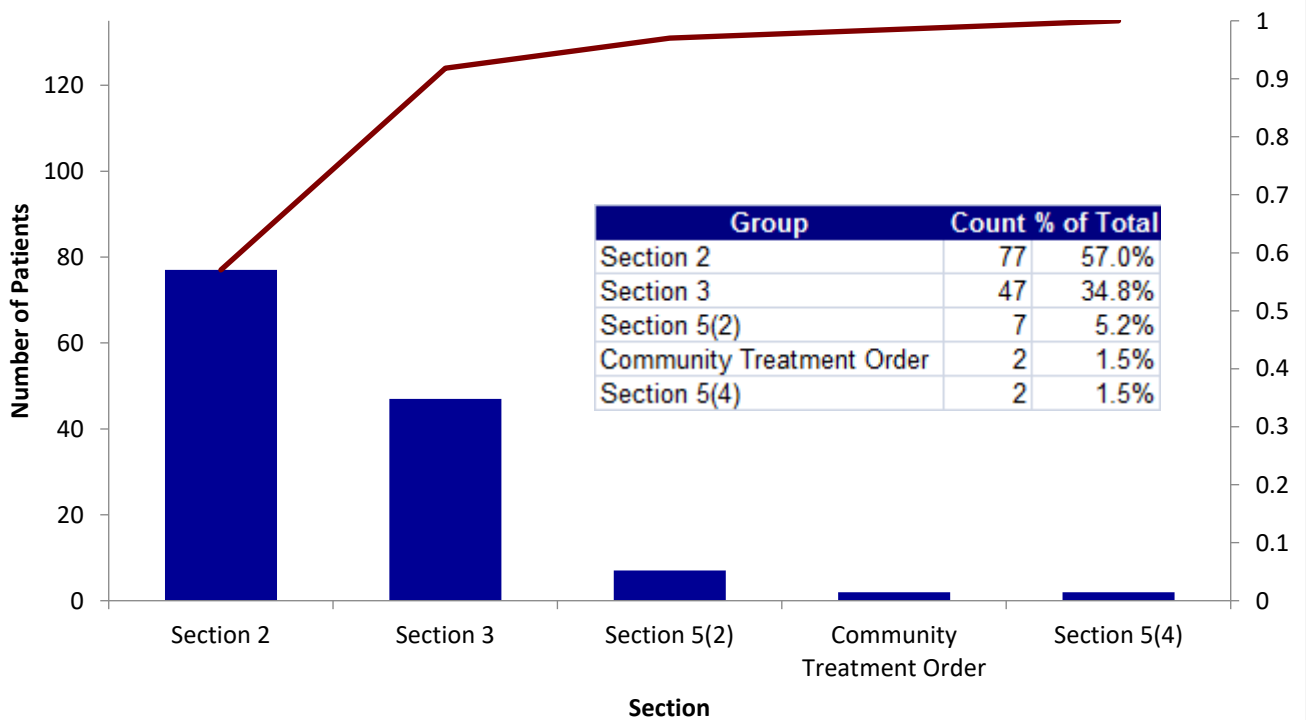
The above chart highlights that Section 64 was not used during the period January – March 2019.

Discharge

Discharge from Detention by Responsible Clinician

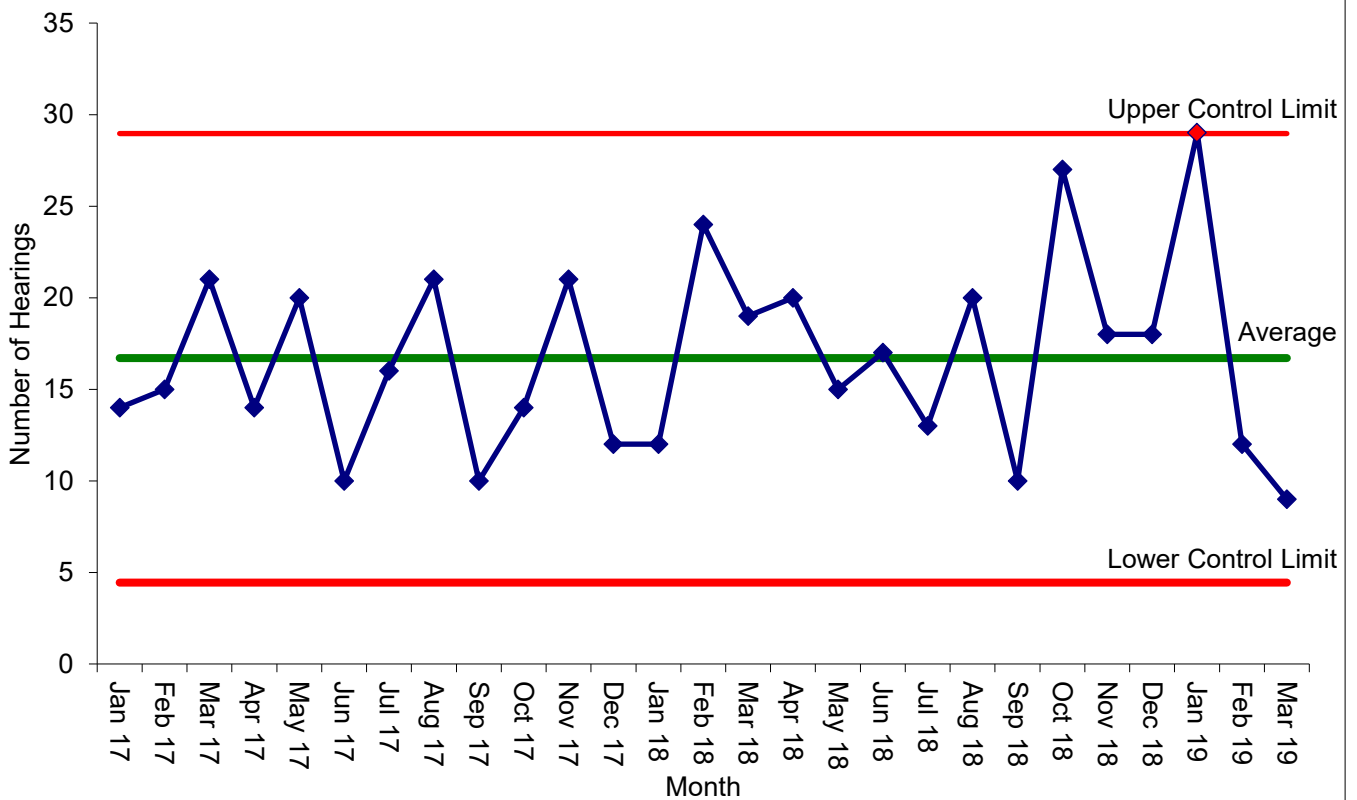


Use of Discharge by Responsible Clinician During the Period January - March 2019

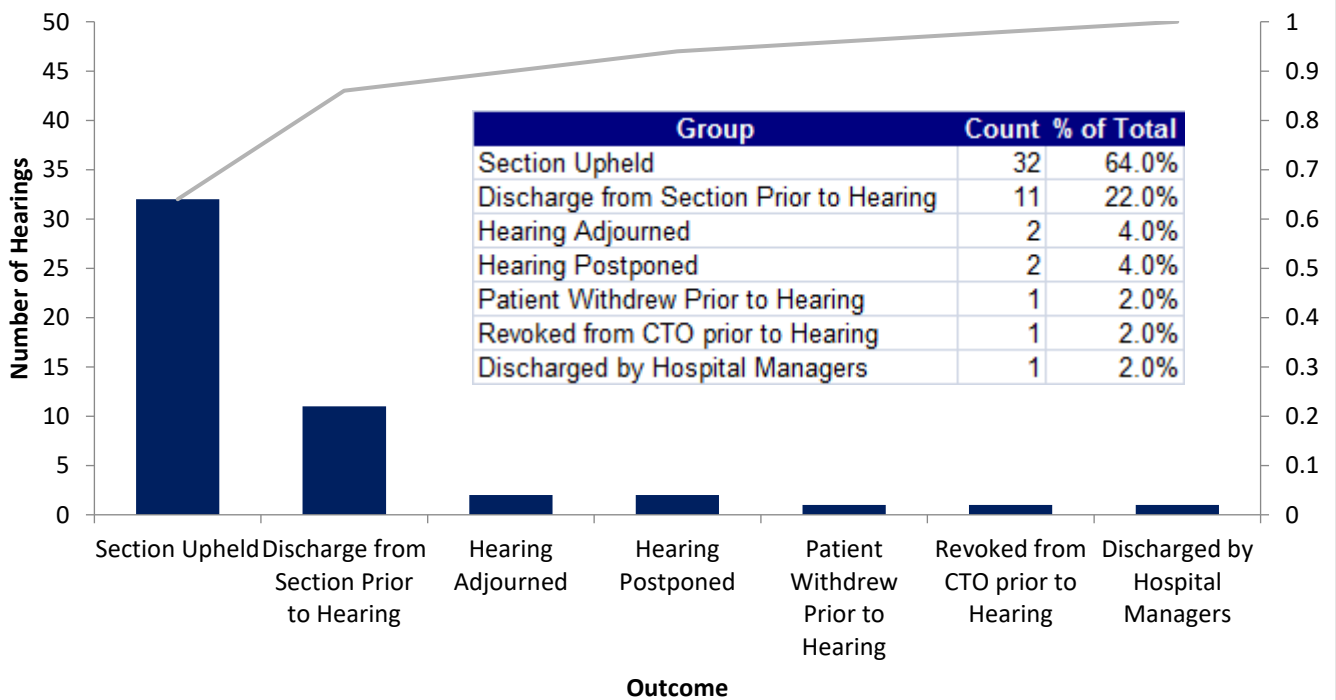


Hospital Managers – Power of Discharge

Hospital Managers PoD Group Hearings Arranged



Outcome of Hospital managers PoD group hearings during the period January - March 2019



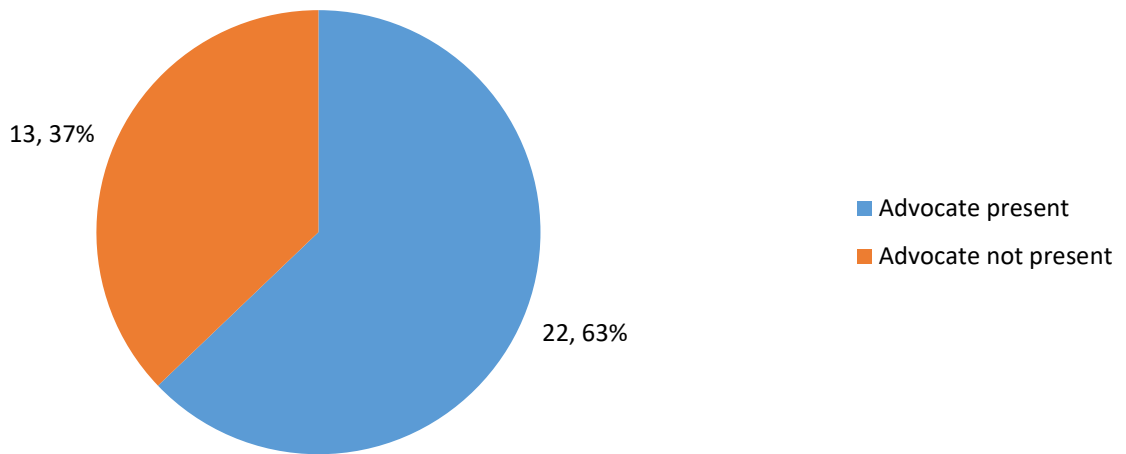
Two hearings were adjourned for the following reasons:

- The RC was considering placing the patient onto a CTO.
- The patient required a translator to read the reports, and no translator was provided until the day of the Hearing. Adjourned as it was evident that there was not enough time for the patient to have the reports translated for the Hearing.

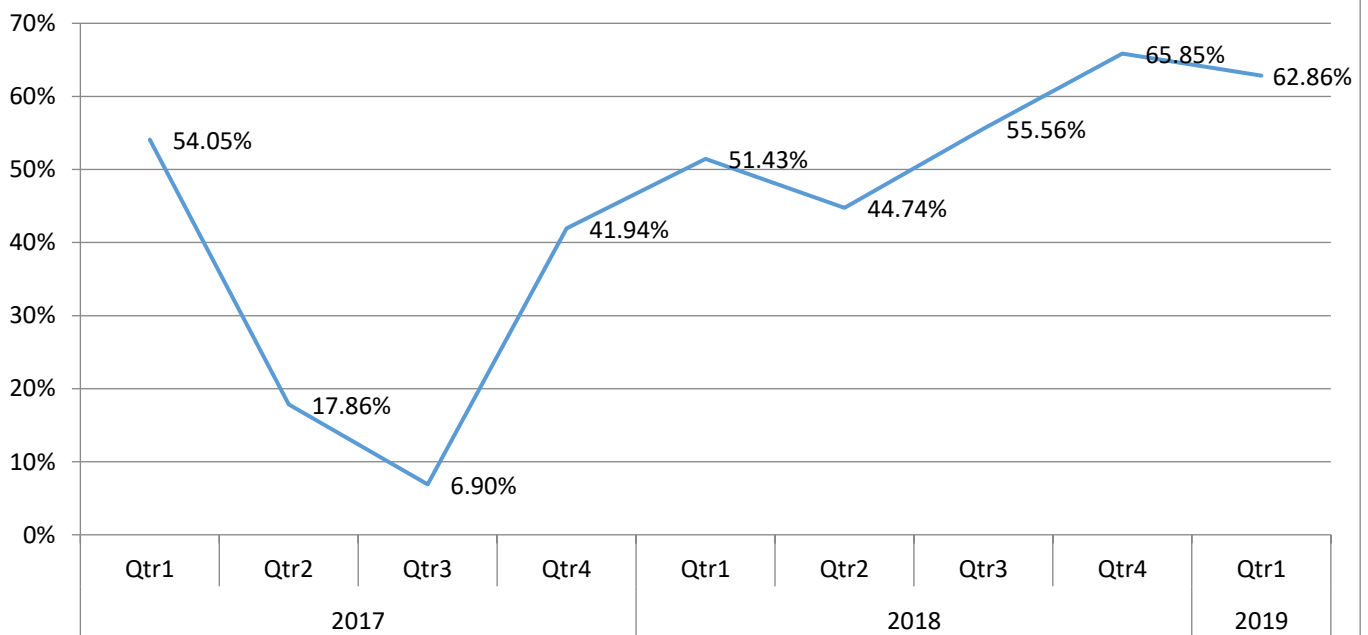
Two hearings were postponed for the following reasons:

- Both as the Responsible Clinicians were unable to attend.

Number of Patients represented by ASC during the period January - March 2019

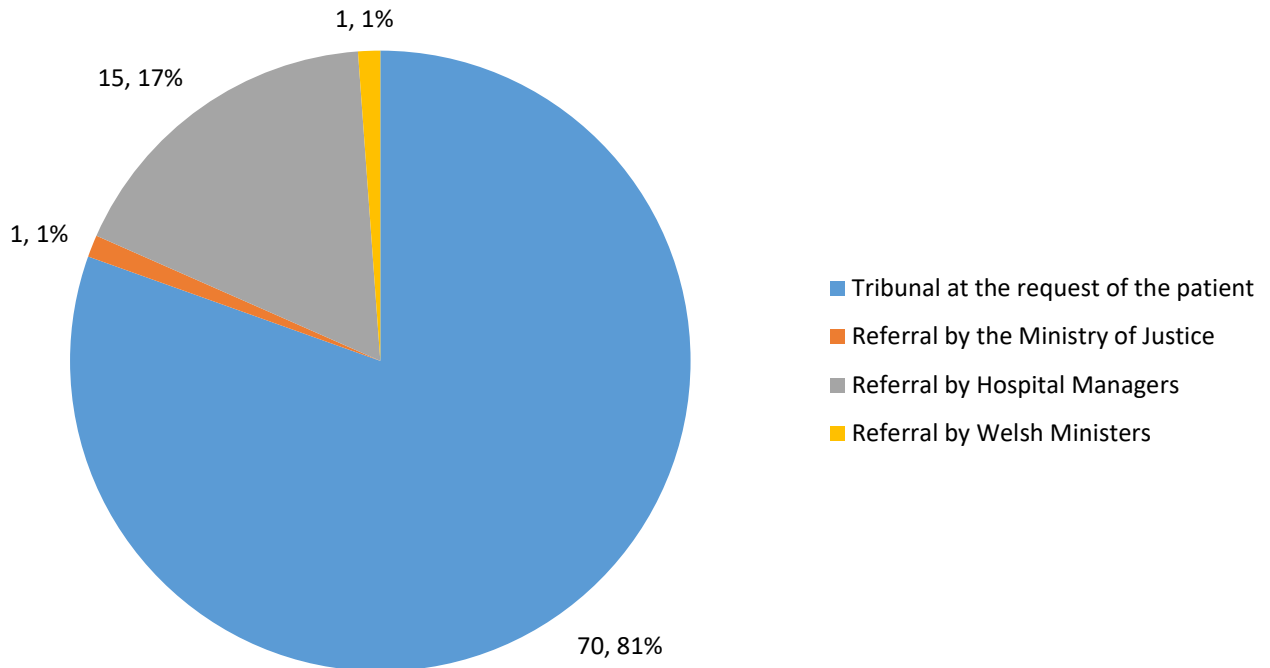


% with Advocate Present

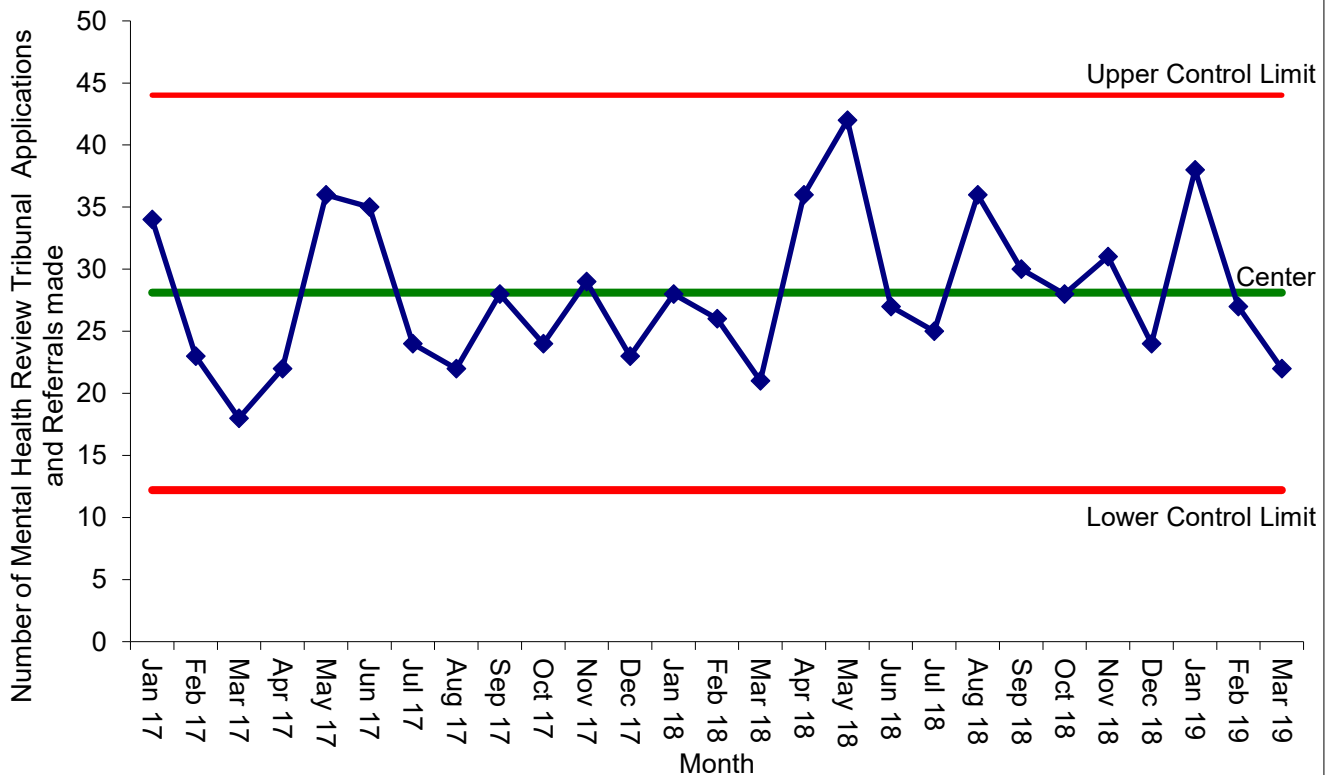


Mental Health Review Tribunal (MHRT) for Wales

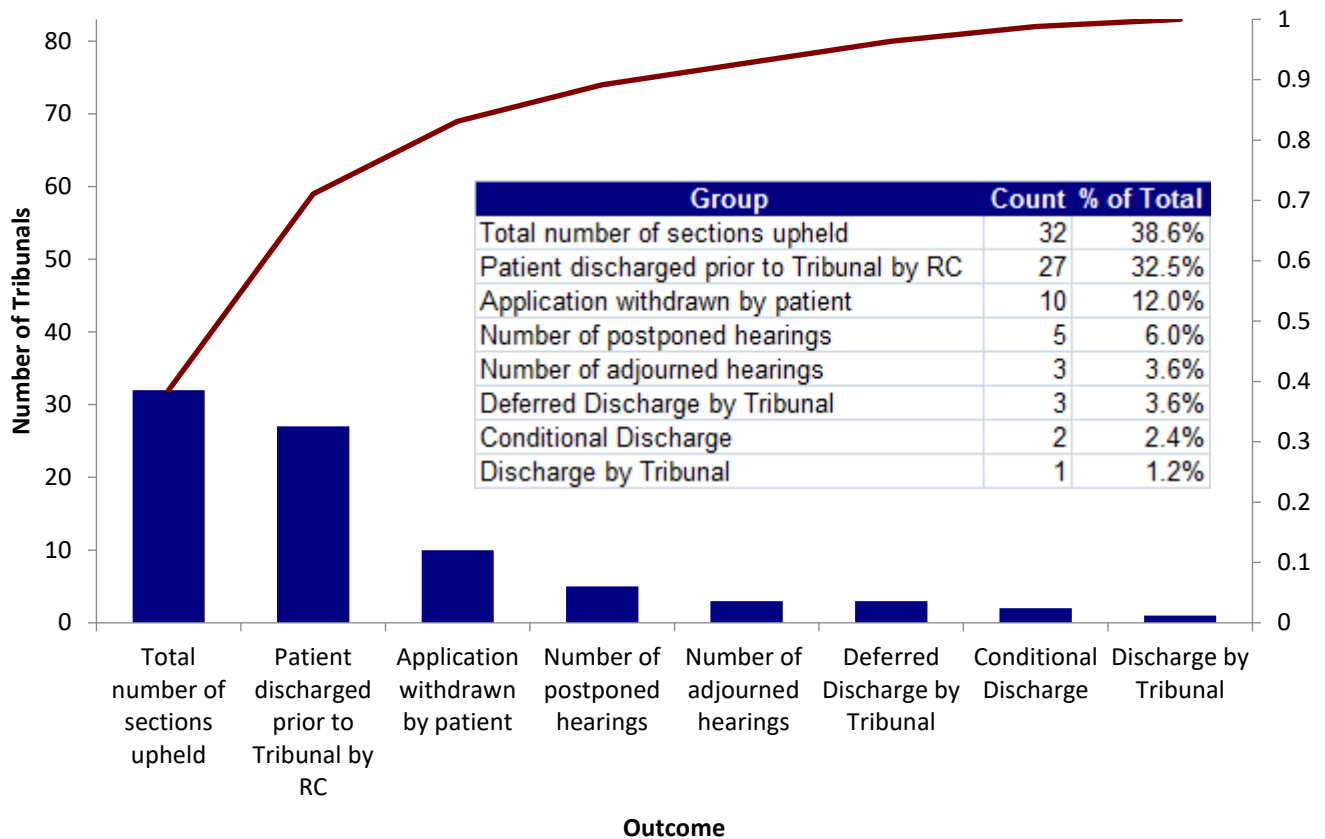
Source of applications to the Mental Health Review Tribunal during the period January - March 2019



Number of Mental Health Review Tribunal Applications and Referrals made



**Outcome of Mental Health Review Tribunals during the period
January - March 2019**



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

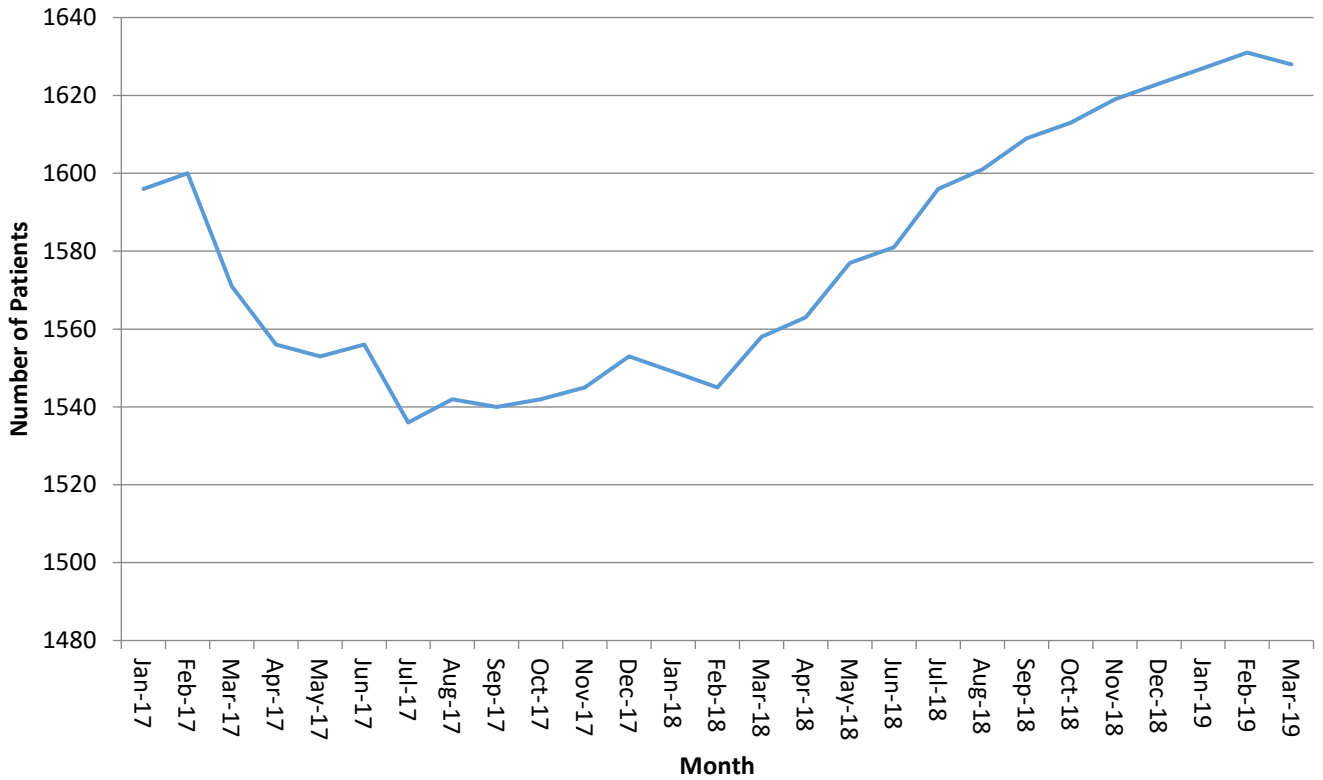
- Two where further evidence was required by the Tribunal panel
- One where both the RC and Solicitor did not arrive

Five hearings were postponed during the period for the following reasons:

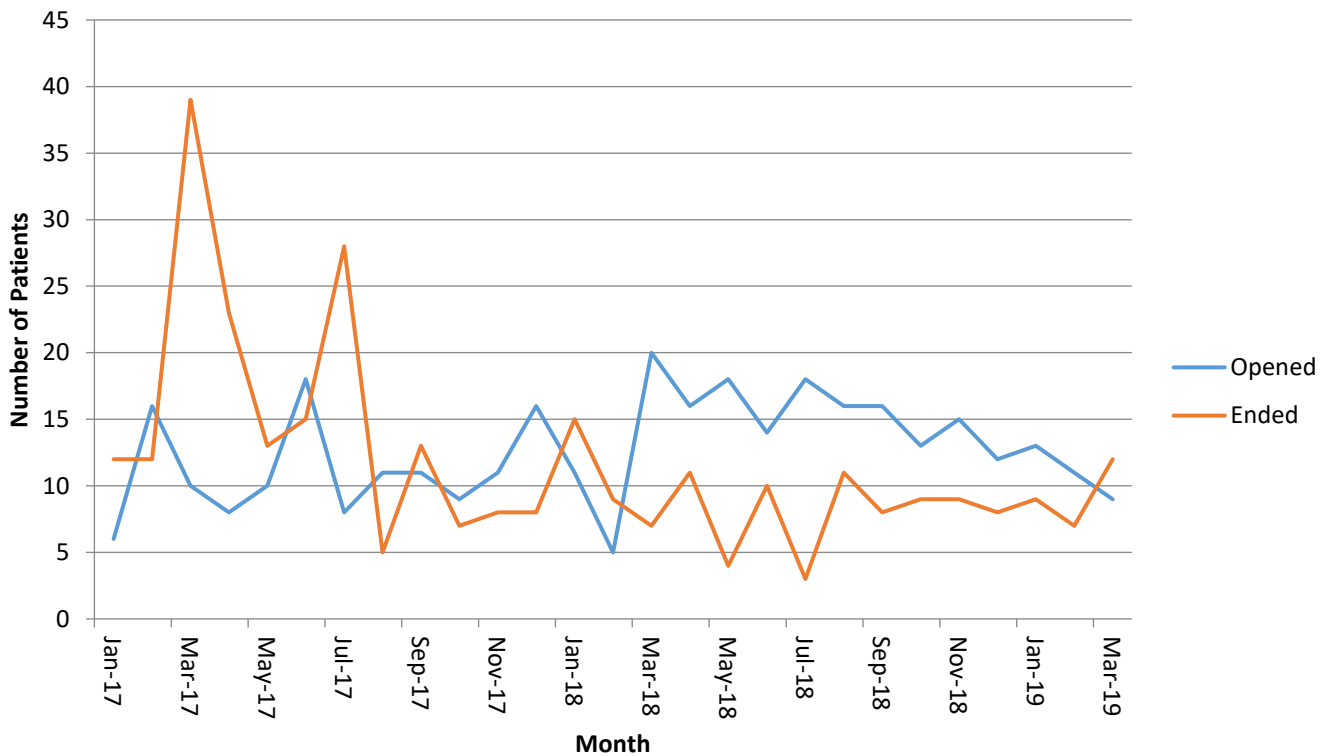
- Two due to RC unavailability due to illness
- One where the Solicitor did not arrive
- One where the Legal Member did not attend
- One where the Lay Member did not attend

Section 117 Aftercare

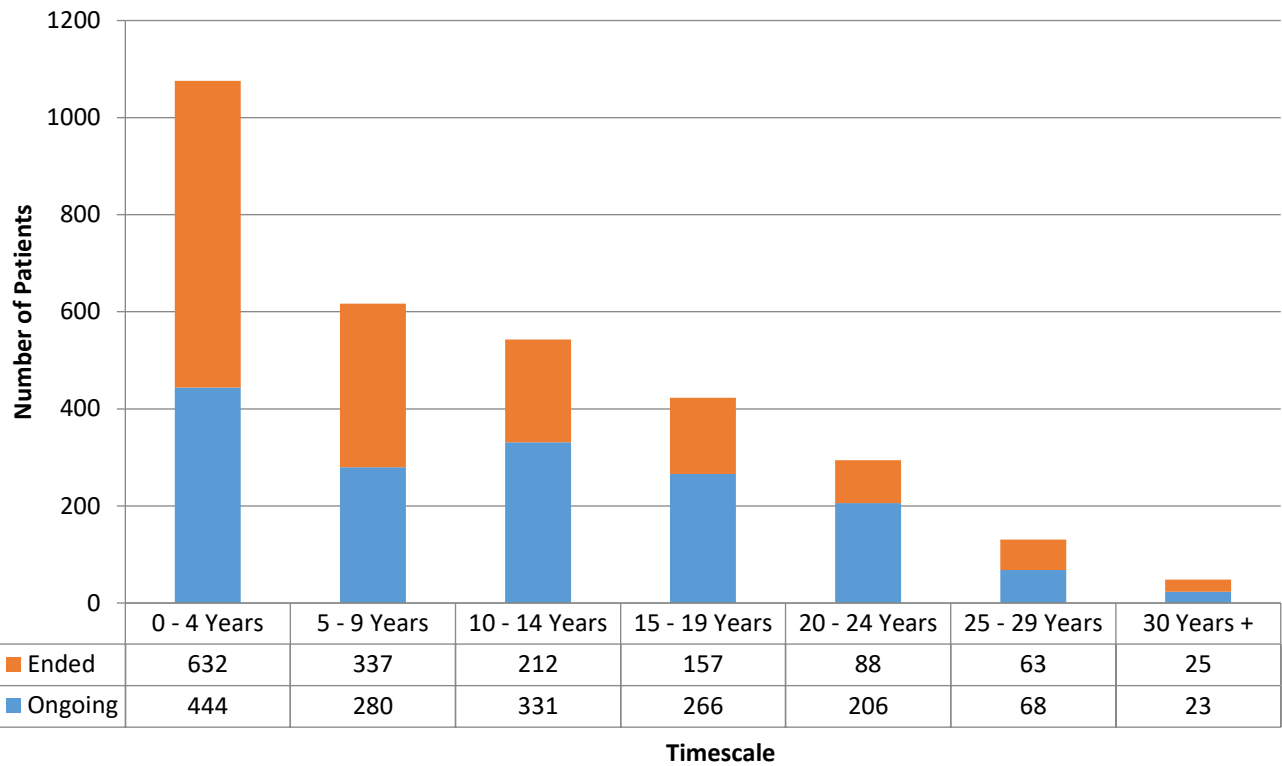
Patients eligible for Section 117 aftercare



Section 117 Activity



Periods of time that patients remain eligible for Section 117 aftercare



**Summary of other Mental Health Activity which took place during the period
January – March 2019**

Exclusion of visitors

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

Section 19 transfers to and from Cardiff and Vale UHB

During the January – March 2019 period;-

- One patient detained under Part 2 of the Mental Health Act has been transferred into Cardiff and Vale UHB
- One patient detained under Part 2 of the Mental Health Act has been transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.
- Three patients detained under Part 3 of the Mental Health Act has been transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.

