Mental Health Legislation and Mental Capacity Act Committee

Tue 30 April 2024, 10:00 - 12:00

MS Teams

Agenda

10:00 - 10:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes from the meeting held on 30.01.2024

Ceri Phillips

Minutes MH Committee 30.01.2024 - CP.pdf (8 pages)

1.5. Actions from the meeting held on 30.01.2024

Ceri Phillips

MH Committee Action Log 30.01.2024.pdf (2 pages)

1.6. Chair's Actions taken since the last meeting

Ceri Phillips

1.7. Any Other Urgent Business agreed with the Chair

Ceri Phillips

10:10 - 10:25
15 min

2. Mental Capacity Act

2.1. Mental Capacity Act Monitoring Report and DoLS Monitoring

15 mins *Jason Roberts*

2.1 - MHLMCA (Jan-Mar 24)8.1 MCA and DOLS report for MHLMCA.pdf (12 pages)

10:25 - 11:05
40 min

3. Mental Health Act

3.1. Mental Health Act Monitoring Exception Report

10 mins *Dan Crossland*

3.1a - Mental Health Act Monitoring Exception Report April 2024.pdf (8 pages)
3.1b - Mental Health Act Monitoring Report January - March 2024.pdf (48 pages)

3.2. Section 117 Supreme Court Ruling Judgement - Verbal Update

10 mins *Dan Crossland*

3.3. UHB Response to the Consultation on the Mental Health Standards of Care (Wales) Bill

10 mins *Dan Crossland*

3.3 - Standards of Care Bill consultation Covering report for MHMCLC April 24.pdf (2 pages)

3.4. RAMP Protocol and the Part 1 Scheme

10 mins *Dan Crossland*

3.4a AMHS - Recovery and Maintenance Programme part 1 protocol - FINAL.pdf (11 pages)
3.4b Part 1 scheme - Cardiff and Vale.pdf (16 pages)

11:05 - 11:20
15 min

4. Mental Health Measure

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

15 mins *Dan Crossland*

4.1 - MHLC - Mental Health Measure April 2024 AMS and CAMHS Draft.pdf (12 pages)

11:20 - 11:25
5 min

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

5.1. Sub-Committee Meeting Minutes:

5 mins *Jeff Champney-Smith / Robert Kidd*

i) Hospital Managers Power of Discharge Sub-Committee Minutes

ii) Mental Health Legislation and Governance Group Minutes

5.1a - PoD minutes April 2024.pdf (3 pages)
5.1b - MHLGG Minutes and Action Log April 2024.pdf (8 pages)

11:25 - 11:30
5 min

6. Items for Approval / Ratification

6.1. Policies:

Ceri Phillips

1. Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act, 1983 (UHB 478)

6.1a - MHCLC Policy Approval Cover Report.pdf (3 pages)
6.1b - Allocation of RC and Nominated Deputy Procedure final.pdf (12 pages)

6.2. Annual Report for the Mental Health Legislation and Mental Capacity Act Committee 2023-24

Ceri Phillips

6.2 - MHLMCAC Annual Report 2023-24 ns.pdf (5 pages)

11:30 - 11:30
0 min

7. Any Other Business

11:30 - 11:30
0 min

8. Review of the Meeting

11:30 - 11:30
0 min

9. Date & Time of the Next Meeting

6th August 2024 via MS Teams

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 30th January 2024
Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance:		
Matt Phillips	MP	Director of Corporate Governance
Rebecca Aylward	RA	Deputy Executive Nursing Director
Daniel Crossland	DC	Director of Operations - Mental Health
David Seward	DS	Mental Health Act Manager
Neil Jones	NJ	Clinical Board Director – Mental Health
Jeff Champney-Smith	JCS	Chair, Powers of Discharge Sub-Committee
Paul Bostock	PB	Chief Operating Officer
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Melanie Bostock	MB	MCA Consent Lead Manager
Catherine Wood	CW	Director of Operations – Children & Women
Observers:		
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Jason Roberts	JR	Executive Nurse Director

Item No	Agenda Item	Action
MHLMCA 30/01/001	**Welcome & Introductions** The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHLMCA 30/01/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 30/01/003	**Declarations of Interest** The CVC declared that she had joined the Board for MIND Cymru.	
MHLMCA 30/01/004	**Minutes of the Meeting held on 31st October 2023** The Minutes of the Meeting held on 31st October 2023 were received and approved. **The Committee Resolved that:** a) The minutes of the meeting held on 31.10.2023 were agreed as a true and accurate record.	
MHLMCA 30/01/005	**Action Log from the meeting held on 31st October 2023** The Action Log was received and discussed.	

	MHLMCA 23/05/010 – The MHAM noted that there had not been much progress with an e-learning module due to resource and timing reasons, however they were in liaison with the development team. It was agreed that the COO would discuss offline how his team could support. **The Committee Resolved that:** a) The Action Log was noted.	
MHLMCA 30/01/006	**Committee Chair's Actions** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 30/01/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
	Mental Capacity Act	
MHLMCA 30/01/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring** The DEND presented the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring report which provided a general update on current issues related to the MCA and DoLS. In addition, the benefits of the Mental Health Practitioner roles were highlighted to the Committee. The DEND highlighted that benchmarking with other Health Boards regarding the DoLS compliance and monitoring assurance was difficult as they did not have meaningful data to compare. The CVC asked what the outcome was for the increased uptake in training. The DEND responded that there had been operational pressures with attendance and training, so mental capacity practitioners were walking the wards and providing timely information. Frontline staff had said that the application of mental capacity and DoLS training was beneficial, and they were feeling more confident in making decisions. The DEND added that however, there was a problem with the documentation process and the timeliness of completing the many different assessments required for DoLS. Consent to Examination and Treatment The DEND highlighted that there had been an action taken from the previous committee to provide assurance around the work being undertaken on consent to examination and treatment due to compliance with training around consent not being where it should be, and the publication of the National Review to consent to examination and treatment standards in NHS Wales the previous May, which showed limited assurance for Cardiff and Vale. The MCA-CLM provided a summary of the Consent to Examination and Treatment section highlighted within the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring report, as per Agenda item 8.1, which informed the Committee around the work being undertaken and the action plan going forward.	

	The IM-CE highlighted the potential risk on their indemnification profile if they were to be seen by the Welsh Risk Pool (WRP) as not being compliant with the training expectations. She asked what the potential impact would be if the training was to be made mandatory. The MCA-CLM responded that they offered an ESR training, and a bespoke face-to-face training tailored more for nurses who would be consenting for the first time. There was a big commitment to mandate the training, and the WRP had asked for it to be looked at as part of the compliance around indemnity. She added that once the training was mandated, there would be leverage to make a bigger push for compliance. The IM-CE asked if the WRP would give them a grace period to meet the compliance measures, given the large numbers involved. The MCA-CLM believed that there would be some leeway given by the WRP in meeting the compliance measures, as the same pressures would be faced across Wales. With 8000 staff to train, the MCA-CLM noted that it would not be possible to be compliant straight away. The CC noted that consent was not an issue specific to mental health, and suggested that consent to examination and treatment would better fit being discussed in the QSE Committee to provide a broader level of assurance and scrutiny. The MCA-CLM informed the Committee that she had highlighted the need for consent training and the use of EIDO leaflets during the Clinical Board's Quality & Safety meetings. The MCA-CLM highlighted that consent related to all staff, not just those undertaking formal consent from patients. She noted that there were time constraints in completing the training, whereas time would be allocated if it was made mandatory. <u>Action:</u> 1. For Consent to Examination and Treatment to be added onto the Quality, Safety & Experience Committee Agenda for assurance. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	
	Mental Health Act	
MHLMCA 30/01/010	**Mental Health Act Monitoring Exception Report** The MHAM presented the Mental Health Act (MHA) Monitoring Exception Report which provided the Committee with further information relating to wider issues of the MHA. The CVC suggested whether there was an induction opportunity for doctors coming into the Welsh system from elsewhere. The MHAM responded that an induction is undertaken with doctors in Mental Health around 136s and 5(2)s, however, the turnover is so high and it is used so infrequently that the information gets lost. He offered to undertake inductions, and noted that there was posters and information on their dedicated SharePoint page.	

	The CC asked where staff could access the forms. The MHAM explained that the documents were on the MHA SharePoint page. He highlighted that staff don't always know that there is a different form for Wales and England. The CBD-MH informed the Committee that he would be happy to link in with Martin Edwards to see if more could be done, despite the inherent difficulties which had been highlighted. He suggested the need to look at their SharePoint pages with junior doctors to understand how to make the information more accessible. The CC and the MHAM estimated that around 10% of their reports/applications were fundamentally defective. The CVC asked what the implications were for defective applications for the patients. The MHAM responded that the ward would be informed that the patient was no longer detained, and if the patient still met the criteria, another doctor must be called to complete another Section 5(2) form. The patient must be informed that they had not been detained lawfully, and that it would be up to them to seek legal advice if they wished to do so. The IM-CE asked for more context around what drove the Did Not Attend (DNA) rates for training, and what was being done to resolve the issue. The MHAM noted that managers were informed that staff must have refresher training yearly, and that managers were informed if staff did not as they would be unable to accept any detention papers. The MHAM additionally highlighted the process for individuals who had not attended the MHA training day. He hoped that changes to the frequency of the workshops would help with attendance. The ICD-PPT noted an unusual exception where a sentenced prisoner was subject to the civil parts of the MHA. He noted that a letter from the Director of Mental Health Nursing would be sent to the prison governor, to ask for advice on the process of their investigation into the way the events unfolded. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report was noted.	
MHLMCA 30/01/011	**Right Care, Right Person Update** The DO-MH presented the briefing note around Right Care Right Person (RCRP) to the Committee, and provided the following summary: - Right Care Right Person (RCRP) launched in Humberside to develop an approach to move away from police responding in the main to welfare calls. The findings were that for many service users, police attendance was not appropriate - Benefits for the police included the release of time to focus on their key priorities more promptly. - The four phases of RCRP were outlined: Phase 1: Concerns for welfare of people Phase 2: AWOL and walkouts of people with mental health needs from other health facilities	

