Bundle Mental Health Capacity and Legislation Committee 22 October 2019

Agenda attachments

00 - MHCLC Agenda v2.docx

1	Welcome and Introductions *Sara Moseley*
2	Apologies for Absence *Sara Moseley*
3	Declarations of Interest *Sara Moseley*
4	Minutes of the Mental Health and Capacity Legislation meeting held on 4 June 2019 *Sara Moseley* 4 - CAJ - MHCLC Mins 4 06 19 v2.docx
5	Action Log - 4 June 2019 *Sara Moseley* 5 - Action Log v2.docx
6	Chair's Action taken since last meeting *Sara Moseley*
7	Any other urgent business agreed with the Chair *Sara Moseley*
8	PATIENT STORY
9	MENTAL CAPACITY ACT
9.1	Mental Capacity Act Monitoring Report *Stuart Walker* 9.1 - MCA update report Oct 2019.docx 9.1.1 - Appendix 1 MCA supporting info Oct 2019.docx 9.1.2 - Appendix 2 - IMCA Report Oct 2019.docx
9.2	Internal Audit Report - Deprivation of Liberty Safeguards 9.2 - Depriviation of Liberty Safeguards Draft report v3.docx
10	MENTAL HEALTH ACT
10.1	Mental Health Act Monitoring Exception Report *Ian Wile* 10.1 - SBAR MHA Monitoring Report October 2019 - V2.docx
10.2	Section 17 Compliance *Ian Wile*
10.3	Health Inspectorate Wales Mental Health Act Report *Ian Wile* 10.3 - HIW Visits.pdf
10.4	Independent Review of Child and Adolescent Mental Health Service *Steve Curry* 10.4 - CAMHS Paper for UHB Board_260919_SMcL_v4 (003) and MHCLC.docx
11	MENTAL HEALTH MEASURE
11.1	Mental Health Measure Monitoring Report *Ian Wile* 11.1 - Mental Health Measure.docx
11.2	Care and Treatment Plan Update Report *Ian Wile* 11.2 - CTP Assurance Update Sept 19.docx
12	COMMITTEE GOVERNANCE *No items to report*

13 PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE

13.1.1 Hospital Managers Power of Discharge Minutes

Jeff Champney-Smith

13.1.1 - Minutes Power of Discharge Group 16 July 2019.docx

13.1.2 Mental Health Legislation and Governance Group Minutes

Robert Kidd

13.1.2 - Minutes of the Mental Health Legislation and Governance Group 18 July 2019.docx

13.1.3 Annual Review of Comments Raised by Members of Power of Discharge

Jeff Champney-Smith

13.1.3 - Review of comments raised by members of the Power of Discharge Group July 2018 - June 2019 report V2.docx

13.2 Review of meetinng

Sara Moseley

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

Friday, 21 February 2020, Coed y Bwl, Ground Floor, Woodland House, Heath, Cardiff

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE

Tuesday, 22 October 2019 at 10.00am
Coed y Bwl, Ground Floor, Woodland House, Heath, Cardiff

AGENDA

1	Welcome & Introductions	Sara Moseley
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4	Minutes of the Committee Meeting held on 4 June 2019	Sara Moseley
5	Action Log – 4 June 2019	Sara Moseley
6	Chairs Action taken since last meeting	Sara Moseley
7	Any Other Urgent Business Agreed with the Chair	Sara Moseley
8.	**PATIENT STORY**	
9.	**Mental Capacity Act**	
9.1	Mental Capacity Act Monitoring Report	Stuart Walker
10.	**Mental Health Act**	
10.1	Mental Health Act Monitoring Exception Report	Ian Wile
10.2	Section 17 Compliance	Ian Wile
10.3	HIW Mental Health Act Report	Ian Wile
10.4	Independent Review of Child and Adolescent Mental Health Service	Steve Curry
11.	**Mental Health Measure**	
11.1	Mental Health Measure Monitoring Report	Ian Wile
11.2	Care and Treatment Plan Update Report	Ian Wile
12.	**Committee Governance**	
12.1	No items to report	
13.	**Items to bring to the attention of the Board/Committee for Information**	
13.1	1. Hospital Managers Power of Discharge Minutes 2. Mental Health Legislation and Governance Group Minutes 3. Annual Review of Comments Raised by Members of Power of Discharge	Jeff Champney – Smith Robert Kidd Jeff Champney - Smith
13.2	Review of the Meeting	Sara Moseley
14.	**To note the date, time and venue of the next meeting:** Friday, 21 February 2020, Coed y Bwl, Ground Floor, Woodland House, Heath, Cardiff	

UNCONFIRMED MINUTES OF
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
HELD ON 4 JUNE 2019
NANT FAWR 1, GROUND FLOOR, WOODLANDS HOUSE, HEATH CF14 4TT

Present:

Charles Janczewski	CJ	UHB Vice Chair
Sara Moseley	SM	Independent Member – Third Sector

In attendance:

Julia Barrell	JB	Mental Capacity Act Manager
Rachel Burton	RB	Director of Operations, Children & Women Clinical Board
Steve Curry	SC	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Dr Peter Durning	PD	Interim Executive Medical Director
Nicola Foreman	NF	Director of Corporate Governance
Dr Jane Hancock	JH	Service User
Amanda Morgan	AM	Service User
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Head of Operations, Mental Health

Secretariat:

Glynis Mulford	GM	Corporate Governance Officer

Apologies:

Eileen Brandreth	EB	Independent Member - ICT
Kay Jeynes	KJ	Nurse Director – PCIC Clinical Board
Lucy Phelps	LP	Service User

19/06/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting. A special welcome was given to Peter Durning, Interim Executive Medical Director and Rachel Burton, Director of Operations for the Children and Women's Clinical Board.	**ACTION**
19/06/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/06/003	**DECLARATIONS OF INTEREST** Charles Janczewski declared his interest as the Chair of the Quality and Patient Safety Committee at WHSCC. Sara Moseley, Independent Member, declared her interest as Director of Mind Cymru and the Chair of the Crisis Care Concordat and Ministerial Assurance Group. The Committee agreed to the declarations of interest.	

19/06/004	**MINUTES OF THE COMMITTEE HELD ON 12 FEBRUARY 2019** The Committee reviewed the Minutes of the meeting held on 12 February 2019, and agreed that the following amendments should be made: • **MH: 19/02/10 - Mental Health Act Monitoring Report:** The second bullet point regarding section 136 should be rephrased "to adhere to the code of practice which was the Statutory Guidance". • The third bullet point should read "Chair of Crisis Care Concordat and Ministerial Assurance Group and the Board was unable to provide assurance in South Wales and the matter has been escalated." • **MH: 19/02/014 – Mental Health Monitoring Report:** First bullet point should read "the delivery unit audit of care and treatment plans". **The Committee resolved that:** a) subject to the agreed amendments being made, the minutes of the meeting held on 12 February 2019 should be agreed as a true and accurate record of the meeting.	
19/06/005	**COMMITTEE ACTION LOG** The Board reviewed the Committee Action Log and in reviewing the log the following comments were made: • **MH: 19/02/016 – Tier 2 CAMHS Update – Benchmarking Information:** The Chair asked when a CAMHS benchmarking report would be received at the Committee. In response, the Director of Operations for Mental Health stated he was not privy to any national benchmarking on CAMHS but noted that information in relation to young people under 18 admitted to a mental health adult ward was provided regularly to Welsh Government (WG). It was noted that the number of such admissions had increased with eight being admitted this year. The Independent Member- Third Sector advised that the admission of under 18s to an adult ward was a concern. Members were assured that Welsh Government transitional guidelines were in place and admissions had occurred due to the needs of the young person. It was noted that a number of beds were allocated for the admission of 16-18 year olds and clear standards had to be complied with. The Committee was informed that clinicians used their discretion and individual assessments to determine what was best for the young person. It was confirmed that there was a good relationship and close working with CAMHS which was responsive when a young person had to be admitted. It was recognised this was an all Wales issue and Welsh Government recognised that there were few alternatives. The Committee noted that the	

	situation would be reviewed once the CAMHS service was repatriated. • **MHCLC: 18/31 – Hospital Managers Power of Discharge Sub Committee Minutes:** The Chair commented on the status of this action and asked for greater clarity regarding its status. It was confirmed that this item related to issues raised in the Mental Health Legislation Governance Group. It was noted that the concerns raised related to care and treatment planning and a paper on this would be considered later in the meeting. The Committee agreed that the action should be noted as being complete. • **MH: 19/02/008 – Health and Care Standards – Mental Capacity Act Training:** It was confirmed that the Executive Medical Director had written to the Executive Nurse Director requesting that Mental Capacity Act training be embedded in the Health and Care Standards. The Committee agreed that the action should be noted as being complete. **The Committee Resolved that:** (a) The Board reviewed the action log from the meeting held on 31 January 2019 and the updates were noted.	
19/06/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's action since the previous meeting of the Committee.	
19/06/007	**PATIENT STORY** The Chair introduced Dr Jane Hancock and thanked her for coming to share her story and her experiences of using the UHB's Mental Health services. Dr Hancock provided the Committee with an overview of her struggles with depression that started when she was 15 years of age. As part of her summary, Dr Hancock outlined: • the impact that being caught up in the Moorgate disaster had on her mental health. • the importance of having a trusting relationship with your psychiatrist and those who were caring for you. • how family issues contributed to her deteriorating mental health. • the issues that had impacted on her ability to trust Mental Health Services and hence not wanting to engage with them. When asked by the Committee Chair what should change, Dr Hancock advised that in the first instance doctors should talk to patients and listen before reading their notes. Dr Hancock highlighted her concerns that if an earlier clinician had made an error in diagnosis that error would be	

	perpetuated if there was an overreliance on notes and not enough time spent talking to the patient. As part of the discussions that followed the Chief Operating Officer reminded Members of the presentation that the Mental Health Team gave to the Board that highlighted the way forward was to deliver services from the user's perspective. The need to address the issue on an individual basis was key. The Committee Chair thanked Dr Hancock for her presentation and reminded the Committee that the First Minister was clear that we should be asking the question 'what matters to you' and not 'what's the matter with you'. **The Committee Resolved that:** a) the patient story be noted.	
19/06/008	**MENTAL CAPACITY ACT MONITORING REPORT** The Interim Executive Medical Director introduced the report and confirmed that: • it set out the UHB's position in relation to the Mental Capacity Act. • training uptake was low amongst medical staff. While there were individual clinicians and service areas that had developed an understanding of MCA and complied with it, the position was not uniform across the UHB. It was noted that Advocacy Support Cymru (ASC), the statutory IMCA provider, had highlighted that there was a general lack of understanding and awareness across the UHB of, for example the Independent Mental Capacity Advocate (IMCA) role and the Court of Protection processes. • The Medical Director said that he would discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave. The Committee Chair advised that the approach was welcomed. **The Committee Resolved that:** a) the Mental Health Act monitoring report be noted.	**PD**
19/06/009	**DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) UPDATE REPORT** The Interim Executive Medical Director introduced the report and highlighted that: • the paper set out the position in relation to DoLs assessments. • the Partnership Review Board met on a quarterly basis and the report summarised its progress and provided a set of statistics that were self-explanatory. • the number of DoLs applications had increased significantly	

following the “Cheshire West” Supreme Court ruling in 2014, but appeared to be stabilising.

- the Deputy Executive Nurse Director had become increasingly involved with DoLs and this support was welcome.
- there remained a financial risk in re-negotiation of the DoLS funding equation. It was noted that the Partnership Board was looking at ways to mitigate this.
- Internal Audit’s DoLS Follow-up Audit had been deferred until quarter 4, 2019/20 to allow the process regarding the new DoLS signatories to bed in. It was confirmed that a paper setting out the signatories would be submitted to the Board for ratification.
- the Mental Capacity Amendment Bill had been enacted and DoLS would be replaced by a new system, to be known as Liberty Protection Safeguards (LPS).

The Committee Resolved – that:

a) the continuing arrangements for the provision of a DoLS service be noted and approved.

19/06/010 **MENTAL HEALTH ACT MONITORING EXCEPTION REPORT**

The Director of Operations, Mental Health Clinical Board introduced the report and noted that:

- during the period there had been no incidents of an individual being detained without authority.
- guidance on the implementation of changes to police powers and places of safety provisions in the Mental Health Act 1983 had been issued by Welsh Government since amendments were made to s.136 by the Policing and Crime Act 2017.
- the amendments reduce the detention period from 72 hours to 24 hours which could be extended under certain circumstances to a maximum of 36 hours. The main issue centred around the time that the detention period started. The Committee was advised that the non-statutory guidance issued by Welsh Government suggested a contrary approach is taken to that in the Code of Practice for Wales in relation to patients taken to A&E. It was noted that legal advice had been obtained that confirmed that practitioners should follow the guidance contained in the Code of Practice for Wales. The Committee was advised that the matter had been escalated to the UHB’s Chair for further consideration and action.
- the data provided in the report in relation to people being admitted to crisis care, was sparse. It was confirmed that the intention was to incorporate information on patients being signposted to other services in the next report. It was also noted that this was regarded as a priority as Welsh Government funding had been received to support the management of people in crisis. In addition, it was confirmed that there would be funding for patients known to secondary care services and presenting to crisis out of

hours who required support from the police.

The Committee Resolved that:

a) the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA be supported.

19/06/011 SECTION 136 PARTNERSHIP ARRANGEMENTS

The Director of Operations, Mental Health Clinical Board introduced the report and provided a detailed overview of the Mental Health Crisis Care Concordat, its origins and the way in which it was working in the Cardiff and Vale area. As part of the discussions that it was noted that:

- As well as supporting people in crisis, the focus of the Cardiff and Vale approach had been on the preventative agenda, with significant investment used from WG funding as well as local UHB funding support to provide mental health and wellbeing support to primary care practice.
- the Welsh Assembly Health and Social Care Committee had recently explored a number of issues with the UHBs in South Wales related to the crisis care agenda and the questions asked had been used as the framework for the paper.
- a Welsh Assembly Committee was undertaking a deep dive exercise to explore the crisis care issue and the UHB was contributing to the discussions.
- The responsibility to provide assurance to the concordat was shifting from sub regional arrangements and the South East Wales concordat meeting was chaired by Gaynor Jones from ABMU. The Health Board had their own arrangements but this had been delegated out to three health boards in South East Wales to share and support the arrangements. This included the police, third sector and local authority to support the discussions.
- It would be assessed against the completed revised concordat and would wait for an invitation from the National Assurance Group to report back nationally.
- One of the reasons people at a national board level agreed to the concordat was the Task and Finish Group asked to bring this together to encourage joint working, breaking down barriers and to learn from people nationally regarding what was / not working. The challenge in South Wales was the Health Boards who had different boundaries to the police. In shifting the focus towards the local Health Board, the challenge would be for this to be interagency led, focussing on the individual. The crisis of care was broad and covered a number of aspects and integrated with a number of pieces of work ongoing. In providing assurance and reporting upwards there was a need to think of the totality of what the concordat covered.
- There was a need to realise the level of mental illness and distress dealt with by agencies that in comparison the Health Service saw the tip of the iceberg. There was a need to send out

	the right message regarding the concordat's remit. A co-chair would be in place to provide balance and perspective to the group as this could not be achieved by looking at health alone. • In summary, the Chair stated the driver was around the assurance mechanism for the minister which needed to be monitored to ensure it was considered safe for everyone. This was a sensitive area and looked at South East Wales with Health Boards cutting across police boundaries. **The Committee Resolved that:** a) A Section 136 report would continue to be received and monitored by the MHCLC. b) an update be provided by the Director of Operations in six months' time	IW
19/06/012	**FEEDBACK ON MENTAL HEALTH LEGISLATION GROUP (MHLG)** As Mr Robert Kidd, Consultant Clinical Psychologist was unavailable to attend the meeting, Sunni Webb made the following comments: • Attendance was good and everyone found the Group valuable. The main aim was to continue to improve the patient experience. • It was recognised that a number of issues on the Groups agenda were also relevant to the Concordat and should be prioritised in the Concordat plan. It was confirmed that the Welsh Ambulance Service was part of Concordat group, and was invited to the MHLG. • The Committee Chair raised a concern regarding a section 136 patient who had been suicidal and not seen by the service for two months. It was confirmed that this matter had been reported to the senior nurse for the Crisis and Liaison Service but no feedback had been received. The Committee was advised that this case had been reported to the police and it was confirmed that an update would be brought back to next committee meeting. The Committee Chair asked for confirmation as to whether this constituted a Serious Incident that should be reported to the Welsh Government. **The Committee Resolved that:** a) the report be noted b) An update on the matter of concern be scheduled for the next Committee meeting. c) The Committee Chair receive confirmation of the status of the matter of concern be checked i.e. whether it was a serious incident that need to be reported to the Welsh Government.	SW SW
19/06/013	**MENTAL HEALTH MEASURE MONITORING REPORT** The Director of Operations, Mental Health Clinical Board presented the report and informed the Committee that:	

- the UHB was compliant with all aspects of the Mental Health Act measure for this reporting period including part 1a and 1b part 3 and part 4.
- Part 2 centred on the requirement to have a treatment care plan for every relevant patient in the mental health service and the UHB was not compliant in this area. It was noted that a Delivery Unit (DU) inspection of care and treatment plans had taken place across Wales and the UHB had been criticised alongside other health boards.
- the action plan discussed at the last meeting had been revised with the support of the local MDT. Objectives and timescales had been included in the action plan which was submitted for the consideration of the Committee.
- Care and treatment planning was about the therapeutic relationship with the patient; supporting service users, helping them address their needs and asking what outcomes they expected. It was noted that this work encompassed a range of actions which would span across 18 months. It was confirmed that the action plan would be brought to the Committee regularly.
- Within the action plan there was a need to develop a planned trajectory for improving performance against care and treatment plans. Members were advised of the two elements required from Welsh Government relating to compliance and the quality of the Care and Treatment plans being measured separately.
- The performance reports were being lifted from PARIS and the DU was reassured that there was a treatment plan available for every relevant patient.
- The Interim Medical Director asked if there was an analysis to what the barriers were to complete the outstanding 14-15%. It was explained that the figures related to:
    - service users and outpatients waiting for a long length of time,
    - those who had been discharged from the service or subject to 117 aftercare,
    - low primary care needs or
    - patients in secondary care for medication needs but did not require an MDT care plan.
- The Delivery Unit's work in relation to care and treatment plans had highlighted a need for cultural change and the importance of having information for patients and relatives and advising them of what treatment and care planning involved was valuable. It was confirmed that the UHB's audit process would continue to involve service users doing a dip test on how care and treatment plans were being actively used and how valuable they were to the individual.
- The Chair of the Powers of Discharge sub Committee commented that although the onus was on the nurse to populate the plan, responsibility lay on both sides for the contract of care.