Death of detained patients

During the period no patients detained under the Mental Health Act died.

Glossary of Terms

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

	<p>/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 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 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>
Section 2	<p>Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales.</p> <p>If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met.</p> <p>The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate.</p> <p>Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made.</p> <p>The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative:</p> <ul style="list-style-type: none"> • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the

	<p>public interest</p> <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 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

	<p>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 concerned with the medical treatment of the patient for</p>

	<p>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 necessary for that purpose, does not have

	<p>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>

Report Title:	Mental Health and the Police Partnership Working & The Crisis Care Concordat							
Meeting:	Mental Health Legislation Committee					Meeting Date:		
Status:	For Discussion	X	For Assurance	X	For Approval	X	For Information	X
Lead Executive:	Chief Operating Officer							
Report Author (Title):	Director of Operations – Mental Health							

SITUATION

The subject of mental health in communities is developing increasing interest and requires ongoing discussions, particularly what we mean when we refer to ‘mental health crisis’. What is clear is that there are many people who seek support in a crisis with a psychological or emotional problem which could relate to a mental disorder or more often a social/well-being range of problems. These could be financial issues, substance misuse, a safety issue or a physical health problem. This presents great difficulties to agencies wishing to offer their own specialist support as these individuals often fall between services.

People often present to statutory public services in this type of crisis including the police. This paper looks at partnership working between the police and Health services in responding to these issues, and in particular through the crisis care concordat. Recently a Welsh Assembly Health and Social Care Committee explored these questions with the UHBs in South Wales and so this report uses those questions as the format of its briefing to the Legislation Committee.

REPORT BACKGROUND

The Mental Health Crisis Care Concordat is a national agreement between health, criminal justice and social care agencies that sets out how services and agencies involved in the care and support of people in a mental health crisis will work together to provide the necessary support. It includes arrangements for more joint work and better information sharing between agencies. Section 135/6 of the Mental Health Act is a significant component within the concordat, regarding which the Legislation Committee requires a briefing to understand the partnership approach being taken in its implementation as well as wider partnership working.

Experience tells us that people often need help with one or more of these issues making it more important than ever that the services work in partnership particularly in preventing the crisis from happening in the first place. As well as supporting people in crisis, the focus of the Cardiff and Vale approach has been that preventative agenda, with significant investment used from WG funding as well as local UHB funding support to surround primary care practice with mental health and well being support. These plans are intended to provide early access and support for people with mental health needs to a range of services that will support them to live well and maintain elements of their lives such as good housing, stable finances, social networks, meaningful activities in order to remain healthy and avoid crisis.

ASSESSMENT

Question

1. *Whether there are sufficient services (i.e. health and social care services) available to support police officers in Wales to divert people with mental health problems away from police custody.*

- Cardiff and Vale currently have a mental health practitioner working in Cardiff Central Police station in a diversion post shortly following the point of arrest.
- There is a Court Diversion post in place which has a daily presence in the Cardiff Magistrate court and sits within the probation services team to ensure communication is optimised. This post offers assessments to the court of individuals suspected of having mental health problems.
- There is a full time Mental Health practitioner working within the Probation team in Cardiff and Vale to support the probation teams function in applying probation measures to individuals as well as the probation monitoring work.
- Our local Crisis Teams work directly with the ambulance services to identify individuals needing hospital care who can safely be diverted away from EU and/or the police straight into mental health services. This avoids unnecessary police contact.
- Cardiff and Vale has two operational 24 hours a day crisis teams for the Cardiff and Vale area to respond to the s.136 arrests or other crisis pathways into MH services to minimize time that the police spend with individuals and ensure access into specialist mental health support.
- The safeguarding processes within the MAPPA and MARAC interagency meetings for high risk people that the police, health and other agencies have concerns about, to ensure individual agencies are not isolated in this responsibility.
- The C&V MHCb has been working with 2 adjacent UHBs and the South Wales Police since January 2019 to develop a model of specialist mental health advice as an extension of the current call centre in Bridgend. We have two very experienced mental health nurses seconded to the Bridgend call center who are offering specialist mental health advice to Officers on the front line. This should improve Police decision making and reduce their time spend supporting people in distress. This model has worked elsewhere. This model will generally help the police more than the health services. An evaluation is due at the end of the calendar year of 2019.

2. *The number of people arrested under section 136 of the Mental Health Act 1983, and the extent to which police custody is being used as a place of safety for people in mental health crisis.*

- C&V have had a great focus on this since the inception of the concordat. Previously out of the total number of 136 arrests which is approximately 5 per week, approximately 50% were assessed in police custody. Since then this number had reduced dramatically with 1 or less per annual quarter period for those people who present with the most challenging behaviour requiring police custody facilities. The incidence of children or young people being assessed in police custody locally is a 'never event'.

3. *Whether local authorities and health services are meeting their duties and complying fully with legislative requirements to provide appropriate places of safety to which the police may take people detained under section 136 of the Mental Health Act 1983.*

- Yes the agreed place of safety in Cardiff and Vale for the compliance with the legislative requirements of s.136 is Hafan Y Coed – there are purpose built modern facilities which comply with quality and safety requirements, with the 24 hour Mental Health Crisis Teams positioned in adjacent accommodation for ease of access and support. If an individual requires any physical health care assessment or treatment prior to the safe provision of a mental health assessment and treatment, this will require attendance at an Emergency Unit prior to return to the mental health place of safety.

4. *Adherence to the Code of Practice to the Mental Health Act 1983 which requires that people detained under that Act should always be conveyed to hospital in the manner most likely to protect their dignity and privacy – taking account of any risks (i.e. by ambulance which should be made available in a timely way, as opposed to police transport).*

- This has been problematic in Cardiff and Vale as is elsewhere in Wales, due Mental Health Act related conveyance not being regarded an emergency alongside physical health conveyance by WAST. The UHB is currently reviewing this with Local Authority and Transport colleagues to consider alternative transport options such as a private or not for profit provider. This is ongoing and will be a cost pressure to the UHB.

5. *How effectively police forces in Wales work with partners (such as health or social care services) to safeguard vulnerable people in police custody, and how well the police themselves identify and respond to vulnerable people detained in custody, specifically those arrested under section 136 of the Mental Health Act 1983.*

- Level 3 MAPPA meetings attended by a senior nurse from mental health
- Level 2 MAPPA meetings attended by the mental health court and probation liaison post-holders
- Mental Health Crisis Teams facilitate assessments within 4 hours
- The Diversion at the point of arrest (DAPA) nurse supports identification of individuals in mental health crisis in the police station.
- The custody Sergeant has access to the FME or Forensic Medical Examiner.

6. *The effectiveness of multi-agency care planning for people with mental health problems when leaving custody, specifically for those detained in police custody under section 136 of the Mental Health Act 1983 to help to prevent repeat detentions.*

- The incidents of s.136 assessments in police custody have now become very rare.
- If people arrested under s.135/6 are known to local mental health services a care and treatment plan should be available which reflects the action to be taken in a crisis relapse by the individual and the agencies involved in their care and treatment. This is audited regularly and acted upon where improvements could be made.

- If people are not known to mental health services (including both health and social services) the police liaison mental health practitioner will offer information and advice on accessing a range of mental health support from health, local authority and third sector agencies in community, primary care and other settings. People cannot be compelled to access support but the choice is made available.
- Where individuals are identified as high risk, there is a well established multi-agency process of inter-agency working prompted by local MAPPA and MARAC meetings. These are well supported by the police, health and local authority services.

7. *Whether effective joint working arrangements are in place, with a specific focus on implementation of the Mental Health Crisis Care Concordat, including whether the Welsh Government is providing sufficient oversight and leadership.*

- We have been working with 2 adjacent UHBs and the South Wales Police to develop a model of specialist mental health advice as an extension of the current call centre in Bridgend. We have two very experienced mental health nurses seconded to Bridgend who are offering specialist mental health advice to Officers on the front line. This should improve Police decision making and reduce their time spend supporting people in distress. This model has worked elsewhere. This model will generally help the police more than the health services.
- We have also been working with the local police in Llandough Hospital who have based a Police Officer on site here to support with implementing the new Memorandum of understanding for staff who are assaulted by patients and patients assaulted by other patients – as well as a range of other law enforcement related issues.
- Chief Constable Matt Jukes and his Deputy recently spent some time with our crisis teams to get a better insight into mental health service provision
- We have been actively participating in the national steering group for the Police's Crisis Care Concordat helping to shape the final document with Cardiff MIND
- The Director of Nursing within C&V Mental Health services is part of the Peel Review focus group & meets with Peter Thomas the police liaison lead bi-monthly
- The new primary care liaison service being rolled out across the GP practices over the next 12 months which will target people with mental health problems of a non serious nature, but with complex social and wellbeing problems because of poor living circumstances, personality difficulties and perhaps drug and alcohol problems. When the service is fully recruited too, the professionals are expected to see up to 50-60,000 people a year with the ability to refer onto the third sector for ongoing social and well-being support. It is recognised these individuals may currently be receiving a poor service currently and are therefore more likely to seek support from out-of-hours services in crisis such as the Police and A&E. This service should reduce pressure on both the Police and ourselves.

8. *They have also requested that Health Boards provide copies of your local crisis care implementation plans too e.g. North Wales police & Betsi Cadwaladr University Health Board, South Wales police & Cardiff & Vale/ ABMU/ Cwm Taf, Gwent police & Aneurin Bevan and Dyfed Powys police & Hywel Dda/ Powys*

- We are working from the crisis care concordat action plan – the responsibility for this now rests with individual UHBs to coordinate the action plans between Health, Local Authority,

Substance Misuse, Ambulance, Police and A&E services. The Director of Operations for Mental Health will be coordinating and leading this from C&V perspective and attending the national assurance group if required/invited. On initial assessment C&V were between 80 and 85% compliant with this concordat.

Outstanding Issues Requiring Further Support

- Quality of Relapse Prevention plans for people known to mental health secondary care services particularly those who present to the other statutory agencies in crisis
- Post 136 assessment pathway tracking for frequent attendees and others.
- When a 136 starts – difference of opinion between the UHB and police currently which needs a resolution.

Summary of Further Action

ASSURANCE is provided by:

The Director of Operations in Mental Health is to coordinate a steering group in C&V to deliver the remaining multi-agency elements of the concordat and represent C&V on the national assurance group.

RECOMMENDATION

The Board is asked to:

- Receive the report, comment and monitor in the future through the MHLC

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click [here](#) for more information

Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:		Not Applicable <i>If “yes” please provide copy of the assessment. This will be linked to the report when published.</i>							

Kind and caring
Caredig a gofalgar

Respectful
Dangos parch

Trust and integrity
Ymddiriedaeth ac uniondeb

Personal responsibility
Cyfrifoldeb personol

**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



GIG
CYMRU
NHS
WALES

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



Minutes of the Mental Health Legislation and Governance Group held at 14:00 on 09 January 2019 in Training Room 2, Hafan Y Coed, Llandough Hospital

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Sunni Webb	Mental Health Act Manager
Peter Thomas	South Wales Police
Simon McDonald	Mental Health Act Administration Manager
Simon Amphlett	Senior Nurse – Crisis and Liaison Services
Gareth John	Consultant Social Worker – DoLS/AMHP
Dr Michael Ivenso	Clinical Director for MHSOP
Roisin Budina	Social Work Manager – Vale Mental Health Team
Dr Deni Mohan	SPR MHSOP
Jeff Champney-Smith	Chair Power of Discharge Group
Dr Mary Lawrence	Approved Clinician Representative
Julia Barrell	Mental Capacity Act Manager
Ceri Lovell	Team Leader – CAMHS Crisis Liaison Team
Adele Watkins	Paediatrics Representative
Clare Davies	Mental Health Lead, A+E UHW
Ceri Martin	Emergency Medicine Senior Nurse
Dr Mary Lawrence	Associate Specialist in Psychiatry

Apologies

Linda Woodley	Operational Manager Vale of Glamorgan
Myfanwy Moran	Operational Manager Cardiff
Alex Allegretto	Independent Mental Health Advocacy Manager
Mark Warren	Interim Nurse Lead – Adult Mental Health
Will Adams	Team Leader – North Cardiff Crisis Team
Dr Munawar Al-Mudhaffar	Consultant in Emergency Medicine
Dr Adeline Cutinha	Deputy Clinical Director for MHSOP
Susan Broad	MCA/DoLs Coordinator
Claire-Louise Thomas	South Wales Police

1 **Welcome and Introductions**

The chair welcomed members and those in attendance especially those from outside of the Mental Health Clinical Board and external agencies.

2 **Apologies for Absence**

Apologies were accepted and noted.

3 **Previous minutes**

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

4 **MHA Activity January – March 2019**

It was noted that there has been no use of Police Stations as a Place of Safety for Section 136 since October 2018 and that of those detained under Section 136, 29% were admitted to hospital.

The South Wales Police representative explained that this increase indicates that Section 136 is being used more appropriately, demonstrating that the Triage Pilot in the Control Room is having a positive impact on the detaining officers ability to decide if the use Section 136 is appropriate.

The use of Section 5(4) has hit the upper limit in this quarter, but isn't of concern as this peak was only six occurrences. However the Mental Health Act Manager explained to the group that use of Section 5(4) is a last resort, and that it should be documented that there had been an attempt to contact a Doctor for assistance prior to its use. Further investigation identified that this had not been recorded.

Action – The Mental Health Act Manager to inform Senior Nurse Managers of the policy for dissemination to ensure accurate recording

It was noted that Section 4 had not been used, and that the usage of Section 2 was broadly similar to previous quarters.

There was a noted exception with one section 2 had being allowed to lapse. Ordinarily this is not good practice, but the situation was explained to the group (the AMHP did not agree with the recommending doctors) and it was accepted that this was the correct course of action in this case.

It was noted that Shift Coordinators were responsible for a high number of Rectifiable Errors. This could be due to there being several new Shift Coordinators who have not received specific training.

Action – The Mental Health Act Manager to arrange training/information for the Shift Coordinators

Advocacy representation at hospital manager hearings remains between 60-65%. It was noted by the Chair Power of Discharge Group that they believed that this is very good representation, and those who were not represented had declined their involvement.

5 **Matters Arising**

Obtaining Section 135(2) Warrant

There was an issue where it was unknown who 'owned' the process for obtaining a Section 135(2) warrant.

The group were informed by the Chair that the Senior Nurse Manager for Adult Acute will 'own' the process of obtaining a warrant under Section 135(2). A meeting will be arranged to agree the process and responsibility out of hours.

Action – Mental Health Act Coordinator to complete Section 135(2) procedure/process

Section 136 A&E poster

Due to an ongoing disagreement with South Wales Police over the use of A&E being used as a Place of Safety for Section 136 it was decided that a poster should be created so A&E staff could quickly and easily check the position of the UHB if required.

This has been created and is now in use in A&E.

Section 136 electronic form

South Wales Police will be stopping the use of paper 136 forms and will be using their electronic devices to record the relevant information.

Progress on this will be discussed at the next meeting.

Conveyance

In the previous meeting Conveyance was raised as a serious issue by the Operational Manager Vale of Glamorgan stating that the lack of ambulance transport is having a negative impact on social workers. They are using their own cars, asking for staff from wards and various other improvised methods to arrange patient transport.

The Consultant Social Worker informed the group that police are unlikely to attend to execute a section 135 warrant if no ambulance is available, meaning that it will not be possible to undertake the assessment. The expectation of the Local Authority is therefore, that the Silver on Call will arrange for a private ambulance for section 135 assessments.

Statutory Consultees

In a previous meeting the Clinical Director for MHSOP informed the group that there had been several issues identifying Statutory Consultees who would then be available for the SOAD. He has arranged to meet with the relevant staff in Therapies to see if a potential way forward would be to name the team, rather than the individual. That team would then provide the name of the consultee.

To stay on the agenda for information from the Clinical Director for MHSOP.

6 Feedback on Operational Issues and Incidents

Late Reports

The Mental Health Act Manager explained that there are escalating issues around reports for both Hospital Manager and Review Tribunal Hearings being supplied late. This is not allowing those involved access to the required information within an adequate timeframe. It was explained that postponement is being considered in these circumstances to ensure the patient has access to a fair hearing and all involved are provided with enough time to prepare.

Action – The Mental Health Act Manager to email this to senior management for dissemination of this information in an effort to improve the situation.

136 Incident

The group were informed of a Section 136 Incident where a patient detained under this Section and in the care of Cardiff and Vale UHB absconded prior to his assessment. This patient was suicidal and has now not been seen for over two months. The absconcion occurred when they were allowed out to smoke and the gate of the compound was opened to allow somebody to enter.

Action – The Senior Nurse for Crisis and Liaison Services to take back to his team to review the situation with a view to reduce the risk of this occurring again.

MAU – Inpatient status

It has been raised that there is doubt and disagreement within the A&E department over the use of Section 5(2) within the Medial Admission Unit area of A&E.

The Mental Health Act Manager has sought legal advice and confirmed that If a patient has been allocated a hospital bed and is occupying that bed he or she is an "in-patient" for the purposes of Section 5(2). This means that Section 5(2) can be used if required in the MAU.

CAMHS Incident

The group were informed of an incident in UHW where a patient under 18 had been detained under Section 2 and subsequently moved to the Medical Assessment Unit. Upon physical examination they were assessed as physically fit and discharged home. The patient was returned the following day.

Action – The Chair of the group to arrange completion of an incident form

The Mental Health Lead for Accident and Emergency in UHW informed the group of an incident where the Police were called and expected to place somebody in Accident and Emergency onto a Section 136. The Police informed Health Staff that they were not sure if Section 136 could be applied in Accident and Emergency. Staff called Hafan Y Coed Shift Coordinator for advice and were informed they did not know the answer.

It was clarified to the group by both the Mental Health Act manager and the South Wales Police Representative that Section 136 can be used in Accident and Emergency.

Action – All staff to disseminate this information to their respective areas

Voluntary Assessment

The South Wales Police Representative informed the group that they believe that it is the correct procedure to take people to Accident and Emergency for voluntary assessments if they are not known to mental health services. No other member of the group was aware of this, and disagreed, whilst agreeing that the only time Police should be taking people they believe should have a Mental Health assessment to Accident and Emergency is if that person has a suspected physical issue that needed attention.

Action – Mental Health Act Manager to investigate

Informal Admission – Section 131

The Consultant Social Worker explained to the group that a patient can only be admitted informally if they have the capacity to understand and agree, otherwise admission should be under either the Mental Health Act or Mental Capacity Act. Patients must not be cajoled into agreeing to admission.

Discharge in Absence

The group discussed whether it is ever appropriate to discharge a detained patient without seeing them. The Medical members of the group explained that there are times when they think this is acceptable. For example, when a patient is on extended Section 17 leave to a placement and the staff keep the

Responsible Clinician informed of the patient's condition and responses to the placement.

Action – The Mental Health Act Manager to provide further information

Assessment delay due to bed shortage

A query was brought to the group around delayed Mental Health Assessments due to bed shortage.

The South Wales Police Representative stated that he knew of no such occurrence, and the Consultant Social Worker stated that an assessment would still go ahead if there was a bed shortage. No member of the group knows of this situation occurring.

Section 117 Policy Review

The current Section 117 Policy is under review.

The Mental Health Act Manager informed the group that the Section 117 Policy is near to first draft.

Missing Person Under 18 Procedure

There is currently no procedure for under 18 missing persons.

The Paediatrics Representative informed the group that this will now be incorporated into other policies as there are situations where this could apply, for instance the Maternity department.

Lack of Ward Based Activities

There has been an ongoing issue for some time around the lack of resources on inpatient Mental Health Wards.

The Chair Power of Discharge Group stated that this is still an issue and is also linked to patients being unable to take authorised periods of leave due to the lack of staff availability as escorts.

Action – chair to take to adult directorate Q&S and to Inpatient Development Group

Late Requests for Section 2 Assessments

To be discussed and the next meeting

RC- MHA Report

An automated report is being trialled that lists upcoming RC duties under the Mental health Act. This daily report is intended to replace the manual reminder emails sent by the Mental Health Act Office.

The Mental Health Act Coordinator stated that he believes the report to be ready to replace some of the manual email requests/reminders sent by the Mental Health Act Office, but would like the views of the Responsible Clinicians. The response from the Responsible Clinician attendees was very positive, and this will be taken to the Consultants Meeting for discussion.

7 Feedback from other meetings

AMHP Forum

Conveyance is still an issue and has been discussed earlier in this meeting.

Consultants Meeting - Extended Section 17 Leave

There is a strong consensus that for some patients extended section 17 leave is more appropriate than a community treatment order dependant on their circumstances. The Mental Health Act Manager stated that consideration to using a Community Treatment Order must be documented when using long term section 17 Leave.

8 Power of Discharge Group

The Chair Power of Discharge Group stated that there are ongoing issues with ward based activities and the inability to take leave due to staffing issues.

Quality of Care and Treatment Plans and Risk Assessments is still an issue. It has been reported that the written reports do not always match the verbal reports due to information not being updated. This is being monitored within the Mental Health Act Office and is being fed back to the Head of Operations and Delivery.

The Chair Power of Discharge Group stated that feedback after a Managers Hearing has increased, but would like to see more to continually improve the service. There is still a concern about the lack of attendance of patients, especially those from a Forensic speciality ward.

9 External Reviews

HIW Inspection Report – Inpatients

An unannounced inpatient ward inspection was carried on by Health Inspectorate Wales on 19th and 20th March.

There is no written report yet but the verbal feedback was very good. The written report will be distributed when it is available

10 **Interface MHA/MCA/DoLS**

The Mental Capacity Act Manager informed the group of an incident where a patient had capacity but had a condition that was life threatening. There was confusion by the patients Responsible Clinician over the most appropriate Act to use, either the Mental Capacity Act or the Mental Health Act. The Mental Health Act Manager stated that some guidance will be created and distributed.

Action – The Mental Health Act Manager and The Mental Capacity Act Manager to create and distribute guidance

11 **Quality Indicators and Audit Activities**

The Chair of the group will discuss with the Acting Clinical Director.

Action – Chair to agree quality indicators and audit objectives with the Acting Clinical Director – This is on hold until the return of the Adult Clinical Director

12 **Any other business**

Section 135 in neglect situations

The Chair informed the group that he had recently undertaken a training course where it was explained that Section 135 could be used to gain access in situations where somebody is suffering from neglect in order to rectify the situation. For example to gain access to fix a blocked drain that was contributing towards that person's ill health.

Action – The Chair to make the presentation used in the training available to the group

AMHP Burnout

There has previously been raised the issue of AMHP burnout due to lack of resources available. This is still an issue and is being exacerbated by late requests for Mental Health Assessments and patient conveyance issues.

Section 57 Treatments

The Chair stated that as far as we are aware Cardiff and Vale UHB does not undertake any psycho-surgery treatments.

Ward Availability

The Mental Health Act Manager relayed difficulties in contacting wards via email, telephone, or in person. This has also been reported to the Mental Health Act Office by Legal Representatives and Advocates. The Senior Nurse Manager, Adult Acute has been informed and is monitoring the situation.

AWOL detained patients

The Mental Health Lead for Accident and Emergency in UHW asked how to report situations such as patients detained under Section 2 absconding and leaving the country so they could be added to the agenda. The group were informed that to add items to the agenda they need to contact either the Chair or the Mental Health Act Manager.

14 Next Meeting

The next meetings to be held in Seminar Room 1, HYC from 14:00hrs:

18 July 2019

17 October 2019

REPORT TITLE:	Mental Health Measure						
MEETING:	Mental Health Legislation Committee				MEETING DATE:	4/6/19	
STATUS:	For Discussion	X	For Assurance	X	For Approval		For Information
LEAD EXECUTIVE:	Steve Curry – Chief Operating Officer						
REPORT AUTHOR (TITLE):	Ian Wile – Director of Operations, Mental Health						
PURPOSE OF REPORT:							

To provide assurance to the committee on the four parts of the mental health measure

REPORT:

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

Part 1 : PMHSS

Following an increase in referrals in October 2018 (1,350 approx.), monthly referral rates appear to have generally increased to approximately 1100 per month. This has been manageable for this reporting period with the team showing compliance with parts 1a and 1b up to the April reporting period in 2019.

Looking ahead, there are increased clinical promotion and development opportunities for the

team practitioners in the new primary care liaison services as well as the expanding psychological therapies hub will cause vacancies during May and June this year, for which vacancies are being advertised in advance. The clinical expertise of these practitioners is not easily replaced or developed.

Part 2 – Care and Treatment Planning Within Secondary Mental Health Services

See attached CTP Action Plan in response to the following compliance:

- January 2019 – 84%
- February 2019 – 85%
- March 2019 – 85%
- April 2019 – 86%

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

100% Compliance

Part 4 – Advocacy

100% Compliance

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click [here](#) for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	<p>Yes / No / Not Applicable</p> <p>If “yes” please provide copy of the assessment. This will be linked to the report when published.</p>									



Care & Treatment Plans

May 10

2019

Following a poor all Wales report on the quality of Care and treatment plans, the C&V MHCB have established a steering group to respond to this long standing issue.

Delivery Unit
Assurance Action Plan

Context

Part 2 of the Mental Health (Wales) Measure 2010 (the Measure) places a statutory duty on Local Mental Health Partners to ensure that all patients who are accepted into secondary mental health services have a written care and treatment plan (CTP) that is developed and overseen by an appointed care coordinator.

Following a poor audit by the Delivery Unit of CTPs across Wales in 2018, C&V was identified as being no exception. The report was Clinical Board wide and required a Clinical Board wide response, hence the chair of the improvement steering group being the Director of Operations. The Mental Health CB and the UHB will monitor the improvements through the Mental Health Legislation Committee. The Delivery Unit made specific recommendations for C&V see below:

1. The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning.
2. The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual's safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning.
3. The Health Board and partner agencies should ensure that formal reviews of CTPs are undertaken in a timely manner that does not exceed the statutory duty for review.
4. The Health Board and partner agencies should ensure that there is an integrated and joined up approach between mental health and drug and alcohol services for people who experience co-occurring issues.
5. Care Coordinators should ensure the inclusion of third sector agencies that are providing regular and ongoing support to an individual within the assessment, planning and review processes.

Refreshed Action Plan for the DU – For Review 6 Monthly

Delivery Unit /UHB Recommendation	Action	Lead and Timescale	Review Notes
1. The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning. (Refers in the main to adult services)	<p>Establish an education and training sub group and package which includes a guide to CTP use and development and the following characteristics:</p> <ul style="list-style-type: none"> • Its use as a Therapeutic tool • Link with service user outcome measures • MDT and Multi-agency delivery • Focuses on a Pilot site in the Vale community mental health services <p>CARE AIMS model supported as a training and clinical practice tool to meet these needs. Ensure a sufficient resource is available from the multi-agencies involved to support the rollout to at least 50% of the pilot site staff in the recently merged Vale of Glamorgan Locality Team in year 1 and 80% of MH clinical staff over 2 years.</p> <p>For all integrated managers and lead nurses in community and hospital settings to discuss this action plan and its contents across community and in-patient settings over the next 4 months</p>	<p>Ownership and lead of Action Plan overall - Ian Wile- Director of Ops – to review the action plan and its contents every 6 months – April 2019 / September 2019 / April 2020 / September 2020</p> <p>Project Support - Dan Crossland – Community Transformation Lead</p> <p>Training and Education subgroup established – November 2018 – Chair – I wile – Director of Ops – to establish CARE AIMS Training provider and coordinate a training plan</p> <p>Comms regarding action plan – April – August 2019</p>	<p>March/April 2019 – Action plan updated for the MHLC in April 2019 by I Wile</p> <p>First wave of 'Care Aims' awareness raising commenced in the LVCMHT from September 2018 to April 2019 as a pilot. To submit a costed plan to the WG for further Care Aims training from the MH investment (SIP) funding for 2019/20. For submission by 30th June 2019.</p> <p>Action plan cascaded to all directorates in MH in May 2019 for distribution and</p>

CARE & TREATMENT PLANNING IN MENTAL HEALTH SERVICES

			signup.
<p>2. The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual's safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning.</p>	<p>Review the simplicity of documentation related to risk assessment and risk management and refine where necessary (layers of documentation have developed with the various iterations related to the use of CPA, UA and now CTP) and change/reduce where necessary</p> <p>Deliver Risk Assessment & WARRN training in sequence with CTP training to 75% of staff in next 2 years (90% of registered nurses within that)</p> <p>Audit compliance every 4 months alongside CTP audit (Delivery Unit Audit Tool) and feed-back to the steering group, MHCB Q&S Committee and report into the MHLC.</p>	<p>Review of Documentation between March 2019 and August 2019 – ANP Will Adams</p> <p>Cycle of training, audit tools and methods agreed – WARRN training commenced and refreshed CTP training to commence in January 2019 over 2 Year period – WARRN training Team</p> <p>Line management audit leads for all clinical areas in adult services to agree audit cycle and feedback method to the directorate and clinical board at least 3 times a year of the quality of risk assessments and CTPs based on the DU audit. Due in May 2019. To feed back this data to the teams for learning to take place on each audit cycle</p>	<p>March/April – 2019</p> <p>Team of 5 part time WARRN trainers established who are tasked with simplifying the risk assessment and risk management documentation</p> <p>This team has commenced WARRN training and are on target.</p> <p>All line managers appraised of their responsibility to provide audit data to their respective directorates in the times agreed.</p>

CARE & TREATMENT PLANNING IN MENTAL HEALTH SERVICES

<p>3. The Health Board and partner agencies should ensure that formal reviews of CTPs are undertaken in a timely manner that does not exceed the statutory duty for review.</p>	<p>See training notes in no. 4 above.</p> <p>Continue to circulate lists of clients with 117 after-care responsibility to the integrated managers for use with MDT reviews</p> <p>For Community service leads to develop a process of reminding case managers of review times which could include a PARIS flagging process.</p> <p>Develop a caseload supervision process to regularly support practitioners with caseload management and standards of clinical practice records including CTPs.</p> <p>See 2 for CTP Audit Actions</p>	<p>Ian Wile/Sunni Webb Leads – lists go to Community Leads/Managers in Adult and MHSOP community Teams bi monthly</p> <p>Community Senior Nurse Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019</p> <p>Community Senior Nurse Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019</p> <p>All above</p>	<p>Completed and routinely working – on a bi-monthly basis. See above for audit requirements</p>
<p>4. Care Coordinators should ensure the inclusion of third</p>	<p>A draft plan is: To arrange for local third sector agencies to</p>	<p>This is a challenging plan with a meeting/event planned with the third sector umbrella</p>	<p>May 2019 update – initial date set with</p>

CARE & TREATMENT PLANNING IN MENTAL HEALTH SERVICES

sector agencies that are providing regular and ongoing support to an individual within the assessment, planning and review processes.	<p>those community services to have formal pathway links with the local statutory services.</p> <p>For relevant local third sector agencies to have a presence in Community teams.</p> <p>To include within the core mental health assessment a question exploring the input of any third sector support.</p> <p>To ensure advocacy services area available where required.</p> <p>Commission Cavamh to do evaluate this aspect of CTP coordination.</p>	<p>organization for C&V (CAVAMH) to explore a detailed and achievable action plan for this – to be the responsibility of:</p> <p>Ian Wile _ Director of Ops Dan Crossland – Transformation Lead Linda Newton – Cavamh lead office Integrated Managers – of CMHTs</p>	Cavamh on the 13 th May 2019 to expand the action plan
5. The Health Board and partner agencies should ensure that there is an integrated and joined up approach between mental health and drug and alcohol services for people who experience co-occurring issues.	Establish a discrete resource in general adult and substance misuse services to improve Integrated working – an ANP in general adult with a significant element of the role dedicated to dual diagnosis and sessional time from a senior clinician in Substance misuse services – both roles to work collaboratively and focus on training, joint care planning MDT working and accessing wider support for individuals. Also to develop a network of substance misuse liaison	Complete – post holder in place and improvement method agreed. Will Adams ANP leading.	May 2019 Update – Dual diagnosis posts in place, and joint working between Community generic services and addictions services commenced with service users spanning both areas. Currently

CARE & TREATMENT PLANNING IN MENTAL HEALTH SERVICES

	<p>leads for each of the community mental health services.</p> <p>Mental Health and Innovation funding in 2018/9 secured to enhance the treatment of service users with dual diagnosis using the COMPASS model. Anticipated benefits are the availability of psychological care for those with co-morbid MH problems</p> <p>To seek feedback from Service Users and audit of caseloads to evaluate.</p>	<p>Funding secured – recruitment to commence January 2019 – Neil Jones CD adult services and Paul Sussex Senior Nurse Substance Misuse services leading.</p>	<p>Will Adams is establishing the liaison posts.</p> <p>JDs for COMPASS Model currently awaiting approval through the UHB.</p>
MHC B Added Issue			
<p>6. Lack of clarity over which service users in secondary care community services meet the 'relevant patient' status to ensure efforts are targeted at those most in need.</p>	<p>Clarify with the MDT whether cohorts of service users such as those with ADHD and those who are stable in services require and are receiving a service equivalent to secondary care. If not and the care and treatment is primary care equivalent to accommodate this until discharge is safe.</p>	<p>Work Commenced by Dr Neil Jones CD adult services to develop a protocol for consultation describing a step down recovery 'primary care' equivalent service within CMHT caseloads not requiring a CTP. Completion of legally scrutinized draft by May 2019 and implement through a description in the UHB Part1 'Scheme of Work' by June 2019 with a view to implement over the ensuing 12 to 18 months.</p>	<p>April 19 Update – legal scrutiny supports this change – currently being included in Part 1 Measure Scheme of work for reference. Policy. Implementation phase of 12 to 18 months commenced</p>

Report Title:	Committee Effectiveness Review – Results and Actions						
Meeting:	Mental Health and Capacity Legislation Committee				Meeting Date:	4 th June 2019	
Status:	For Discussion	x	For Assurance		For Approval	x	For Information
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

SITUATION

It is good practice and good governance for Committees of the Board to undertake an effectiveness review on an annual basis.

