Mental Health and Capacity Legislation Committee Meeting

Tue 20 April 2021, 10:00 - 13:00

Agenda

1. Welcome & Introductions

Sara Moseley

2. Apologies for Absence

Sara Moseley

3. Declarations of Interest

Sara Moseley

4. Minutes of the Committee Meeting held on 19th January 2021

Sara Moseley

1.4 minutes January Meeting - AF.pdf (13 pages)

5. Action Log – 19th January 2021

Sara Moseley

5. MHLC - Action Log April 2021 update JE.pdf (2 pages)

6. Chair's Action taken since last meeting

Sara Moseley

7. Any Other Urgent Business Agreed with the Chair

Sara Moseley

8. Patient Story

8.1. Sectioned under the Mental Health Act - A Patient's Experience

Ian Wile / Ruth Walker

9. Mental Capacity Act

9.1. Mental Capacity Act Monitoring Report

Ruth Walker

- 9.1a MHCLC assurance report - April 2021 FINAL.pdf (3 pages)
- 9.1 Mental Health Act Monitoring Report.pdf (46 pages)
- 9.1b Appendix 1 - MCA and DoLs Indicators - February 2021 completed.pdf (9 pages)
- 9.1c Appendix 2 - 11.03.21 - E - LPS letter to LHBs including data request.pdf (3 pages)

9.2. DoLs Report – Verbal Update

Ruth Walker / Jason Roberts

10. Mental Health Act

10.1. Mental Health Act Monitoring Exception Report

Ian Wile

- 10.1 Mental Health Act Monitoring Exception Report je.pdf (8 pages)

10.2. Reforming the Mental Health Act – Update

Sunni Webb / Ian Wile

- 10.2 Review of the Mental Health Act Exception Report JE.pdf (8 pages)

11. Mental Health Measure

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

Ian Wile

- 11.2 MHLC - Mental Health Measure (Apr. 21) je.pdf (8 pages)

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

12.1. Induction Support for New Committee Members - Verbal Update

Nicola Foreman

12.2. Sub-Committee Meeting Minutes:

Jeff Champney Smith / Robert Kidd

a) Hospital Managers Power of Discharge Minutes
b) Mental Health Legislation and Governance Group Minutes

- 12.3a Power of Discharge Group minutes 23 March 2021.pdf (4 pages)
- 12.3b MHLGG minutes 11 March 2021.pdf (8 pages)

12.3. Corporate Risk Register – Mental Health Clinical Board Risks

Nicola Foreman / Ian Wile

- 12.4a MHCLC - Corporate Risk Register Covering Report - April 2021.pdf (3 pages)
- 12.4b Corporate Risk Register April 2021.pdf (1 pages)

13. Items for Approval Ratification

13.1. Committee Work Plan

Nicola Foreman

13.1a Covering report - work plan 2021.22.pdf (2 pages)
13.1b Copy of MHCL Work plan 2021.22.pdf (1 pages)

13.2. Committee Annual Report 2020/21

Nicola Foreman

13.2a Committee Annual Report Cover je.pdf (2 pages)
13.2b Annual Report of MHCLC 20.21.pdf (6 pages)

14. Review of the Meeting

Sara Moseley

15. Date, time and venue of the next meeting:

Sara Moseley

Tuesday, 20th July 2021 at 10:00 am

Via MS Teams

Unconfirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 19th January 2021 – 10am.
Via MS Teams

Chair:		
Sara Moseley	SM / CC	Interim Chair and Independent Member – Third Sector
Present:		
Eileen Brandreth	EB	Independent Member - ICT
Michael Imperato	MI	Independent Member - Legal
In Attendance:		
Julia Barrell	JB	Mental Capacity Act Manager
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Transformations and Innovation Lead
Aaron Fowler	AF	Head of Risk and Regulation
Neil Jones	NJ	Consultant - Community Addictions Unit (CAU)
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Amanda Morgan	AM	Service User
Sian Rowlands	SR	Head of Corporate Governance
Matthew Russell	MR	Social Worker CMHT
Ruth Walker	RW	Executive Nurse Director
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Head of Operations, Mental Health
Linda Woodley	LW	Local Authority Representative
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Scott McLean	SMc	Director of Operations – Mental Health

MHCL 21/01/001	**Welcome & Introductions** The CC welcomed everybody to the meeting and thanked the Committee in advance for the brevity they would bring to the meeting. Apologies were raised to the Service User for the delay in board papers being sent and assurance was given that the delay would not happen again.	**ACTION**
MHCL 21/01/002	**Apologies for Absence** Apologies for Absence were noted from Steve Curry, Nicola Foreman and Scott McLean.	
MHCL 21/01/003	**Declarations of Interest** The CC declared an interest in the meeting as the Director of Mind Cymru and advised the Committee that a letter had been sent by Mind Cymru that related to ethnicity monitoring for people detained under the Mental Health Act.	

MHCL 21/01/004	**Minutes of the Committee Meeting held on 20th October 2020** The Committee reviewed the minutes from the meeting held on 20th October 2020. Resolved that: a) The CC noted a clarification regarding point: *"MHCL 20/10/009 - The Committee noted that further work needed to be undertaken to progress the audit outcomes by the next meeting"* The CC advised the Committee that it was not on the agenda and asked that it be on the agenda for the next meeting. b) The CC noted point: *"MHCL 20/10/010 - The CC asked what learning had taken place in preparation for the next COVID-19 wave."* The CC noted that the population was in the midst of the second wave of the pandemic and asked the Head of Operations, Mental Health (HOMH) for an update on specific COVID-19 related issues that would affect the subject matter of the meeting. The update was noted in Any Other Urgent Business.	
MHCL 21/01/005	**Action Log – 20th October 2020** The Executive Nurse Director (END) advised the Committee that work had commenced on action MHCL 20/10/009 and that time would be spent at the meeting to provide clarity on what the Committee needed. The CC advised the Committee that action MHCL 20/10/13 could be closed as membership of the Committee would be looked at once revisions of the Terms of Reference had been agreed. The CC advised the Committee that action MHCL 20/10/14 needed to be updated and it was agreed that a date for an update to be provided would be agreed offline.	**NS / NF**
MHCL 21/01//006	**Chair's Action taken since last meeting** The CC advised that she had met with the Director of Corporate Governance (DCG), the END and the Chief Operating Officer (COO) and had looked at the minutes and brought a suggested revision to the meeting. No other actions had been taken	

MHCL 21/01/007	**Any Other Urgent Business Agreed with the Chair** The CC asked the HOMH to update the Committee around the prevailing COVID-19 situation within Mental Health. The HOMH advised the Committee that the administration of the Mental Health Act had “moved mountains” which had enabled the appropriate remote work that was needed. The HOMH advised the Committee that the Mental Health Act Manager (MHAM) had looked at putting sound proofing into some of the ward areas. The MHAM responded that the work would start over the following weeks and would ensure that patients had the appropriate facilities in place and she advised the Committee that all hearings were taking place remotely and that no patients had attended the Mental Health Act office. The HOMH advised the Committee that they had authorised temporary administrative support for the team. The HOMH advised the Committee that they had continued to run as an essential service and the approach during the 2nd wave had been to put a resource ring in place around inpatients, the community specialist services and primary care. The HOMH advised the Committee that COVID-19 activity had affected inpatient areas and the team had right-sized the service to fit the staffing profile that had been available. The HOMH advised the Committee that the Transformations and Innovation Lead (TIL) and himself had conducted an audit that looked at referral activity into Mental Health. The audit showed that capacity was around the same or above what it was pre-COVID-19. The HOMH noted to the Committee that Primary Care were getting, on average, 2500 referrals per month across all Primary Care services and that some services had struggled with staff loss through COVID-19. The HOMH advised the Committee that full use of the third sector had been utilised and that the responsiveness and flexibility to demand had been magnificent. The CC asked the HOMH to extend the Committee’s thanks to all staff. The END advised the Committee that from a clinical perspective in relation to Infection Prevention &Control (IP&C) the Mental Health Service had managed a number of outbreaks and she had been extremely impressed by the work they had undertaken.	

	The Consultant Clinical and Forensic Psychologist (CCFP) advised the Committee that whilst operating under COVID-19 there had been no delays with section 62 as Second Opinion Appointed Doctors (SOAD) were working remotely.	
MHCL 21/01/008	**Patient Story** No patient story presented was shared at the meeting. It was agreed that efforts would be made to ensure that stories were shared at future meetings.	
MHCL 21/01//009	**Mental Capacity Act** **Mental Capacity Act Monitoring Report:** The CC asked the report authors if there was anything that they wanted to draw to the Committee's attention. The CC advised the Committee that the paper highlighted a drop in the use of the Independent Mental Capacity Advocates (IMCA) service and asked if this was due to restrictions on contact. The END responded that there had been some feedback from the IMCAs around the flexibility of letting them on site and she acknowledged that it had been difficult to get the position right but she had not received any concerns. The Independent Member - ICT (IMI) noted that IMCAs had had varied experiences in gaining access to patients on wards and asked if there was any intention to issue guidance to make it clear what the position should be. The END responded that guidance had not been issued because it was felt that the situation had settled. She confirmed that she would be happy to issue guidance depending on what was happening in given clinical area at any one time. The Mental Capacity Act Manager (MCAM) advised the Committee that overall the IMCA service was doing as much as they could remotely but on some occasions there had been a need to see the patient. The IMI noted that there had been a significant drop in referrals and asked if that was because the need had disappeared and how that would be interpreted. The END advised the Committee that there had been some challenges around availability. The MCAM advised the Committee that the main drop was the use in IMCAs as the relevant person's representative under DoLs. The IMI asked who would make the referral.	

	The MCAM responded that the DoLs supervisory body function would appoint and that if there was nobody else appropriate to appoint to the position of relevant person's representative then the referral would be made to IMCA. The CC advised the Committee that this item would be kept under review because making sure that people are represented properly was really important and that the matter would be discussed at the next meeting to track the position. The CC advised the Committee that there was a persistent issue with low compliance with staff training and noted that it should be added onto the risk register. The END responded that the issue needed to be addressed and a plan would need to be put in but advised the Committee that the release of staff was difficult especially at the time of the meeting. She confirmed that she would bring a proposal as to what that training would look like, what opportunities were available and how medical staff would access the training. The CC advised the Committee that it would be brought to a meeting later in the year when capacity would be better.	**RW** **NS**
MHCL 21/01/010	**DoLs Report – Verbal Update** The END invited the Committee to share what information should be brought to the Committee in regards to DoLs. The CCFP advised the Committee that he would want to see a figure on the number of section 49 reports because it felt like the Organisation was asked to do those but that there was not a sense of how many there are or where they are. The Head of Risk and Regulation (HRR) advised the Committee that the MCAM and he monitored the section 49 requests that came in and that they acted as a point of contact and reference to assist colleagues. He advised the Committee that it was unknown whether all colleagues were reporting s.49 requests to him or the MCAM. The MCAM added that not all section 49 reports would be about mental capacity issues and that sometimes they could concern clinical issues rather than anything to do with mental capacity. The END advised the Committee that one of the greatest challenges was how many DoLS orders the organisation managed, where did they occur and whether there was a process in place to understand how the system was measured. The END advised the Committee that it would be good to know where DoLS predominantly originated because there were places that they had been expected, like locked wards, but they had not been received.	

	The END advised the Committee that there was quite a lot of information to process and that legislation would need to be looked at to be clear about what was required and what would be reported into the Committee. The CC advised the Committee that the introduction in the paper was really good and clear and she agreed with the END's assessment of what the Committee should be looking at and proposed that a course of action was taken. The CC advised the END that she would be happy for the END to go away and come back with clear recommendations for the Committee. The END responded that she would propose separating the report and providing a separate one on DoLs and a separate one on the Mental Health Act. The MCAM responded that DoLs was part of the Mental Capacity Act and that because it was about depriving people of their liberties, it was important to discuss and she added that the COVID-19 practice for DoLS suggested that their use needed to be reported within the organisation. The IMI asked if there were any insights on how other health boards reported on DoLS and whether there was any best practice that could be identified. The END responded that there were people reporting DoLS in a more robust way compared to Cardiff and Vale UHB and that the Health Board could learn from others". The END concluded that there would be new legislation coming into force in the near future but that a date was not set. She advised that she would not be comfortable as lead to wait until that legislation was in place to fully report so it was her intention to report on plans in the interim. The CC responded that the new legislation would be in place in 2022. The CC thanked the END and MCAM for their work.	
MHCL 21/01/011	**Mental Health Act** **Mental Health Act Monitoring Exception Report** The MHAM advised the Committee that the team had met with the Police in regards to ethnicity monitoring. She noted that she was confident that an improvement in the data would be seen moving forward and in particular the data for between October and December. The MHAM advised the Committee that discussions were continuing around the time that the clock began ticking under the MHA for patients within Accident & Emergency (A&E) and she confirmed that	

	the team had been in discussion with Richard Jones (of Blake Morgan Solicitors) on the topic to finalise a stance. The CC advised the Committee that an answer on the ticking clock in A&E would need to be found and asked the HOMH to take that to the crisis care concordat meeting to push for an answer. The Independent Member - Legal (IML) asked if an independent counsels advice around A&E would be useful. The CC responded that to fix the A&E issues, clear national guidance would be needed and it would be important to get the position right. The IML advised the Committee that the ethnicity data seemed to be emerging too slowly which had a great significance given the impact of COVID-19 which appeared to effect ethnic minorities more. The CC responded that the ethnicity data was not just required in relation to Sections 135 and 136 of the Mental Health Act, it was also needed in relation to the use of the Mental Health Act across the board. She added that it was not just the responsibility of the police, it was the health board's responsibility to capture the data which would be within the organisation's control. The CC advised the Committee that the UHB should be position itself to be on top of these issues before the new Mental Health Act came into force. The MHAM commented on the ethnicity data and advised that there had been a blip with the electronic form which had been corrected and was live on PARIS for the data to be recorded.	
MHCL 21/01/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.** The HOMH advised the Committee that the report covered all 4 parts of the measure and that part 1A drew attention to pre-COVID-19 activity numbers which had now been reached and exceeded in terms of referrals. Given staff losses and high volume activity it had not taken much to breach and a lot of the activity around the 28 day referral to assessment had occurred over the course of the previous week. The HOMH advised the Committee that compliance had reduced dramatically when capacity did not reach demand. The HOMH advised the Committee that 3 extra staff had been employed who would specifically provide assessment services and would commence their roles in the coming months. The HOMH advised the Committee that at the time of the meeting, people were being booked into the service at 37 to 38 days instead of the 28 day target which meant that 100's of service users were waiting. The HOMH advised the Committee that the Director of Operations – Mental Health (DOMH) had asked him to bring the CAMHS position to	

	the Committee and he advised that there had been a high level of referrals and Interruption with staffing numbers due to COVID-19. He noted that CAMHS was, at the time of the meeting, non-compliant and the team were taking on extra staff to help reset the trajectories. The IMI asked why there were no figures in the report for CAMHS in relation to part 1A. The HOMH responded that he was not sure why the data was not included in the report and confirmed that he had received figures from the DOMH earlier that day and advised the Committee that compliance was around 56% in December. The IMI advised the Committee that CAMHS figures always appeared to be missing from Committee and asked the CC to advise the DOMH that the figures should be a standing item on future agendas. The CC responded that the Committee would need to write to the directorate to impress upon them that the requirement to report was mandatory. The IML responded that he had been in email correspondence with the DOMH that day about CAMHS and confirmed that he would convey the position to him later that week. The CC responded that she wanted it in writing as well and that assurance could not be provided without seeing what was going on and that there was a need to have the position on the record. The CC advised the Committee that the report mentioned the National Assembly for Wales which was wrong as the body was now called the Senedd. The CC advised the Committee that in terms of part 1A of the report there was a massive increase in the number of people waiting and she shared her hope that the impact of the measures put in place would find their way through in time. The CC advised the Committee that she welcomed the continued focus on care and treatment plan quality and completions. The HOMH advised the Committee that part 1A of the report was symptomatic of broader pressures within Primary Care and that the Mental Health service would be investing in tier 0 capacity with the third sector and would also support GPs to ensure that they refer into the appropriate areas. The HOMH advised the Committee that care and treatment planning was the heartbeat of the therapeutic relationship for mental health and that compliance with part 2 of the report was very good. It was the first time that the service had hit 90% in a long time.	

	Resolved that: a) The Mental Health and Capacity Legislation Committee noted the content of the report and the work undertaken by the Mental Health Clinical Board.	
MHCL 21/01/013	**Items to bring to the attention of the Committee for Noting / Information** **Feedback on Committee Training Session & Review** The Head of Corporate Governance (HCG) advised the Committee that the paper was for noting. **Resolved that:** a) The Committee noted the summary of the second Committee training session.	
MHCL 21/01/014	**a) Hospital Managers Power of Discharge Minutes** The Chair of the Powers of Discharge sub-Committee (CPDSC) advised the Committee that there was nothing to raise and that the minutes were shared for information. The CPDSC advised the Committee to note that the service were now providing 3 person hearings and had dropped the 4th member. **b) Mental Health Legislation and Governance Group Minutes** The CCFP advised the Committee that there had been positive things noted about the way the service had adapted to working virtually. He also added that: - he needed to pursue the issue of reading the rights to CTO clients in adult Q&S. - there had been progress in working relationships with the CAMHS teams. - the service had met with various people from the emergency unit about the use of the Mental Health Act for patients presenting at UHW. - information regarding the UK Governments reform of the Mental Health Act would need to be brought to the Committee. The CC advised the Committee that a briefing on the content and focus of the white paper would be added to the agenda for the next meeting.	

	The CCFP asked the Committee whether in terms of the detention of people with learning disabilities, how that have a knock on effect with DoLs.	
MHCL 21/01/015	**Corporate Risk Register** **Corporate Risk Register – Mental Health Clinical Board Risks** The CC advised the Committee that items discussed that day and recommended for inclusion within the Corporate Risk Register, DoLS Training and CAMHS reports would not sit on the Corporate Risk Register and should instead be noted as actions. The HRR advised the Committee that he had worked with the HOMH to refine the Mental Health Clinical Board's extreme risks which would be reported at that month's Board meeting and were shared at the meeting for further scrutiny and assurance that appropriate mitigating action would be taken. THE HOMH specifically discussed the risk relating to conveyancing of Service Users in and out of community settings. Problems with WAST waiting times had led to the HOMH and his team seeking alternative conveyancing options with the St. Johns Ambulance Service who had provided a similar contract to Cwm Taf University Health Board. The HOMH advised the Committee that St. Johns Ambulance could provide a service at short notice and had a vehicle and staff available should approval be given for proposals. The Local Authority Representative (LAR) confirmed support for the proposal. She noted concern that an incident could occur when individuals were detained who should be in hospital settings but had been left in the community for a significant waiting periods. She noted that a national solution had been discussed with WG over a year ago. The IML advised the Committee that this had been a concern pre-COVID-19 and asked the HOMH how much of the proposal would be a "sticking plaster" and whether there would be scope to move to a longer term solution. The HOMH responded that he was looking for a long term solution and advised the Committee that he could not see the operational side of WAST changing anytime soon which was why he had looked at St. Johns ambulance as a medium to long term resolution. The HOMH advised the Committee that he would take the issue to the Chief Operating Officer (COO) and report back to the Committee. The CC advised the Committee that the risk outlined was not a downward trend risk and that the retention of the severity of that risk in terms of safety, dignity and care would need to be on the Board's radar.	

	The LAR reiterated that the risk had been ongoing since 2017 and that it was not just a COVID-19 related issue and advised that the position worsened because WAST were not responding. The HRR advised the Committee that the downward trend shown to the Committee was not intended to suggest the risk had reduced in terms of severity and that it was the score that had reduced following a rescoring using the risk management scoring matrix correctly. The CC responded that upon looking at the risk register it did not capture the mitigating actions so it was difficult to evaluate. The HRR responded that the team would continue to work with the HOMH and increase the detail in the action section of the risk register. The IMI asked what the foundation was for WAST saying that they would not transport an unwell person. The HOMH responded that WASTs stance was that an unwell person with mental health problems was not in immediate danger in comparison with someone with physical health problems. The IMI asked if the Committee were formally pushing back on that stance. The CC responded that as a committee the concern should be escalated and noted that the committee's position could be put in writing to compel commissioners of the service to take action. The CC asked the HOMH to speak with the COO and to come back to with a proposal which could be taken forward under Chairs Action.	
MHCL 20/10/016	**Items for Approval Ratification** **Terms of Reference** The CC advised the Committee that discussions had been had around membership of the Committee and welcomed the Committee's input and thoughts. The END advised the Committee that when the function of the Committee was explored it had become clear that it was a Committee about providing assurance to the board in relation to the application of the Mental Health legislation which included the Mental Health Act and DoLs and that it was not a wider Committee than that. The END advised the Committee that it was time to narrow down and be very clear about the focus of the Committee and who should be "around the table" as well as the accountable officers for the areas of responsibility brought to the Committee. She advised that it was important to bring in colleagues as when important.	

	The CCFP advised that it would be helpful to have colleagues from the Local Authorities (LA) attend the Committee meetings. The CC responded that in relation to that aspect of the work consideration was needed for LA input. Amanda Morgan (Service User) asked about the role of service users and carers within the Committee and their value within the forum. The CC responded that the discussion that had happened previously was that certainly in relation to patient stories that the focus would be on people's experience of the legislation to enable a rounded view of the impact of the legislation. The CC advised the Committee that more thought would need to be given to the role of Service Users and Carers within the Committee. The IMI added that there was a real issue between making sure the Committee was open to hearing those most affected by legislation and avoiding anecdotal and operational matters. She thought that a balance needed to be struck between the need to be open to listening to the views of those who use the service and the need to gain assurance that the Health Board was complying with its legislative responsibilities. The Service User advised the Committee that, as the voice of a carer, it was unclear on how much value was being added to the vast majority of the Committee agenda and that there had been a constant battle about whether they had been a part of the committee or not. The CC responded that rather than having Service Users and Carers as part of the substantive Committee, they could be brought when different aspects were looked to assess how the legislation was affecting individuals. The END advised the Committee that the conversation had been really helpful and that information could be gathered from Service Users that would help and inform the Committee. The CC advised the Committee that Primary Care input was missing and that it would be useful to understand what was going on from the Primary Care perspective. **Work Plan and Committee Annual Report 2020/21** It was agreed that the Committee Work Plan and Annual Report would be brought to the next MHCLC meeting.	**NF / NS**
MHCLC 20/10/017	**Review of the Meeting** The IMI advised the Committee that this was her last meeting and thanked the Committee for their support.	

	The CC thanked the IMI for her input and noted that she had looked at things thoroughly. The CC noted that the timings for this Committee should be the same from this point. 1 hour and 30 minutes.	
MHCL 20/10/018	**Date & Time of next Committee Meeting** 20th April 2021 9am – 10.30am	

ACTION LOG
MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE
UPDATE FOR APRIL 2021 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
Actions in Progress					
MHCL 20/10/009	DOLS	Internal Audit Report on DoLS - further work needed to be undertaken to progress the audit outcomes by the next meeting.	**20/04/21**	Ruth Walker	**Verbal update** to be shared as part of standing DoLS Report agenda item 9.2 on agenda.
MHCL 20/10/14	Mental Health and Equality	DCG to liaise with the EDWOD to discuss the possibility of equality training and updates being shared with the committee.	**20/07/21**	Nicola Foreman	Ongoing discussions to be had following departure of the EDWOD **Bring to July meeting**
MHCL 21/01/009	Mental Capacity Act Monitoring Report	Update on use of IMCA's to be provided.	**20/04/21**	Ruth Walker	**Verbal update** to be shared as part of the Mental Capacity Act Monitoring Report, item 10.1.
Actions referred to committees of the Board					
MHCL 19/10/012	HIW Mental Health Act Report	Bring all Estates concerns together to be reported at a Management Executive Meeting.	TBC	Nicola Foreman	Ongoing.
MHCL 19/06/008 MHCL 20/02/005	Mental Capacity Act Monitoring Report	To discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave. The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee.	Date to discuss at HSMB	Stuart Walker	Agreement not reached with LNC at present. Discussions are ongoing. This item will be reviewed by the S&D Committee and reported back to a future meeting.

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring report**						
Meeting:	**Mental Health and Capacity Legislation Committee**				**Meeting Date:**	20.04.2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Deputy Executive Nurse Director** **Assistant Director of Patient Safety and Quality**						

Background and current situation:

The purpose of this report is to provide a general update on current issues and to introduce a set of key MCA and DoLs indicators, which have been identified in order to provide the Committee with a greater level of assurance and monitoring, than has previously been in place. Once agreed, it is proposed that the fully populated dashboard is presented at each Committee meeting. The Committee should be advised, that not all data is currently available but this will be fully addressed by the next Committee meeting in July 2021.

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

A range of proposed MCA and DoLS indicators have been identified in order to strengthen current monitoring and assurance processes.(see Appendix 1).

The UHB is currently working with Welsh Government to provide a level of baseline data, to inform the implementation of the Liberty Protection Safeguards (LPS), which are planned to come in to force in April 2022. The UHB will respond by April 12th 2021 as required (see Appendix 2).

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

ASSESSMENT

Liberty Protection Safeguards (LPS)
As the Committee will be aware, the Liberty Protection Safeguards (LPS) are planned to come into force in April 2022. These safeguards will provide protection for people aged 16 and above whose care and treatment requires a deprivation of their liberty and who lack the mental capacity to consent to their arrangements. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the existing Deprivation of Liberty Safeguards (DoLS) system.

These important safeguards will help to protect the rights of some of our most vulnerable populations in Wales, help to improve their outcomes and ensure that the Mental Capacity Act is

working as intended – where the individual is at the heart of all decision making.

LPS will introduce a number of changes to DoLS, including extending the scope of the scheme to 16 &17 years olds and individuals in domestic settings.
More information is available within the UK Government fact sheets;
https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets

Cardiff & Vale UHB is currently in discussions with both Cardiff and The Vale Local Authorities to develop an implementation group in preparation for the statutory changes.

Independent Mental Capacity Act (IMCA) referrals

There has been a total of 73 referrals to the IMCA service, between October 2020 – December 2020. Reasons for the referrals are summarised below:

- Serious Medical Treatment – 7
- Long Term Move of Accommodation – 14
- Adult Safeguarding – 1
- Care Review – 2
- Relevant Person's Representative (RPR) – 42
- IMCA 39d – 7
- IMCA 39C – 0
- IMCA 39a – 0

Service issues/Areas of concern

Since the last report to Committee there have been a number of issues of concern:

- Lack of understanding and acknowledgement from professionals across the health board in relation to Court of Protection processes and requirements. This has been identified a training issue and the UHB will liaise with Legal and Risk services to provide some relevant training for staff in the next two months as well as the provision of suitable guidance to support staff with difficult clinical decision making.

- There have been inconsistencies across wards and hospitals in regards to speaking to clients over telephone/face time. Some have been able to facilitate this while others have not. Partnership discussions are taking place about re-instating normal face to face assessments so that the process is more robust

Positive practices observed by IMCA's

- AN IMCA is currently acting as the RPR for P whose discharge to a care home is currently being arranged. P was hesitant about the idea of moving to a care home setting, however the discharge liaison nurse arranged a 'virtual tour' with the staff at the care home which P participated in. The IMCA spoke to P after she had the tour who expressed

that she felt a lot more confident about the move. The IMCA has highlighted that it is positive that P has been supported with relevant information in order to make an informed decision, as outlined in the principles of the MCA 2005.

Recommendation:

The Mental Health and Capacity Legislation Committee is asked to **NOTE** the contents of the report and agree that the proposed set of MCA and DoLS indicators are suitable and appropriate to provide the required level of assurance and monitoring.

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.*

NHS WALES GIG CYMRU

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Report to the

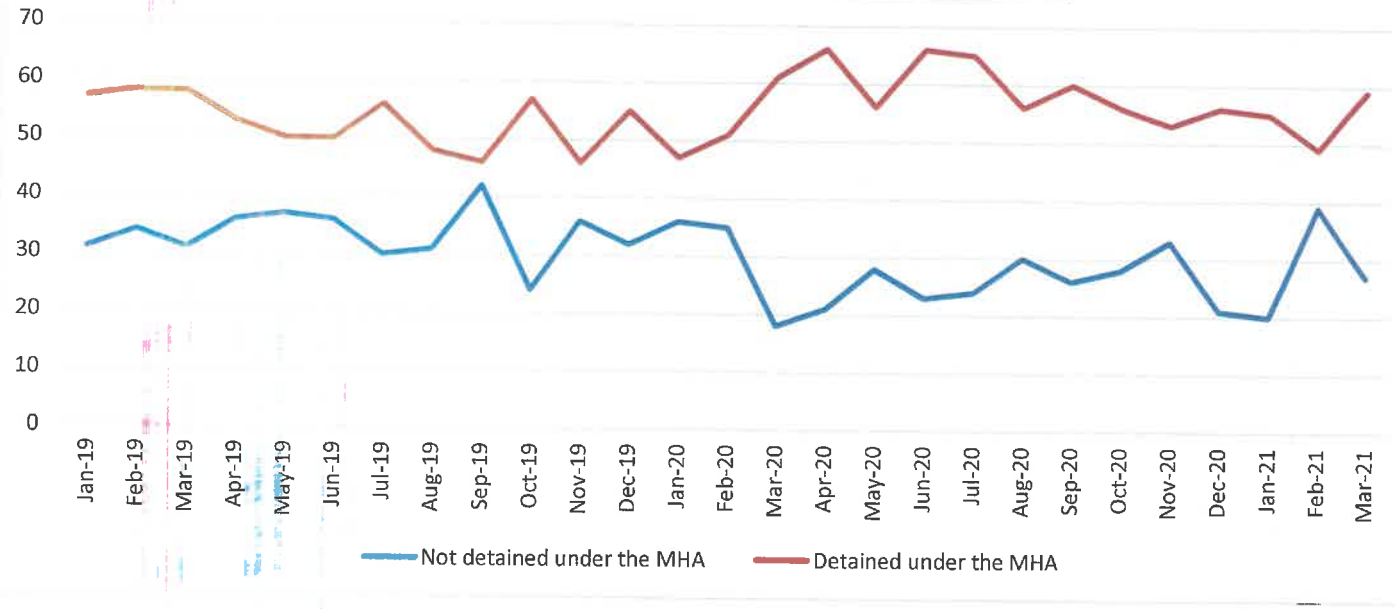
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

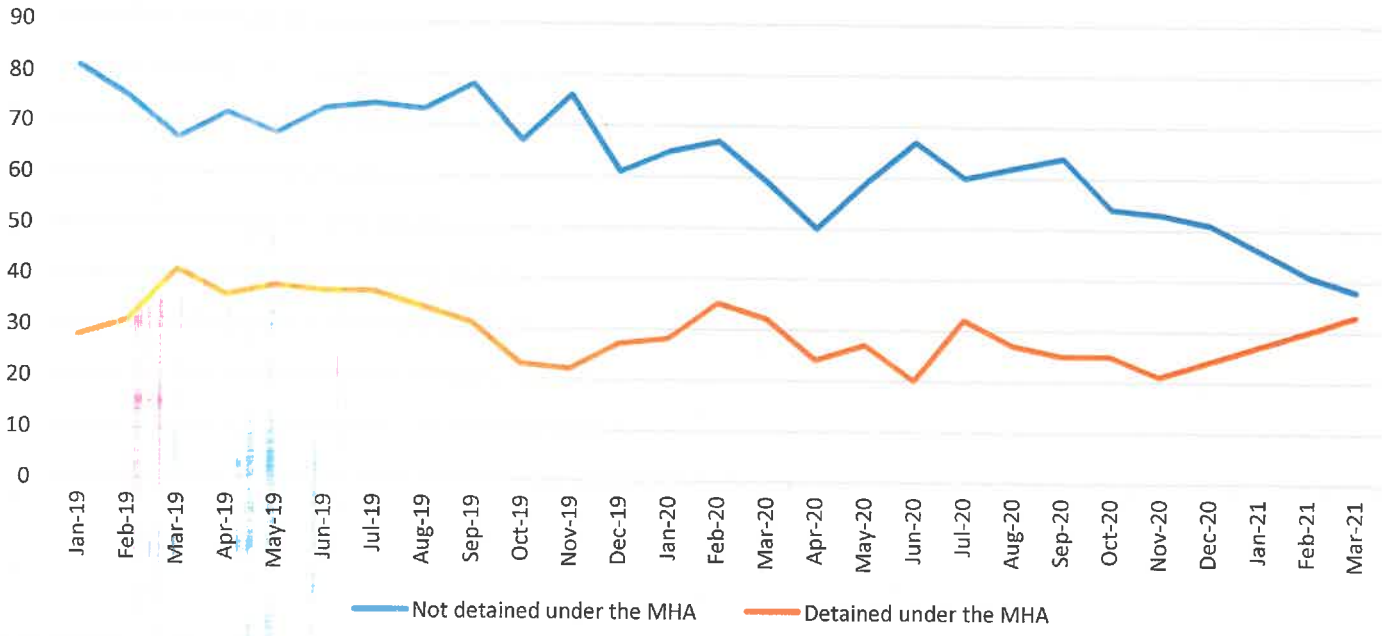
January- March 2021

Contents	Page

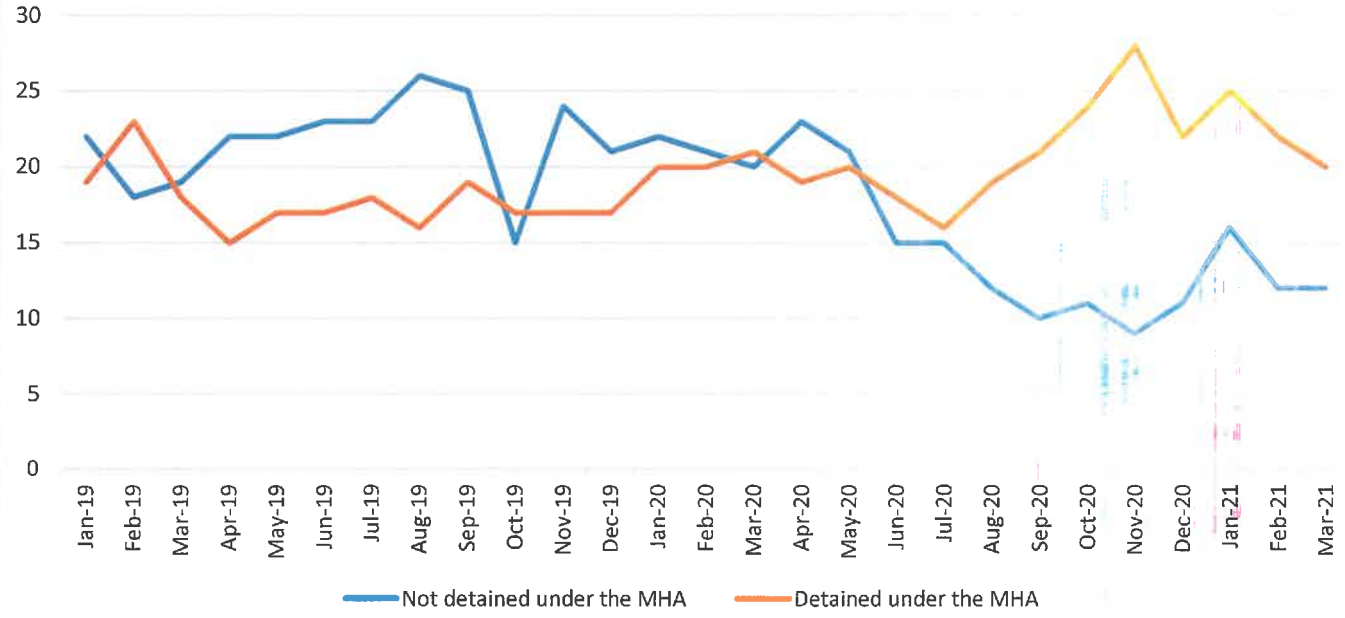
Adult Acute- Detained MHA/ Not Detained MHA



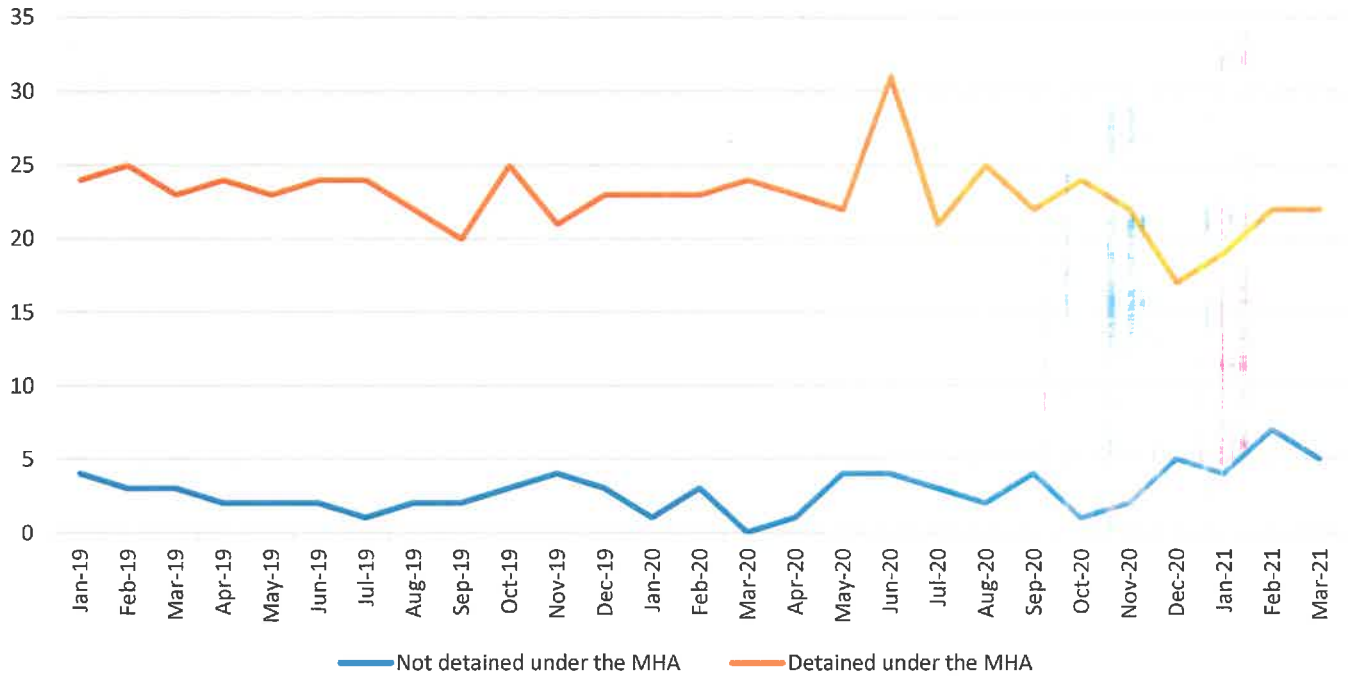
Mental Health Services for Older people- Detained/ Not Detained MHA