	Phase 3: Transportation in police vehicles Phase 4: Handover of Section 136s and voluntary mental health patients - The UHB was in a good position and they had met with RCRP twice. The launch for welfare was in February 2024, and data had already started being collected and interpreted. The UHB had a sanctuary provision and a local 136 policy that reflected the RCRP initiative. A WASPI (Welsh Accord on Sharing Personal Information) had been developed with the police and other providers. - There had been no mention of police resources or finances being transferred to Welsh health and local authority partners, which could present some challenges. - CAVUHB had commissioned both a children's sanctuary and an adult sanctuary, There was an expectation to engage with these partners further in long-term commissioning, as they were likely to benefit from the RCRP initiative. The DEND noted that the communication training lead from South Wales Police (SWP) would conduct an online training session that week, and offered to share the link with those interested. The DO-MH added that it came on the 1st December 2023 launched in Betsi Cadwaladr UHB for local implementation. The CVC noted concern around transportation and the potential implications of not transferring resources, and queried the potential implications for risk management. The DO-MH responded that over recent years, there had been a decline in welfare checks, which had made it more difficult to obtain them. This had led to an almost gradual implementation of the RCRP approach. He added that transportation had been a long-standing challenge, and that the National Collaborative Commissioning Unit (NCCU) had commissioned St John's ambulance cars across all regions in Wales to help mitigate these challenges. The DO-MH agreed that there had been several high-profile cases in the previous weeks which related to welfare checks, conveyancing, and communication. **The Committee resolved that:** a) The contents of the report were noted.	
MHLMCA 30/01/012	**Section 117 Supreme Court Ruling Implications Update** The DO-MH presented the Supreme Court Judgement – Section 117 of the Mental Health Act (MHA) report which provided the Committee with a summary of the ruling and the potential implications for Cardiff and Vale UHB. The ICD-PPT acknowledged that providers had historically developed in Cardiff and had taken many English patients over the years, which might make their position slightly different from other Welsh Health Boards. The DO-MH agreed and noted that English provider collaboratives had more experience in commissioning and planning for cross-border arrangements with Wales, which put CAVUHB in a vulnerable position as they were more likely to be commissioned due to their location and skillset. He suggested that it could be cheaper for English Integrated Care Boards (ICBs) to purchase placements in their area.	

	The CVC queried whether there had been any financial or planning implications from the increase in Section 117s post-COVID. She suggested this be considered outside of the meeting. The CC asked for a financial estimate of what the two current cases represented. The DO-MH responded that both cases were likely to be around low secure provision, which could be minimum £250,000 per person per year. As time progressed, the number of cases was expected to increase. He explained that often patients were unknown to CAVUHB and the local services, and so there was disruption between the commissioning arrangements and what CAV can deliver at short notice. The DO-MH concluded that this presented a real challenge clinically, operationally, and financially. The CBD-MH referred to the Supreme Court landmark ruling, and explained that the significance was that there was no onus on the placing authority to support someone in a placement that may be struggling. He added that all future bills would fall to the local area, and that Wales happened to be a popular place for these placements. The DO-MH summarised that: - The legal advice obtained had helped to clarify ownership around usual residence, but it was not particularly favourable to CAVUHB - There were challenges around the obligations legally/morally/ethically of other Health Boards to properly fund placements to prevent disincentives – however, the legal advice and guidance received was not relevant in any of the challenges or proceedings against the ICBs - Discussions were ongoing around usual residence and what qualified for ordinary residence in local areas - Further cases would be presented to the Committee to give an idea of how many Section 117 transfers were likely to be recommissioned in the local area for assurance and to develop a better perspective. **The Committee resolved that:** a) The potential impact of the ruling was noted.	
MHLMCA 30/01/013	**HIW Annual Report** The DO-MH presented the Health Inspectorate Wales (HIW) Annual Report from a mental health perspective, and provided the following summary: - Immediate assurance was used in Mental Health across Wales, which represented 35% of all HIW immediate assurances. - The quality of mental health interactions was high, but there were issues with managing violence and aggression training, and records of restraint and observation were not always up to date. - There continued to be long-standing access difficulties for people wanting to access mental health services. - The system was highly complex, and the flow between services impacted on care. - The 40 recommendations were highlighted in relation to discharge arrangements in Cwm Taf Morgannwg UHB, some of which related to electronic record systems. - CAVUHB wasin a better position with the PARIS system for mental health, and had provided positive reassurance and responses to many of the recommendations. - A mental health HIW annual report was expected within the next few months. **The Committee resolved that:**	

	a) The content of the HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021 was noted.	
	Mental Health Measure	
MHLMCA 30/01/014	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** The DO-MH and the DO-CW presented the Mental Health Measure Report which outlined the performance of CAVUHB against the various mental health specific targets. The IM-CE asked for an update on the work being undertaken by both clinical boards on the 16-25 age group. The DO-MH provided the following summary in response: - Both clinical boards had worked closely together on key priorities, using the service improvement money from Welsh Government (WG) to address challenging priorities with significant clinical impact. - Transition workers had been put in place for eating disorder services, and there were regular joint planning meetings between Children and Women's services and the Mental Health Clinical Board. - The headroom service provided early intervention for psychosis starting at age 14, and work was being undertaken with the Cynnwys service for emotionally unstable personality disorders. - A big challenge was the alignment and agreement on a pathway between these services to ensure a continuity of treatment. The CC noted that it was both the number and the level of complexity of patients which had increased the demand, and so he acknowledged that the demand capacity modelling exercise would be challenging. The CBD-MH agreed, and highlighted the hard work undertaken around inpatient stays for challenging individuals with high complexity between the ages of 16-18 as they moved into adult services. There had been an increased number of those individuals, and the working relationships between staffing groups to support them had improved significantly. The DO-MH noted that the Delivery Unit had visited the previous week to engage in demand and capacity modelling workshops with clinical and directorate teams. The Committee was reassured that the Clinical Board was engaged with this work. **The Committee Resolved that:** a) The contents of the report were noted.	
	Items to bring to the attention of the Committee for Noting / Information	
MHLMCA 30/01/015	**Sub-Committee Meeting Minutes:** <u>Hospital Managers Power of Discharge Sub-Committee Minutes – January 2024</u> The C-PDSC highlighted the following: - A debate had started around capacity and representation, with discussions with Advocacy around what that looked like - Feedback had been received about sticking to the strict criteria for detention and the use of discretionary powers	

	- Discussions were ongoing about dangerousness in terms of barring hearings – the topic would be discussed at the All Wales Conference on the 29th February 2024. The DO-MH noted that: - The issue of dangerousness and how this was defined was a challenge for mental health managers, the Power of Discharge Group, and clinicians. - They had met with clinicians and written to them around how to work together and come to a general consensus about what information was required to provide to MHA managers and hospital managers. - A national discussion would take place on the 29th February, and a lessons learnt would be brought back to the meeting. <u>Mental Health Legislation and Governance Group (MHLGG) – January 2024</u> The ICDPPT highlighted the following: - They discussed the activity monitoring report and the exceptions - They also discussed the need to make further progress using the AMaT software to order their activity, and an ongoing issue with starting MHA assessments towards the end of the day. - They discussed the Section 117 ruling and concerns amongst staff about what this meant, where they noted an issue with children's services' understanding of Section 117 aftercare. - It was decided that they would not continue to monitor the reform of the 1983 MHA. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
	Items for Approval / Ratification	
MHLMCA 30/01/016	**Policies** The following policies were approved for publication: i) Receipt of Applications for Detention under the Mental Health Act Procedure ii) Mental Health Review Tribunal Procedure and Guidance **The Committee resolved that:** a) The two policies were approved.	
MHLMCA 30/01/017	**Any Other Business** No items.	
MHLMCA 30/01/018	**To note the date, time and venue of the next meeting:** 30th April 2024 at 10:00-12:00 Via MS Teams	

Action Log
Mental Health Legislation and Mental Capacity Act Committee – 30th January 2024
(Updated For 30th April 2024 Meeting).

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
ACTIONS COMPLETED					
MHLMCA 23/10/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring**	For a comparative benchmarking piece of work on Consent across the Welsh Health Boards to be presented to the following Committee.	**30.01.2024**	Rebecca Aylward / Jason Roberts	**Completed** *Update provided on 30th January 2024 within Agenda item 8.1.*
MHLMCA 23/10/009	**Mental Health Act Monitoring Exception Report**	To spread awareness and increase education on the process for completing the necessary legal documentation, and for an update to be brought to the following Committee.	**30.01.2024**	David Seward	**Completed** *Update provided on 30th January 2024 within Agenda item 9.1.*
MHLMCA 23/10/011	**Section 117 Supreme Court Ruling Implications**	For an update on any new developments and for clarity over the potential risks regarding the Section 117 rulings to be brought to the following Committee.	**30.01.2024**	Daniel Crossland	**Completed** *Update provided on 30th January 2024 within Agenda item 9.3.*
MHLMCA 30/01/009	**Consent to Examination and Treatment**	For Consent to Examination and Treatment to be added onto the Quality, Safety & Experience Committee Agenda for assurance.	**26.03.2024**	Jason Roberts / Rebecca Aylward	**Completed** *Item has been added to the Forward Plan for the QSE meeting on 26th March 2024.*
MHLMCA 23/05/010	**Mental Health Act Monitoring Exception Report**	Mental Health Act e-Learning module to be added to ESR as a mandatory module once written.	**30.04.2024**	Jason Roberts / David Seward / Paul Bostock	**Update in April 2024** The item was rescheduled to the April 2024 meeting, with discussions to happen offline around what support and resource could be provided to the team – *update to be provided in April 2024's Action Log.*
MHLMCA 23/05/013	**Draft Mental Health bill - Joint Committee Report**	Update to be provided at a future meeting to include timescales on implementation of the draft Mental Health Bill	**30.04.2024**	Jason Roberts / David Seward	**Update in August 2024** *The item has been added to the Forward Plan for the MH meeting on 6th August 2024.*
Actions in Progress					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
ACTIONS REFERRED TO COMMITTEES OF THE BOARD / OTHER					

eport Title:	**Mental Capacity Act (MCA) and DoLS monitoring**				Agenda Item no.	**2.1**
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**		Public	x	Meeting Date:	**30/04/2024**
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	**Executive Nurse Director**					
Report Author (Title):	**Deputy Executive Nurse Director**					

Main Report

Background and current situation:

The purpose of this report is to provide a general update on current issues relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The MCA indicators provide a level of detail on the number and type of IMCA referrals along with an overview of MCA training compliance across the UHB. As previously, there is additional information contained within this report relating to the further training being provided with the use of additional Welsh Government (WG) funding.