The questions which were asked by Members of the Committee were agreed at the meeting of the Committee in February. It was also agreed that Survey Monkey would be used as a tool to gather the feedback.

ASSESSMENT

Attached at appendix 1 are the results for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee.

Attached at appendix 2 is a proposed action plan to improve the results which fall below 100%.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee Effectiveness Review for 2019.
- Approve the action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

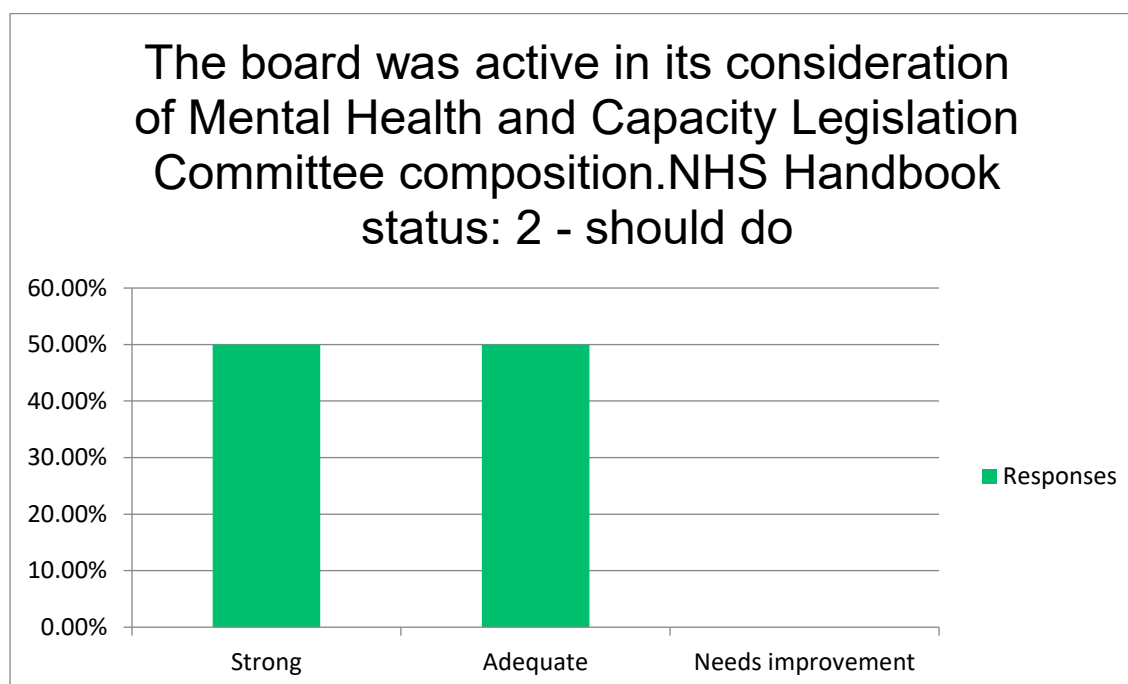
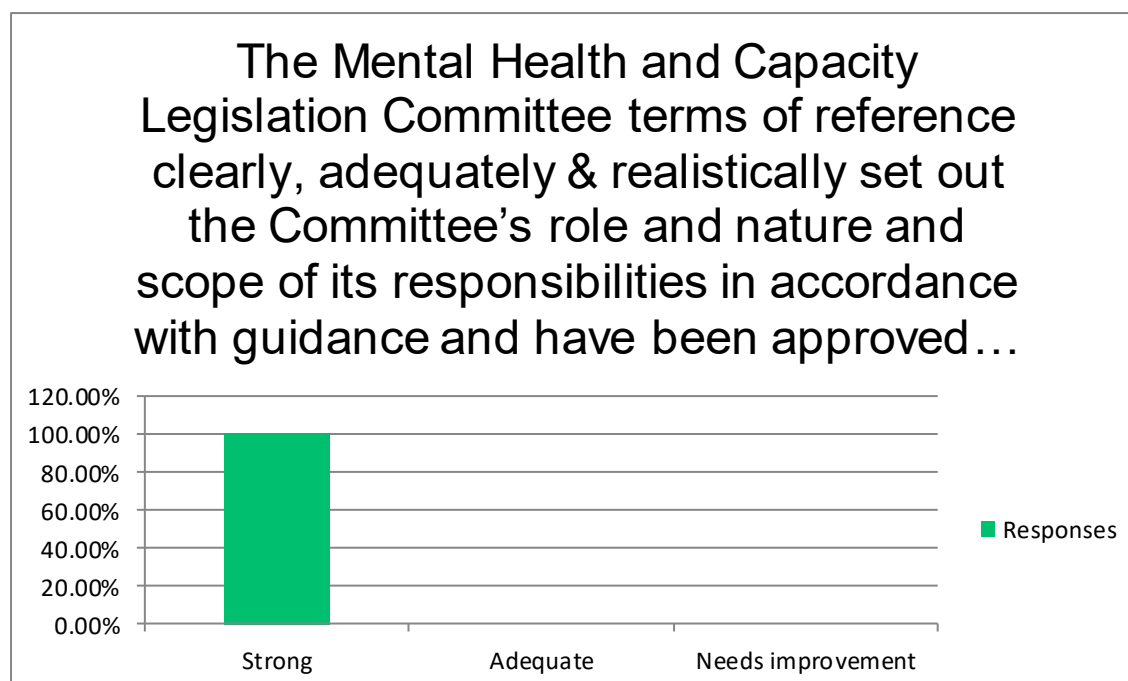
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	
Five Ways of Working (Sustainable Development Principles) considered <i>Please tick as relevant, click here for more information</i>			
Prevention		Long term	x
		Integration	
		Collaboration	
		Involvement	
Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>		

Mental Health and Capacity Legislation Committee – Self Evaluation 2019 Action Plan

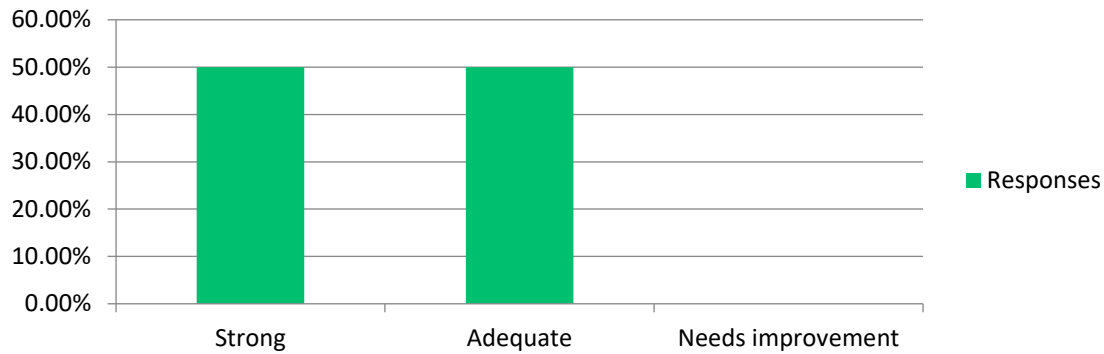
Question asked	Action Required	Lead	Timescale to complete
The board was active in its consideration of Mental Health and Capacity Legislation Committee composition	The Board will be approving the composition of the Committee at its meeting on 30 th May 2019. In future this will be reviewed and confirmed on an annual basis.	Director of Corporate Governance	March 2020 for next review
The Mental Health and Capacity Legislation Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.	Need to ensure that actions agreed by the Committee are agreed with Independent Members and not as suggestions from Management. Need to also ensure that actions are in the next interests of the Health Board and Stakeholders and ethically sound.	Director of Corporate Governance	From June 2019 Committee Director of Corporate Governance will ensure this happens and challenge actions from the minutes where this is not the case
The Mental Health and Capacity Legislation Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.	Meeting packages need to be reviewed and uploaded within the timescales set out within standing orders. This is an area which requires improvement. The Corporate Governance Department are being set clear timescales for delivery but it also required Executive Directors to ensure their reports are submitted on time. In future and in	Director of Corporate Governance / Committee Chair	From October 2019

Question asked	Action Required	Lead	Timescale to complete
	discussion with the Chair reports not submitted within the deadline will be removed from the agenda		
Mental Health and Capacity Legislation Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.	Need to ensure that items on the agenda are manageable and time allocated is appropriate. Discussion to take place between Director of Corporate Governance and Committee Chair to ensure that this is the case	Director of Corporate Governance / Committee Chair	By October 2019 meeting
Appropriate internal or external support and resources are available to the Mental Health and Capacity Legislation Committee and it has sufficient membership and authority to perform its role effectively.	Membership of Committee has recently been approved by the Board. This will now take place on a 12 month basis. Discussion to take place with the Chair to see if the Committee requires any further internal or external support	Director of Corporate Governance / Committee Chair	12 month review of Committee to take place by March 2020 Discussion to take place with Chair regarding internal and external support to take place by October 2019.
Has the committee formally considered how its work integrates with wider performance management and standards compliance?	Performance Management standards discussion to take place and any action as a result to be implemented	Committee Chair and Deputy Chief Executive	By October 2019
The Mental Health and Capacity Legislation committee's self-evaluation process is in place and effective	This is the first review of Committee effectiveness which has taken place. This will be done on a 12 month basis with action plan for improvement then	Director of Corporate Governance	Review for this year complete and action plan developed. Next review to take place by March 2020

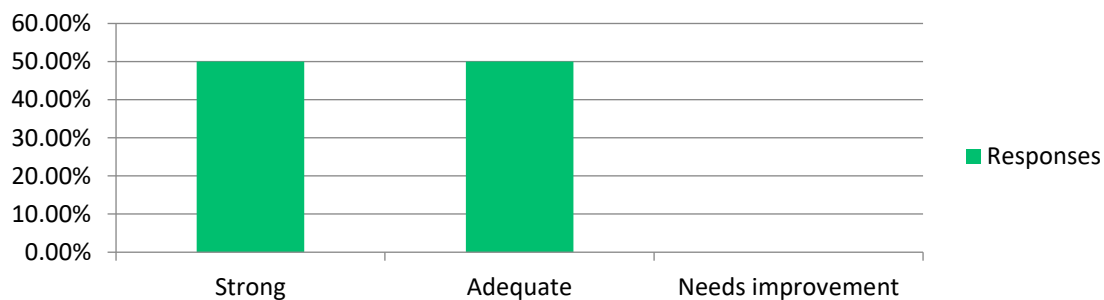
Question asked	Action Required	Lead	Timescale to complete
	developed for areas requiring improvement		
What is your overall assessment of the performance of the Mental Health and Capacity Legislation Committee?	Overall assessment should improve with the completion of the action plan	Director of Corporate Governance	March 2020 is when the next review takes place so improvements can be measured then when results are received

RESULTS – MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE.

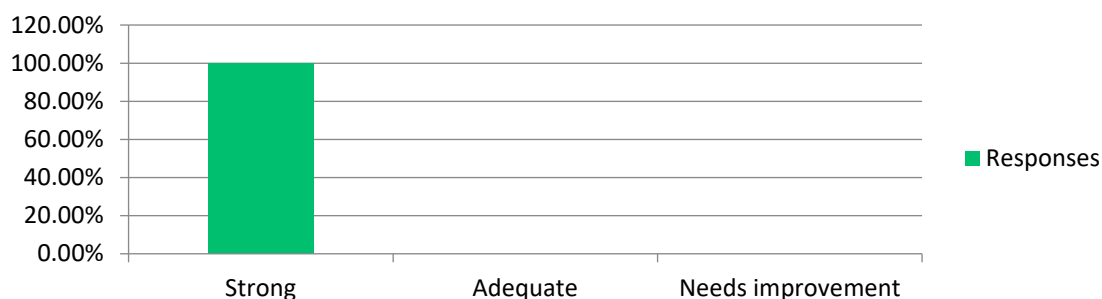
The Mental Health and Capacity Legislation Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



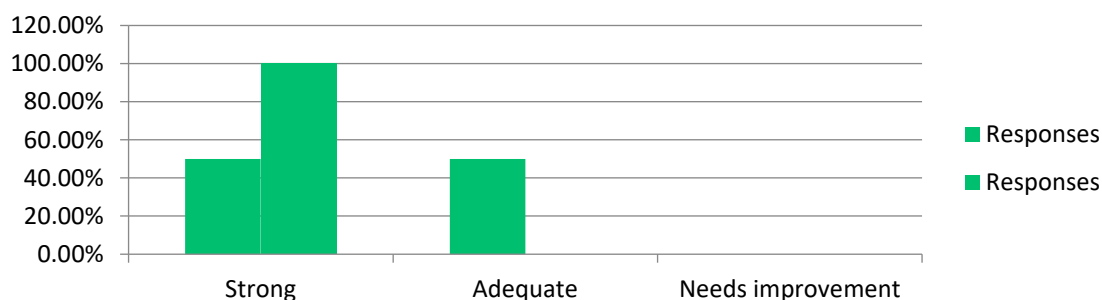
The Mental Health and Capacity Legislation Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful...



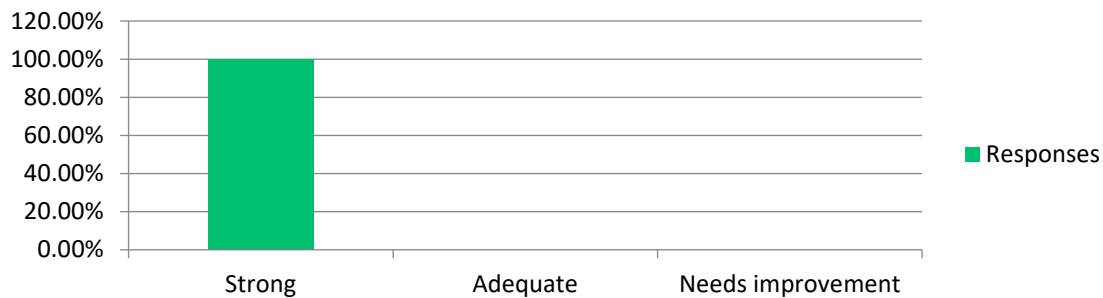
Mental Health and Capacity Legislation Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's...



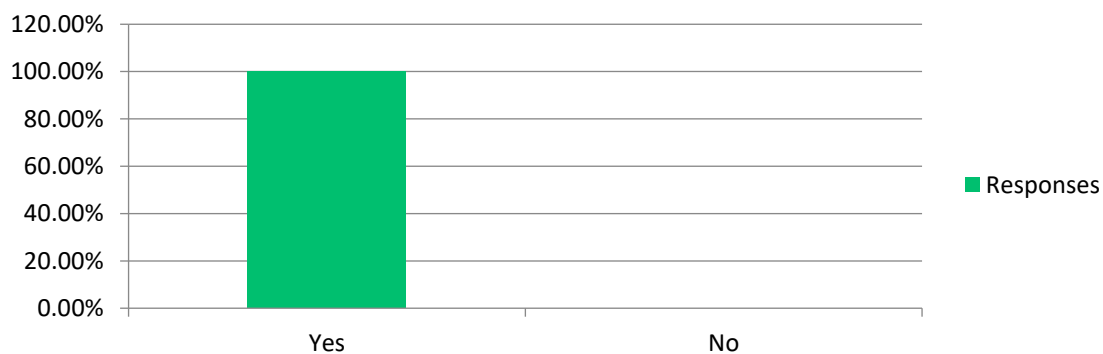
Mental Health and Capacity Legislation Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's...

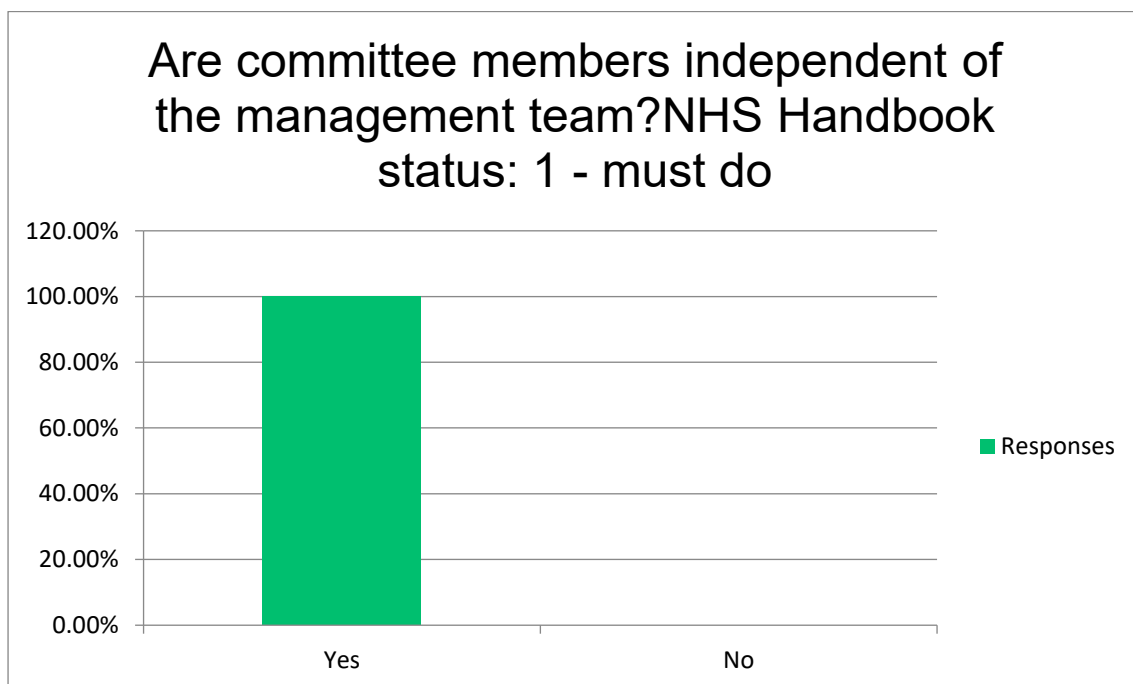
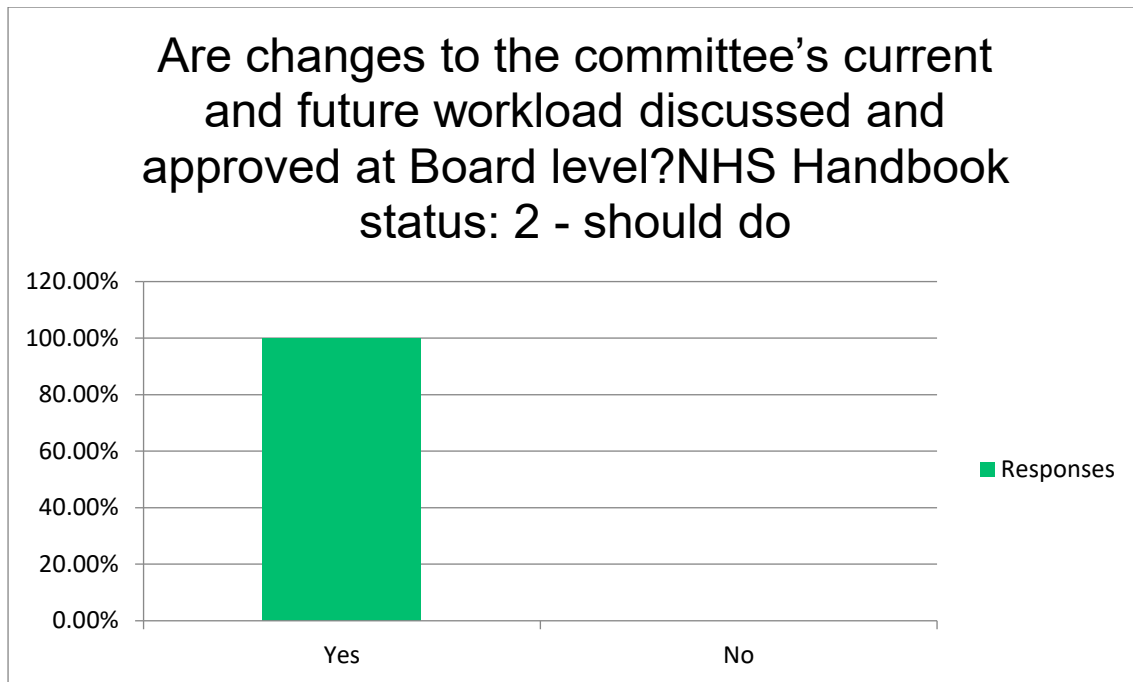


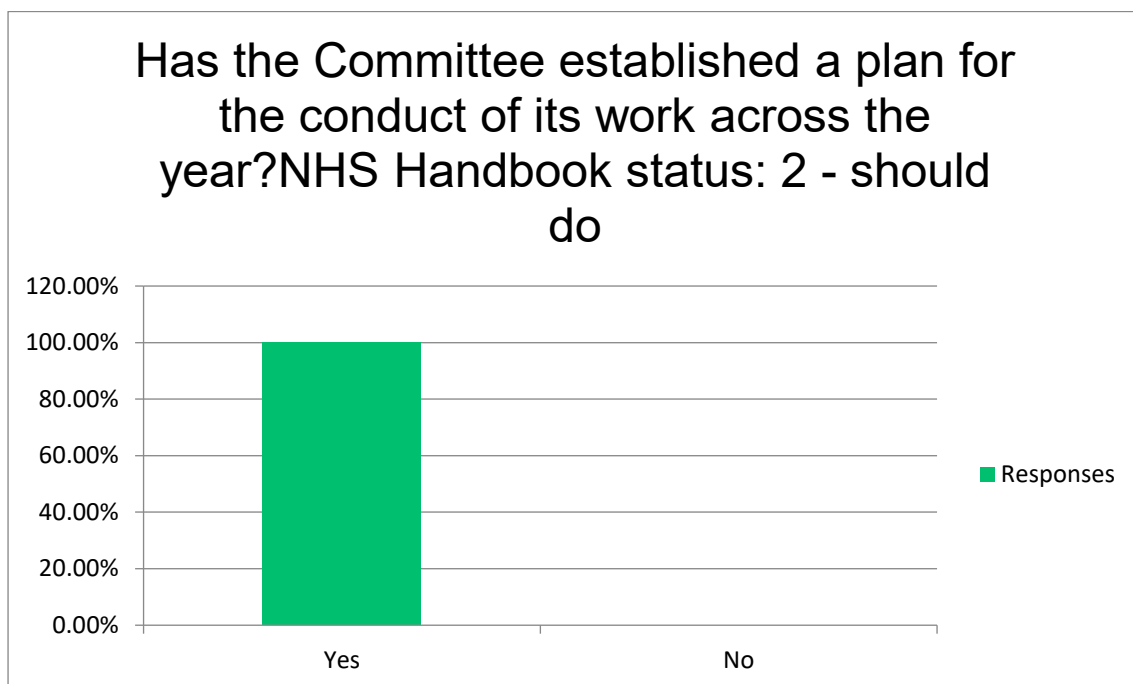
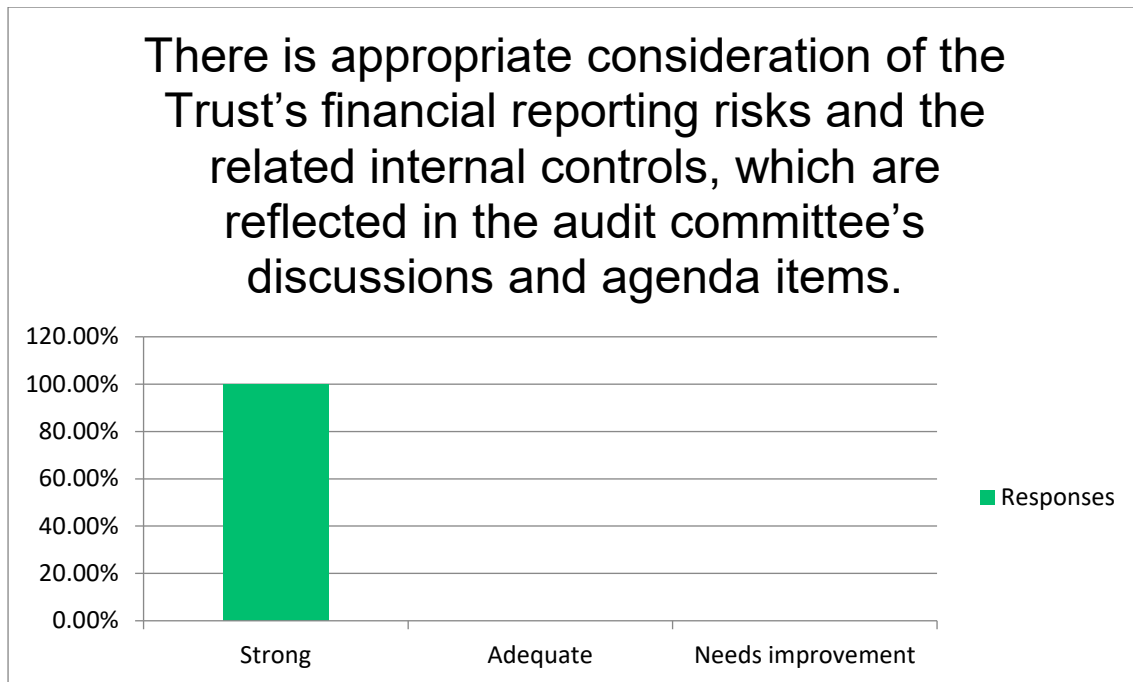
The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.NHS Handbook status: 2 -...



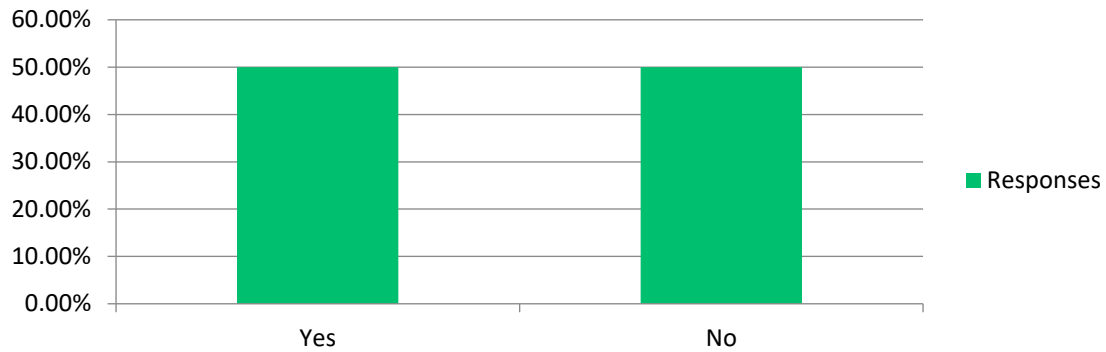
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?NHS Handbook status: 2 - should do



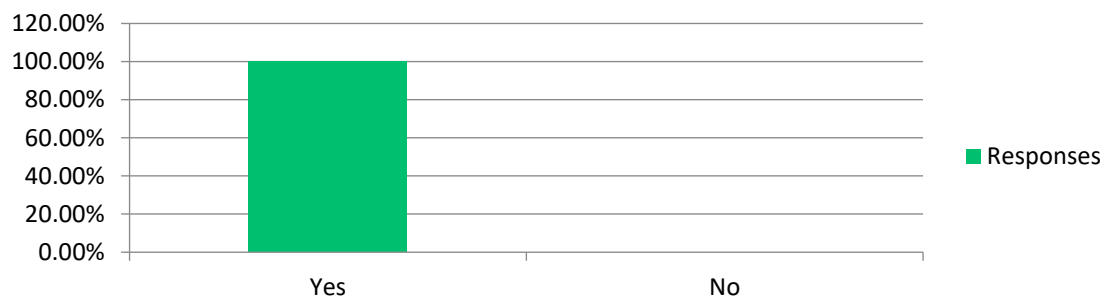




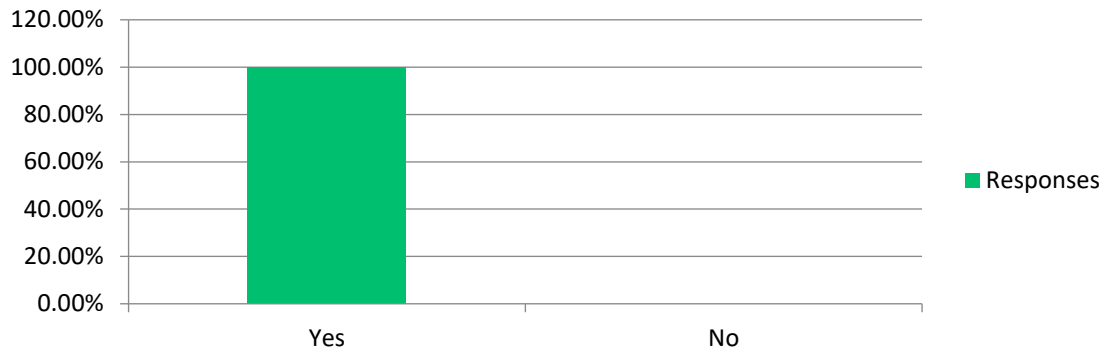
Has the committee formally considered how its work integrates with wider performance management and standards compliance? NHS Handbook status: 2 - should do



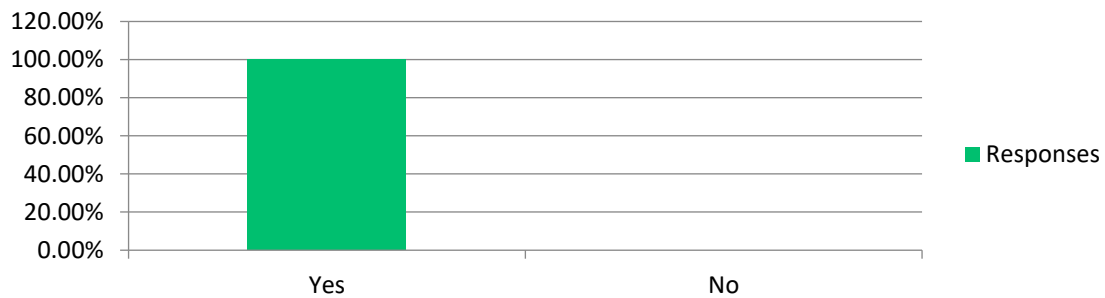
Has the committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Annual Governance Statement and the Board Assurance Framework? NHS Handbook...