- Due to staff shortages for the following quarter, part 1a would be breached for around 50%. This was a temporary situation and would not be complied with for a couple of months. The service would be back to full capacity and in compliance by July. The risks were low but the targets were taken seriously.

The Committee Resolved that:

a) the report together with the updated action plan be noted.

19/06/014 **DELIVERY UNIT ACTION PLAN IN RESPONSE TO CARE AND TREATMENT PLAN**

The Chair confirmed that as the Delivery Unit Action Plan had been discussed in relation to the Mental Health Measure Monitoring Report, the item should be noted.

The Committee Resolved that:

(a) the report be noted.

19/06/015 **COMMITTEE'S SELF ASSESSMENT OF EFFECTIVENESS**

The Director of Corporate Governance introduced the report and provided an overview of the findings arising from the self-assessment. It was noted that:

- going forward the assessment process would involve attendees and not only members.
- the action plan had been developed to help strengthen and improve the effectiveness of committee.
- consideration should be given to how the committee interacted with other Board committees.

The Committee Resolved that:

a) the results of the Committee's Effectiveness Review for 2019 be noted.
b) The action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review be approved.

19/06/016 **ANNUAL ALL WALES BENCHMARKING REPORT**

The Director of Operations, Mental Health informed members that the data collection for the annual benchmarking exercise had commenced.

The Committee Resolved that:

(a) The Committee noted the report.
(b)

19/06/017	**HIW MENTAL HEALTH INSPECTION REPORTS** The Director of Mental Health Operations advised the Committee that as yet no report had been received therefore no immediate assurance could be provided.	
19/06/018	**INHERITANCE REPORT FOR CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)** The Chief Operating Officer introduced the report and highlighted the following: • the report had been prepared following a 12 month project to repatriate CAMHS back to the UHB and highlighted the key issues that had been inherited from Cwm Taf UHB. • the Directorate Management Team had 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. Three areas of action to address these issues were proposed. • an independent review of the service had been commissioned that will provide an overview of how it compared to similar services across UK. It was confirmed that this report would be brought to the October meeting of the Committee. • it was emphasised that the key challenge the service faced related to a shortage of relevant skills and so consideration needed to be given to how to manage the service differently, for example by the provision of digital platforms. It was confirmed that Transformation monies had been made available and would be used to invest in young people and children services. • the Health and Social Care Minister had a keen interest in the service and the UHB was required to report to WG on its performance regularly. It was confirmed that the Minister had made it clear that the UHB needed to improve its performance as it had an impact on the performance of Wales overall. The Committee Chair confirmed that he was delighted that the service had been repatriated back to the UHB and acknowledged the hard work of all those involved. The Committee Chair also confirmed that the Board had asked for a deep dive review of CAMHS performance to be undertaken and confirmed that he would be happy to provide feedback to the Committee. The Committee noted that the Strategy and Delivery Committee had been asked to take on the responsibility of monitoring CAMHS performance and in particular intervention rates. It was noted that discussions were taking place in relation to the integration of CAMHS primary and secondary care at the Strategy and Delivery Committee. The Independent Member – Third Sector confirmed that she fully supported the integration of primary and secondary care CAMHS services and suggested that the Regional Partnership Board should be linked in to this work.	SC

The Committee Resolved that:

a) the status of the Specialist CAMHS service inherited by the UHB and the implications for performance be noted.
b) it be noted that a definitive trajectory for improvement would be developed over the coming months as the work on service redesign, productivity and recruitment is progressed further
c) the plans to review the service models and recruit to the existing vacancies be noted.

19/06/019 **HOSPITAL MANAGERS POWER OF DISCHARGE**

The Chair of the Powers of Discharge sub-Committee presented the report. The following comments were made:

- Concerns with the lack of activity in Hafan y Coed had repeatedly been raised. A mechanism was now in place which would be monitored.
- From the governance point of view the Group was happy with how well the observations proceeded and was pleased with the feedback.
- The Chair thanked Jeff Champney-Smith for his participation in the work undertaken and his reinstatement as Chair.

The Committee resolved that:

a) The reported be noted.

19/06/020 **REVIEW OF THE MEETING**

The Committee Chair facilitated a review of the meeting and Members agreed that it had been a very good meeting and the patient story had helped in setting the scene for the discussions that followed.

19/06/021 **ANY OTHER URGENT BUSINESS**

There was no other urgent business raised.

19/06/022 **DATE OF THE NEXT COMMITTEE MEETING:**

Tuesday, 22 October 2019, 10.00am Woodlands House, Heath, Cardiff CF14 4TT

ACTION LOG
FOLLOWING MHCLC COMMITTEE MEETING
JUNE 2019

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions In Progress					
MH 19/06/008	Mental Capacity Act Monitoring Report	To discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave.	Date to discuss at HSMB	P Durning	
19/06/011	Section 136 Partnership Arrangements	An update to be provide in six months' time	22 October 2019	I Wile	To be presented at the February 2020 meeting.
19/06/012	Feedback on Mental Health Legislation Group	To provide an update on section 136 patient who had not been seen for 2 months To inform Chair of whether this constituted a Serious Incident	22 October 2019	S Webb S Webb	Contact has been made with the patient who last attended his GP in May 2019. The Senior Management Team, Mental Health Officer and SWP concur that this is not an SI as the patient is not a missing person.
19/06/018	Inheritance Report for Children and Adolescent Mental Health Service	To provide a report on the Independent Review of the CAMH Service to the next Committee.	22 October 2019	S Curry	Report on agenda of October meeting *(see agenda item 4.4)*
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:**	**22/10/19**	
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 requested that information about the use of MCA within the UHB should be tabled at each meeting, in order to retain awareness of this issue.

REPORT

BACKGROUND

The Mental Capacity Act 2005 (MCA) has been in force for 12 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 in question. 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 UHB-wide sessions at various locations, every other month
- "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 using MCA. The MCA Manager also tries to ensure that other policies adequately and accurately reflect MCA where appropriate.

Additional information

Use of MCA within the UHB

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

Independent Mental Capacity Advocacy (IMCA)

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

UHB's Consent Policy – a revised version of this policy, which includes MCA, has been out for consultation. It will be tabled for ratification at a future Quality, Safety and Experience Committee meeting.

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 some way to go until MCA is embedded in clinical practice. This is also confirmed by Advocacy Support Cymru, the statutory Independent Mental Capacity Advocacy (IMCA) provider.

ASSURANCE is provided by:

This information does not provide direct assurance about compliance with MCA, which can only be done by scutinising 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:	~~Yes / No /~~ Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION
October 2019

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
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
1/4/19 – 30/6/19	34

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. However, it is clear that MCA is not embedded in clinical practice across the UHB, as some of the queries are basic – e.g. how to undertake surgery on a patient who can't consent because of dementia.

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

Referrals from the UHB to IMCA are as follows:

Decision/Issue	July – Sept 2018	Oct – Dec 2018	Jan – March 2019	April – June 2019
Accommodation	22	15	16	12
Adult Safeguarding	1	1	4	0
Care Review	2	4	1	3
Serious Med T/ment	9	8	7	8
DoLS s.39A	0	1	0	0
DoLS s.39C	0	0	0	0
DoLS s. 39D	3	11	8	8
DoLS RPR	28	60	30	65
TOTAL	**65**	**100**	**66**	**96**

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

3) Healthcare Inspectorate Wales (HIW) reports

There were 2 inspection reports about UHB services published by HIW in the period April to June 2019:

- **Vale Locality Mental Health Team** – this reported that Drs were not using the UHB form to record “mental health capacity assessments” [sic]

- **UHW A&E** – this stated –

If it were identified that a patient lacks capacity, and they required one-to-one care, therefore being deprived of their liberty, then staff must complete a Deprivation of Liberty Safeguarding (DoLS)[10] application. Staff should also make a referral to the independent mental capacity advocate (IMCA)[11], and complete an appropriate care plan to accompany this.

However, The Royal College of Emergency Medicine - The Mental Capacity Act in Emergency Medicine Practice states -

MCA DoLS generally applies to admitted patients within the hospital in the non-emergency setting therefore it is unlikely to be applicable in the ED.

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 Casebook for the period January – March 2019 contains 6 Cardiff and Vale cases that were either fully or partially upheld. MCA issues do not appear to be a factor in any of them.

The April - June 2019 Casebook includes 6 cases that were either fully or partially upheld. One case includes a complaint that a relative's best interests were not considered, but this aspect of the complaint was not upheld.

6) Staff MCA training as at 30th September 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 for this meeting are not broken down by Clinical Board, as they have been previously. It has been difficult for LED to provide the figures, compounded by the discovery that many clinicians have had their compliance recorded as MCA Level 1, when it should have been recorded as MCA Level 2.

The compliance figures remain disappointing, particularly amongst doctors, as MCA is a key part of the legal framework that governs the provision of treatment and care.

Prof Group	**No. required to undertake training**	**No. who have undertaken training**	**Compliance %**
Allied Health Profs	996	595	59.74
Nursing & Midwif	4280	2608	60.93
Medical & Dental	1460	204	13.97
TOTAL	**6736**	**3407**	**50.58**

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 April 2019 – June 2019 – 96 Referrals

- Serious Medical Treatment – **8**
- Long Term Move of Accommodation (LTMA) – **12**
- Safeguarding Vulnerable Adults – **0**
- Care Review – **3**
- Relevant Person's Representative (RPR) – **65**
- 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

- Issues around DoLS – The IMCA team continues to receive a high number of Relevant Person's Representative (RPR) referrals where family are actively involved and there is no clear reason as to why they have not been appointed to undertake the RPR role.

- IMCA was instructed in relation to a LTMA decision. P had been assessed as requiring nursing care, and it was felt that the current placement was no longer safe for him. A best interests meeting needed to take place around moving to a nursing placement, however, P was admitted to hospital with pneumonia before a meeting could take place. IMCA agreed with the social worker that they would visit P in hospital to ascertain his wishes and views about moving to a nursing placement, however when IMCA attended the ward, they were informed that P had been discharged to a nursing home that morning. IMCA raised concerns that the best interests process was not followed for P and the social worker had already arranged for P to be discharged to a nursing home without properly consulting with advocacy.

- IMCA appointed as the RPR for P who is currently an in-patient. P is objecting to being in hospital and is consistent in her wish to return home. P is adamant that she does not wish to consider any other placement options. A best interests meeting took place last month which P attended. In the meeting, it was established that it would be in P's best interests to return home with a 24-hour package of care. The IMCA raised concern that this had not been explored prior to the meeting and therefore, it was not clear as to whether this is a viable option. Therefore, how could this be determined as being in P's best interests? P continues to remain in hospital, and a new best interests meeting is due to be arranged. A question is raised as to whether the previous best interests meeting gave P false hope around going home.

Deprivation of Liberties Safeguards (DoLS)

Draft Internal Audit Report

Cardiff and Vale UHB

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1920-19
Report status:	Draft Internal Audit Report
Fieldwork commencement:	7th August 2019
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Management response received:	
Final report issued:	
Auditor/s:	Lucy Jugessur, Cara Vernon
Executive sign off:	Stuart Walker, Medical Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director
	Julia Barrell, Mental Capacity Act Manager
	Susan Broad, MCA / DoLS Co-ordinator
Committee:	Audit Committee

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

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

Disclaimer notice - Please note:

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

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

1. Introduction and Background

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

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

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

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

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

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

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

2. Scope and Objectives

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

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

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

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

3. Associated Risks

The potential risks considered in this review are as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

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

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

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

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

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

5. Assurance Summary

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

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

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

Design of Systems/Controls

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

Operation of System/Controls

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

6. Summary of Audit Findings

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

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

We note the following areas of good practice:

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

We did not identify any findings under this objective.

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

We note the following areas of good practice:

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

We identified the following findings:

- There are only 33 staff who have undertaken the statutory and mandatory training on DoLS.
- Audit was advised that a number of planned DoLS training sessions have had to be cancelled due to the number of employees that have

been unable to attend. It was reported in the DoLS Annual Report that only one monthly training session has taken place so far this year and all others have been cancelled due to non-attendance.

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

We note the following areas of good practice:

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

We did not identify any findings under this objective.

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

We note the following areas of good practice:

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

We identified the following findings:

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

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

We note the following areas of good practice:

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

We identified the following finding:

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

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

We note the following areas of good practice:

- It was identified in the previous Internal Audit review that there was a delay in the authorising of DoLS requests. As part of the current review

Audit selected a sample of 30 DoLS requests and all had been authorised in a timely manner. The Health Board has increased the number of senior staff that are authorised to approve DoLS requests.

We did not identify any findings under this objective.

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

We note the following areas of good practice:

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

We did not identify any findings under this objective.

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

We note the following areas of good practice:

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

We identified the following finding:

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

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 - Timescales for undertaking DOLs Urgent Authorisations (Operating effectiveness)	Risk
Audit obtained a report of all DoLS authorisation requests from January to July 2019 which included 230 urgent requests. A sample of 25 urgent requests was reviewed to establish if they had been completed in line with the required statutory timescales. Below are our findings: • 22 of the urgent requests had failed to be completed within the required 7 days. • The longest time it took to complete an urgent request was 26 days. For those 22 urgent requests not completed within 7 days it took on average 15 days to complete the urgent requests.	Patients may be unlawfully deprived of their liberties
Recommendation	**Priority level**
Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	**High**
Management Response	**Responsible Officer/ Deadline**

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

Finding 3 - Completion of standard and further authorisations (Operating effectiveness)	Risk
There were only 27 standard and further DoLS authorisation requests between January - July 2019 and therefore Audit reviewed three standard and two further DOLs authorisation requests to establish if they had been completed in line with the required statutory timescales of 21 days. For the three standard DOLs authorisation requests the following was noted: • One had been completed on the day it was received; • One had been completed in 26 days whilst the third had been completed in 85 days. • The average time taken was therefore 37 days. For the two further DoLS authorisation requests the following was noted: • One further DOLs authorisation request was completed in 21 days • The other request was completed in 24 days, just marginally over the required timescales for completion. There has however been an improvement in the number of days taken for the completion of standard and further DoLS authorisation requests as it took on average 80 days to undertake a standard and further DoLS assessment when we carried out the previous review.	Patients may be unlawfully deprived of their liberties

Recommendation	**Priority level**
Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 4 - Liberty Protection Safeguards (Operating effectiveness)	Risk
The new Liberty Protection Safeguards (LPS) are coming into force in October 2020. The law is already in place but the Code of Practice has not been produced yet detailing the process to follow. DoLS will be running alongside LPS for a year from October 2020 – October 2021. Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice being produced.	The Health Board is unaware of issues relating to DOLs compliance
Recommendation	**Priority level**
The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.	**Low**
Management Response	**Responsible Officer/ Deadline**

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

REPORT TITLE:	**MENTAL HEALTH ACT MONITORING**								
MEETING:	**Mental Health & Capacity Legislation Committee**						**MEETING DATE:**	**22 October 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 since.

Section 136
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.

Training

Power of Discharge Group
The annual All Wales Hospital Managers Conference funded by Welsh Government took place on 17 September 2019. This event was well received; feedback indicated that those present were extremely grateful for having the opportunity to meet other members from across Wales.

There was a 79% attendance rate with many making a significant journey from north/west Wales. The majority of those that left feedback rated the event Very good/good.

Receipt and Scrutiny
A number of sessions have been provided to Shift Coordinators who are responsible for the receipt and scrutiny of detention papers out of hours. A total number of 11 members of staff were in attendance. The training was well received and some of the positive feedback was as follows:

- *"Workshops are important to improve our knowledge and skills.*
- *I think S/C training should be given on/before staff engage in band 6/7 job.*
- *Training needs to be repeated yearly.*
- *Very interesting.*
- *Very good training for s/c and shows the importance of checking forms correctly.*
- *I think Band 5 nursing staff and above need regular MHA training."*

Preceptorship Pathway
14 Band 5 staff nurses attended and all feedback indicated that the session was good/excellent. Those in attendance are now fully aware of the Mental Health Act policies and procedures available to support them in their role. A further session is due to take place in December.

Mental Health Act Awareness
A monthly mental health awareness training day has been introduced to breaking the learning down into the following modules:

- Brief Introduction into Part 2 Detentions
- Mental Health Review Tribunals
- Hospital Managers hearings
- Consent to treatment
- Section 17 leave and AWOL
- Community Treatment Order
- Forensic Detentions
- Discharge

This session will be available to any colleagues who would like to attend, if they are unable to stay for the day and wish to learn about a specific area then they are welcome to attend a specific module. The first day is due to take place on 04 November 2019 and is already fully booked with 30 due to attend.

Cardiff and Vale Action for Mental Health (CAVAM)
A Mental Health Act Awareness session was delivered to CAVAM who support voluntary sector, service user, and carer involvement in the development of mental health services across Cardiff and the Vale of Glamorgan. Only four were attendance but this session was again well received.