The report also contains detail in relation to the progress made following the appointment of the MCA Practitioners.

The DoLS indicators provide an overview of the last year's applications and assessments.

Further to the UK Government's announcement regarding the indefinite delay of the LPS, we will continue to focus on promoting awareness and understanding of the MCA in practice and look at how we can strengthen and improve our current DoLS processes going forward. This is further supported by work being undertaken at a national level, through Public Health Wales.

WG funding for MCA/DoLS continues to be available in line with previous years. The UHB have bid for the full amount available (£266,000) and are awaiting confirmation that this has been successful. There is also additional funding available for advocacy services and the UHB is currently in discussion with our partners and Procurement to identify how this could strengthen current arrangements.

Further to the last meeting, Consent to Examination and Treatment has now been added onto the Quality, Safety and Experience Committee Agenda for assurance going forward.

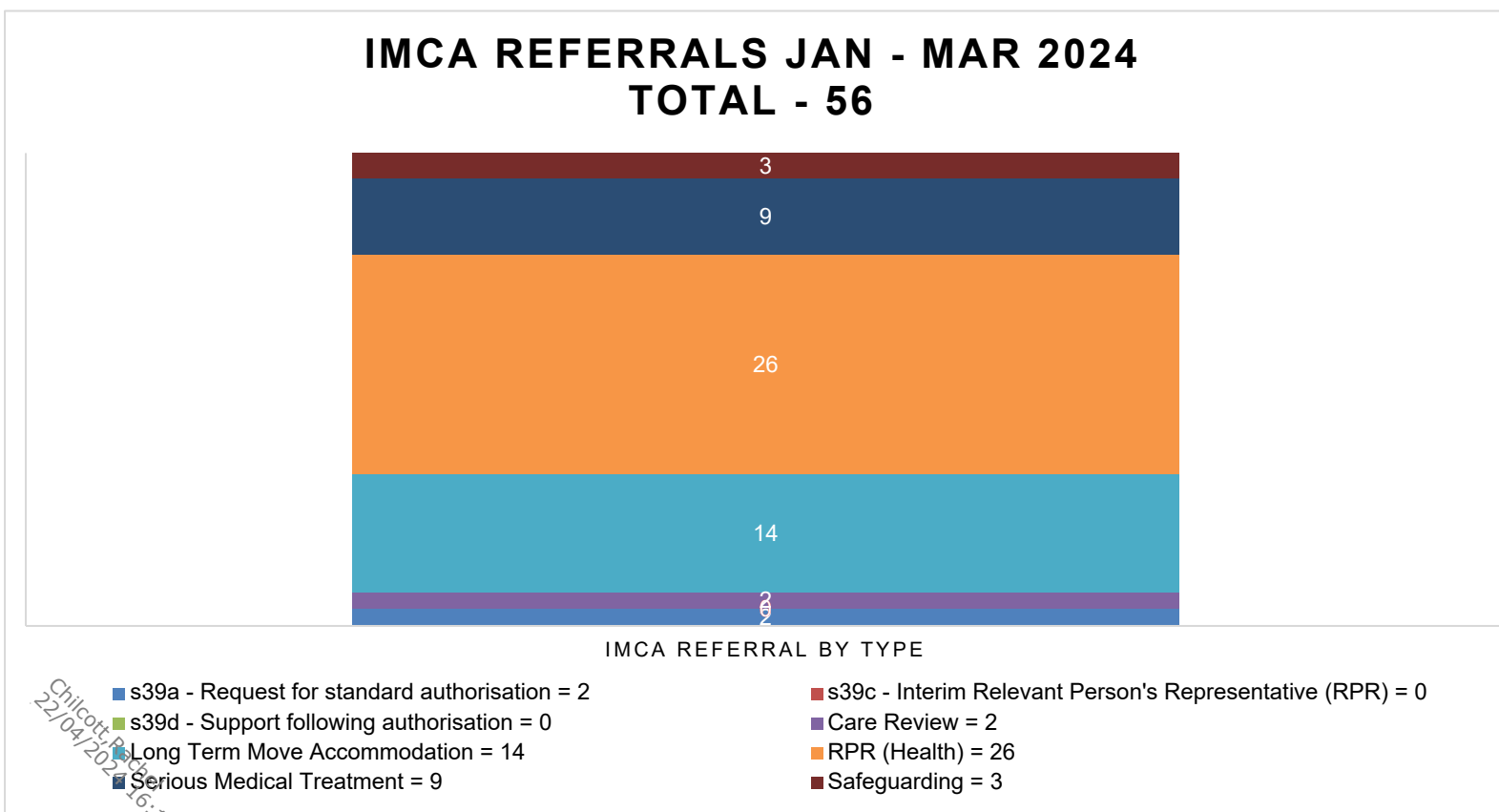
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Mental Capacity Act Monitoring actions:

- **Mental Capacity IMCA Referral type**

The MCA Indicators outline the breakdown of IMCA referrals for the period from January to March 2024. Referral rates are noted to have reduced slightly this quarter (total of 64 referrals Oct-Dec 2023). The number of RPR referrals has also decreased this quarter from 32 last quarter to 26 however, referrals for Serious Medical Treatment have increased from 7 to 9.

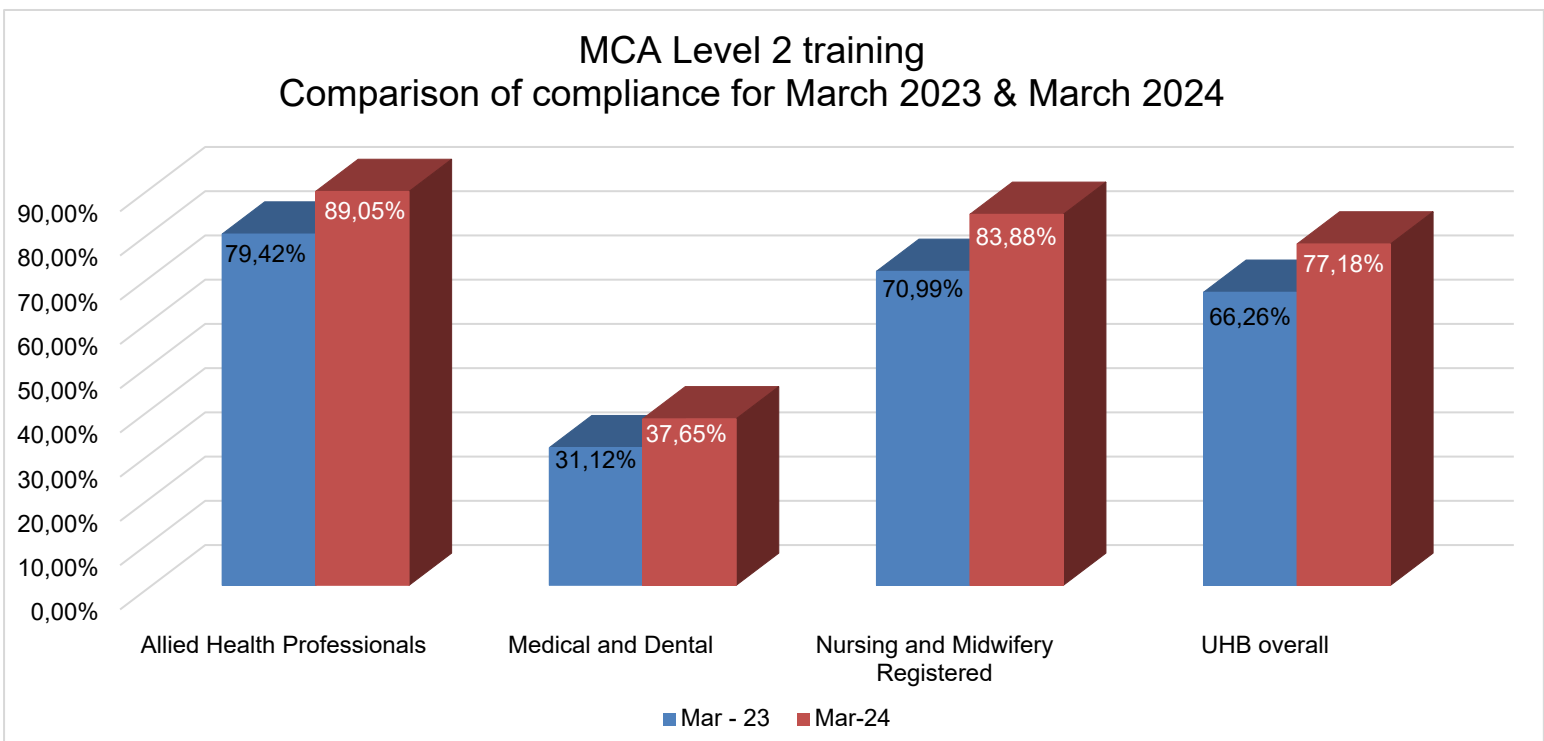
Referral rates will continue to be monitored as it would be expected that these would increase with training and improved awareness of staff.