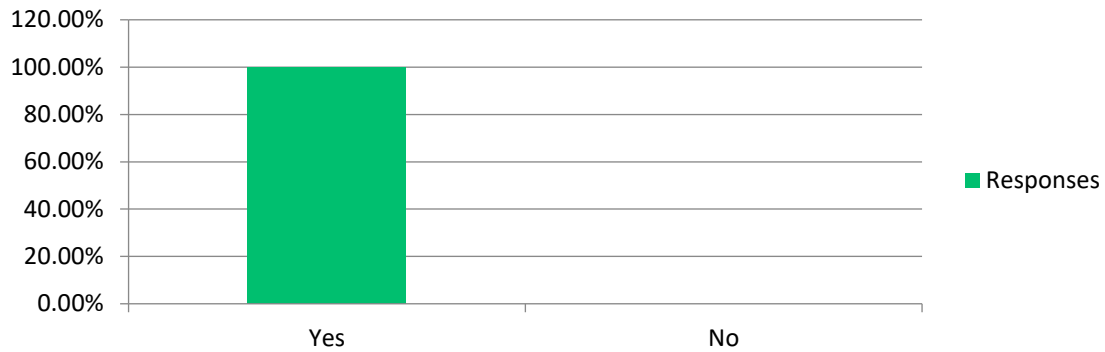
Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged? NHS Handbook status: 2 - should do



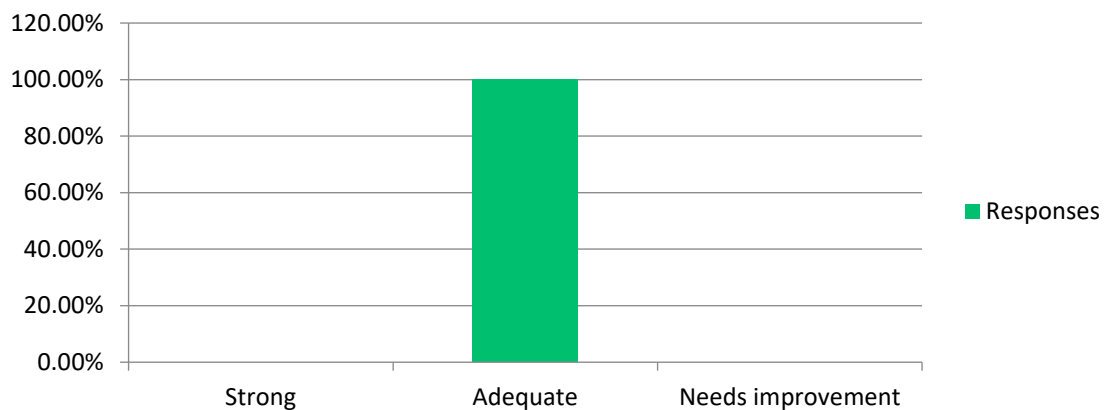
Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters? NHS Handbook status: 2 - should do

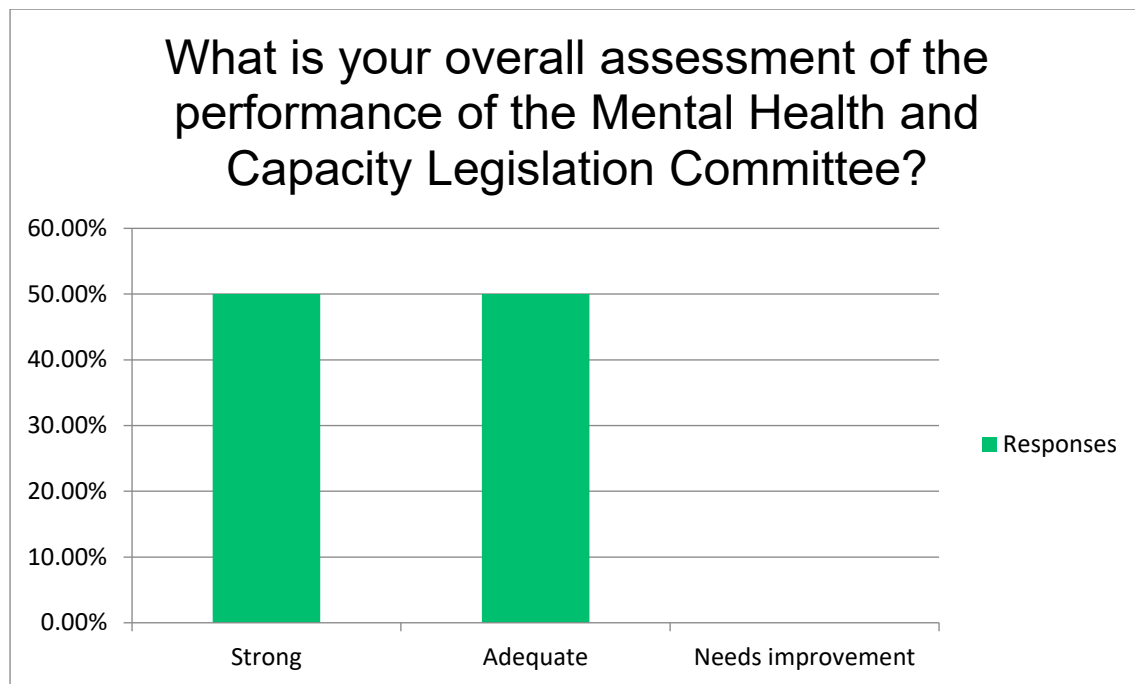


Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities? NHS Handbook status: 2 - should do



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



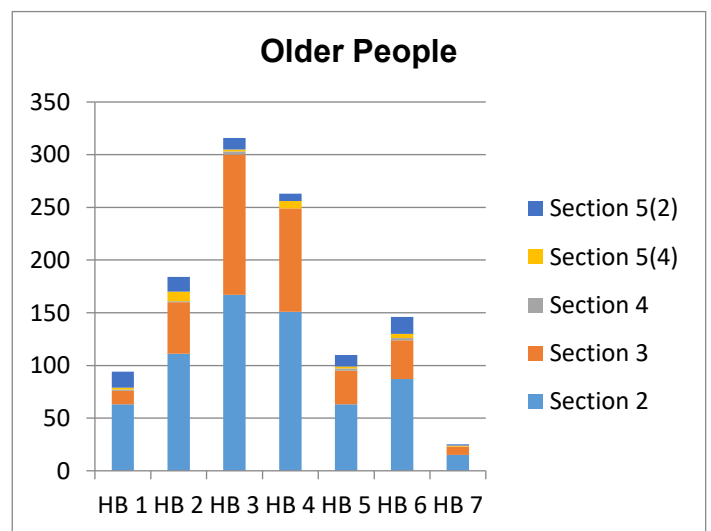
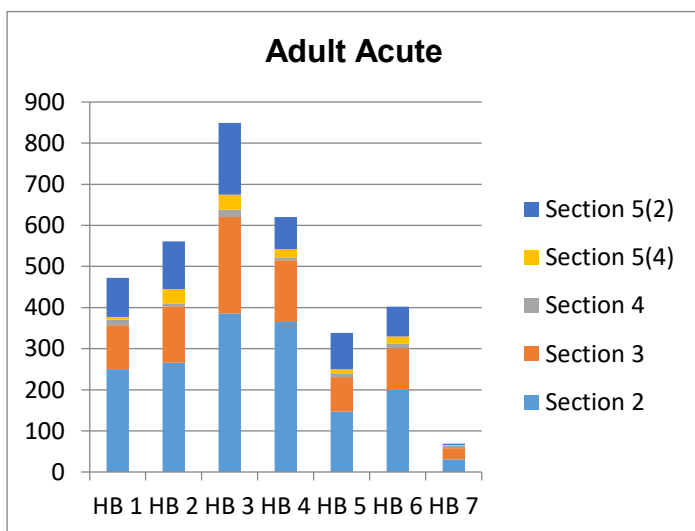
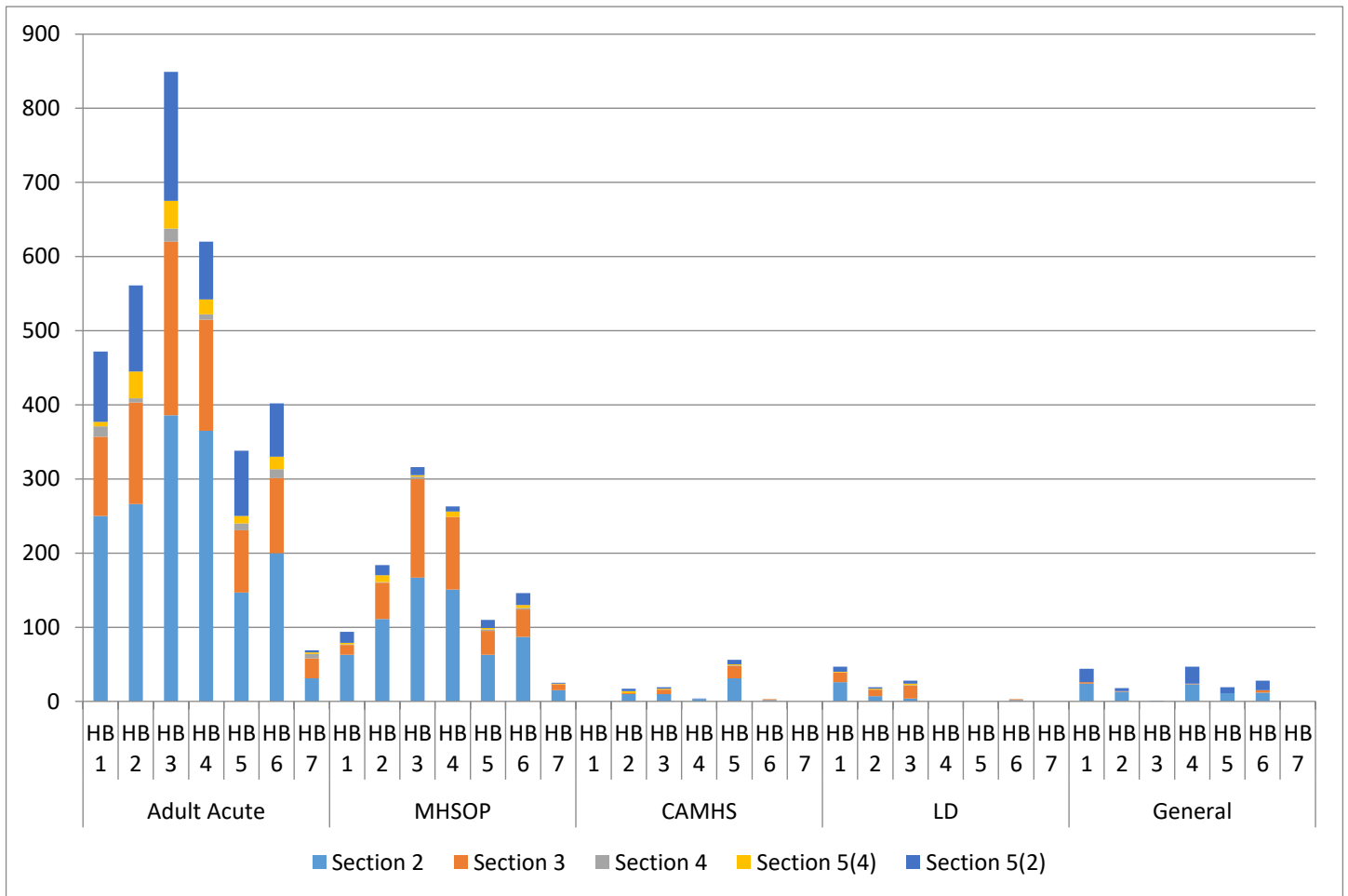


Benchmarking data April 2018 – March 2019:

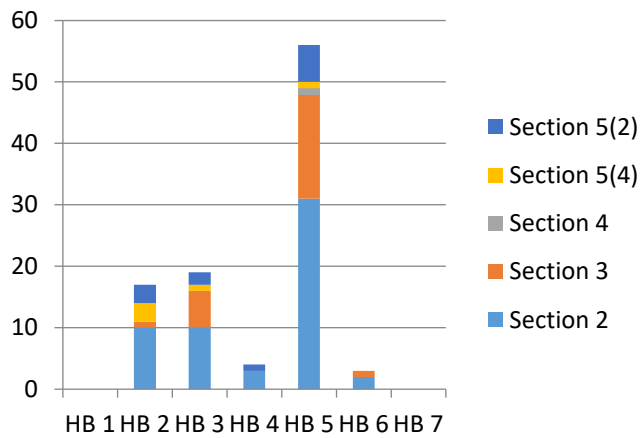
Health Board	Population
Abertawe Bro Morgannwg University Health Board	531,858
Aneurin Bevan University Health Board	587,743
Betsi Cadwaladr University Health Board	696,284
Cardiff & Vale University Health Board	493,446
Cwm Taff University Health Board	299,080
Hywel Dda University Health Board	384,239
Powys Teaching Health Board	132,515
Total Population of Wales:-	3,125,165

Part 2 MHA Activity

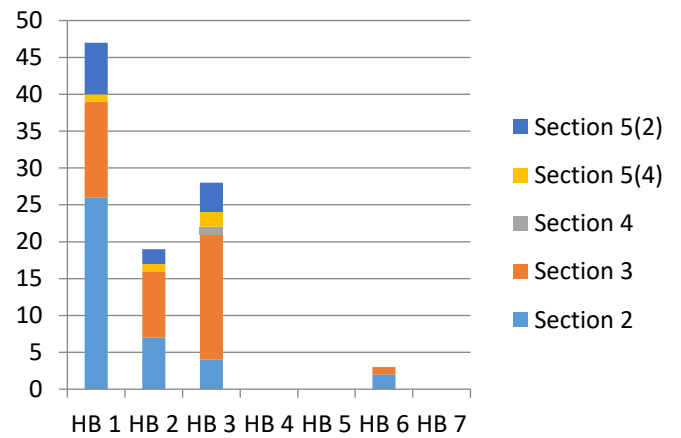
During the period a total of 4802 patients were made subject to the part 2 provisions of the MHA 1983 across Wales.



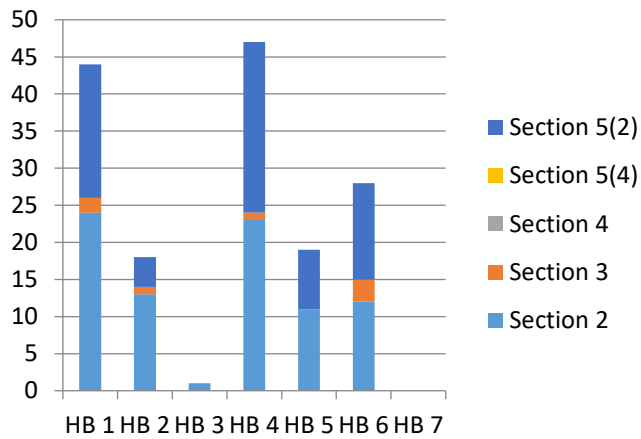
Child and Adolescent



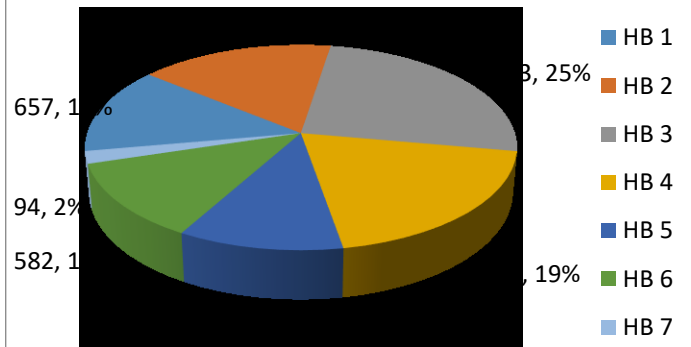
Learning Difficulties



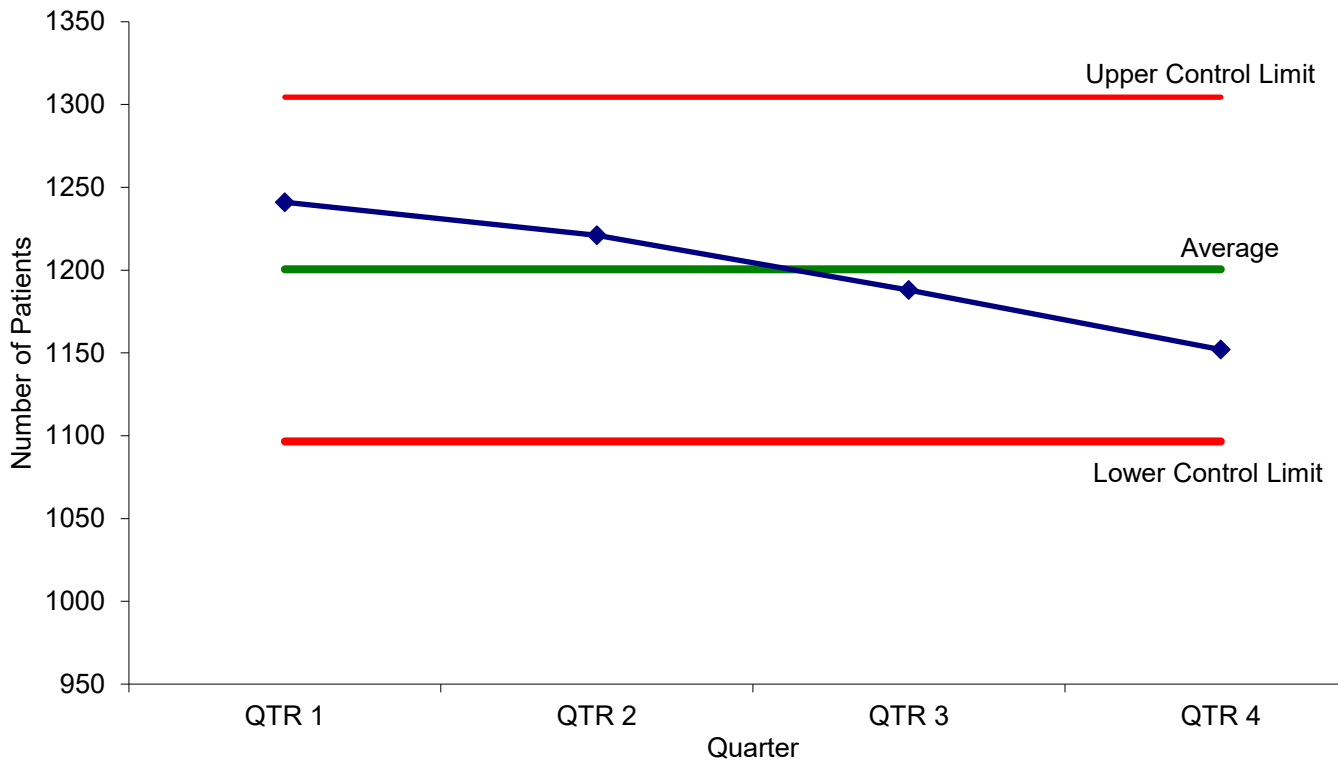
General (non-Mental Health)



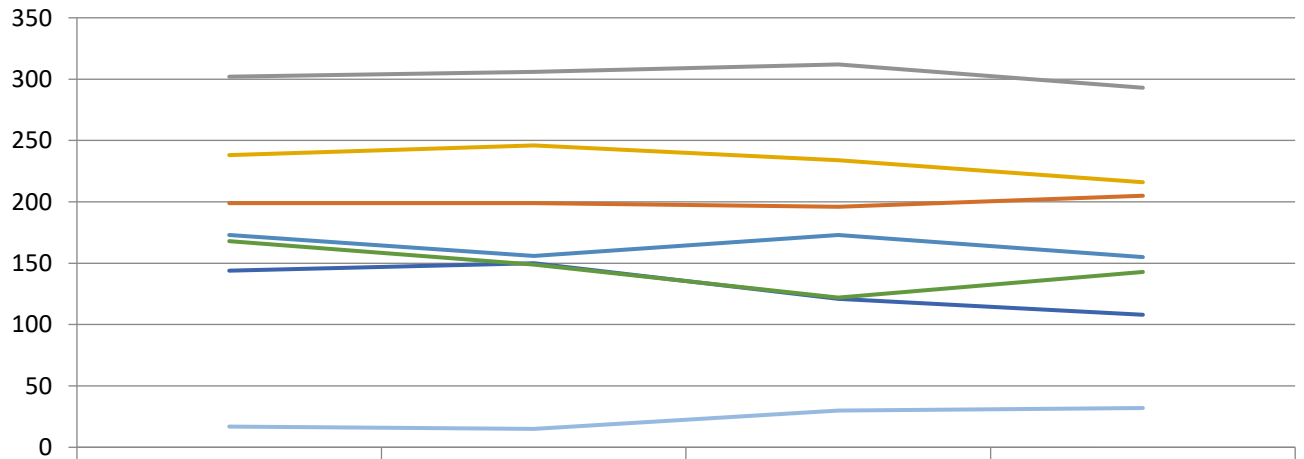
Total Section (2, 3, 4, 5(2), 5(4))



New Detentions under Part 2 over the period

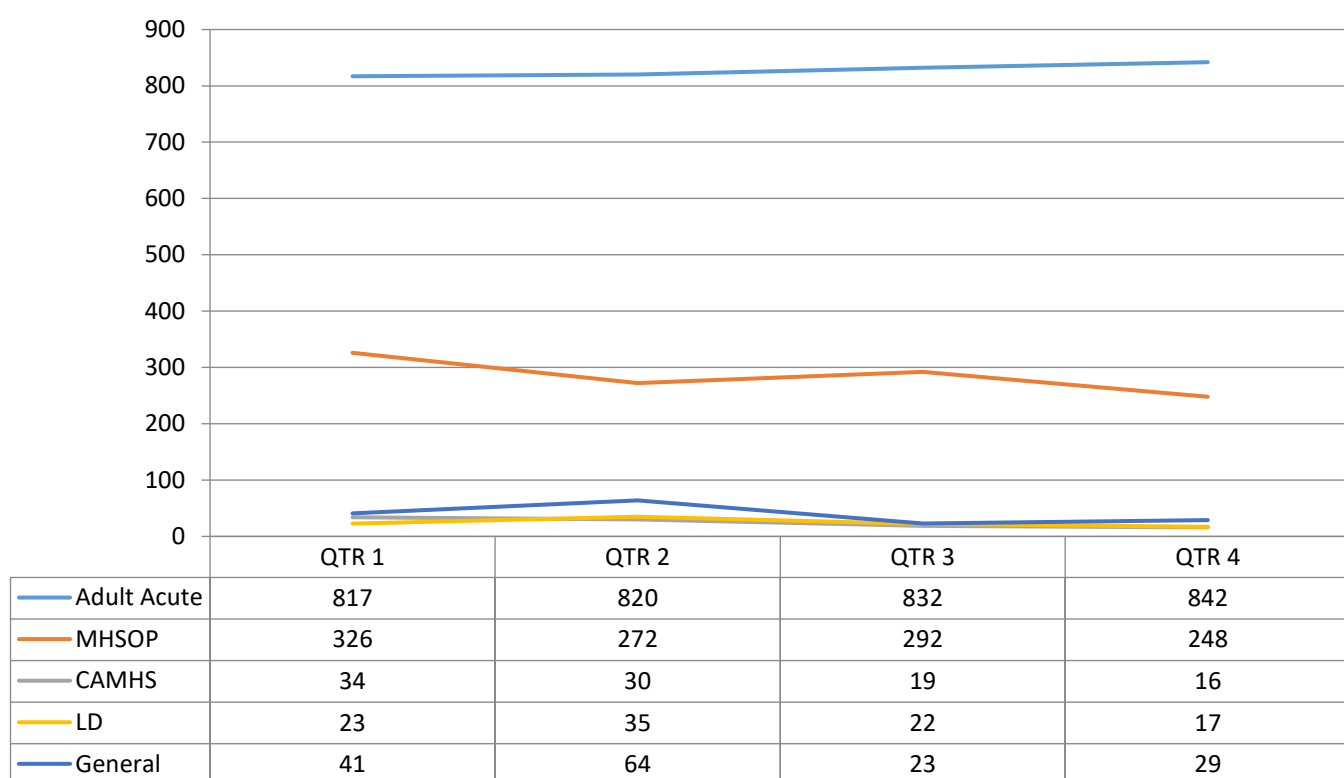


New Detentions under Part 2 per HB



	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	173	156	173	155
HB 2	199	199	196	205
HB 3	302	306	312	293
HB 4	238	246	234	216
HB 5	144	150	121	108
HB 6	168	149	122	143
HB 7	17	15	30	32

New Detentions under Part 2 per speciality



The above charts show a clear steady reduction in the use of Part 2 as a whole. Looking at the detail shows that within the specialities a general decline, with the exception of Adult Acute which rose steadily. The largest change over the year was within MHSOP, which showed a difference of 78 applications between the first and final quarter.

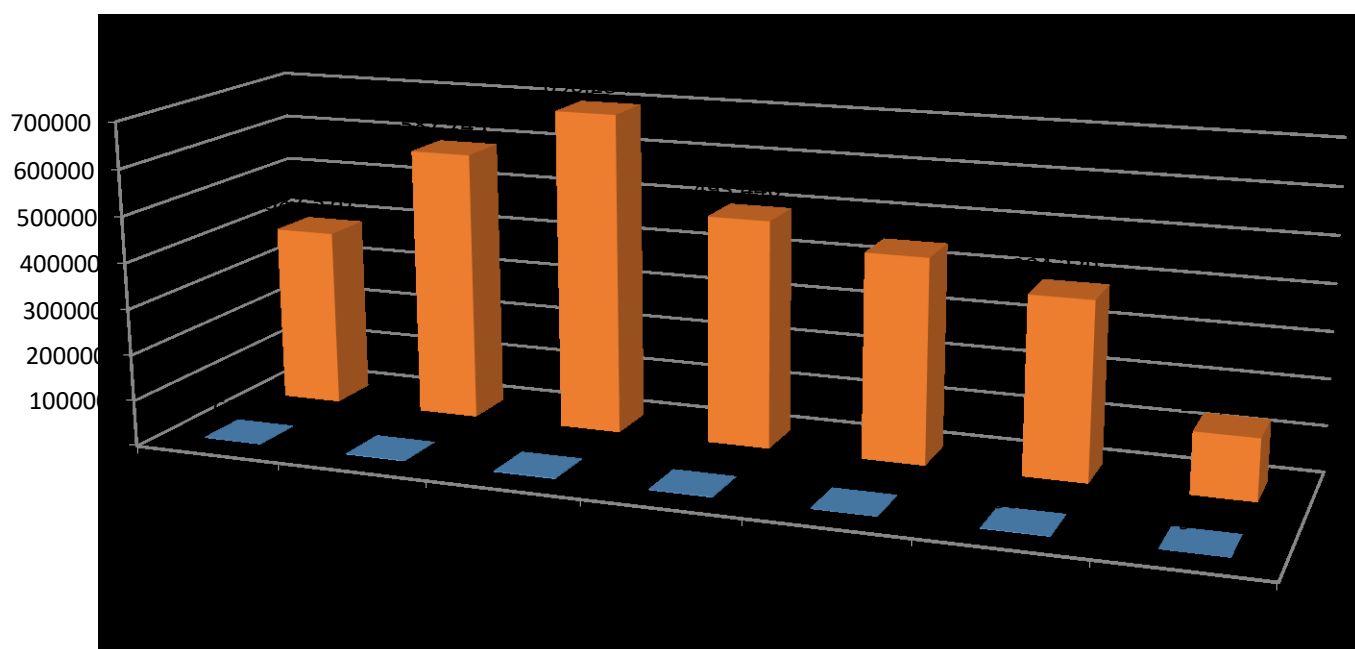
It is difficult to see on the chart but the most significant change was within CAMHS, where the difference between the first and last quarter showed a greater than 50% drop in numbers.

Part 2 MHA Activity Compared to Health Board Population

Population figures taken from <https://statswales.gov.wales>

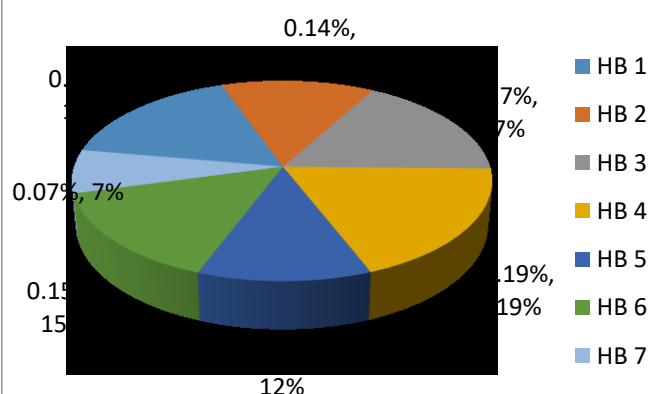
The latest available population by Health Board figures available at the time of writing were mid-2017.

Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to Health Board Population

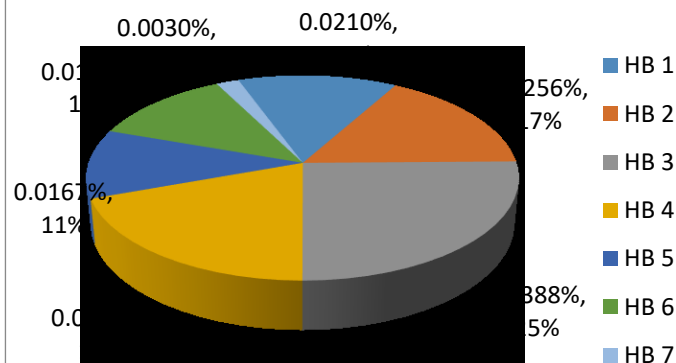


	HB 1	HB 2	HB 3	HB 4	HB 5	HB 6	HB 7
On Section	657	799	1213	934	523	582	94
Population	387,570	587,743	696,284	493,446	443,368	384,239	132,515

Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to Health Board Population

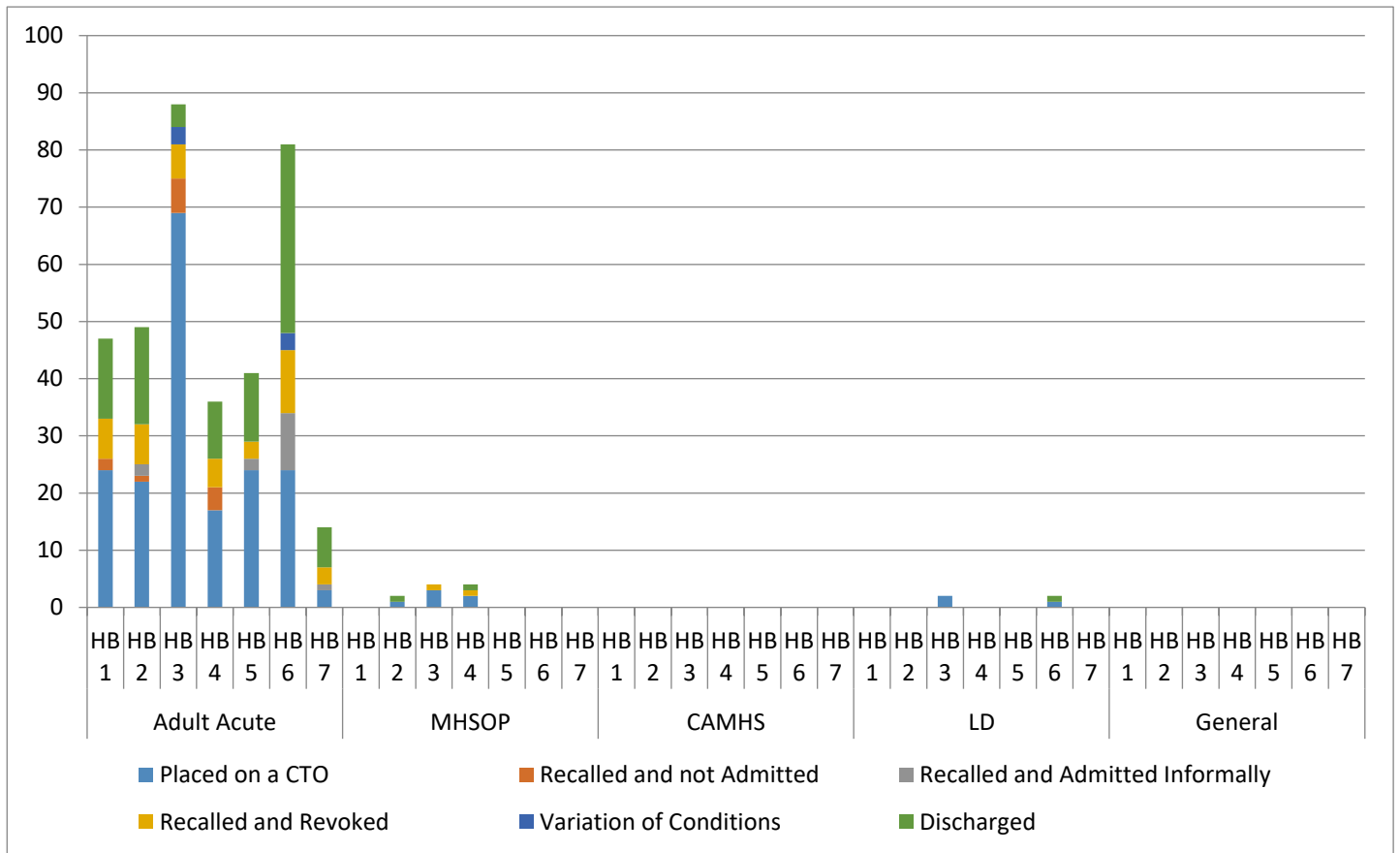


Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to the Population of Wales

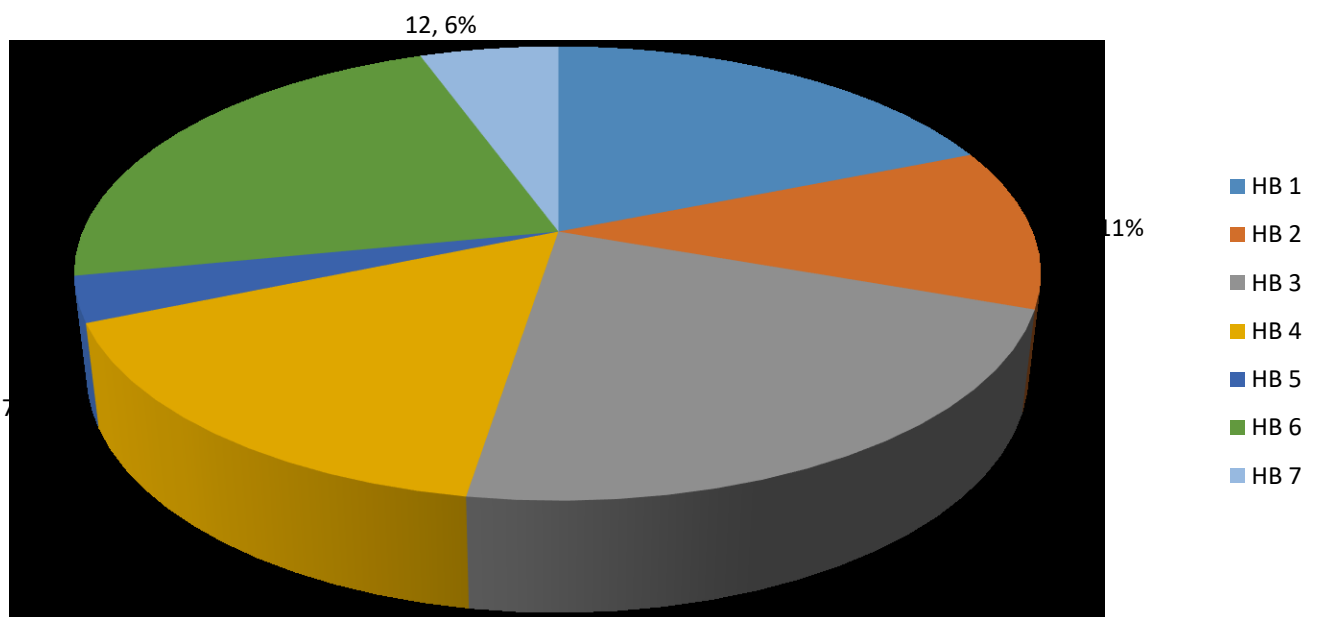


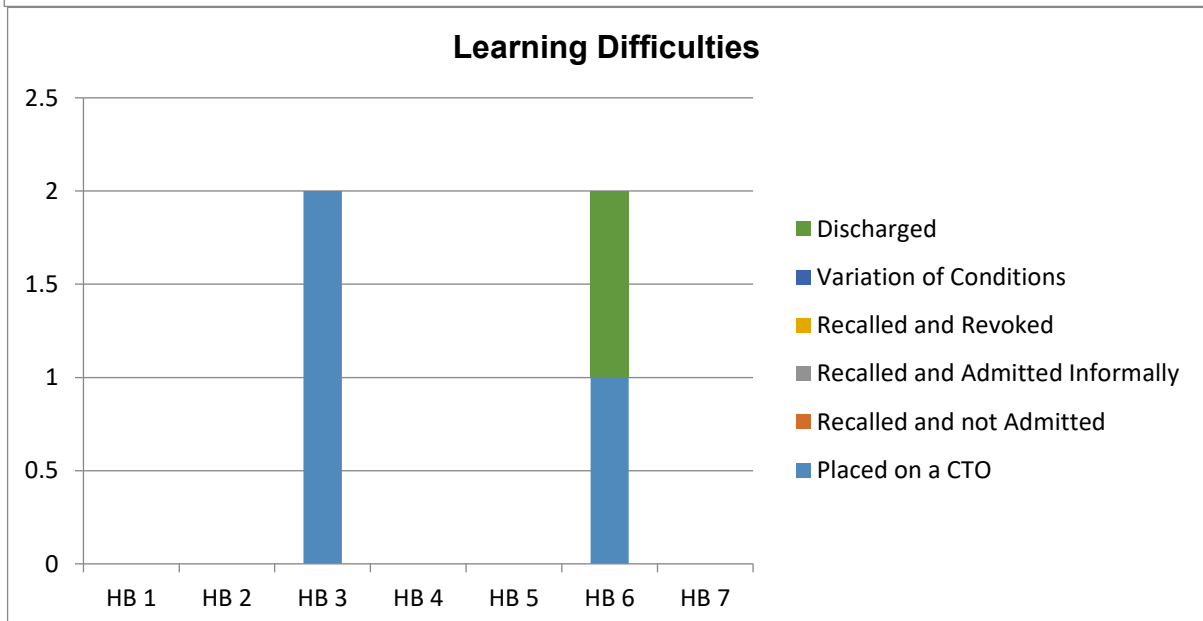
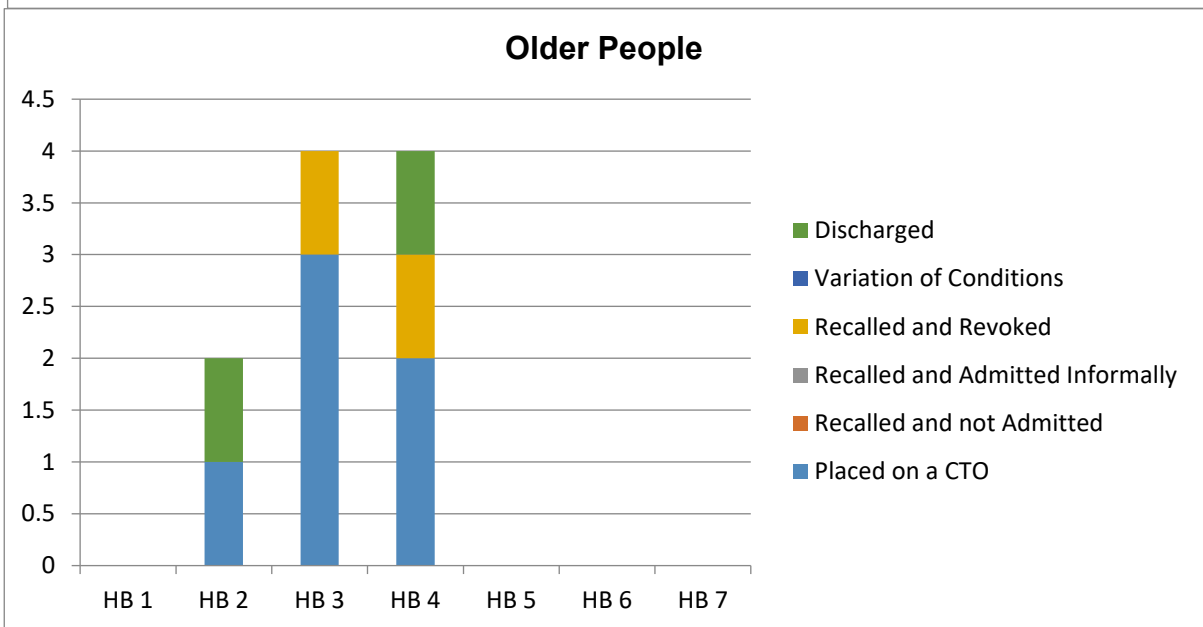
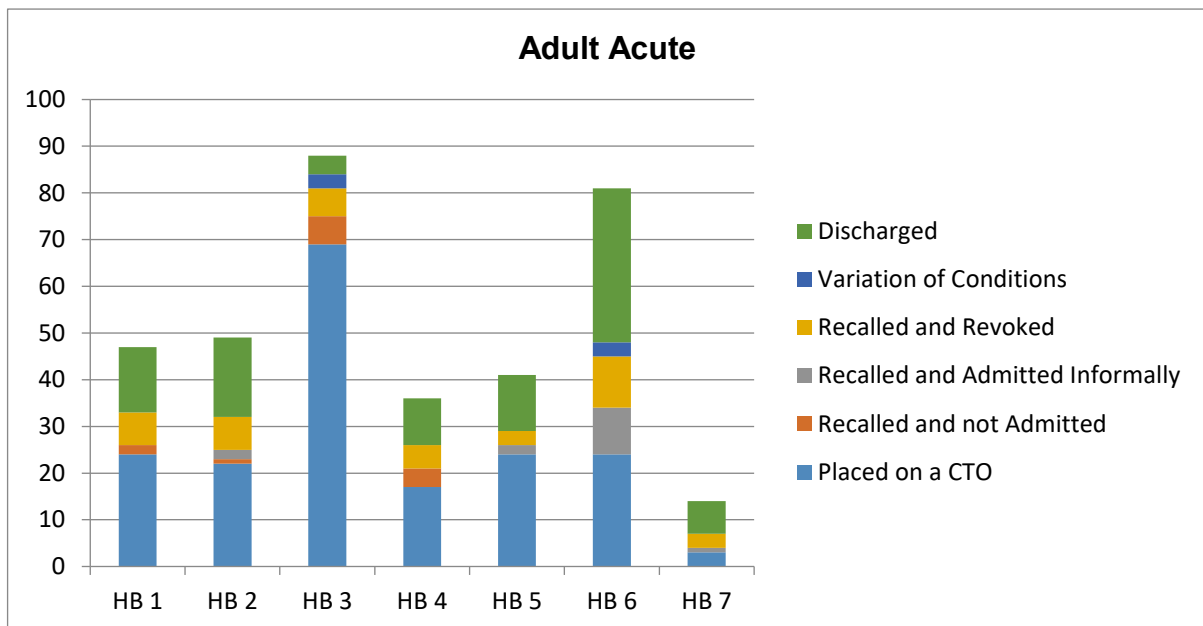
Community Treatment Order

During the period a total of 192 patients were made subject to a Community Treatment Order across Wales.

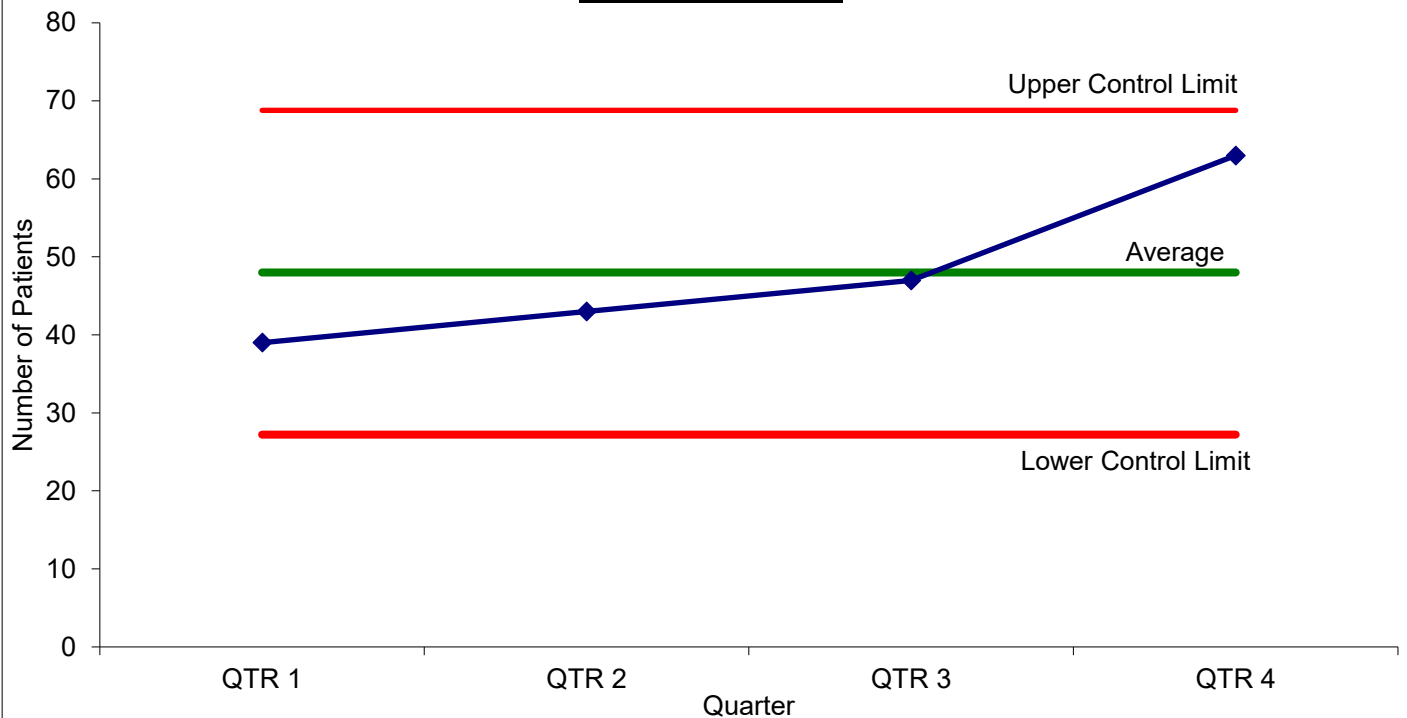


Patients Subject to Community Treatment Order on 31/03/2019

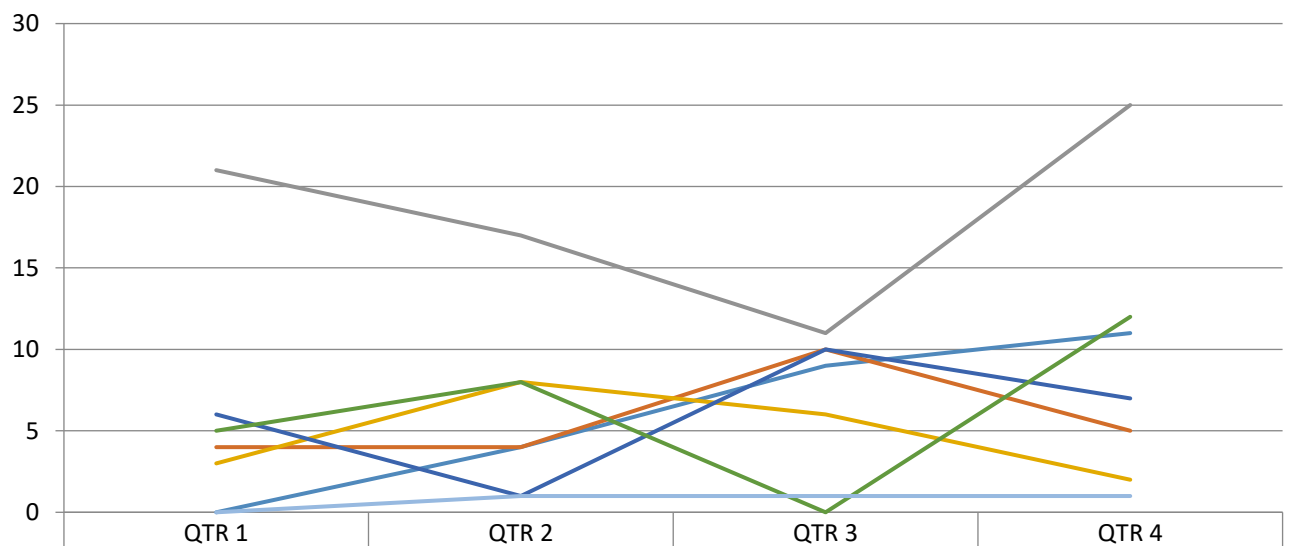




Patients made subject to a Community Treatment Order accross Wales during the period

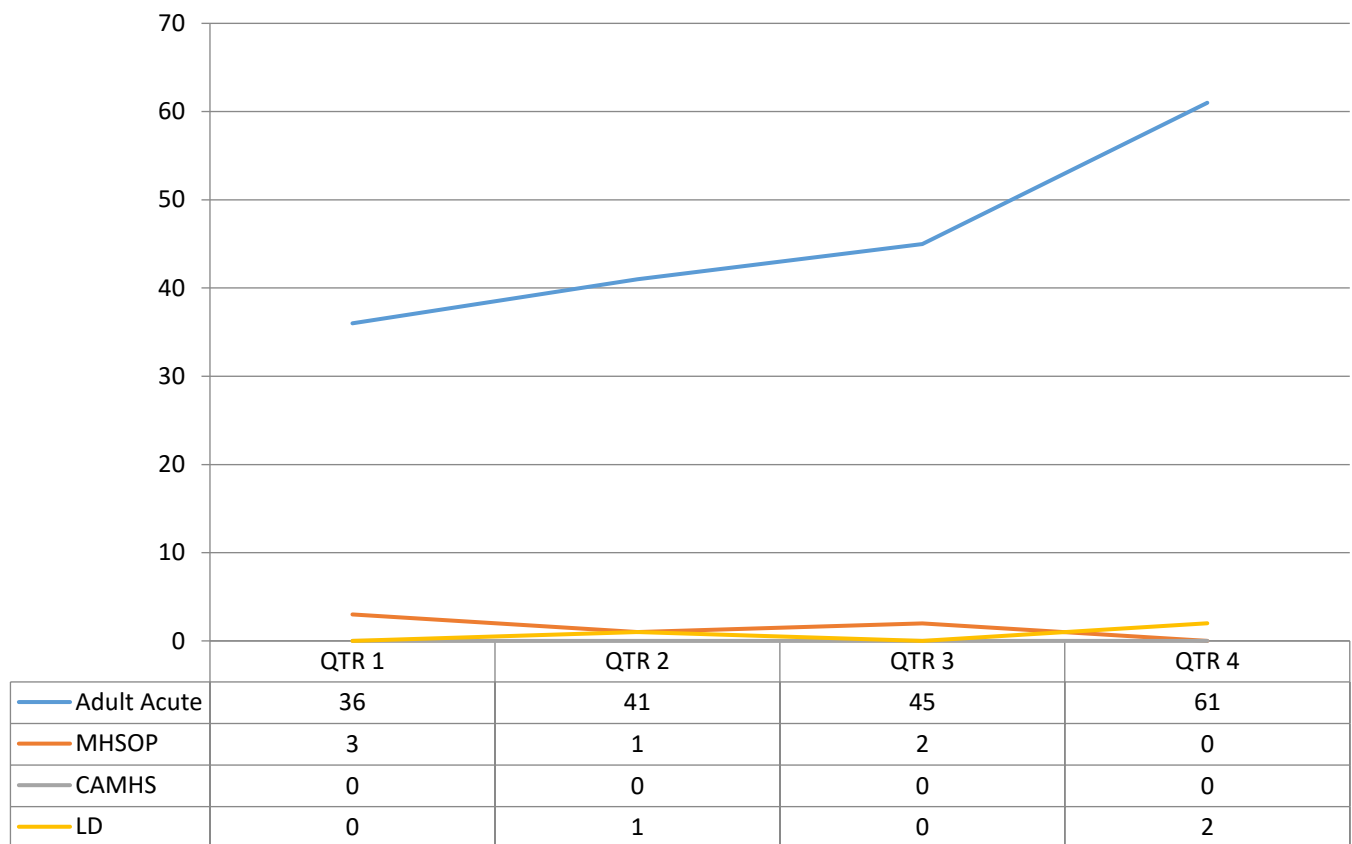


Patients made subject to a Community Treatment Order accross Wales per HB



	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	0	4	9	11
HB 2	4	4	10	5
HB 3	21	17	11	25
HB 4	3	8	6	2
HB 5	6	1	10	7
HB 6	5	8	0	12
HB 7	0	1	1	1

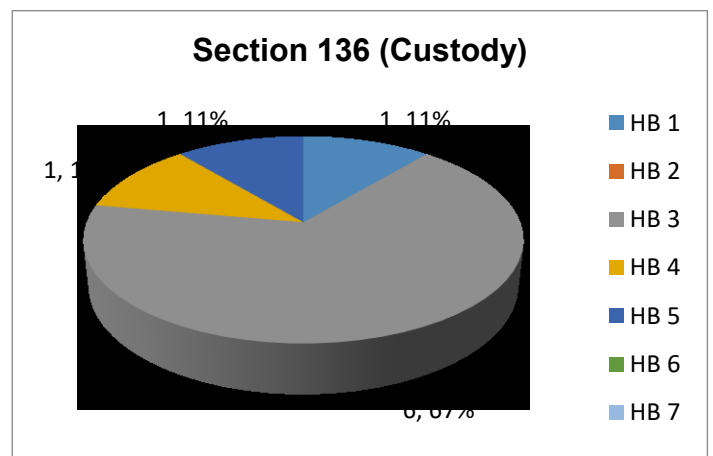
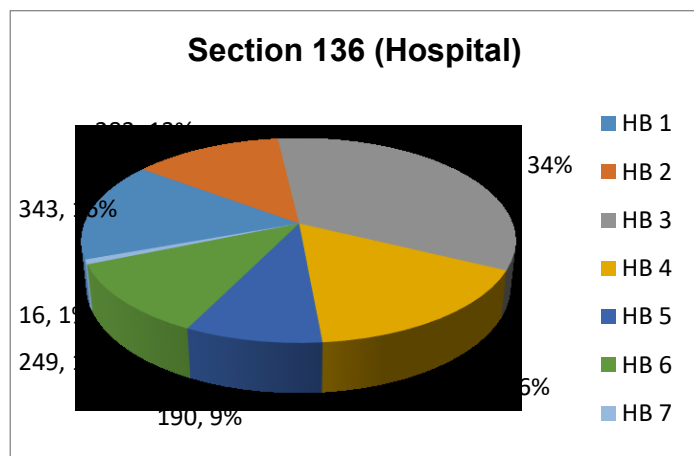
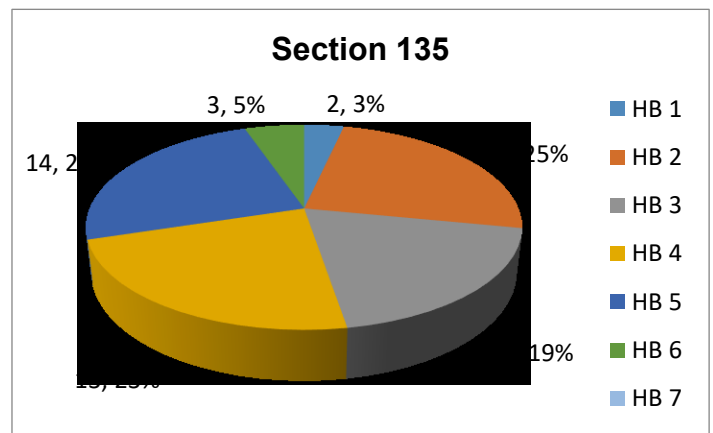
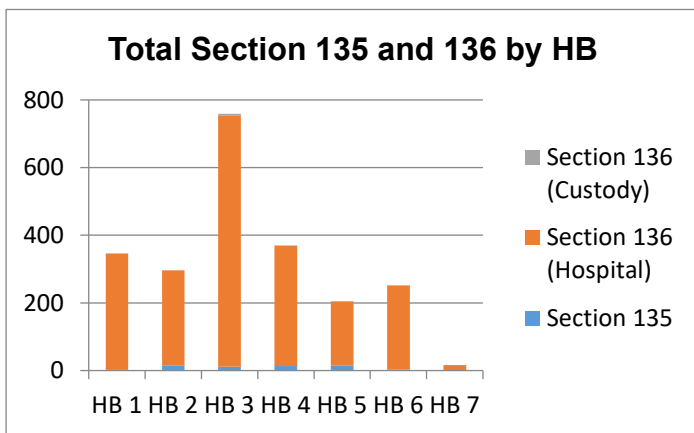
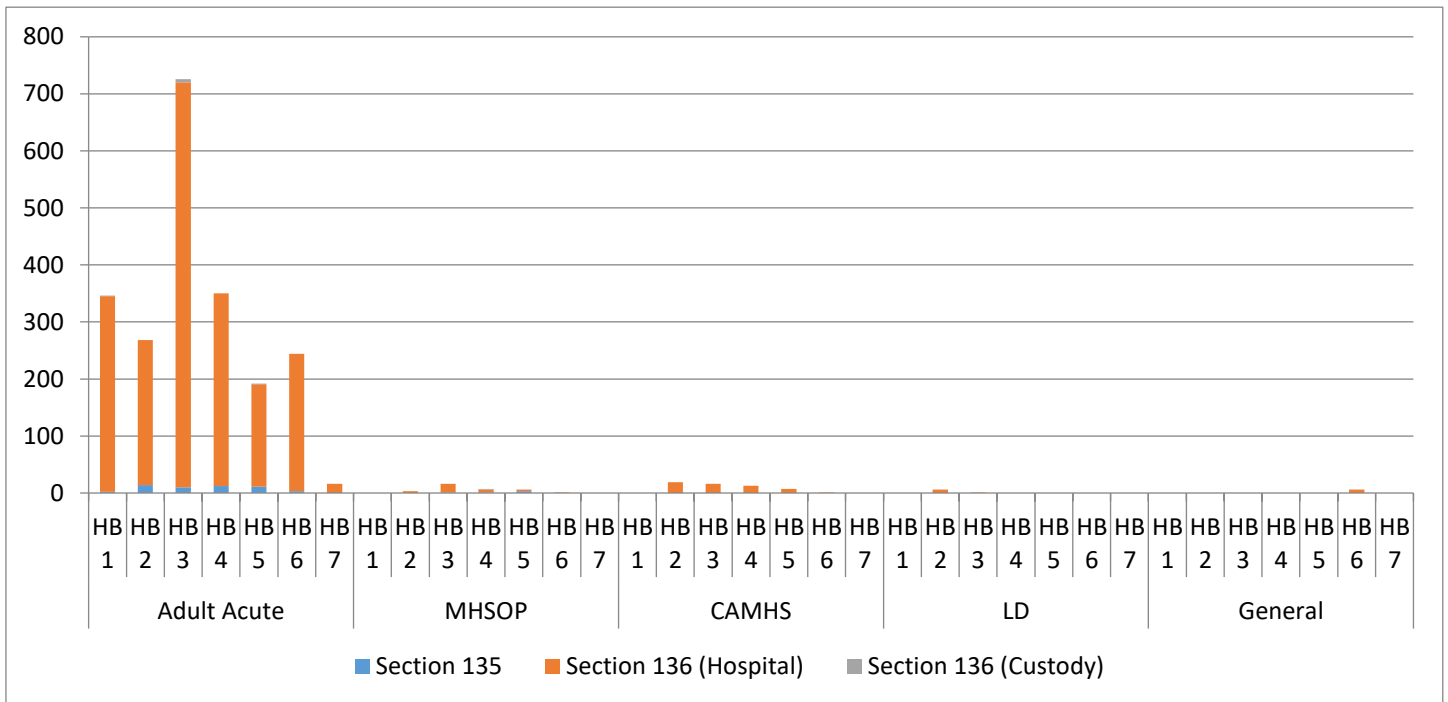
**Patients made subject to a Community Treatment Order accross Wales
per speciality**



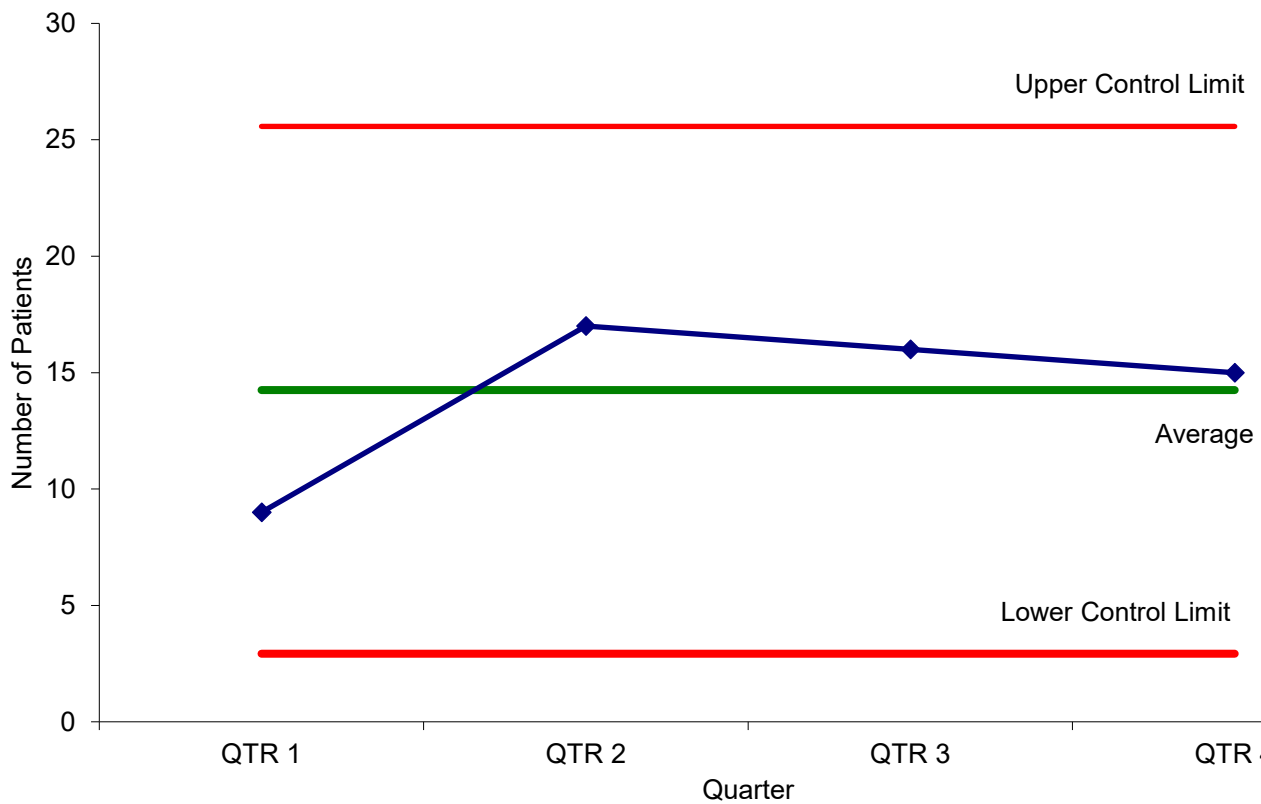
The above charts show a clear steady increase of the use of Community Treatment Order over the period. However, this is not reflected across all specialties or Health Boards. Its use within both Learning Difficulties and Mental health Services for Older People is very minimal, whilst being non-existent in the Child and Adolescent Mental Health Services. There has been a steady rise in its use within Adult Acute, which has spiked significantly in Quarter 4.

Section 135 & 136

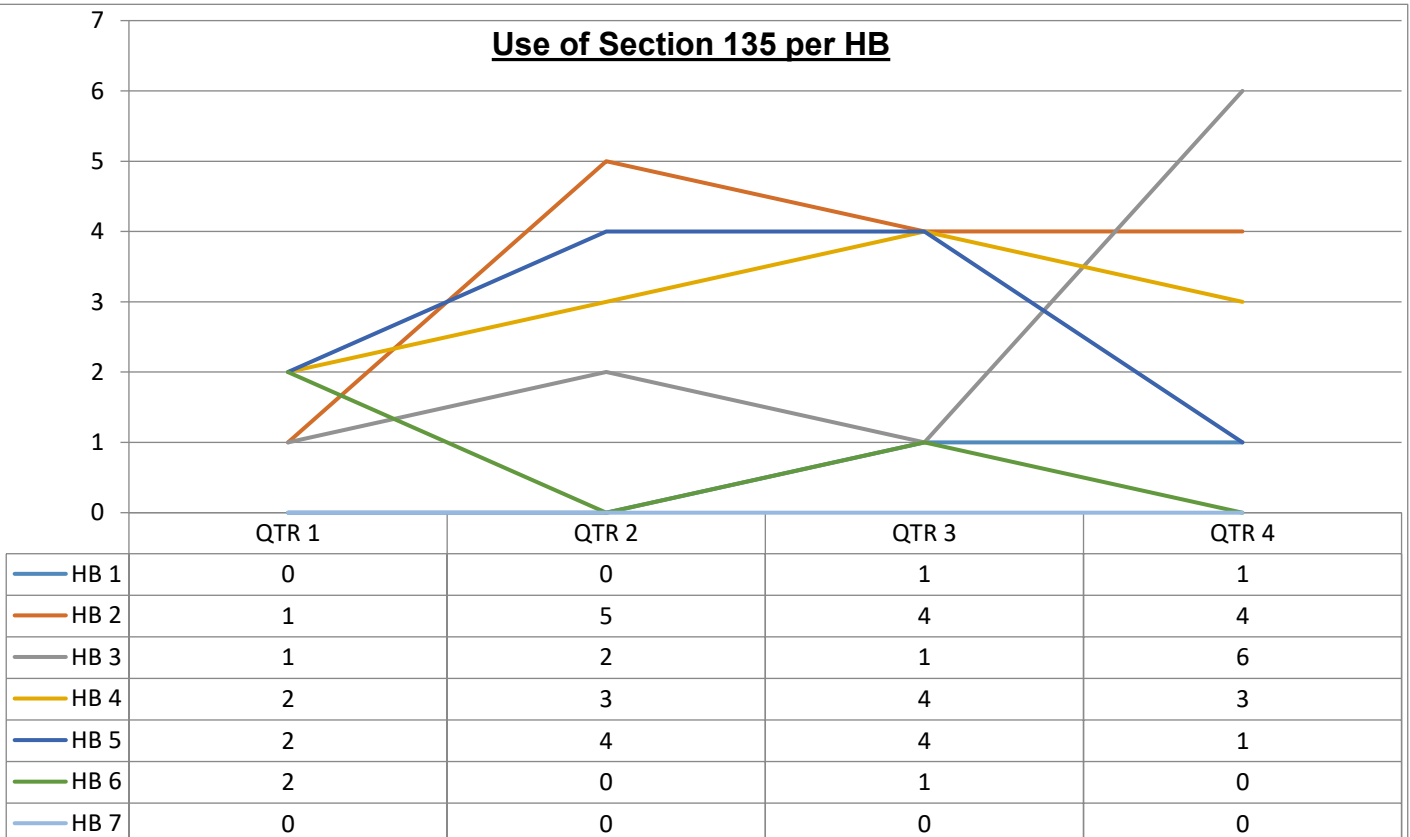
The charts below provide data on how section 135/136 is used across Wales broken down into specialities, HB's and total activity.