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 (CoP), are monitored.

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

The following policies and procedures have been reviewed and are due to be ratified at the MHCB Quality and Safety meeting in October 2019:

- Mental Health Review Tribunal Procedure and Guidance
- Receipt of Applications for detention under the Mental Health Act Policy

A review of the section 117 policy is currently ongoing.

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 to 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	x

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:	No

NHS Mental Health Service Inspection (Unannounced)

Cardiff & Vale University Health Board

Hafan y Coed

Willow, Beech & Oak wards

Inspection date:

19 - 21 March 2019

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Hafan y Coed within Cardiff and Vale University Health Board on the evening of 19 March 2019 and following days of 20 and 21 March. The following sites and wards were visited during this inspection:

- Beech ward
- Oak ward
- Willow ward

Our team, for the inspection comprised of three HIW inspectors, one of which acted as lay reviewer. And three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found that Willow, Beech and Oak wards at Hafan y Coed provided effective patient centred care. However, we found that the health board did not always meet all standards required within the Health and Care Standards (2015), the Mental Health Act (1983), Mental Health (Wales) Measure (2010) and the Mental Capacity Act (2005).

There was evidence of good leadership on all three wards and within Hafan Y Coed as a whole. Staff had a strong sense of team ethic, and prioritised the care and rehabilitation of patients.

This is what we found the service did well:

- Staff on the three wards provided care to patients in a caring and professional manner
- Patient notes and care plans were of a very high standard
- Patient feedback was sought on up-to-date issues with a view to continuously improving the care provided
- The three wards had good leadership structures in place, supported by the organisational structure of Hafan y Coed

This is what we recommend the service could improve:

- Areas of Mental Health Act documentation require improvement
- Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed
- Inconsistency of information displayed for patients and relatives across the wards

- Areas of good practice employed on some wards are not shared with others to maintain consistency
- Some patients are sleeping out[1] from their designated ward due to additional demand and clinical need

[1] Sleeping out is where a patient is required to spend a night on another ward within the same unit. This is a clinical decision and is fully risk assessed taking into account the individual circumstances and needs of patients.

3. What we found

Background of the service

Cardiff and Vale University Health Board provides NHS mental health services at Hafan y Coed, Llandough University Hospital, Penlan Road, Penarth, CF64 2XX.

Our inspection concentrated on the three locality wards, these being:

Oak ward - A 17 bed mixed gender locality ward, all patients having their own room with en-suite. At the time of the inspection there were 25 patients listed on the ward, 3 being on Section 17 leave and 2 sleeping out on other wards.

Beech Ward - A 17 bed mixed gender locality ward, all patients having their own room with en-suite. At the time of the inspection there were 20 patients listed on the ward, 1 being on Section 17 leave and 2 sleeping out on other wards.

Willow Ward – A 17 bed mixed gender locality ward, all patients having their own room with en-suite. At the time of the inspection there were 22 patients listed on the ward, 4 being on section 17 leave and 1 sleeping out on another ward

The service employs a team which consists of between 11.4-13.13 whole time equivalent registered nurses and 12.19 whole time equivalent healthcare support workers on each ward. These include a ward manager, a deputy ward manager. Ten registered nurses and twelve healthcare support workers. The multidisciplinary team includes Psychiatry, Psychology, on-site GP and pharmacy. There is a central activity hub within Hafan y Coed where patients can benefit from occupational therapy and physio therapy sessions appropriate to their needs.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff treating patients with dignity and respect in a clean and clutter free environment.

Patients on the whole provided positive feedback on the care they received whilst at the hospital.

We had concerns around patients being required to sleep out on other wards, and the way in which this was implemented.

Staying healthy

Overall, patients told us that they were encouraged to maintain a healthy lifestyle. We were satisfied the service offered an increasing range of activities, support and services to promote healthy living. However, a large majority of activities including the gymnasium were off the wards and predominantly in the central activity hub area. Patient access to this was limited, based on staff availability and the clinical presentation of the patient at the time of their request.

Occupational Therapy and Physiotherapists are actively involved in arranging and running various activities. Dietician input is available for patients, and this is based on a referral made by the responsible clinician.

Each of the three wards had its own outside garden area. This area is an enclosed paved area, surrounded on all sides by the hospital. There is a small amount of furniture in the garden and a smoking shelter. The garden does not have a very pleasant feeling about it and appears quite intimidating with the buildings on all sides. It was also very untidy and unkempt, with weeds overgrowing much of the floor area. There was a significant amount of cigarette ends strewn on the floor.

The ward areas were clean and tidy, and the environments still had a new feel to them.

We saw a range of activities such as pool table, books and televisions available in some of the sitting rooms on the wards. Patients had access to drink stations on each ward to make hot beverages. Snacks were also available to patients outside of normal meal times.

We did not see any information displayed or the availability of leaflets advising on health promotion or how to maintain a healthy lifestyle.

Improvement needed

The health board must ensure that information is displayed and made available for patients to promote a healthy lifestyle

Dignified care

Overall, we were satisfied that patients were treated with dignity by the staff teams. The observation screens to allow staff to view the inside of each bedroom on all three wards were digital. There was a non-recording camera in each room relaying the footage onto a screen at the entrance to the room. These screens were operated by staff swiping their ID badges. When not in use they were covered by a metal panel. However, we saw a number of screens that were switched on, without the metal cover being replaced. Staff reported that some of these covers were faulty and would not remain closed. This issue must be addressed and rectified.

We saw that staff spoke with patients in a respectful and supportive manner. Patients seemed comfortable interacting with staff of all grades. There were individual en-suite bedrooms which had been personalised, taking into consideration patient and staff safety and welfare.

There were a number of communal areas which provided sufficient space for patients to have personal quiet time away from their rooms. There were several of these on each ward. Staff told us that they were able to control who could access each room remotely, as access was gained using personal electronic armbands issued to each patient.

We saw that all patients were addressed by their first names, according to patient preference. The three wards were mixed gender, they were not organised into male / female areas. However, each patient bedroom could only be unlocked by that individual patient, therefore this assisted in maintaining the privacy and dignity of each patient.

Improvement needed

The health board must ensure that the observation system on all wards is in full working order and screens are appropriately covered when not in use.

Patient information

In the reception area and entrance to each ward, we saw a selection of information for patients, relatives or carers which would aid understanding of specific mental health diagnoses.

Each ward had information leaflets regarding the facilities and arrangements offered. Patients told us they were satisfied that staff communicated information in a timely manner. There were however, inconsistencies in the level of this information displayed across the wards. There were a number of empty notice boards which could be utilised to make the presentation of this information more purposeful.

As part of the admission process to the hospital, all patients and nearest relatives are provided with information relating to their rights while detained under the Mental Health Act (section 132 of the Mental Health Act). This included information about the section of the MHA that they are detained under, consent to treatment and leave of absence. This information was regularly discussed and re-presented to patients and recorded in the patient notes.

During our inspection we saw advocacy services being utilised by patients from the three wards. We were assured by patients and staff that this service was considered very good. Advocates would often assist patients in understanding and communication during ward rounds and multidisciplinary meetings.

Visiting times on the wards are set but with some flexibility afforded where appropriate. Visiting outside of set times are pre-arranged, and the length of the visit can be adjusted based on the patients need and other factors such as, the distance visitors have travelled.

Improvement needed

The health board must ensure that relevant information is displayed appropriately and consistently throughout the three wards.

Communicating effectively

All patients told us that they understood what was happening with their care and had access to their Care and Treatment Plan. Patients attended multidisciplinary team meetings, and where appropriate worked with their key nurses to review and develop their care and activity plans.

There was a patient feedback questionnaire available for patients to complete, and the results from these were collated by senior management. They were regularly reviewed to take account of any issues raised on the wards. This formed part of the 'you said, we did'[2] process on the wards. Where applicable,some information provided in the questionnaires was treated as confidential.

All three ward managers had their offices within the confines of the ward. They were available to speak with patients where appropriate, and encouraged feedback. Patients we spoke with told us they were comfortable speaking with staff about incidents and issues. Patients felt they were listened to by staff.

Individual care

People's rights

Legal documentation to detain patients under the Mental Health Act, or to restrict patients leaving the hospital was completed to a high standard, and was compliant with the relevant legislation.

Patients could utilise the Independent Mental Health Advocacy (IMHA) service with a representative that attended the hospital regularly. Patients and staff told us that this service was utilised well.

There were suitable places for patients to meet with visitors on the three wards, along with arrangements in place to make private telephone calls. The visiting rooms however, had windows that looked out over the wards which could reduce the level of privacy offered

[2] https://www.gov.uk/government/publications/you-said-we-did-2014

Patients were allowed to bring personal possessions into the wards. However, items were risk assessed prior to storing in the relevant patient bedrooms. We saw that items which posed a risk to patient safety, or were not suitable due to lack of space in bedrooms, were stored in specific areas on the wards. These items were labelled and identified according to the relevant patient. Patients also had a lockable safe within their rooms, which was accessed using their electronic wristband.

Patients who were required to sleep out, did not have a personal area to store their belongings. Where patients were authorised to have restricted items in their usual ward, these were removed from the patient prior to the overnight stay, if the sleep out was on a more restricted ward. The rationale for this was provided to the patient, and then the items were returned to the patient, once they returned to their home ward the following morning.

Improvement needed

The Health Board must fully consider the impact on the rights of individual patients when there is a requirement for them to sleep out on a more restricted ward.

Listening and learning from feedback

As highlighted earlier in the report, we found that the unit had developed its own patient feedback questionnaire which was regularly reviewed to encompass patient views on up-to-date issues.

At the entrance to each of the three wards there was a 'you said, we did' board. These illustrated how the ward had listened to feedback and acted upon it where appropriate.

The individual ward managers were able to decide where and what information was displayed for patients. We found that there was some inconsistency across the three wards about what and how much information was displayed.

Each ward had a discharge tree where patients could leave feedback about their journey to recovery. We found that Willow ward utilised this where the leaves of the tree were still in situ with detail from past and present patients. We found this to be an element of noteworthy practice, for the benefit of existing and new patients. The tree on the other two wards had leaves removed and was poorly maintained. We advise that the remaining wards maintain their discharge trees, to ensure there is consistency across all three wards.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Staff on the three wards provided safe and effective care for patients. There were processes in place to identify patients' needs, and to maintain their safety whilst receiving an improving standards of care, from a motivated team.

We found some inconsistency in the processes being utilised on the three wards and recommend the sharing of good practice between the wards.

The garden areas are in need of maintenance to provide a therapeutic area outside for detained patients.

Safe care

Managing risk and promoting health and safety

There were processes in place to manage risk and maintain health and safety. All three wards provided individualised patient care.

The unit is relatively new and was purpose built as a mental health unit. The wards inspected were three of ten wards. There was a large spacious reception area with easy access to all wards and treatment areas, including easy access for wheelchair users and people with mobility difficulties.

There were regular Health and Safety audits carried out on the wards which included a ligature point audit. There was also a risk assessment in place for the ligature points.

The staff alarm system was sophisticated and accessible. Each staff member had their own alarm fob as well as numerous locations throughout the wards having alarm strips on the walls. There were protocols in place for reacting to alarm incidents.

The furniture fixtures and fittings on all three wards were appropriate to the patient groups. The wards were in a good state of repair, however, the décor throughout was generally bland. The senior management team were supportive

of ward managers presenting and implementing ideas to improve the wards' appearance.

Ward managers were able to adapt spaces within their specific wards for use by patients. On Willow ward, an activity room had been created from a sitting room where patients could access a games console, board games, books and a pool table, where appropriate. Access to this room was via the electronic arm band system and could be controlled by staff.

Fully stocked first aid kits were on each ward and all contents were in date.

Infection prevention and control

We found that all three wards were visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately. There were cleaning schedules for the wards and this work was carried out by health board domestic staff.

Patients were also encouraged to keep their personal spaces clean and tidy, as part of their rehabilitation.

We saw hand hygiene products available in relevant areas on the units and information displayed on the importance of using these. Staff had access to infection prevention and control and decontamination Personal Protection Equipment when required.

Nutrition and hydration

Patients were provided with meals at the hospital which included breakfast, lunch and evening meal. The weekly menu was available in each ward for patients to choose from. Some patients told us that the food was bland and the menu could become repetitive after a while.

Snacks and fruit were also available throughout the day. Patients were discouraged from storing any food in their rooms due to the risks associated with inappropriate food storage.

Patients were able to make hot drinks at the beverage stations on each ward. There was no facility for patients to securely store or cook their own food on the ward. Some patients told us that this is something they would like to see changed to afford them a little more independence.

Medicines management

We found that some improvement is required with medicines management, particularly with the securing of medication on the wards

The three wards had a designated room for secure storage and administration of medication which was locked. However, we found on Beech ward that the drugs trolley was not attached to the wall. Medication fridges on all the wards were left unlocked when the room was unoccupied but locked.

The patients' legal status was not always recorded on the Medication Administration Records, with some sections being recorded incorrectly. When medication had not been administered, on a small number of occasions we found that the reason had not been recorded.

We found that a hard copy of the medication management policy was not consistently held in the medication rooms across the three wards. However, it was accessible electronically.

Improvement needed

The health board must ensure that medication trolleys are secured to the wall and fridges are kept locked within the locked treatment rooms of each ward.

Safeguarding children and adults at risk

There were established processes in place to ensure that staff on all three wards safeguarded vulnerable adults and children. Safeguarding referrals were also completed if required. We saw evidence of the safeguarding process having been utilised, and a robust system of safeguarding management was shared with the health board as a whole.

Children were allowed to visit the hospital, however they were not permitted onto the individual wards. This was due to the visiting room on each ward being considered as part of the ward. There was not an appropriate room with books and toys within Hafan y Coed where parents could meet with young family members.

Improvement needed

The health board must provide an appropriate space where patients can meet with young family members at Hafan y Coed.

Effective care

Safe and clinically effective care

Overall, we found governance arrangements in place on all three wards, which helped ensure staff on both units provided safe and clinically effective care to patients.

Record keeping

Patient records were held in an electronic format and were password protected.

The system was well organised and very easy to navigate. We saw evidence of comprehensive needs assessments that fed into the care and treatment plan, underpinned by a dynamic risk assessment. Multidisciplinary team discussions and consideration of consent were also recorded.

Other risk assessments were also present covering nutrition, healthcare, falls, and Waterlow assessments[3], along with involvement of families and advocacy with the patient.

It was evident that staff on the three wards were providing a good level of assessments and monitoring of patients' well-being. The care and treatment plans were outcome focussed and comprehensive. Physical health assessments were undertaken on admission, and there was ongoing monitoring for this. We saw good use of recognised mental health and occupational therapy assessment tools with evidence based clinical practice. All patient interventions were appropriate to meet individual patient need, with clear details provided in the records. There was evidence of regular reviews of assessments and care plans.

[3] http://judy-waterlow.co.uk/waterlow_score.htm

We found evidence within the patient records of compliance with the Mental Health Act measure.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across the three wards inspected. It was evident that detentions had been applied and renewed within the requirements of the Act.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Where a Second Opinion Appointed Doctor[4] (SOAD) was used, a record of the statutory consultees' discussion was completed and kept with SOAD documentation.

Consent to treatment certificates were kept with the corresponding Medication Administration Record on two wards, however on Willow ward these are filed separately, which increases the potential for drug administration errors. Best practice allows for staff administering medication to refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

The health board's mental health act administration team ensured that patients were provided with their statutory rights under the Act, including appealing against their detention. There was evidence that patients were supported by the advocacy service. We found that the Mental Health Act monitoring paper filing system was difficult to navigate, because individual forms are not segregated into specific areas.

We noted that all leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. These forms were detailed and had been fully completed.

We found a number of issues with the Mental Health Act monitoring files we examined. These were addressed individually with the mental act administrator and are listed below:

[4] http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=816&id=112916

- Some expired section 17 leave authorisation forms had not been marked as no longer valid, in the patients' statutory folder, or on the PARIS system in accordance with chapter 27.17 of the code.
- Certificates that no longer authorise treatment or parts of treatment had not been marked as such, in the patient statutory folder or on the PARIS system in compliance with chapter 25.87 of the code.
- No evidence of patients' capacity to consent to treatment was documented by the responsible clinician, in accordance with chapters 24.29, 24.31, 24.34 of the code.
- An amended form CO2 was observed in the statutory folder of one patient.
- There was no record that the clinician in charge of the treatment had communicated the results of the SOAD visit with the patient in accordance with chapter 25.69 of the code.
- A form CO2 authorising treatment had not been completed by the current responsible clinician in charge of the patients' treatment and needs to be reviewed in accordance with chapter 25.84 of the code.

Improvement needed

The health board must ensure that consent to treatment records are filed with the corresponding medication administration records.

The health board must ensure that Mental Health act documentation is completed correctly, no longer required paperwork is marked as such.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of seven patients.

There was evidence that care co-ordinators had been identified for the patients and, where appropriate, that family members were involved in care planning arrangements.

On both units there was an extensive range of risk assessments completed, that set out the identified risks and how to mitigate and manage them. There were also good physical health assessments and monitoring recorded in patient notes.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training and were aware of their responsibilities regarding the Deprivation of Liberty Safeguards (DoLS). There were no patients detained under DoLS during our inspection

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

There was evidence of good leadership on all three wards, and the unit as a whole. Staff were confident in carrying out their roles to the best of their ability

There was an emphasis on improvement within the unit, to achieve the best outcomes for patients.

We saw a strong sense of team ethic from director level to operational staff working on the wards.

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that the three wards focussed on continuously improving their services to patients. This was, in part, achieved through a rolling programme of audit and established governance structures, which enabled key/nominated members of staff to meet regularly, to discuss clinical outcomes associated with the delivery of patient care.