- **Mental Capacity Training**

The following graph demonstrates overall compliance by staff group, with a comparison of March 2023 and March 2024 to outline progress over the last year.

This shows a significant increase in compliance across the UHB of 10.92% overall, despite ongoing challenges and variable attendance rates at available training. Medical and Dental compliance with MCA Level 2 mandatory training continues to be poor and concerns have been raised though there does appear to have been some improvement. It is also worth noting that these figures do not take account of non-mandatory training such as the external MCA training provided by Edge and supplementary training sessions developed by the MCA Team, as these are recorded separately.



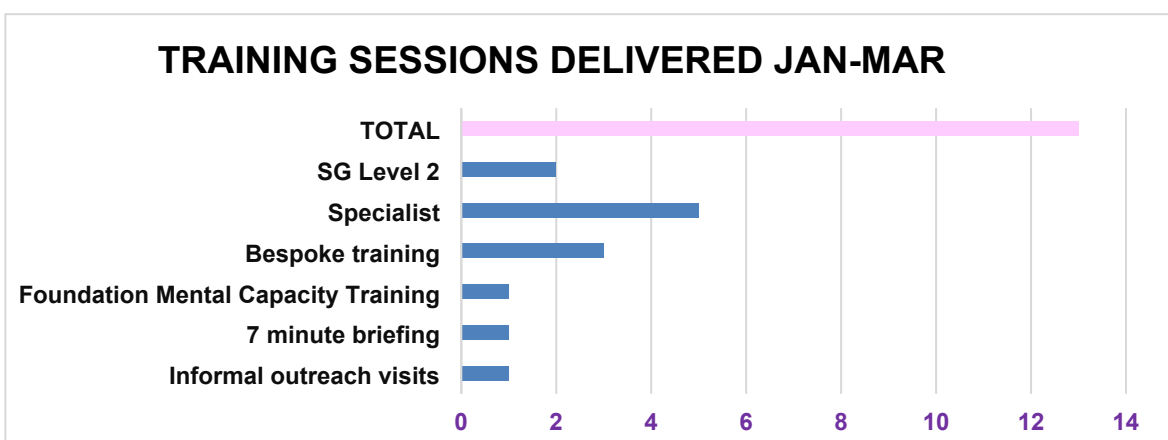
MCA Practitioner led training: Jan- Mar 2024

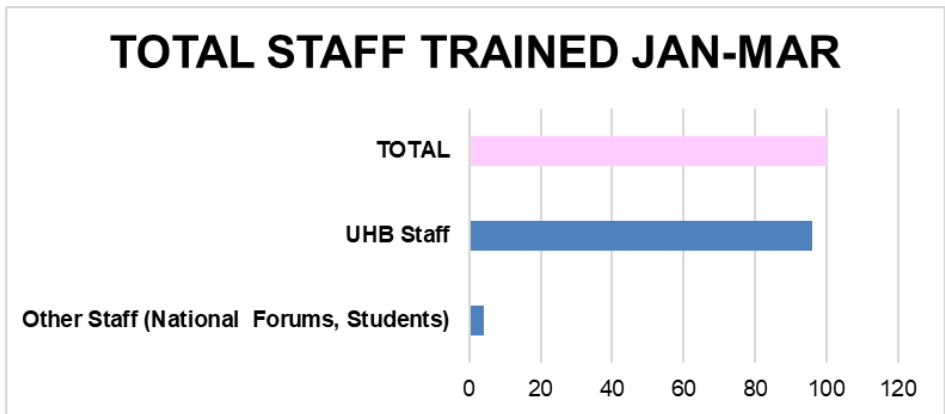
Total training delivery has reduced this quarter compared to previous quarters, with a total of 100 staff trained across 13 sessions; compared with to 413 trained over 23 sessions in the previous quarter. This largely appears to be due to factors including; winter pressures and industrial action and has resulted in insufficient capacity to proceed with some sessions and a higher than average failure to attend. The team have also had reduced staffing capacity due to a vacancy since February 2024 however, it is hoped that this will be filled shortly. This has unfortunately halted the 7 Minute Briefings that were completed frequently last quarter, due to limited capacity.

The focus of training this quarter has been to pilot & rollout a new training package *Practical Application of the MCA: How to Assess & Support Decision Making.* A key aim of the new training was to improve attendance following feedback from clinical boards that half day training was preferable for releasing staff than shorter 1.5-2 hour sessions. Early attendance figures are promising with 100% attendance at the pilot and 80% attendance at the first two booked sessions.

The pilot sessions provided useful feedback and following sign off of content from the head of Legal & Risk, the first two sessions were completed in March 2024. This is now booked twice monthly in the 2024/5 financial year including some additional bespoke sessions for departments with a key role in specialist MCA management such as Speech & Language Therapy and Neurosciences. The training introduces new resources aimed at supporting compliance & staff confidence.

Training has included key UHL staff and hospital social workers attending the new training as part of the MCA-Discharge pilot that is currently underway.





Training Feedback Quarter Jan-Mar 24	% Agree or strongly agree	% Neutral, disagree or strongly disagree
My learning outcomes were met	89%	11%
Training was effective and easy to understand	100%	0%
I feel confident about applying principles of MCA to practice	89%	11%
Helped with practical application of MCA as well as theory	100%	0%
I feel confident in knowing how to access MCA support	100%	0%

"*This training is a massive change in culture, there is a lot of work needed to embed this especially between Health & Social Services"*

"Excellent session – this training needs to be available to all registrants"

"Really great session and amazing that CAV has an MCA Team!"

Highlights of training activity this quarter include:

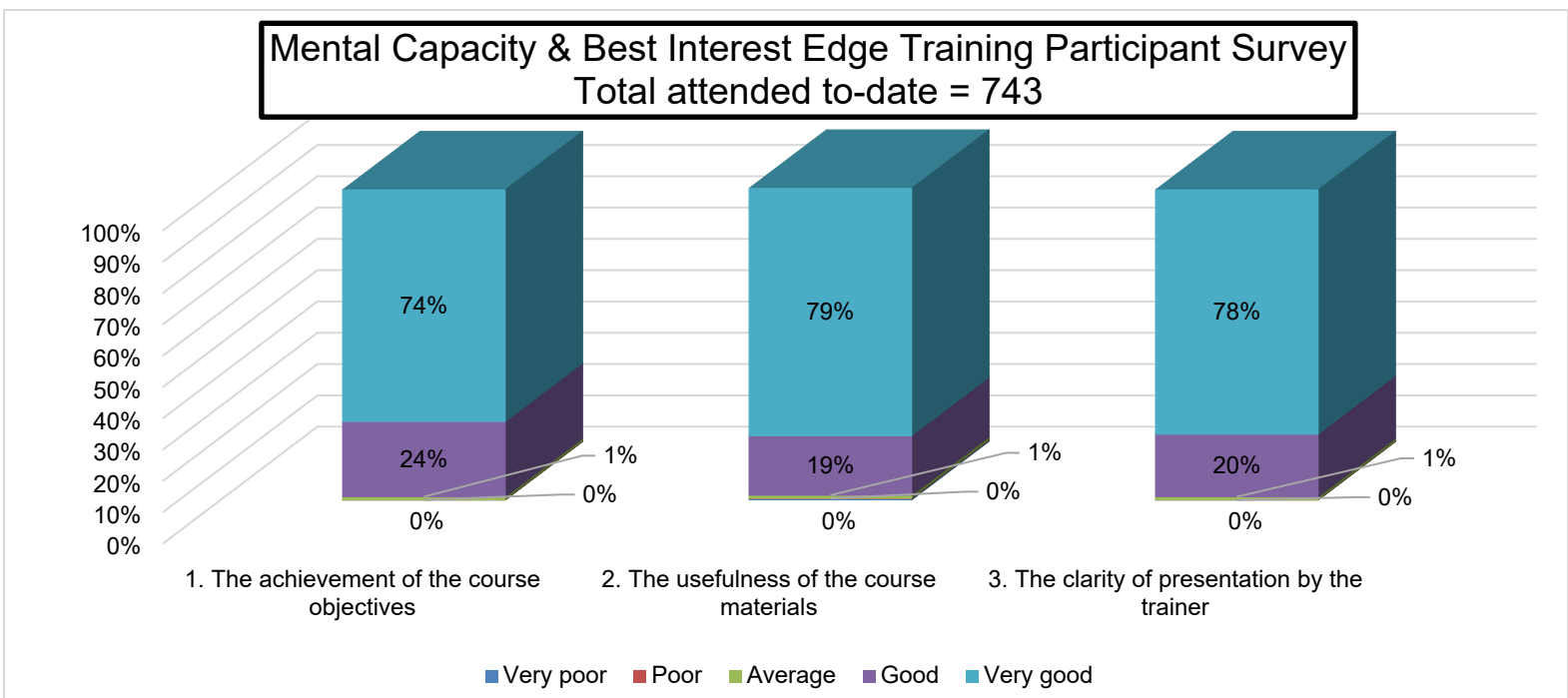
- Supporting the Safeguarding training strategy through presentation at Level 2 and Level 3 Adult Safeguarding days
- Successful completion of Pilot & first sessions of new Practical Application training
- Involvement with All Wales MCA-DoLS network Training Subgroup with exciting work plans for 2024/5

- **Additional training**

Mental Capacity and Best Interests Training (Edge Training)

This training was overall well received and sessions ended in February 2024.