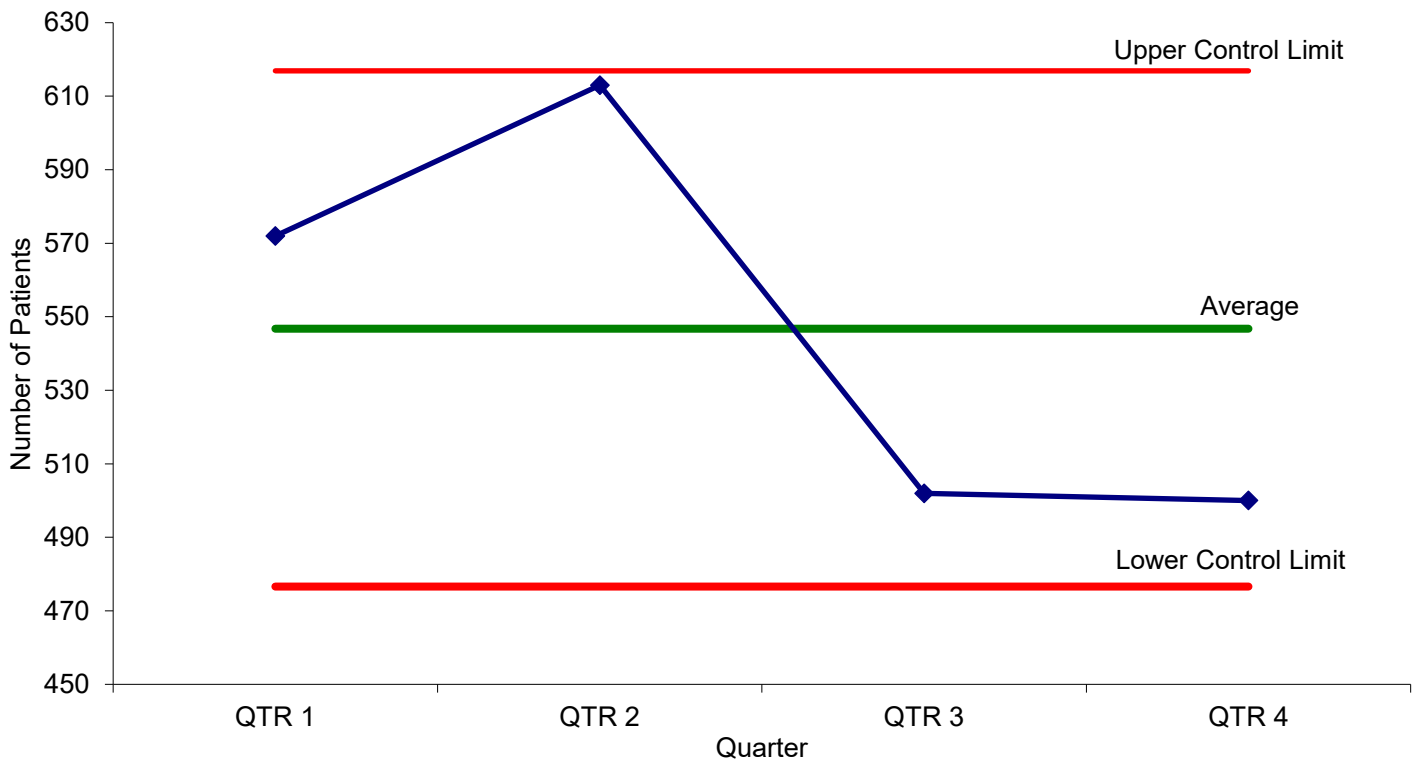
Use of Section 135 during the period



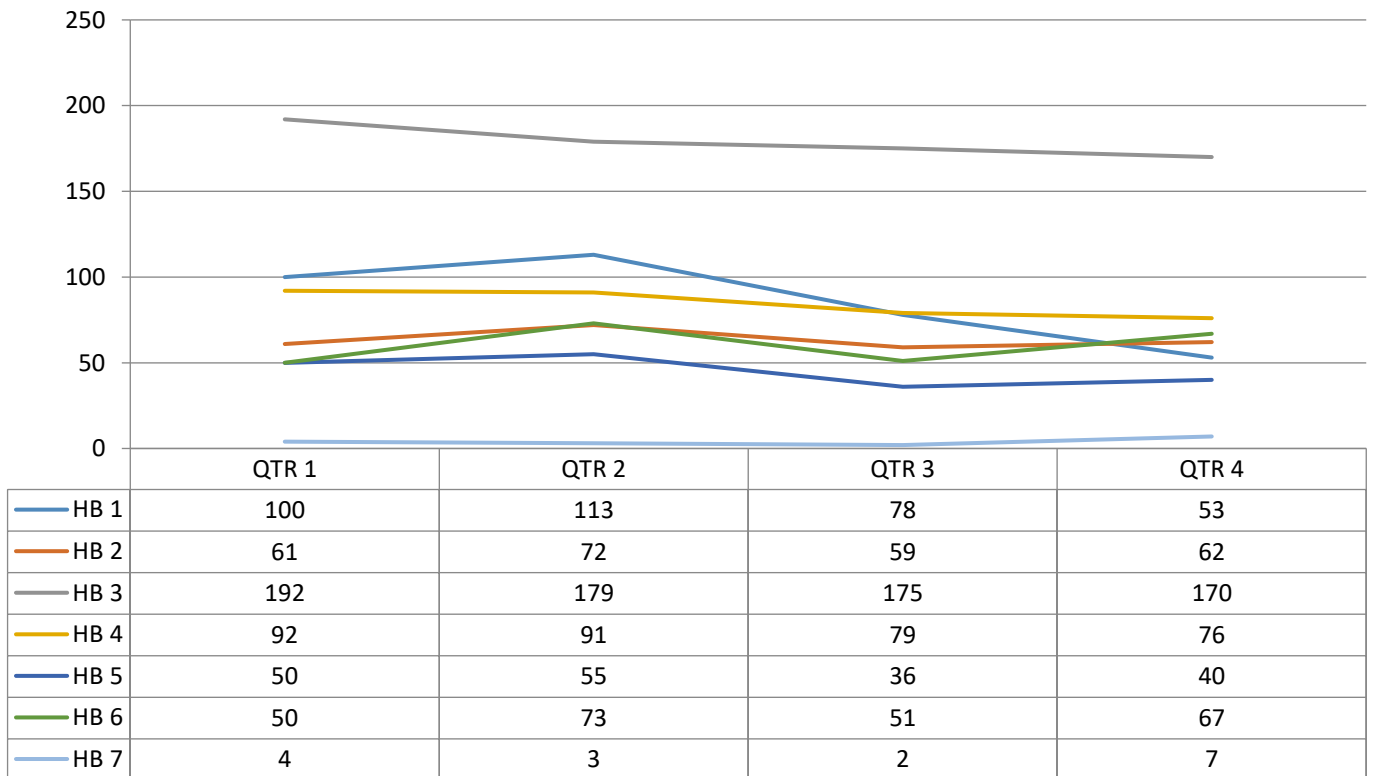
Use of Section 135 per HB

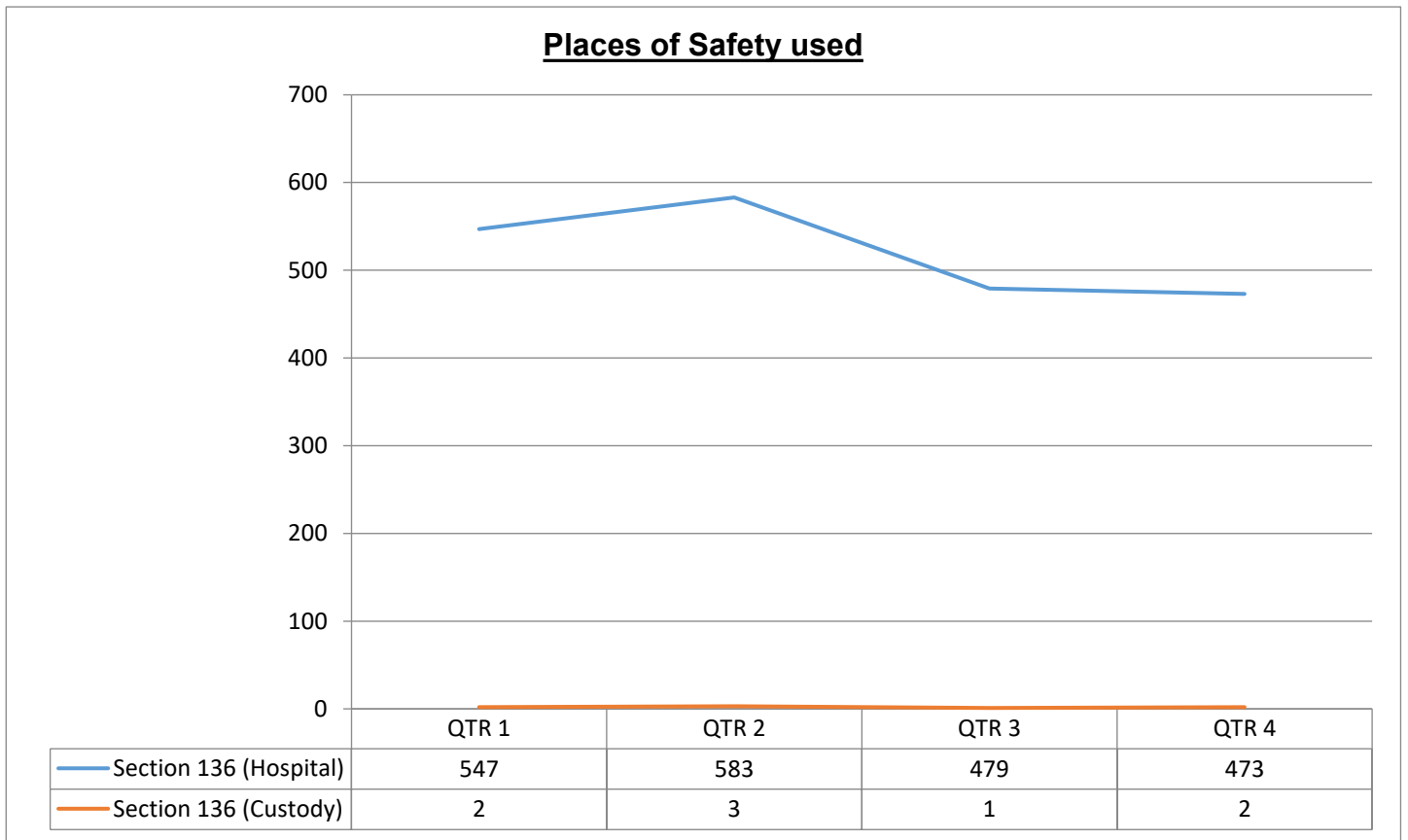


Use of Section 136 during the period



Use of Section 136 per HB



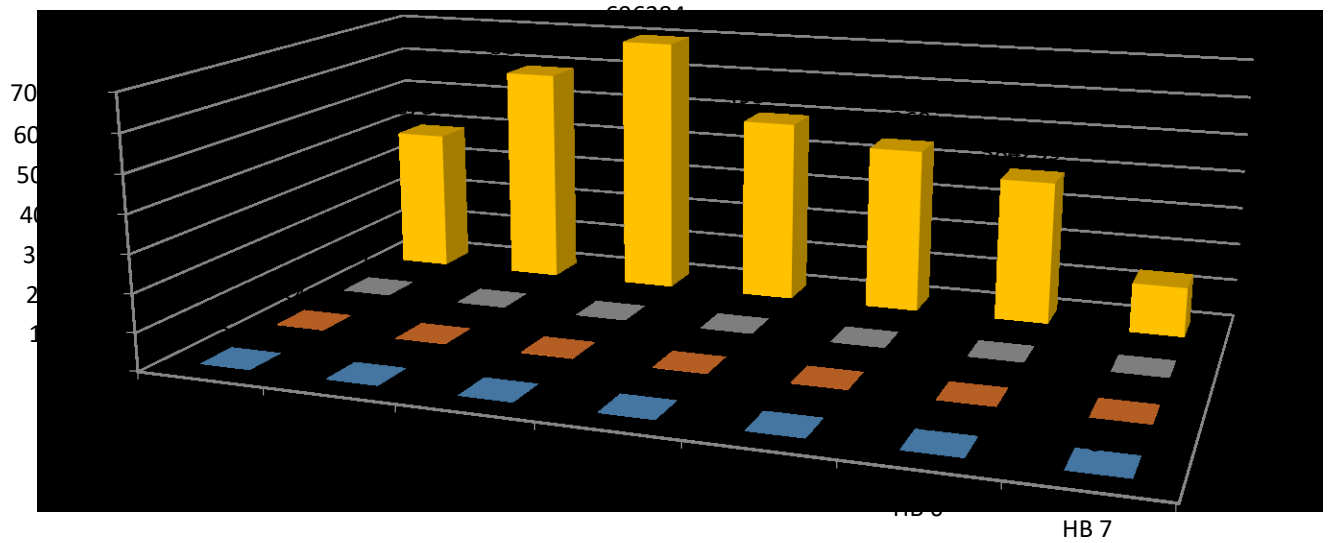


The above charts show a rapid and significant decrease in the use of Section 136 during the period, between Quarters 2 and 3. This decrease was across all Health Boards, with some showing a larger decrease than others.

Also shown is the minimal use of Custody as the Place of Safety, of which the total across Wales is eight during the period.

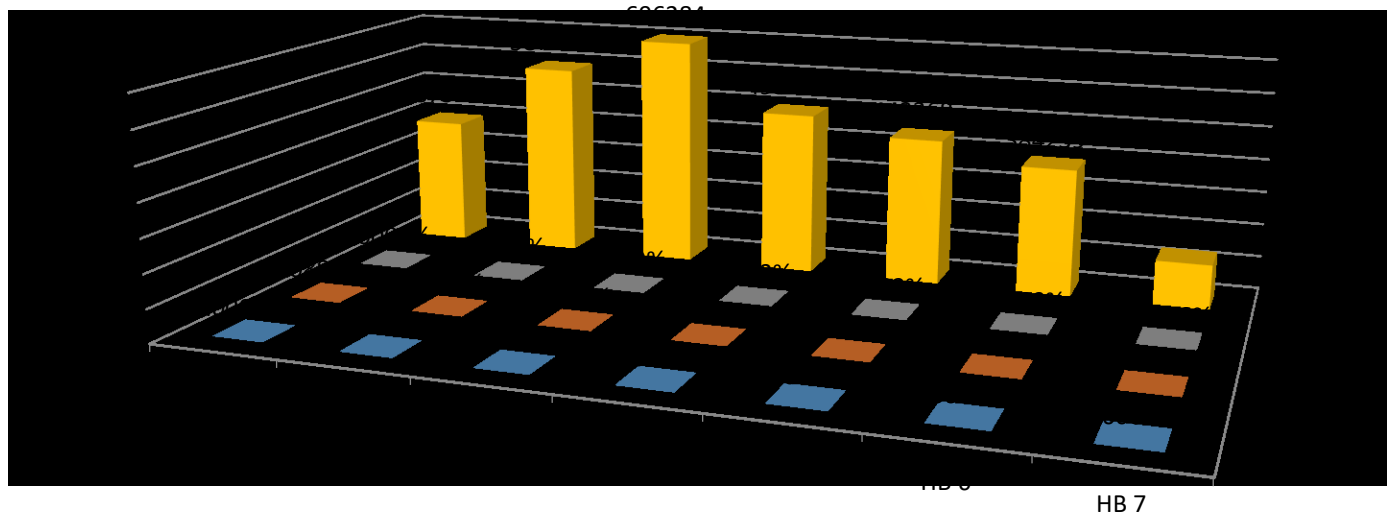
Section 135 and 136 Compared to Health Board Population

Section 135 and 136 Compared to Health Board Population (Numbers)



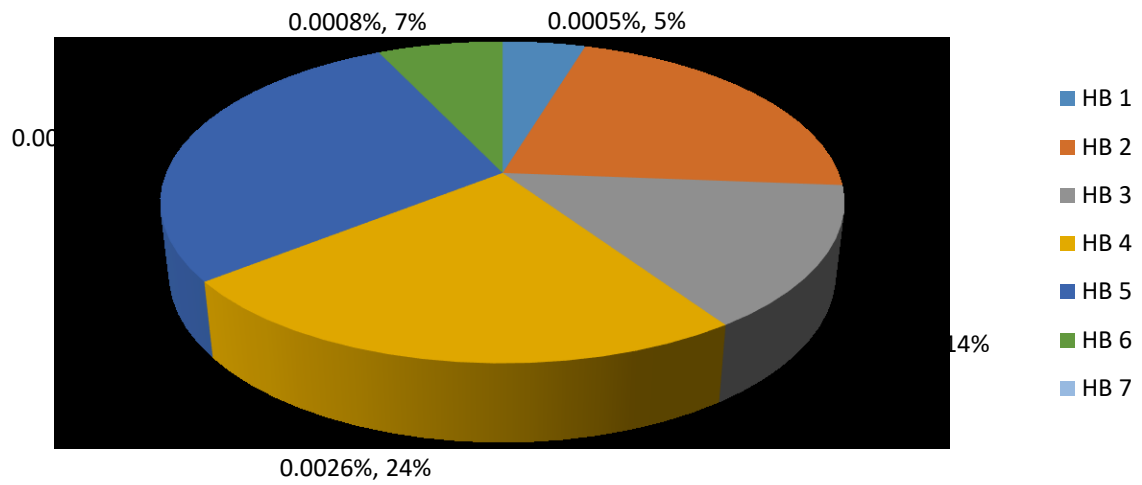
	HB 1	HB 2	HB 3	HB 4	HB 5	HB 6	HB 7
Section 135	2	14	11	13	14	3	0
Section 136 (Hospital)	343	282	742	356	190	249	16
Section 136 (Custody)	1	0	6	1	1	0	0
HB Population	387570	587743	696284	493446	443368	384239	132515

Section 135 and 136 Compared to Health Board Population (Percentage)

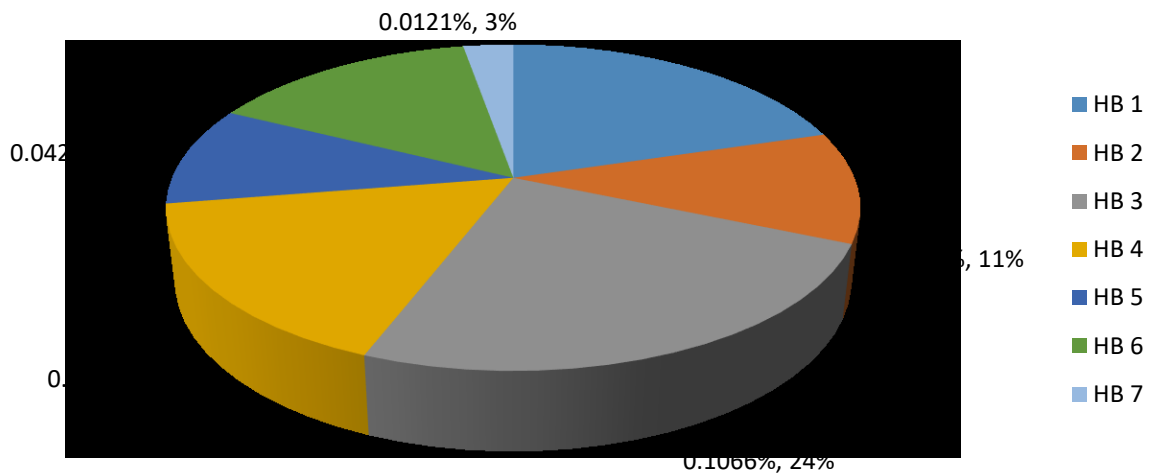


	HB 1	HB 2	HB 3	HB 4	HB 5	HB 6	HB 7
Section 135 to UHB Population	0.0005%	0.0024%	0.0016%	0.0026%	0.0032%	0.0008%	0.0000%
Section 136 (Hospital) to UHB Population	0.0885%	0.0480%	0.1066%	0.0721%	0.0429%	0.0648%	0.0121%
Section 136 (Custody) to UHB Population	0.0003%	0.0000%	0.0009%	0.0002%	0.0002%	0.0000%	0.0000%
HB Population	387570	587743	696284	493446	443368	384239	132515

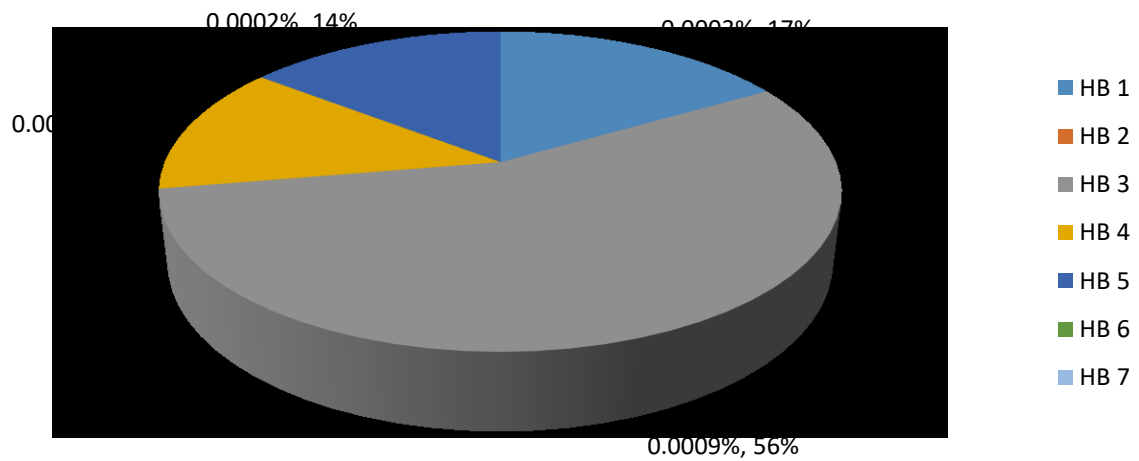
Section 135 to UHB Population



Section 136 (Hospital) to UHB Population

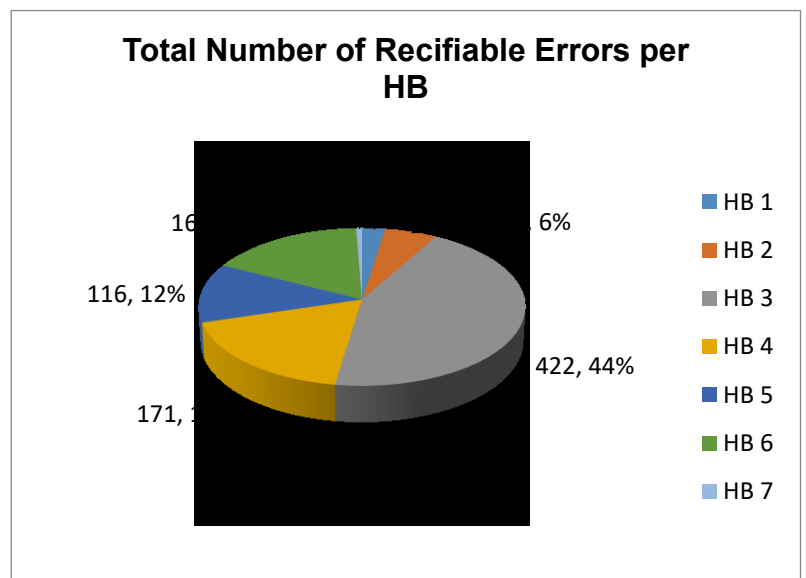
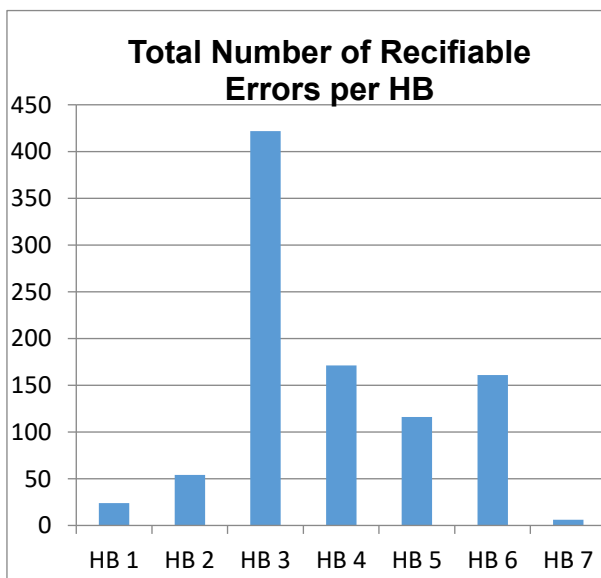
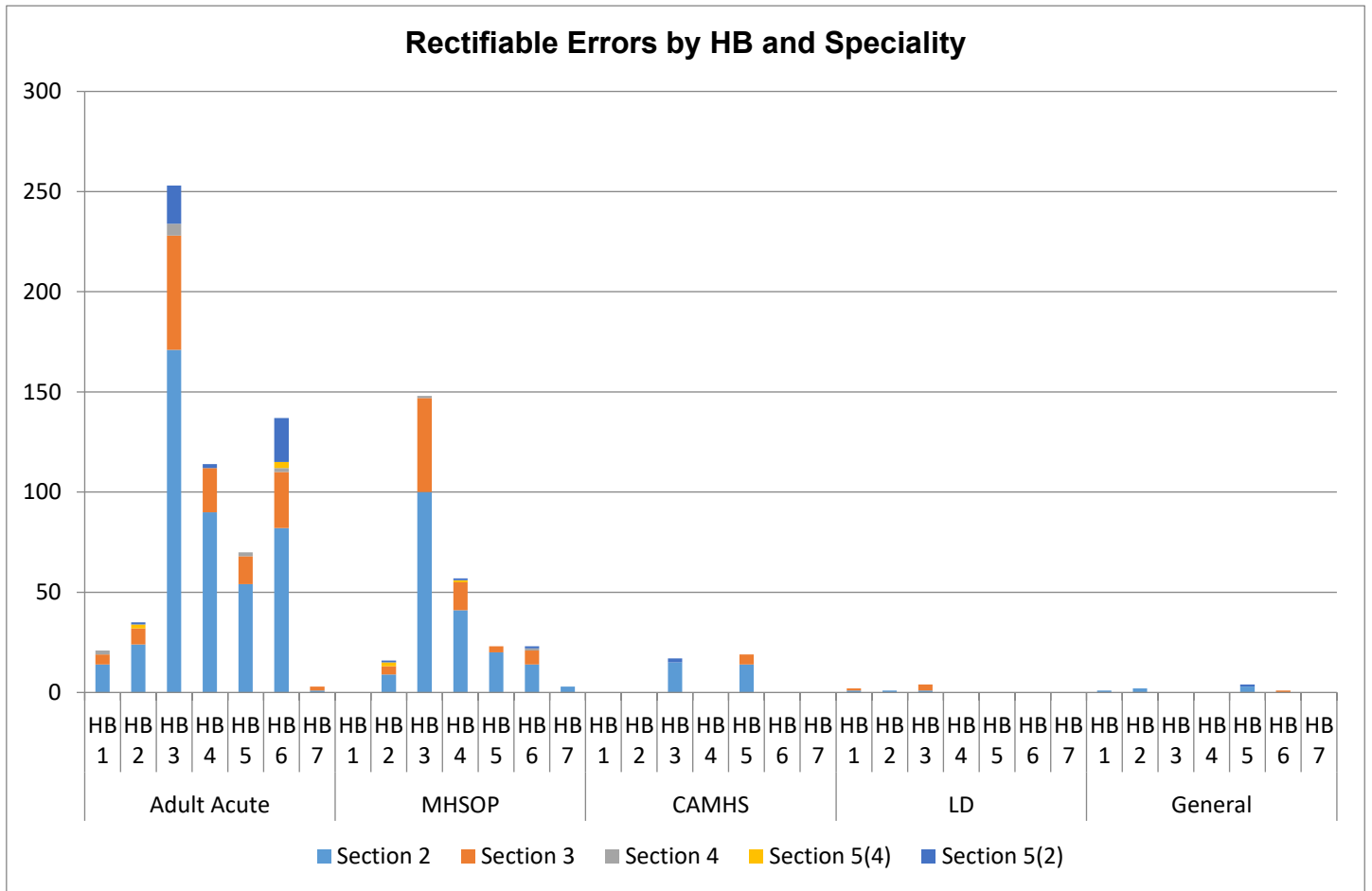


Section 136 (Custody) to UHB Population

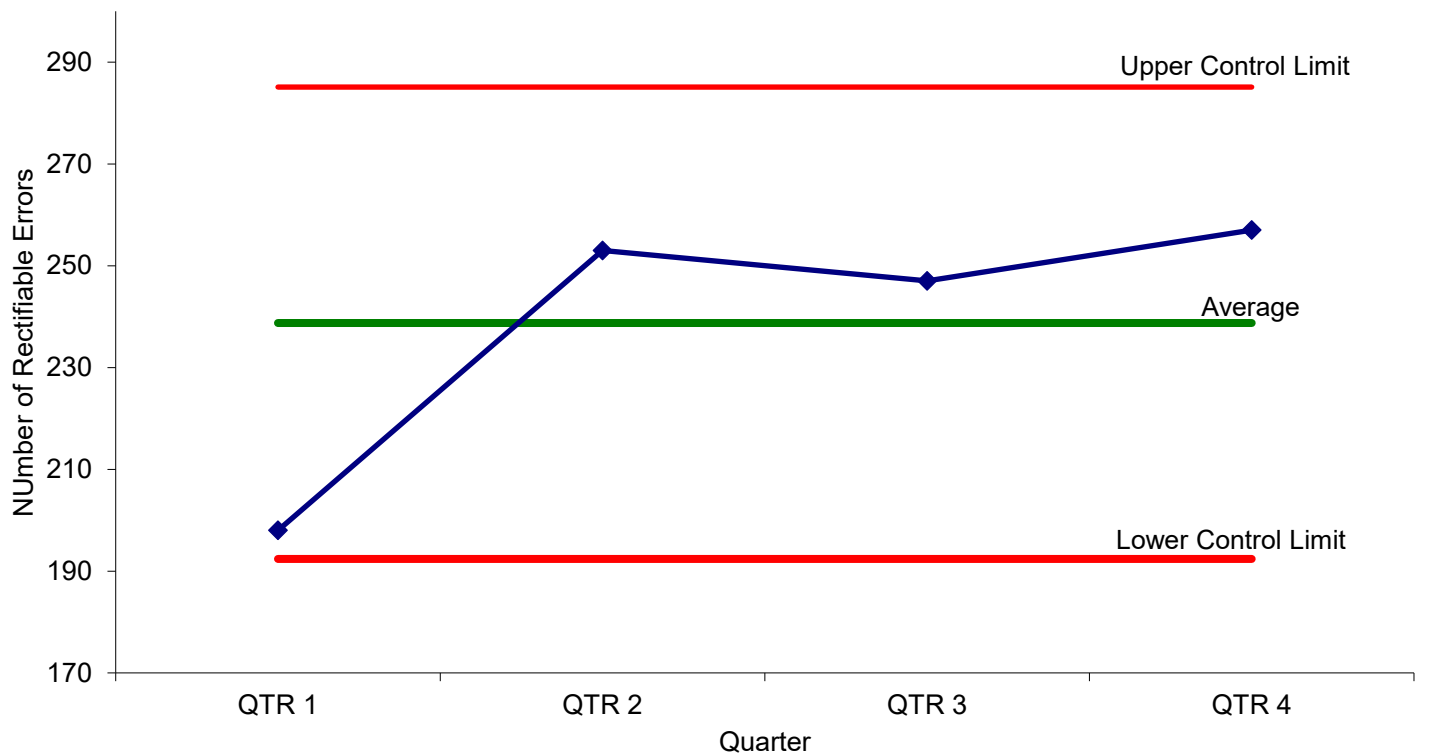


Rectifiable Errors

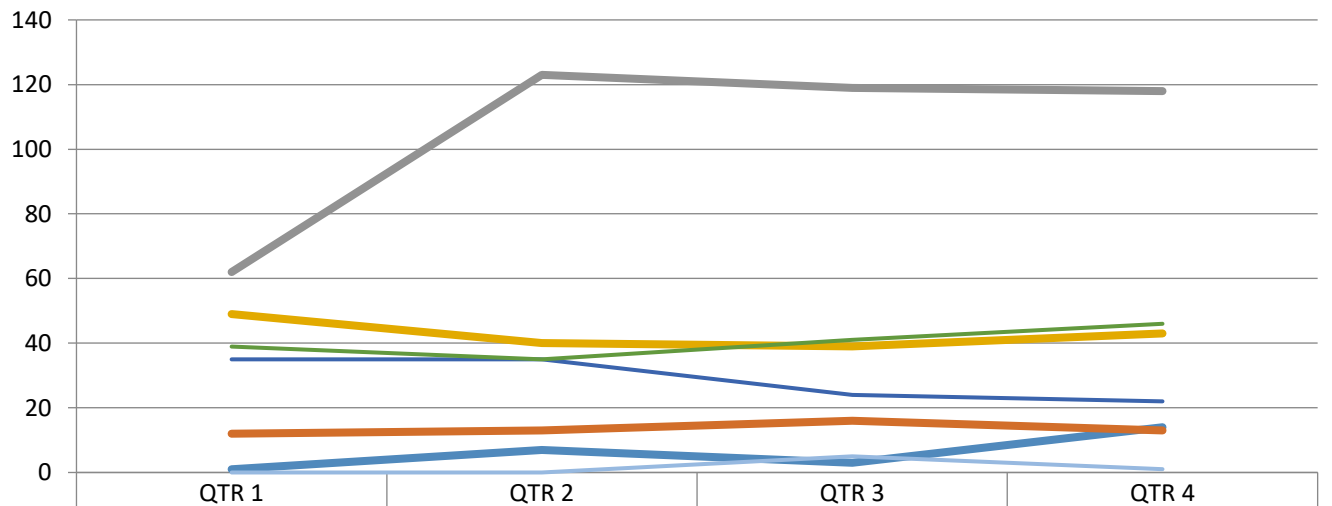
Rectifiable errors by HB and speciality.



Rectifiable Errors during the period



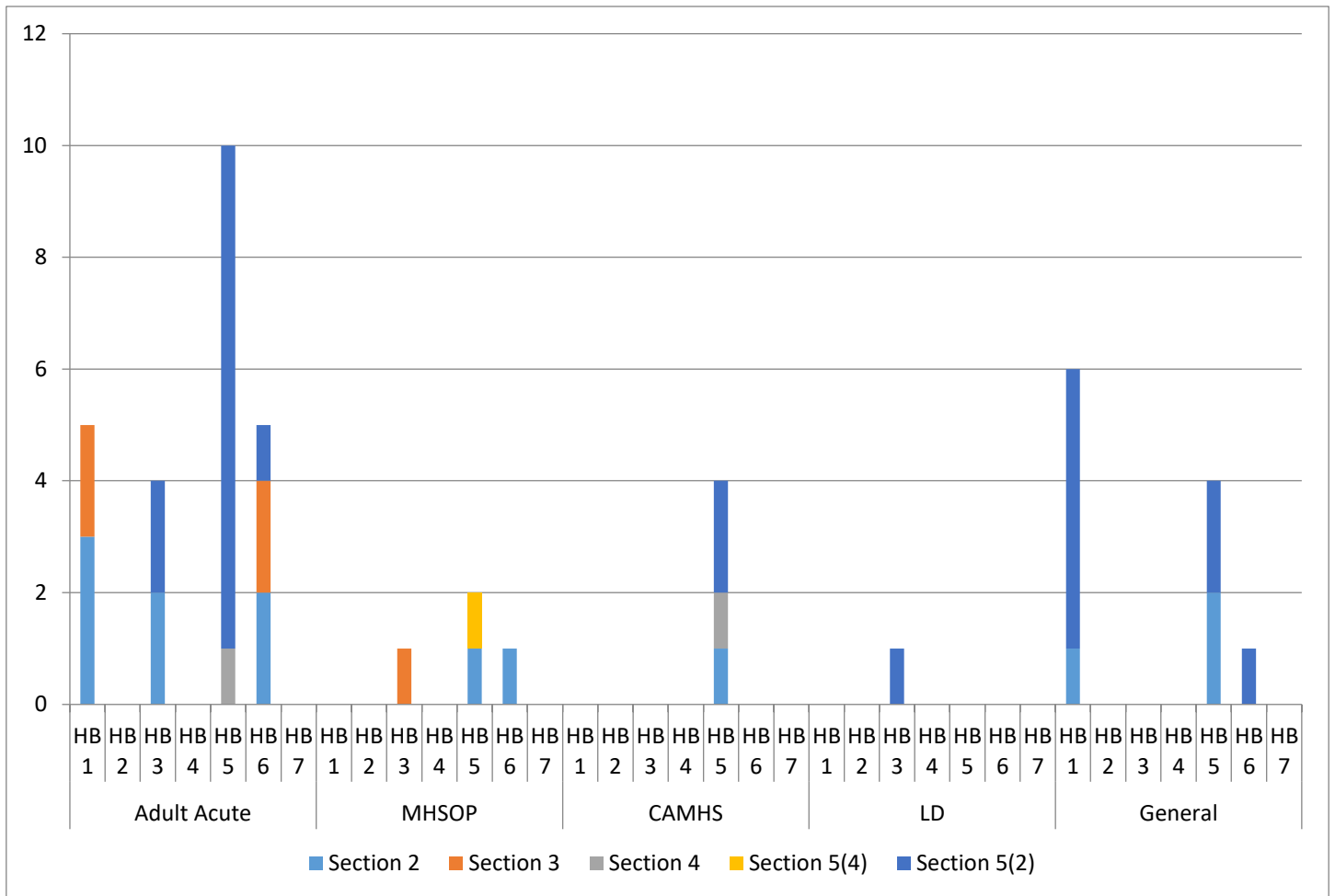
Rectifiable Errors per HB



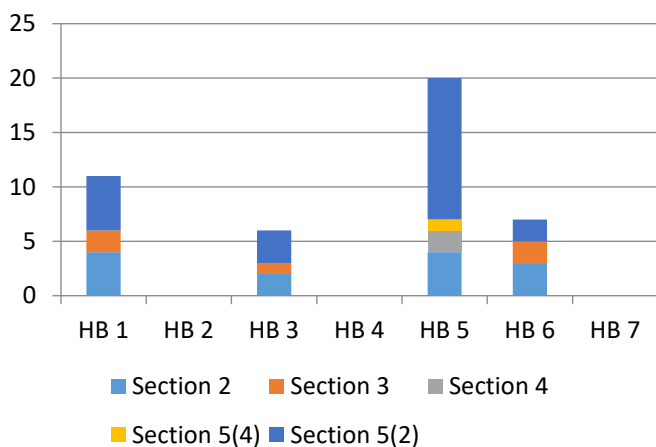
	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	1	7	3	14
HB 2	12	13	16	13
HB 3	62	123	119	118
HB 4	49	40	39	43
HB 5	35	35	24	22
HB 6	39	35	41	46
HB 7	0	0	5	1

Fundamentally Defective

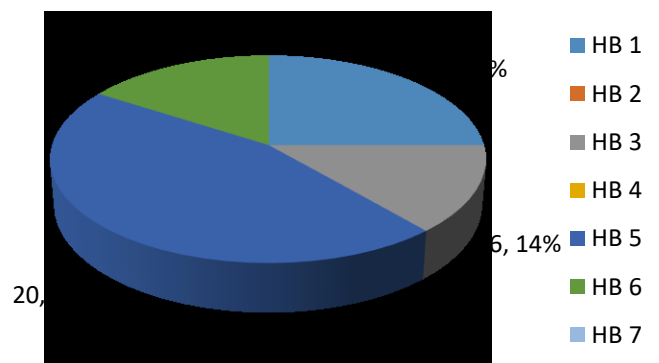
Number of fundamentally defective applications by speciality and HB.