We were made aware of the health board's Quality Checks in Health Care process, which is a peer review system utilised at Hafan y Coed. This produced detailed reports which helped to promote and achieve improvement in the three wards inspected.

There were ongoing issues with the health board's management and upkeep of the garden areas within the three wards. This is currently under review.

There was dedicated and passionate leadership from the ward managers, who were supported by committed teams, strong multidisciplinary teams and senior health board managers, who were based within the unit. We found that staff were committed to providing patient care to high standards.

It was positive that throughout the inspection, staff on all wards were receptive to our views, findings and recommendations.

Staff and resources

Workforce

The three wards had established teams that evidenced good team working. As these formed part of the ten wards within the Hafan y Coed unit, they benefited from the resilience and support provided by a robust resource management system, managed by the senior nurse on duty.

Staff were appraised annually and there were regular clinical and management supervision sessions for all staff. The staff we spoke with all felt empowered to share views on improvements that could be made, and felt supported to implement changes where appropriate.

However, senior ward staff expressed concerns about the reduction in the allocation of supernumerary management time from three to one day a week. We were told this has impacted on senior ward staff being able to complete additional duties required within their role.

There was a programme of mandatory training in place with a good level of compliance. Unit managers had responsibility for ensuring staff were compliant and that the recording and audit system was up to date.

Improvement needed

The health board must consider the concerns raised by senior ward staff in relation to the reduction of management time

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No Immediate Concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Hafan y Coed

Ward/unit(s): Willow, Beech, Oak.

Date of inspection: 19 – 21 March 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
There were no immediate assurance issues				

Appendix C – Improvement plan

Service: Hafan y Coed

Ward/unit(s): Willow, Beech, Oak.

Date of inspection: 19 – 21 March 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that information is displayed and made available for patients to promote a healthy lifestyle	1.1 Health promotion, protection and improvement	Advanced Nurse Practitioner for physical health will gather and display relevant information	ANP for physical healthcare	30 June 2019
The health board must ensure that the observation system on all wards is in full working order and screens are appropriately covered when not in use.	4.1 Dignified Care	1. Stickers have been placed on all ROS doors reminding staff to close them when not in use 2. All ROS systems have been serviced by Estates & Maintenance dept. 3. Local Estates & Maintenance staff are now trained and equipped to repair the	 Estates dept. Deputy Directorate	Complete Complete Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		system.	Manager	
The health board must ensure that relevant information is displayed appropriately and consistently throughout the three wards.	4.2 Patient Information	A digital camera is being purchased to enable staff photographs to be displayed on ward boards A review will be undertaken to ensure that there is consistency of information across the three wards. Ward notice boards will then be updated accordingly	Deputy Directorate Manager Senior nurse for adult in-patient areas	31 July 2019 End June 2019
The Health Board must fully consider the impact on the rights of individual patients when there is a requirement for them to sleep out on a more restricted ward.	6.2 Peoples rights	The Sleeping Out guidance will be reviewed and updated to include information that will be provided to patients. Currently the guidance includes: • factors that ward staff need to consider when reviewing patient caseload in order to determine the most suitable patients to transfer to a different ward • A requirement that patients are asked if they would be happy to	ANP for physical healthcare	30 June 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		sleep out and a clear policy that no patient is obliged to comply against their wishes Patient records are electronic and therefore fully accessible to any member of staff to ensure continuity of care. Ward staff on the "sleeping out ward" are encouraged to liaise with their colleagues for information and advice as required All wards are built to the same specification and as a result no patient will be accommodated in an inferior environment.		
Delivery of safe and effective care				
The health board must ensure that medication trolleys are secured to the wall and fridges are kept locked within the locked treatment rooms of each ward.	2.6 Medicines Management	Senior Nurse has reminded all staff of safe storage of medication. This has been achieved through email, ward managers meeting and the adult Q&S fora. This will be monitored by Senior Nurses	Senior nurse for adult inpatient service	31 May 2019 Review Sept

Improvement needed	Standard	Service action	Responsible officer	Timescale
		on an ongoing basis		2019
The health board must provide an appropriate space where patients can meet with young family members at Hafan y Coed.	2.7 Safeguarding children and adults at risk	1. Staff have been reminded of the purpose of the visitors room and to advice patients and visitors how to access this resource. 2. Review the visitors' room protocol to ensure that the necessary steps are taken to ensure a more child friendly environment is created. This must include the provision of suitable toys and books, taking in to consideration the necessary infection, prevention and control factors	Senior nurse for adult inpatient service	31 May 2019- 31/08/19
The health board must ensure that consent to treatment records are filed with the corresponding medication administration records. The health board must ensure that Mental Health act documentation is completed correctly, no longer required paperwork is marked as cancelled and legal documentation is	Application of the Mental Health Act	Senior Nurse for inpatients has reminded staff to file consent to treatment records with the corresponding medication administration records Forms that have been scanned and uploaded to the Paris system that have expired are manually marked as "no longer valid" when we receive the subsequent form.	Senior Nurse for adult Inpatient service	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
not amended.		There is a change request with the Paris Development team (CR6311) for this to be completed automatically to reduce the risk of human error. The MHA Office have procured rubber stamps and are now stamping hard copies of forms that are no longer valid. An automatic electronic notification is in trial. This will be sent to RC's daily and includes current and upcoming consent to treatment needs.		
Quality of management and leadership				
The health board must consider the concerns raised by senior ward staff in relation to the reduction of management time	7.1 Workforce	The Clinical Board is working with the executive team to increase the funded nursing establishment on the inpatient wards to enable additional supernumerary time for the ward managers.	Director of Nursing for Mental Health	Sept 2019

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Jayne Tottle**

Job role: **Director of Nursing for Mental Health Services**

Date: **31/05/2019**

Report Title:	**CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS): EXTERNAL REVIEWS, ACTION PLAN AND REDESIGN**							
Meeting:	**MHCLC**					**Meeting Date:**	**22/10/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√
Lead Executive:	**Chief Operating Officer**							
Report Author:	**Director of Operations, Children & Women's Services Clinical Board**							

SITUATION

The purpose of this paper is:

1. to appraise the Board of the recommendations of a Welsh Government Delivery Unit review of Primary Care CAMHS (PCAMHS) in Cardiff & Vale UHB (C&VUHB) and resulting action plan
2. to appraise the Board of the recommendations of an external review of Secondary Care CAMHS (SCAMHS) in C&VUHB
3. to present the Board with improvement trajectories relating to CAMHS
4. to present the Board with the broader service redesign intentions of the CAMH service which will support service improvement and sustainability

BACKGROUND

The CAMH service in C&VUHB comprises 45WTE staff providing services to citizens aged under-18 as follows:

- **Local Primary Mental Health Support Services:** mental health assessment for a child or young person, advice, training and targeted interventions in the community for children and young people with mild to moderate mental disorders.
- **Primary Mental Health Teams:** specialist CAMHS professionals who work with other agencies such as local authority children's and education services to provide initial consultation and advice, training, assessment and targeted interventions to young people and their families at risk of developing mental health problems.
- **Secondary Mental Health Services:** direct case management and treatment for young people with a moderate to severe mental health condition.

Specialist learning disability, substance misuse, CAMHS inpatients and out-of-hours on-call arrangements are provided under a service level agreement with Cwm Taf Morgannwg University Health Board.

Previous verbal and written reports at Board and Board subcommittees have described worsening performance against the tier-1 target associated with CAMHS. Like other Boards across Wales, and indeed the broader UK, C&VUHB have responded to national media coverage of growing demand for CAMH services and associated service delivery pressures. It was in this context that two external reviews delivered their findings: the Welsh Government Delivery Unit review of the C&VUHB PCAMH service was received in July 2019, followed by the report of an external review of SCAMHS in early September 2019.

The external review of SCAMHS was commissioned by the Children & Women's Clinical Board following the repatriation of the service from Cwm Taf Morgannwg UHB in early 2019.

ASSESSMENT

Purpose 1: to appraise the Board of the recommendations of a Welsh Government Delivery Unit review of PCAMHS in C&VUHB, and resulting action plan

This report was received in July 2019. In August 2019 the UHB were informed that the action plan formed in response to the review should be presented at a meeting of the Board.

The recommendations, action plan and timelines are presented at Appendix 1.

Purpose 2: to appraise the Board of the recommendations of an external review of SCAMHS in C&VUHB

The external review of SCAMHS was received in early September 2019.

Summary recommendations are presented at Appendix 2. An action plan and timelines are being developed by the team. The actions relating both the PCAMHS and SCAMHS reviews will be integrated into a single action plan going forward.

Purpose 3: to present the Board with improvement trajectories

Appendix 1 presents the timeline for improvements against specific recommendations from the PCAMHS review. The action plan being developed in response to the recommendations of the SCAMHS review will do similarly.

Children & Young People referred to CAMHS should be assessed within 28-days of referral. As referenced earlier in this paper this target has proved challenging for many Boards to deliver sustainably. Purpose 4 (below) will describe the service redesign intentions which will support this target being achieved sustainably. It is however important to appraise the Board of immediate operational actions being taken to support short/medium term improvement.

Appendix 3 presents the basic demand-&-capacity infrastructure for PCAMHS. These data demonstrate significant capacity/demand mismatches over previous months, resulting in deterioration in performance against the target. Increases in substantive staff, the procurement of locum staff and the procurement of a digital assessment solution are expected to address the capacity/demand mismatch in the short/medium term, thus allowing the headroom for medium/long-term service redesign.

Should the capacity increases presented at Appendix 3 be realised in Q3 2019/20, as expected, then improvement against the 28-day target is expected to be as presented at Appendix 4.

Purpose 4: to present the Board with the broader service redesign intentions of the CAMH service which will support service improvement and sustainability

Congruent with the objectives of ‘Shaping our Future Wellbeing,’ ‘Together for Children & Young People,’ and ‘Mind over Matter,’ the Community Child Health team have produced a vision for the transformation of Emotional & Mental Health Services in C&VUHB.

The team vision is presented at Appendix 5 and will develop iteratively in collaboration with multi-agency partners, children & young people and their families.

SUMMARY

- We have a received comprehensive external reviews of our PCAMH and SCAMH services
- We have a clear line of sight to improvements in infrastructure and performance
- We have a routemap to service transformation including improved integration between primary and specialist CAMHS, and between NHS services and those services delivered by our multi-agency partners
- We have a clear workplan underpinning the route to service transformation

ASSURANCE is provided by:

- Action plan monitoring by the Welsh Government Delivery Unit
- Action plan updates to the Clinical Board Quality & Safety committee
- Action plan updates to the C&VUHB Strategy & Delivery subcommittee
- Tier-1 target monitoring and performance management by Executive Team, with Chief Operating Officer as Lead Executive Director

RECOMMENDATION

The Board is asked to:

- **NOTE** the findings and recommendations of the PCAMHS and SCAMHS external reviews
- **NOTE** the action plan presented in response to the PCAMHS recommendations
- **ENDORSE** the broader service redesign intentions of the CAMH service which will support service improvement and sustainability

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	

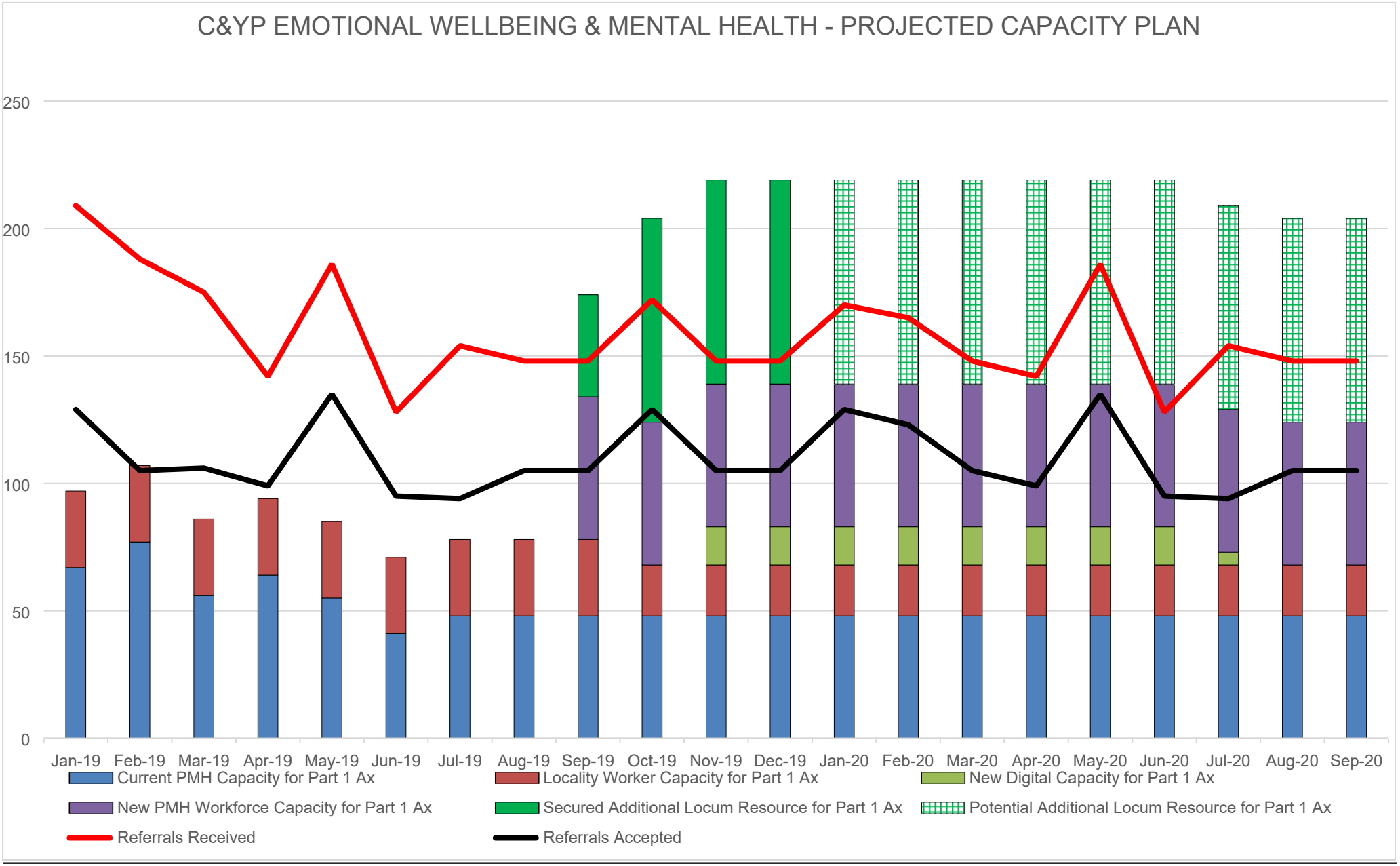
Appendix 1 - Recommendations of PCAMHS review, Actions and Timeline

		STATUS (2019)					
	RECOMMENDATION	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**PROGRESS AS AT 31st AUGUST 2019**
DU001	C&VUHB and the City of Cardiff and Vale of Glamorgan County Councils should develop a clear set of thresholds for assessment within PCAMHS, ensuring that the service is compliant with Part 1 of the Measure and provides timely access to assessment and intervention						~ Work is in progress as part of the Single Point of Access (SPoA) development. This includes developing a clear set of thresholds and communicating them ~ Each service who will form part of the SPoA is in the process of developing criteria which will form part of a simple guide for referrers which is planned for Nov-19
DU002	C&VUHB should work with representatives of General Practice in Cardiff and the Vale of Glamorgan to ensure that thresholds for PCAMHS, together with referral requirements, are clearly communicated, understood and followed by staff in PCAMHS and General Practice. Particular attention should be paid to meeting the needs of C&YP in a crisis, and to the potential to offer GPs provision of e-advice						~ Planned attendance at a number of community services meetings to communicate referral process and service offer in Oct-19 ~ Development of SPoA comms and service offer booklet to be launched when new telephone line goes live in Nov-19 ~ Monies received from the successful bid for developming an augmented (clinical) SPoA will support an improved referral process and provision of consultation and advice for GPs and other referrers
DU003	A disconnect is evident between PCAMHS and SCAMHS. The planned review following repatriation of SCAMHS by C&VUHB should be undertaken, ensuring that it addresses the use of a whole system and enables flow into and from PCAMHS						~ Whole System Model developed and currently being mobilised ~ Part-implementation of the SPoA has already supported a more integrated approach to service delivery and referral management: the further (clinical) SPoA development identified will improve this further ~ The recommendations of the SCAMHS review will be integrated with the recommendations of the DU review in order that the improvement work required addresses the actions of both reviews in tandem rather than in isolation ~ Further work will be done in Q3/Q4 to joined up clinical pathways for patients with mild to severe presentations
DU004	The service has an extensive waiting list for therapeutic interventions. Greater emphasis needs to be placed on undertaking intervention work within PCAMHS, in order to more appropriately balance assessment and intervention functions						~ Significant progress has been made with the intervention waiting list which has reduced to <30 and with all patients having appointments booked in Sept/Oct/Nov ~ List of patients who have waited for long periods expected to be cleared to zero by November 2019 ~ New model of intervention delivery and recording has been implemented. Waiting times per therapeutic modality, and capacity to deliver the interventions will be monitored and escalated against defined triggers
DU005	C&VUHB should establish agreed standards for the recording of assessments undertaken within PCAMHS. The electronic recording system should be used as the sole record. Compliance with these standards should be regularly audited by PCAMHS managerial staff						~ Significant work underway with PARIS to ensure that patient data is entered, managed and monitored through the PARIS System singularly ~ Clinical Lead will ensure assessment is fit for purpose and updates to PARIS will be made accordingly
DU006	C&VUHB and its partner organisations should ensure that suitable clinical environments are available in which to assess and provide interventions to C&YP						~ Work underway to review accommodation utilised for clinical delivery ~ Working with Localty Managers to identify additional space, with some potential space already identified in Llanishen and/or Barry, awaiting confirmation with UHB estates and planning that the space can be allocated to the team