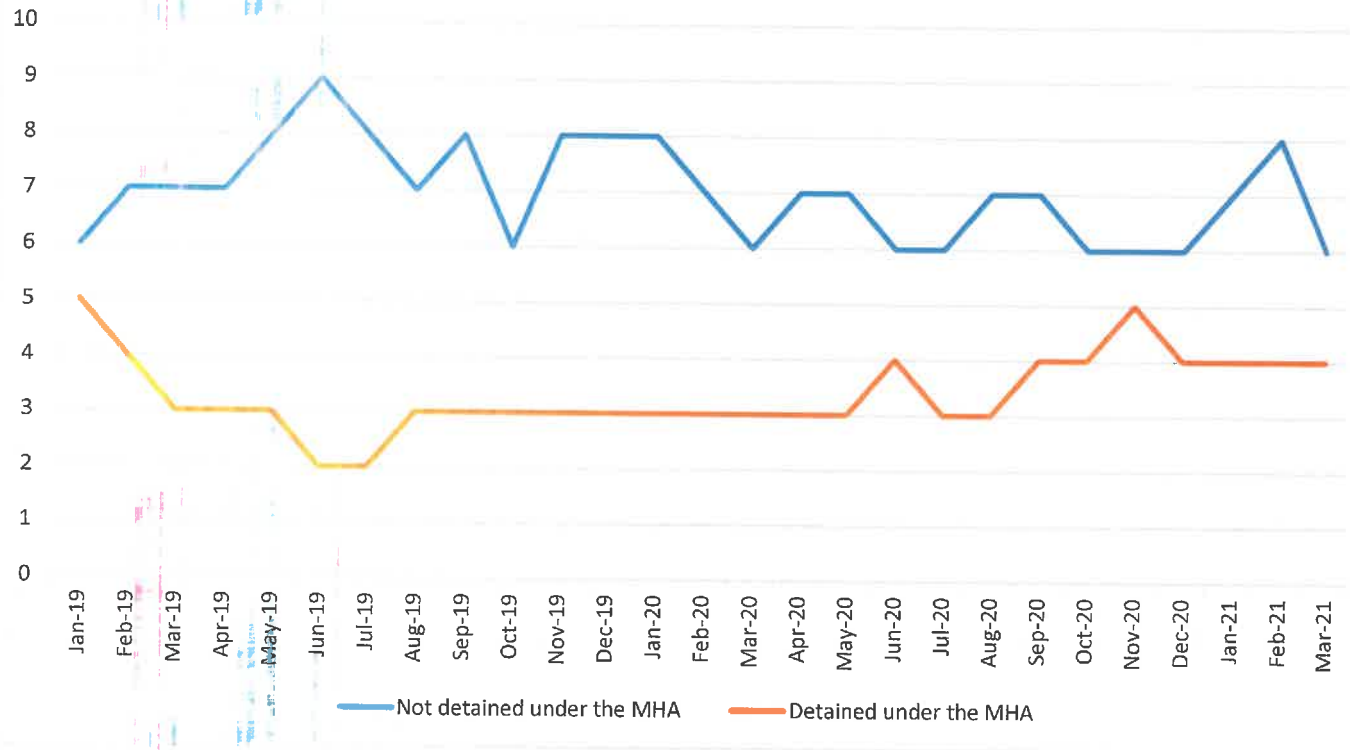
Rehabilitation- Detained MHA/ Not Detained MHA



Low Secure- Detained/ Not Detained MHA



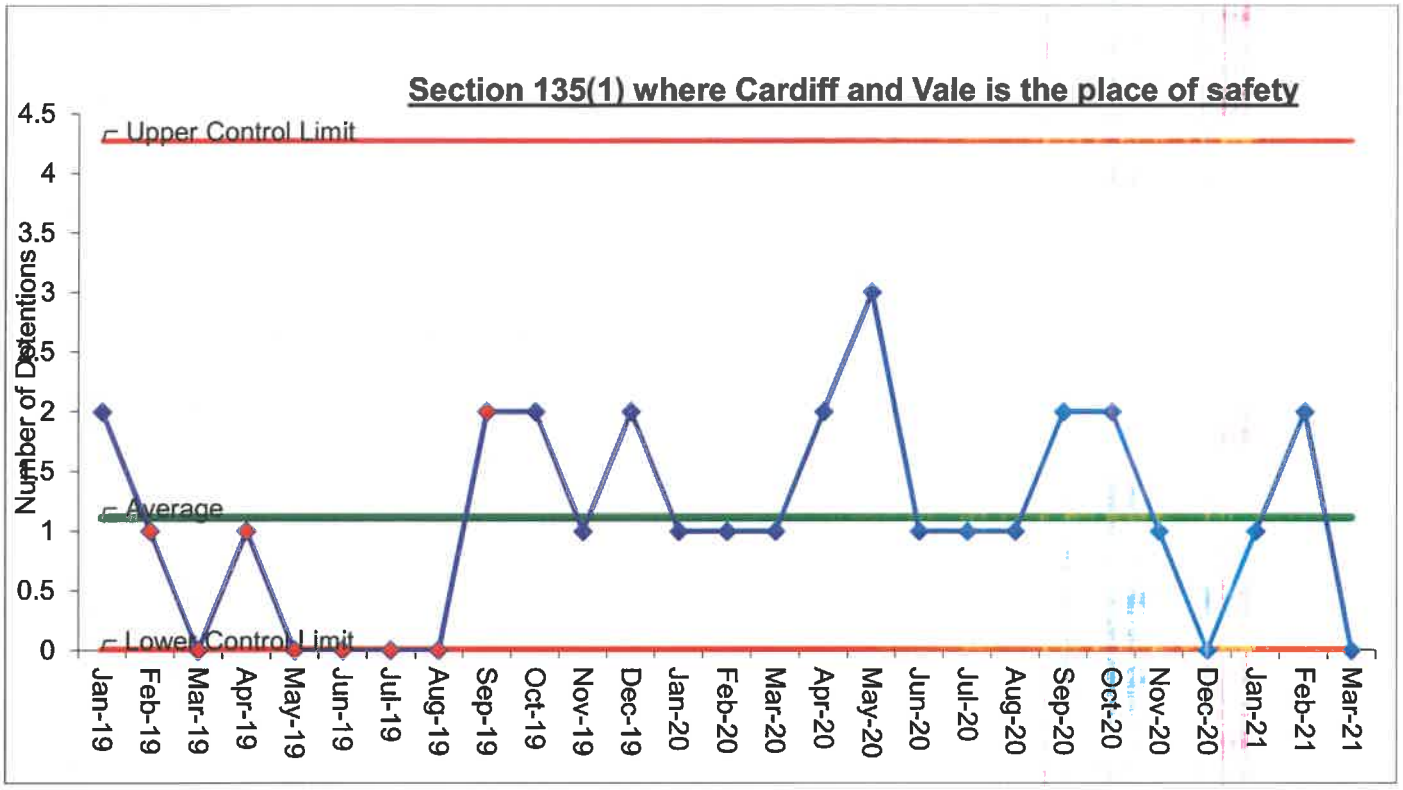
Neuropsychiatry- Detained MHA/ Not Detained MHA



Addictions- Detained MHA/ Not Detained MHA

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

During the period Section 135 (1) powers were used on three occasions. Two patients were subsequently admitted under Section 2, and one was discharged home.



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

Voluntary Assessment

On the 14th of July, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

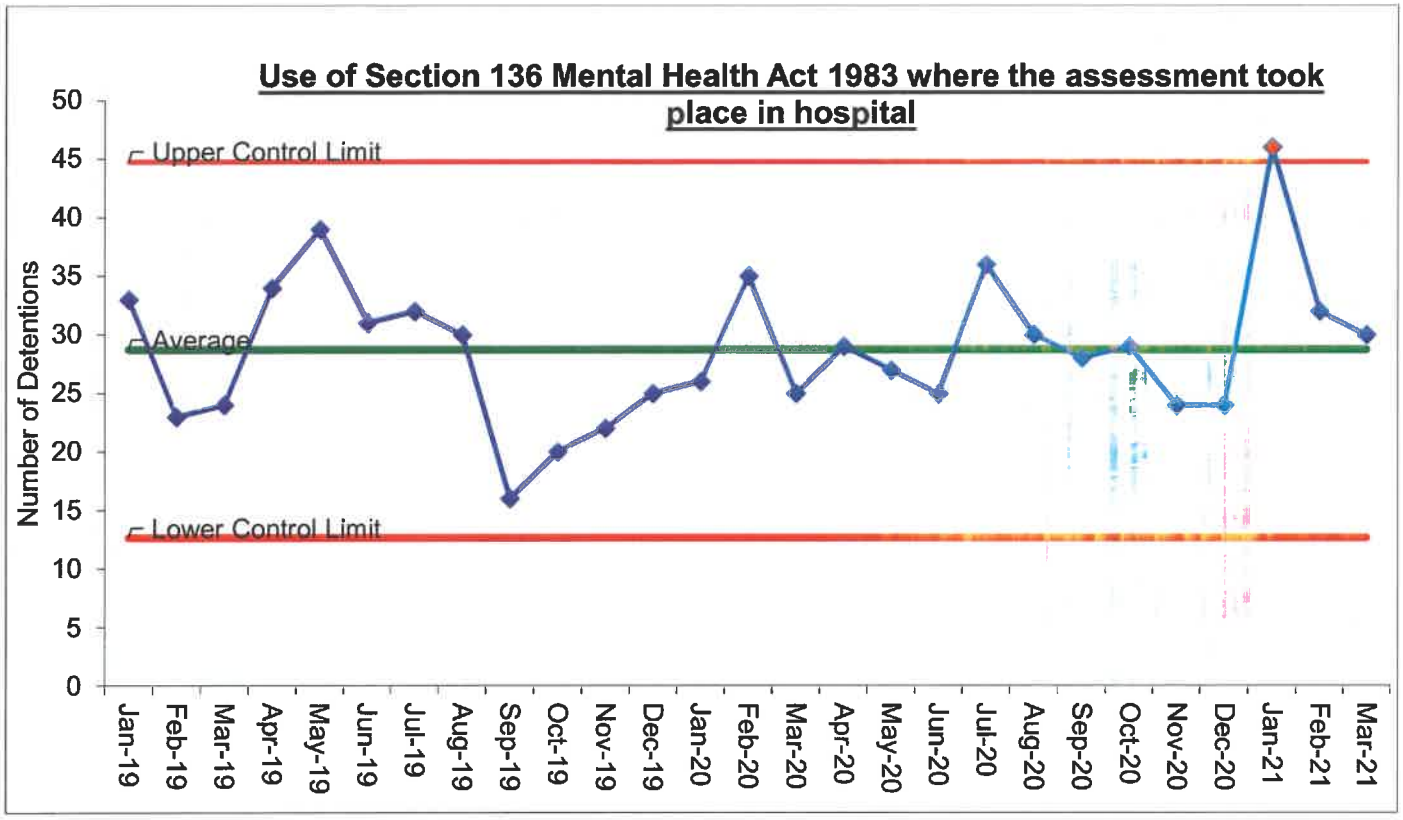
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

There has been an initial transition period where the AWMF has been underutilised, but this is improving. A number of measures have been put in place to improve compliance, including (at the advice of South Wales Police) our refusal to accept and assess anybody brought by the Police without the attempt of completing an AWMF.

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

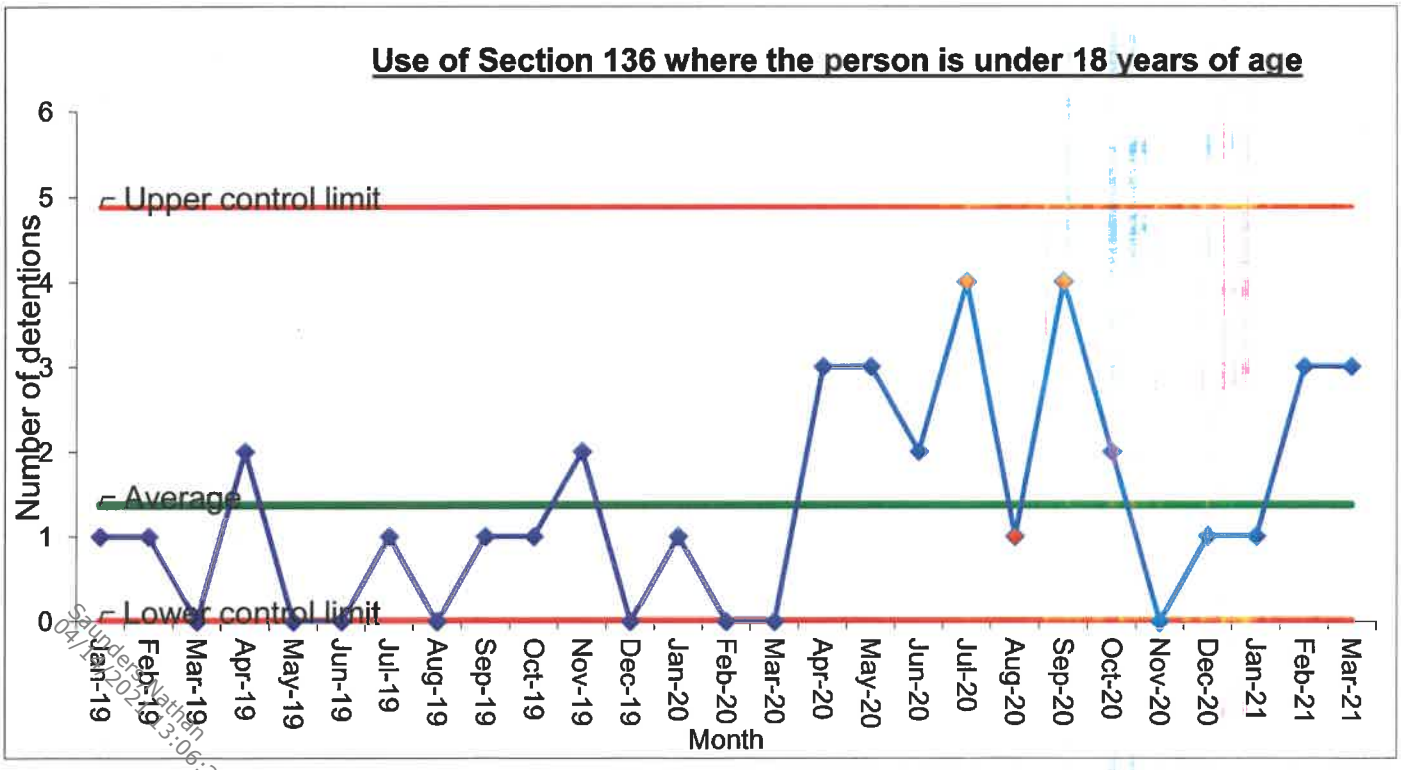
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

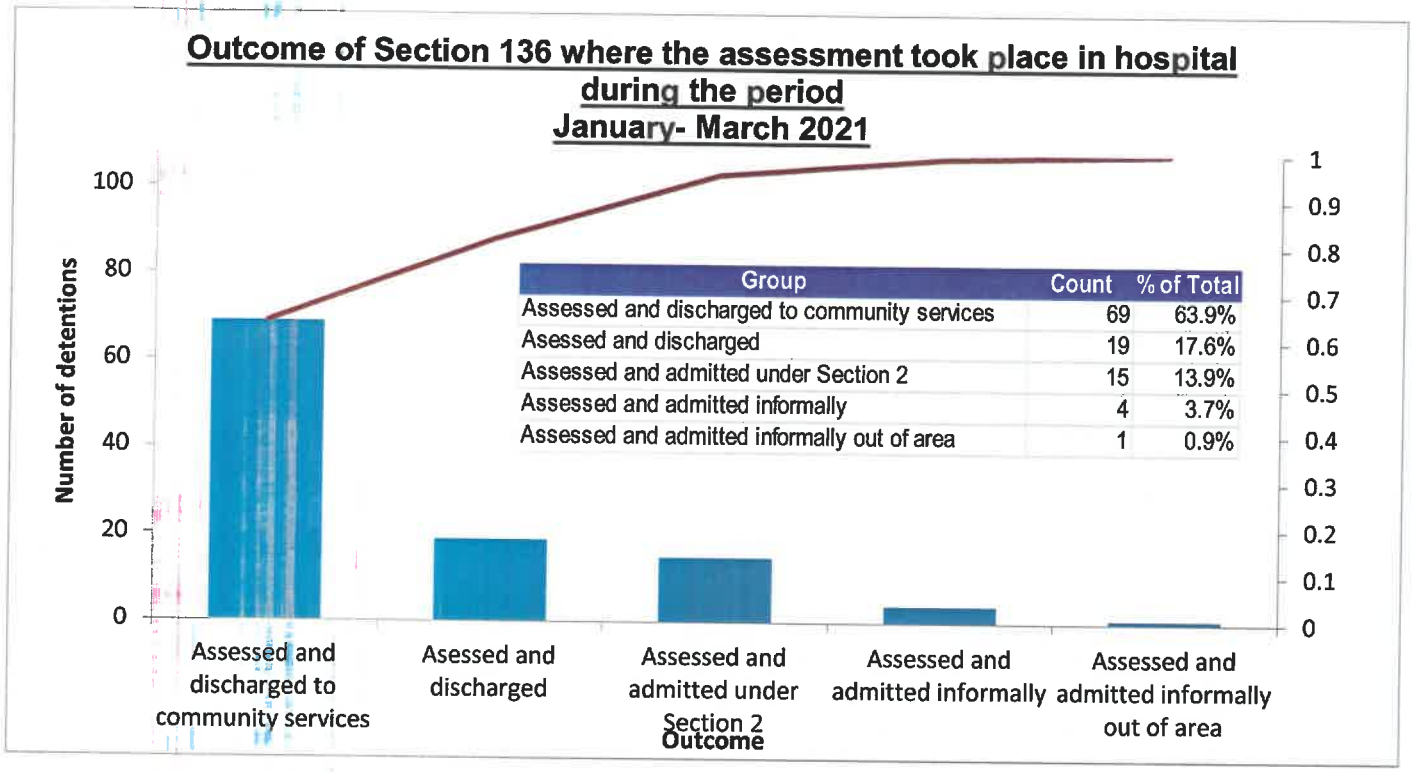
During the period a total of 108 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



Seven of those assessments were carried out on patients under the age of 18.

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



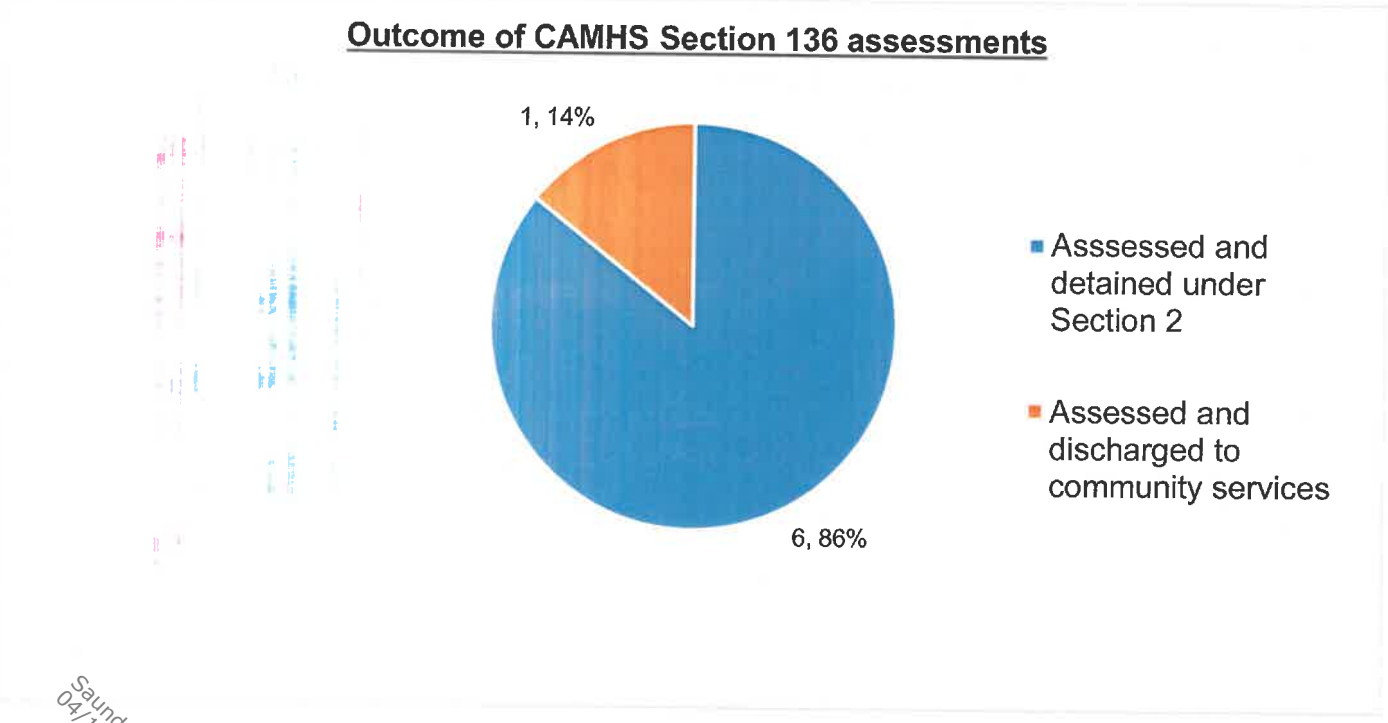


Group	Count	% of Total
Assessed and discharged to community services	69	63.9%
Asessed and discharged	19	17.6%
Assessed and admitted under Section 2	15	13.9%
Assessed and admitted informally	4	3.7%
Assessed and admitted informally out of area	1	0.9%

The pareto chart highlights that 81.5% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

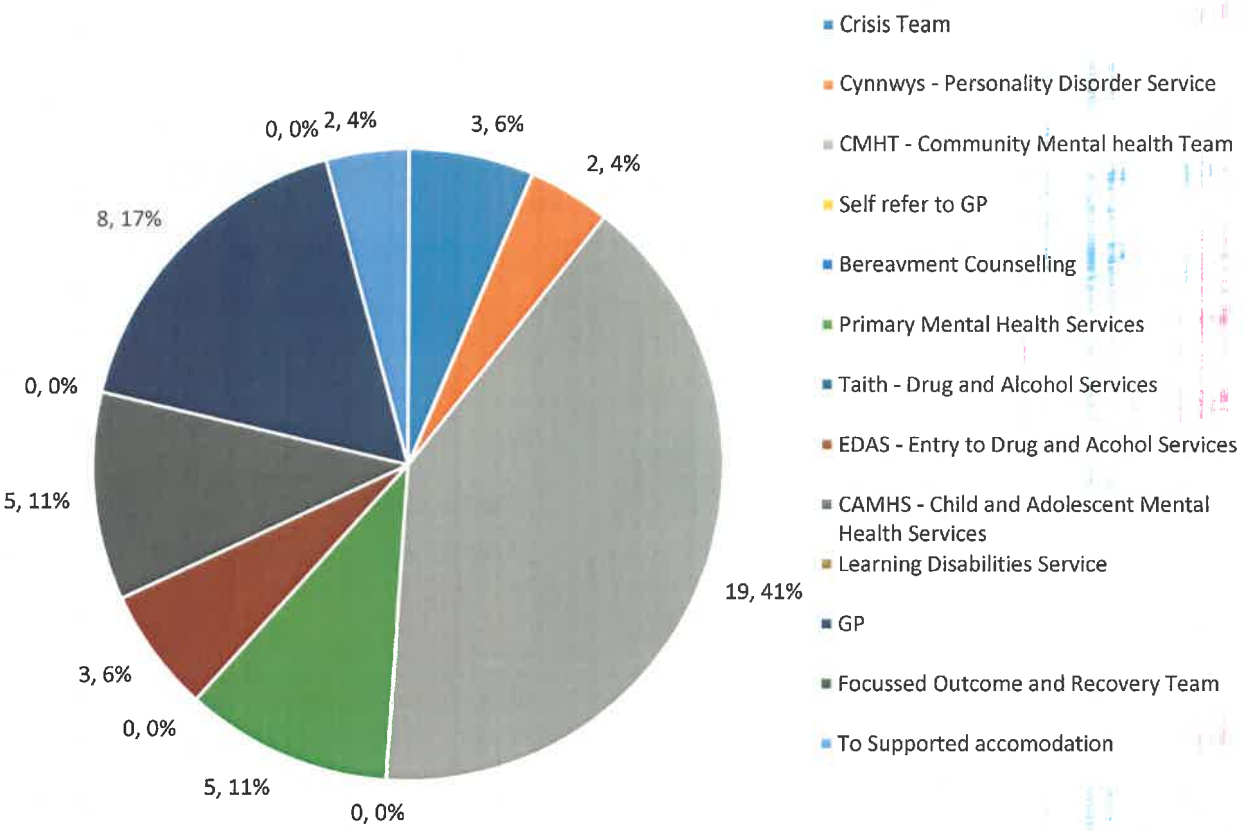
One of those assessed was admitted informally to a hospital under a different set of Managers.

Included in the above data are the outcomes for those under 18 years of age. Those outcomes are as follows;-



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

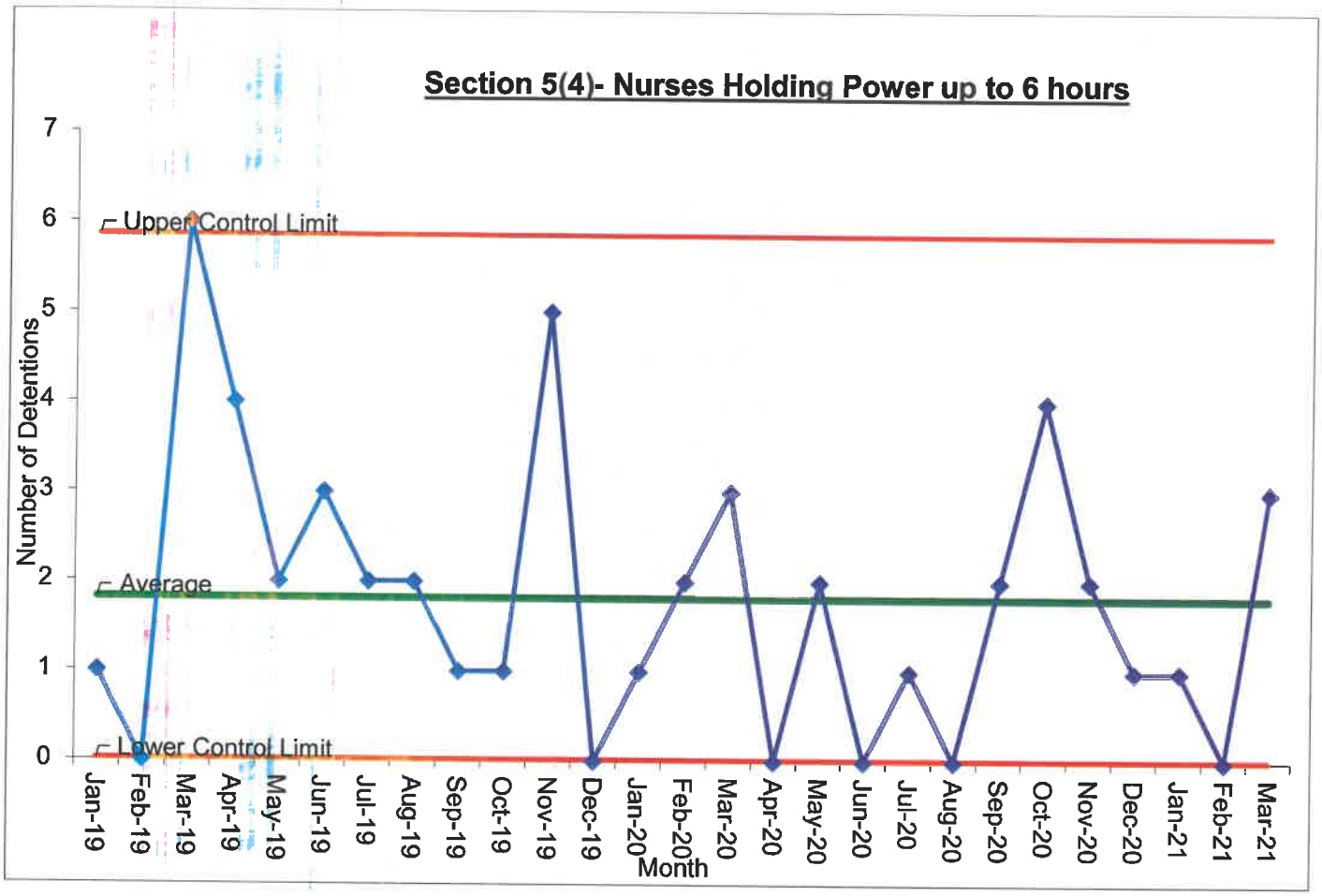
Discharge to Community Services



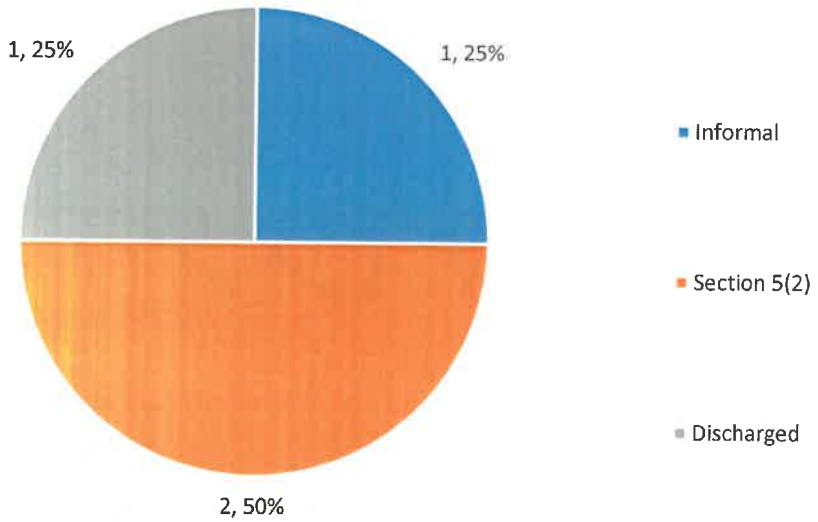
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

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

Section 5(4) - Nurses Holding Power

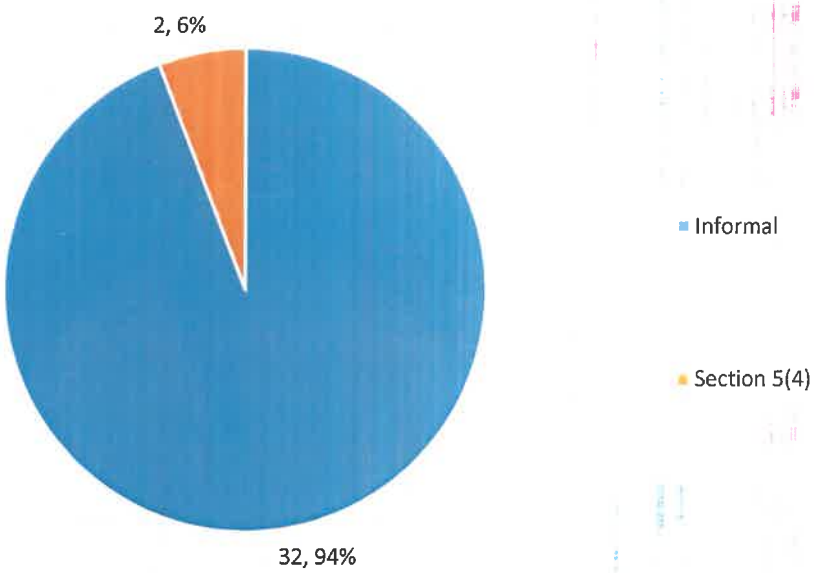


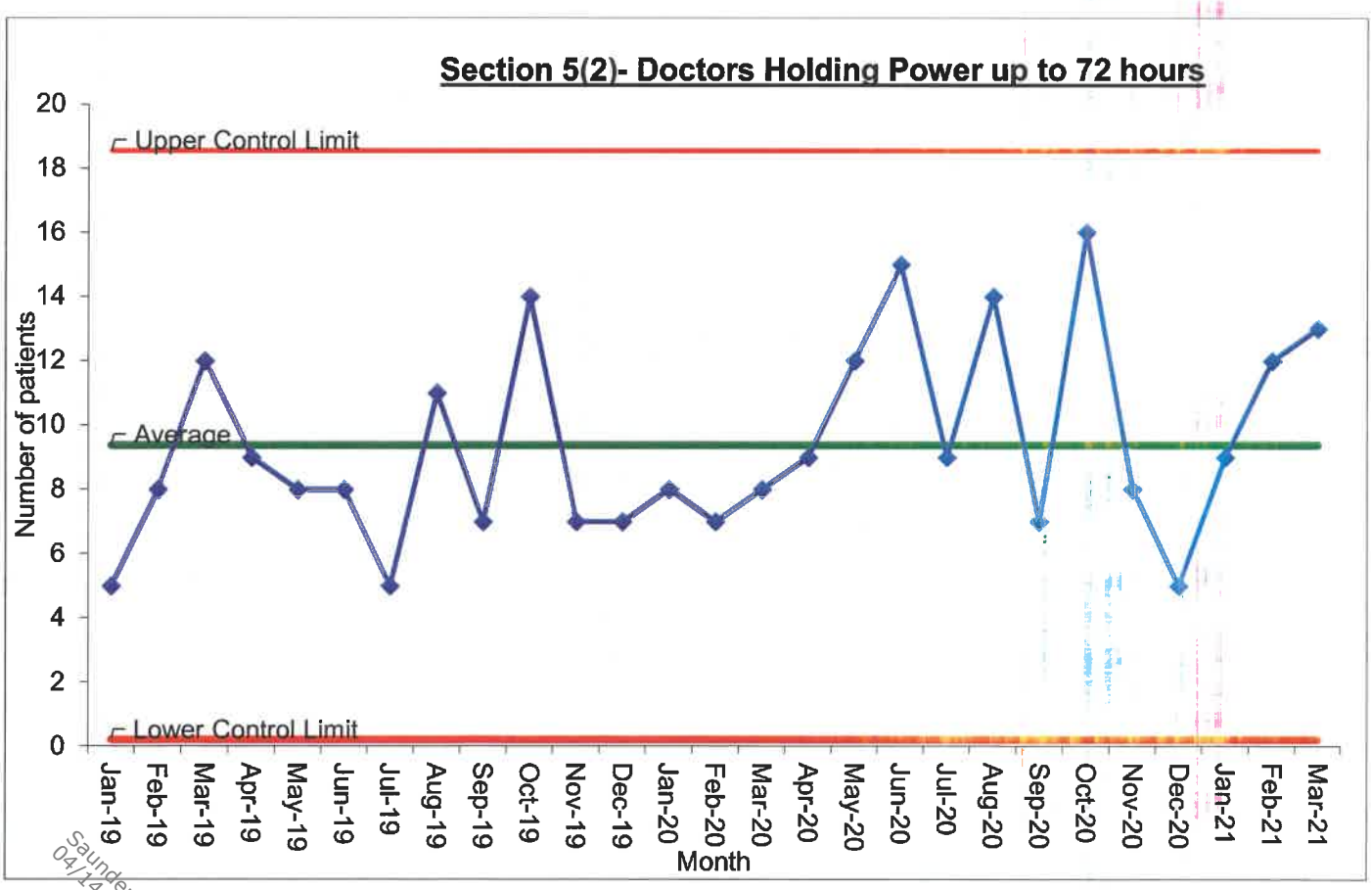
Outcome of Section 5(4) during the period January- March 2021