Fundamentally Defective Applications Per Health Board

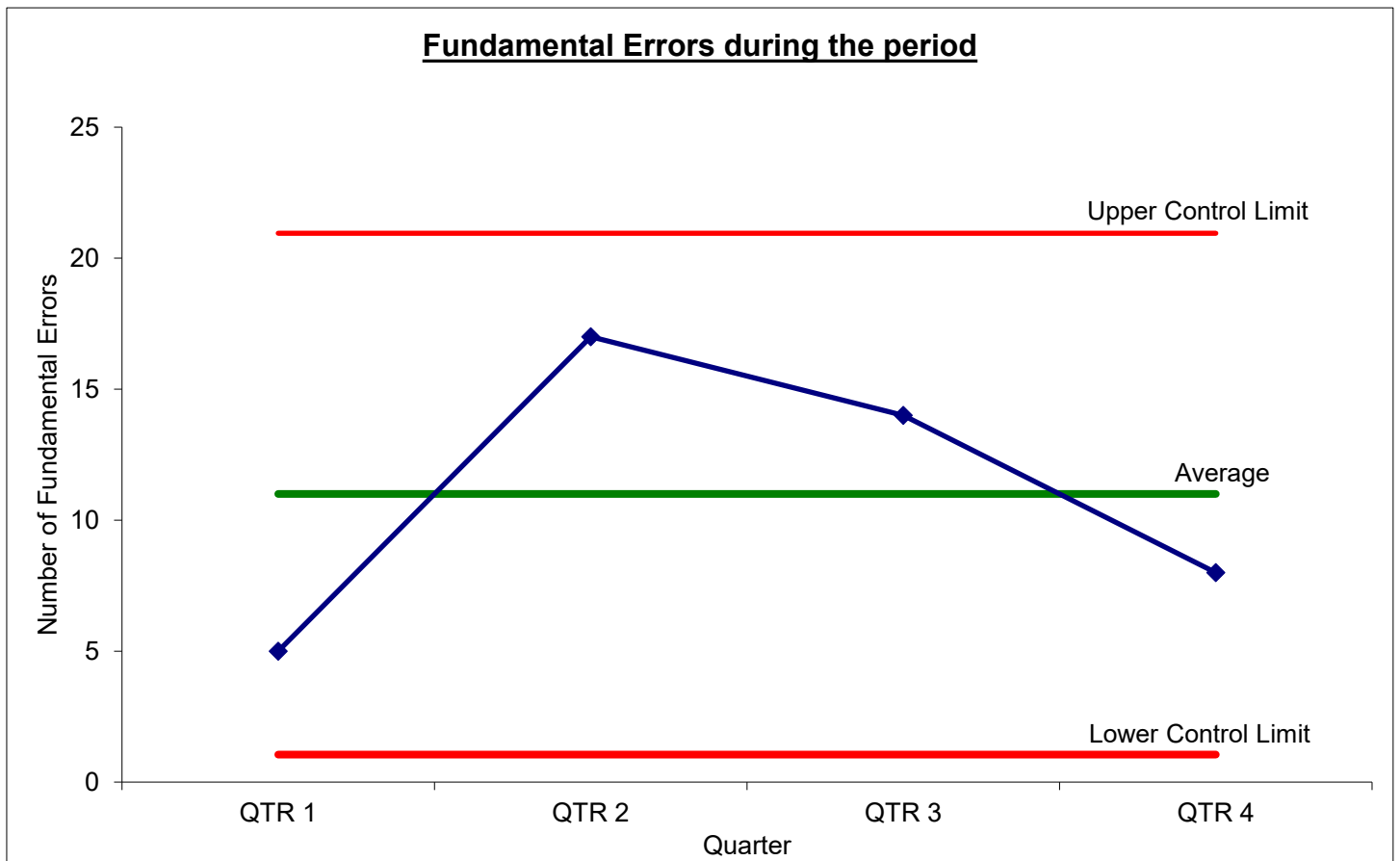


Fundamentally Defective Applications Per Health Board

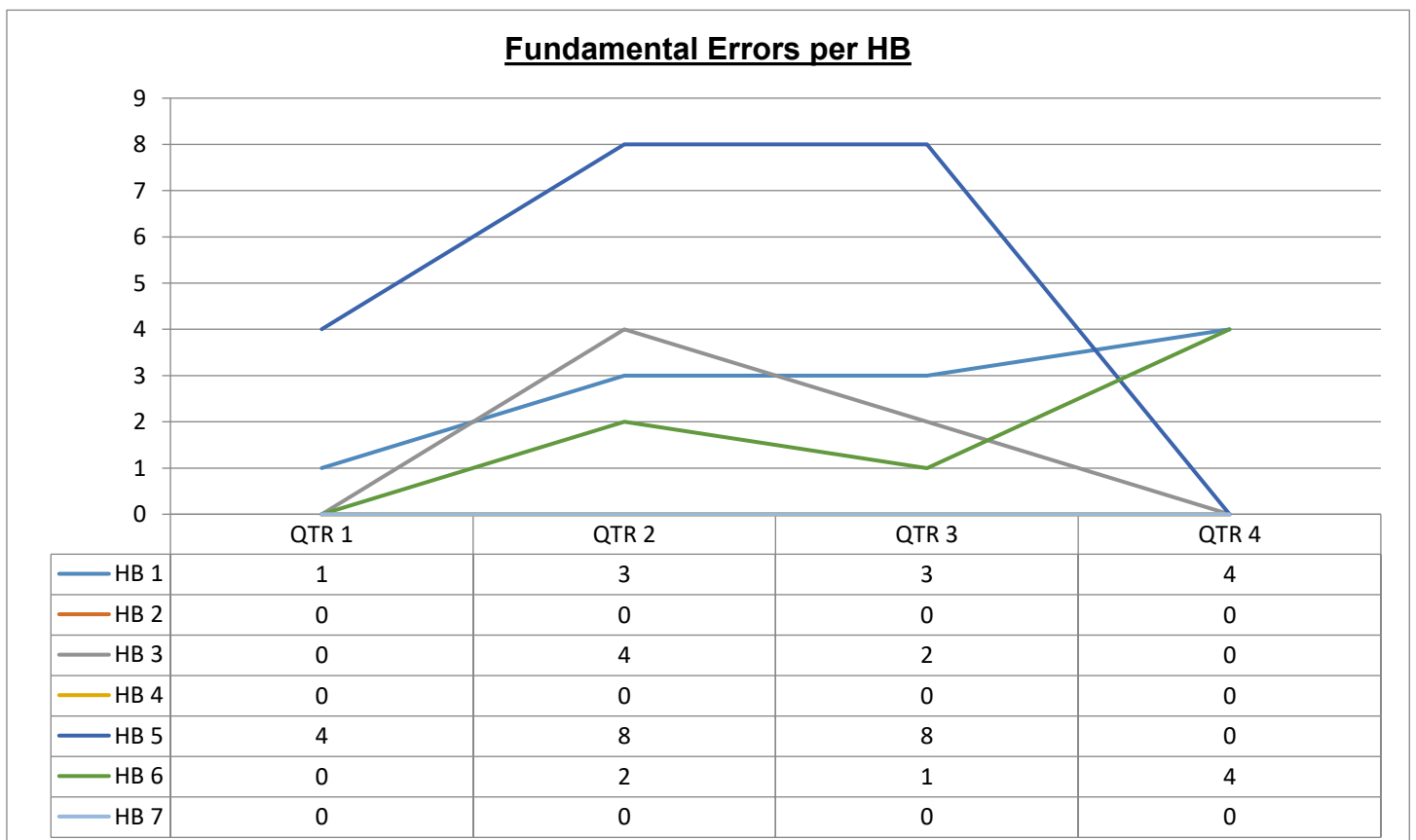


Fundamentally Defective Yearly Activity

Fundamental Errors during the period

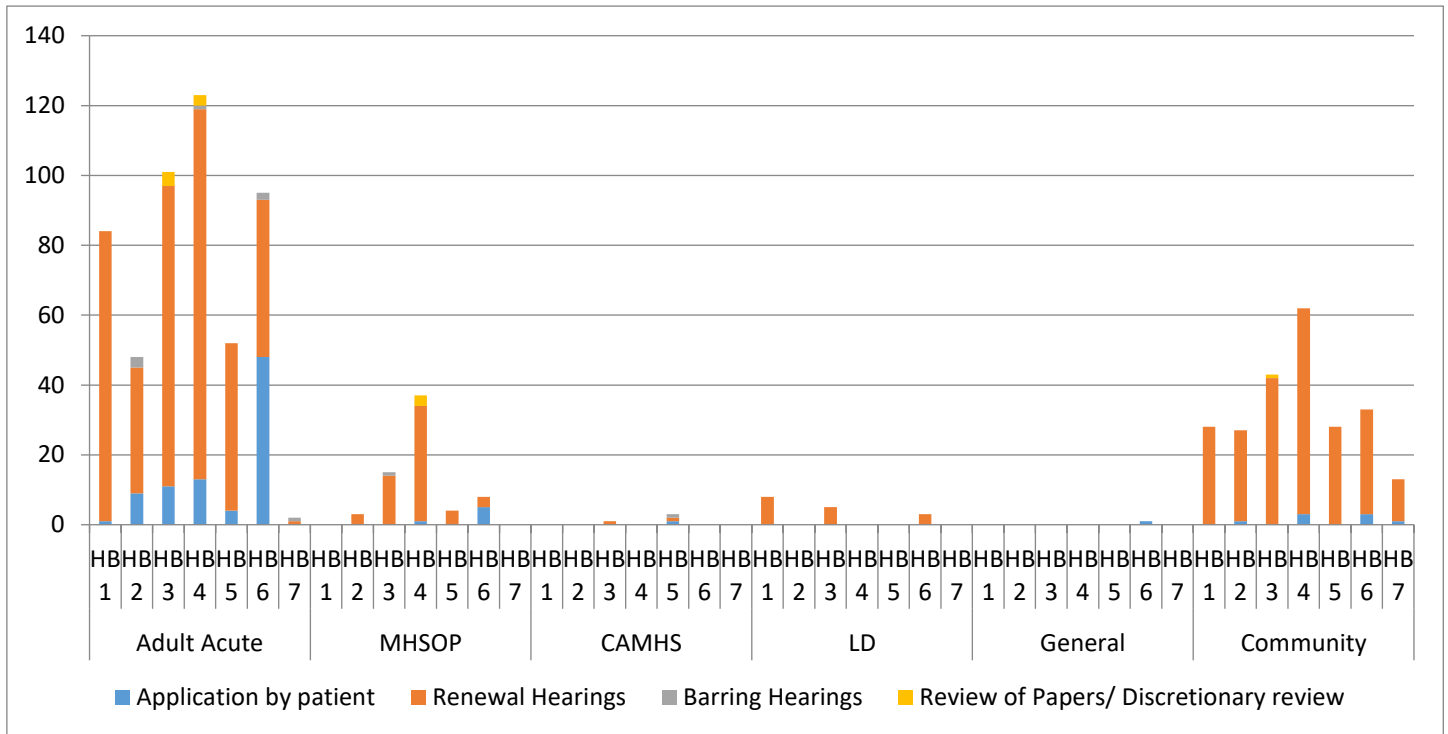


Fundamental Errors per HB

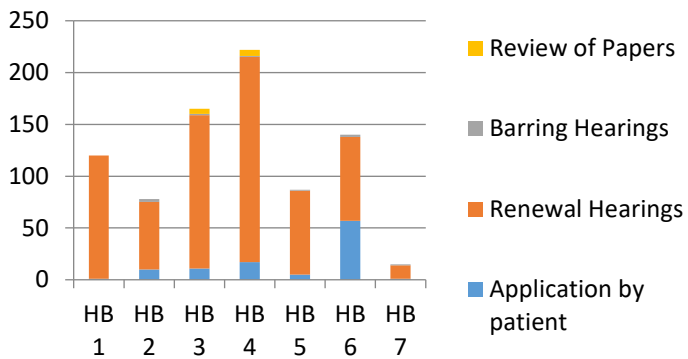


Hospital Manager Hearings Activity

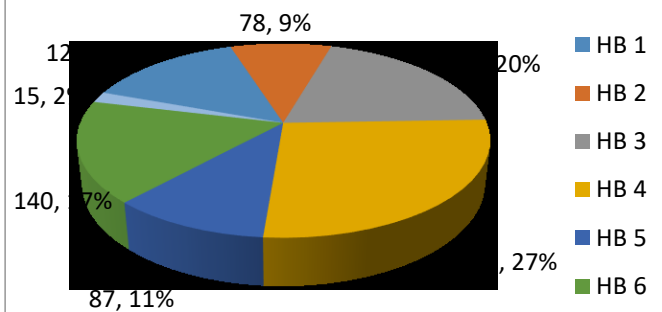
Hospital Managers' Hearings arranged during the period by speciality and HB.



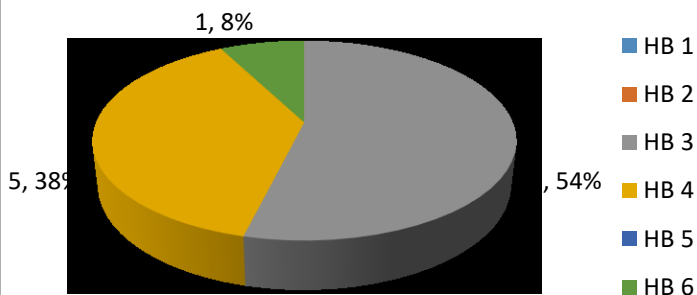
Hearings Arranged by Health Board



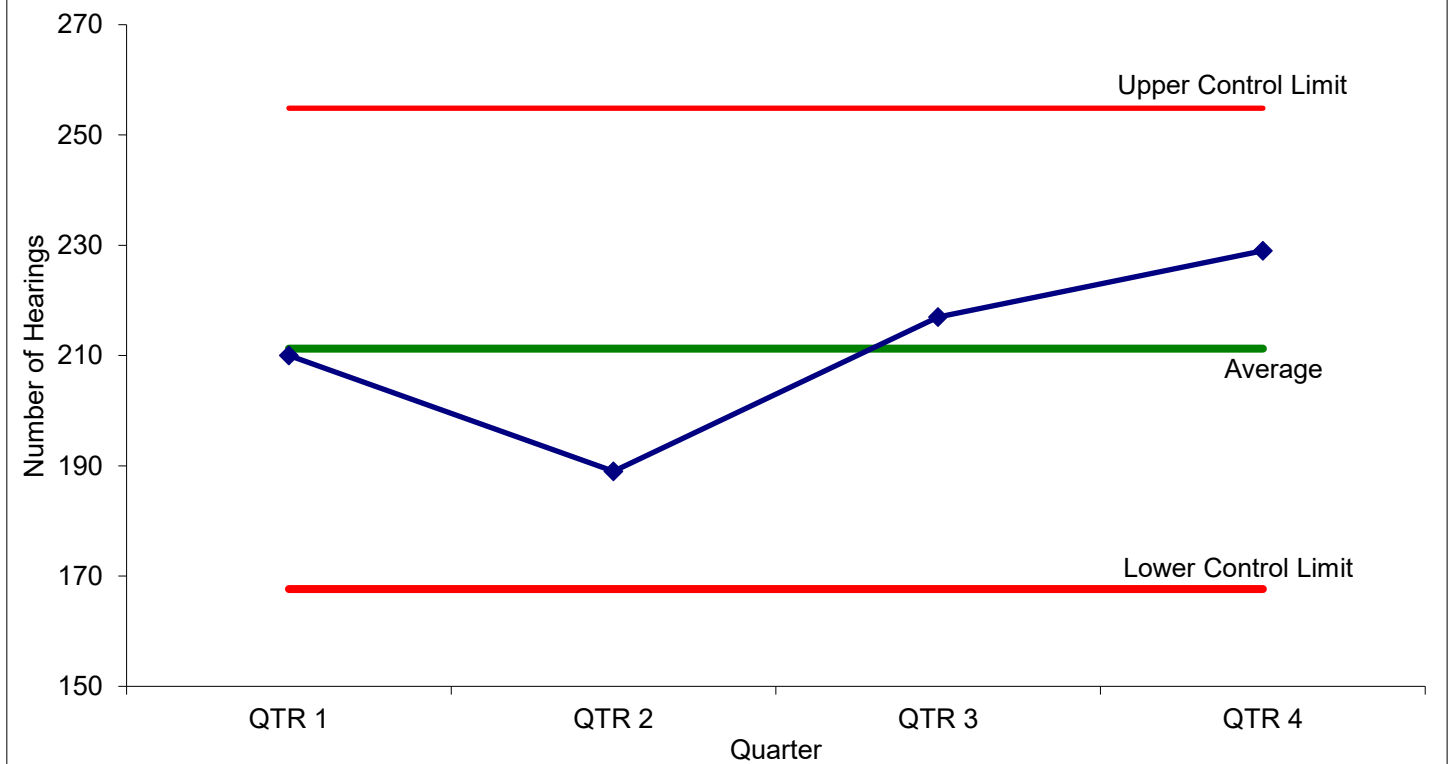
Hearings Arranged by Health Board



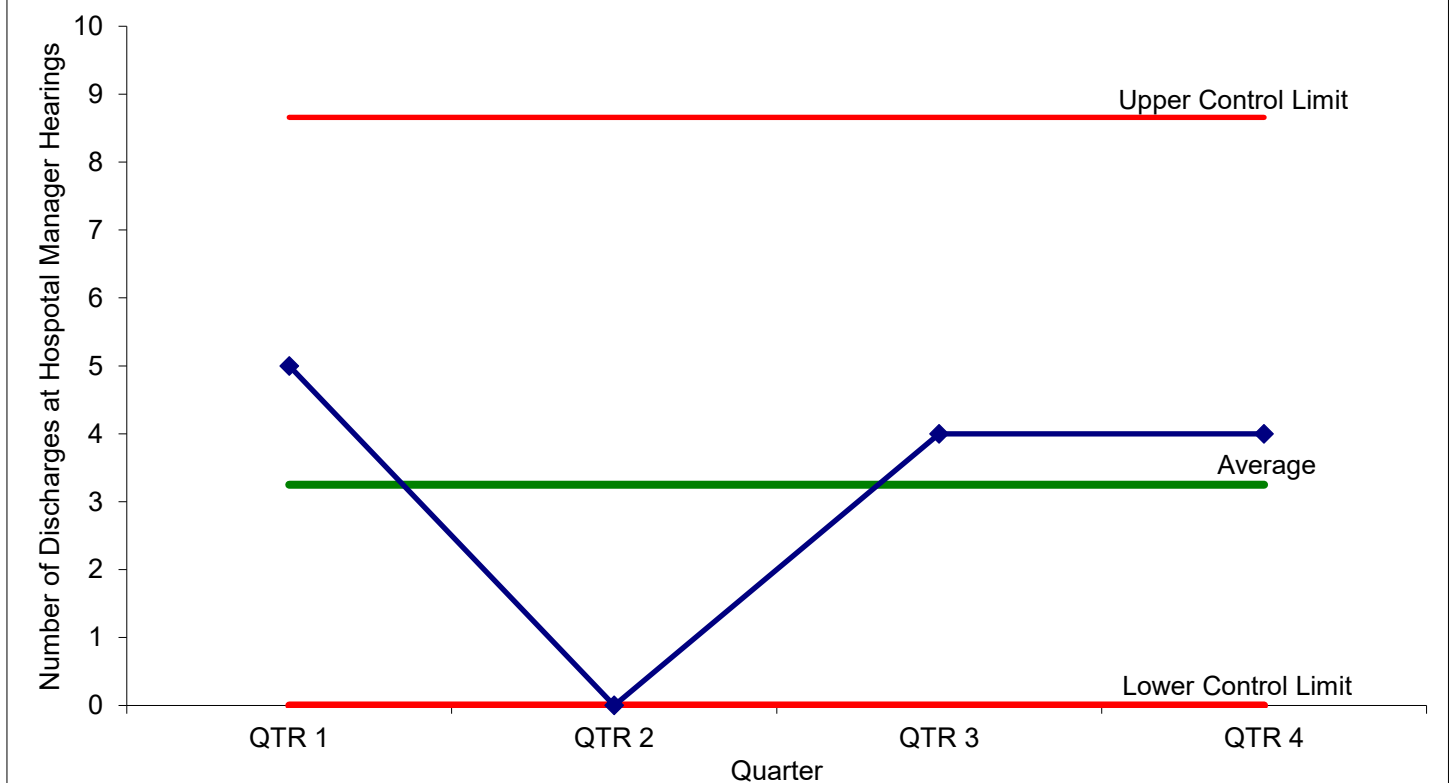
Patients Discharged by Hospital Managers



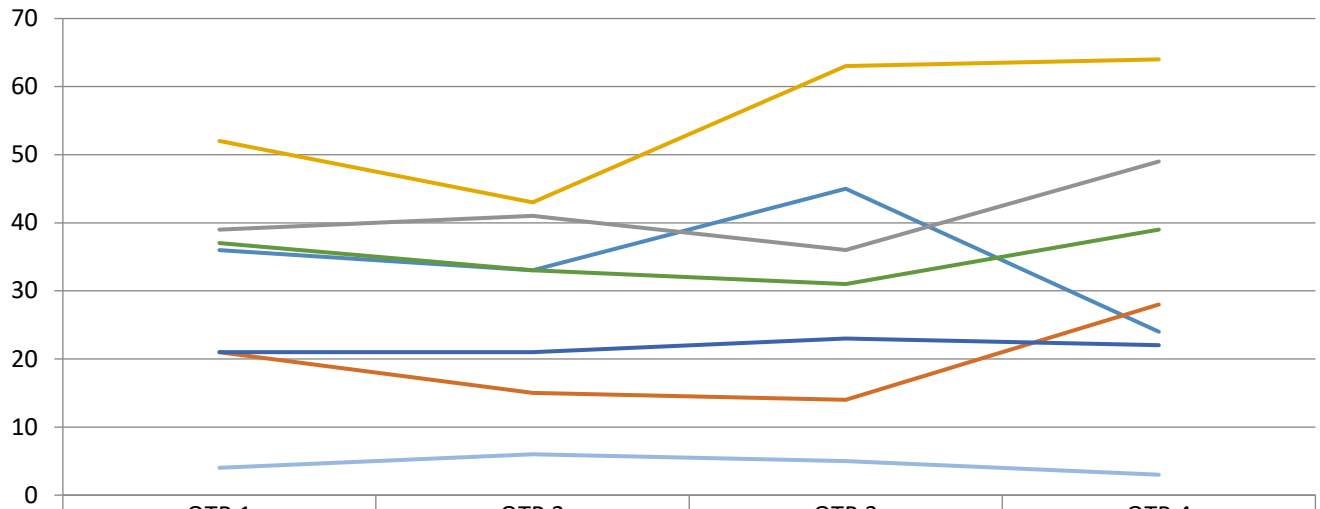
Hospital Manager Hearings Arranged during the period



Patients Discharged from Detention at Hospital Manager Hearings

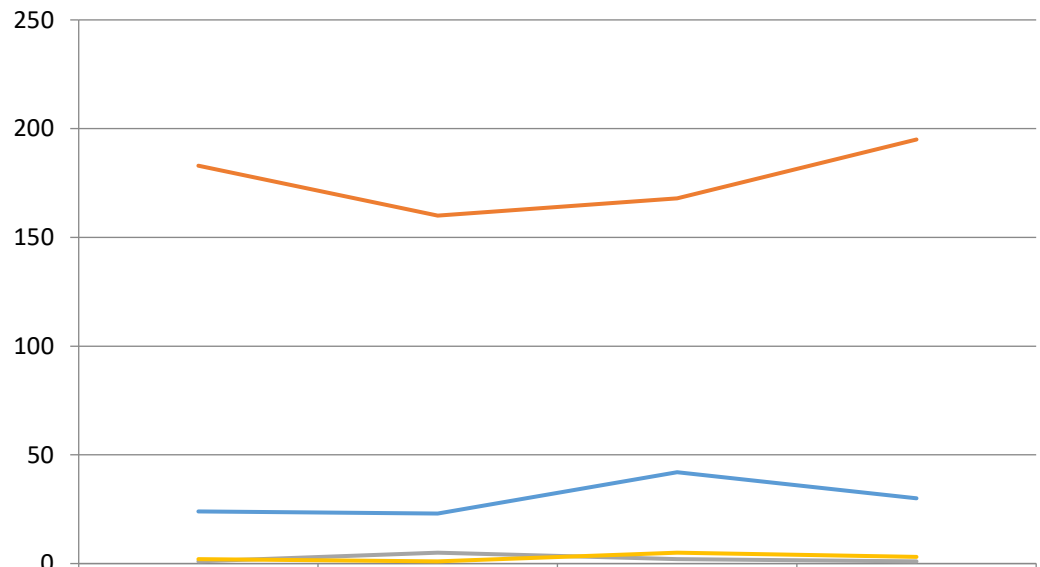


Hospital Manager Hearings Arranged per HB



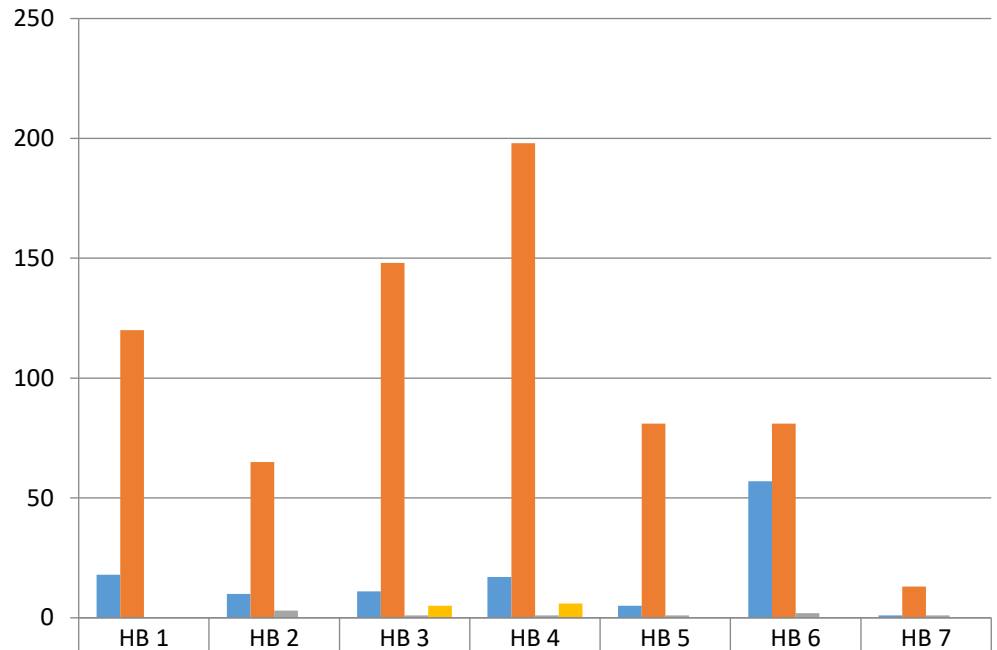
	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	36	33	45	24
HB 2	21	15	14	28
HB 3	39	41	36	49
HB 4	52	43	63	64
HB 5	21	21	23	22
HB 6	37	33	31	39
HB 7	4	6	5	3

Source of Hospital Manager Hearings



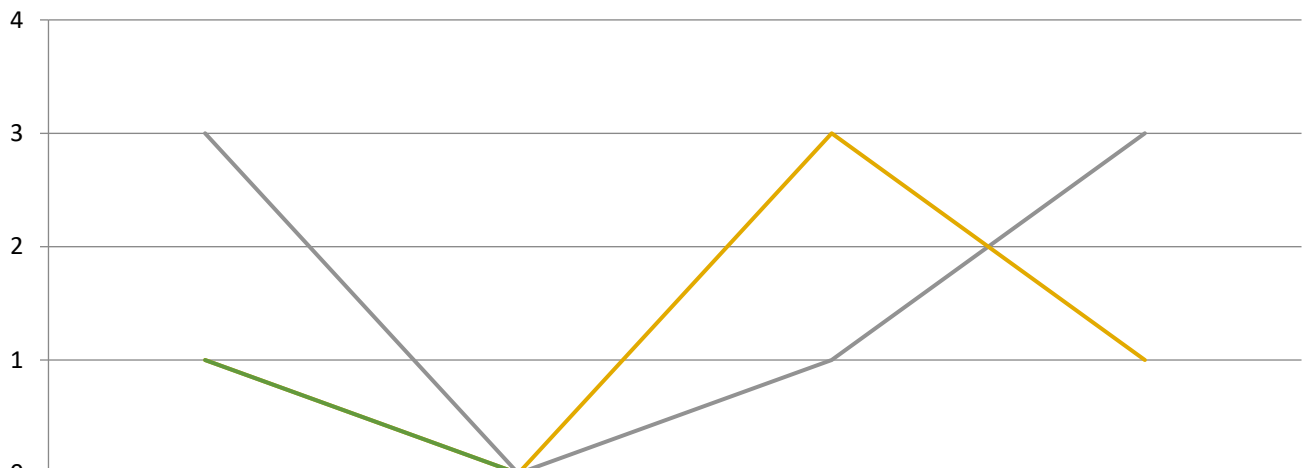
	QTR 1	QTR 2	QTR 3	QTR 4
Application by patient	24	23	42	30
Renewal Hearings	183	160	168	195
Barring Hearings	1	5	2	1
Review of Papers/ Discretionary review	2	1	5	3

Source of Hospital Manager Hearings per HB



Application by patient	18	10	11	17	5	57	1
Renewal Hearings	120	65	148	198	81	81	13
Barring Hearings	0	3	1	1	1	2	1
Review of Papers/ Discretionary review	0	0	5	6	0	0	0

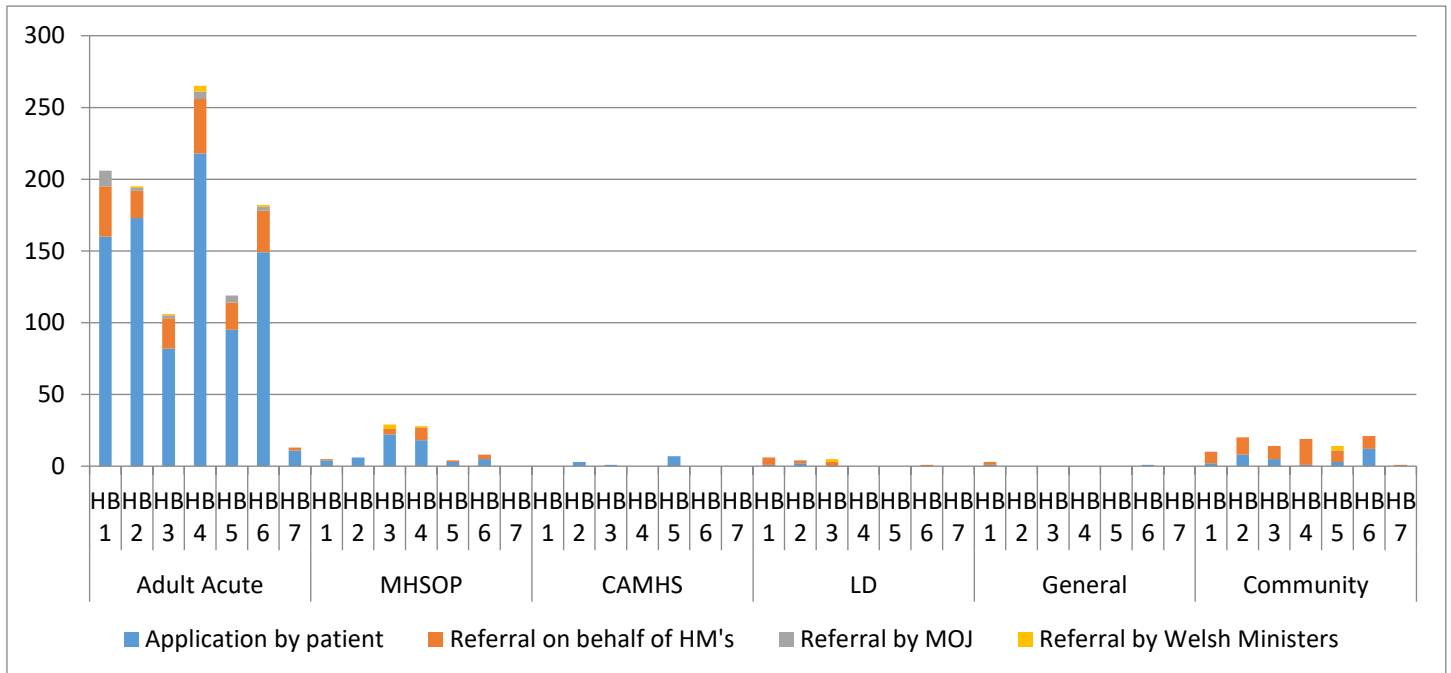
Patients Discharged from Detention at Hospital Manager Hearings



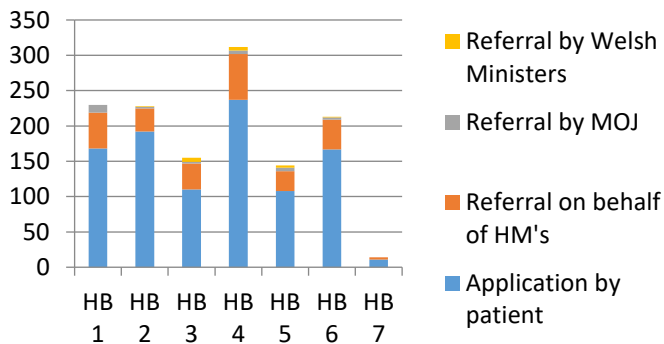
	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	0	0	0	0
HB 2	0	0	0	0
HB 3	3	0	1	3
HB 4	1	0	3	1
HB 5	0	0	0	0
HB 6	1	0	0	0
HB 7	0	0	0	0

MHRT Activity

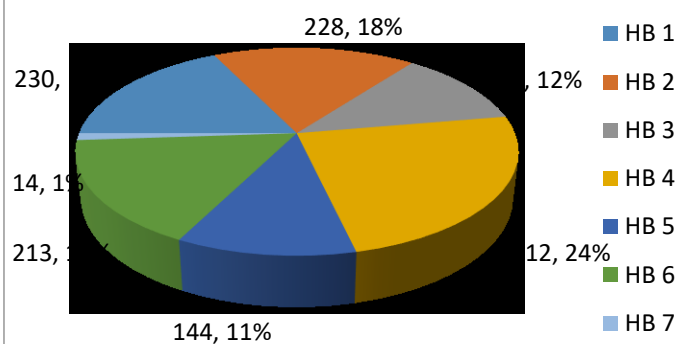
Mental Review Tribunal arranged during the period by speciality and HB.