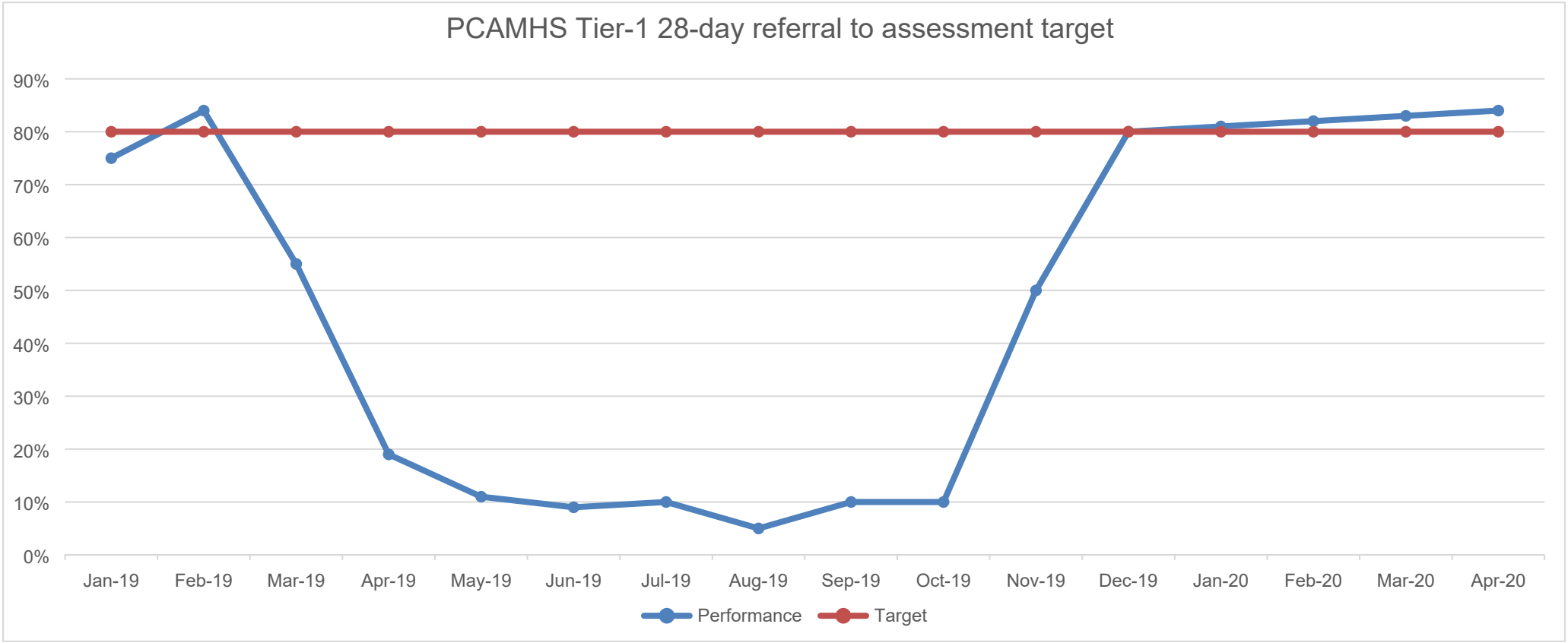
Appendix 2 - Summary recommendations of SCAMHS review

Service capacity	• Recruit creatively to full capacity • Focus on the top-15 highest referring GP practices and top-15 highest referring schools to enable learning and/or support • Initiate a clinical review/triage of the current waiting list • Aim to raise the overall caseload levels for generic SCAMHS clinicians to align with the national average, trialling a reduction of appointment length • Investigate and address the reasons for the high level of service-related cancellations of appointments • Implement a text reminder function as part of the phase 2 IT implementation in November 2019
Patient flow	• Single Point of Information – overhaul the current webpage with service user/carer/stakeholder representation • Single Point of Access development • Develop and agree service-wide processes for reviewing cases not responding to or engaging with therapy
Service delivery and clinical pathways	• Develop Whole System Emotional Wellbeing Mental Health Strategy for Cardiff and Vale • Define complete and comprehensive operational procedures – define roles and responsibilities for each of the functional silos • Consider increasing the availability of group sessions • Undertake a comprehensive data cleansing process to effectively optimise service demand and capacity management based on reliable data • Increased outreach focus - explore options to operate from locations in other parts of the city
Choice and Partnership Approach (CAPA)	• Job plans – individual clinician and team job plans to be formed and shared across the service • Move from model underpinned by professional titles to one underpinned by core competencies • Formalise the role of a CAPA manager
Staffing mix	Consider developing the following skillsets or roles: • Eating Disorders clinical lead: to take ownership of and responsibility for the Virtual Eating Disorder team • Systemic/Family therapy: clinicians and external stakeholders perceive that a greater level of family therapy required • Interpersonal psychotherapy: for working with depression in adolescents • Creative approaches: such as music, art, drama therapy for working with younger clients • Coaching: specific training for coaching clients through goal-setting and behavioural changes Specific professions / teams: All clinicians: • Develop a workforce development plan based on defined core competencies and skills • Consultation session once per month sharing between the PCAMHS and SCAMHS services • Clinical supervision: could be delivered thematically, systemic, CBT, etc. Nurse clinicians: • Clinical leadership development training • Nurse prescriber training • Recruit additional Band 5 RNs as a long-term solution to the recruitment and capacity challenges, including a career pathway with overt leadership and skills development training Medical clinicians: • Formal medical clinical supervision/CPD • Consider competency-based role redesign as part of the broader MDT work Admin: • Training in basic therapeutic skills / conflict resolution / de-escalation

Appendix 3 - PCAMHS demand/capacity infrastructure



Appendix 4 - PCAMHS 28-day assessment target trajectory



Appendix 5 - Service redesign intentions of the CAMH service

Strategic Vision for and Transformation of Emotional & Mental Health Services

1 Underpinning principles

- Child Rights approach
- Coproduced services
- Multiagency response
- Focus on early intervention and prevention
- Easy and timely access to appropriate

2 NHS Mental Health Services for Children and Young people delivered through a single point of access to include:

- Specialist CAMHS
- Primary Mental Health
- Emotional wellbeing service
- Consultation and advice
- Digital Platform

Neurodevelopmental Assessment services which are delivered as a shared Community Child Health/SCAMHS model will also form part of the single point of access model.

3 Family Help and Support Services

Embedded mental health workers as part of the family advice and support services in Cardiff, and Families First advice line in the Vale of Glamorgan, providing support to the wider team. These will act as 'trusted referrers' to the NHS CAMHS services.

4 A locality wellbeing approach with skilled mental health workers providing consultation and advice and a conduit to NHS mental health services.

The locality model will work with Primary care, Schools, School Nurses, School counsellors, 3rd sector organisations, 'not for profit' social enterprise and community assets to deliver early support and access to Mental Health NHS services if required

The locality approach will work in partnership with other services to provide consultation and advice. It will deliver training and development activity to support other services to identify early signs and highlight appropriate routes to access early help.

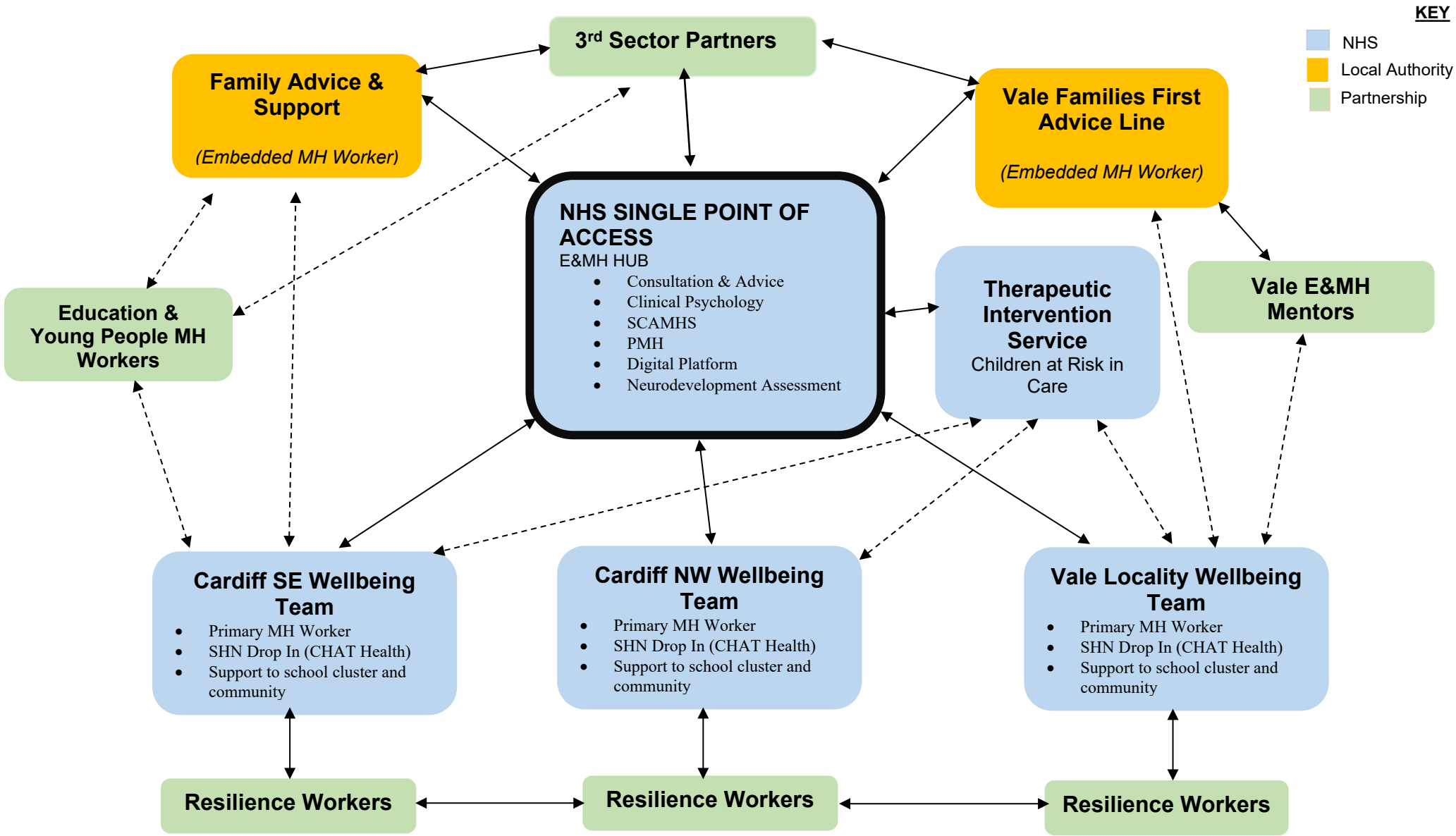
This model supports a whole school/community approach which is congruent with 'Mind over Matter.'

5 Adverse Childhood/Developmental Trauma

Psychologically-led universal work with Education wellbeing teams and schools, building ACE aware behavioural approaches through Transformation.

A Psychology-led therapeutic and evidence-based intervention service for children 'on the edge of care,' 'in care,' and those in the adoption system, working in partnership with Social Services and Education.

Cardiff & The Vale of Glamorgan: Emotional & Mental Health Support



MILESTONES

ACTION	STATUS										PROGRESS
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	
Single Administrative Point of Access for referals and multidisciplinary triage											In place
Resellience workers supporting Adverse Childhood Experiences embeddd within Clinical Psychology and Education Wellbeing teams											Staff in place and mobilising
Open Access Early Support commissioned: Change-Grow-Live											In place
Chat Health text advice service for young people in place											Launching September 30th
Digital platform for Assessment and Intervention available as a clinical option											Contract awarded, mobilising and agreeing pathway with a view to first patients seen November. Information sharing arrangements being finalised
Psychology referrals to be routed through the SPOA											Recuitment to commence September
School Nurse wellbeing drop-in sessions in schools											Recuitment to commence September
Link to Councils Early Help services through Embeded Mental Health Workers , with 'trusted referral status' to NHS SPOA											Recuitment to commence September
Link to Education and Youth Services. Mental Health workers funded through Youth Wellbeing Grant											Youth Service grant funding agreed - awaiting formal confirmation letter
Clinical Psychology Parent Support Worker in place as part of SPOA											Recuitment to commence September
3rd Sector service commissioned (Parent Support)											SLA to be written with 3rd sector Health and Social care facilitator
Full Administrative and Clinical Single Point of Access (SPOA) in place											Recuitment to commence September
Delivery of consultation and advice through SPOA											Recuitment to commence September
Therapeutic team to support to Children in Care in place											Recuitment to commence September
Website and Information development											Support needed to do a focused piece of work on this. Funding available in year

Emotional & Mental Health Service **HOW DO I GET HELP?**

FOR MY PATIENT

Refer to the NHS Single Point of Access for all routine referrals via the Welsh Administration Portal (WAP). You can also ring for clinical advice on Tel: __

FOR MY CHILD

Cardiff - Contact the Family Advice and Support Service on Tel: ____
Vale of Glamorgan– Contact the Families First advice line on Tel: _____

These services have trained mental health workers who can refer to the NHS Mental Health Services if required.

FOR MYSELF

Speak to your school wellbeing worker, youth worker, or school nurse. If they are unable to help, with your consent, they will discuss with a Mental Health worker who will help you to get the right service for you. You can also self-refer to the Emotional Wellbeing Service 0800 008 6879 or emotionalwellbeingservice.org.uk.

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. In recent months the data collection pressures on Mental Health have increased which together with changes to local protocols for community teams have led to data assurance issues which are also detailed in this paper, with proposed solutions.

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. In 2019, there have been changes to data collection requirements as well as practice policy which have presented data assurance challenges to the MHCB as well as the UHB. These include:

- Part 1a – Target 80% - no data collection issues
- In relation to Part 1b of the measure, (Target 80%) MATRICS CYMRU has provided an evidence base for lower level psychological interventions which has required a greater diversity of therapies for inclusion in the PMHSS service, creating challenges to provide them on a 56 day cycle within current resources. In addition there has been clarification required on when an intervention commences. This has now been clarified with the

delivery Unit and the Clinical Board has taken a position with the definition – this is reflected in a re-run of the reports.

- Part 2 – CTP Target 90% – It has been recognized that the ability of PARIS to accurately report valid and service user specific care plans is unreliable to the degree that the measure requires and additionally there has been allied practice changes described in the new RAMP policy that recognises service users in MH who do not meet relevant status under the Measure. For the short term there is a requirement to manually collate the information through a sample and audit process to be agreed with the Delivery Unit. This is not sustainable and requires additional resource which is being sought.
- Part 3 – the requirement for an assessment outcome letter of a re-referral assessment within 10 days. Due to an increase in Part 3 referrals this requires an electronic solution. PARIS are working to establish a reliable process for recording follow up letters which clinicians and administrators to clinical teams can understand and work with.
- Part 4 no issues