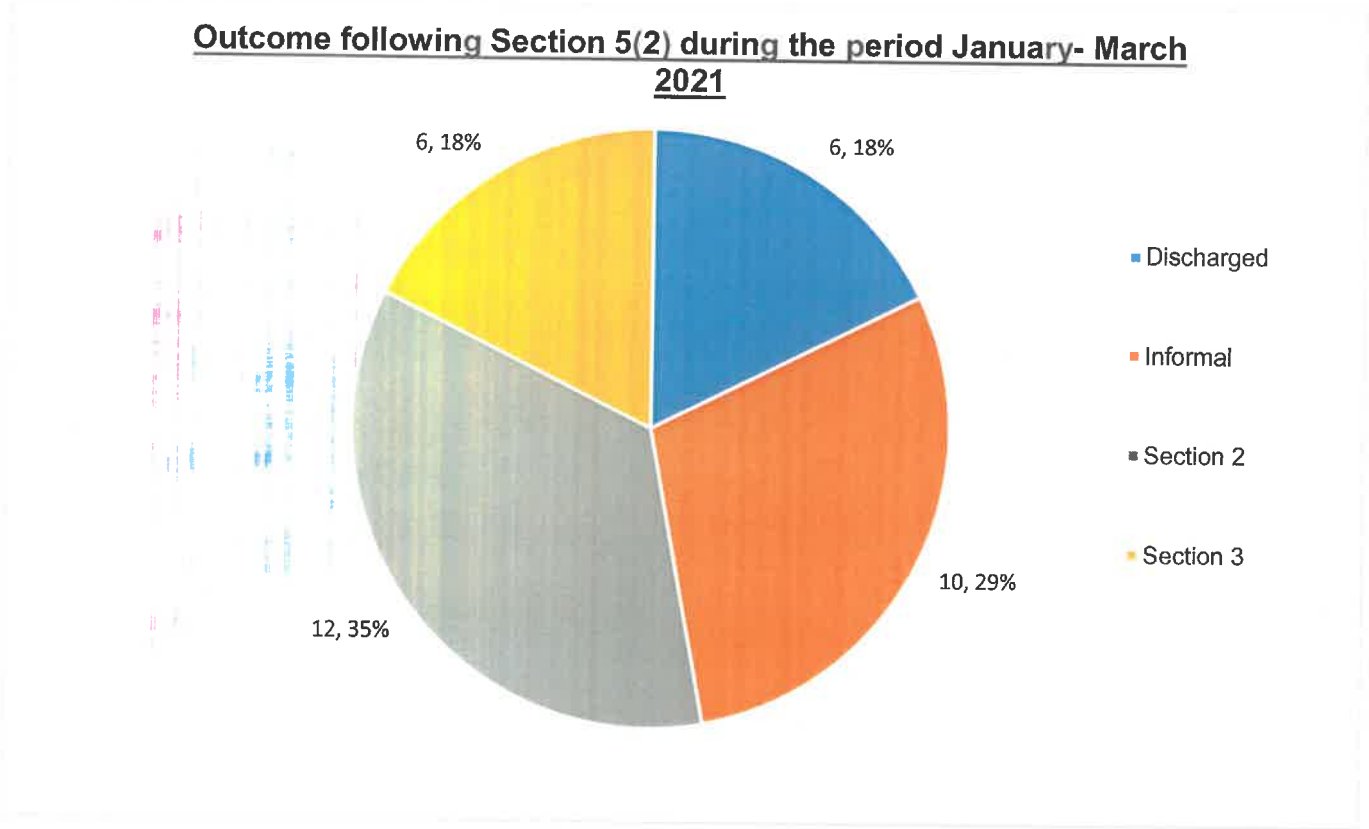


Section 5(2) - Doctors holding power

Legal Status Prior to Section 5(2) during the period January- March 2021



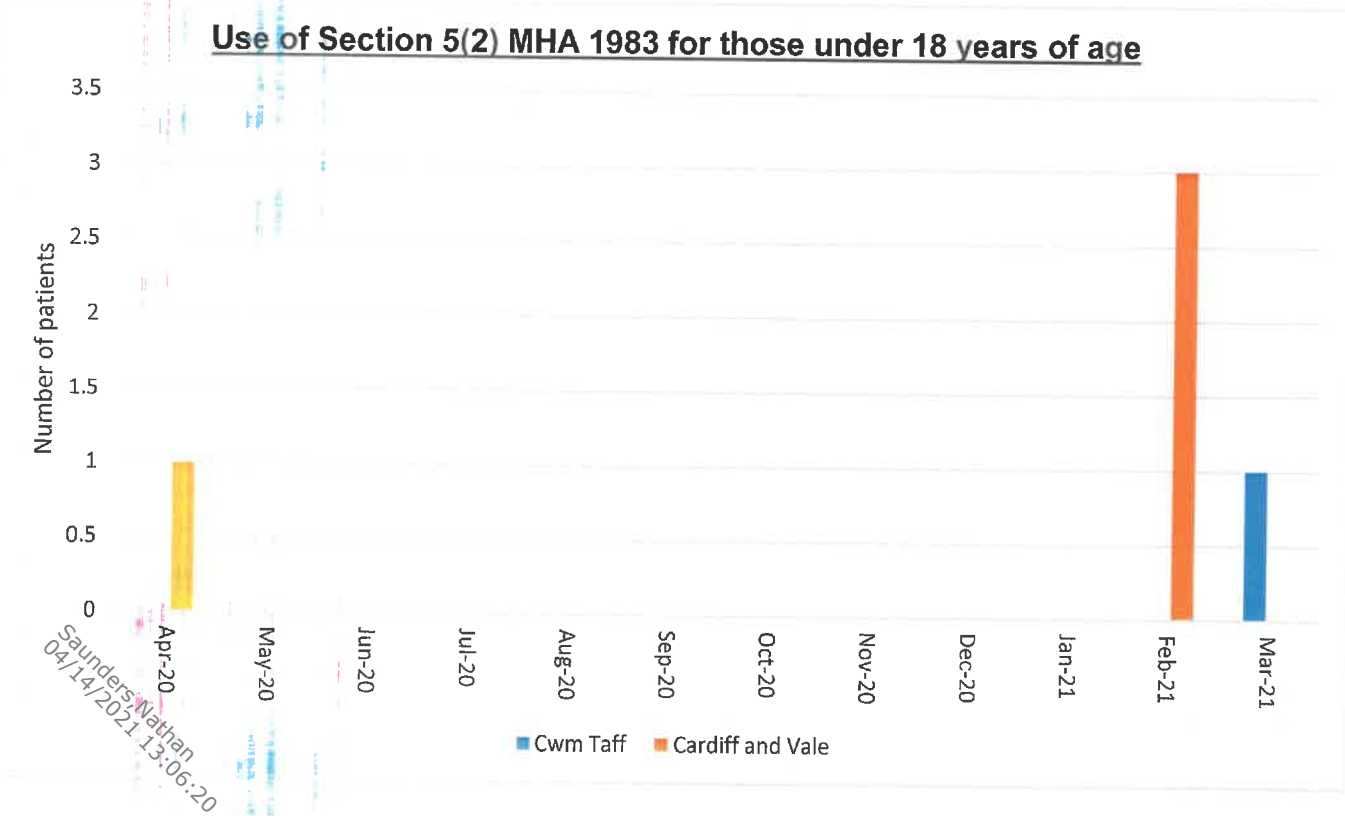


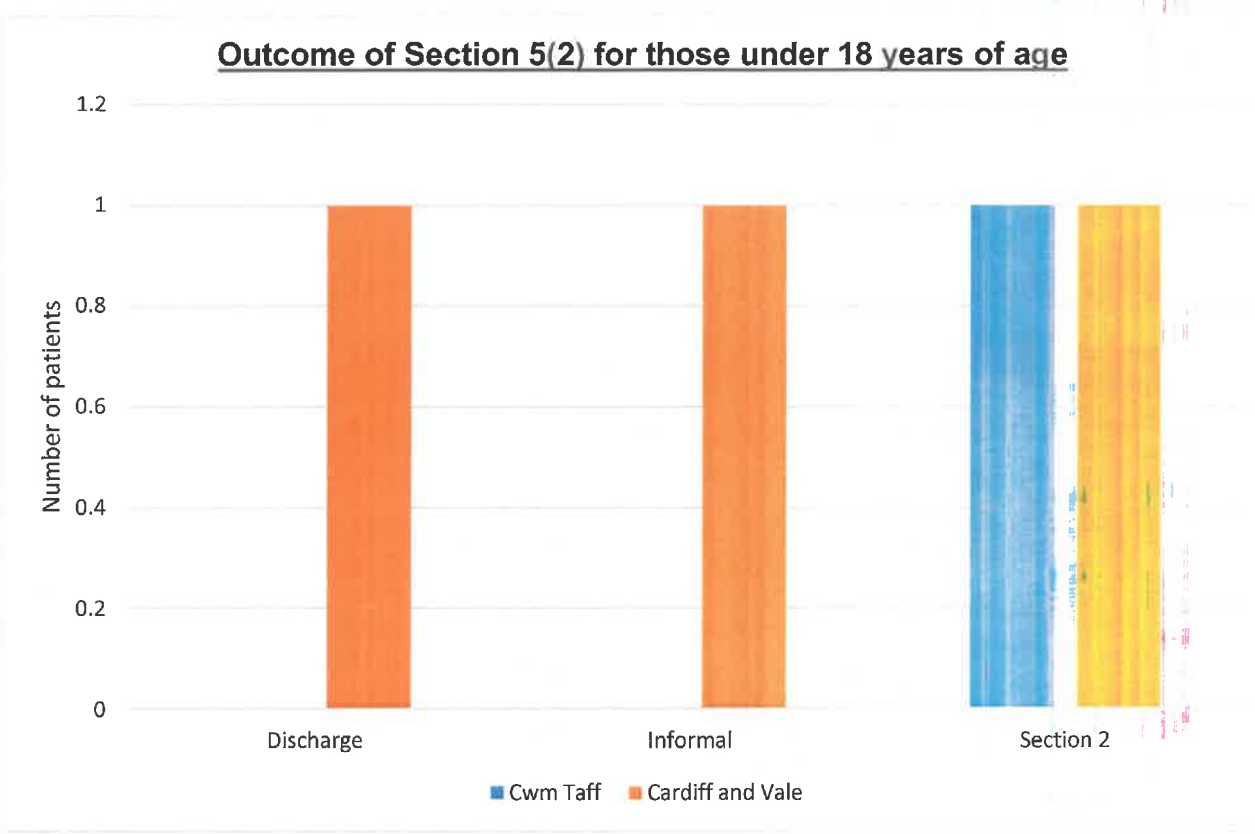


CAMHS Commissioned Inpatient Data

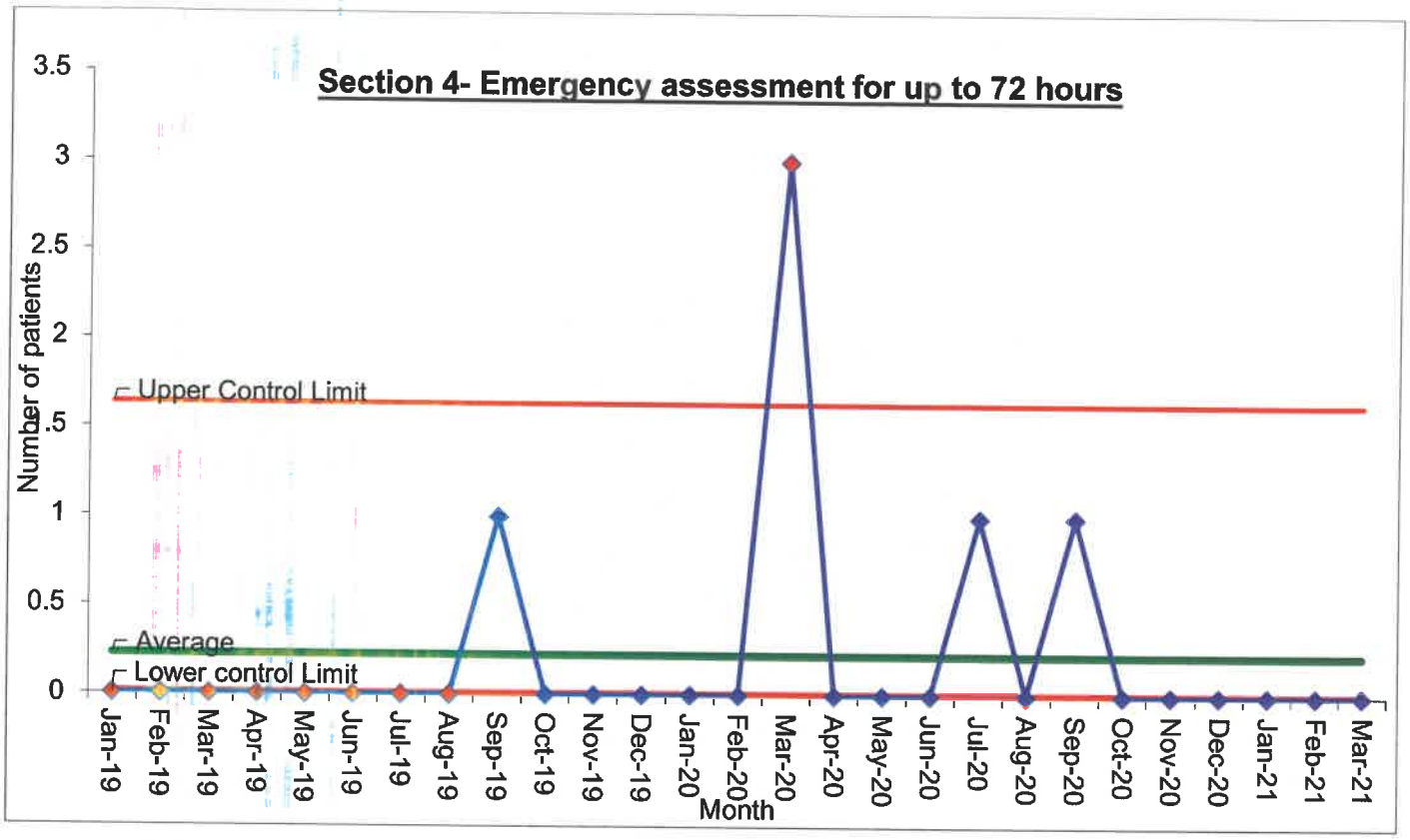
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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



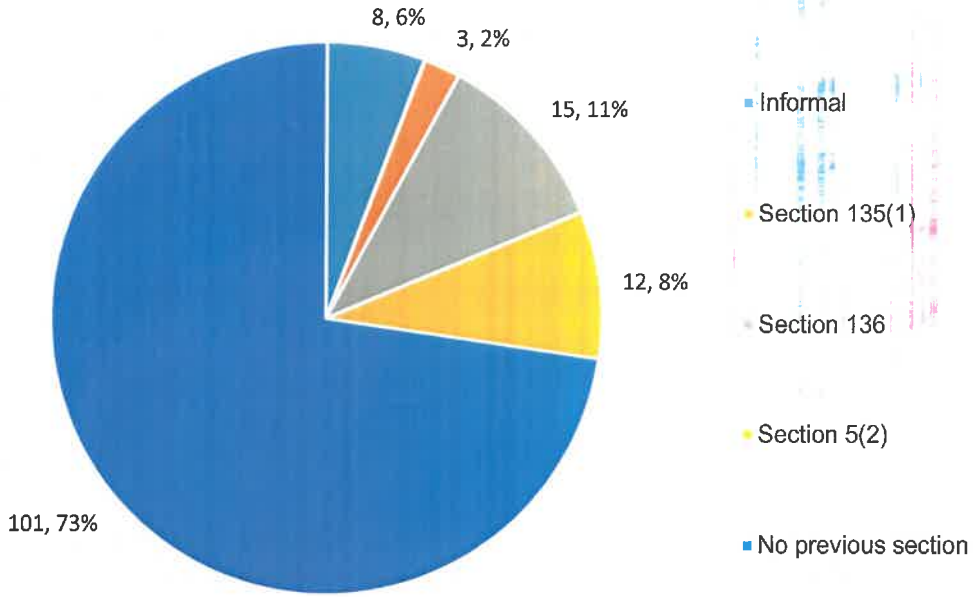


Section 4 - Admission for Assessment in Cases of Emergency

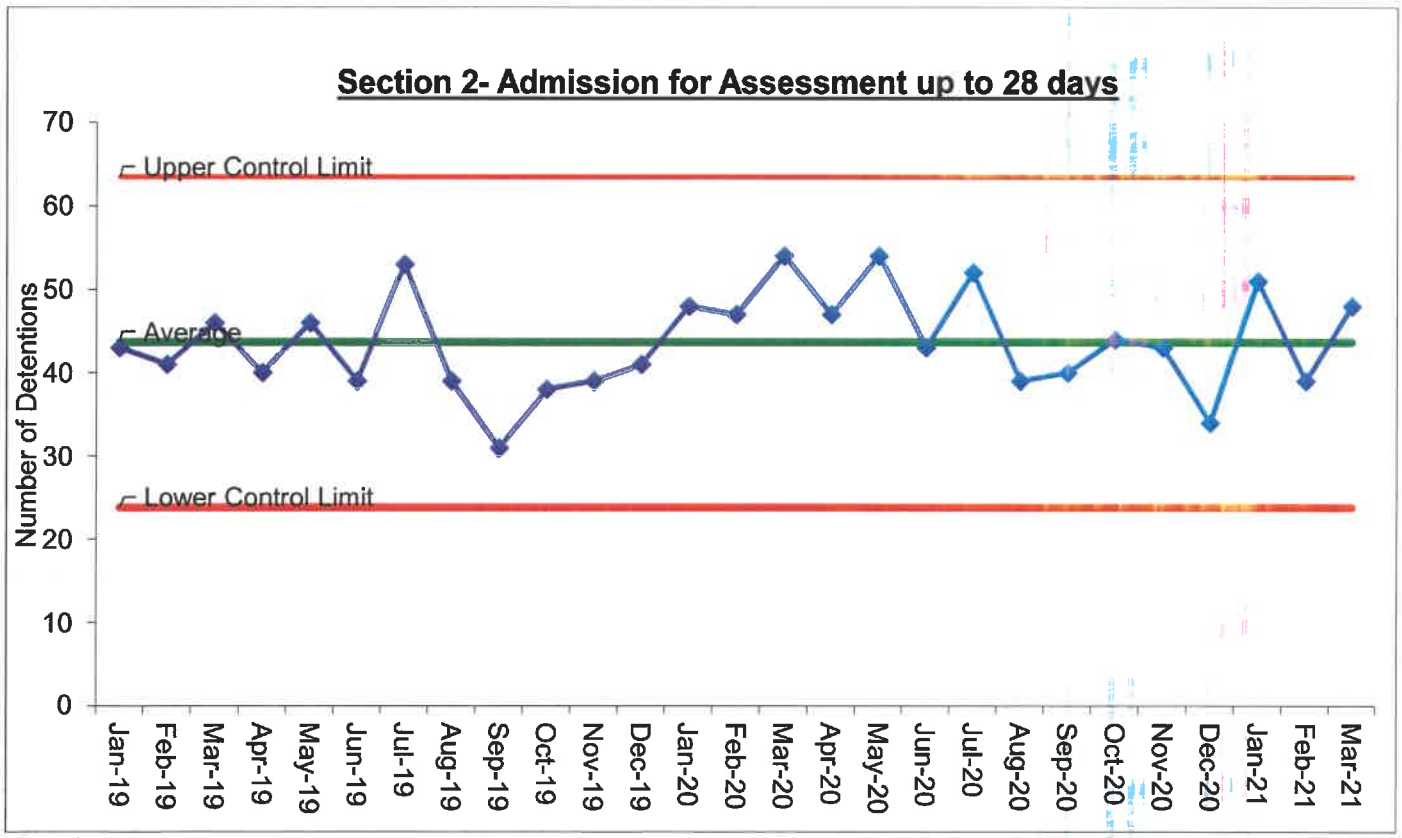


Section 2 – Admission for Assessment

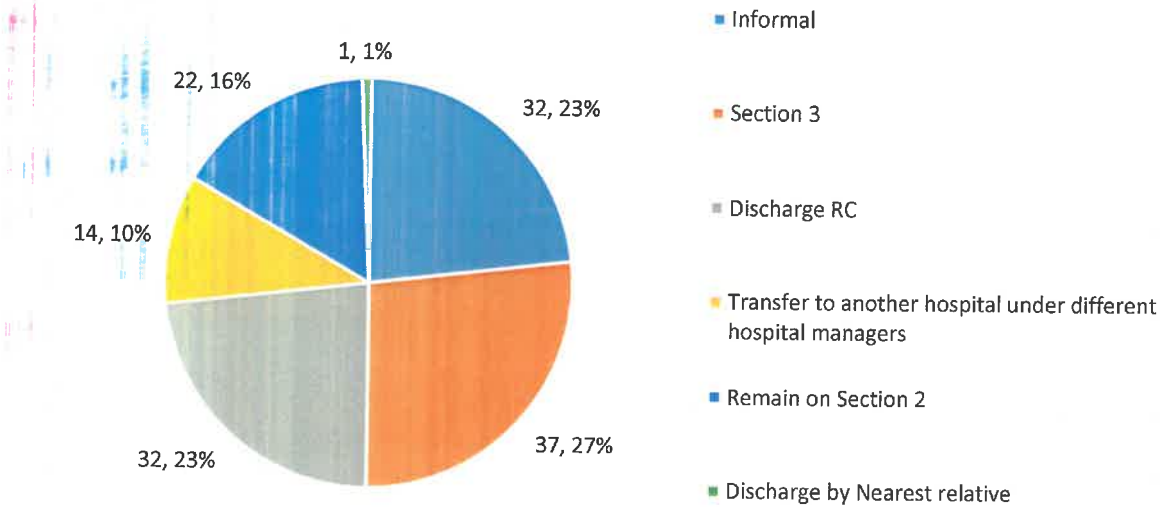
Legal status prior to Section 2 during the period January- March 2021



Section 2- Admission for Assessment up to 28 days



Outcome following Section 2 detention during the period January-March 2021

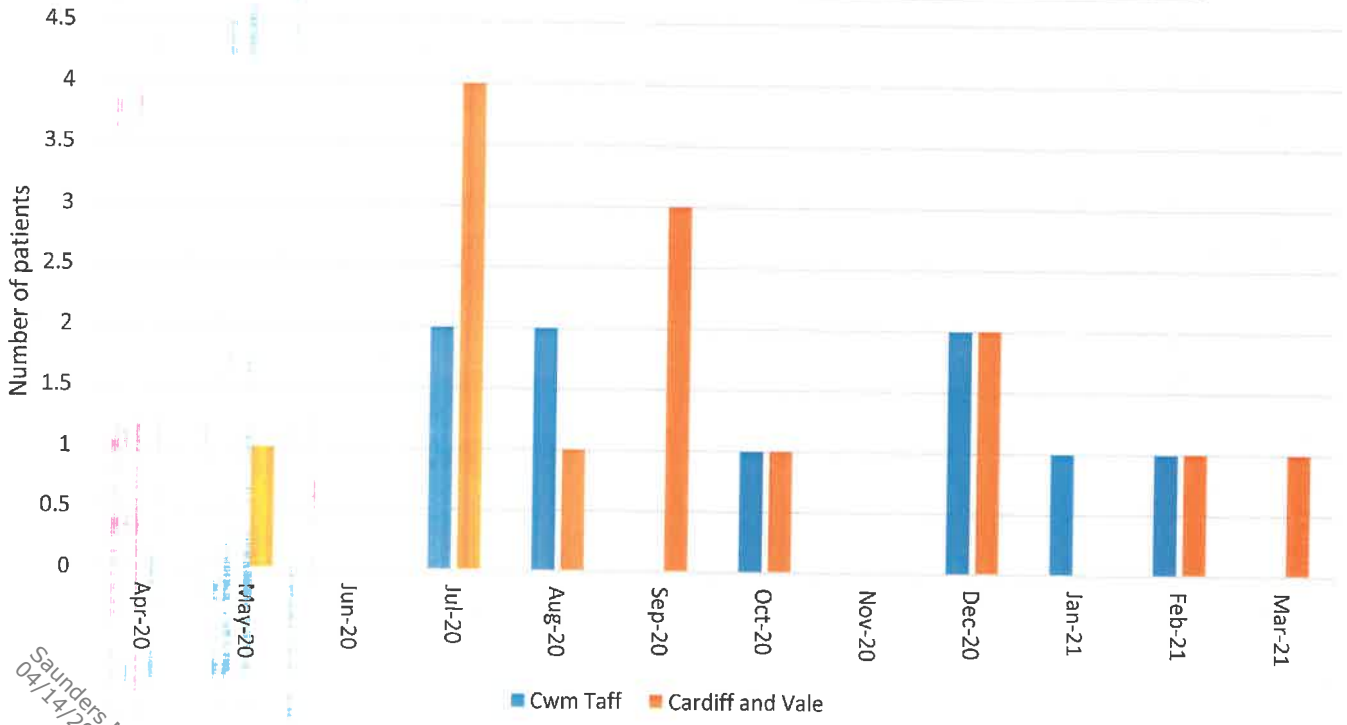


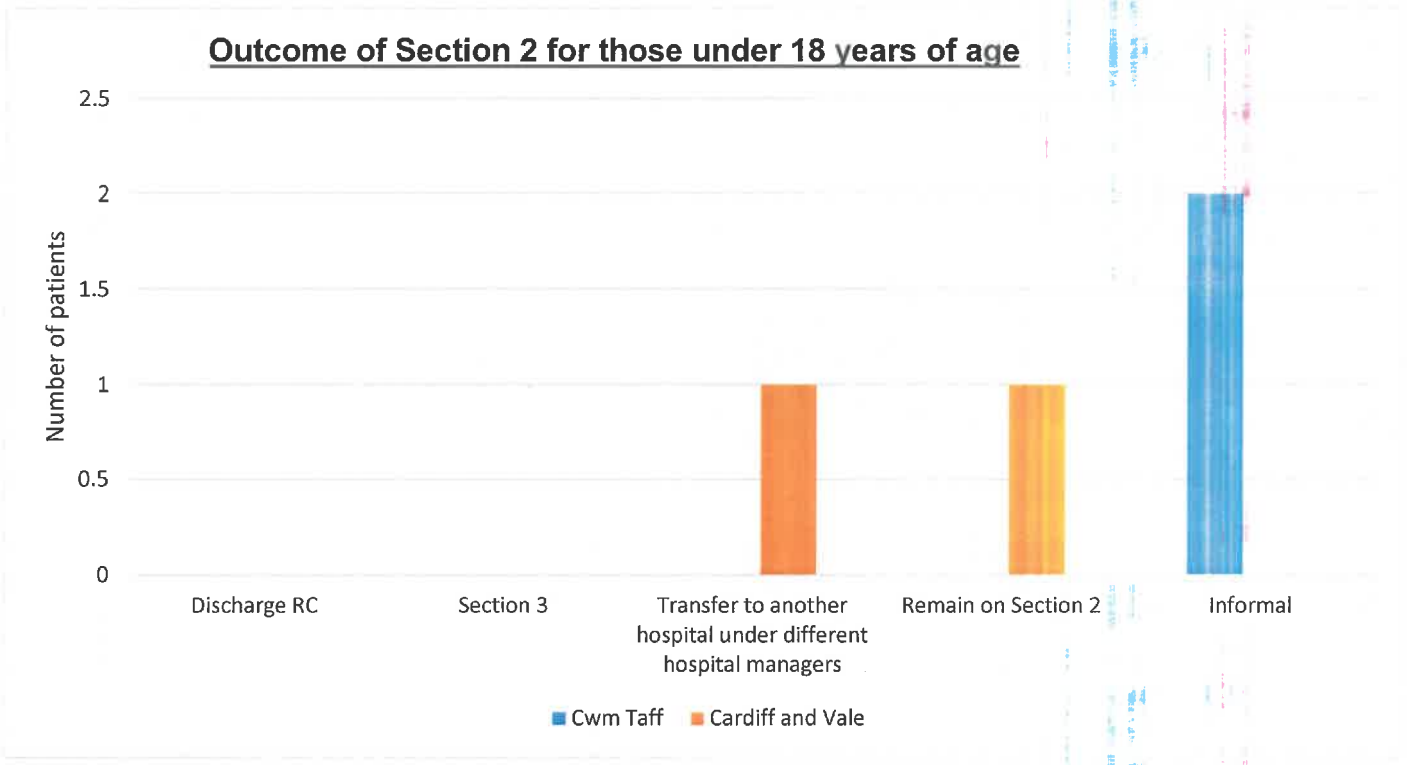
CAMHS Commissioned Inpatient Data

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

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

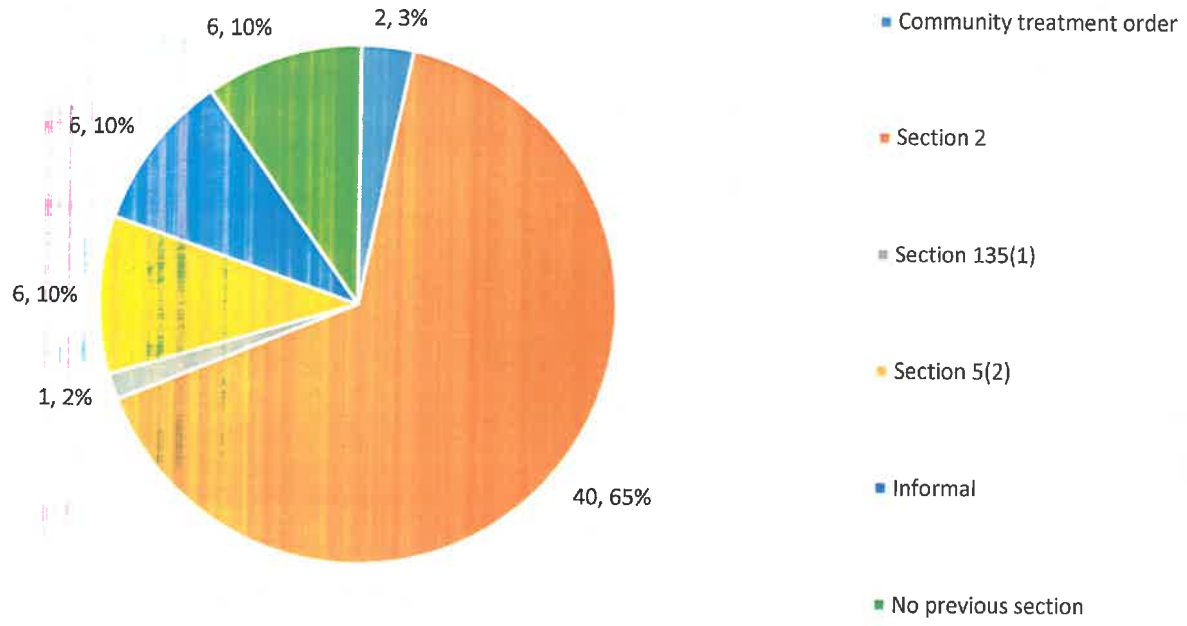
Use of Section 2 on those under 18 years of age by detaining authority

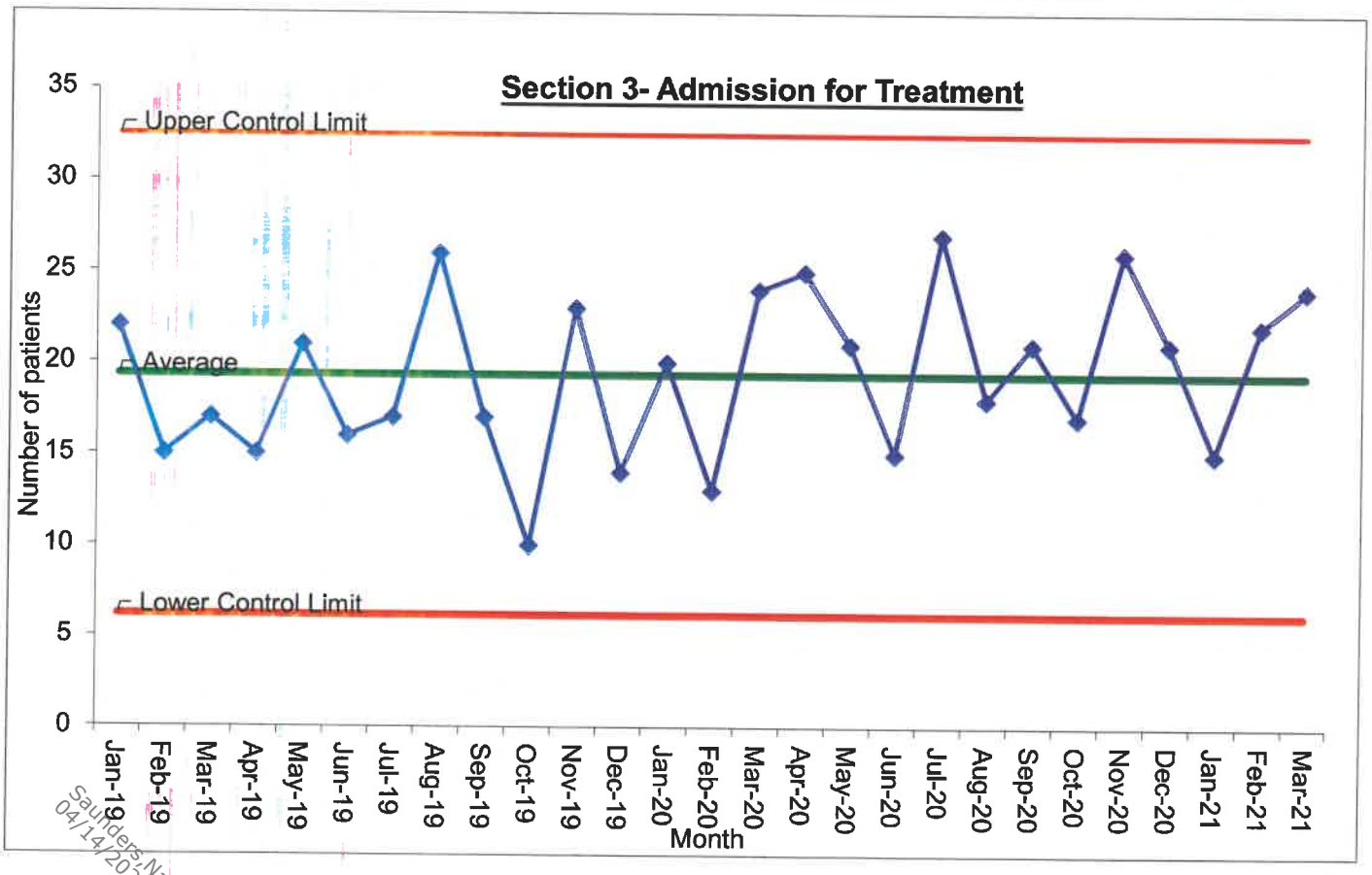




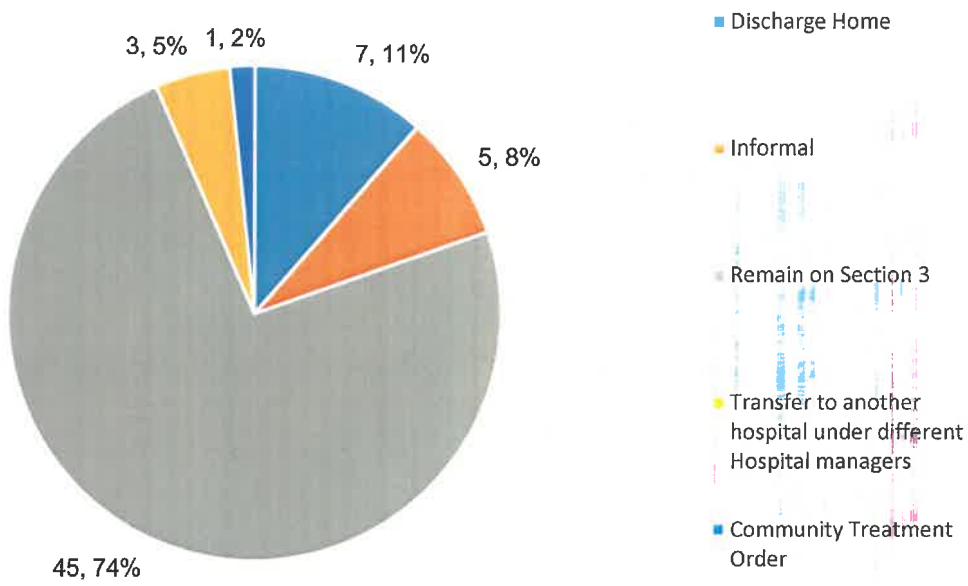
Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period January- March 2021





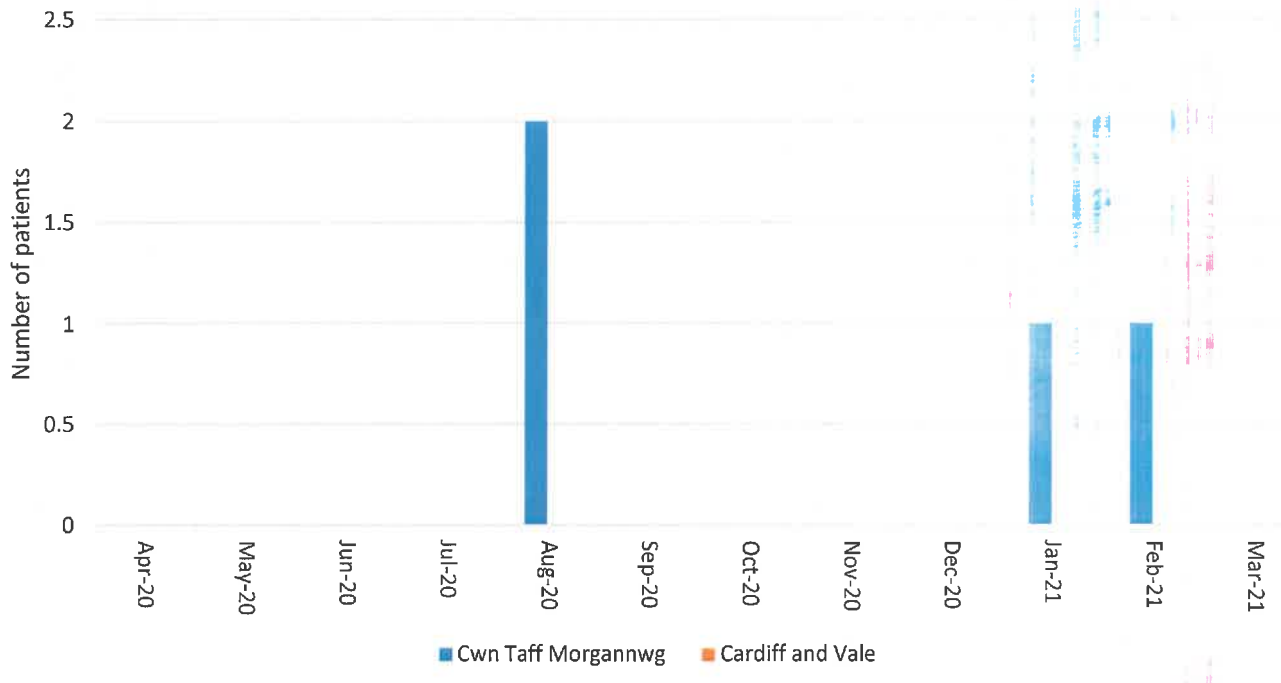
Outcome following Section 3 during the period January- March 2021