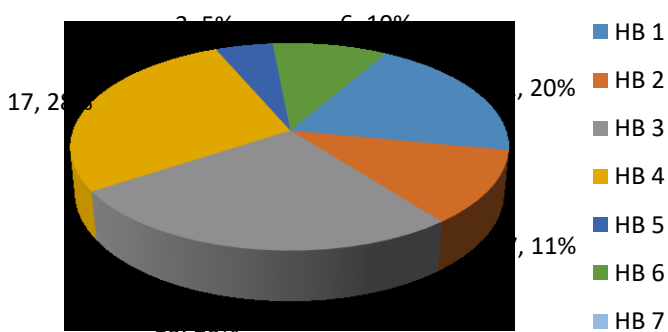
Tribunals Arranged by Health Board



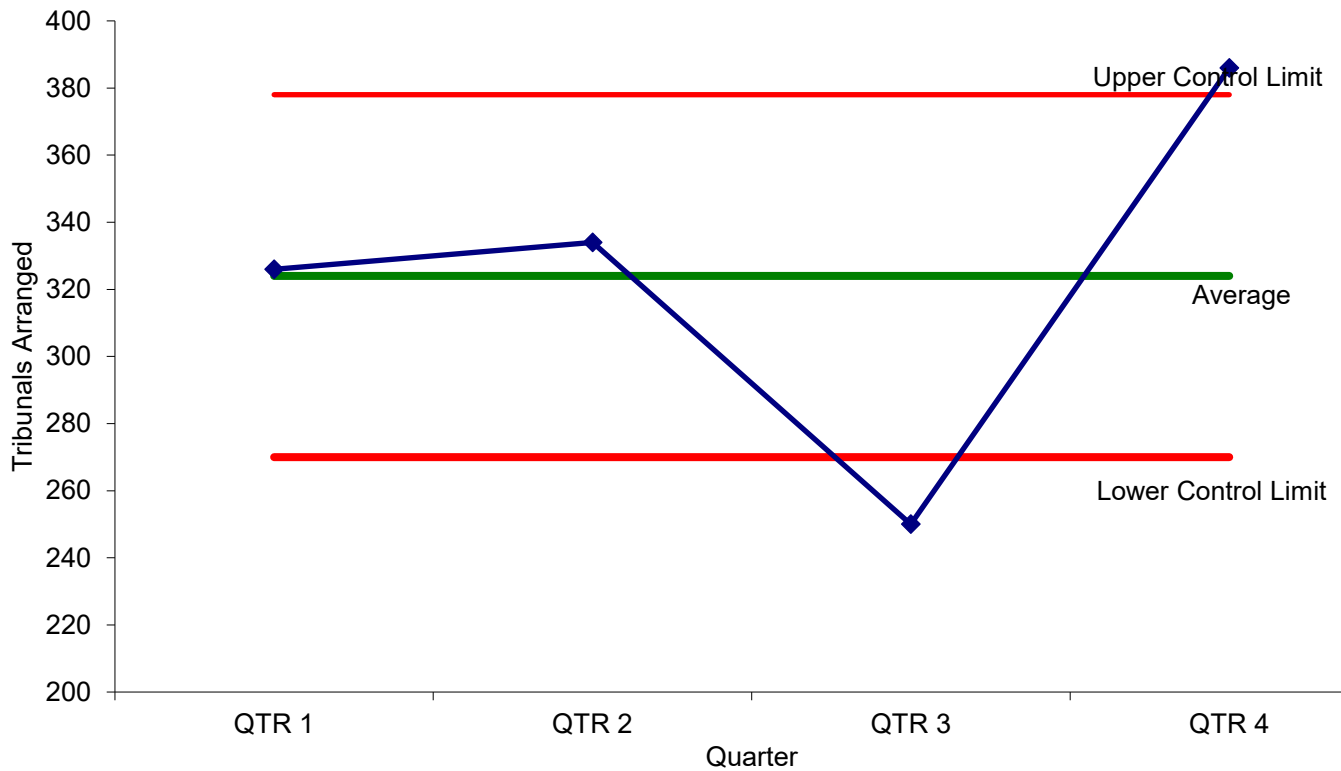
Tribunals Arranged by Health Board



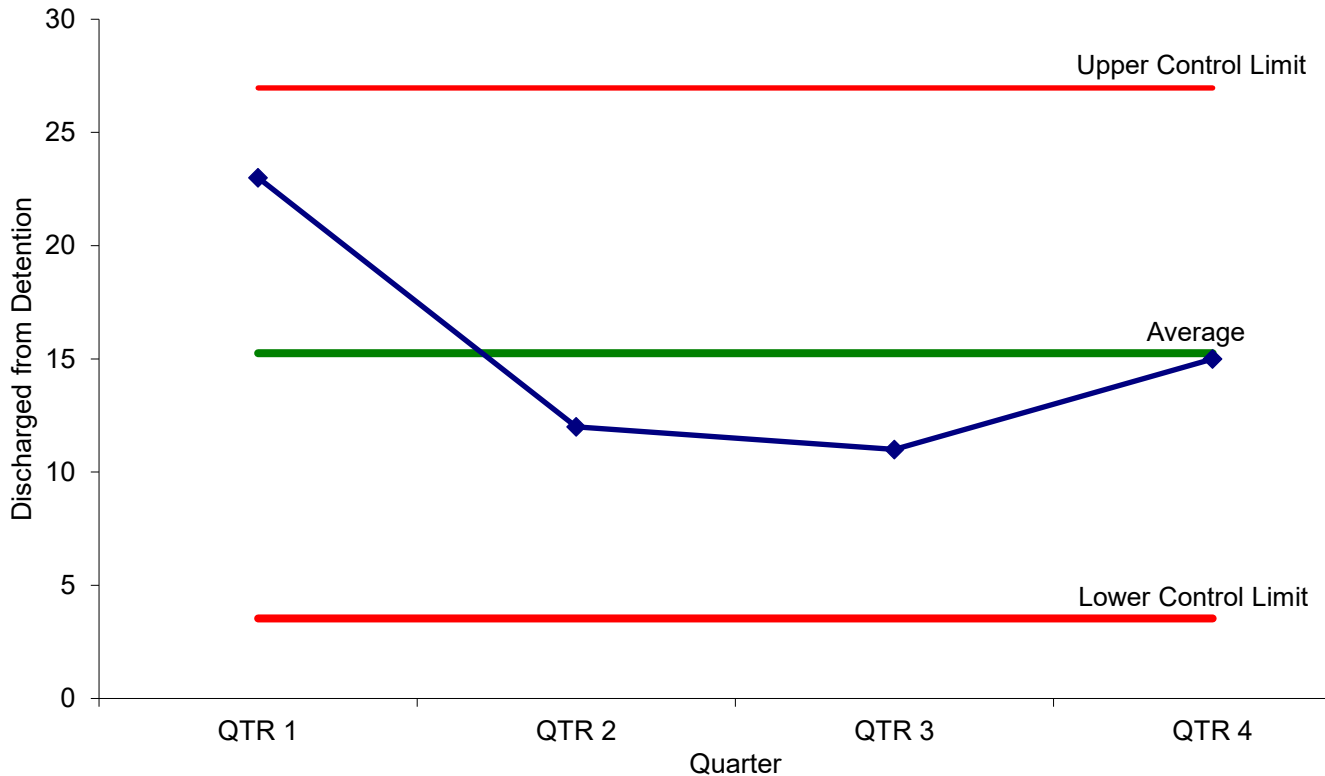
Discharged by MHRT



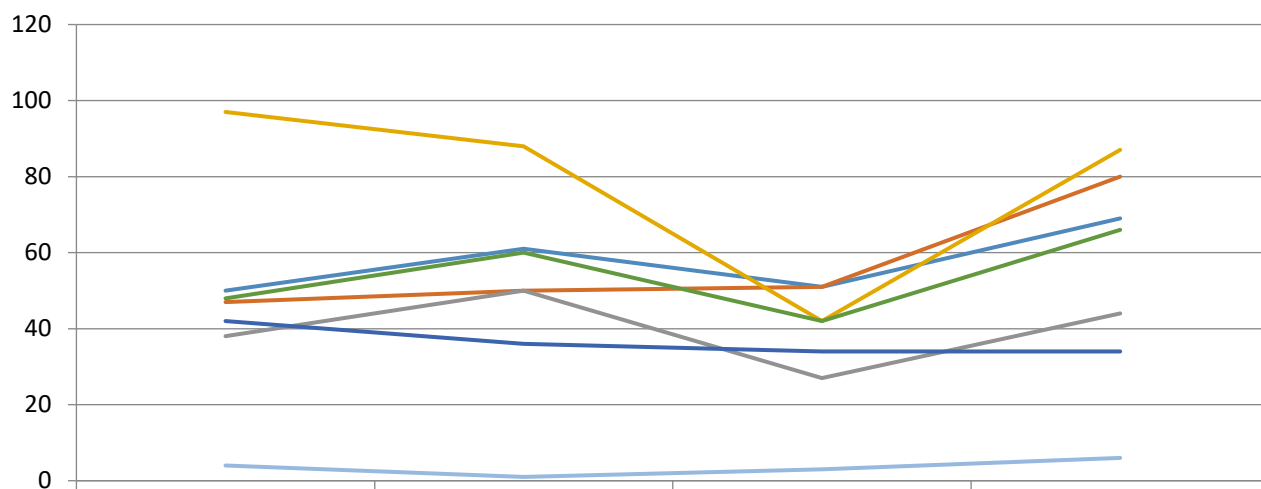
Mental Health Review Tribunals Arranged during the period



Patients Discharged from Detention by a Mental Health Review Tribunal during the period

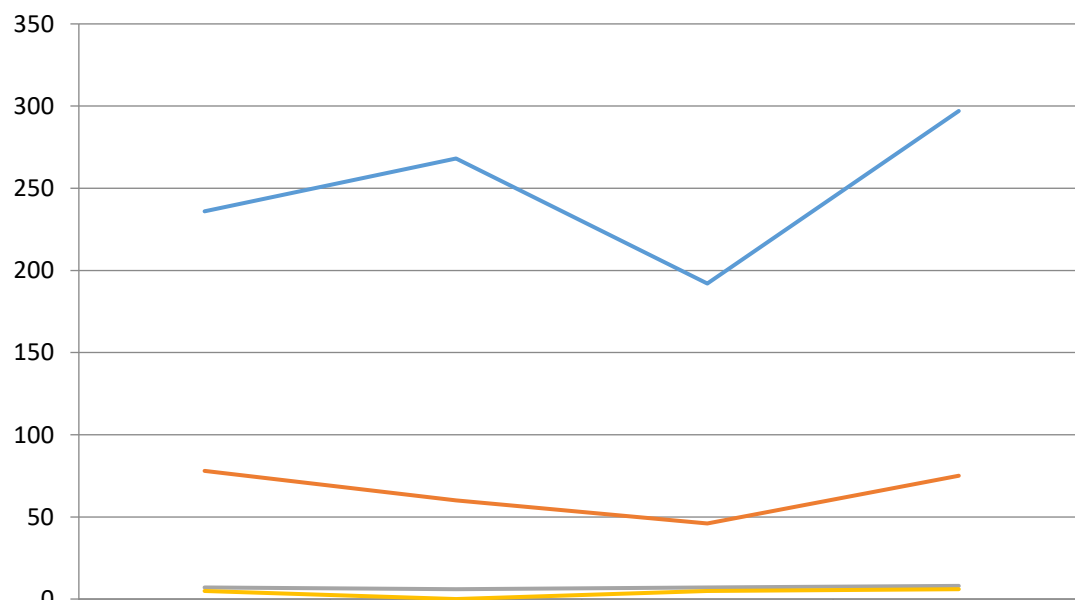


Mental Health Review Tribunals Arranged per HB



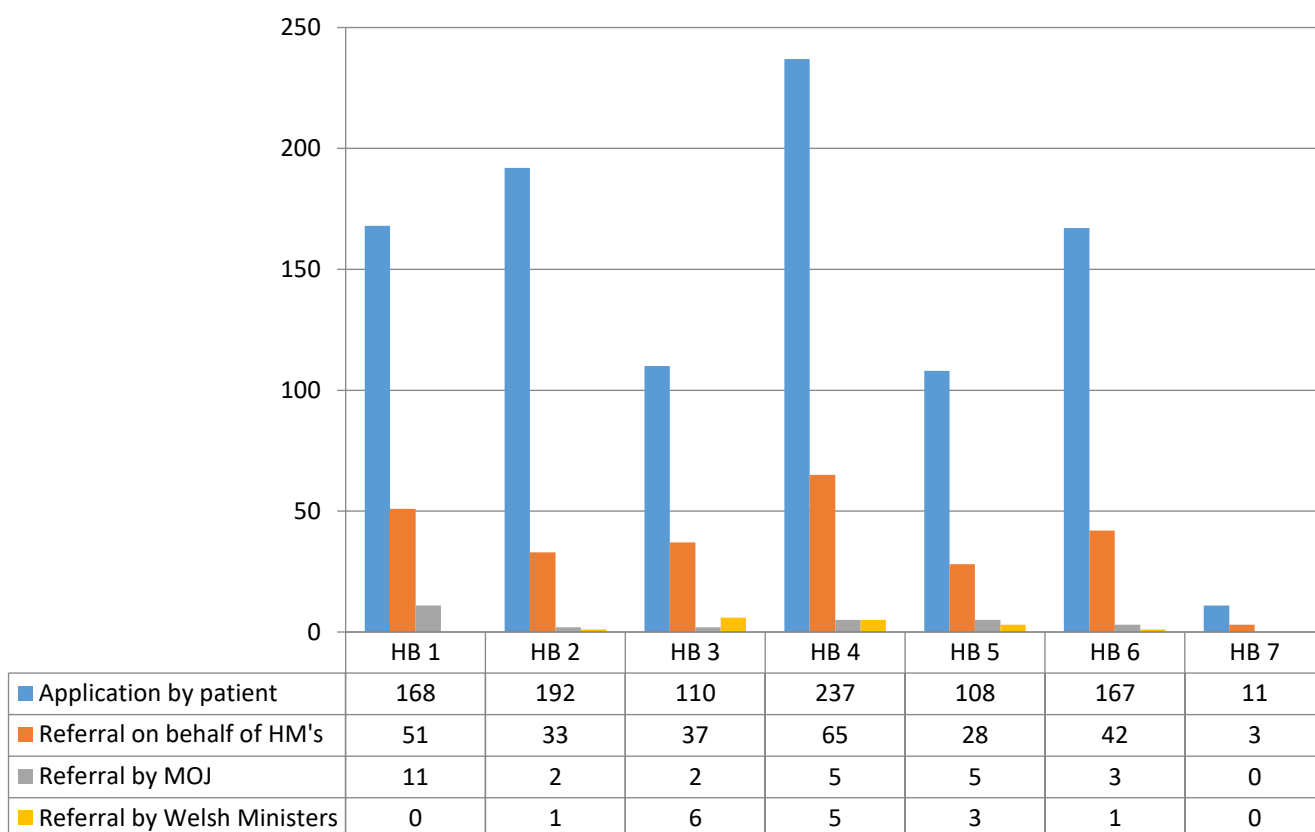
	QTR 1	QTR 2	QTR 3	QTR 4
HB 1	50	61	51	69
HB 2	47	50	51	80
HB 3	38	50	27	44
HB 4	97	88	42	87
HB 5	42	36	34	34
HB 6	48	60	42	66
HB 7	4	1	3	6

Source of Applications for a Mental Health Review Tribunal

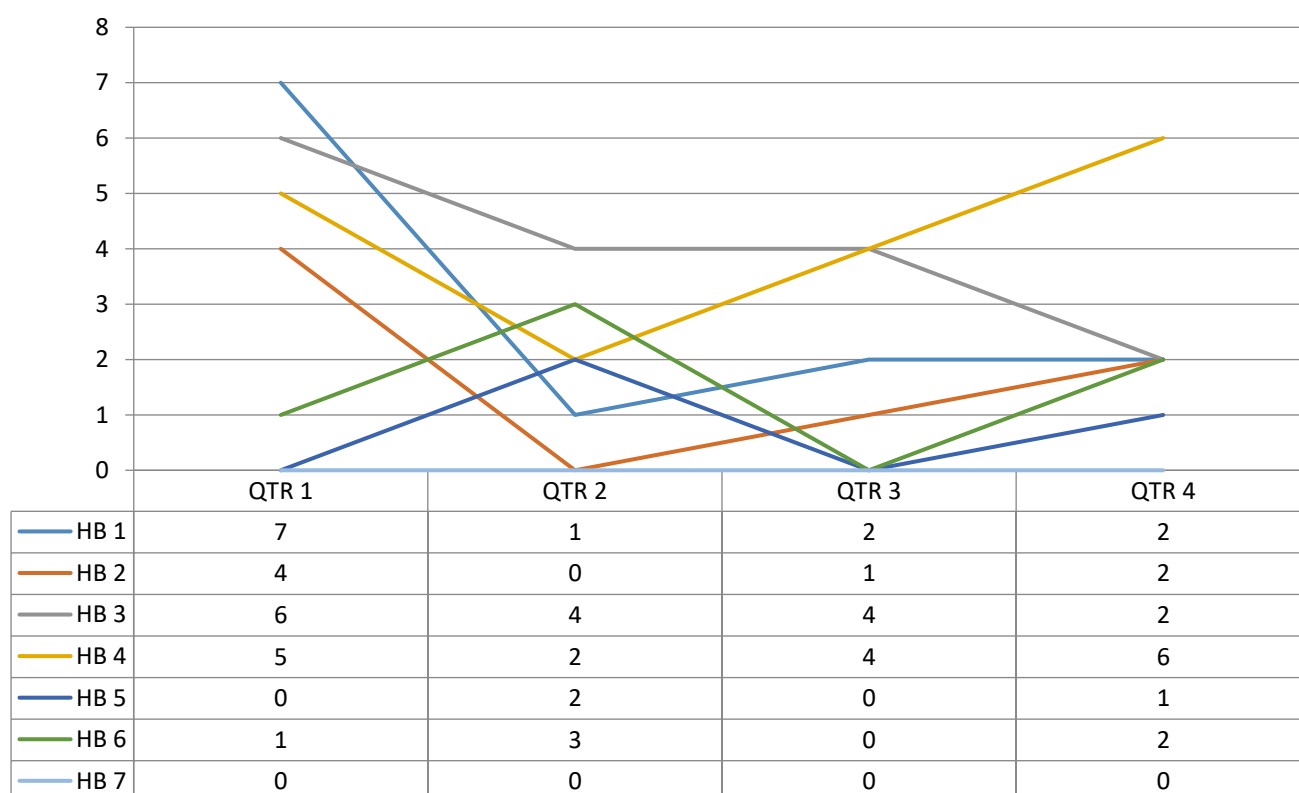


	QTR 1	QTR 2	QTR 3	QTR 4
Application by patient	236	268	192	297
Hospital Managers	78	60	46	75
Ministry of Justice	7	6	7	8
Welsh Ministers	5	0	5	6

Source of Applications for a Mental Health Review Tribunal per HB



Patients Discharged from Detention by Mental Health Review Tribunal



REPORT TITLE:	Specialist CAMHS Service				
MEETING:	Mental Health Capacity Legislation Committee			MEETING DATE:	04.06.19
STATUS:	For Discussion	✓	For Assurance	For Approval	For Information ✓
LEAD EXECUTIVE:	Steve Curry, Chief Operating Officer				
REPORT AUTHOR (TITLE):	Rose Whittle – Directorate Manager; Community Child Health Katie Simpson – CAMHS Repatriation Project Manager				
PURPOSE OF REPORT:					

SITUATION:

The Specialist CAMHS service was repatriated into Cardiff and Vale University Health Board, from the 1st April 2019. The decision to repatriate the service was made in late 2017 following ongoing concerns about the performance of the service.

Throughout the repatriation project, the Health Board has had the opportunity to work more closely with the service to ensure the smooth and safe transfer into the Community Child Health Directorate. As part of the process, the Directorate Management Team have identified a wide range of concerns about the service in relation not only to performance against required targets, but to the management of capacity and demand, clinical practice and HR and workforce. The project undertook engagement activities with a range of stakeholders whose feedback and concerns echo those identified by the Directorate Management Team.

With the service now repatriated to Cardiff and Vale, it is imperative that the Health Board has an understanding of the current performance and concerns identified and the proposed actions identified by the Directorate to address these and transform the service.

REPORT:

BACKGROUND:

The Specialist CAMHS service delivers secondary care mental health services for children and young people up to the age of 18. The service for the Cardiff and Vale residents has been commissioned for delivery by Cwm Taf University Health Board since 2007 under a managed clinical network arrangement. At the end of 2017, the decision was taken to repatriate the service back to Cardiff and Vale University Health Board, following significant concerns about the under performance of the service.

ASSESSMENT:

A review of the historical performance has been undertaken, as well as identifying the projected performance of the service for continued delivery at the current rate of activity. In summary, the key areas for consideration include:

- Over the last three reporting years, the service has never achieved the required 80% target and is typically operating at between 50-60%. This has been a consistent trend despite the allocation of waiting list funding to boost capacity on a number of occasions.
- In 2016 and 2017 the longest wait and waiting list size came down significantly, although this

could have been as a result of the Neurodevelopment service being established and patients being transferred into this service. For the past 12 months the waiting list has stabilised at around 160-190 patients and the longest wait is currently approximately 18 weeks, although these patients have appointments booked.

- Derived demand for the specialist CAMHS service is typically between 50-60 assessments per month, with a 28-day target this would suggest the total waiting list will need to reduce to below 60 patients if the service is to meet the standard reliably.
- The service has an establishment of 50wte but 10.5wte of these posts were vacant (21%) on transfer.
- With current vacancies, and without additional capacity, the capacity of the service is calculated at 35 assessments per month which means, without action, the waiting list is likely to grow by around 20 patients per month; performance against the 28-day target is therefore likely to deteriorate further without additional actions.
- A range of clinical and workforce issues have been identified including insufficient practice development in line with emerging evidence base, poor integration across the team and with wider clinical teams e.g. PCAMHS and lack of appropriate skill mix across professions.

Proposed actions are identified to improve the waiting list performance in the short term, whilst longer term actions are undertaken to address the clinical, HR and stakeholder concerns identified.

Proposed Actions

There are three components to the emerging SCAMHS plan:

- Further work will be undertaken with the service to increase the capacity of practitioners to deliver increased initial assessments every month to meet the incoming demand (i.e. productivity gain within the existing staffing). This will include the Directorate commissioning an independent and objective review and evaluation of the current service delivery to determine baseline performance against the evidence base, identifying the areas for improvement and the viability for continuing with the Choice and Partnership Approach. The procurement process for this has been instigated, with the expectation for the review to be completed by 1st September 2019.
- The Directorate Management Team are recruiting to the existing vacancies to boost capacity back to the current baseline. Since the transfer 3.6wte of the vacant posts has been recruited to, however some has been filled through the promotion of existing team members and will therefore not boost capacity immediately. Job descriptions and skill mix are being reviewed to maximise recruitment opportunities within a nationally narrow recruitment field.
- Additional capacity – the demand-capacity assessment suggests, at this stage, that the core capacity within the service will be insufficient to both meet the ongoing demand and reduce the backlog as required. The exact details of this cannot be fully understood until the productivity and redesign work (referenced above) has progressed further. Nonetheless given the historical performance issues and the inherited position it is likely that further investment will be required. A further £2 million has been recurrently allocated to the Health Board from 2019/2020 by Welsh Government for mental health services, with child and adolescent mental health services identified as a key priority for the funding to be attributed to. The intention is to utilise a proportion of the CAMHS share of this funding to support both non-recurrent backlog reduction and sustainable increases in capacity. In addition we expect to utilise slippage accrued from the current vacancies to support the implementation of short term actions for improvement.

RECOMMENDATION:

The Committee is asked to:

- **NOTE** the status of the Specialist CAMHS service inherited by the UHB and the implications for performance
- **NOTE** that a definitive trajectory for improvement will be developed over the coming months as the work on service redesign, productivity and recruitment is progressed further
- **NOTE** the plans to review the service models and recruit to the existing vacancies
- **ENDORSE** the intention to utilise a proportion of the Welsh Government funding for Mental Health to support the Specialist CAMHS service

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click [here](#) for more information

Sustainable development principle: 5 ways of working	Prevention	✓	Long term	✓	Integration		Collaboration		Involvement	
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EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:

Completed as part of the repatriation project – August 2018



**MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL
MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 16
APRIL 2019 IN SEMINAR ROOM 2, HAFAN Y COED.**

Present:

Jeff Champney-Smith	Chair, PoD Group
Elizabeth Singer	Vice Chair, Pod Group
Teresa Goss	PoD member
John Owen	PoD member
Mike Lewis	PoD member
Wendy Hewitt-Sayer	PoD member
Dr John Copley	PoD member
Peter Kelly	PoD member
Carol Thomas	PoD member
Mary Williams	PoD member
Mair Rawle	PoD member
Alan Parker	PoD member
Sarah Vetter	PoD member
Tony Summers	PoD member
Simon Williams	PoD member
Elaine Gorvett	PoD member
Sunni Webb	Mental Health Act Manager
Sharon Dixon	PoD member
Huw Roberts	PoD member
Patricia Hallett	PoD member
Rashpal Singh	PoD member

In attendance:

Simon McDonald	Mental Health Act Coordinator
Morgan Bellamy	Assistant Mental Health Act Administrator

Apologies:

Sunni Webb	Mental Health Act Manager
Sharon Dixon	PoD member
Huw Roberts	PoD member
Patricia Hallett	PoD member
Rashpal Singh	PoD member

1 Welcome and Introductions

The Chair of the group welcomed everyone to the meeting.

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

Extension of Office

A discussion took place around extending the length of time the current Chair will remain in post. It was unanimously agreed that this would be beneficial to all due to current changes in structure and procedure, for example the Mental Health Legislation and Governance Group.

Cancellation of Hearings

The number of hearings that have been cancelled was discussed. It was decided that the bulk of these was not indicative of any pattern and this high number is just by chance. One hearing was cancelled one hour prior to the start of the Hearing and was a cause for concern for some members. The Chair of that hearing had been told that this was a possibility, but hadn't passed this information on to the other panel members.

ACTION – The MHA Office to contact all panel members if a similar situation arises rather than just the Chair. If possible the message will not contain any patient identifiable data and is to be sent to normal email accounts rather than through CJSN. This is to enable the members to easily see the message on their phones.

Adjournments

The Chair reminded the group that if a Hearing is adjourned, then it must be for a good, solid reason. That reason should be recorded in the outcome of the minutes.

Decision Amendments

The Chair informed the group that the wording of any outcome can be amended as long as the entire panel is in agreement and that it hasn't been sent out to the patient.

Writing the outcome after the Panel Members have left site

A discussion took place around writing the Hearing outcome elsewhere without the other members present. This is now to be trialled using the following rules:-

- All panel members must agree prior to leaving the Hearing that the outcome will be written-up by the Chair elsewhere.

- The Outcome section of the minutes must solely contain the reason why there is no outcome and signed by the entire panel.
- The Outcome will be discussed between members either over the phone or via CJSJ
- The Outcome must be finalised and provided to the MHA Office within two working days of the Hearing.
- The final version must be agreed over CJSJ from each panel member to the MHA Office. This agreement must contain a copy of the final Outcome text to ensure clarity.
- After discussion it was agreed that the managers would **always** retire before their decision, as to whether to discharge from section or confirm the renewal of the section, was conveyed to the patient and clinical team. This was to ensure that all panel members had the opportunity to discuss the reasons and rationale for their decision.

ACTION – The MHA Coordinator to provide the generic CJSJ address for the MHA Office.

IMHA Attendance

The Chair informed the group that they have a discussion with the Advocacy Service concerning patients who are represented by an IMHA but the patient no longer wished them to attend the Hearing/Tribunal. The Advocacy Service advised that if the patient strongly objects, even if they do not have capacity, then they will not attend.

4 Minutes of Meeting held on 22 January 2019

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

5 Matter Arising

Activities -

This has been taken to the Mental Health Legislation and Governance Group which has not yet met to discuss the outcome.

ACTION – Chair to bring the outcome of this matter to the next meeting.

Breakaway Training

The group were informed that we are waiting for a bespoke training package from the SIMA Manager. Members were reminded that they should not be alone with patients, whether they are with other panel members or other staff members. Their own safety must be the main consideration.

Issues with Individual Hearing Attendees

A discussion took place around issues some members have had with certain members of staff. They were reminded that if there are any such issues with an individual that should be taken to the MHA Manager.

6 MHA Activity Monitoring report January – March 2019

The group read and accepted the both reports.

ACTION – The Mental Health Act Administration Manager to produce an analysis on how close patients were discharged to their Hearing date (MHAM + MHRT) and the MHA Section these patients were on.

7 Concerns/compliments from the Power of Discharge Group hearings January – March 2019

One of the members noted that the number of compliments has risen and how good this was to see.

It was noted that there has been an increase in the number of Nearest Relative issues, namely the lack of them. The question was asked if the issue arises with a similar frequency in Tribunal hearings. The MHA Administrator explained that this was not known as they do not get involved with this side of the Tribunal Hearings. The MHA Coordinator explained about a new process that would automatically notify CMHT Teams of detained patients with no Nearest Relative, and that the patient would remain on the CMHT Teams list until either an NR was appointed or the patient was discharged.

It was agreed that the deputy chair was to collate the yearly compliments and recommendations into a report.

8 Committee and Sub Committee Feedback

The Chair explained that there was no feedback as the meetings have not yet occurred. Feedback will be provided at the next Power of Discharge Group.

The group were informed that there are plans for Care and Treatment training for clinical staff.

The Chair informed the group that the observations have not all been completed yet. However, to date there has been no negative feedback.

The group were told that one of the observers has now left their role and won't be observing in the future. However a Senior Manager and the Clinical Director will be involved in the next round of observations. This was welcomed by the PoD members.

9 Training

Decision Writing Workshop

The workshop is scheduled for the afternoon of 22 May 2019

Breakaway/SIMA Training

The situation is as described in the Matters Arising section

10 Any other business

The Chair relayed a situation where there was a difficult Hearing that resulted in discharge that occurred on the same day the MHA Office staff were absent. The group were informed that the MHA Manager had assured that this situation won't happen again and every effort will be made to ensure that a Managers Hearing will not be scheduled for the same day that the MHA Office will be closed.

One of the members wished to point out the amazing level of expertise that the MHA Office staff. This was accepted graciously.

The MHA Administrator informed the group of the recent All Wales MHA Forum. Specifically an issue was discussed of a private institution with sending reports via the post. From a data security point of view this is no longer acceptable, leaving the options of recorded mail or manual pickup from the MHA Office. Of the two members who will be affected, both agreed that the best course of action would be manual pickup.

One of the members raised an issue about data security post a Managers Hearing in an outlying site. The concern was that to get the outcome to the MHA Office they need to rely on the local admin staff who they do not know. Also, these same staff are the people who are asked to securely dispose of the patient identifiable data, however there was concern about whether this was being done correctly?

ACTION – MHA Coordinator to liaise with the outlying site Administration Managers to ensure correct process is being carried out.

11 Date of future meeting

To be held at 10:00 hrs in the Seminar Room, First Floor, HYC, UHL on 16 July 2019.