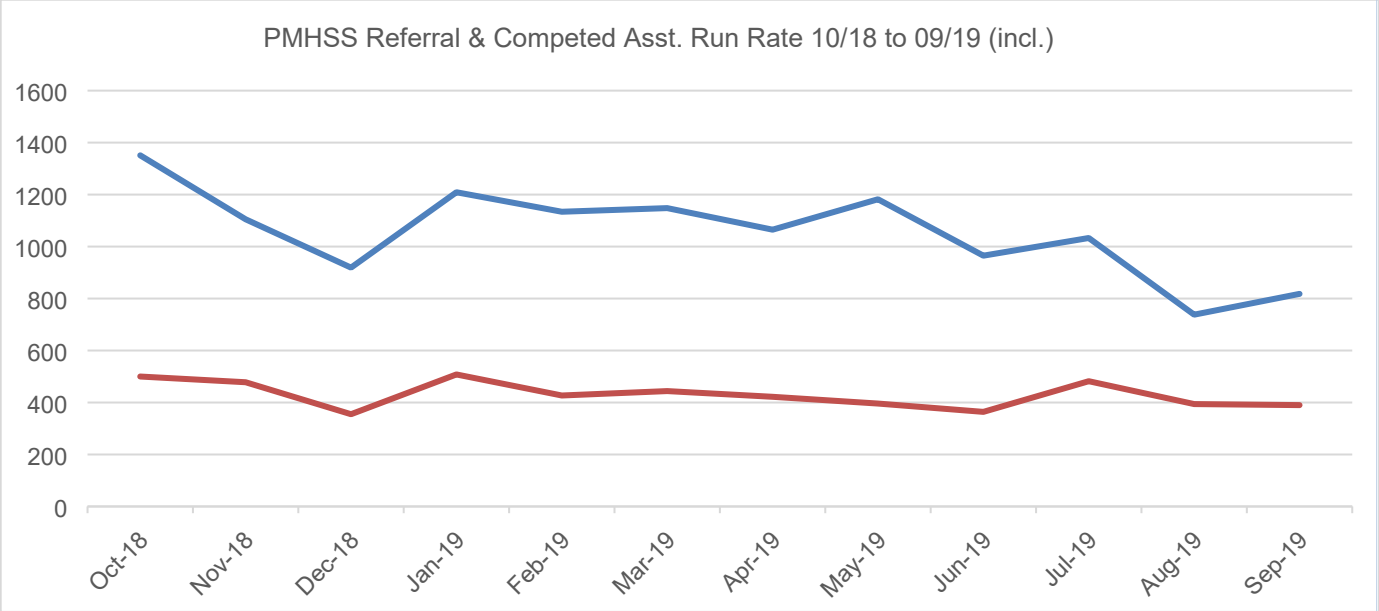
ASSESSMENT AND ASSURANCE

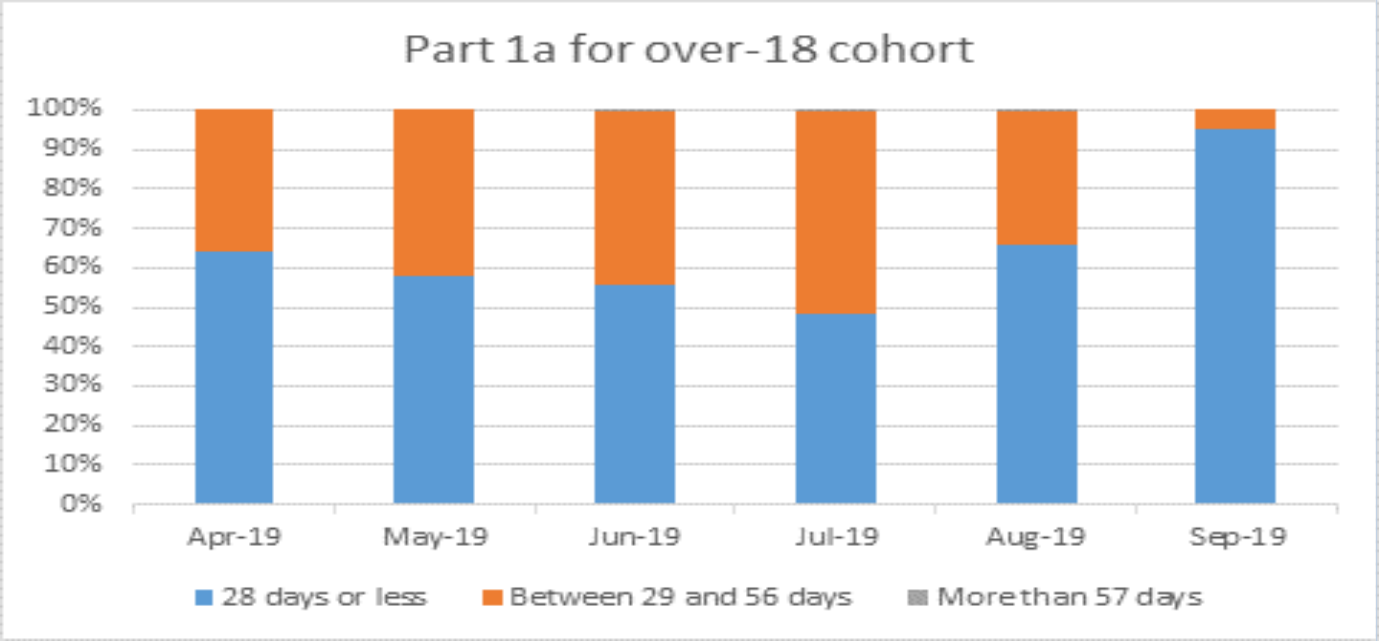
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

Part 1a – 28 day referral to assessment compliance target of 80%

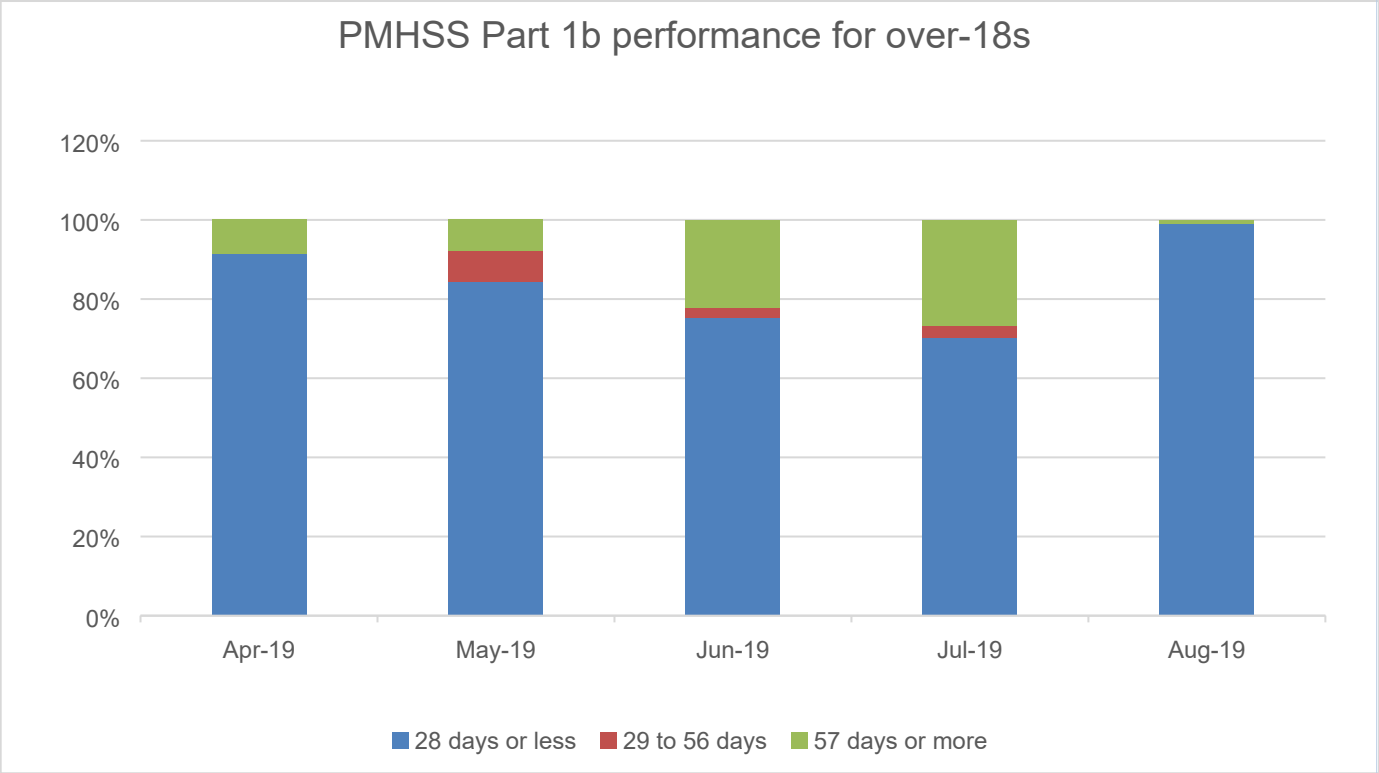
Referral activity over the past twelve months has seen a period of general decrease particularly in the last quarter most likely due to the establishment of the Primary Care Liaison Service. Completed assessment rates have similarly declined slightly but have started to level out over the past six months essentially due to having filled all four Band 6 posts vacated earlier in the year. Said period of reduced capacity has obviously had an impact on Tier 1 targets with much of 2019/20 reporting breaches in the Part 1a target. Of note is during this period of non-compliance the average waiting time for Part 1 assessment was at most 35 days. Subsequently we will report compliance in September and are on target for October. Barring huge spikes in referrals (as per October '18) or an exodus of staff (as per early '19), I am confident we will be able to maintain this performance for the over 18 cohort.





Data Issues – None Currently

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



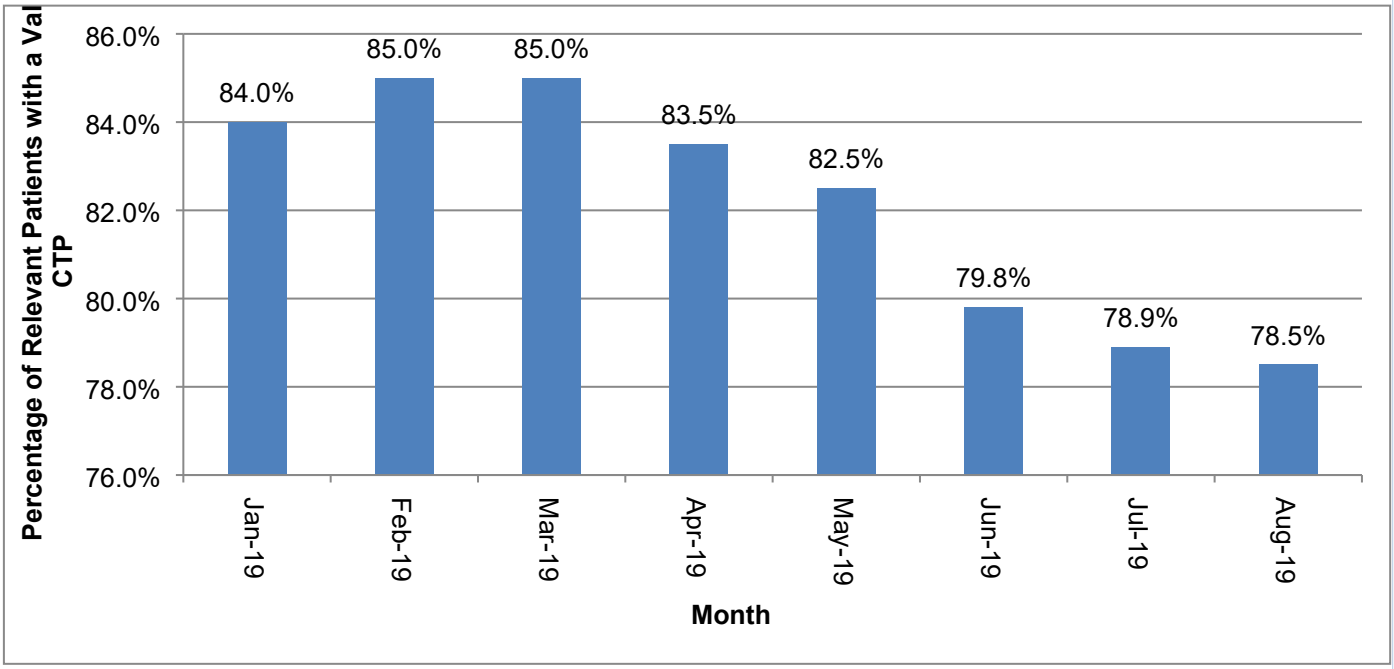
Data Issues/ Solution:

The team leader of PMHSS has clarified with the WG previously through the national community of practice meeting for the PMHSS element of the Measure that preparatory information and advice given in advance of face to face intervention is the beginning of the therapeutic intervention and is within the RTT rules for this activity target.

In the meantime the Clinical Board's position will remain as the above and PARIS has now developed a reliable process of reporting this - With this changed in the report it's taken us from 58% to 96% currently. This report is re-run retrospectively.

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

This standard requires a valid care and treatment plan for all 'relevant' service users on secondary care mental health caseloads - target 90%:



Data Issues/solution

The C&V MH service has had an electronic patient information system for a number of years which has been utilized for the purpose of data collection. This has not been ideal in that often duplications of patient's records and care plans are generated as patients pass through different teams in the service which can skew results. These have been cleansed routinely. In addition C&V MHCB has recently changed its position on how identify 'relevant' patients on our secondary care caseloads as there are growing cohorts of individuals who do not meet relevant status with sufficient complexity or seriousness of need to require MDT to support them. These patients are to be re-categorized in the service as Part 1 with an enhanced monitoring service for them as described in the associated new policy RAMP. Additional challenges have been identified with the record of the care plan being 'valid' – ie reviewed within an adequate time period or at least 12 months. The PARIS team have only now identified a process of data collection for this.

Due to the concerns over its data collection ability for the forthcoming period, manual data collection of activity for Part 2 of the Measure will likely commence in October 2019 where 50 sets of patient records, 15 from MHSOP and 35 from adult services will be audited for those 2 elements. This has been decided in conjunction with the Delivery Unit:

- That one exists for people who meet relevant status

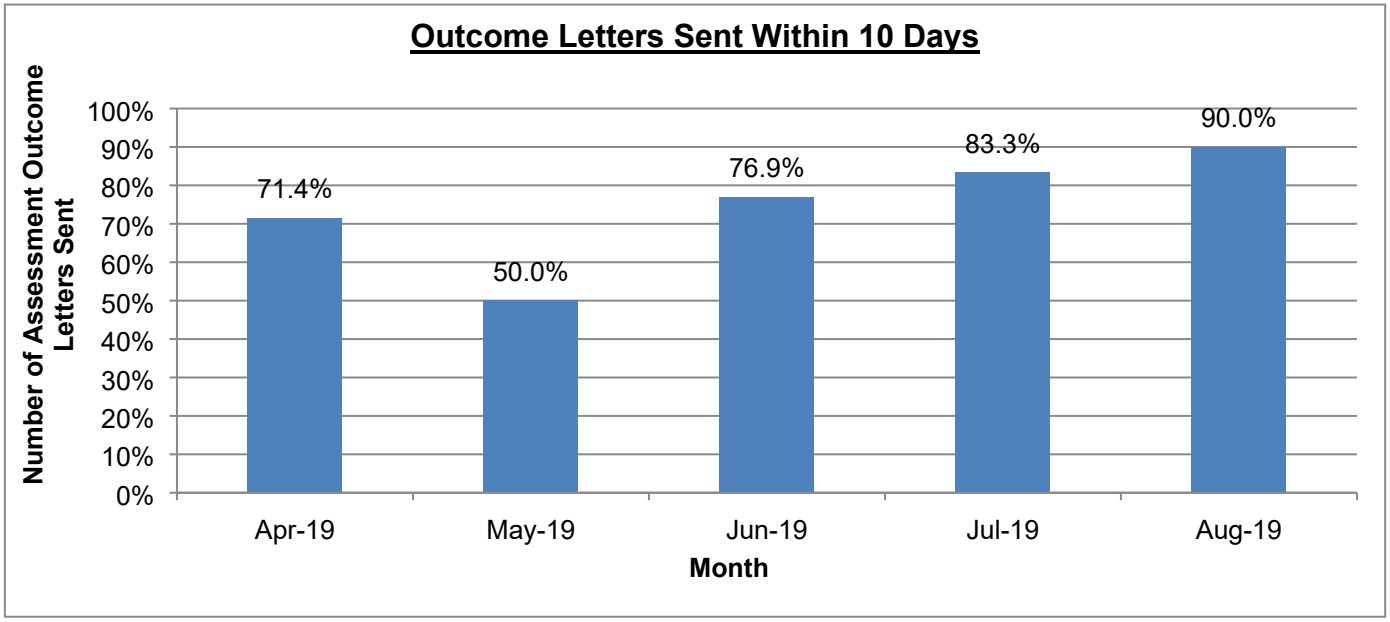
- Its valid

All data collection is undertaken through an additional responsibility given to the minimal PARIS resource and/or current admin posts in mental health.

In terms of the quality of CTPs please see attached the CTP Improvement/Assurance Action plan

Part 3 - Right to request an assessment by self –referral - (The target relates to service users who have self referred, having a confirmation letter regarding the outcome of their assessment within 10 days).

The below chart details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.



Data Collection Issues - In monitoring Initially the numbers seen by Cardiff and Vale were very small and manual data collection was possible. More recently in early 2019 the increase numbers require an electronic monitoring solution due to the resource required to manually collate. This has been allocated to an administrative post in the mental health act office. There is assurance that the date collection method now established is accurate but resource intensive. In August 2019 the service is compliant.

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

Part 4 continues with 100% Compliance.
There has been a slight reduction in activity from Quarter 1 to Quarter 2 but remains consistent with previous years for the second quarter. The advocacy contract is due for renewal in December 2020 and Procurement through Shared Services has begun the first round of discussions with all Health Boards.

Data collection issues - none

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:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Care & Treatment Plans

October 4

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)	Establish an education and training sub group and package which includes a guide to CTP use and development and the following characteristics: • 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 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.	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 Project Support - Dan Crossland – Community Transformation Lead Training and Education subgroup established – November 2018 – Chair – I wile – Director of Ops – to establish CARE AIMS Training provider and coordinate a training plan	**Update September 2019** – Care Aims training bid to the WG approved in August 19 – to commence roll out to all staff including 3rd sector and LA from January 2020 for 12 months. LA made available a number of training places for UHB MH staff on strengths based care planning which was attended by a number of key staff. Clinical and Caseload supervision (and hence CTP on the job training) for all disciplines within community and inpatient services is being established through the CTP audit and feedback processes and the PDSA cycle – this has commenced in the Vale Locality MH team in 2019, with 2 of the 5 Cardiff community teams adopting caseload supervision. RAMP pilot commenced in the Vale in September 2019 with allied staff awareness training - which includes an improved understanding of the care process and CTP competency.