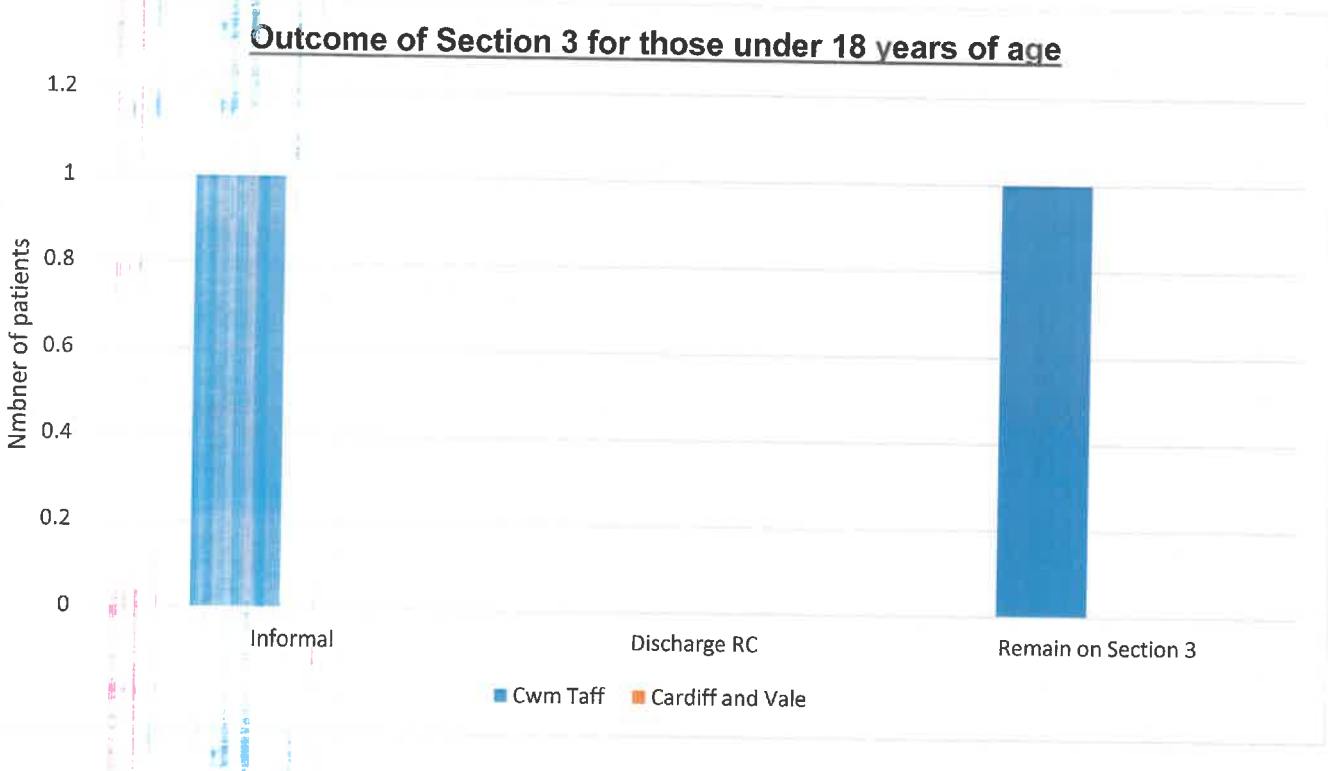
CAMHS Commissioned Inpatient Data

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

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



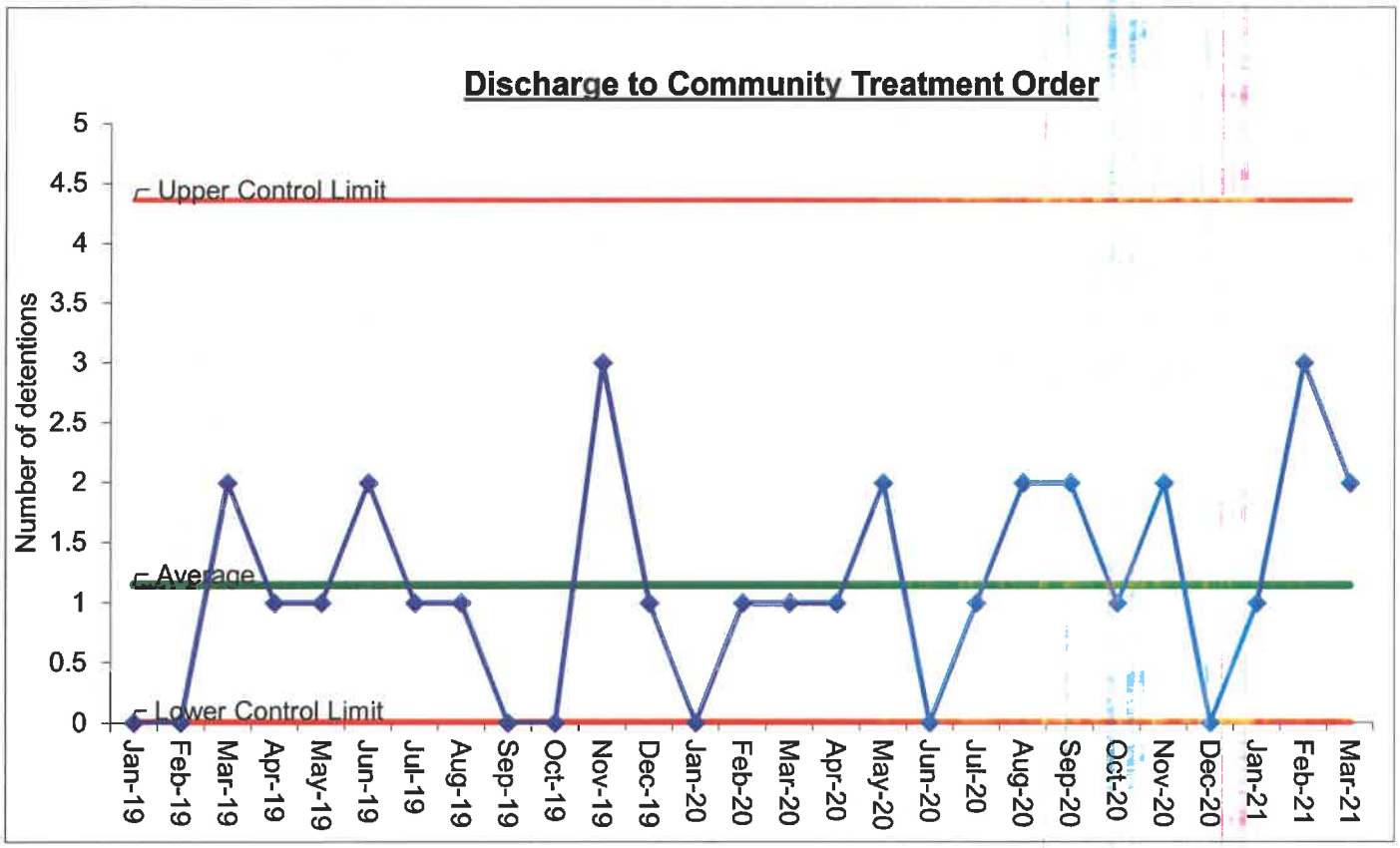
The above data would include those under 18 years of age.

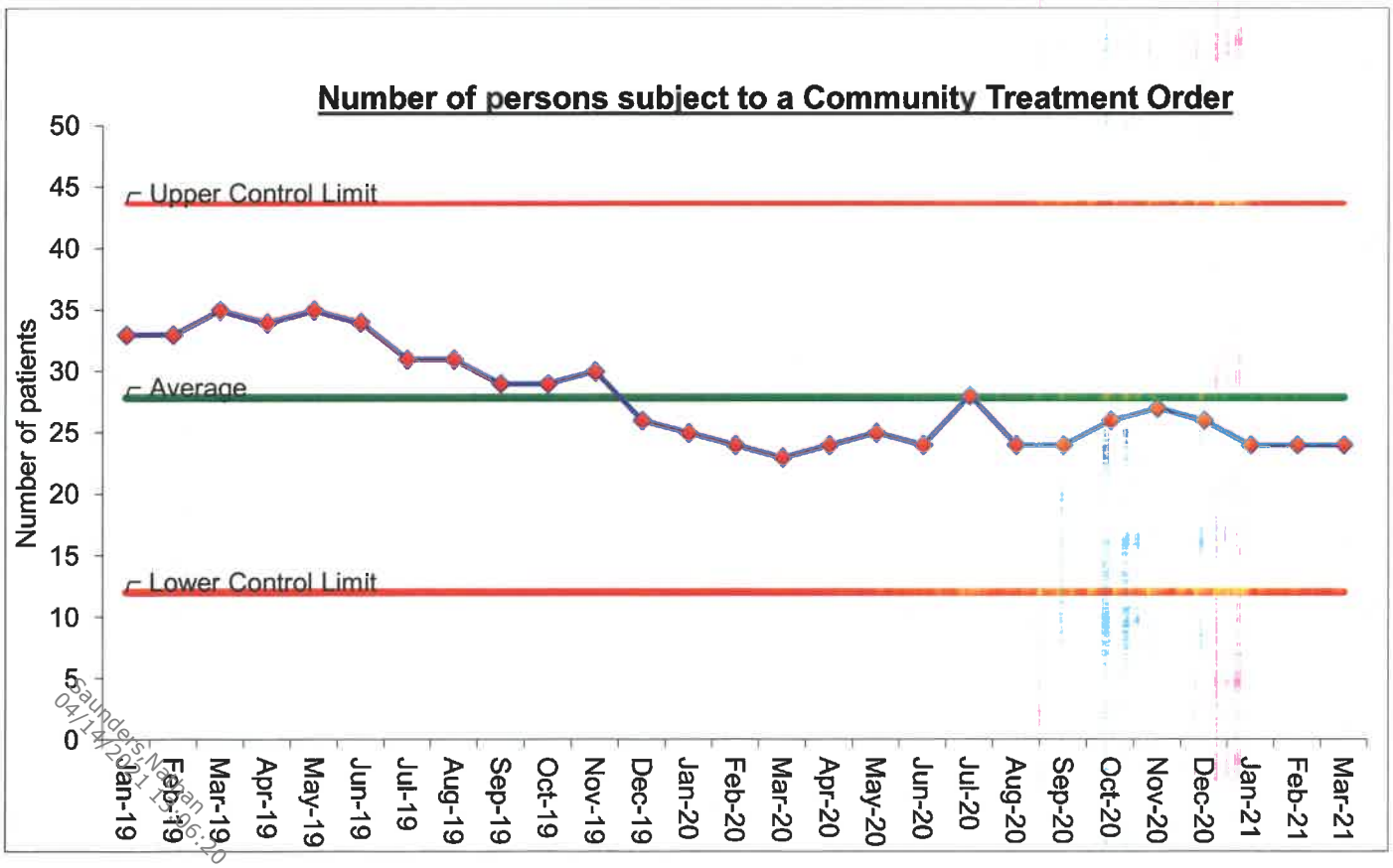


Community Treatment Order

During the period January- March 2021 six patients were discharged to Community Treatment Order.

As at 31 March 2021, 24 patients were subject to a Community Treatment Order (CTO).

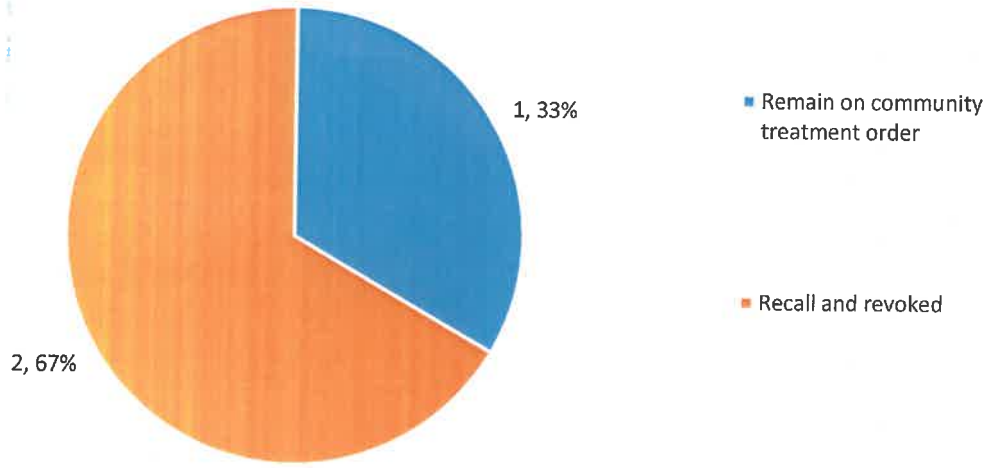




Recall of a community patient under Section 17E

During the period, the power of recall was used on three occasions. On 2 occasions the patients CTO was revoked, on one occasion the patient remained under their Community Treatment Order.

Outcome of Recall to hospital from Community treatment order



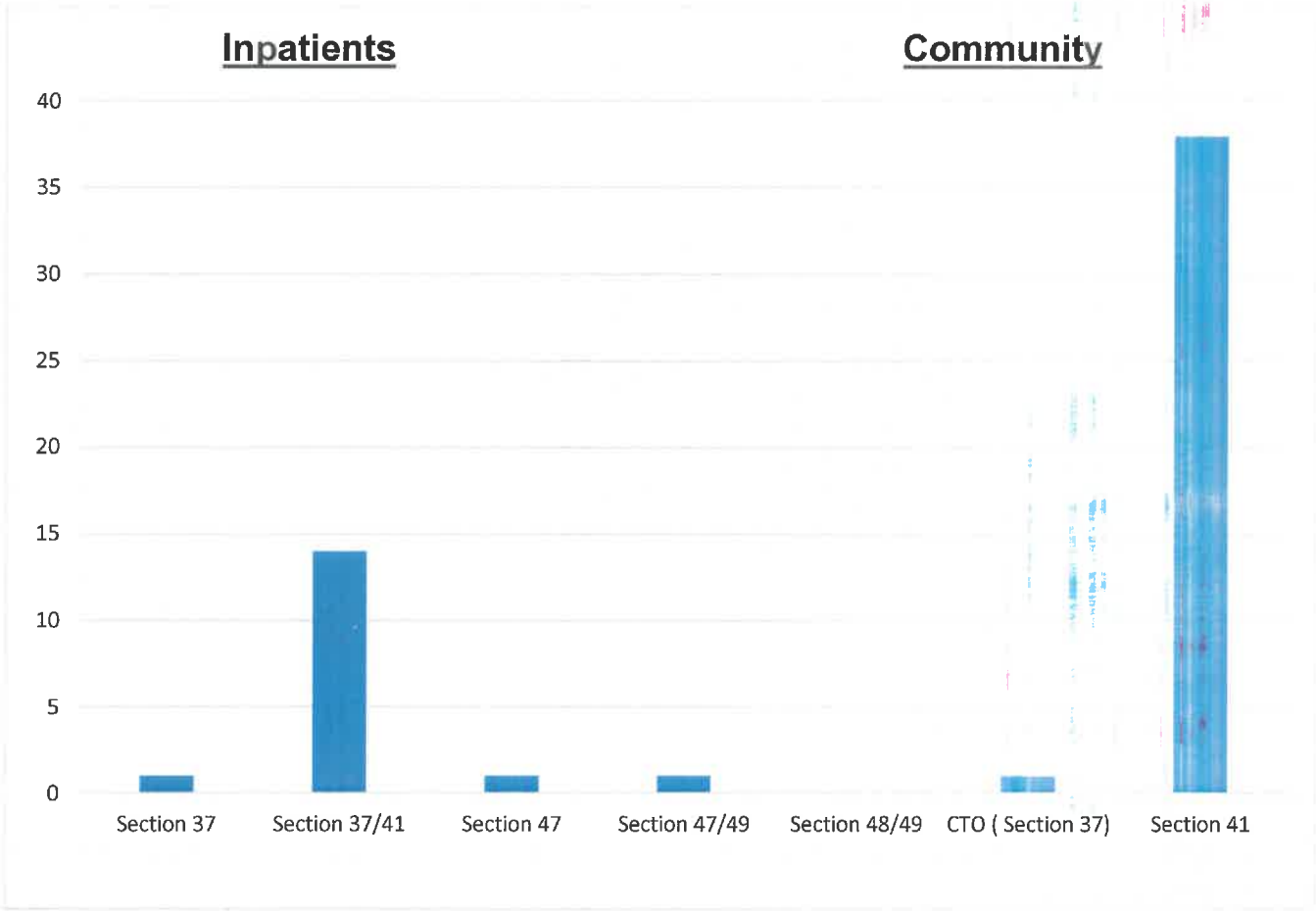
CAMHS Commissioned Inpatient Data

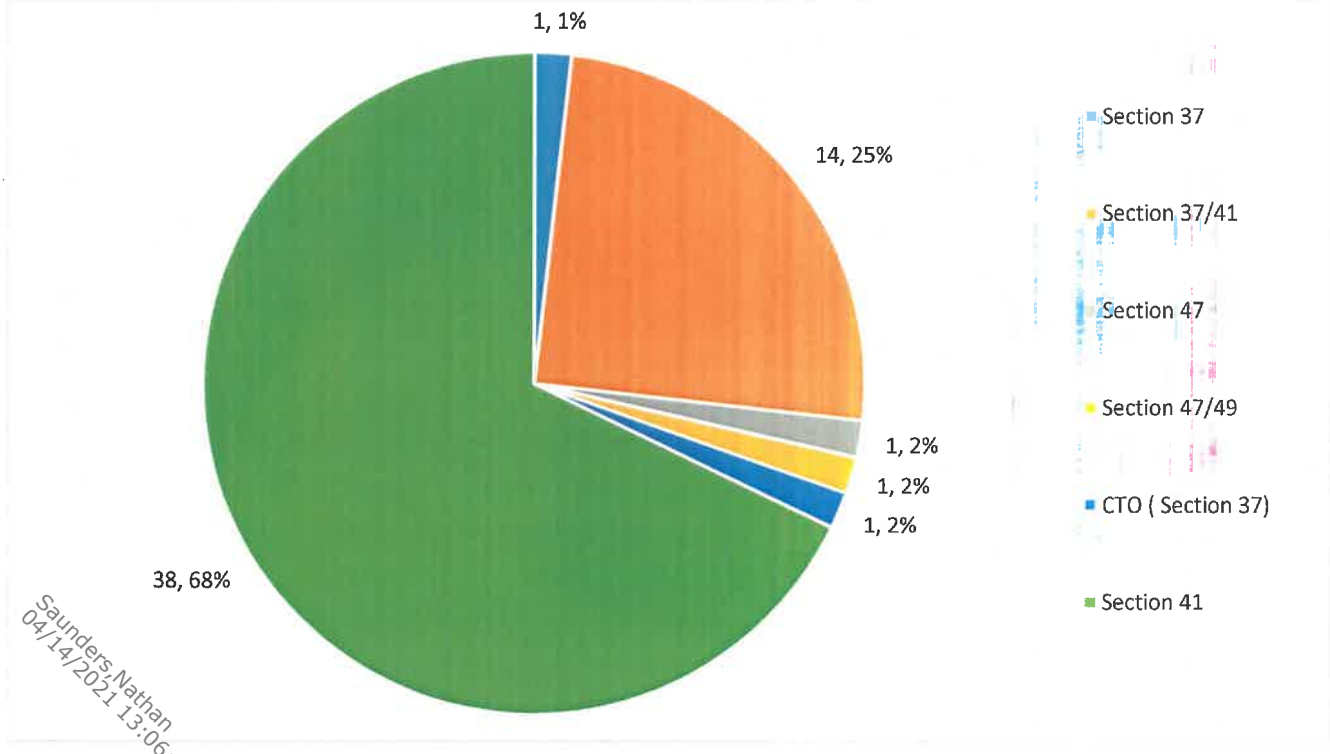
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

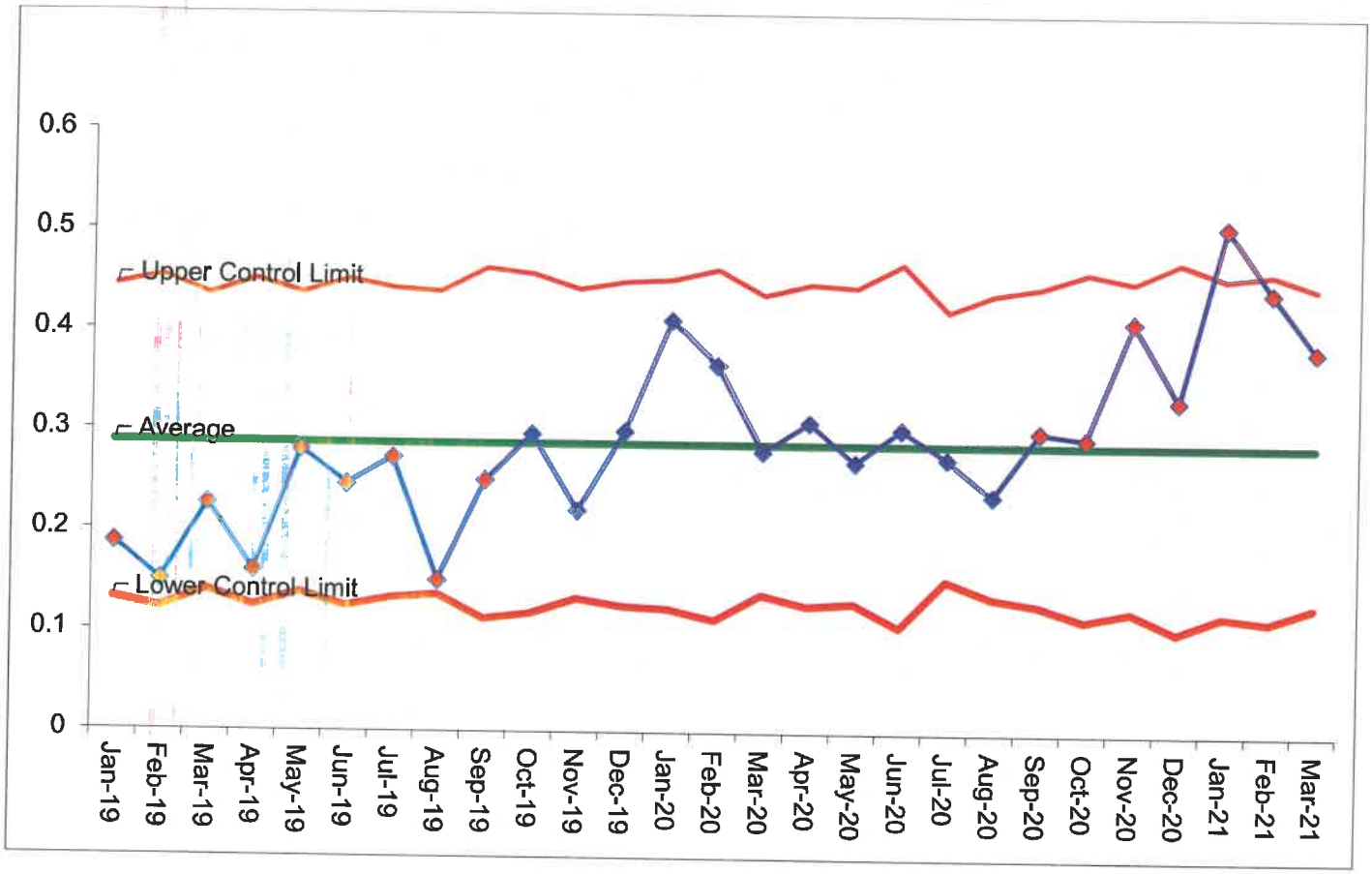
Part 3 of the Mental Health Act 1983

The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31 March 2021.



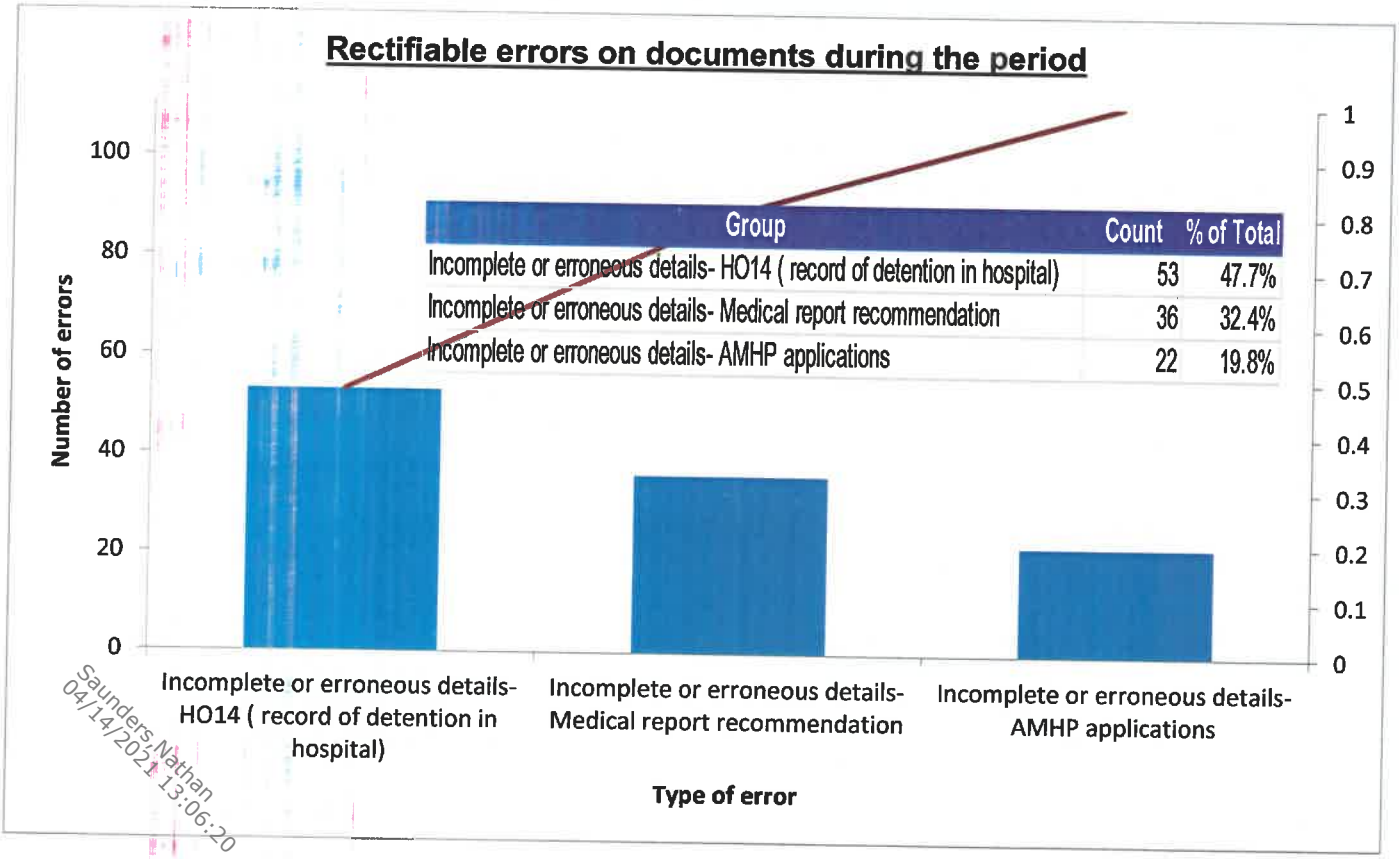


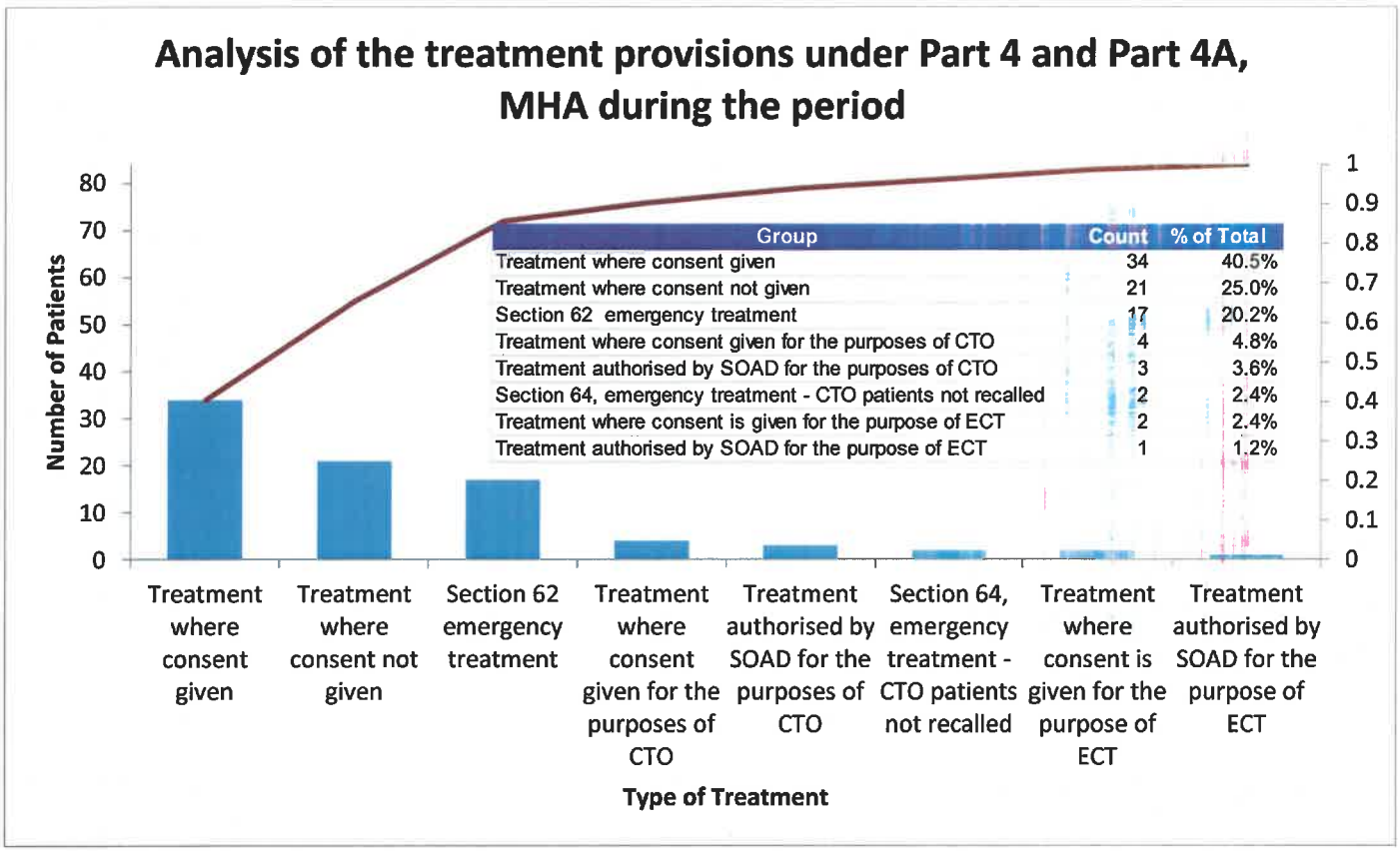
Scrutiny of documents during the period



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

Rectifiable errors on documents during the period





Urgent Treatment

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

Urgent treatment is defined as treatment that is:

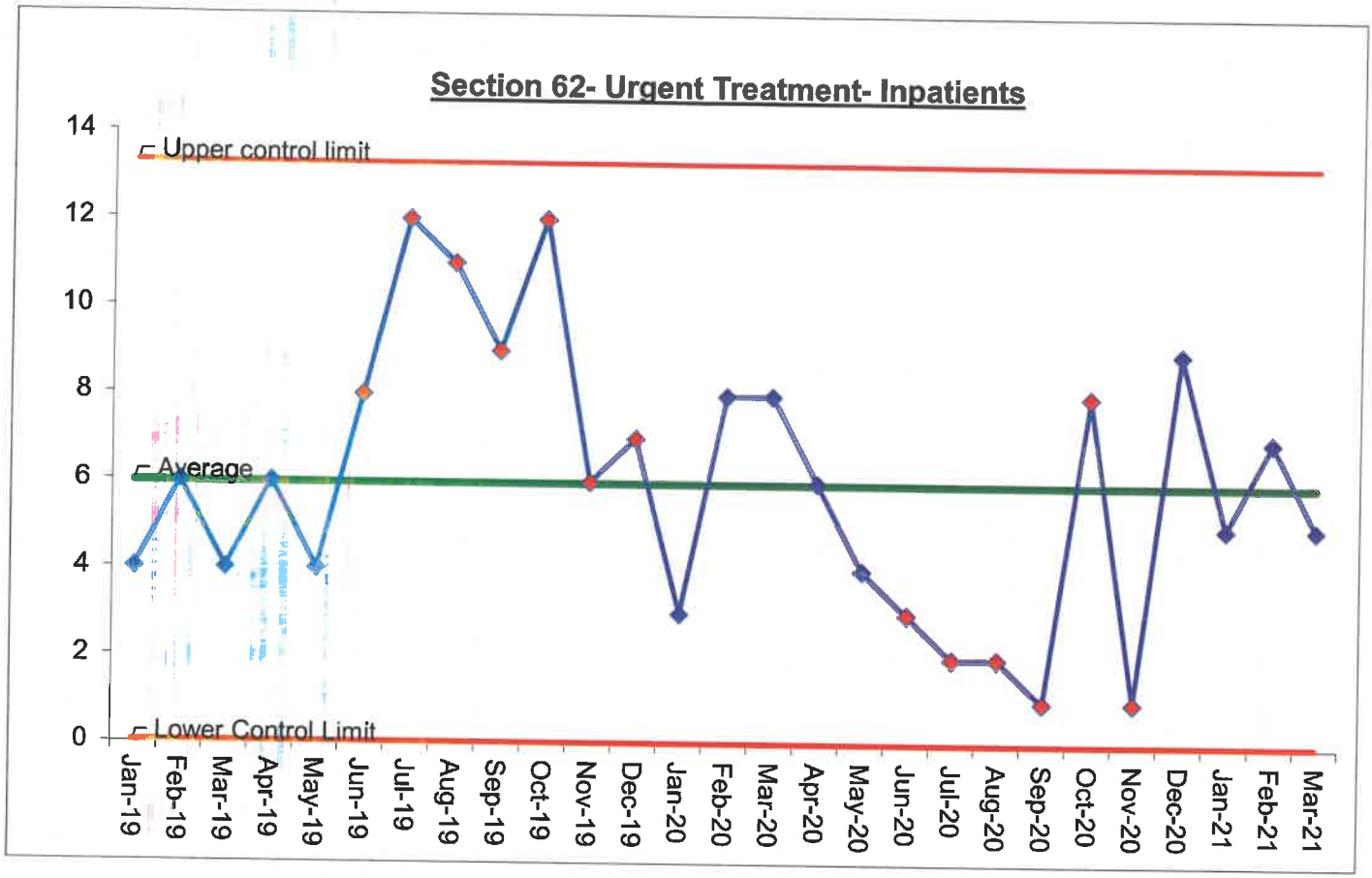
- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That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

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

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

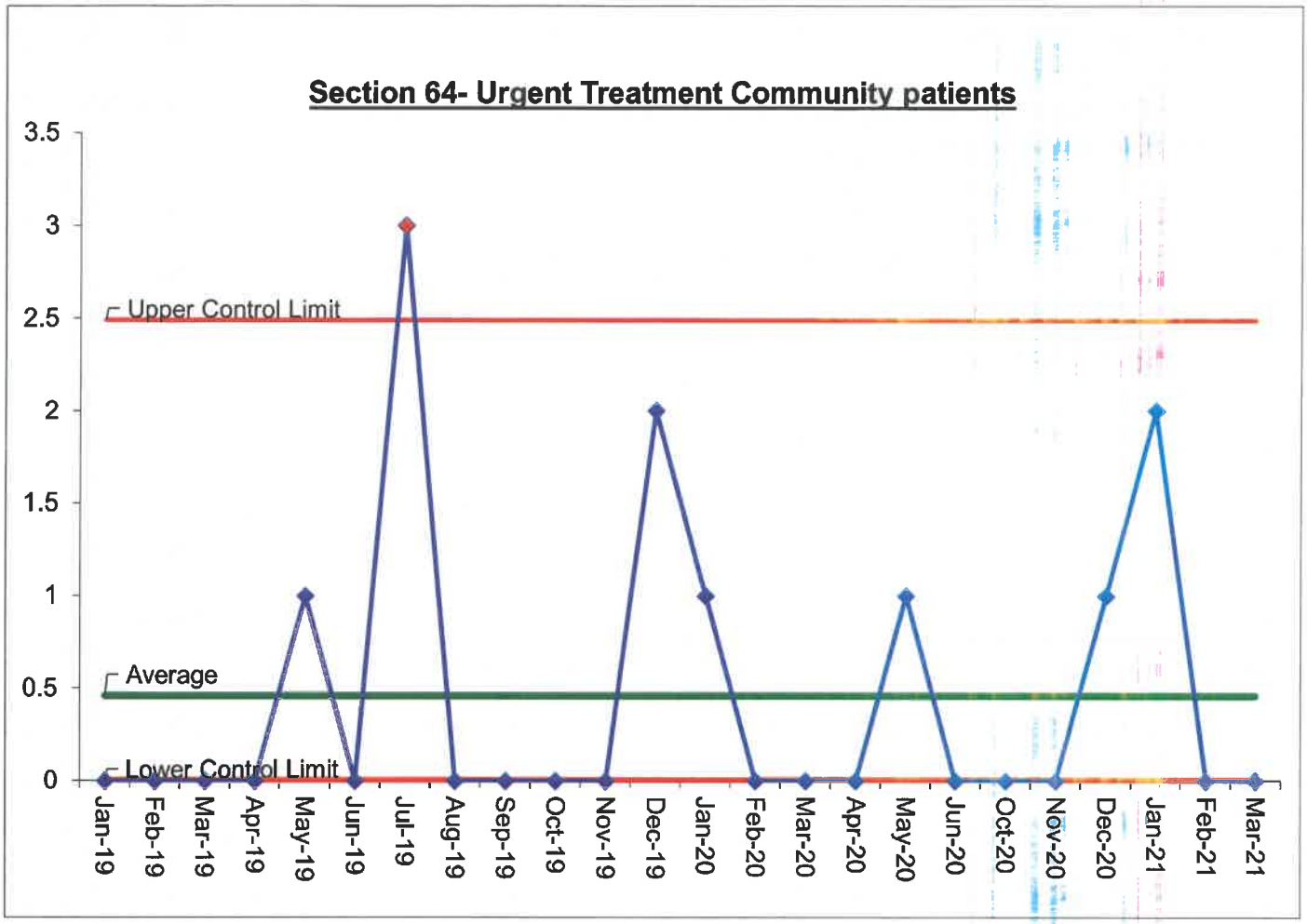
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.

- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.