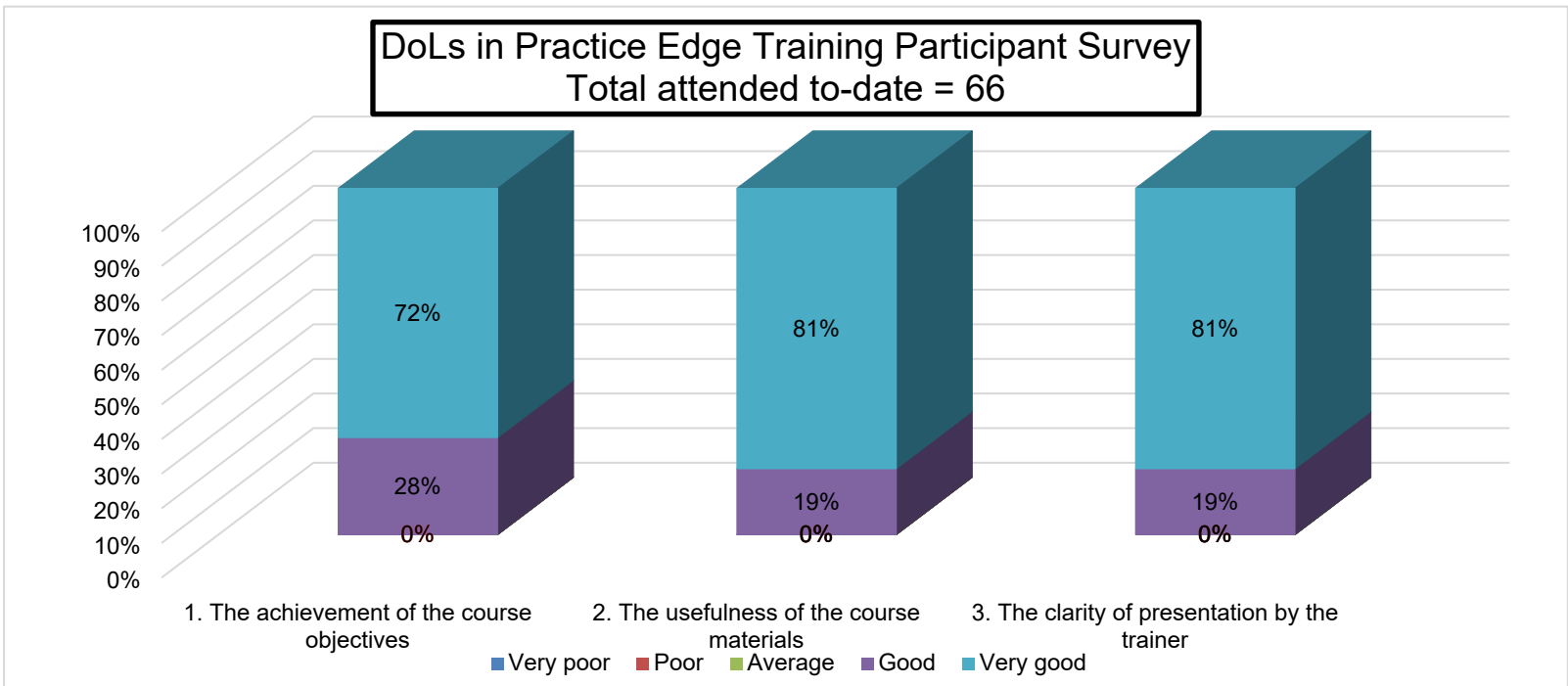
The table below provides data relating to feedback on its perceived quality and usefulness. Given that attendance rates had reduced in recent months and the training that is now available internally from the MCA team, no further sessions have been arranged.



DoLS in Practice Training (Edge Training)

This training was commissioned in order to help raise awareness around what amounts to a deprivation of liberty in order to ensure that we are effectively safeguarding our vulnerable patients and staff are completing DoLS referrals where appropriate. 66 staff attended this training and feedback is outlined in the graph below.

In addition, two sessions were held specifically for those working with Children and Young People however, actual attendance for this was poor with only 15 staff undertaking the training.



Assessing Decision Making Capacity MSc module

A total of 17 UHB staff have now undertaken the Level 7 MSc module 'Assessing Decision Making Capacity'. Staff feedback outlines that staff like the diversity of the course, that course content is clear and informative and several attendees have found their improved knowledge invaluable when having to complete complex mental capacity assessments. Given the positive feedback from those undertaking the course, it is hoped that we can secure a further 3 places on the course for the 2024/5 academic year.

- **Overview of MCA Team achievements**

In addition to the significant training and development work, the MCA Team have been progressing a comprehensive work programme.

Highlights this quarter include:

- MCA-Discharge pilot in UHL, in conjunction with IDS Team & Local Authority services, aimed at improving MCA compliance, sharing responsibility with LA in preparation for the Trusted Assessor model and exploring the impact on discharge delays
- Increased direct support with complex case management including MDT attendance, contribution to multi-agency meetings with Adult Services and Legal & Risk, and 1x direct patient input
- Creation of a new Sharepoint Page complete with forms, resources, training information and links to adjacent teams. Good feedback has been received from senior nurses in relation to this.
- Completion of Assessing Mental Capacity & Decision Making masters module by MCA Specialist Practitioner PJ
- Attendance at CB's Q&S to feedback MCA Scoping Audit
- Contribution to wider work on Restraint & Complex Behaviour Management, All Wales DoLS/MCA Network and Welsh Government Dementia Learning & Development practice group

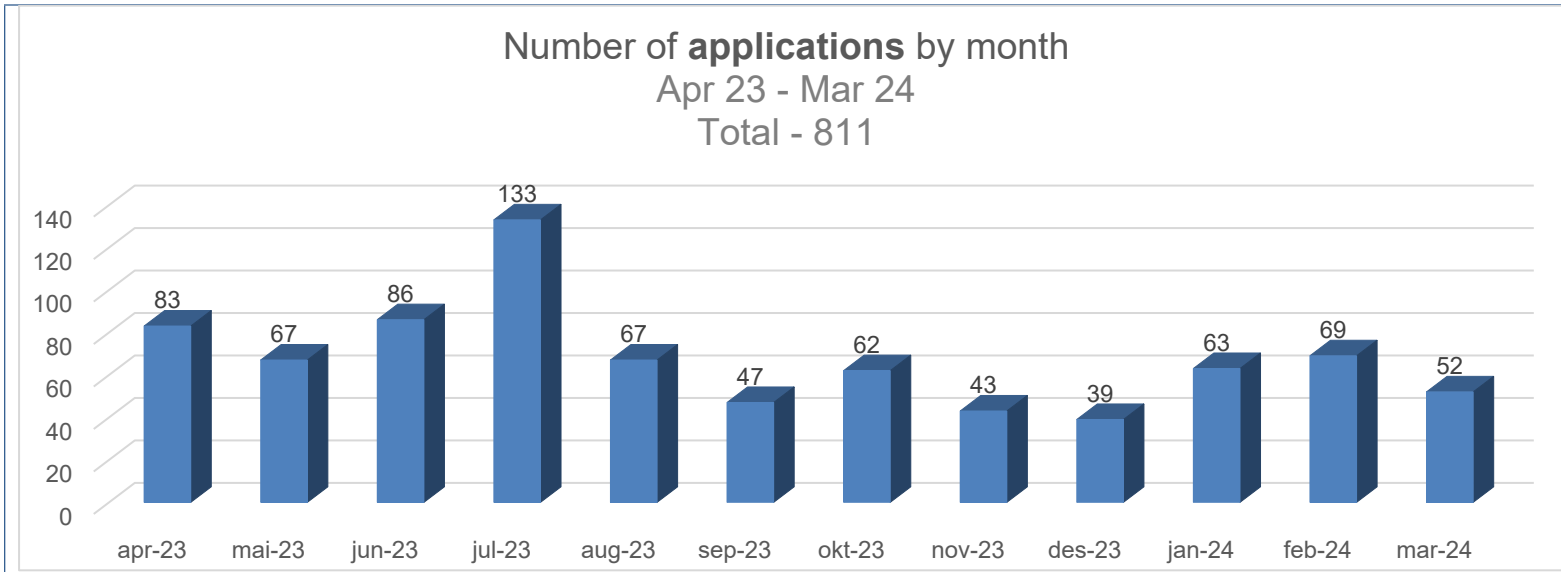
- **Deprivation of Liberty Safeguards Monitoring actions:**

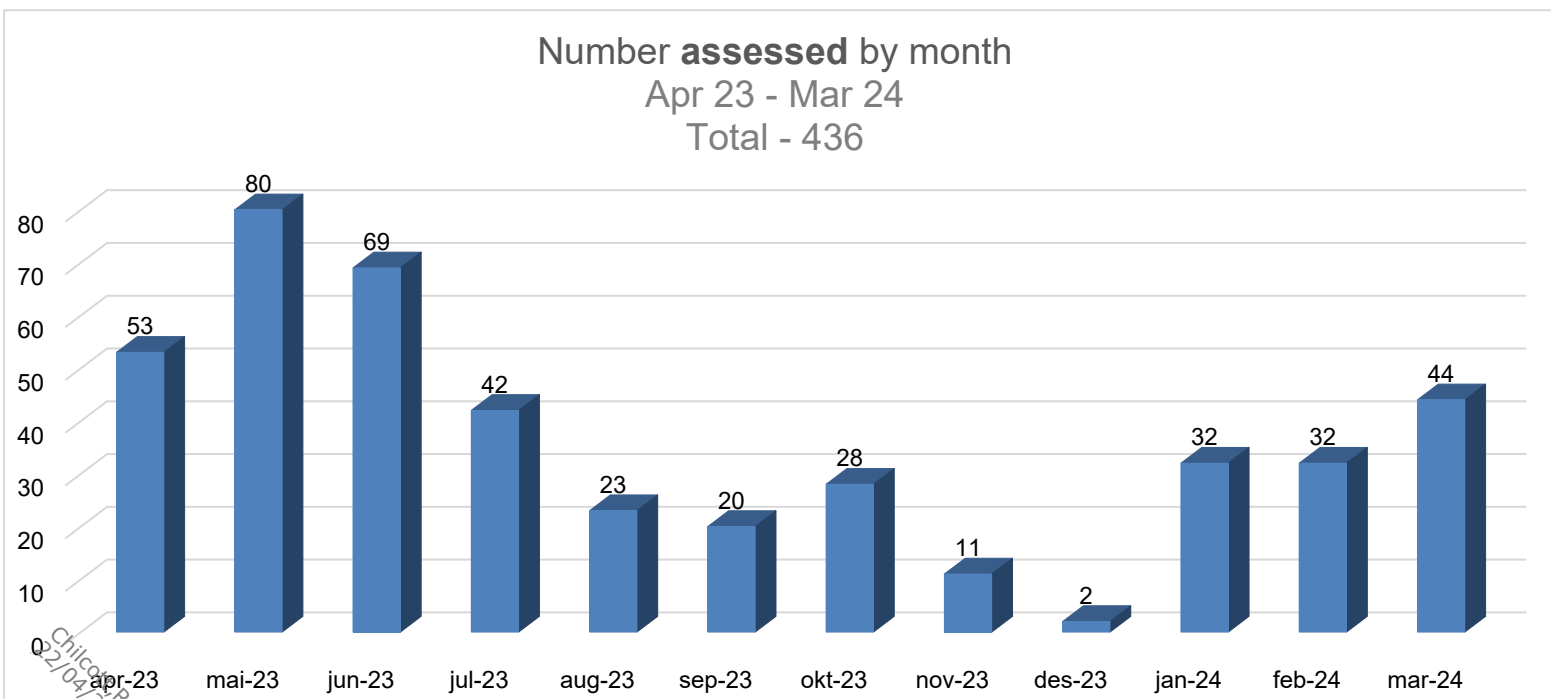
Quarterly overview from Apr 2023 - Mar 2024