	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	Comms regarding action plan – April – August 2019	X2 WG Pilot sites in C&V for well being outcomes development in clinical practice commenced in the summer '19 as 3 year project – this will support staff to understand care processes and consequently CTP production Operational policy for cmhts currently under review – to strengthen elements related to roles and responsibilities for completion and monitoring of CTPs
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.	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 Deliver Risk Assessment & WARRN training in sequence with CTP training to 75% of staff in next 2 years (90% of registered nurses within that) Audit compliance every 4 months	Review of Documentation between March 2019 and August 2019 – ANP Will Adams 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 Line management audit leads for all clinical areas in adult services to agree audit	March/April – 2019 Team of 5 part time WARRN trainers established who are tasked with simplifying the risk assessment and risk management documentation This team has commenced WARRN training and are on target. All line managers appraised of their responsibility to provide audit data to their respective directorates in the times agreed. **Update Sept 2019 –** numbers of trainers now increased to 10 with sessions provided fortnightly to groups of upto15 staff – on target for 90% compliance in 24 months

	alongside CTP audit (Delivery Unit Audit Tool) and feed-back to the steering group, MHCB Q&S Committee and report into the MHLC.	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	
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.	See training notes in no. 4 above. Continue to circulate lists of clients with 117 after-care responsibility to the integrated managers for use with MDT reviews For Community service leads to develop a process of reminding case managers of review times which could include a PARIS flagging process. Develop a caseload supervision process to regularly support practitioners with caseload management and standards of clinical practice records including CTPs.	Ian Wile/Sunni Webb Leads – lists go to Community Leads/Managers in Adult and MHSOP community Teams bi monthly Community Senior Nurse Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019 Community Senior Nurse	Completed and routinely working – on a bi-monthly basis. See above for audit requirements **Update September 2019 –** routinely practiced – electronic flag now on PARIS system to indicate when annual review is due. Audit indicates that there is a steady improvement in reviews completed Currently undertaking a workforce exercise in redefining leads roles in the community and accountability for the measure and audit responsibility

	See 2 for CTP Audit Actions	Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019 All above	
4 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.	A draft plan is: To arrange for local third sector agencies to those community services to have formal pathway links with the local statutory services. For relevant local third sector agencies to have a presence in Community teams. To include within the core mental health assessment a question exploring the input of any third sector support. To ensure advocacy services area available where required.	This is a challenging plan with a meeting/event planned with the third sector umbrella organization for C&V (CAVAMH) to explore a detailed and achievable action plan for this – to be the responsibility of: Ian Wile _ Director of Ops Dan Crossland – Transformation Lead Linda Newton – Cavamh lead office Integrated Managers – of	May 2019 update **–** initial date set with Cavamh on the 13th May 2019 to expand the action plan **September 2019 Update –** above meeting held in May with an agreed plan – 3rd sector agencies now embedded in clusters and localities to work with MH services. More established arrangements are working well such as MIND in the Vale who attend the Community Team MDT meetings with plans to formalize this in the two Cardiff localities via PDSA methodology. POBL now present one day a week in vale Hafal carer workers now based in all community teams Advocacy services regularly used as per contract with

	Commission Cavamh to do evaluate this aspect of CTP coordination.	CMHTs	South Wales Advocacy. IMTP launch in August with the 3rd sector and SUs and carers reinforced the commitment of partner agencies to work in a complementary way.
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 leads for each of the community mental health services. Mental Health and Innovation funding in 20189 secured to enhance the treatment of service users with dual diagnosis	Complete – post holder in place and improvement method agreed. Will Adams ANP leading. Funding secured – recruitment to commence January 2019 – Neil Jones CD adult services and Paul Sussex Senior Nurse Substance Misuse services 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 Will Adams is establishing the liaison posts. JDs for COMPASS Model currently awaiting approval through the UHB. **September 2019 Update** – Above JDs now approved. The Band 7 Team Leader post for the Dual Diagnosis Team (no longer Compass) is being interviewed for on 15th October, and the 8a Psychologist post is currently live on Trac. For the Band 6 nurse post, we are rotating a nurse from the core CAU teams and have already back filled in anticipation of this.

	using the COMPASS model. Anticipated benefits are the availability of psychological care for those with co-morbid MH problems To seek feedback from Service Users and audit of caseloads to evaluate.		A steering group will be set up for the beginning of November to help shape the direction for the new team moving forward.
MHCB Added Issue			
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.	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.	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	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 **September 2019 Update-** Policy ratified in August 2019 by partner agencies – legal scrutiny completed and satisfactory. Pilot of RAMP commenced in the Vale Locality Community Team in September 2019 for PDSA cycle roll out to other localities when lessons learned clear. Process mapping in Gabalfa CMHT in October 19 in preparation for roll-out

		12 to 18 months.	

Attachment 1

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

Present:

Jeff Champney-Smith	Chair, PoD Group
Elizabeth Singer	Vice Chair, Pod Group
Mike Lewis	PoD member
Dr John Copley	PoD member
Carol Thomas	PoD member
Mary Williams	PoD member
Alan Parker	PoD member
Huw Roberts	PoD member
Patricia Hallett	PoD member

In attendance:

Simon McDonald	Mental Health Act Coordinator
Sunni Webb	Mental Health Act Manager

Apologies:

Sarah Vetter	PoD member
Tony Summers	PoD member
Simon Williams	PoD member
Elaine Gorvett	PoD member
Sharon Dixon	PoD member
Mair Rawle	PoD member
Peter Kelly	PoD member
Wendy Hewitt-Sayer	PoD member
Teresa Goss	PoD member
John Owen	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

There were no members points for discussion

4 Minutes of Meeting held on 16 April 2019

The minutes were accepted as a true and accurate record of the previous meeting with the following amendments:
Patricia Hallett, Huw Roberts and Rasphal Singh were not present
Bethan Ellis was in attendance.

5 Matter Arising

Communication – Email

The Mental Health Act Manager confirmed that the MHA Office will communicate predominantly through personal email addresses for the convenience of the members. The exception to this will be if the message contains patient identifiable information, in which case the CJSM system will be used.

Generic CJSM address

This had been circulated to members after the last meeting

Patient Activities

The Chair advised that this issue had been raised at the MHLGG meeting. The deputy Chair asked the group if they could provide specific concerns around patient activities to take to the next MHLGG. There were principally two areas raised:

1. Lack of availability of ward staff to allow patients to be able to have escorted leave
2. The staff being too busy to support ward based activities

Proximity of Patient Discharge by MHRT to MHAM

In the past year only one patient had been discharged by the MHRT after the patients MHAM. The date of the MHRT was 40 days after the MHAM, where the outcome was a Deferred Discharge for a further two weeks into the future. The time span was long enough for the patient's presentation to have changed.

Data Security

Two of the managers had experienced difficulties at Barry Hospital. The reception staff were unaware of the agreement regarding the minutes being faxed/scanned and sent to the MHA office. It was agreed that Sunni Webb would bring this to the attention of the admin managers for action.

6 MHA Activity Monitoring report January – March 2019

The group read and accepted both reports. There had been one adjournment by the managers because the panel couldn't agree. A further panel was convened but the patient was discharged just prior to the hearing. There was a short discussion regarding the details of the case as two of the managers were present.
It was noted that over a third of patients were discharged from section prior to a Mental Health Review Tribunal.
Advocacy were present in over 50% of hearings. The Chair pointed out that quite often patient declined the input of the advocacy service.
A manager asked whether the patient had a right to a solicitor being present and if so should the Hearing be postponed pending one being appointed. There was a discussion regarding the issue. The Mental Health Act Manager advised that whilst patient can instruct a solicitor it was a matter for them to ensure attendance at a Managers Hearing. There were different rules that applied to solicitors attending the Mental Health Review Tribunal. If the situation arises then the managers should seek advice from the office.

7 Concerns/compliments from the Power of Discharge Group hearings April – June 2019

It was noted that the number of compliments has risen and how good this was to see. One concern related to the office contacting managers in advance of a Hearing. The Mental Health Act Manager confirmed that this isn't possible given the workload of the staff. It is for managers to ensure they have a system in place.

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 Clinical Board had plans to track changes/improvements.
The Chair informed the group that the observations have not all been completed for the previous year and also there will be a further round of observations. However, to date there has been no negative feedback. Senior staff, including the Clinical Director, will be involved in the next round of observations. This was welcomed by the PoD members.

9 Training

Annual All Wales Hospital Managers

The Chair and the Mental Health Act Manager explained the format for the day. There will be greater opportunities for discussions with PoD members from other Health Boards. There will be a mixture of lectures and facilitated workshops

There was a short discussion regarding travel arrangements. Either the PoD members can car share or the Mental Health Act Manager will look at the cost of hiring a coach. PoD members are asked to inform the office of their preference. If a bus is arranged it will necessitate meeting at a central point. Action PoD members to inform Sunni Webb asap regarding transport arrangements

Breakaway/SIMA Training

Eight PoD members had taken part in the training. There was a brief discussion and all participants agreed that they had enjoyed the session. They all had a better understanding of the different techniques including the use of safe holds. However, none were sure that they would be able to put into practise all the techniques they had been shown. The Chair to have a further discussion as to whether this was essential training as PoD members were never on their own with a patient. Also, there are financial consequence for the department.

Other Disorders

At the next training session Dr Cantrell will be invited to discuss this topic with the group.

Working with interpreters and people with communication difficulties

This will be addressed at a future training session

10 Any other business

The poor acoustics in the rooms used for the Hearings was discussed. The Mental Health Act Coordinator confirmed that the matter was in hand as he was putting together a bid for charitable funds. He was optimistic that it would be successful.

There was a brief discussion regarding the interpretation of the Code of Practise with some PoD members stating that there was variation across Health Boards and between the NHS and the Private Sectors. The Mental Health Act Manager reminded the members that the situation was not always black and white and that if in doubt then members should seek clarification from the office.

The Mental Health Act Manager asked if Chairs would take more care when writing their reasons to ensure that their writing was legible.

11 Date and time of next meeting

To be held at 10:00 hrs in the Seminar Room, First Floor, HYC, UHL on 15 October 2019.

Minutes of the Mental Health Legislation and Governance Group held at 14.00 on 18 July 2019 in Seminar Room 1, Hafan Y Coed, Llandough Hospital

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Elizabeth Singer	Vice Chair Power of Discharge Group
David Seward	Mental Health Act Administrator
Alex Allegretto	Independent Mental Health Advocacy Manager
Susan Power	Lead Team Manager Emergency Duty Team
Linda Woodley	Operational Manager Vale of Glamorgan
Peter Thomas	South Wales Police
Justin Williams	Team Leader South Crisis Team
Gareth John	Consultant Social Worker- DOLs/ AMHP
Ceri Lovell	Team Leader- CAMHS Crisis Liaison Team
Bianca Simpson Lepore	Mental Health Act Administration Manager

Apologies

Claire- Louise Thomas	South Wales Police
Charles Janewski	Vice Chair, Cardiff and Vale University Health Board
Myfanwy Moran	Operational Manager Cardiff
Adele Watkins	Paediatrics Representative
Jeff Champney Smith	Chair Power of Discharge Group
Dr Michael Ivenso	Consultant Representative MHSOP
Lorinda Walters	Complex Care and commissioning manager
Stephen Johnson	Welsh Ambulance Service Team
Dr Clare Davies	Emergency Unit Consultant Representative
Dr Adeline Cutinha	Consultant Representative
All Senior Nurse Managers	

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. The need to consider the scheduling of the meeting for senior nurse managers to attend was noted.

3 **Minutes of meeting held on 09 May 2019**

The CAMHS incident from page four of the previous minutes were briefly discussed- it was agreed that the chair of the group would look further into this to hopefully prevent such an incident happening again.

The issue of missing persons aged 16 or under was again briefly mentioned. The group were informed that the paediatric representative is looking into this further and will hopefully provide feedback soon.

Cardiff and the Vale University Health Board are not implementing Section 57 treatments.

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

Action- Chair of the group to further investigate the CAMHS incident

4 **MHA Activity April- June 2019**

The Mental Health Act Monitoring report was not discussed at this meeting.

5 **Matters Arising**

The Section 5(4) policy/ procedure has now been distributed and is available and active.

The written procedure for obtaining a Section 135(2) warrant is almost complete. A final meeting with Darren Shore needs to be arranged. Following this the procedure will be taken back to the quality and safety group and should then be finalised.

The presentation by Neil Allen (Barrister and Senior Lecturer, Manchester University) needs to circulated to all members of the group. The presentation suggested a 135 warrant could be used for preventing neglect as well as coordinating a Mental Health Act Assessment. There was some debate in the room as to whether this would be a correct use of the Act or not.

Action- Presentation by Neil Allen to be disseminated by the Chair of the group

There has been no feedback in regard to statutory consultees and therefore this item will remain on the agenda.

The Mental Health Act Administrator informed the group that late reports are still a problem for the Mental Health Act Office but that the issue is improving. The main problem appears to be when clinicians anticipate a patient's discharge and thus don't submit reports on time.

The incident of a patient having been brought to the emergency unit in handcuffs but not on a section 136 was raised. This issue have been passed to the strategy and CAMHS team to be discussed further. Details of this are to be passed to Peter Thomas- South Wales Police. The item will be scrutinised by others but there is no further input from this group at present.

Action- Details of CAMHS incident to be sent to Peter Thomas

A route cause analysis had been completed in regard to clinicians discharging a patient in absence. It was agreed that in certain circumstances discharge in absence is acceptable practice.

The Vice Chair of the power of the discharge group raised the group's concerns of a lack of activities on the wards. This matter is being escalated to the quality and safety group but it was noted that the power of discharge group members can meet with Karen Jones (activities nurse) if desired.

It was agreed that the issue of quality indicators and audits would be more appropriately discussed with the clinical director once she has returned to work.

The group discussed at length the ongoing issue of the police and voluntary assessments and people being brought to Health Board premises without being detained. Peter Thomas reiterated that the main problem is with people that are picked up by the police as needing a mental health assessment but with no mental health history. People that are unknown should be directed to either their own GP, the out of hours GP or the psychiatric liaison team in UHW if at all possible. The chair raised the issue of how the Police are assured that someone is making an informed capacitious agreement to go with them for a voluntary assessment, and are not unduly suggestible or compliant.

The Health Boards position is that people should only be taken to the emergency unit for physical health issues. It was agreed that it is an inappropriate use of both the police and the Health Boards time if people are brought to Hafan Y Coed incorrectly. Peter Thomas explained that in some other Health Boards there is an open door policy in regards to unknown patients. He informed that group that the triage policy appears to be having a positive impact on the amount of appropriately detained people. The admission rate in Cardiff and Vale UHB is now approximately 30%. Peter explained to the group that the police are often put in difficult situations whereby they don't feel qualified to make a decision in regards to someone's capacity to come into hospital voluntarily or not. There is some research as to whether having extra general practitioners based in the emergency unit would ease the pressure on services. The group were informed that all officers have received training on how to deal with mental health issues. This included awareness of the Mental Capacity Act, voluntary assessments and section 135.

Peter Thomas asked the Health Board to change its policy in regard to unknown people and it was agreed that the issue of voluntary assessments and how to treat unknown people should be discussed further and with a wider group of people.

Action- The Team Leader South Crisis Team to take this forward

Action- The MHA Coordinator to devise a method of recording and reporting on the numbers of voluntary assessments

Mental Health Act training for the shift coordinators needs to be arranged.

Action- MHA Training to be arranged for Shift Coordinators

6 Feedback on operational issues and incidents

It was confirmed if someone is an inpatient on the medical assessment unit. This means that they are counted as an inpatient and that Section 5(2) can be used.

The problem of executing section 135 warrants, police attendance and ambulance availability was raised. Some new phone numbers for accessing the ambulance service need to be disseminated. At present the AMHPs are not aware of these. Conveyance problems are still causing AMHPs significant stresses. AMHPs are being told they will be waiting at least four hours and on some occasions that an ambulance will not be attending at all. The silver on call is still being used to authorise private transport if necessary. Further training is required for all silver on call staff to make them aware of this policy. Peter Thomas informed the group that Shane Mills from the Welsh Government is currently undertaking a report on conveyance issues. Peter Thomas agreed to contact Mr Mills to ask him to distribute the report to local authorities.

Action- Phone numbers for ambulance contact to be distributed to AMHPS

Action- Silver on call training to be arranged for private ambulance authorisation

Action- Peter Thomas to request Shane Mills' report to be distributed amongst group

One member of the group mentioned that AMHPs are being pressured to use Guardianship orders to convey people to care homes. Gareth John informed the group the local authorities stance is that non capacious patients who are not objecting can be taken using the Mental Capacity Act, whilst those who are objecting should be referred to the court of protection.

The 117 policy has been distributed to the MHLAGG for comment and will then be passed to the policy group.

Assessment delays due to lack of beds are not currently a problem for the UHB. Delays are usually solvable. This is the same with late requests for MHA assessments. The emergency duty team confirmed they would not coordinate assessments for patients on section 5(2)'s that do not expire over the weekend.

There remains good working relationship between the Health Board and Advocacy Support Cymru at present. Unfortunately there are still difficulties contacting Willow ward, Hafan Y Coed. This issue has been raised to senior nurses.

The Operational Manager Vale of Glamorgan noted that in her opinion she was still finding non capacious patients on wards that weren't detained under any legal framework.

There are no CAMHS issues at present.

7 Feedback from other meetings

AMHP forum- all issues were discussed previously. It was suggested that the minutes from the AMHP forum could possibly be provided to the Committee meetings as this would give them a more public airing.

There is still some debate as to which doctors are best placed to carry out section 5(2) assessments in place of patients normal RC's. The MHA Dept alongside consultants are looking into how best to resolve this.

The PoD group highlighted several issues at their recent meeting: Care and Treatment plans for hospital managers hearings are still a problem- they are not being provided promptly and are often not reviewed adequately. PoD members are also concerned at the amount of time it sometimes takes to secure accommodation for patients. This then results in them being detained in hospital on an inpatient section when it is perhaps not always the least restrictive option. This situation has caused PoD members some debate as to whether to exercise their power of discharge or not.

8 Power of Discharge Group comments compliments and feedback April- June 2019

This was not discussed during this meeting

9 External reviews

There has been an external review since the last MHLAGG meeting. As a result of this the Mental Health Act Office has implemented changes in the consent to treatment process. Responsible Clinicians are responsible for ensuring these new processes are adhered to but MHA office staff are aware of the extra time that is being asked of RC's. There is some query as to whether consent to treatment is being reviewed regularly enough by RC's. The consultant representative agreed to take this back to her colleagues.

10 Interface MHA/ MCA/DOL's

There is still ongoing debate amongst professionals as to which legislation to use at what time during a patients admission. The Mental Health Act Manager and Mental Capacity Act

Manager have created a poster to clarify which Act to use at what time. The group agreed that a review of this by Richard Jones would be useful before circulating it to a wider audience. Gareth John informed the group that he had provided a briefing on this subject to AMHPs. He agreed to circulate this to the group.