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

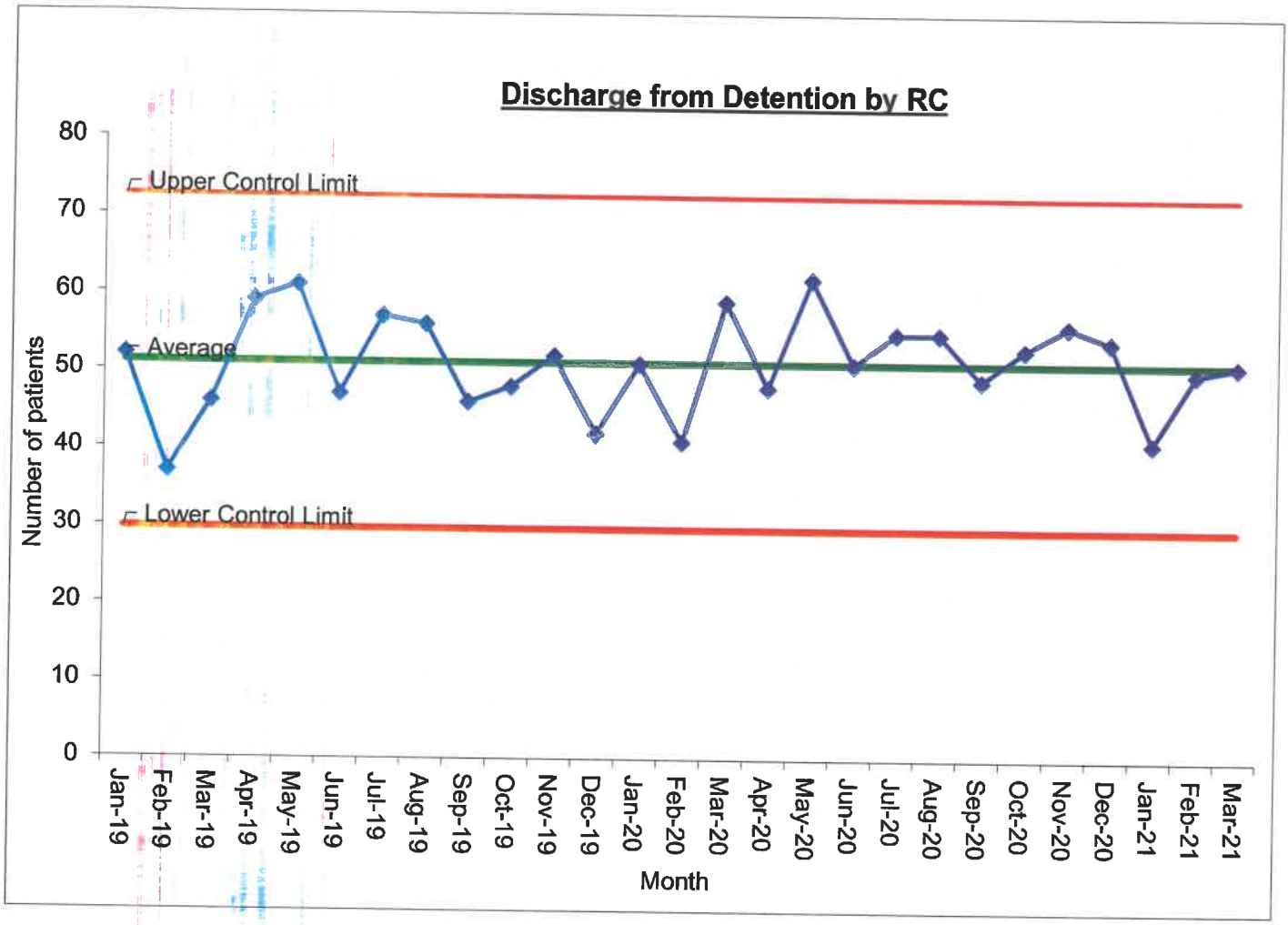
- Pending SOAD – 3 month rule x 9
- Pending SOAD – No longer consenting x 3
- Pending SOAD – No longer has capacity to consent x 1
- Pending SOAD – Change of medication x 2
- Pending SOAD – ECT x 2

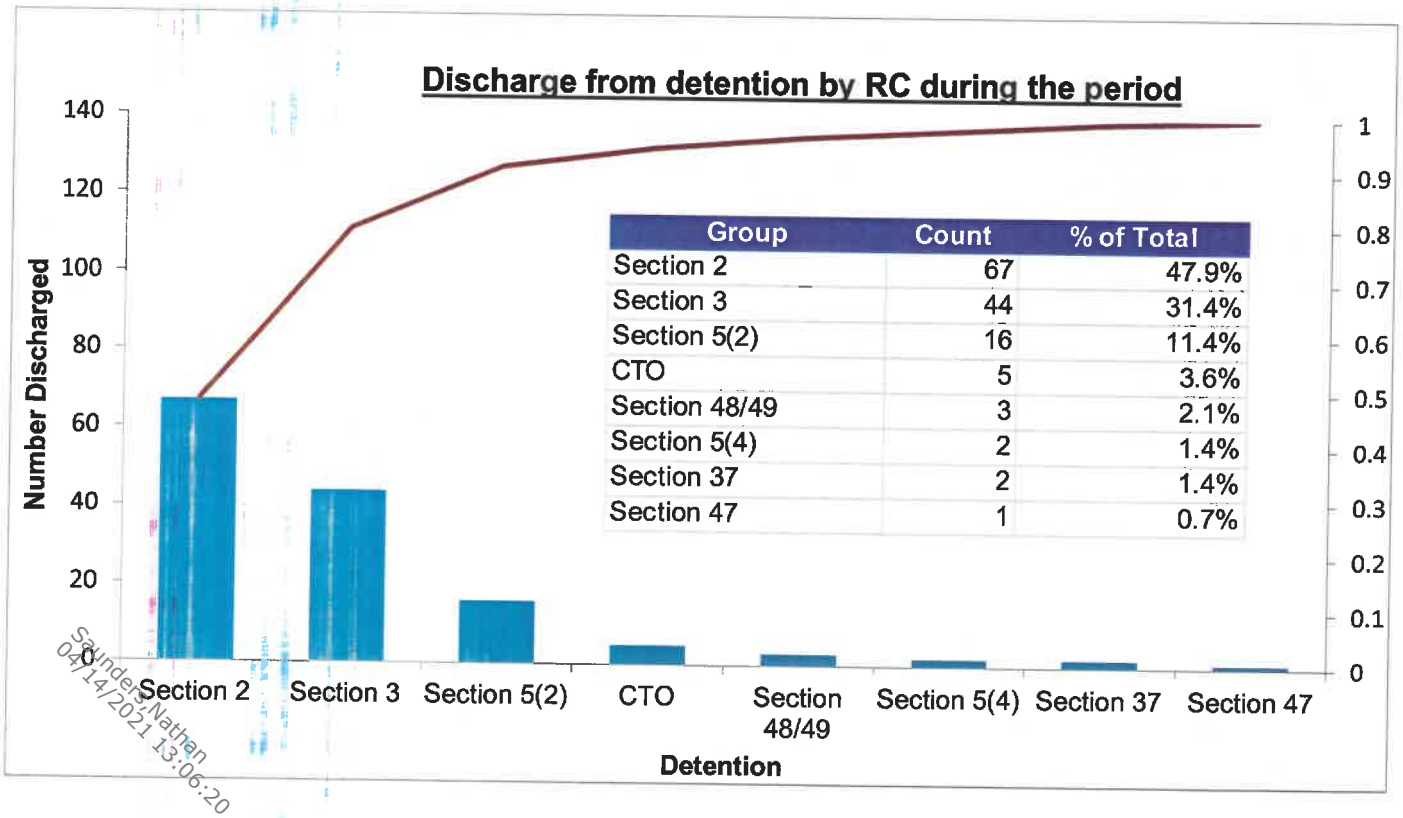


The above chart highlights that Section 64 was used on two occasions during the period for following reasons:

- Addition of medication x 1
- Pending SOAD 1 month rule x 1

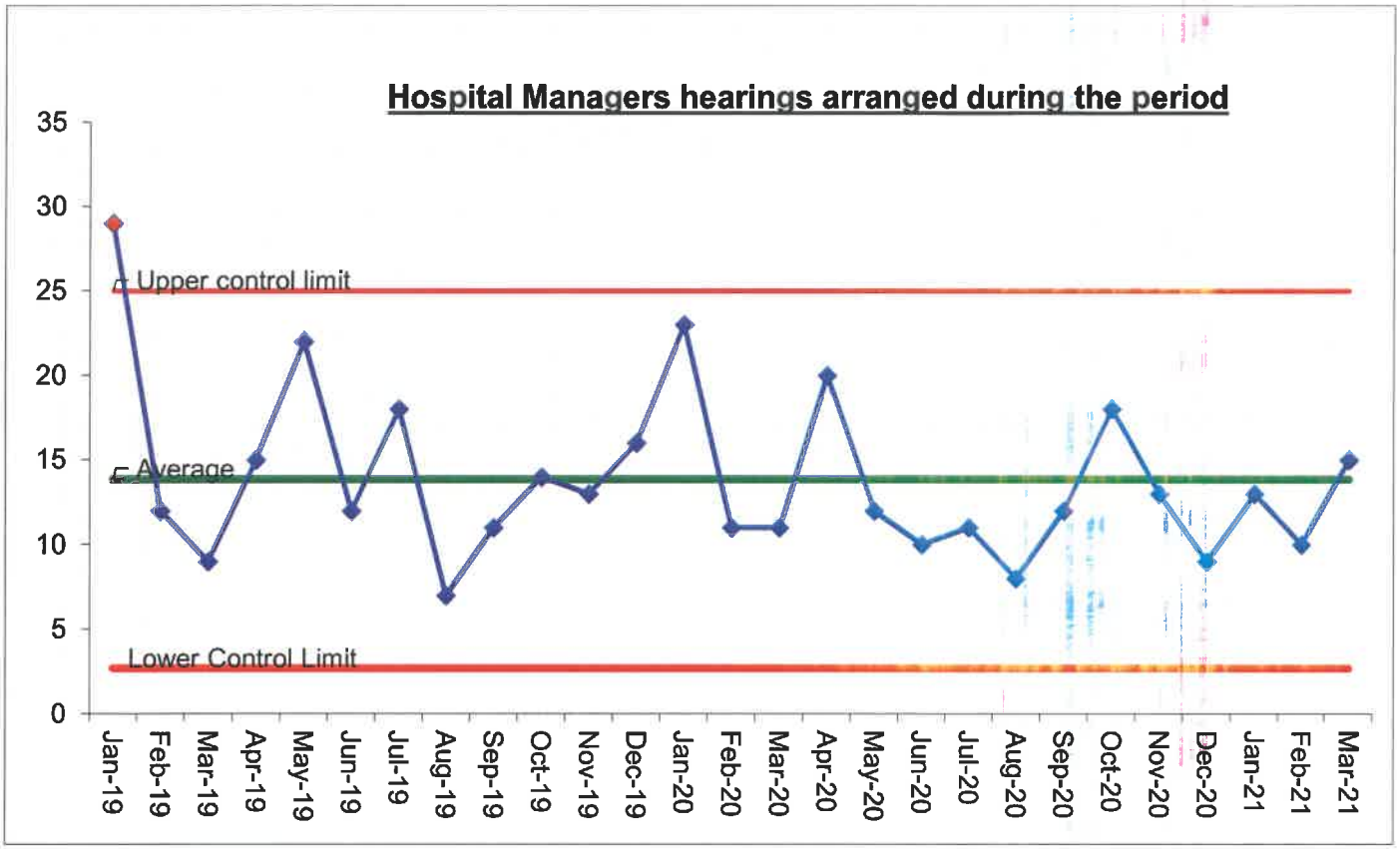
Discharge

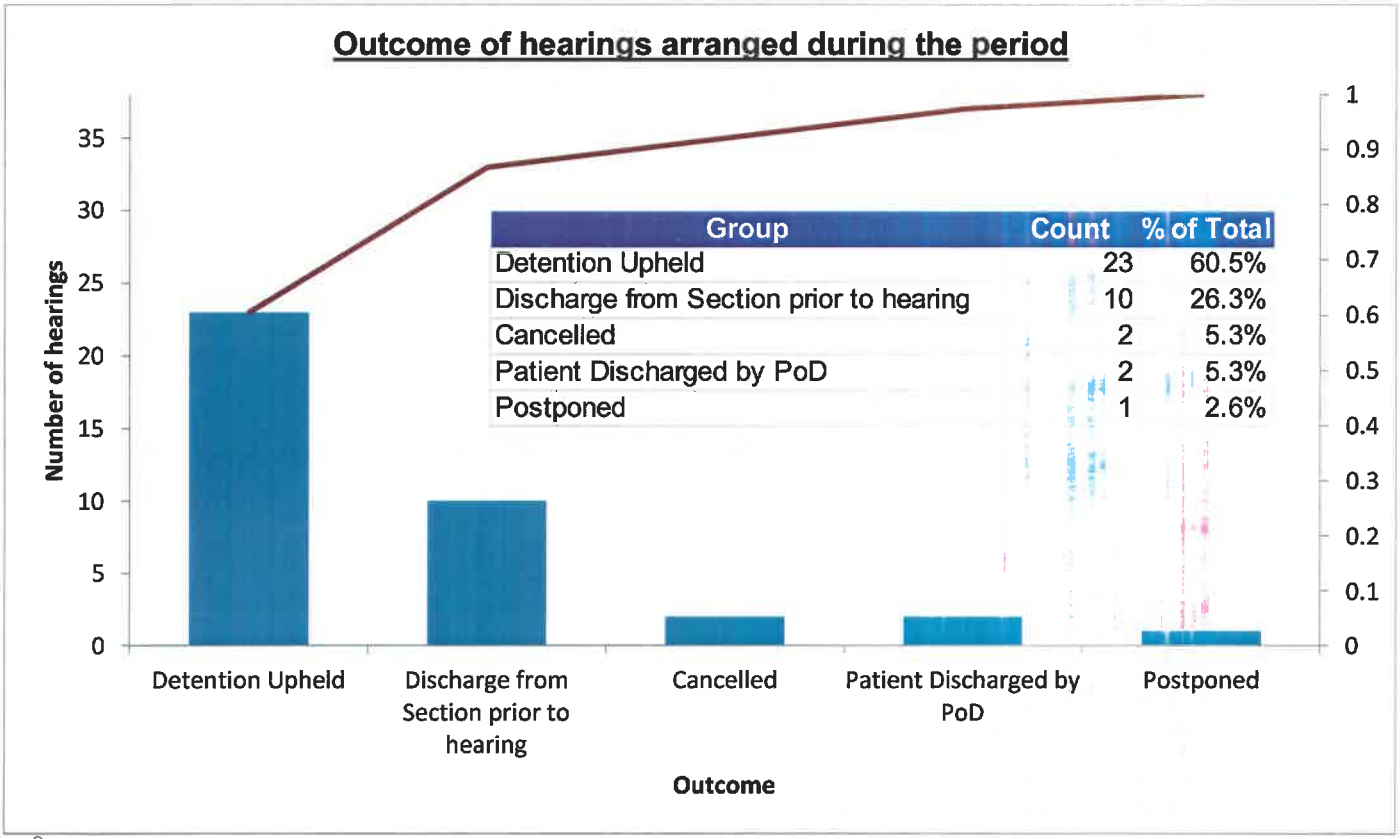




Group	Count	% of Total
Section 2	67	47.9%
Section 3	44	31.4%
Section 5(2)	16	11.4%
CTO	5	3.6%
Section 48/49	3	2.1%
Section 5(4)	2	1.4%
Section 37	2	1.4%
Section 47	1	0.7%

Hospital Managers – Power of Discharge

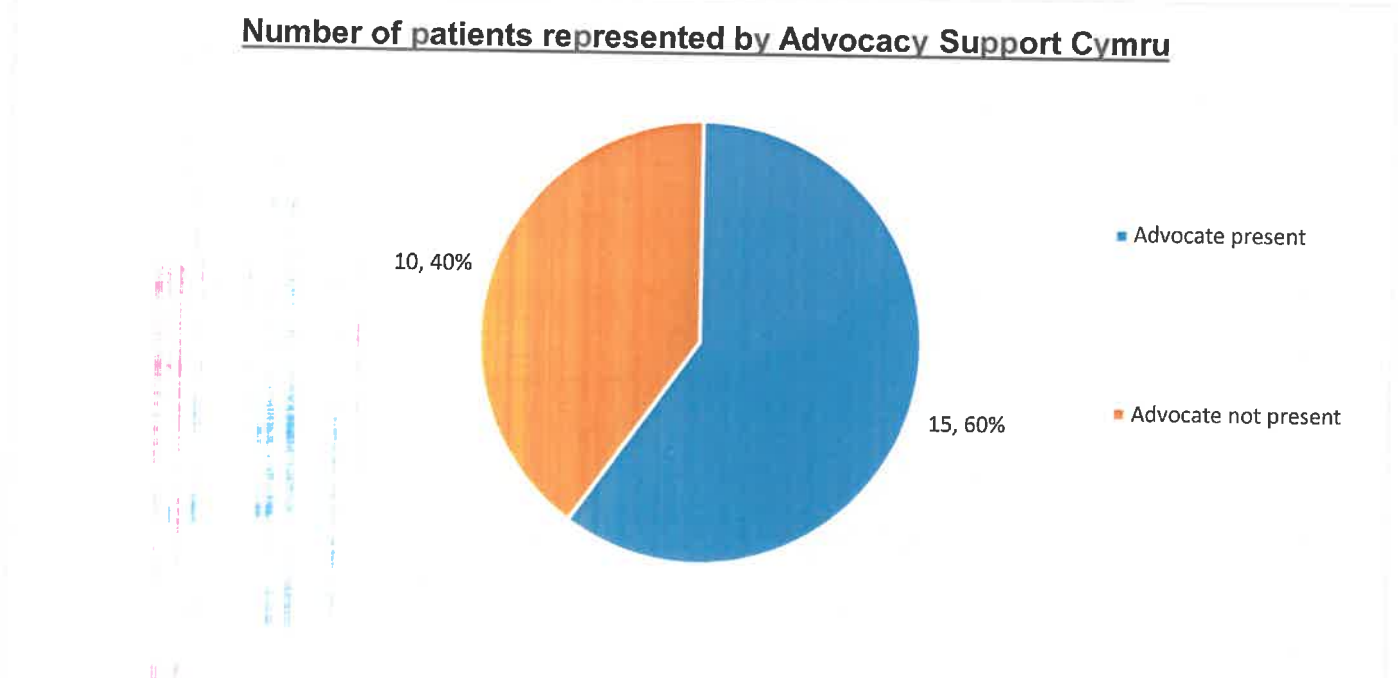


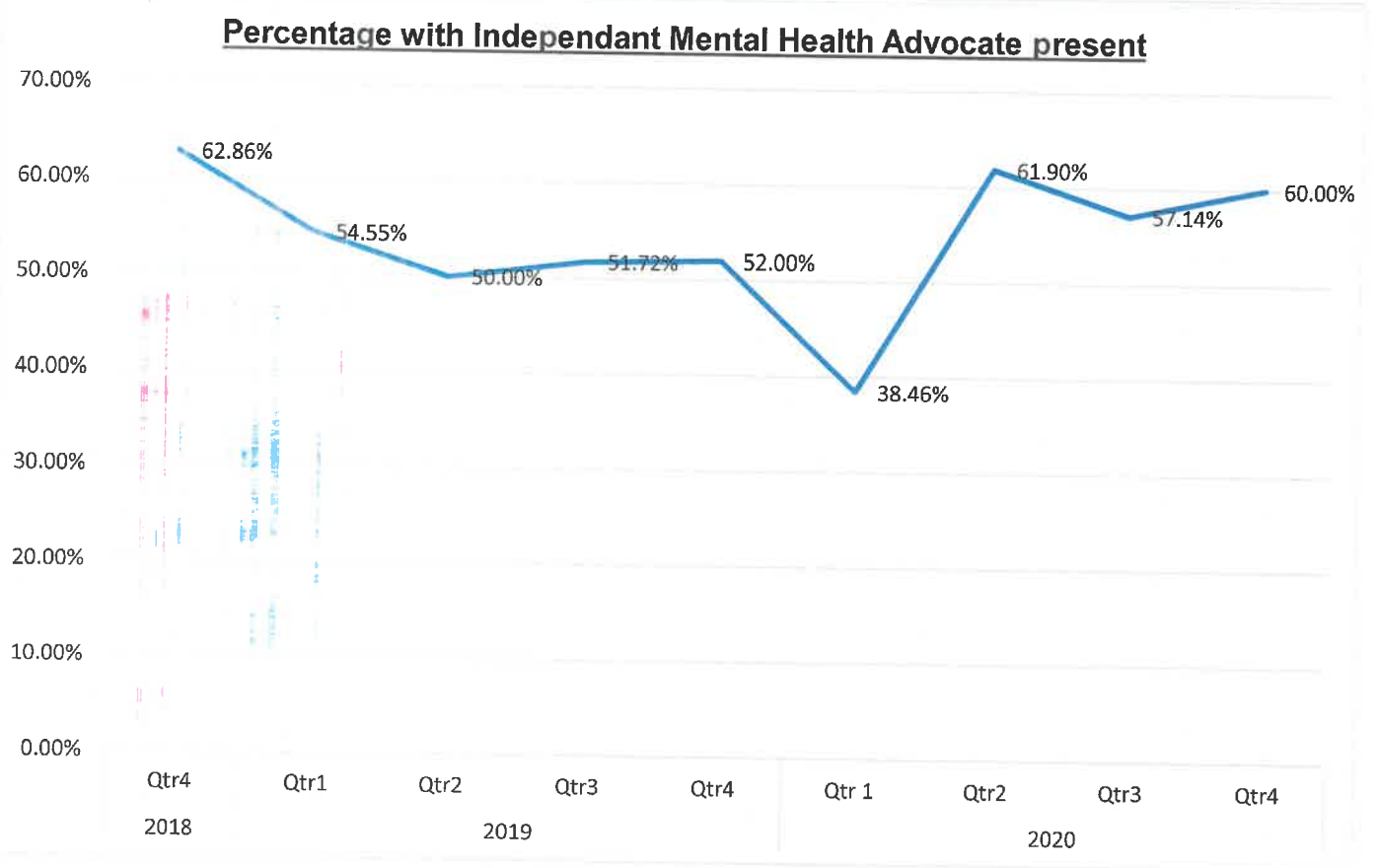


Group	Count	% of Total
Detention Upheld	23	60.5%
Discharge from Section prior to hearing	10	26.3%
Cancelled	2	5.3%
Patient Discharged by PoD	2	5.3%
Postponed	1	2.6%

One hearing was postponed for the following reason:

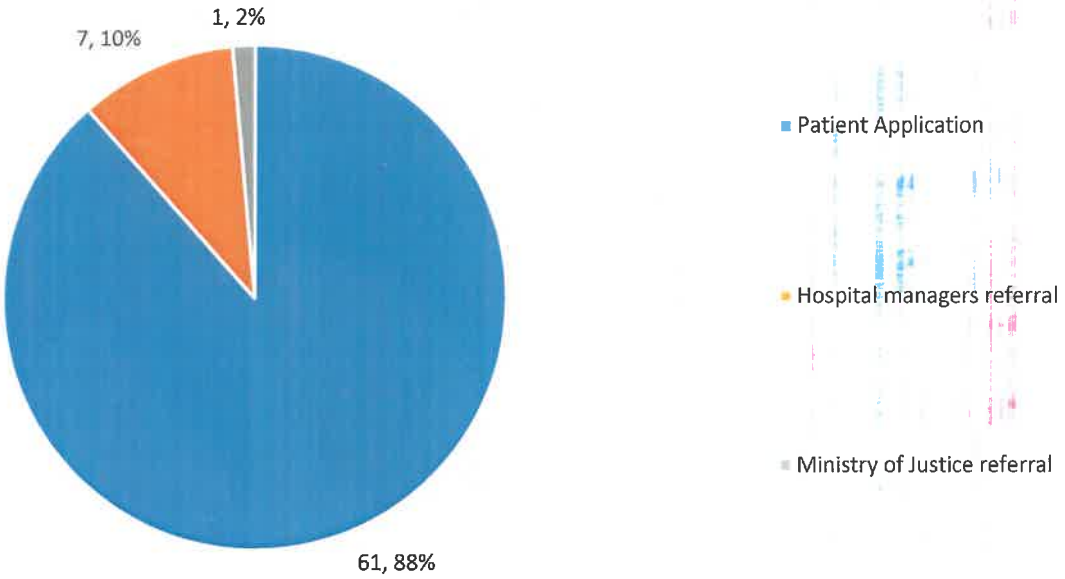
- Further assessments/ information was needed.



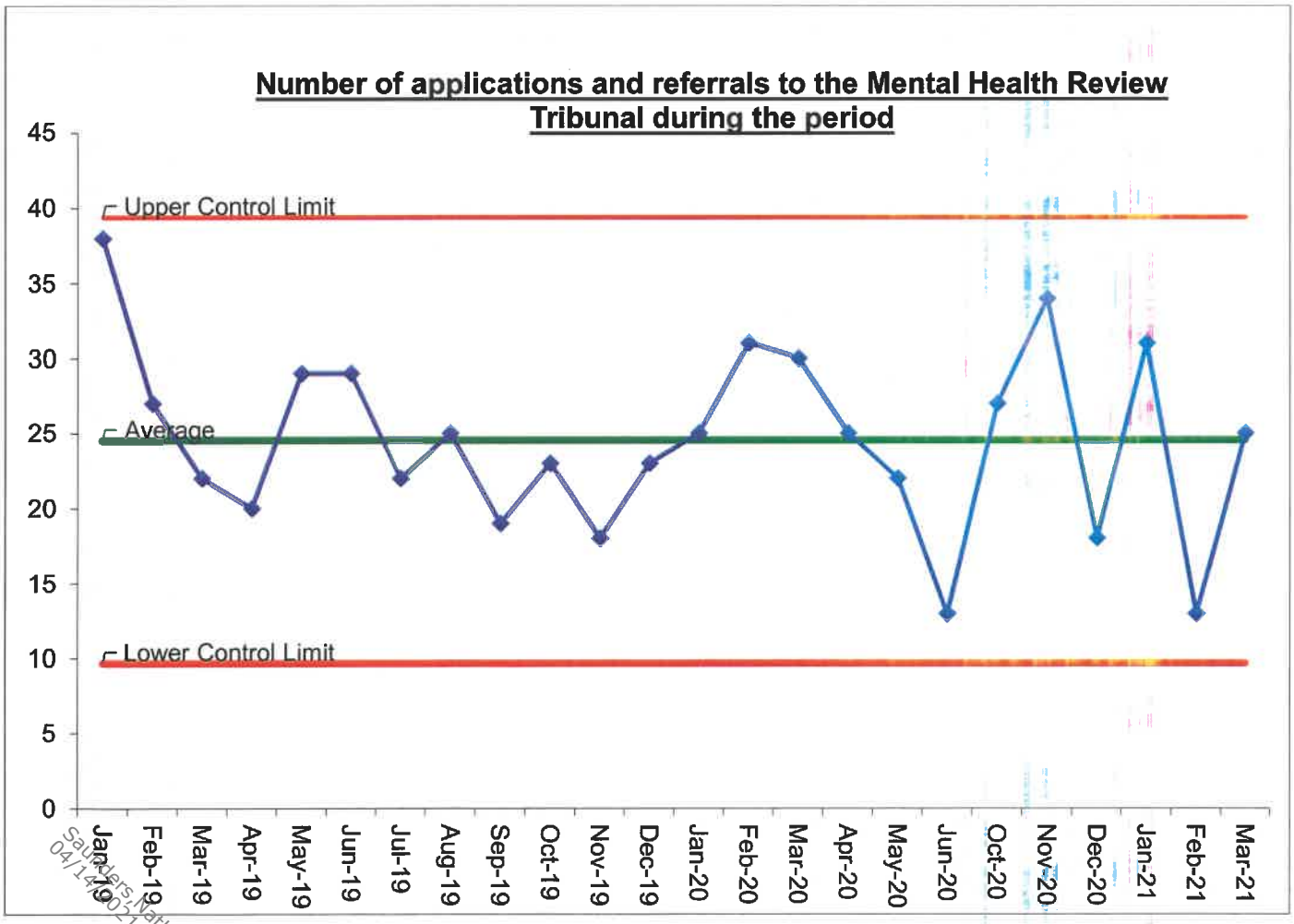


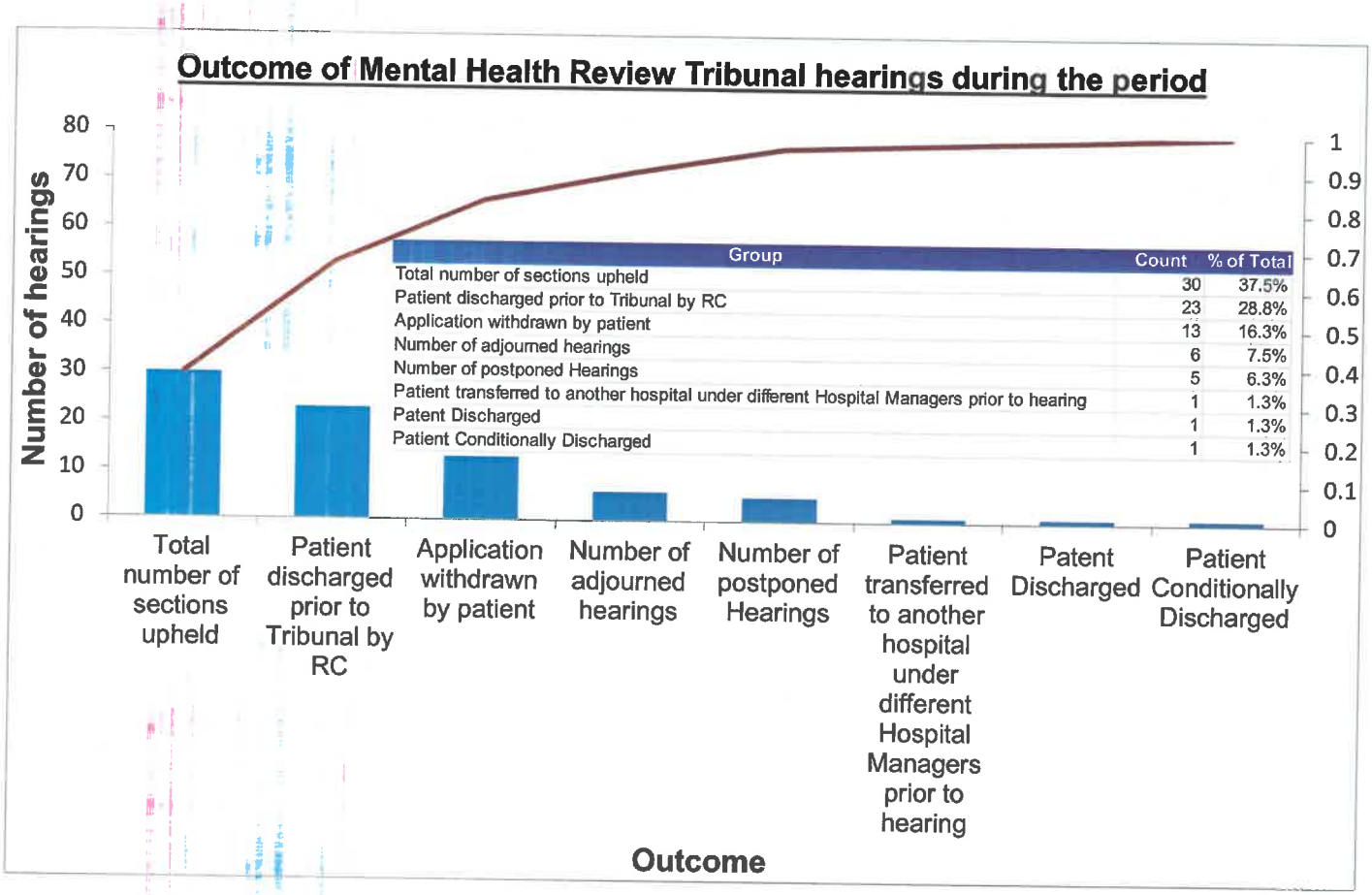
During the period the Mental Health Act Office made sixteen referrals to Advocacy Support Cymru where the patient was deemed not to have capacity make this decision. Four hearings were either postponed/ cancelled and therefore weren't attended by an advocate On four occasions an advocate was instructed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

Source of applications to the Mental Health Review Tribunal during the period



Number of applications and referrals to the Mental Health Review Tribunal during the period





Group	Count	% of Total
Total number of sections upheld	30	37.5%
Patient discharged prior to Tribunal by RC	23	28.8%
Application withdrawn by patient	13	16.3%
Number of adjourned hearings	6	7.5%
Number of postponed Hearings	5	6.3%
Patient transferred to another hospital under different Hospital Managers prior to hearing	1	1.3%
Patent Discharged	1	1.3%
Patient Conditionally Discharged	1	1.3%

Six hearings were adjourned for the following reasons:

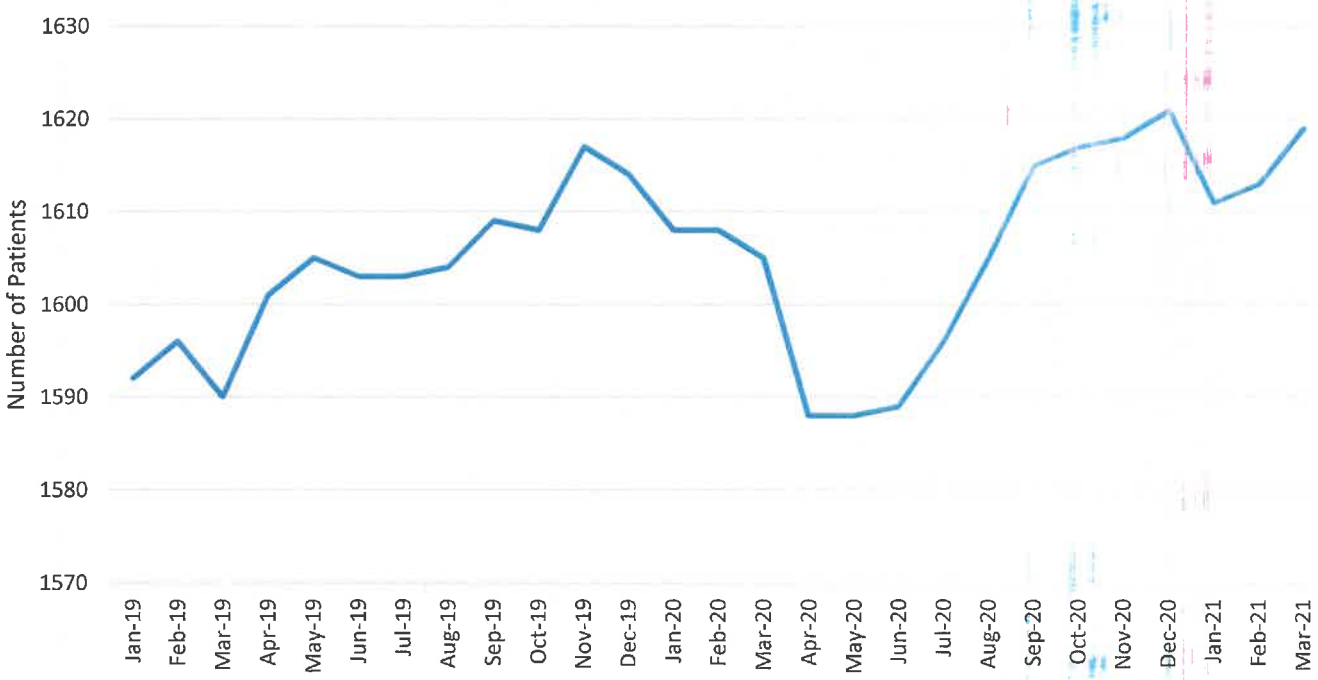
- Updated reports were needed x 4
- At the patients request as has not had the chance to go through all reports
- Patient communication difficulties

Five hearings were postponed for the following reasons:

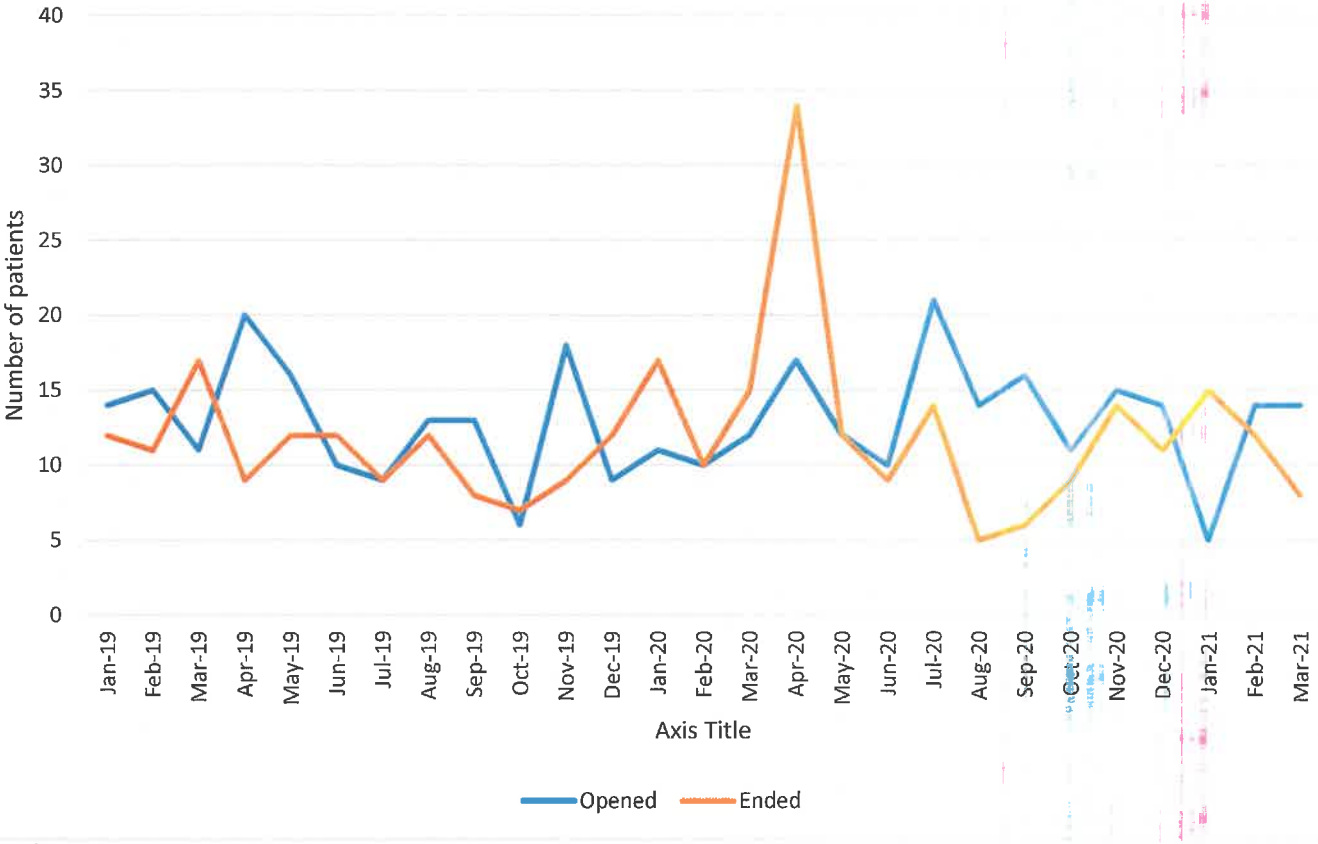
- At the request of the legal representative x 4
- Social work representative unable to attend x 1

Section 117 Aftercare

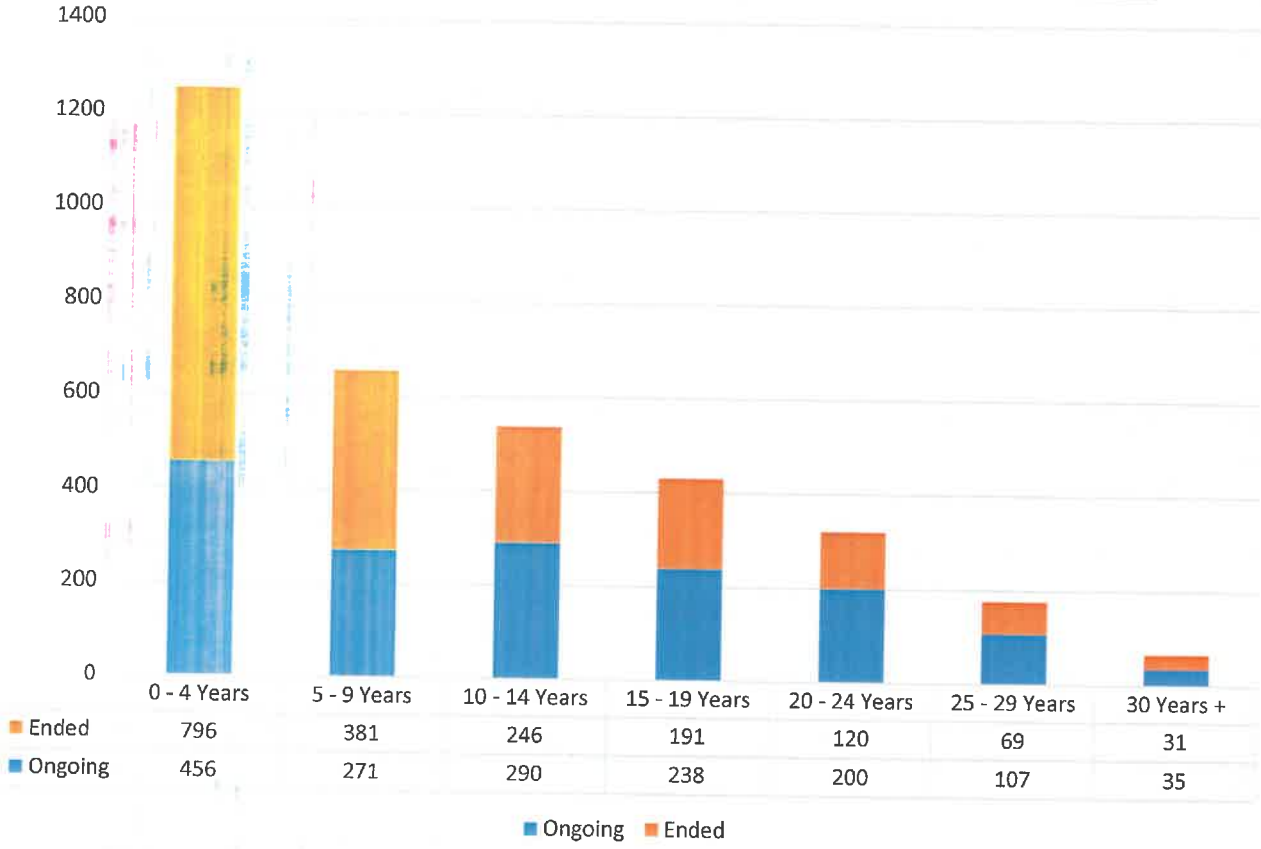
Patients eligable for Section 117 aftercare



Section 117 Activity



Periods of time that patients remain eligible for Section 117 aftercare



	0 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	20 - 24 Years	25 - 29 Years	30 Years +
Ended	796	381	246	191	120	69	31
Ongoing	456	271	290	238	200	107	35

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

January- March 2021

Exclusion of visitors

Due to COVID -19 there is no visiting allowed on any of our mental health wards at present.

Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- 22 patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
    - Two to return to their home area
    - Four to a specialist unit
    - One to CAMHS
    - Twelve to a private PICU bed
    - Three due to a lack of beds

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

- Four from PICU bed
- Six to return to their home area

One patient subject to a Community Treatment Order under Part 2 of the Mental Health Act was transferred back to Cardiff and Vale UHB from a specialist placement.

Death of detained patients

During the period there were no deaths of detained patients.

Glossary of Terms

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

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

	section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.
Section 4	In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours. An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor. A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of: • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.

Section 2	Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of.

	Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer

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

	can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position

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

Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.

Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.

DoLS

1. Number of DoLS applications made
2. No of DoLS applications completed
   a. No of DoLS applications assessed
   b. No of DoLS applications withdrawn
4. Breach of timescales including length of breach
   a. Urgent authorisation
   b. Standard authorisation
   c. Further authorisation
5. Requests for reviews of the DoLS authorisation
6. Appeals made to Court of Protection
   a. No of 21a Application
   b. No of Joined as Party / Welfare order
8. Appointment of IMCA as RPR

MCA

9. Number of queries to MCA Manager
10. Number of IMCA referrals
11. Number of monitoring reports from the IMCA service
12. Appointment of IMCA under:
    a. s39a
    b. s39c
    c. s39d
13. Number of HIW reports received regarding compliance of clinicians
14. Number of complaints received from patients/carers regarding compliance of clinicians
15. Number of Public Service Ombudsman for Wales Reports citing issues around MCA
16. Number of staff who have undertaken MCA training
    a. Children & Women Clinical Board
    b. CD&T Clinical Board
    c. Medicine Clinical Board
    d. Mental Health Clinical Board
    e. PCIC Clinical Board
    f. Specialist Clinical Board
    g. Surgery Clinical Board

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

CAPACITY LEGISLATION COMMITTEE INDI

Quarter 1			Quarter 2			Q
jan-21	feb-21	mar-21	apr-21	mai-21	jun-21	jul-21
80	90					
*74 (5)	*76 (28)					
*12 (5)	*20 (8)					
*62 (33)	*56 (20)					
See Below	See Below					
See Below	See Below					
See Below	See Below					
1	0					
0	0					
1	2					
10	16					
10	10	13				
0	0	0				
0	0	0				
0	0	0				
Not available as yet						

Urgent Jan 21					
Date Signed	Date Rec'd	Assessment	Authorised	Breach	
31.12.2020	08.01.2021	11.01.2021	14.01.2021	7 Days	Fax Error application re
29.12.2020	08.01.2021	25.01.2021	27.01.2021	22 Days	Fax Error application re
11.12.2020	11.12.2020	07.01.2021	12.01.2021	25 Days	
13.01.2021	13.01.2021	25.01.2021	27.01.2021	7 Days	

Standard/Further Jan 21				
Date Signed	Date Rec'd	Assessment	Authorised	Breach
02.12.2020	02.12.2020	06.01.2021	13.01.2021	21 Days
02.12.2020	02.12.2020	08.01.2021	11.01.2021	19 Days
27.12.2020	27.12.2020	22.01.2021	27.01.2021	10 Days

05.10.2020	05.10.2020	25.01.2021	28.01.2021	94 Days		
Urgent Withdrawn Jan 21						**Informatio**
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**
18.10.2020	11.01.2021				78 Days	Yes
28.12.2020	11.01.2021				7 Days	Yes
08.12.2020	12.01.2021				28 Days	No
07.12.2020	20.01.2021		20.01.2021		23 Days	No
05.01.2021	19.01.2021				7 Days	Yes
16.10.2020	20.01.2021		20.01.2021		89 Days	No
27.11.2020	20.01.2021				48 Days	Yes
29.12.2021	21.01.2021			08.01.2021	3 Days	Yes
08.01.2021	21.01.2021	18.01.2021			3 Days	Yes
24.12.2020	30.01.2021	30.01.2021			30 Days	Yes
20.12.2020	22.01.2021				26 Days	Yes
21.12.2020	22.01.2021				25 Days	Yes
29.12.2020	22.01.2021				17 Days	Yes
29.12.2020	22.01.2021				17 Days	Yes
30.12.2020	28.01.2021	28.01.2021			22 Days	Yes
14.12.2020	22.01.2021				32 Days	Yes
30.12.2020	22.01.2021				18 days	Yes
08.01.2021	29.01.2021		29.01.2021		14 Days	No
14.12.2020	22.01.2021			26.12.2021	5 Days	Yes
11.01.2021	30.01.2021	30.01.2021			12 Days	Yes
05.01.2021	22.01.2021			13.01.2021	1 Day	Yes
21.12.2020	22.01.2021		08.01.2021		11 Days	Yes
30.12.2020	22.01.2021				16 Days	Yes
21.10.2020	22.01.2021				84 Days	Yes
21.09.2020	22.01.2021				116 Days	Yes
01.10.2020	22.01.2021				104 Days	Yes
24.11.2020	22.01.2021				52 Days	Yes
08.12.2020	22.01.2021				38 Days	Yes
08.12.2020	22.01.2021				38 Days	Yes
14.12.2020	22.01.2021				32 Days	Yes
19.12.2020	22.01.2021				27 Days	Yes
19.12.2020	22.01.2021				27 Days	Yes
19.12.2020	22.01.2021				24 Days	Yes
24.12.2020	22.01.2021				22 Days	Yes
24.12.2020	22.01.2021				22 Days	Yes
26.12.2020	22.01.2021				20 Days	Yes
28.12.2020	22.01.2021				18 Days	Yes
05.01.2021	22.01.2021	15.01.2021			3 Days	Yes
15.12.2020	27.01.2021	27.01.2021			36 Days	Yes
08.01.2021	22.01.2021	20.01.2021			5 Days	Yes
Standard/Further Withdrawn Jan 21						**Informatio**
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**
18.12.2020	11.01.2021				3 Days	Yes
30.11.2020	11.01.2021				20 Days	Yes
11.12.2020	22.01.2021				21 Days	Yes
26.07.2020	25.01.2021				162 Days	Yes
07.12.2020	25.01.2021				28 Days	Yes
30.11.2020	27.01.2021				38 Days	Yes

03.12.2020	29.01.2021				36 Days	Yes

ICATORS

Quarter 3			Quarter 4	
aug-21	sep-21	okt-21	nov-21	des-21

eceived on 08/01/2021
eceived on 08.01.2021

Urgent Feb 21		
Date Signed	**Date Rec'd**	**Assessment**
27.10.2020	27.10.2020	10.02.2021
05.01.2021	05.01.2021	08.02.2021
08.02.2021	08.02.2021	16.02.2021
09.02.2021	09.02.2021	22.02.2021

Standard/Further Feb 21		
Date Signed	**Date Rec'd**	**Assessment**
25.11.2020	25.11.2020	22.02.2021
25.11.2020	25.11.2020	10.02.2021
27.11.2020	27.11.2020	16.02.2021

on rec'd for w/d by	
MA	New App
No	No
No	No
No	Yes
No	Yes
No	No
No	Yes
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	Yes
No	No
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No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No
No	No

on rec'd for w/d by	
MA	New App
No	No
No	No
No	No
No	No
No	No
No	No

11.01.2021	11.01.2021	11.02.2021
Urgent Withdrawn Jan 21		
Date Rec'd	**Date W/D**	**Discharged**
08.01.2021	05.02.2021	
05.01.2020	07.02.2021	
06.12.2020	07.02.2021	
13.12.2020	07.02.2021	
12.09.2020	07.02.2021	
02.12.2020	07.02.2021	
14.01.2021	07.02.2021	27.01.2021
24.09.2020	07.02.2021	
08.10.2020	07.02.2021	
04.12.2020	07.02.2021	
25.12.2020	07.02.2021	29.01.2021
14.01.2021	07.02.2021	27.01.2021
26.01.2021	07.02.2021	
26.01.2021	07.02.2021	
17.11.2020	09.02.2021	
30.01.2021	10.02.2021	10.02.2021
04.01.2021	15.02.2021	15.02.2021
03.02.2021	22.02.2021	15.02.2021
30.01.2021	22.02.2021	09.02.2021
28.01.2021	23.02.2021	23.02.2021
07.02.2021	23.02.2021	
01.02.2021	23.02.2021	
18.01.2021	23.02.2021	17.02.2021
31.01.2021	23.02.2021	
15.02.2021	24.02.2021	
14.02.2021	26.02.2021	
11.02.2021	26.02.2021	26.02.2021

Standard/Further Withdrawn Jan 21		
Date Rec'd	**Date W/D**	**Discharged**
01.10.2020	09.02.2021	
07.12.2020	09.02.2021	
07.12.2020	11.02.2021	

No	No

Authorised	**Breach**
11.02.2021	89 days
11.02.2021	27 Days
17.02.2021	1 Day
01.03.2021	6 Days

Authorised	**Breach**
28.02.2021	69 Days
11.02.2021	57 Days
22.02.2021	67 Days

16.02.2021	14 Days				
			Information rec'd for w/d by		
Transfer	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
05.02.2021		21 Days	No	No	Yes
		26 Days	Yes	No	No
		56 Days	Yes	No	No
		48 Days	Yes	No	No
		141 Days	Yes	No	No
		60 Days	Yes	No	No
		6 Days	Yes	No	No
		129 Days	Yes	No	No
		115 Days	Yes	No	No
		58 Days	Yes	No	No
		28 Days	Yes	No	No
		6 Days	Yes	No	No
04.02.2021		5 Days	No	No	Yes
04.02.2021		5 Days	No	No	Yes
		47 Days	Yes	No	No
		4 Days	No	Yes	No
		35 Days	Yes	No	No
		12 Days	Yes	No	No
		3 Days	Yes	No	No
		17 Days	Yes	No	No
18.02.2021		4 Days	No	No	Yes
20.02.2021		12 Days	No	No	Yes
		23 Days	Yes	No	No
	20.02.2021	13 Days	Yes	No	No
	24.02.2021	1 Day	Yes	No	No
25.02.2021		4 Days	No	No	Yes
		8 Days	Yes	No	No

			Information rec'd for w/d by		
Transfer	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
		110 Days	Yes	No	No
		43 Days	Yes	No	No
		45 Days	Yes	No	No

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

11 March 2021

Dear colleagues,

Summary

To set out Welsh Government governance arrangements to implement the Mental Capacity (Amendment) Act 2019 and to seek partner organisations' assurances that equivalent executive level engagement, planning and scrutiny is in place to deliver LPS implementation within your organisation.

To request that organisations complete and return a baseline data request by April 12.

Context

As you may be aware, the Liberty Protection Safeguards (LPS) are planned to come into force in April 2022. These safeguards will provide protection for people aged 16 and above whose care and treatment requires a deprivation of their liberty and who lack the mental capacity to consent to their arrangements. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the existing Deprivation of Liberty Safeguards (DoLS) system.

These important safeguards will help to protect the rights of some of our most vulnerable populations in Wales, help to improve their outcomes and ensure that the Mental Capacity Act is working as intended – where the individual is at the heart of all decision making.

LPS will introduce a number of changes to DoLS, including extending the scope of the scheme to 16 &17 years olds and individuals in domestic settings. More information is available within the UK Government fact sheets;

https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets

You will be aware of the substantial interest during the passage of this legislation in the UK Parliament. There are both devolved and non-devolved functions within the legislation.

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Implementation of these safeguards will require significant planning and workforce development to implement within your organisation, and it is important that this work is prioritised in the lead in to April 2022. Welsh Government has established a National Steering Implementation Group for LPS, informed by dedicated work streams that relate to the development of a national minimum data set, LPS monitoring and reporting arrangements, introduction of 16 and 17 year olds, workforce and training requirements and transitioning from DoLS to LPS. Each includes representation from local authorities and local health boards across Wales and other key stakeholders with an interest.

Welsh Government is developing draft regulations for consultation that set out the roles Independent Mental Capacity Advocates and Approved Mental Capacity Professionals who can undertake assessments and determinations, and monitoring and reporting arrangements.

These draft regulations will be published for consultation later this Spring, alongside a workforce and training strategy and a national Minimum Data set on LPS. This consultation is being planned to align with a UK Government consultation on regulations for England in relation to LPS, and a Code of Practice for England and Wales.

Given the limited time before implementation in April 2022, it is imperative that your organisation ensures that internal structures to deliver implementation are in place ahead of the consultation, when the draft regulations, draft Code of Practice and draft workforce strategy will be made available. You will then need to start the implementation process on the basis of those draft documents.

We are very conscious that these changes are taking place in a period where we are all focussed on keeping people safe and protecting them from the pandemic. However, we also know that vulnerable individuals in our communities are not able to access the full protections owed to them under the current DoLS arrangements. The case for change is well-evidenced and we need to progress transition to LPS. In order to achieve this, we would like to seek assurances that there is executive level engagement with the implementation of LPS, and that there is already planning in place for structures to deliver LPS implementation within your organisation. It is imperative that responsibility for the implementation of LPS does not rest solely with existing DoLS teams. For instance, you will need to take into account settings for 16 and 17 year olds.

In addition, we are attaching a questionnaire to develop a better evidence base for baseline information relating to workforce and training. This questionnaire seeks vital information that will inform the workforce strategy and impact assessments. Social Care Wales previously issued a request for updates from local authorities, and this questionnaire seeks to build on the accuracy and scope of that exercise. This letter has also been copied to key staff involved in the DoLS process in your organisation. Could you please ensure that a lead respondent is identified within your organisation who will be able to collate responses across the organisation. We are asking for full responses to this request by 12 April, to ensure there is sufficient time to consider responses and build them into planning assumptions.

Responses to this request should be sent to mentalhealthandvulnerablegroups@gov.wales by 12 April.

I am grateful for your support in this matter. Full engagement with services will be vital to ensure that LPS implementation is effective and delivers the necessary protection for those who need to be deprived of their liberty.

Yours faithfully,

Tracey Breheny
Dirprwy Gyfarwyddwr, Iechyd Meddwl, Camddefnyddio Sylweddau a Grwpiau Bregus
Deputy Director, Mental Health, Substance Misuse and Vulnerable Groups

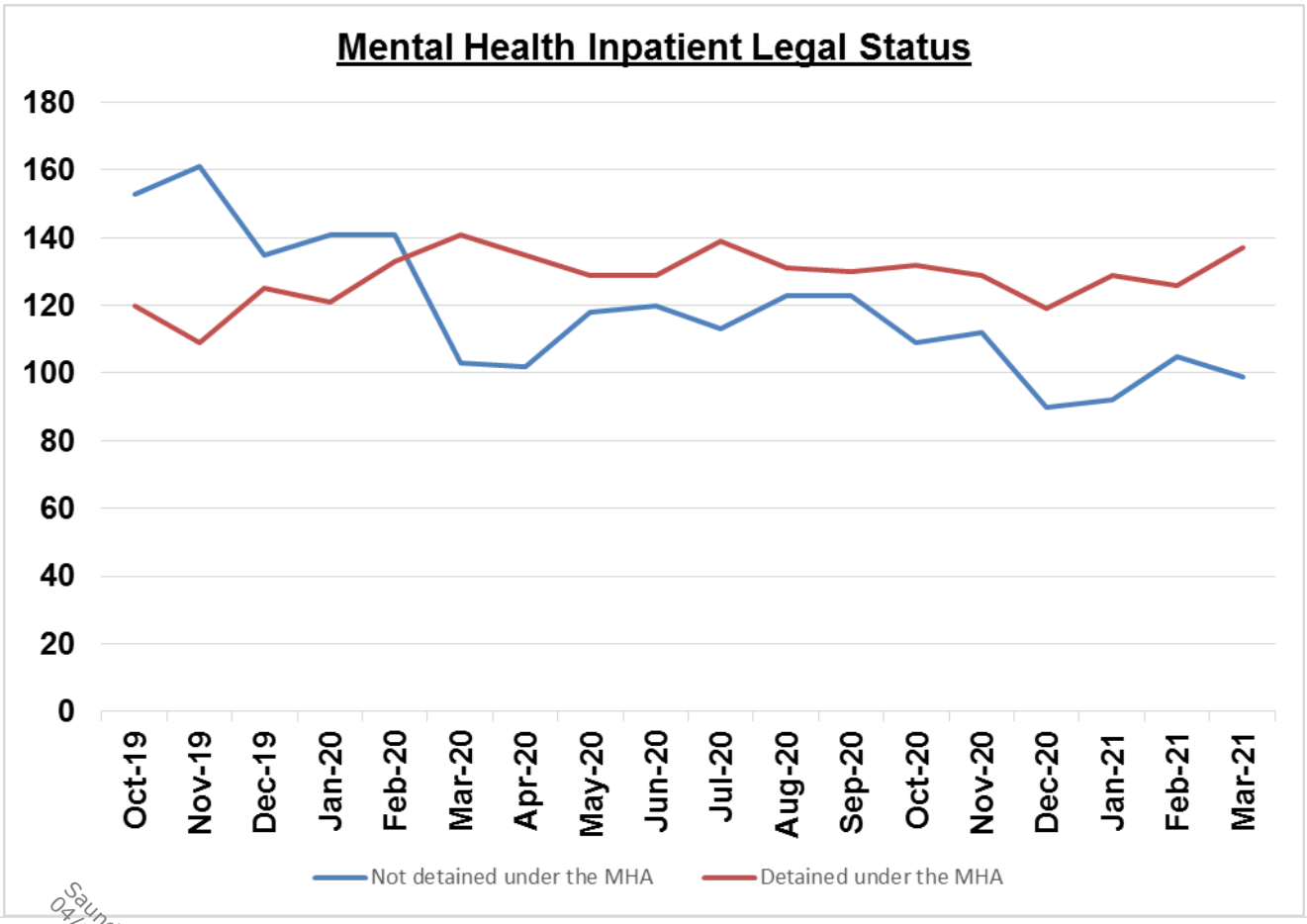
Alistair Davey
Deputy Director, Social Services and Integration Directorate
Dirprwy Gyfarwyddwr, Y Gyfarwyddiaeth Gwasanaethau Cymdeithasol ac Integreiddio

Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**20 April 2021**		
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**										

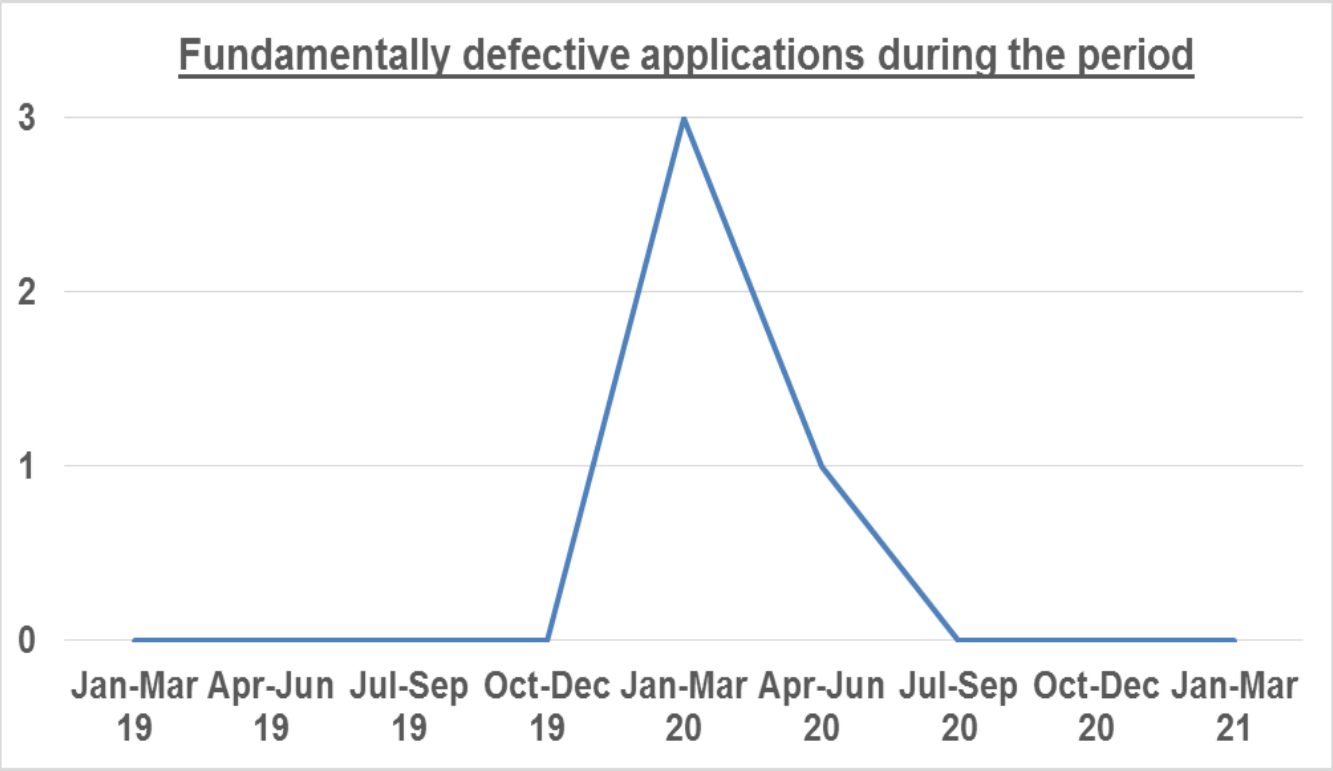
Background and current situation:
This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital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

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:
Use of the Mental Health Act is increasing. 58% of in patients were detained under the Act the end of Qtr. 4.

Graph 1 – Mental Health Inpatient Legal Status



Graph 2 - Fundamentally defective applications



During the period there were no fundamentally defective applications for detention recorded.

Section 136

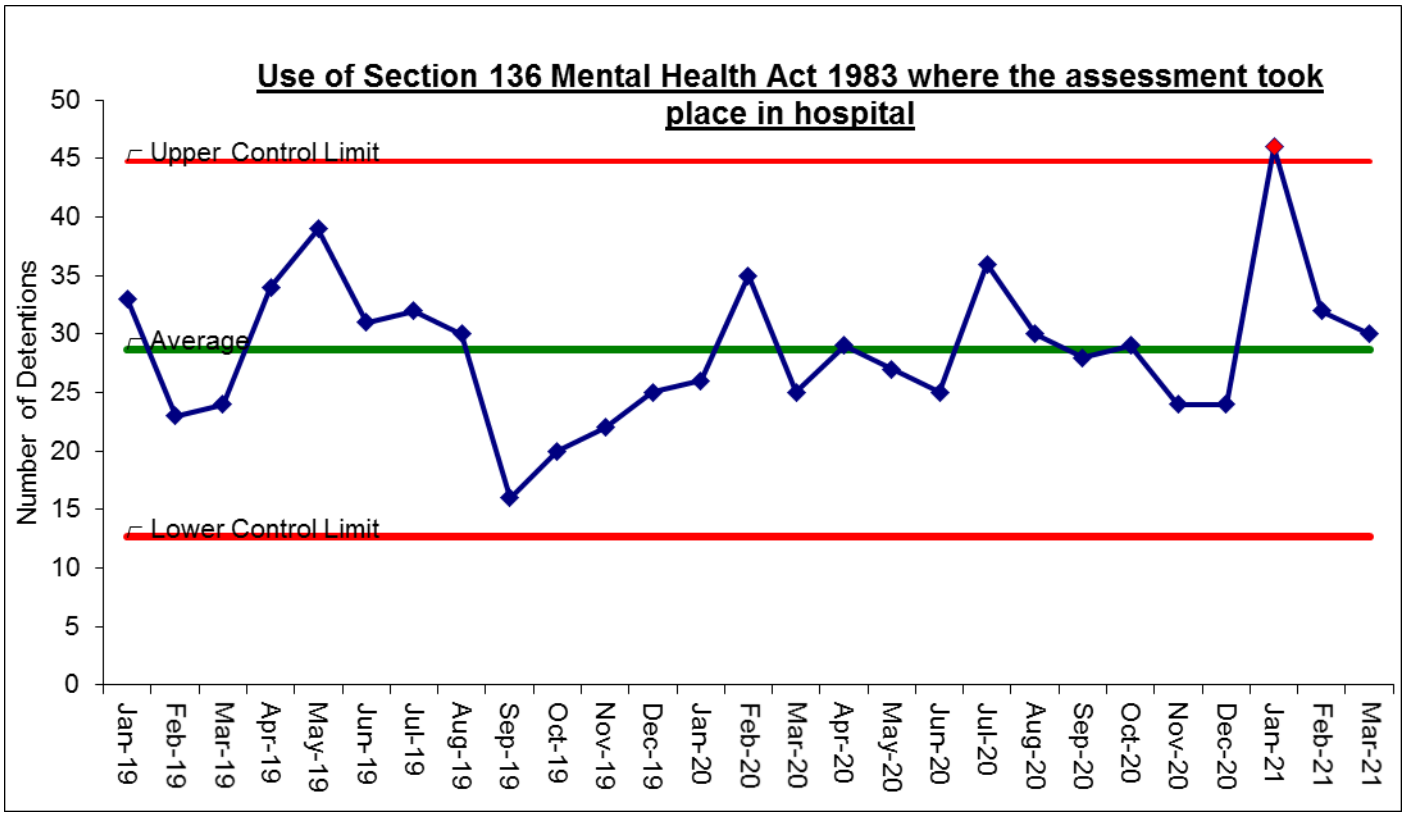
The ongoing issue in relation to when the clock starts ticking in A&E remains unresolved. Further legal opinion has been sought. The Mental Health Clinical Board are awaiting the response.

A substantial increase in the number of section 136 assessments conducted in January 2021 has been noted. Further investigation indicates that 81.5% of individuals assessed were not admitted to hospital. This figure is significantly higher than previous quarters, where reports indicate that at least a quarter of 136 assessments resulted in hospital admission:

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

Graph 3 - Use of Section 136 Mental Health Act 1983 where the assessment took place in

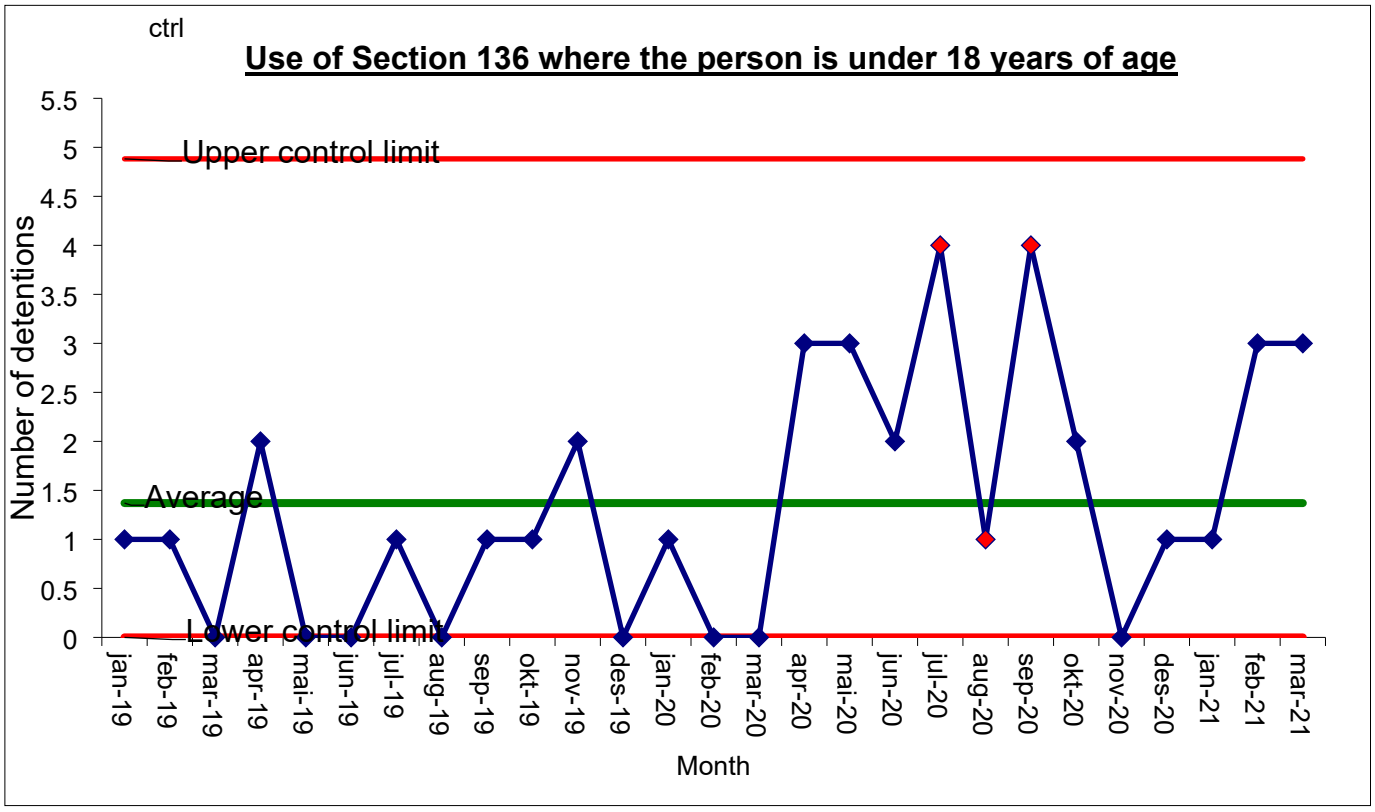
Hospital



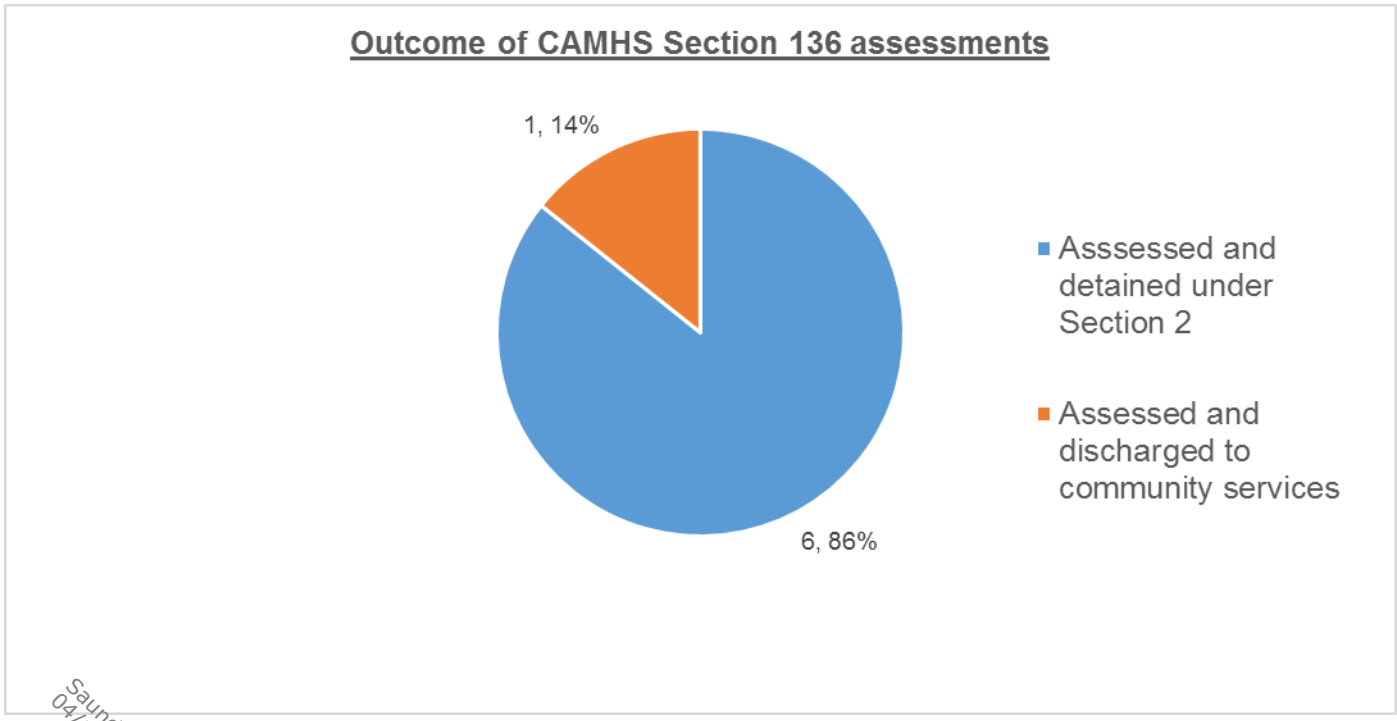
Section 136 - CAMHS

The number of those under 18 assessed under section 136 has increased in comparison to the previous quarter. There were no repeat presentations recorded during the period, each section 136 assessment was in relation to a different patient.

Graph 4 – Use of Section 136 where the person is under 18 years of age



Graph 4 – Outcome of CAMHS Section 136 Assessments



Mental Health Review Tribunal

The Mental Health Act Manager and a Consultant representative met with the Vice President of the Mental Health Review Tribunal for Wales to raise concerns in relation to tribunal proceedings taking place via telephone conference without there being a video link option available for the patient.