The below charts provide an overview of the DoLS activity for the last financial year (data provided by DoLs Team, Vale Local Authority).

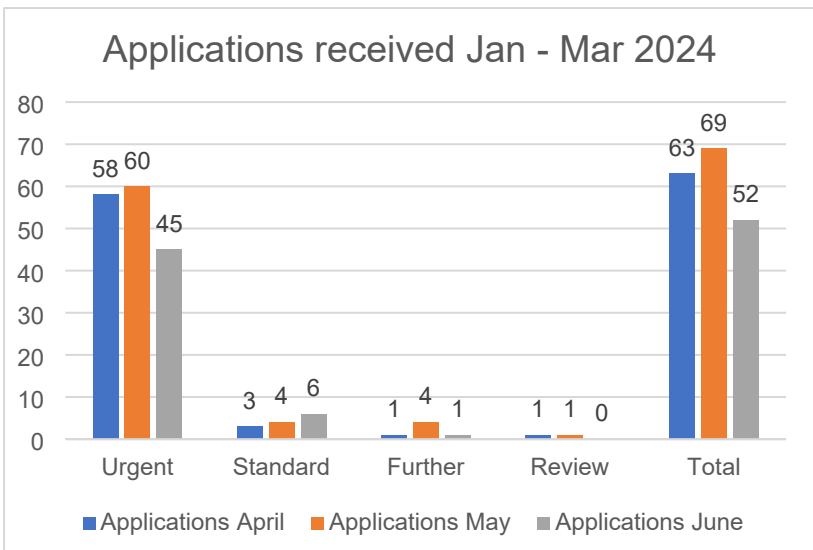
The mean number of referrals per month was 67.5 however, the chart below demonstrates significant variation in referral rates by month. There appears to have been a peak in July 2023 (113 referrals), although the reasons for this are unclear. Referral rates for the last quarter have been more stable.

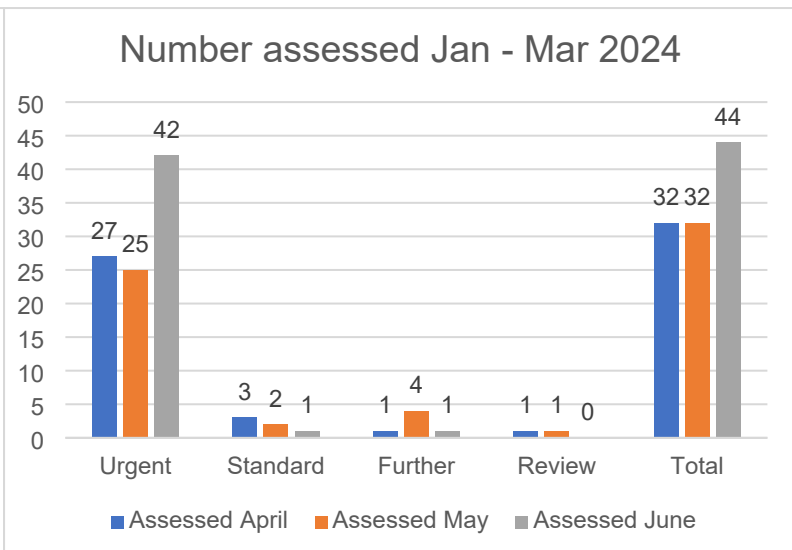
A total of 436 assessments were completed over the last year. WG funding has enabled an additional 124 assessments to be carried out; an increase of almost 30% above planned assessment capacity (current funding arrangements provide for 6 assessments per week for the UHB).





The below charts outline the applications received and number of assessments by referral type. As would be expected within a healthcare setting, on average 89% of these were urgent applications which should be assessed within 7 days of referral. Assessment figures for the last quarter demonstrate that assessment capacity was at 58% when taking into account the number of referrals for the same period, though this does not identify how many of these assessments werecompleted within timeframe. Unfortunately the data relating to breaches for the last quarter was unavailable at the time of writing, therefore this will be added to the next Committee report.





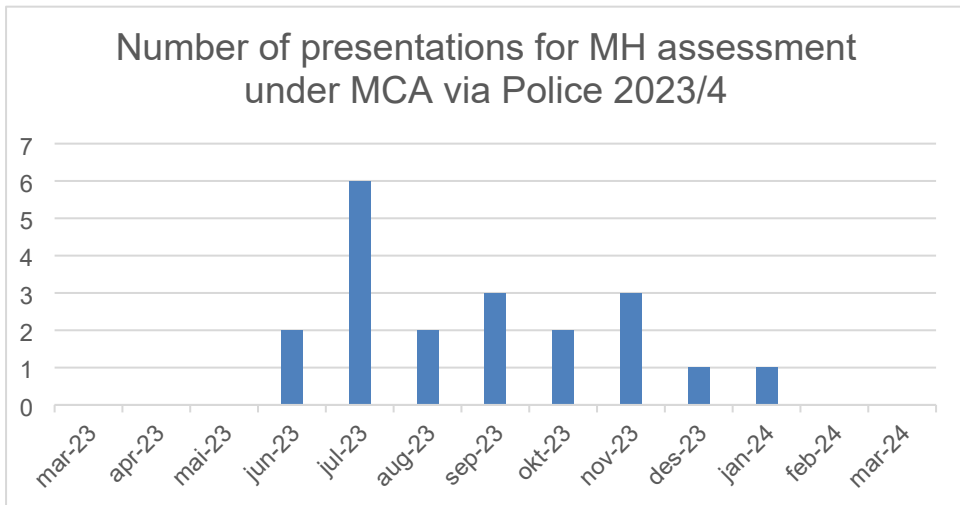
As highlighted previously, limitations on assessment capacity mean that the 7 day timeframe for urgent assessments is routinely unachievable however, it is hoped that the work being conducted both locally and nationally to streamline the DoLS process will help to address this in the not too distant future.

The DoLS Team have welcomed a new Team Manager, Rebekah Vincent-Newson, who is keen to work collaboratively with the MCA Team to develop current administrative processes and ensure that clinical areas are provided with timely feedback in relation to assessment time frames and delays.

Voluntary assessment under the MCA

Following discussion at the Mental Health Legislation and Governance Group (MHLGG), it was agreed that the MCA Team would maintain a record of the All Wales Monitoring Forms received from police where the MCA has been used to convey a person for a voluntary mental health assessment, as opposed to the police exercising their powers under s136 of the Mental Health Act.

During the 2023-4 financial year this amounted to a total of 20 assessments. The team will continue to monitor these presentations going forward and it will be helpful to identify any impact from the changes being intorduced by the 'Right Change Right Person'programme being rolled out by South Wales Police.



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

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation, and improvement and provide an environment where innovation thrives	