Action- MCA/ MHA Poster to be sent to Richard Jones for comment

11 Quality indicators and audit activities

The clinical director will comment on this when she has returned to work.

12 Any other business

Peter Thomas will distribute the 136 figures from across the force.

13 Date of future meetings

Provisionally booked on 17th October 2019

Review of Comments raised by Members of the Power of Discharge Group during the period 01 July 2018 and 30 June 2019

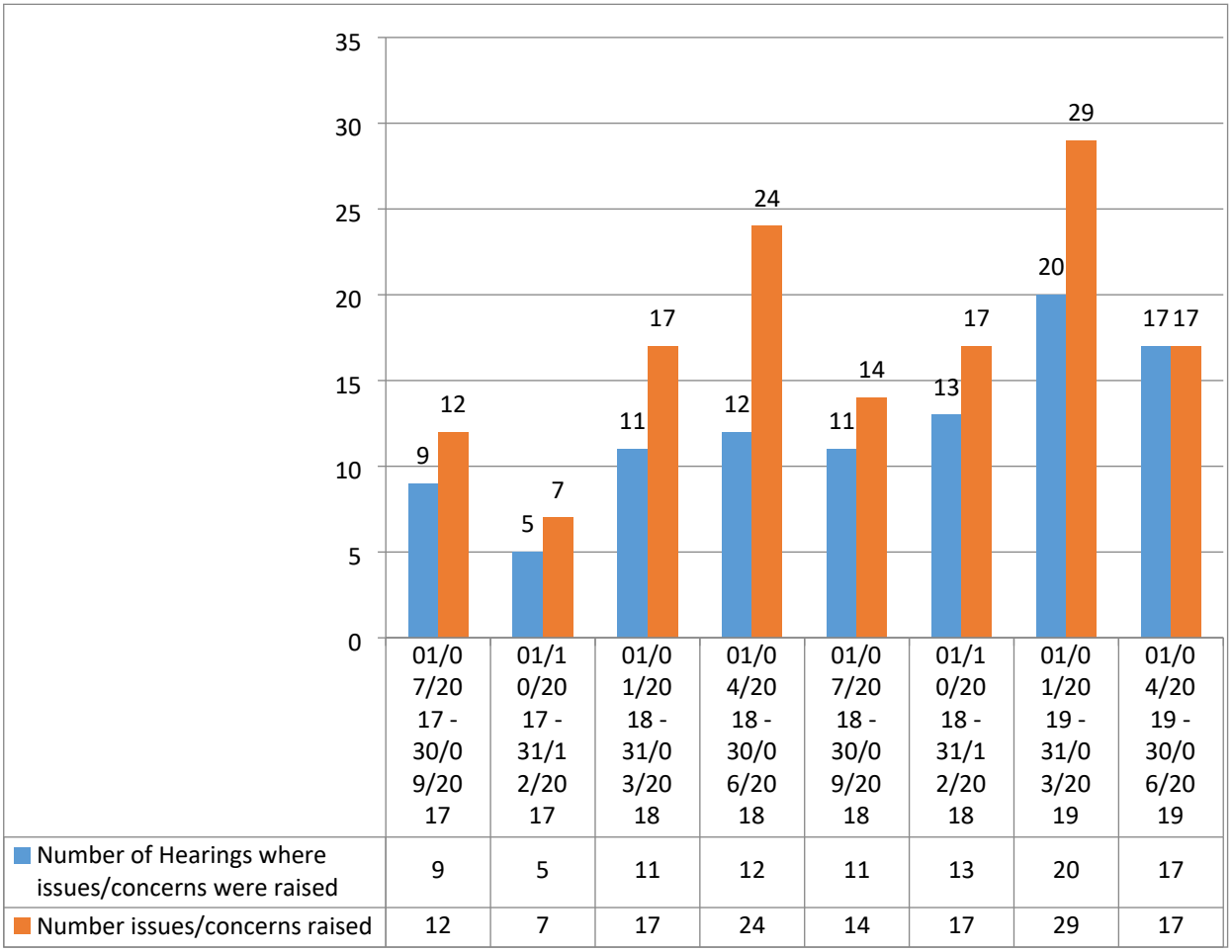
Introduction

As part of their role, Hopital Managers have an opportunity to raise issues and concerns they identify during the Managers Hearing. They can also commend/compliment the professional team. The professional team and advocacy services are also invited to feedback their comments on the running of the Managers Hearings.

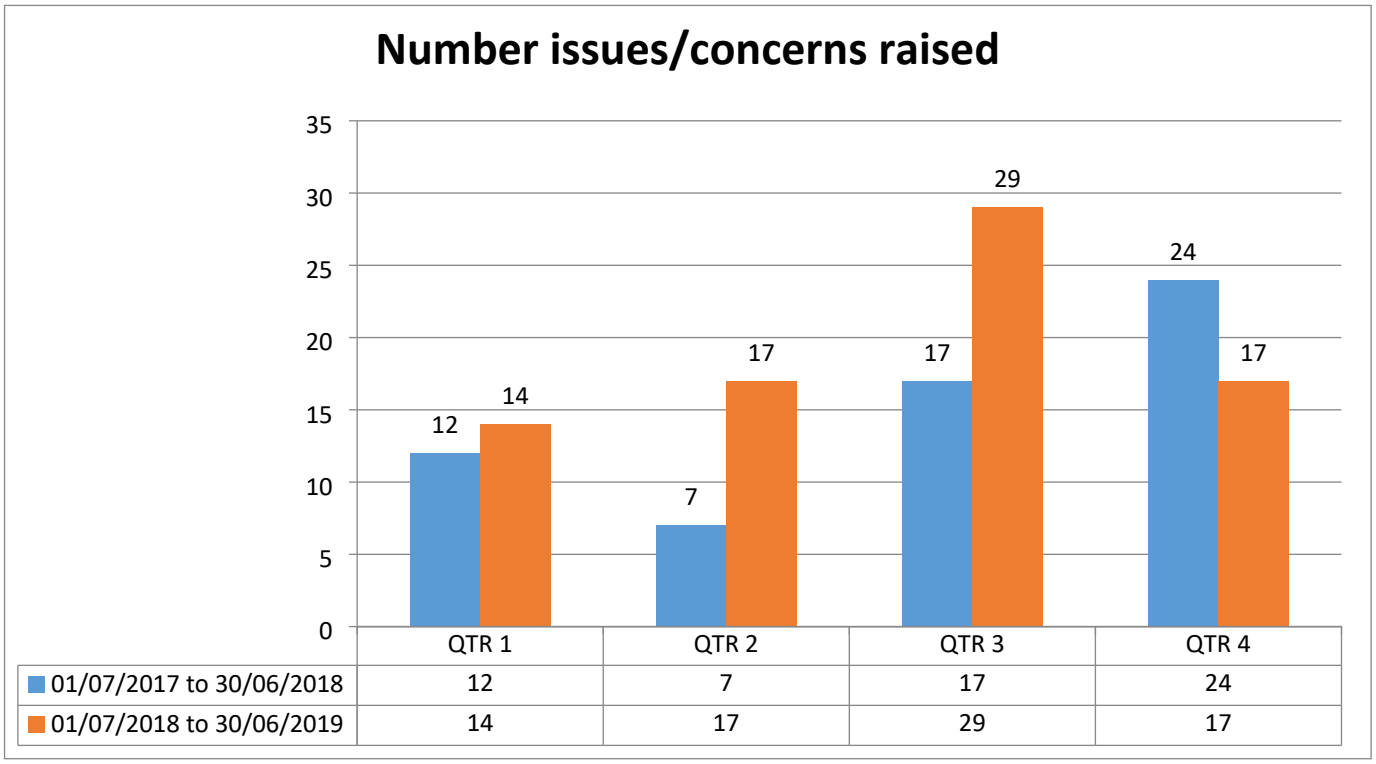
This paper outlines the issues and concerns raised by Hospital Managers in the 12 months from the 01 July 2018 and consider any conclusions/lessons learnt.

Activity

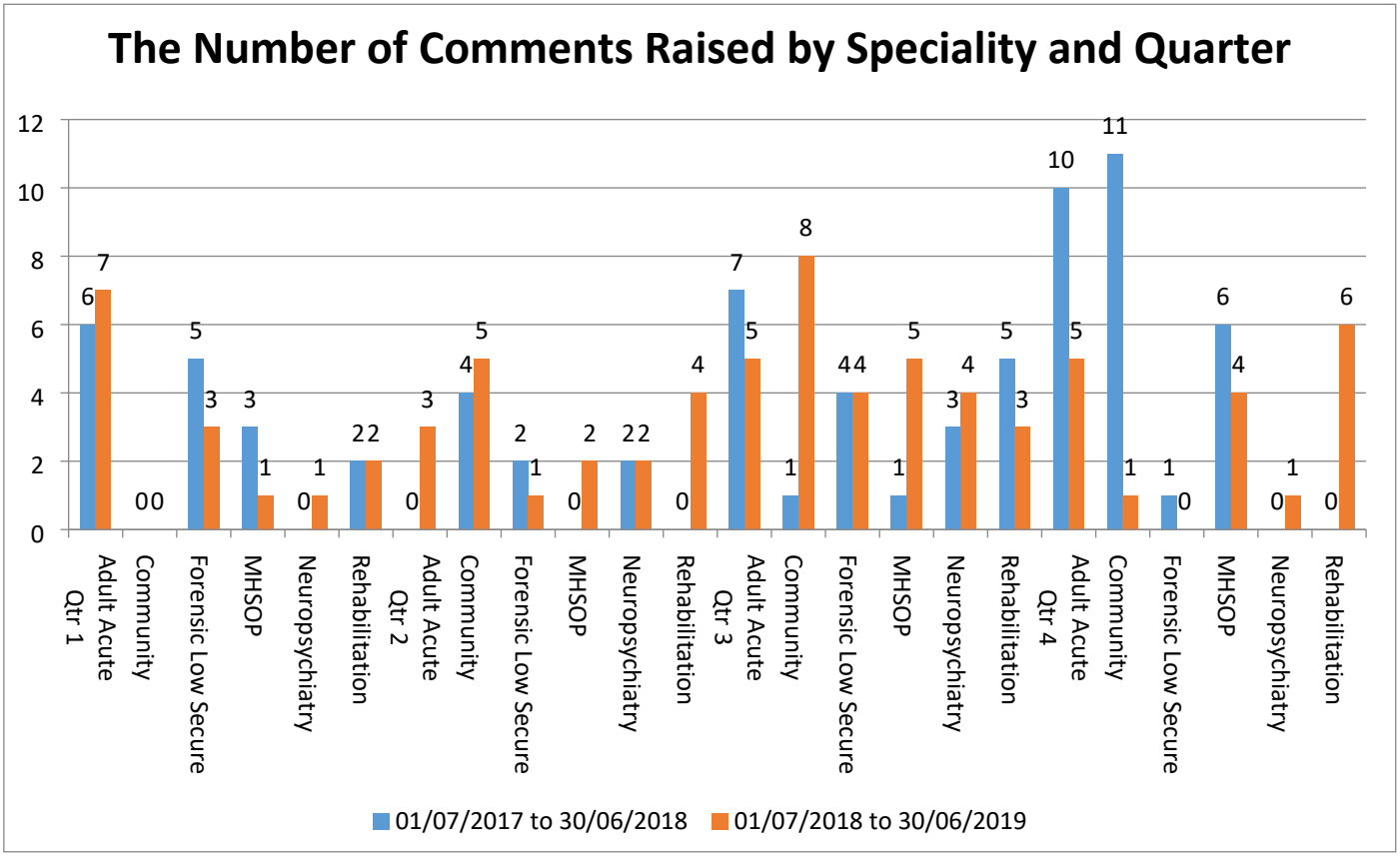
Between the 1 July 2018 and the 30 June 2019 Associate Hospital Managers raised 77 issues in 61 hearings. This compares to 60 issues in 37 hearings in the previous one year period. In this period there were 136 managers hearings compared with 137 hearings in the previous year. The tables below show a breakdown of the number of hearings in which issues were raised and the number of issues raised each quarter:



	01/07/2017 - 30/09/2017	01/10/2017 - 31/12/2017	01/01/2018 - 31/03/2018	01/04/2018 - 30/06/2018	01/07/2018 - 30/09/2018	01/10/2018 - 31/12/2018	01/01/2019 - 31/03/2019	01/04/2019 - 30/06/2019
Number of Hearings where issues/concerns were raised	9	5	11	12	11	13	20	17
Number issues/concerns raised	12	7	17	24	14	17	29	17



The below tables provide a breakdown on the number of Hearings and Comments raised by speciality.



Analysis of issues

The issues raised have been grouped under the following headings:

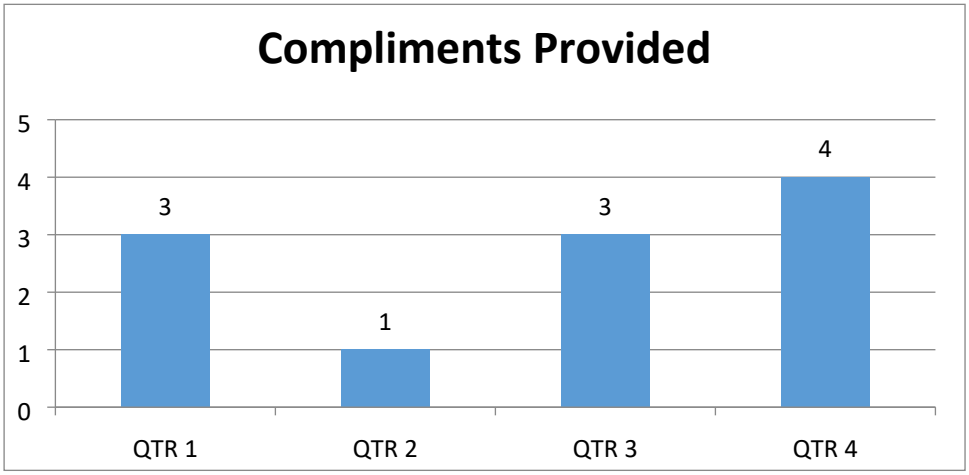
1. Measure - this includes the Care and Treatment Plans, Risk Assessment and appointment of care coordinator - 29 issues
2. Nearest relative - 10 issues
3. Finances - 6 issues
4. Leave and ward activities - 6 issues
5. Communication - 4 issues
6. Quality/accuracy of reports -4 issues
7. Attendance at hearings - 7 issues
8. Housing - 2 issues
9. Other - 9 issues

Of the 77 issues raised 29 related to the Measure including risk assessments. Either care plans were out of date or not outcome focused or didn't reflect the current status of the patient. The risk assessments similarly were either out of date or didn't reflect the current position of the patient.

The issues (10) with the nearest relative (NR) seem to arise principally when either the NR is estranged from the patient and needs to be displaced or where the local authority has been designated as the NR. The panels reporting issues when the local authority was the NR were concerned about the lack of contact with the patient. A comprehensive response to the issues are made and reviewed at the Power of Discharge Business meeting

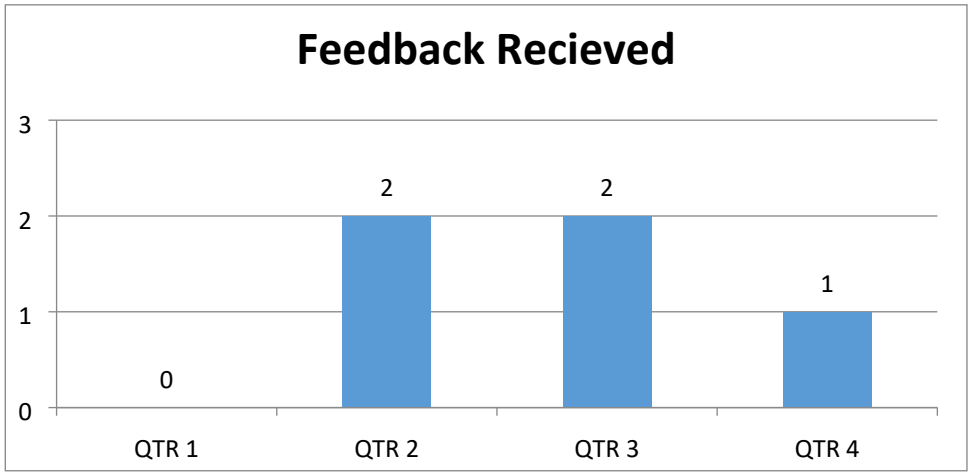
Compliments and Feedback

Compliments



The managers offered compliments on eleven occasions up from five the previous year. Most compliments concerned the quality of reports (nine) whilst two commented on the excellent relationship between the patient and the care coordinator.

Feedback



Feedback for the panels has been received from both the service and advocacy. The Mental Health Act team were complimented in supporting the Hearing process and a panel were praised for showing both consideration to the patients well-being whilst balancing risk.

Advocacy have provided feedback that includes;

1. Managers knowledge of S47
2. Comments from a social worker were both inaccurate and dismissive
3. Panel respecting the role of the advocacy representative
4. Chairs view concerning discharge.

Conclusion

It would appear that in the majority of hearings, managers find no issues that need to be raised/taken further. At the business meeting the Mental Health Act manager provides an update of the actions taken by the professionals involved in the hearings were issues/concerns are raised. The Chair of the POD group has raised concerns in relation to the Measure at the legislation committee meeting. This has been recognised as an issue across the directorate and a training programme is being taken forward. Where necessary appropriate legal advice is sought.

The feedback from advocacy has been considered during the Peer Supervision sessions and where necessary training has been undertaken.

Hospital Managers are aware of their very specific role and remit. The ability to raise issues of concern hopefully provides useful feedback for the professional team and assist with the resolution of some patient concerns.