General feedback from clinicians in attendance at tribunals has been that when the nurse and patient are using the same telephone it is very hard to hear their evidence. This has sometimes been resolved by the individual giving evidence through the receiver rather than on speakerphone, but this deprives the other party of hearing half of the discussion, which in the case of the patient jeopardises their sense of having had a fair hearing:

This lack of visual feedback is particularly disappointing given that the medical member no longer examines the patient before the hearing so misses the opportunity to form their own opinion.

Patient feedback in relation to tribunal proceedings being conducted via telephone conference has been provided by Advocacy Support Cymru and is as follows:

- They find phone calls difficult and anxiety provoking,
- They find telephone hearings impersonal,
- They need to see the people making decisions,
- They cannot express themselves properly over the phone,
- They do not feel enable to take part,
- They feel detached from the proceedings,
- Proceedings can be 'awkward',
- They do not see the point of a telephone hearing,
- They are waiting until the ruling changes to apply for a MHRT,
- They do not feel a telephone hearing is worthwhile,
- Face to face hearings are preferred but see video conferencing as a necessary compromise.

This feedback has also been passed onto the Mental Health Review Tribunal for Wales in order for consideration to be given for tribunal proceedings to be conducted by video conference.

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

Fundamentally defective applications

Arrangements between the Local Authority and UHB are working well, communication in relation to receipt of applications for detention under the MHA continues to improve. Development sessions have been reinstated by the Mental Health Act Office. A number of sessions have been delivered to Shift Coordinators who are responsible for receipt and scrutiny out of hours.

Section 136

The current situation poses challenges for both the UHB and SWP as we are unable to agree on the correct approach to be taken in A&E.

If it is accepted that the clock starts ticking in A&E there is a danger that the UHB could exceed the detention period under certain circumstance, resulting in no authority to conduct a mental health assessment if the patient does not agree to it. For example when the time taken for medical treatment exceeds the 24/36 hour period.

Mental Health Review Tribunal

Risk to staff

Clinicians are becoming increasingly concerned about the safety of staff during Mental Health Review Tribunals and as tribunal hearings are being held by telephone, this means that the nurse attending the hearing is often sat on their own with the patient while giving evidence that the patient may not like hearing.

This was particularly concerning at a recent tribunal hearing in which it was apparent to the Responsible Clinician that the young female nurse felt unable to provide the information she would like to have provided due to her fear of how the patient might have reacted. Under normal circumstances there would have had at least five (minimum) other people around for support while giving evidence that might cause distress or anger. During this hearing she was alone with the patient in a room in which there were no means of summoning support or escaping easily.

Risk of insufficient evidence being presented to the panel could lead to unsafe discharge

Nursing staff can be prevented from providing examples and opinions due to concerns for their safety caused preventing them from providing specific examples and opinions in fear of the patient's reaction. This can result in the panel not hearing important facts and opinions about the patient's presentation and care, which may have an impact on the panel's decision-making.

There is neither the space nor the manpower to enable more than one nurse to attend the hearing and it is not felt that this would be an acceptable solution as it would breach social distancing guidance for the duration of the hearing (often over 2 hours) and would negatively impact on patient care by reducing the staff available for therapeutic work on the ward.

The panel is also deprived of valuable information that would be obtained should the panel have the benefit of being able to see the patient. For example, feedback has been gathered from nursing staff who have described patients pacing round the room in an agitated state during hearings. Similarly, the panel will be unaware of the patient's presentation which can be of particular relevance to the panel.

Development sessions

Mental Health Act awareness session continue to take place on a monthly basis. In addition to the Receipt and Scrutiny workshops the Mental Health Act Department has implmented the consent to treatment workshop.

During the period the Mental Health Act Department has provided the following development sessions:

Date	Title	No.	General consensus feedback
05/01/21	Receipt & Scrutiny Training	2	Excellent feedback. Good revision of the issues.
14/01/21	Receipt & Scrutiny Training	3	Excellent feedback. Good via Teams as meant I didn't have to leave the ward.
19/01/21	Receipt & Scrutiny Training	1	Excellent feedback. Training was to the point and informative
27/01/21	Receipt & Scrutiny Training	2	No feedback received.
28/01/21	Mental Health Act Training Day	9	Excellent/Good feedback. Very informative. Well organised. Splitting off

			into groups for case studies was very good. Trainer was engaging.
04/02/21	Junior Doctors Induction	2	No feedback received.
05/02/21	Receipt & Scrutiny Training	1	Excellent feedback. 1 on 1 session worked well.
11/02/21	Receipt & Scrutiny Training	2	No feedback received.
16/02/21	Receipt & Scrutiny Training	3	No feedback received.
24/02/21	Consent to Treatment Workshop	5	Excellent/Good feedback. Small group worked well on Teams. Trainer was very knowledgeable on the subject. Good coverage of the topic.
25/02/21	Receipt & Scrutiny Training	2	Excellent/Good feedback. Good balance of theory and practical.
26/02/21	Mental Health Act Training Day	6	Excellent/Good feedback. Information was delivered very clearly and easy to understand. Good structured course.
10/03/21	Consent to Treatment Workshop	3	Excellent feedback. Really useful and yearly refreshers would be beneficial. Informative and well balanced.
16/03/21	Receipt & Scrutiny Training	1	Excellent feedback. Information provided beforehand. Easy to follow.
24/03/21	Consent to Treatment Workshop	3	Excellent feedback. Content was useful. Material provided will make revision easy.
26/03/21	Mental Health Act Training Day	7	Excellent feedback. Case studies helped put information into practice. Good presenters with clear slides.

Recommendation:

Fundamentally defective applications

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

Section 136

Continue to monitor in the Mental Health Act Office and work with South Wales Police.

Section 136 – CAMHS

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

Mental Health Review Tribunal

Continue to work with the Mental Health Review Tribunal for Wales to find a suitable resolution, to ensure that action is taken to mitigate the risks highlighted above and protect the patients' right to a fair hearing.

Development sessions

Continue to develop a robust rota to ensure that development sessions in relation to all areas of the Mental Health Act are available and easily accessible.

ASSURANCE is provided by:

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

The Committee is asked to:

- **NOTE** the report
- Support the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**20 April 2021**		
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**										

Background and current situation:
In 2017, the government asked Professor Sir Simon Wessely to lead the Independent Review of the Mental Health Act 1983 (MHA), to propose recommendations for modernisation and reform. The final report was published in December 2018 and made over 150 recommendations.
The government has now published its response in the form of a White Paper, which is currently out for a 12-week public consultation. Following consultation, the government plans to draft a revised Mental Health Bill, which will be introduced when Parliamentary time allows. The following summary sets out the government's main plans for legislative change.

Statutory principles
The government proposes to seek to include four principles "up front" in the MHA, as well as in the code of practice (in which there are currently five principles). The proposed principles are:

- choice and autonomy – ensuring patients' views and choices are respected,
- least restriction – ensuring MHA powers are used in the least restrictive way,
- therapeutic benefit – ensuring patients are supported to get better and discharged as quickly as possible, and
- the person as an individual – ensuring patients are viewed and treated as individuals.

Detention criteria
The government also proposes to tighten the criteria for detention under the MHA to address the rising rates of detention and its disproportionate use among certain ethnic groups. First, the section 3 detention criteria for admission for treatment will be amended to clearly stipulate that, for someone to be detained, it must be demonstrated that:

- the purpose is to bring about a therapeutic benefit;
- care and treatment cannot be delivered to the individual without their detention; and
- appropriate care and treatment is available.

Second, the section 2 (admission for assessment) and 3 detention criteria will be amended to require that there must be a "substantial likelihood of significant harm" to the health, safety or welfare of the person, or the safety of any other person.

Mental Health Tribunals
The government wants to introduce more tribunal hearings to check on whether a patient's detention continues to be appropriate. Under the proposals:

- section 2 patients could appeal within 21 days of detention (rather than the current 14 day

limit);
- section 3 patients could appeal three times in the first 12 months of detention (rather than two currently); and
- automatic referrals would take place every 12 months.

It also intends to expand the powers of the tribunal to include granting leave, transferring patients (e.g. to a less secure hospital), and to direct services in the community. There would be a duty on health and local authorities to take all reasonable steps to follow the tribunal's decision.

The government is seeking further views on whether managers' panel hearing should be abolished.

Advance choice documents (ACDs)

The government proposes to introduce ACDs. These can be made when the individual has the relevant capacity and set out the person's preferences about their future treatment. They will only be considered if the individual loses capacity to make care and treatment decisions. Clinicians will be required to consider the contents of an individual's ACD while they are detained under the MHA.

Statutory care and treatment plans

It also wants to amend the MHA to require that all detained patients must have a care and treatment plan, with clear expectations about how this should be developed with the patient. The responsible clinician, working with other professionals, will be responsible for maintaining the plan, which must be made within seven days and approved by the clinical director of the hospital within 14 days.

Consent to treatment

The government proposes to introduce additional safeguards when certain forms of treatment are being provided without consent. For example, the approval of a court will be required if urgent electroconvulsive therapy is being provided in the face of the person's refusal, and the requirement for a second opinion appointed doctor (SOAD) certificate to provide medication without consent would be brought forward to 14 days, or 2 months, if the patient lacks capacity.

It is also proposed to introduce the ability for patients to challenge a specific treatment with the tribunal. This would be dealt with by a single judge sitting alone, who could make a finding that the responsible clinician should reconsider their treatment decision.

Nominated person

The government will replace the nearest relative with a new statutory role, the nominated person (NP), who the patient can personally select to represent them. The NP will have the same rights and powers as nearest relatives have now.

The NP can be selected by the individual during the MHA assessment, or in an ACD. If the person lacks capacity to nominate, an interim NP will be appointed by an approved mental health professional (AMHP) until the person has capacity to make their own nomination. Children under 16 can also nominate an AP if they are "Gillick competent" i.e. they have sufficient understanding to understand what is proposed and make a decision about consent.

The government will also seek to legislate so that the NP's objection to admission can be temporarily overruled, if the AMHP believes the objection is unreasonable. Currently, the only means of overruling a nearest relative is to remove or displace them. Also, the power to displace the nearest relative sits with the County Court and the government wishes to explore whether this power should sit with the tribunal.

Independent mental health advocates (IMHAs)

It is proposed to expand the role of IMHAs to include:

- supporting patients to take part in care planning;
- supporting individuals in preparing ACDs;
- challenging particular treatments; and
- applying to the tribunal on behalf of the patient.

The Wessely review recommended that IMHAs should be available to support informal patients. The government agrees that IMHAs are well placed to do this, but due to the additional burdens for local authorities and advocacy providers, this will be subject to future spending decisions.

Community treatment orders (CTOs)

The Wessely Review concluded that, whatever their merits, CTOs are used too often, patients stay subject to them for far too long, and they are used disproportionately on Black people. The government proposes to reform CTOs so that they can only be used where there is a strong justification, they are reviewed more frequently and by more professionals, are time limited (to two years unless the person has relapsed or deteriorated), and that people subject to them really need them to receive a genuine therapeutic benefit.

The Mental Capacity Act (MCA) interface

The Wessely Review recommended a clearer dividing line to be introduced in legislation between the MHA and MCA, based on whether or not a patient is clearly objecting to detention or treatment. The effect would be that all patients without the relevant capacity who do not object will receive care and treatment under the Deprivation of Liberty Safeguards (DoLS) or in the future, the Liberty Protection Safeguards (LPS) and not under the MHA. The government says that it will wait to assess the impact of the implementation of the LPS before introducing these reforms, and is seeking further views.
The Wessely Review also recommended that the government should consult on whether the MHA should enable the giving of 'advance consent'. This would allow people to consent in advance to a set of arrangements that would otherwise give rise to a deprivation of liberty and, if they subsequently became unwell, they could be admitted as informal or voluntary patients, as opposed to being detained under the MHA or subject to the DoLS/LPS. The government's view is that the law already enables advance consent to be given in certain circumstances and is consulting on whether the MHA or the code of practice could be amended to usefully make this clearer.

Accident and Emergency

The government wants to improve the powers available to health professionals in A&E departments so that individuals in need of urgent mental health care, stay on site, pending a clinical assessment. Too often, the police are used in these cases.#

In part, the government thinks this be addressed by changes to section 4B of the MCA, which are due to come into force as part of the new LPS system. These will enable A&E clinicians to deprive a person of their liberty to provide life-sustaining treatment or a vital act. But the government also believes that additional powers may be needed. It is therefore seeking views on extending section 5 of the MHA for this purpose. This provides powers to hold a person temporarily, while their mental health is assessed, but it cannot currently be applied in A&E.

Patients in the criminal justice system

The government proposes to speed up the transfer from prison to mental health inpatient settings, by introducing a 28-day time limit and establishing a new professional role for the purpose of managing the transfer process (which could be given to AMHPs).

It is also proposed to introduce of a new power of 'supervised discharge', which would enable the discharge of a restricted patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage the risk they pose.

People with a learning disability and autistic people

The White Paper raises concerns about the inappropriate admission of people with learning disabilities and autism to mental health hospitals. It is therefore proposing to revise the section 3 detention criteria to be clearer that autism and learning disabilities are not considered to be mental disorders for this purpose. Under section 2 there would be a requirement that there must be a probable mental health cause to their behaviour that warrants assessment in hospital.
The government also recommends the creation of new commissioning duties on local authorities and clinical commissioning groups to ensure an adequate supply of community services for these groups and monitor the risk of crisis at an individual level.

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

Statutory principles

There have been no comments in relation to the proposed statutory principles.

Detention criteria

Medical colleagues have expressed some concern in relation to the detention criteria and to the challenge that using this principle along with the new criteria for least restrictive treatment could bring. It is felt that an indirect consequence of this recommendation could result in an increasing the number of detentions.

Some colleagues feel the proposal seems quite marked towards Autism and LD and feel it may suit that cohort of people. However with Borderline Personality Disorder, there is a clear chance of a ping pong ball scenario, as they might be detained with substantial risk at the time of admission, refuse to engage in any meaningful therapeutic activities and as they don't meet the therapeutic criteria, can and will be discharged. A similar situation can be seen with the acutely psychotic or manic patient without having adequate time for care planning or care adjustments. Potentially this could lead back to many patients becoming 'revolving door' patients once again.

It is also felt that as a consequence of raising the bar too high the prognosis for the patient could be detrimentally effected. With most (if not all) mental illnesses, the earlier they are caught and treated, the quicker the recovery and the better the long term prognosis. These recommendations could mean that before you can compel someone to treatment, they will have become really unwell and therefore admission is likely to be prolonged.

Medical opinion has suggested that if you are only able to detain at the highest risk level, then more risk events are going to occur, explaining that "substantial likelihood" and "significant" are difficult to define especially in the context of a risk assessment.

Mental Health Tribunals

The right to "Appeal" is vital to the protections of the patient. Having independent bodies look at detentions is of course important.

Feedback from a Responsible Clinician perspective has been received and makes the following points:

- This needs to be balanced with the workload of already pressured Multi Disciplinary Teams and clinical teams. The paperwork associated with tribunals (and detentions as a whole) can be extremely onerous as it is. By increasing the frequency of tribunals this is only going to increase,
- Ultimately it is the clinical team that have the responsibility for managing the patient's health and risk,
- Management of the client should not be taken out of the clinical team's hands by a body that can't possibly have the required in depth knowledge,
- The clinical team should be responsible for the patient's welfare and risk.

If the MHRT grant leave (without the Responsible Clinician being comfortable with that idea), the responsibility of that decision should fall to the MHRT, who should also give practice directions to police or ambulance in assisting the patients back o hospital when they "refuse" to return from leave. It should not fall on ward staff or the Responsible Clinician.

To manage the increase in tribunal applications the review suggests a *"judicial filter"*, whereby a Judge will carry out a paper review and decide which cases will be put through for a hearing based on whether or not he considers there to be a change of circumstances.[1]

These recommendations significantly increase access to the Tribunal. To meet the demands if the Tribunal in relation to the applications alone will require substantial resource across the board. Professionals are currently under pressure, spending a significant amount of time preparing submissions for the tribunal. This impacts on the amount of time they can spend interacting with their patients. Professionals have expressed concerns about how they will manage to keep up with the demands of the Tribunal without there being a detrimental impact to the patient.

It is also anticipated that the Mental Health Act Team will require a significant amount of extra resource to manage the number of applications to the Tribunal on behalf of the UHB.

Advance choice documents (ACDs)

There is current disparity between mental health and physical health. Regardless of the form of ill health – where there is capacity – decisions should be respected.

Statutory care and treatment plans

The recommendations require all statutory care and treatment plans to be developed by day 7 and subject to internal scrutiny and approval by the Medical Director or Clinical Director (or equivalent) within 14 days of detention. Considerable thought will be required in relation to this recommendation as there will be substantial resource requirements to adhere to these timeframes.

Consent to treatment

Concerns have been expressed in relation to the clinical safety of this recommendation, with the views being that this not be beneficial to the patient. Therefore contradicting the Acts idea of improving the quality of patient life. Clinicians also feel that this cannot be delivered safely without a

[1] *Modernising the Mental Health Act. Increasing Choice, reducing compulsion. Final report from the Independent review* Department of Health and Social Care [

medical person being involved in discussion/part of the decision making process and that a Judge may not have enough expertise in mental health.

Clinicians feel that as the team who hold the responsibility for treatment and risk. The decision around what treatments to use should therefore remain with that team.

Nominated person

Whilst in principle this recommendation is a good one. There have been concerns expressed in the carers' forum for long time. The worry being, patients when unwell or not getting on well, might choose to nominate a person (who might or might not agree to take up that role and might choose people who would agree with the choice they want to make rather than the right one).

Concerns have been expressed in relation to the huge burden on families who are actually looking after patients during crisis and support them, if the patient makes wrong choice of choosing nominated person. It has been known for patients to force friends to write letters on their behalf. Friends will often comply as they don't want to jeopardize the friendship but in private they will confide in why they did it and wish the nearest relative won't do what they have done. So, one can imagine the complexities. Similarly, some group of patients can form pacts and nominate each other in order to completely alienate their families.

The current due to its hierarchy of who can be nearest relative is easy to follow and consistent However the new system could be quite volatile, changeable and misused which would negate the intended purpose.

Independent Mental Health Advocates (IMHAs)

There have been no comments in relation to Independent Mental Health Advocates.

Community Treatment Orders (CTOs)

There have been no comments in relation to community Treatment Orders.

The Mental Capacity Act (MCA) interface

Not practical to implement especially when the person making an active attempt to leave.
Consent in advance to informal admission can be tricky as in the current clinical structures it is difficult for them to give well informed consent without knowing the useful information like setting, ward, facilities/resources available, length of admission etc. We also need clarity of what happens if this cohort of patient would refuse medication after been admitted to and lacks capacity to consent for medication as well, when do we seek SOAD and what were the provisions for urgent treatment?

At the outset, the principle seems to be good but at the implementation level and with some cohort of patients it can be challenging, Example in cases of where the capacity can be fluctuating and one might be doing more damage by not intervening early. Same, might apply for any acute psychotic patient who believes in conspiracy theories about NHS, Government and Pharmaceutical companies. This would then contradict the available research that prognosis is better when the duration of untreated psychosis is less.

Accident and Emergency

We have received mixed views in relation to extending the use of section 5 of the MHA to A&E departments. Whilst some medical professionals are supportive of this approach others are concerned it may be used to delay the mental health act assessment.

Patients in the criminal justice system

There are current concerns that people are not being assessed as needing hospital because there are no available beds. It is felt that imposing a time limit might make the situation worse as it will be harder to find a bed within this tight time frame.

The general consensus among our AMHP's within the forensic team is that the AMHP is not in a position to take up this extra role, nor do they think their specialist skills would lend itself to this. The Team would welcome the welsh equivalent of the NHSEI to manage the prison and IRC (Immigration Removal Centre) transfer process.

In principle it is felt that introducing a new power to discharge patients into the community with conditions that amount to a deprivation of liberty could be a less restrictive option and therefore an alternative to detention. However concerns have been expressed into the practicality of this, firstly in terms of determining 'reasonable' restrictions that are proportionate but will actually make a huge difference in reducing risks and secondly, the enforcement of breaches of these restrictions. Questions have arisen in relation to who will be responsible for that?

People with a learning disability and autistic people

There have been no comments in relation to people with a learning disability and autistic people.

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

Concerns have been raised in relation to the substantial increase in work demand and how this will impact on staff, potentially to a point contributing to burn out.

The demand on the Second Opinion Appointed Doctor service provided by Healthcare Inspectorate Wales and the Mental Health Review Tribunal for Wales will significantly increase. Careful consideration to the current workforce arrangements will be required to manage the substantial increase in workload to our partner agencies and the UHB as a whole.

The Mental Health Act Department will require significant additional resource to manage the substantial increase in the number of Tribunal hearings alone.

Wide consultation has taken place in order to gather feedback and collate a response on behalf of Cardiff and Vale UHB. The consultation undertaken specific to Reforming the Mental Health Act was as follows:

- The document was shared with Inpatient and Community Mental Health Teams,
- The document was shared with the Adult/MHSOP Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority and the Mental Health Clinical Board,
- Comments were also invited via individual e-mails from all those mentioned above.

All comments have been considered and incorporated within the UHB response as described above.

Recommendation:

ASSURANCE is provided by:

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

The Committee is asked to:

- **NOTE** the report,
- Support the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA,
- Support the approach taken by the Mental Health Clinical Board in collating a response to the White Paper on behalf of Cardiff and Vale UHB.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

REPORT TITLE:	**Mental Health Measure (Wales) 2010 incl. Part 2**								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	**April 2021**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Chief Operating Officer								
REPORT AUTHOR (TITLE):	Director of Operations, Mental Health								

PURPOSE OF REPORT:

The purpose of this report is to provide the Committee with assurance on compliance with the four parts of the Mental Health Measure (Wales) 2010.

REPORT:

SITUATION

The UHB's performance in relation to the Mental Health Measure (Wales) 2010 is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee. For the information of the committee the Delivery Unit has restarted its 90 day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

BACKGROUND

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

ASSESSMENT AND ASSURANCE

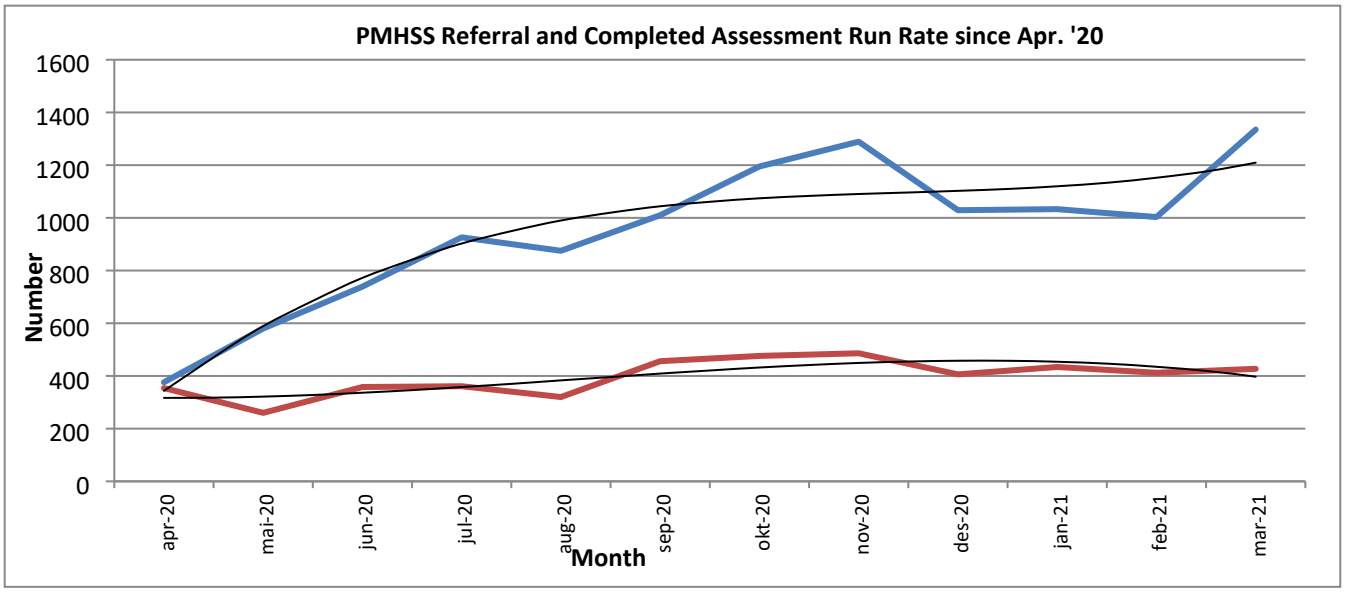
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

<u>Part 1 : PMHSS</u>

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

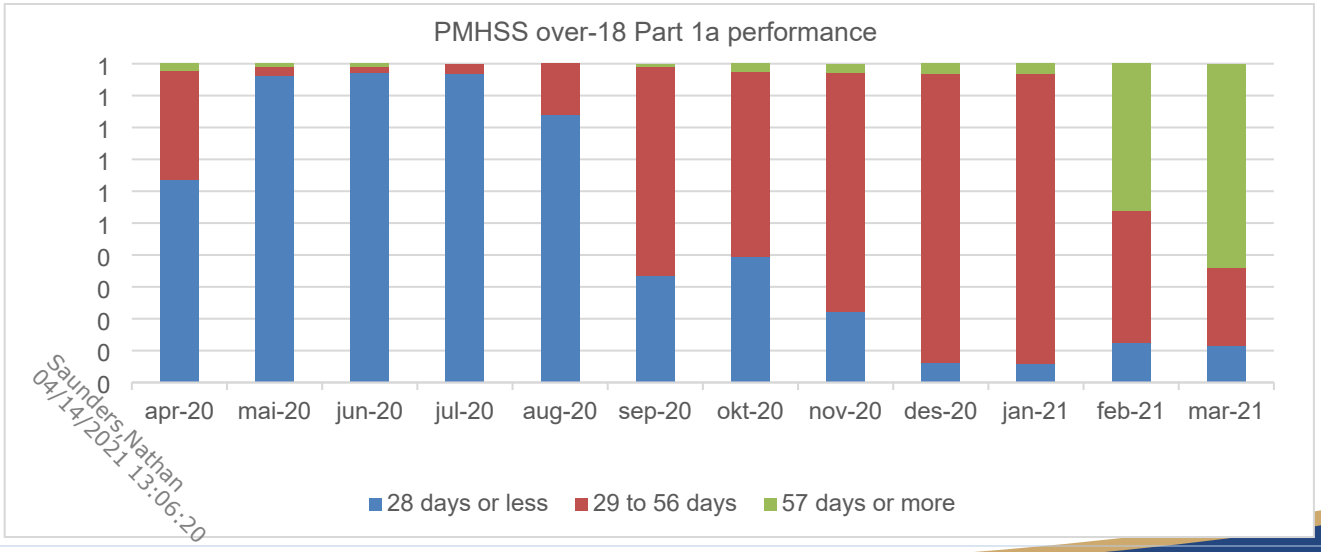
Referral activity for Q3 and Q4 2020 has seen an initial increase in referrals going into Q3 before a notable decline in numbers from December before March produced referral numbers the second highest the service has ever received, just under 1,350. There is no obvious reason for this spike in referrals at the end of the financial year. Completed assessment rates have steadily increased looking at the financial year as a whole (See Graph 1).

Graph 1 - PMHSS Referral and Completed Assessment Run Rate since April 2020



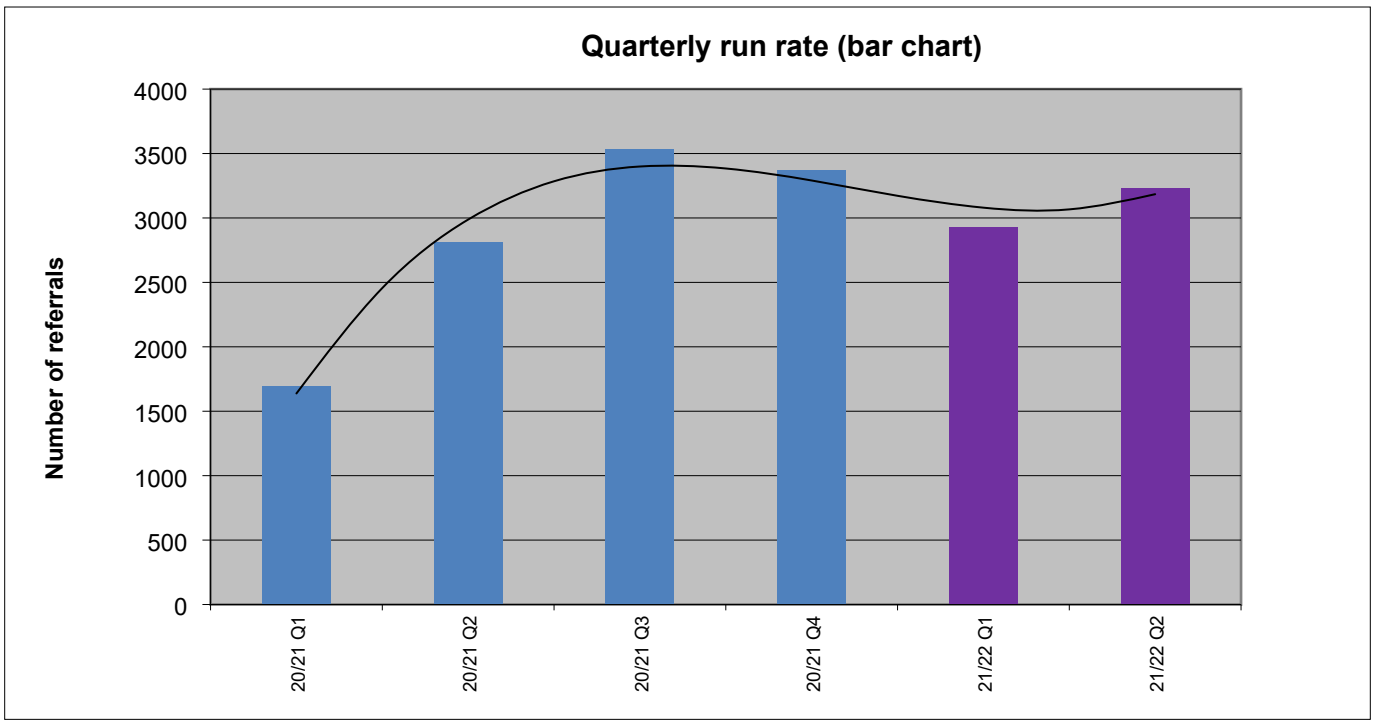
Regarding the over-18 Part 1a performance (see Graph 2), the initial impact of COVID-19 affected performance in the early stages of lockdown, compliance was reinstated quickly before a shortfall in four qualified (3.6wte) staff in August subsequently affected performance going forward and continues up to time of report. At time of writing the service has four vacancies, one secondment vacancy and one potentially long-term sickness absence.

Graph 2 – PMHSS OVER 18 Part 1a Performance



Despite quite a dramatic drop in referral numbers due to COVID-19, referral numbers steadily increased from Q1 to Q3 before stabilizing in Q4. Early forecasts suggest a reduction in referral going into Q1. (See Graph 3).

Graph 3 – Quarterly Run Rate - Referrals



From March 2020 onwards the MHCB took a decision to amalgamate the PMHSS and Primary Care Counselling referrals. This decision was based on the strategic direction of the service to make access to MH services simplified for GPs and Service Users, avoiding referrals to the PCCS going to the back of their waiting lists for up to 6 months. These service users are now screened and triaged by the merged SPOE. The service is monitoring this closely and protecting this new SPOE as it is subject to a Tier 1 target, with investment into the 3rd sector and the Primary Care Liaison team.

A year on from when SPOE was launched the indications are:

- Reduced demand for counselling. Since inception (Apr. '20) referral numbers to PCCS have remained at an average of just over 165 per month compared with a monthly average of over 550 in 2019/20,
- Better uptake of a first appointment for counselling. Approximately 75% of the referrals to PCCS in April '20 had at least one session of counselling. A similar audit to that undertaken looking at PCCS activity for April '20 has yet to be undertaken.

Actions to restore Part 1 compliance:

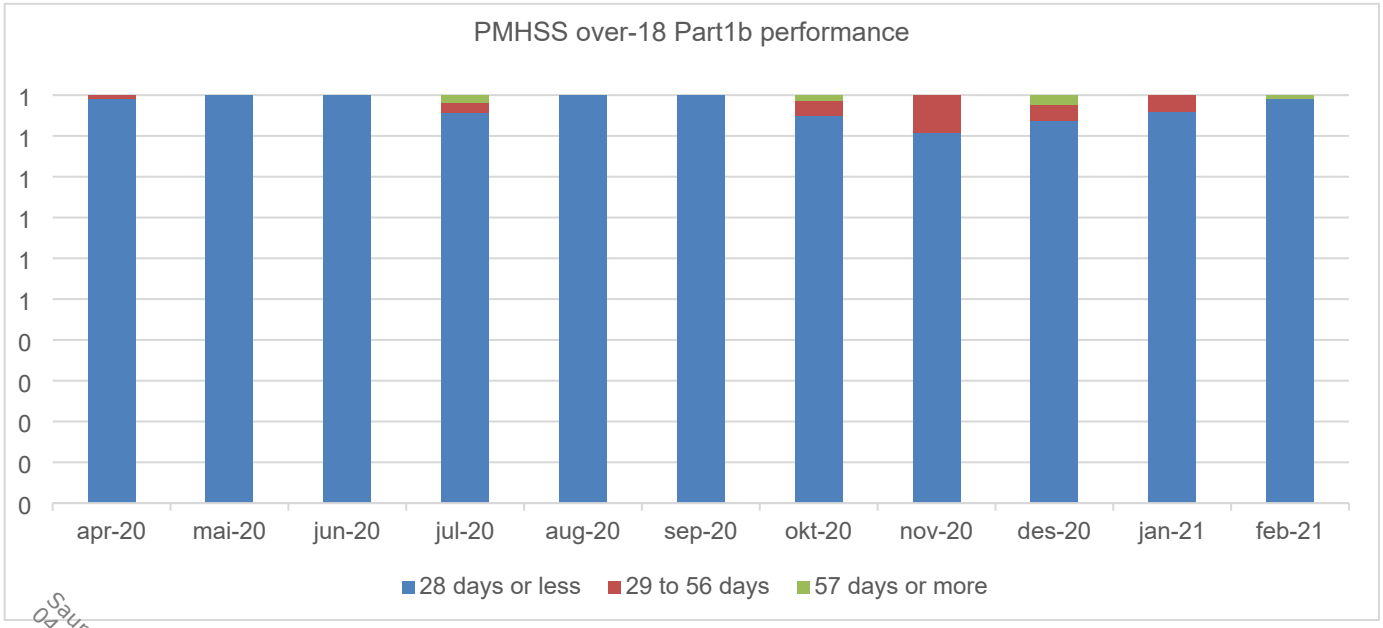
- Ensure all referrals that can be accommodated at Tier 0/1 through intervention of the third sector or the GP PCLT are dealt with there – completed,
- Encourage direct referrals by the public into Tier 0 third sector support through advertising and awareness raising on the UHB website and public health advertising – completed,
- Encourage GPs to refer directly to the third sector through awareness raising in the PCIC CD forum and via the cluster development managers – completed,
- Develop additional capacity within the Primary Care Liaison Team to offer some extra capacity to accommodate staff losses through COVID-19 – completed,
- Develop additional capacity within the third sector to offer some extra capacity to accommodate staff losses through COVID-19 – completed,
- Increase PMHSS establishment of Band 6's by 3.0wte. At time of writing although this has created some new appointments only now are they coming into post but at the same time PMHSS has three additional vacancies due to three current staff serving notice.

Revised trajectories currently being developed in light of the impact of the above measures. Currently referrals are being booked in at 37 days.

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

Having clarified reporting processes, PMHSS has been compliant with the Part 1b performance target since August (See Graph 4). This has continued during the COVID-19 period.

Graph 4 – PMHSS Over 18 Part 1b Performance



Saunders,Nathan 04/14/2021 13:06:20

Part 2 – Care and Treatment Planning

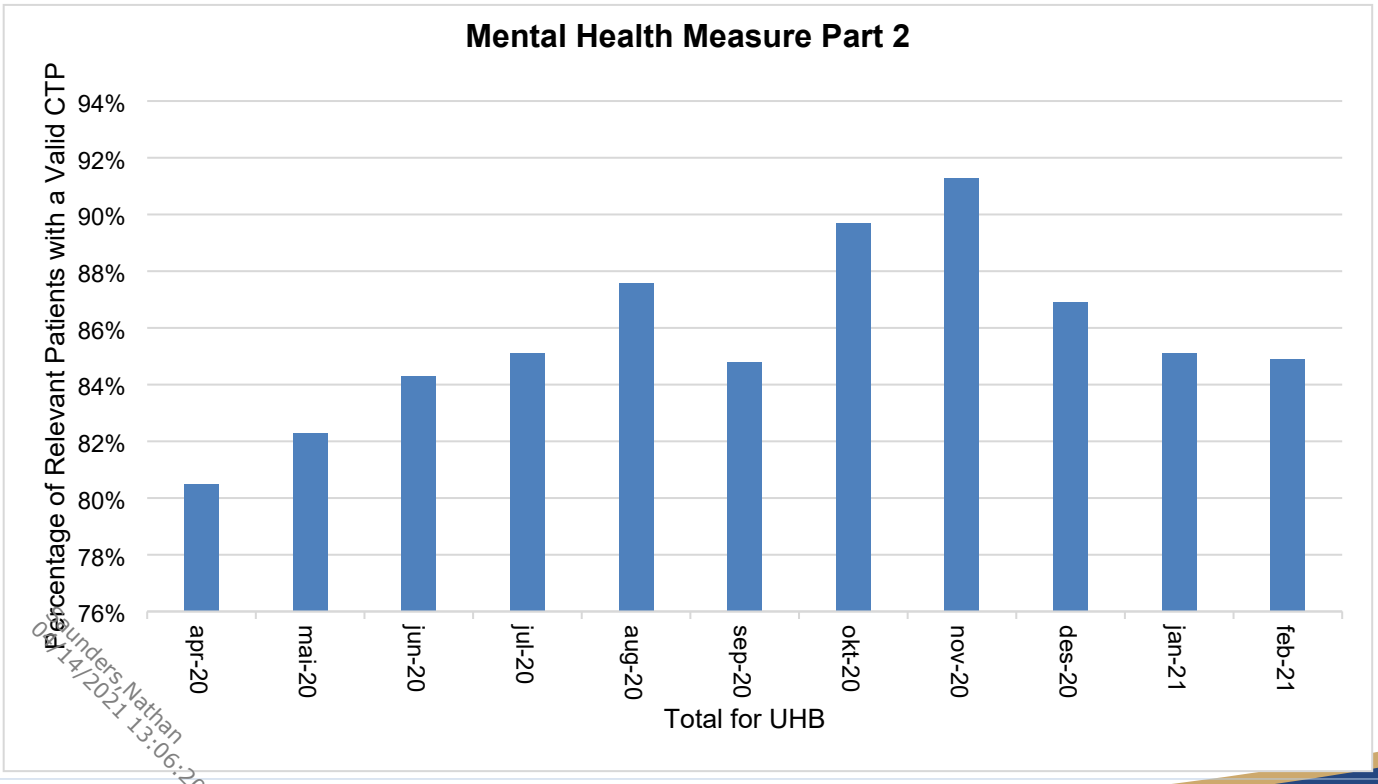
Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

Care and Treatment planning is a complex and challenging area to get right, particularly co-producing outcomes based care planning which requires cultural change from services. Prior to the COVID-19 period the service was following an action plan co-written with the Delivery Unit which included a multi-dimensional improvement approach, including commissioned 'Care Aims' training, routine auditing of care and treatment plans, moving SUs expectations into practice through support of the Recovery College, simplifying documentation and defining a 'relevant patient' under the Measure therefore clarifying who and who does not require a formal Care and Treatment Plan. This plan remains relevant.