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

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

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

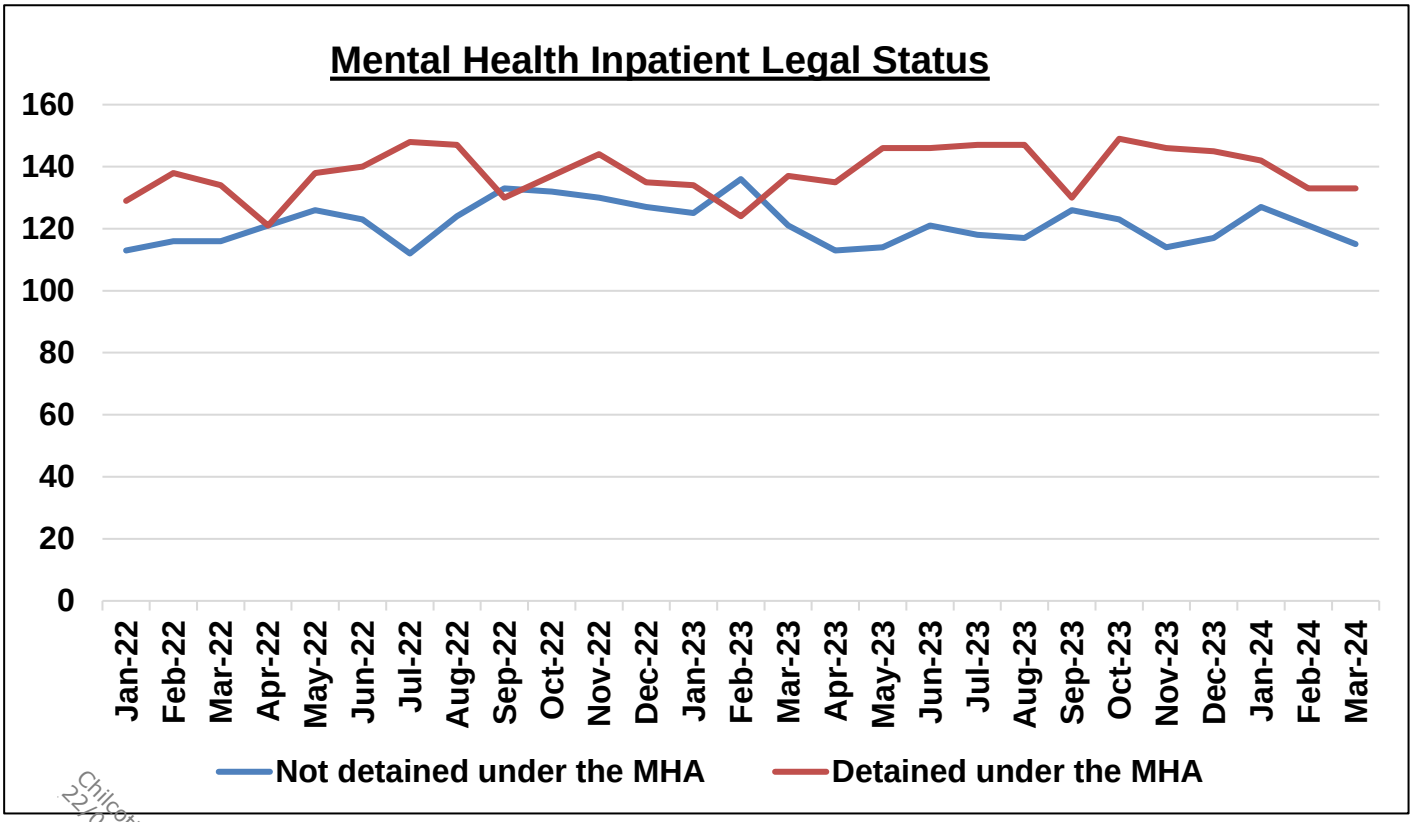
Report Title:	Mental Health Act Monitoring Exception Report				Agenda Item no.	3.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee		Public	X	Meeting Date:	30 April 2024
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Interim Chief Operating Officer					
Report Author (Title):	Mental Health Clinical Board Director of Opertations					

Main Report
Background and current situation:

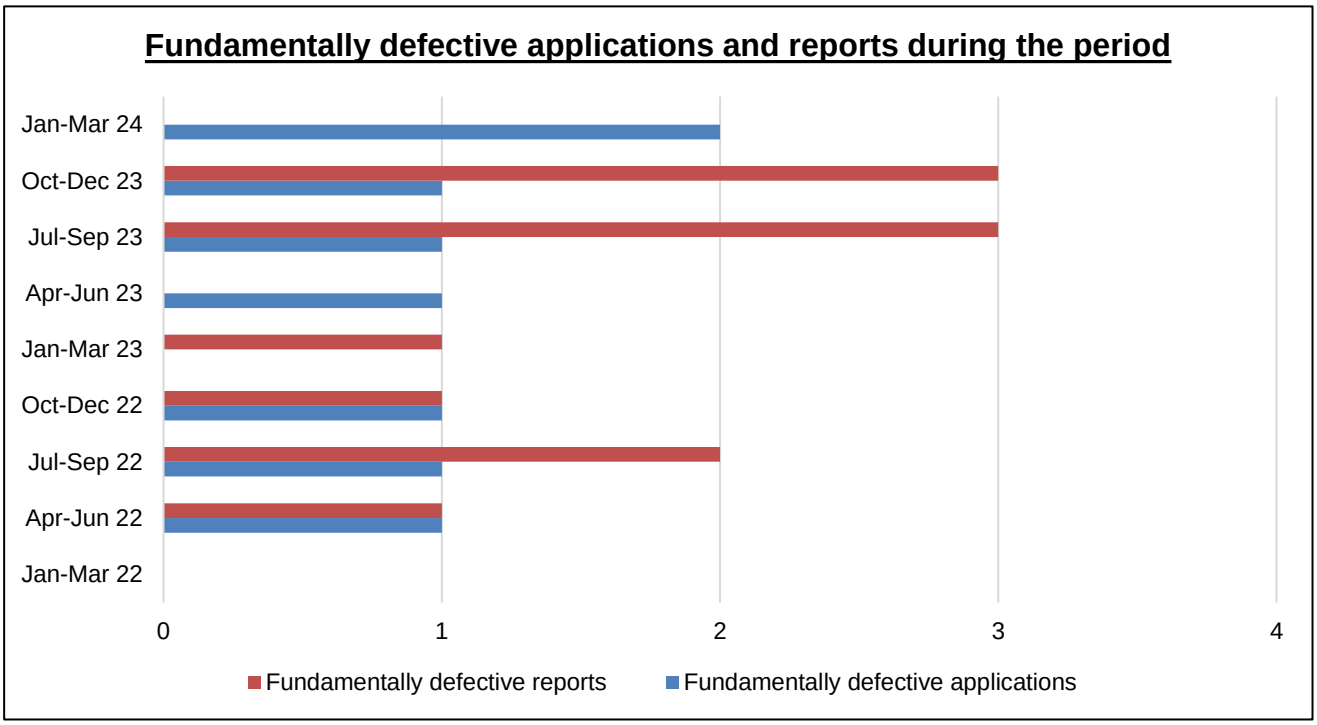
This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that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

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

Use of the MHA



Fundamentally defective applications and reports



During the quarter there were two fundamentally defective applications.
P was assessed in England and detained on a Section 2 straight to HYC. The correct Welsh AMHP application was used however, the AMHP didn't provided a 'wet' signature and typed his name instead which the Welsh Regulations do not allow. This wasn't picked up by the shift coordinator accepting the papers. The team in England were contacted the next day when MHAO picked up the error but the AMHP who completed the application wasn't available for a few days therefore, this was marked as fundamentally defective. The patient was advised and they agreed to stay informally.

P was transferred to HYC from Cygnet Kewstoke on a Section 3 however, when the MHA office in Cynget were sending us the detention papers after the transfer, they noticed that the Section 3 renewal hadn't been completed. The Section 3 was deemed fundamentally defective, P advised of this and they were held under Section 5(2) until a new MHA assessment could be arranged, they were subsequently detained under Section 3.

Lapsed applications

During the quarter there were 2 lapsed applications.

P was detained under a Section 2 but in the final week of the section, P went AWOL from HYC and couldn't be located before the expiry date, therefore the Section 2 lapsed. P was located and re-detained under Section 2 to HYC PICU.

P was transferred to HYC from Cygnet Maidstone on a Friday evening with the Section 2 expiring on the Sunday evening. Our team confirmed with Maidstone AMHP service they would complete the Section 3 assessment and there were no plans to imminently transfer P back to HYC. Transfer was arranged for the Friday evening and the Section 2 expiry date wasn't picked up by the shift coordinator accepting the paperwork, nor by ward staff, therefore the Section 2 lapsed. P was held under a Section 5(2) and subsequently detained under a Section 3.

Section 136 A&E

There could be instances when treatment under a 136 is related to the mental disorder but the patient is not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse, for example,

Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.

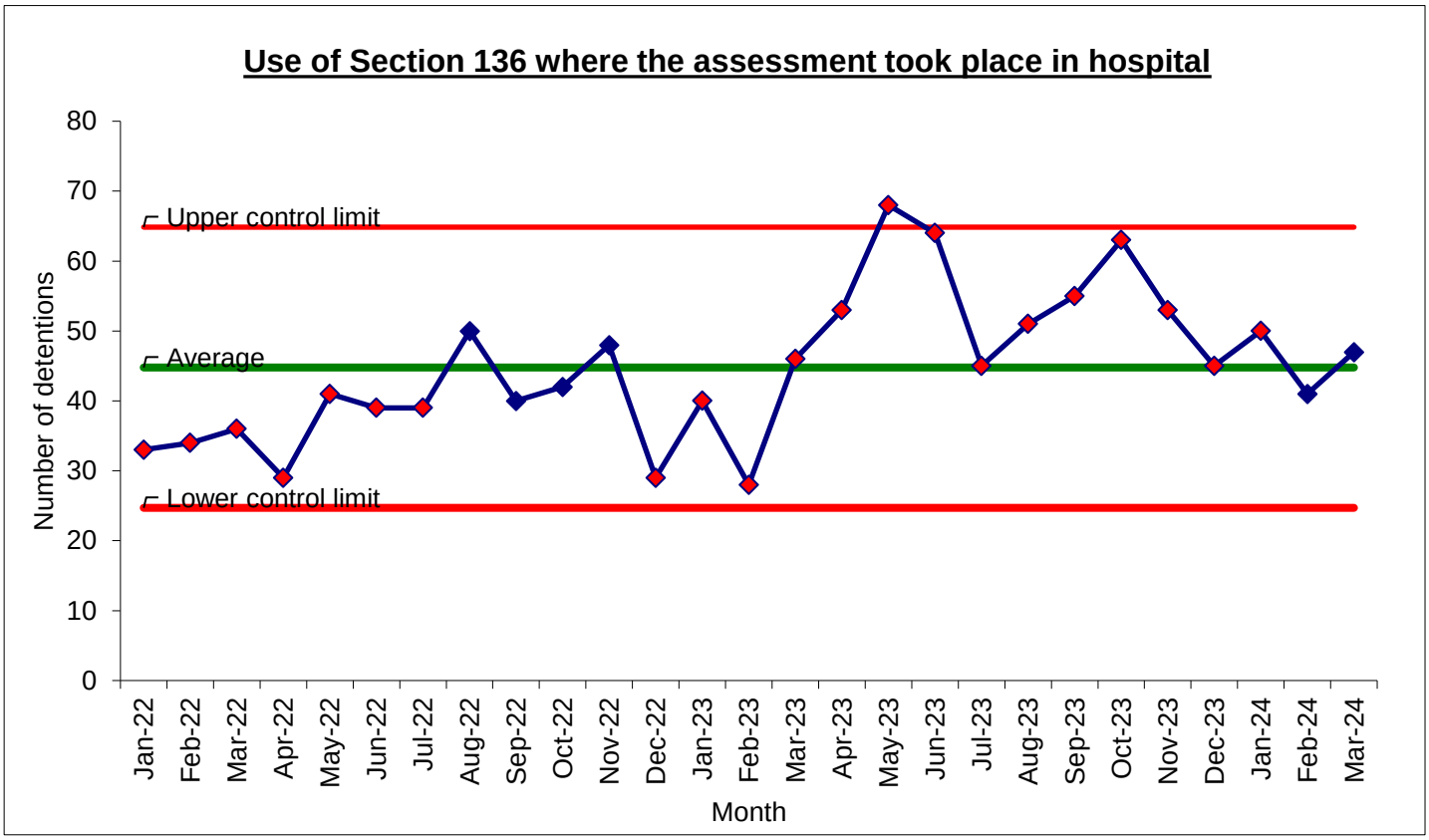
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