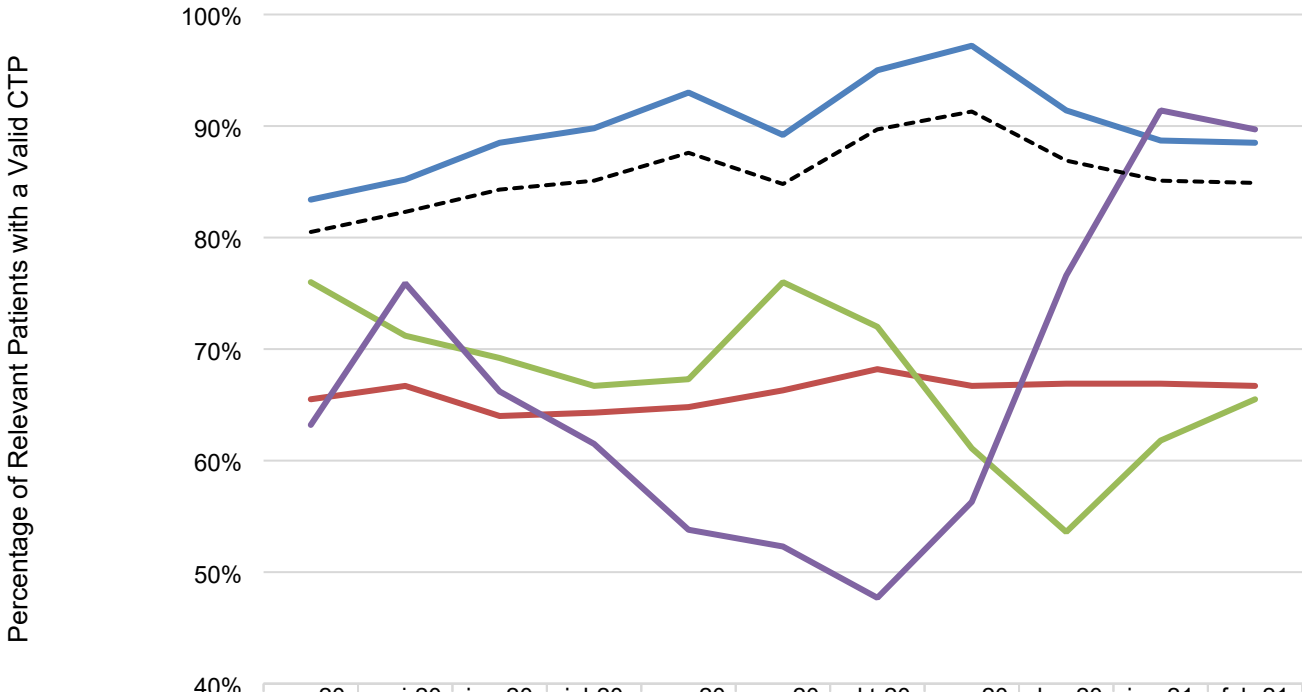
The future success of Care and Treatment planning is also tied to the strategy around out-patient transformation, within which many of the poorer examples of care and treatment planning sit. A program of work has now commenced with Dr Neil Jones leading the work stream and the Director of Operations supporting.

Since the previous Mental Health Legislation Committee meeting Care Aims and Open Dialogue training has continued in spite of the COVID-19 restrictions and compliance with CTP completion has reached over 90%. During the period October 2020 to February 2021 the Learning Disabilities Service has shown significant gains, from the low point in October 2020 of 47.7% to a high of 91.4% in January 2021.

Graph 5 – Mental Health Measure – part 2 – April 2020- February 2021



Graph 6 – Mental Health Measure Part 2 By Service

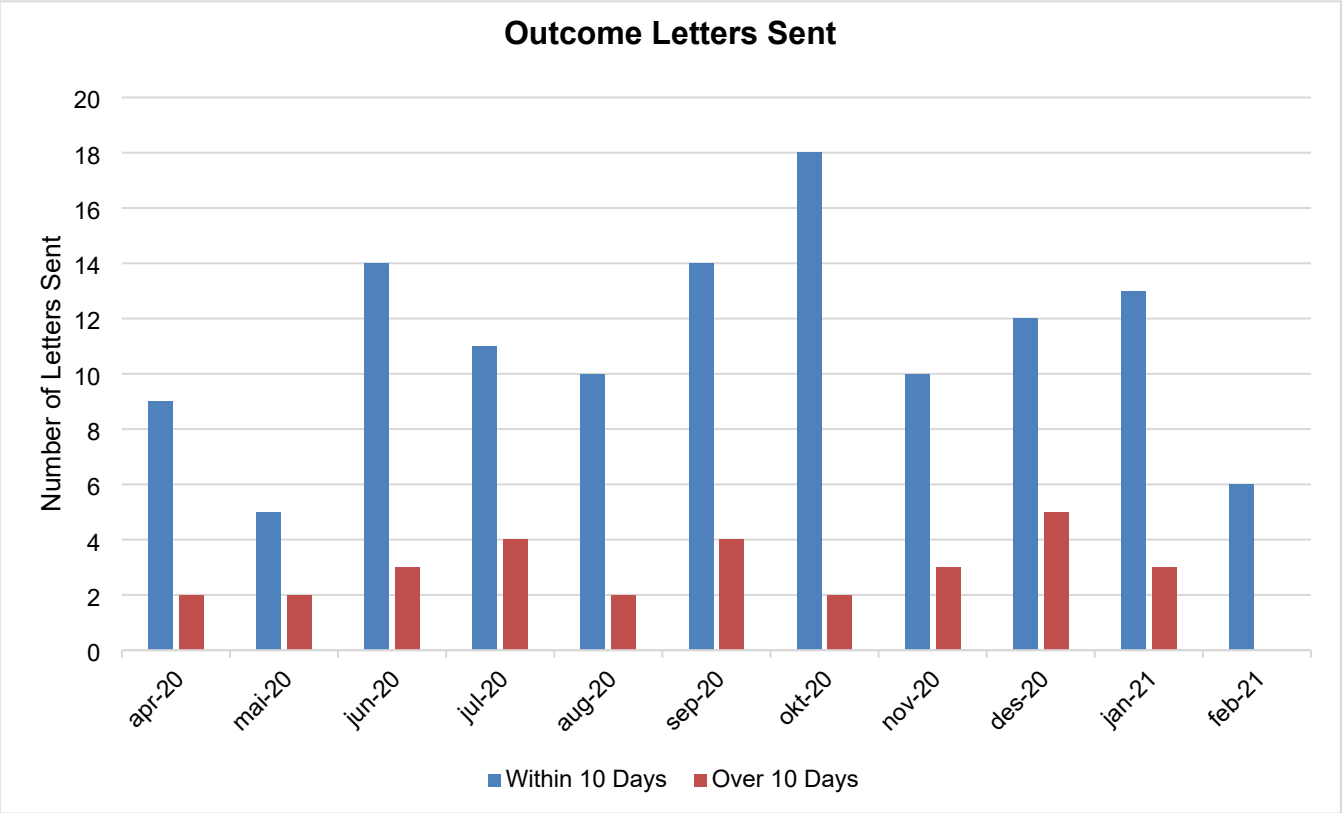


	apr-20	mai-20	jun-20	jul-20	aug-20	sep-20	okt-20	nov-20	des-20	jan-21	feb-21
Adult	83,4%	85,2%	88,5%	89,8%	93,0%	89,2%	95,0%	97,2%	91,4%	88,7%	88,5%
MHSOP	65,5%	66,7%	64,0%	64,3%	64,8%	66,3%	68,2%	66,7%	66,9%	66,9%	66,7%
CAMHS	76,0%	71,2%	69,2%	66,7%	67,3%	76,0%	72,0%	61,1%	53,6%	61,8%	65,5%
LD	63,2%	75,9%	66,2%	61,5%	53,8%	52,3%	47,7%	56,3%	76,6%	91,4%	89,7%
Total for UHB	80,5%	82,3%	84,3%	85,1%	87,6%	84,8%	89,7%	91,3%	86,9%	85,1%	84,9%

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.

Graph 7 – Outcome Letters Sent



The performance of the service fluctuates with steady improvement seen between September 19 and December 19 with 100% compliance in January. Since then the teams have seen circa 80% compliance amid the administration pressures of COVID-19, with a peak of 100% in February 2021.

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

Part 4 continues with 100% Compliance.
The IMHA services continues to run a reduced service. In response to the pandemic.

The IMHA agreement expired on the 31 December 2020 and renewal process was halted due to a delay in the recommendations following the review of the Mental Health Act being communicated. As such the existing agreements were extended for 12 months in line with Regulation 72 (1)(c) of the Public Contract Regulations 2015.

The Health Boards are currently meeting with Procurement to agree collaboratively the options

beyond December 2021 and are on track to go live with tender on the 13th April.

Recommendation:
The Committee is asked to:

- **NOTE** the report.

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:	Not Applicable

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON 23rd March 2021 VIA Teams

Present:

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

In attendance:

Sunni Webb	Mental Health Act Manager
David Seward	Mental Health Act Team Lead

Apologies:

Mair Rawle	PoD member
Amanda Morgan	PoD Member
Rashpal Singh	PoD member

1 Welcome and Introductions

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

2 New Members and Independent Members

There were no new members.

3 Apologies

All apologies were received and noted.

4 Members points for open discussion

There were no member's points for open discussion. The Chair explained the reason for scheduling the business meeting earlier than usual was to synchronise with the legislation committee meeting. He suggested that the meeting deal with the business aspects of the agenda before moving on to discuss the Annual Review process and the White Paper. This was agreed.

5 Minutes of Meeting held on 26th January 2021

These were agreed as an accurate record of the meeting with no amendments.

6 Matters Arising

Acoustics in meeting rooms – the boards were on site and work across the Health Board had started. If there are problems with acoustics during any Hearing the panel chair is asked to inform the MHA Manager. Although acoustic boards have been installed on the wards not all Hearing are being booked into these rooms. . The MHA staff are asking ward staff to book rooms with acoustic boards for all Hearings.

Annual Review – The Chair explained the history behind the revised proces**s.** Seven people had returned the proforma although not everyone had found it easy to complete. It was agreed that it was sometimes quite difficult to operationalise the Health Boards statements. Some PoD members felt that the headings needed to be more expansive. As agreed, during individual reviews the Chair would discuss with members the revised review process. All feedback would be taken back to the working group with a view to amending as necessary. All agreed the previous process was not robust.

White Paper – there was a wide ranging general discussion and consideration as to whether the PoD should submit a collective response. In Cwm Taf and Swansea Bay the PoD response was being incorporated within the Boards response. The MHA Manager would clarify with the Operational Manager whether the PoD submission should be incorporated within C&V Health Boards response. In the meantime PoD members were to send any points they wish to include in a collective response to the Chair by the 6/4/2021. He would collate the issues raised

and if appropriate convene a meeting via Teams. In the meantime the Chair reminded members that they were at liberty to send an individual response.

Action – PoD members

7 Virtual Managers Hearings

Fourth panel member – there have been no issues since dispensing with the fourth member and no Hearing has needed to be adjourned.

All agreed that the virtual hearing process was working well.

8 MHA Activity Monitoring Report October- December 2020

As the business meeting was scheduled before the end of the quarter no new data was available. There will be two quarters to review at the next business meeting. There had been two discharges in the last quarter. One patient from a contested S3 appeal and another following a Barring Hearing. There was a short discussion on the issue of dangerousness.

There were two discharges by the hospital managers this quarter.

9 Concerns/compliments from Power of Discharge group Hearings

There was no new data to be considered because of the timing of the meeting.

10 Committee and Sub-Committee Feedback

Mental Health Legislation and Governance Group – the Chair informed the meeting that there was nothing to report.

Mental Health and Capacity Legislation Committee – The Chair advised that there had now been final agreement on Care and Treatment Plan. The advice is that the primary nurse may be the care coordinator for the inpatient stay and fulfil the legal requirements of the care coordinator. The Care and Treatment Plan is the record of the patients treatment and should reflect the current treatment plans. The nursing intervention plan was not an alternative to the CTP. Members were asked to reflect on the quality of the CTP in the minutes and to include comments within the recommendations including compliments when appropriate.

Cuckooing - This has yet to be discussed further**.**

Action – Chair PoD

11 Training

Training is still on hold at present. If any issues or training is felt necessary please contact the Chair or the MHA Manager. Some Panel members had taken part in on-line training with a private provider and consideration was being given in other Health Boards to delivering training on-line.

The MHA Manager informed the meeting that there was to be an all Wales on-line training session on CTO's for medical staff. She would look at the applicability for the PoD managers.

Action – MHA Manager

There was a request for update training on the impact of Human Rights legislation and Mental Health Act to bring members up to date.

Action – MHA Manager

12 Any Other Business

Mental Health Act Office Update

The MHA Manger advised that David Seward was going to be on adoption leave for 6 months. Morgan Bellamy was acting into this role and would be delivering training and leading the team. There would be two assistant admin post who would be dealing principally with the Managers Hearings and Tribunals. Nicola was already in post and Interviews were being conducted for the second post. Simon was currently on secondment as IT lead for the Clinical Board. Bianca had taken over a number of his duties including the data collection. The Chair wished David well in his new adventure.

⑩ Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin)
https://www.mentalhealthlaw.co.uk/Devon_Partnership_NHS_Trust_v_SSHSC_(2021)_EWHC_101_(Admin)
The MHA manager drew this issue to the attention of the PoD group. In essence, for S2/S3/S4 and Guardianship when an examination is required it is expected that this will be done face to face and not via video link or telephone. This does not apply to managers hearings or the Tribunal hearings.

Social Fund – it was suggested that there was a social fund for those occasions when flowers needed to be sent or gifts purchased. This was agreed. The Chair to consider how to organise this.

Action - Chair

13 Date and time of next meeting

To be held at 10:00 hrs on 6th July 2021, venue to be confirmed.

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

Attachment 1

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 11th March 2021 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Jeff Champney-Smith	Chair of the Power of Discharge Group
Sunni Webb	Mental Health Act Manager
Simon McDonald	Digital Lead for Mental Health
David Seward	Mental Health Act Team Lead
Bianca Simpson-Lepore	Mental Health Act Admin Team Lead
Lynda Woodley	Operation Manager (OM) Vale
Alex Alegretto	Independent Mental Health Advocacy Manager
Mary Lawrence	Approved Clinician Representative
Katherine Lewis	Consultant Social worker DoLs/ AMHP
Tayeeb Tahir	Approved Clinician Representative
Catherine Morris	Emergency Unit representative
Tara Robinson	Lead Nurse for Adult Mental Health

Apologies

Julia Barrell	Mental Capacity Act Manager
Matthew Russell	Operational Manager (OM) Cardiff
Adele Watkins	Paediatrics representative
Natalie Williams	Deputy Senior Nurse Crisis and Community Services
William Adams	Specialist Liaison nurse
Emma Powderhill	Team Lead South Crisis Team

1 Welcome and Introductions

The chair welcomed members and those in attendance.

2 Apologies for Absence

Apologies were accepted and noted.

3 Minutes of meeting held on 17th December 2020

The minutes were distributed after the last meeting and no requests for changes have been submitted. The minutes have been accepted as a true and accurate reflection.

4 MHA Activity October- December 2020

MHA Monitoring report

At the last meeting July- September's data was looked at. There is nothing to report from October- December's data.

Exceptions Report

The MHA manager informed the group that the exceptions report was looked at previously but she did go through the pertinent issues as a refresh.

The disagreement between the Health Board and the Police forces stance on when a Section 136 begins was highlighted again. The Head of Operations and delivery, Mental Health Clinical Board is taking further legal advice as to where we stand with this matter as it has been ongoing for a number of years. One member of the group queried when the Section 136 would start if it was eventually decided that A&E was the allocated place of safety- it was confirmed that in this situation it would be from when the person arrived at A&E. The chair of the group suggested that the Police's stance on this matter may have arisen from English guidance which wouldn't necessarily be applicable here in Wales. He suggested the Health Board's stance on when a detention under Section 136 commences is arguably fairer for the patient. The operational manager for the Vale expressed that this matter is the cause of stress and anxiety and would be grateful for further advice.

The MHA manager confirmed that ethnicity for Section 136 patient is now being reported on in all but exceptional circumstances.

The number of CAMH's Section 136's has decreased since last quarter.

There were no fundamentally defective applications last quarter and none so far during this quarter.

The Mental Health Act Manager confirmed that the next Committee meeting will be in April and that they will have access to the next exceptions report.

5 Matters Arising

Section 136- recording of self harm

The digital lead confirmed that the wording on the Welsh Government data set is actual harm to self and that that can encompass any sort of harm whether it be self-inflicted or not. The group were informed that we cannot change the data set as it is set by Welsh Government and previous discussions with them about changing the submission haven't resulted in changes being agreed. However there was some discussion as to whether the Health Board could capture our data set to allow sub- sections within the harm to self data. There is a hope that the police form will be able to be uploaded to PARIS at some point and that we may be able to amend things from there.

SOAD telephone consultations

These were discussed at the last Medical advisory committee meeting and some clinicians do have concerns about the thoroughness of telephone consultations and would prefer video calls. They were however understanding of the unprecedented times that we are all working in. One of the approved clinicians informed the group that CMHTs are currently using the attend anywhere system for outpatient appointments and that this is much easier to use than either Skype of Microsoft teams. The Mental Health Act manager informed the group that all CMHT's should have the facilities to support patients to access their remote hearings if they wish to.
The Mental Health Act Manager agreed to liaise with HIW in regard to the possibility of changing to video calling.

Action- MHA Manager to contact HIW

The issue of pharmacists wanting to be informed of whether they are named as a consultee was also briefly mentioned. It was agreed that this would be good practice. Responsible clinicians are waiting on a report from pharmacy to inform them of which pharmacist is allocated to each ward.

Patient Rights- CTO

This will need to be re-audited in 2021. One member of the group felt that the importance of reading rights to CTO patients regularly needs to be better embedded into CMHTS as it is in wards. There is still often a debate in

CMHTs as to whose responsibility it is but the MHA manager confirmed that there is a policy in regard to this. Rights for patients with a learning disability were discussed and it was agreed by all that allowing patients to access their rights in an accessible manner needs to be highlighted and pushed forward in all areas. The easy ready versions of the rights leaflets need to be uploaded to the CAV web and will be distributed to Tara Robinson who will discuss them further at the Quality and Safety Group.

Voluntary assessment data

The electronic police form covers the four different routes which someone can enter hospital by but we are currently not confident that it is being used every time. There is a police contact case note available to all on PARIS and staff are encouraged to use this. Police are still taking patients directly to CMHTs occasionally.

Silver on Call training

No progress as yet, to be kept on the agenda

Action – Chair to continue to follow up

SI Review- 117 alert

This was picked up as an administrative error by the MHA Team- there was no 117 alert on PARIS. This information has been fed back to Will Adams.

SI Review Closure form

There was also discussion about when was appropriate to end Section 117 for patients. It was suggested that it was acceptable to discharge a patient who was no engaging with services but not acceptable to discharge someone who was engaging but could access the appropriate support via their GP rather than through their CMHT. Again legal advice is being sought about this.

Recording of report section 136 admissions

There was a lengthy debate as to how best it would be to alert clinicians to repeat Section 136 admissions for patients. It was broadly agreed that any alert is better than none and that alerts should be automatic on PARIS as opposed to clinicians having to search for them. The debate centred on whether the alert should happen for repeat admissions within a certain time frame or for all historical Section 136 admissions. The digital lead suggested PARIS may be able to facilitate both. He will look into this.

Acton- Digital lead to investigate PARIS alerts- this is potentially a priority.

Section 117 discharged

Discussed previously

MHA/MCA/ suicide meetings

No confirmation of further meetings in regard to this but the digital lead did think that a relevant piece of work was being undertaken by junior doctors under the supervision of Dr Katie Fergus. There were still concerns that the Mental Health Act was perhaps being ruled out at an early stage in a person's assessment unnecessarily. There was suggestion that Simon Amplett was due to be completing a report around these issues. The chair of the meeting agreed to chase this up.

Action- Robert Kidd to chase up any reports/ progress.

Quality Indicators and audit activities

The chair of the meeting confirmed he had sent previous audit schedules to the deputy clinical director with an aim to put more regular audits and reviews in place. It is hoped there will be a further update at the next meeting.

Pharmacy- statutory consultees

Discussed previously.

6 Feedback on operational issues and incidents

Covid

The Mental Health Act manager confirmed that Microsoft teams is now being used for hospital managers hearings and that unfortunately it isn't as reliable as Skype was. A number of attendees have had I.T issues with Teams.
The group as a whole discussed their concerns as to Mental Health Review Tribunals being held over teleconference. This has been raised to the Tribunal before but as of yet they have not changed their stance. One particular case was discussed as it was felt the patient could not adequately represent himself via telephone. This was raised to the MHRT before the hearing but they did not make the reasonable adjustments necessary for the patient. The Advocacy manager confirmed that the numerous advocacy services across Wales have similar concerns and that this matter will be raised by both themselves and the Health Board.
The Mental Health Act Manager agreed to start drafting an email to this effect.

Action- Sunni to compose an email concern.

SI Review

No further update

Repeat 136 admissions

remove from agenda

Transport issues

The group were pleased to learn that the agreement with St Johns ambulance is now in place and is running well. Both AMHPs and patients are happy with Improvement this has had in terms of patients reaching hospital in a timely fashion. The operational manager confirmed this is currently only a pilot and would appreciate clarity as to the situation going forward.

Action – Chair to obtain clarity

CAMHs RC issue

Tara Robinson confirmed that she is currently working with the CAMHs team to help foster more positive and transparent working relationships with the CAMHs consultants. There are several issues to work through with regard to this- such as consultants being on call on rotas and therefore RC's changing daily.

Digital signatures
No substantial progress made - still in testing.

7 Feedback from other meetings

AMHP Forum
The cross over period at 17.00hrs was again discussed with the social work team lead and one of the consultant representatives. There doesn't appear to be an agreed structure for when the on call consultant will undertake an assessment or not and this is posing some difficulties for the AMHPs and the EDT team who run on only skeleton staff. It was agreed that this will be taken back to the MAC meeting to find a way reasonable way forward. It was again raised that the service provided by St Johns ambulance has been of real benefit.

Consultants Meeting
Nothing to add

PoD group

The chair of the PoD group confirmed that the 4th member has now been dropped and that there have been no problems as a result of this.
The PoD group are happy with the information that for inpatients the care coordinator will invariably be an inpatient nurse and that the information contained in the nursing intervention plans should be being reflected in the patients CTP accordingly. CTPs still feature highly in the comments from PoD members.

8 Power of Discharge Group comments/ compliments and feedback- July-September 2020

Nothing further to add

9 External Reviews

External reviews are to take place on both East 12 UHL and Hazel ward UHL.

There is currently no time frame for feedback to be submitted.

10 Interface MHA/MCA/DoLs:

Review of the Mental Health Act
The chair of the group voiced his concerns that the potential changes suggested in the white paper may not sit well with the Mental capacity Act.

LPS update- The mental health Act manager agreed to disseminate the new LPS guidance to the group on behalf of the MCA Manager.

Action- Sunni to send out guidance

11 Quality indicators and audit activities
This has been discussed with Dr Neil Jones- there is some auditing at present but it is not consistent. This item should be kept on the agenda. It is hoped that more progress will be made by the next meeting.

ACTION – Chair to follow up.

12 Any other business

Review of the MHA consultation

The MHA manager encouraged those present to submit their responses and encourage their colleagues to as well. Responses should be submitted by the end of March.

Remote examinations

A recent high court judgement confirmed that examinations cannot be done remotely. One of the responsible clinicians queried how far this ruling goes as far as CTO extensions, issuing consent to treatment etc. The Mental Health Act Manager confirmed that the Health Board is taking a cautious approach and that if the Act says and "examination" is required then this must be a face to face examination. One of the consultants asked for this information to be communicated back to clinicians as they were unsure of whether this message has reached all the relevant people. The MHA manager confirmed she would do this. Tara Robinson also stated that she would relay this to the quality and safety group.

13 Date of future meetings

08 July 2021
07 October 2021
06 January 2022

Report Title:	**Corporate Risk Register**								
Meeting:	Mental Health Capacity and Legislation Committee					**Meeting Date:**	20/04/2021		
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information**	✓	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates and has, since January 2021, been shared with the Board and it's sub-committees at Public meetings for additional scruinty and assurance having previously been shared in private.

The Register includes those risks which are rated 15 and above and provides the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Each risk within the Register is linked to a Committee of the Board and the Board Assurance Framework. The entries within the Corporate Risk Register which are linked to the Mental Health Capacity and Legislation Committee for assurance are attached at Appendix 1.

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

The Register will continue to develop over the following months and to kick start this process, the Risk and Regulation team have, since November's Board meeting met or communicated with all risk leads to review and amend (where appropriate) each risk recorded on the Register.

Alongside this process the Risk and Regulation Team have also introduced a Risk Management Training programme that is being delivered to risk leads across the Health Board. The intention of this training is to embed the Health Board's Risk Management Strategy and Procedure into everyday practice and to ensure that Clinical Boards and Corporate Directorates are able to describe and score risks in a consistent manner.

The Mental Health Clinical Board has shown a willingness to engage with the Risk Management team with key risk leads attending risk management training sessions and communicating with the team to develop their understanding of the Health Board's risk management process.

The next step in this process is a training session scheduled for the 11th May 2021 which will be attended by Mental Health Risk Leads to focus on the Clinical Board's Risk Appetite and the development of a specific Mental Health consequence scoring structure to be added to the Health Board's risk management scoring matrix. It is hoped that specific Mental Health scoring guidance will enhance understanding of the Health Board's scoring matrix and ultimately promote the uniform scoring of risk across the Health Board.

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

At March's Board meeting a total of 2 Extreme Risks reported to the Board were linked to the Mental Health Capacity and Legislation Committee for assurance purposes. The risks reported can be summarised as follows:

Risk Description Summary	Risk Score (1 to 25)
Poor WAST response to MH services with conveyancing of 1) detained patients to hospital from community and 2) transferring medically unwell patients on the UHL site from MH to Physical health facilities	15
Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	15

These risks have remained stagnant since March's Board meeting however it is anticipated that both entries will be de-escalated at May's Board meeting following the successful implantation of appropriate controls for each risk.

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

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that will be rolled out by the Head of Risk and Regulation to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Committee is asked to:

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

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	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

CORPORATE RISK REGISTER MARCH 2021

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
	1	Jan-20	**Patient Conveyancing** There is a poor (delayed) WAST response to MH services with conveyancing of 1) detained patients to hospital from community and 2) transferring medically unwell patients on the UHL site from MH to Physical health facilities. This risks rapid deterioration of patients' mental and/or physical symptoms with a potentially adverse impact on patients safety, quality of service and reputation	5	4	**20**	Attempts made to performance manage WAST response with no improvement. Escalation of risks through local WAST meets. Use of costly private transport providers for most urgent and high risk cases.	5	3	**15**	Ongoing monitoring and escalation	5	2	**10**	Apr-21	Mental Health and Capacity Legislation Committee	Patient Safety
	2	Aug-20	**Young Person in Adult Mental Health Placement** Young person with complex needs required admission to adult mental health services as no suitable alternative available. There is a risk that the patient will be in a sub-optimal clinical environment which will adversely impact on the patient's safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.	5	5	**25**	Additional staff allocated to the care of the patient.	5	3	**15**	Safeguarding discussions ongoing with private care providers with no realistic placement available for the forseeable future.	5	2	**10**	Apr-21	Mental Health and Capacity Legislation Committee	Patient Safety

Report Title:	**Mental Health Capacity and Legislation Committee – Annual Workplan 2021-22**							
Meeting:	Mental Health Capacity and Legislation Committee					**Meeting Date:**	13.04.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	**Director of Corporate Governance**							

Background and current situation:

The purpose of the report is to provide Members of the Mental Health Capacity and Legislation Committee with the opportunity to review the Mental Health Capacity and Legislation Committee Work Plan 2021/22 prior to presentation to the Board for approval.

The work plan for the Committee should be reviewed on an annual basis to ensure that all areas within its Terms of Reference are being delivered.

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

The work plan for the Mental Health Capacity and Legislation Committee has been developed based upon the requirements set out in its Terms of Reference which was approved by the Board at the end of March

Recommendation:

The Mental Health Capacity and Legislation Committee is asked to:

REVIEW the Work Plan 2021/22;
APPROVE the Work Plan 2021/22;
RECOMMEND approval to the Board of Directors.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
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.*

Mental Health Capacity and Legislation Committee Work Plan 2021- 22					
A -Approval D- discussion I - Information	**Exec Lead**	**20-apr.**	**20-jul.**	**19-sep.**	**18-jan.**
Agenda Item					
Mental Health Act					
MHA Monitoring Exception Report	SC	D	D	D	D
Section 17 Compliance	SC	D	D	D	D
Section 138 Partnership Arrangements	SC	D	D	D	D
Policies in support of operation of MHCL	SC	D	D	D	D
Hospital Managers Power of Discharge Sub Committee Minutes	SC	D	D	D	D
Mental Health Measure Act Monitoring					
Mental Health Measure Monitoring Report	SC	D	D	D	D
Care and Treatment Plans Update Report	SC	D	D	D	D
Mental Capacity Act					
MCA Monitoring Report	SC	D	D	D	D
DOLs Monitoring Report	SC	D	D	D	D
DOLs Audit	SC			D	
Inspection Reports					
HIW MHA Inspection Reports (where they relate to legislative compliance)	SC	D	D	D	D
Public Service Ombudsman Wales Reports (where they relate to legislative compliance)	SC	D	D	D	D
Annual Reports					
Hospital Managers Power of Discharge Sub Committee Annual Report	SC		D		
HIW MHA Annual Report	SC		D		
MHCL Committee Governance					
Annual Work Plan	NF	A			
Self assessment of effectiveness	NF		D		
Review Terms of Reference	NF	A			
Produce Committee Annual Report	NF	A			
Minutes of MH&CL Committee Meeting	NF	A	A	A	A
Action log of MH & CL Committee Meeting	NF	D	D	D	D

Report Title:	**Mental Health and Capacity Legislation Committee Annual Report 2020/21**						
Meeting:	Mental Health and Capacity Legislation Committee				**Meeting Date:**	20th April 2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Corporate Governance Officer**						

Background and current situation:

The purpose of the report is to provide Members of the Mental Health and Capacity Legislation Committee with the opportunity to discuss the attached Annual Report prior to submission to the Board for approval.

It is good practice and good governance for the Committees of the Board to produce an Annual Report from the Committee to demonstrate that it has undertaken the duties set out in its Terms of Reference and provides assurance to the Board that this is the case.

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

The Committee has achieved an overall attendance rate of 100% and has met on three occassions during the year.

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

The attached Annual Report 2020/21 of the Mental Health and Capacity Legislation Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Mental Health and Capacity Legislation Committee is asked to:

- **REVIEW** and retrospectively **APPROVE** the Annual Report 2020/21 of the Mental Health and Capacity Legislation Committee, for submission to the Board for approval.

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	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration		Collaboration		Involvement	x
Equality and Health Impact Assessment Completed:	Not Applicable								

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of Mental Health, Capacity and Legislation Committee 2020/21

1.0 INTRODUCTION

In accordance with best practice and good governance, the Mental Health, Capacity and Legislation Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members. During the financial year 2020/21 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Chief Operating Officer (Executive Lead for the Committee) and the Director of Corporate Governance. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS AND ATTENDANCE

The Committee met three times during the period 1 April 2020 to 31 March 2021. This is in line with its Terms of Reference. The Mental Health, Capacity and Legislation Committee achieved an attendance rate of 100% (80% is considered to be an acceptable attendance rate) during the period 1st April 2020 to 31st March 2021 as set out below:

	21.07.20	20.10.20	19.01.21	Attendance
Eileen Brandreth	✓	✓	✓	**100%**
Akmal Hanuk	✓	✓	✓	**100%**
Michael Imperato	✓	✓	✓	**100%**
Sara Moseley	✓	✓	✓	**100%**
Total	**100%**	**100%**	**100%**	**100%**

4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 19th January 2021 and are to be approved by the Board on 25 March 2021.

5.0 WORK UNDERTAKEN

During the financial year 2020/21 the Mental Health, Capacity and Legislation Committee reviewed the following key items at its meetings:

PRIVATE MENTAL HEALTH, CAPACITY AND LEGISLATION COMMITTEE

There were no private meetings held during the reporting year of 2019/20.

PUBLIC MENTAL HEALTH, CAPACITY AND LEGISLATION COMMITTEE – SET AGENDA ITEMS

April 2020 - March 2021

PATIENT STORY

The Patient Stories presented are as below:

1. In October 2020 a service user shared the story of their experiences using the Mental Health Services.

MENTAL CAPACITY ACT

At each meeting the Committee was provided with updates on the Mental Capacity Act 2005 (MCA) which has been in force for over 12 years and covers people aged 16 years and over. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

Members of the Committee were also informed of the work undertaken by the Independent Mental Capacity Advocate (IMCA) highlighting the number of referrals made and areas of concern / service issues. The IMCA Procedure had been slightly revised which was approved by the Vulnerable Adult risk management working group.

- **Deprivation of Liberty Safeguards (DoLs)**

Updates were also provided on the Deprivation of Liberty Safeguards (DoLs) in regard to compliance. The Cardiff and the Vale DOLS / MCA team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff & Vale UHB, Cardiff City Council and the Vale of Glamorgan Council, through a Partnership Management Board consisting of senior representatives of each Supervisory Body.

At the October 2020 meeting the Committee was provided with updates on new legislation that will see Liberty Protection Safeguards replace DoLs with effect from April 2022.

MENTAL HEALTH ACT

- **Mental Health Act Monitoring Report**

The report, which was shared at each meeting, provided the Committee with further information relating to wider issues of the Mental Health Act. Any exceptions highlighted in the Mental Health Act Monitoring report were 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 are only as the Act allows. In July 2020 the Committee was provided with an update on the number of people detained. The figures had risen slightly due to the ongoing COVID-19 pandemic

- **Child and Adolescent Mental Health Service**

In October 2020 the Committee was advised of care and treatment plan trends which incorporated the pressures of the COVID-19 pandemic and were provided with assurance on the parts of the Mental Health Measure applicable to children and young people (those aged <18). A report provided further assurance that compliance against 28 day referral to assessment had been achieved and sustained since May. In August, the service achieved its compliance target for the first time in 16 months and the position was sustained in September. The service continues to monitor their capacity for the delivery of interventions.

MENTAL HEALTH MEASURE

- **Mental Health Monitoring Report**

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.

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 introduced 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. Parts 1 to 4 of the measures relate as follows:

- Part 1a – 28 day referral to assessment compliance target of 80%
- Part 1b – 28 day assessment to intervention compliance target of 80%
- Part 2 – Care and Treatment Planning Within Secondary Mental Health Services
- Part 3 - Right to request an assessment by self –referral
- Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

The committee was also presented with a report on the parts of the mental health measure application to children and young people under the age of 18.

- **Care and Treatment Plans**

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.

In January 2021 the Committee was presented with an update report for the Mental Health Measure Monitoring Reporting including Care and Treatment Plans.

An update was provided at each meeting outlining issues, concerns and solutions.

- **Policies / Procedures**

1 policy and 2 procedures were approved by the Committee as follows:

1. July 2020 - Joint Section 117, Mental Health Act, 1983, Policy and Procedure
2. October 2020 - The Independent Mental Capacity Advocacy procedure
3. October 2020 - The Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD) procedure

- **Committee Governance**

Reports submitted to the Committee for review and approval:

1. Committee Self-Assessment: an overview of the findings arising from the self-assessment
2. Committee Annual Report 2020/21
3. Committee Terms of Reference
4. Committee work plan

Also presented to the Committee were the minutes from the:

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

DEVELOPMENT SESSIONS

During 2020/21, the Mental Health Capacity Legislation Committee hosted three training and development sessions.

The purpose of these sessions was to train committee members and increase their understanding of the legislation that the Committee would be scrutinising. It was agreed and it was agreed by members that training would be given to new members to the committee as and when required.

2nd September 2020

- At the September 2020 Development Session an Introduction to the Mental Health Act 1980 presentation was shared.

2nd December 2020

- At the December 2020 Development Session presentations were shared on the Mental Capacity Act 2005 (including Deprivation of Liberty Safeguarding procedures) and the Mental Health (Wales) Measure 2010.

13th January 2021

- At the January 2021 Development Session the committee's Terms of Reference, it primary role and function were reviewed alongside the role of patient involvement in the committee moving forward.

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Mental Health, Capacity and Legislation Committee meetings by presenting a summary report of the key discussion items at the Mental Health, Capacity and Legislation Committee. The report is presented by the Chair of the Mental Health, Capacity and Legislation Committee.

7.0 OPINION

The Committee is of the opinion that the draft Mental Health, Capacity and Legislation Committee Report 2020/21 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

SARA MOSELEY

Interim Committee Chair