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

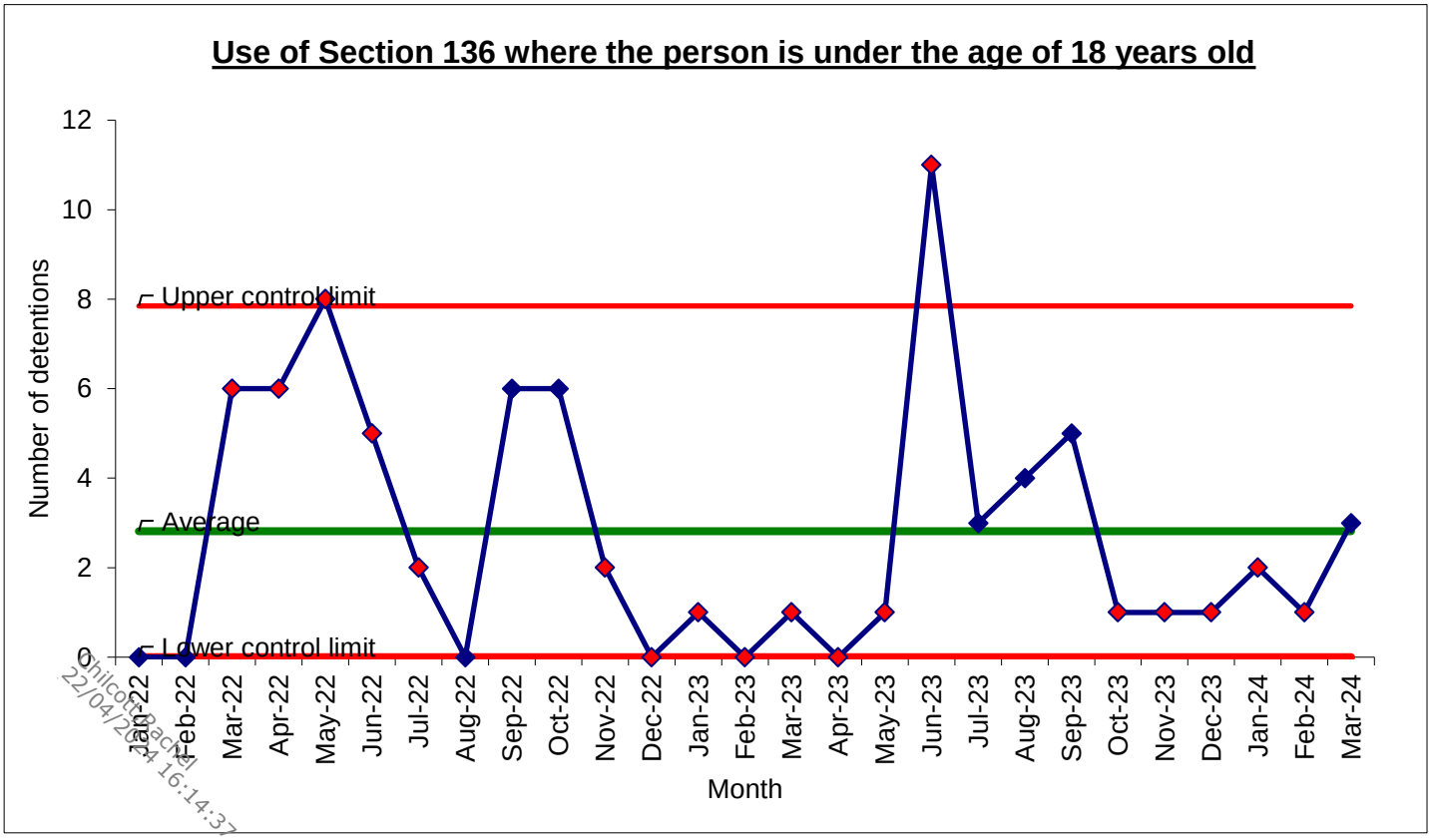
It was noted that 83.3% of individuals assessed were not admitted to hospital, with 51.4% being discharged to community services and 31.9% were discharged with no follow up. Overall during the period 15.9% of patients were admitted to hospital following a 136 assessment which is lower than the previous quarter at 19.2%. One patient's 136 lapsed with no assessment taking place.

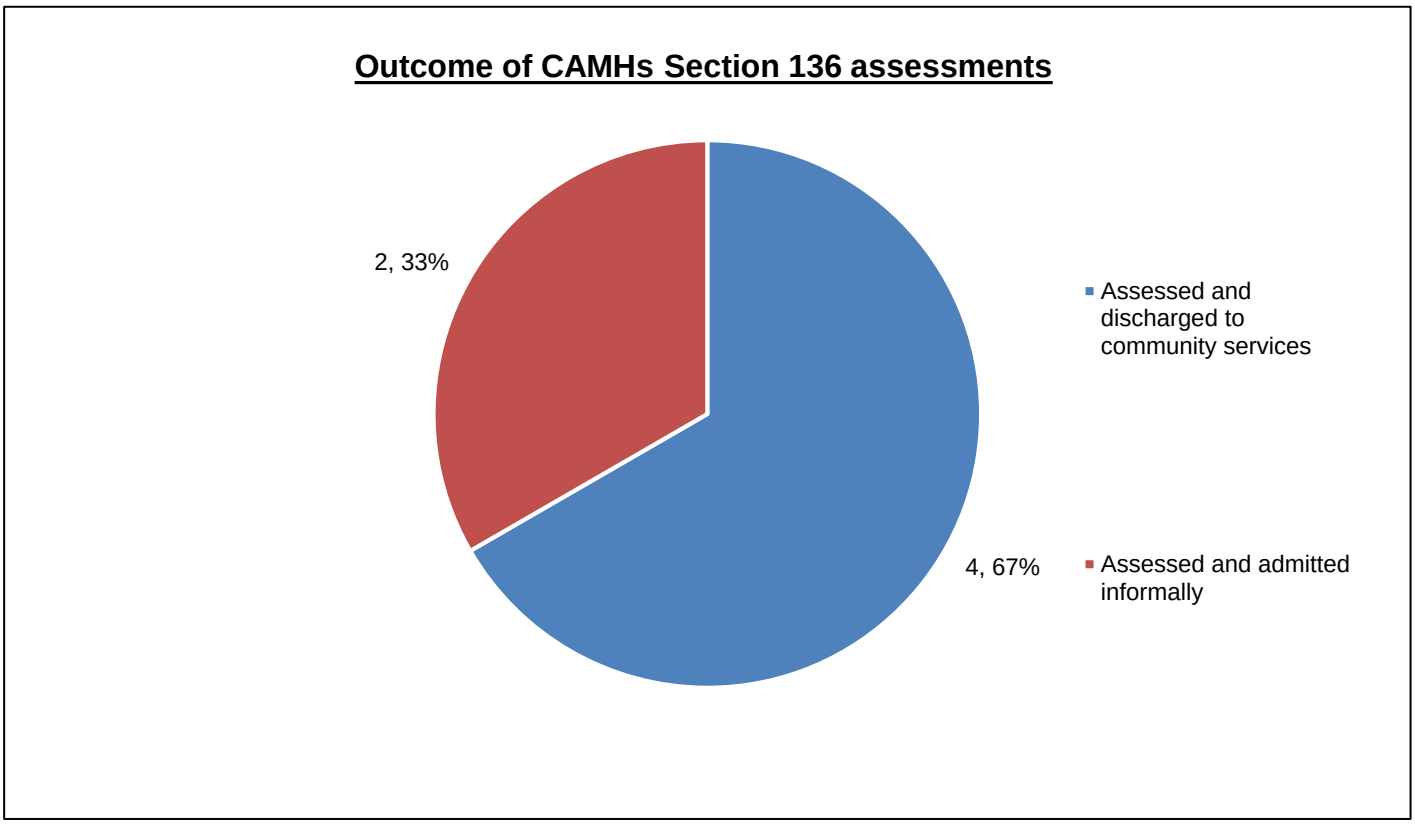
Period	% not admitted to hospital
January – March 2024	83.3
October – December 2023	80.1%
July – September 2023	83.5%
April – June 2023	80.4%
January – March 2023	71.1%
October – December 2022	73.9%
July – September 2022	69.0%
April – June 2022	71.5%
January – March 2022	63.4%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has increased from 3 in the previous quarter to 6 in this quarter. None of these were repeat presentations.





Mental Health Review Tribunal for Wales (MHRT)

A solution has been agreed with the Tribunal regarding the parking at HYC. A new application form that gives the patient the opportunity to state their language preference has been disseminated throughout the wards and CMHT's – the Tribunal have said they are hoping to gather data from the new forms.

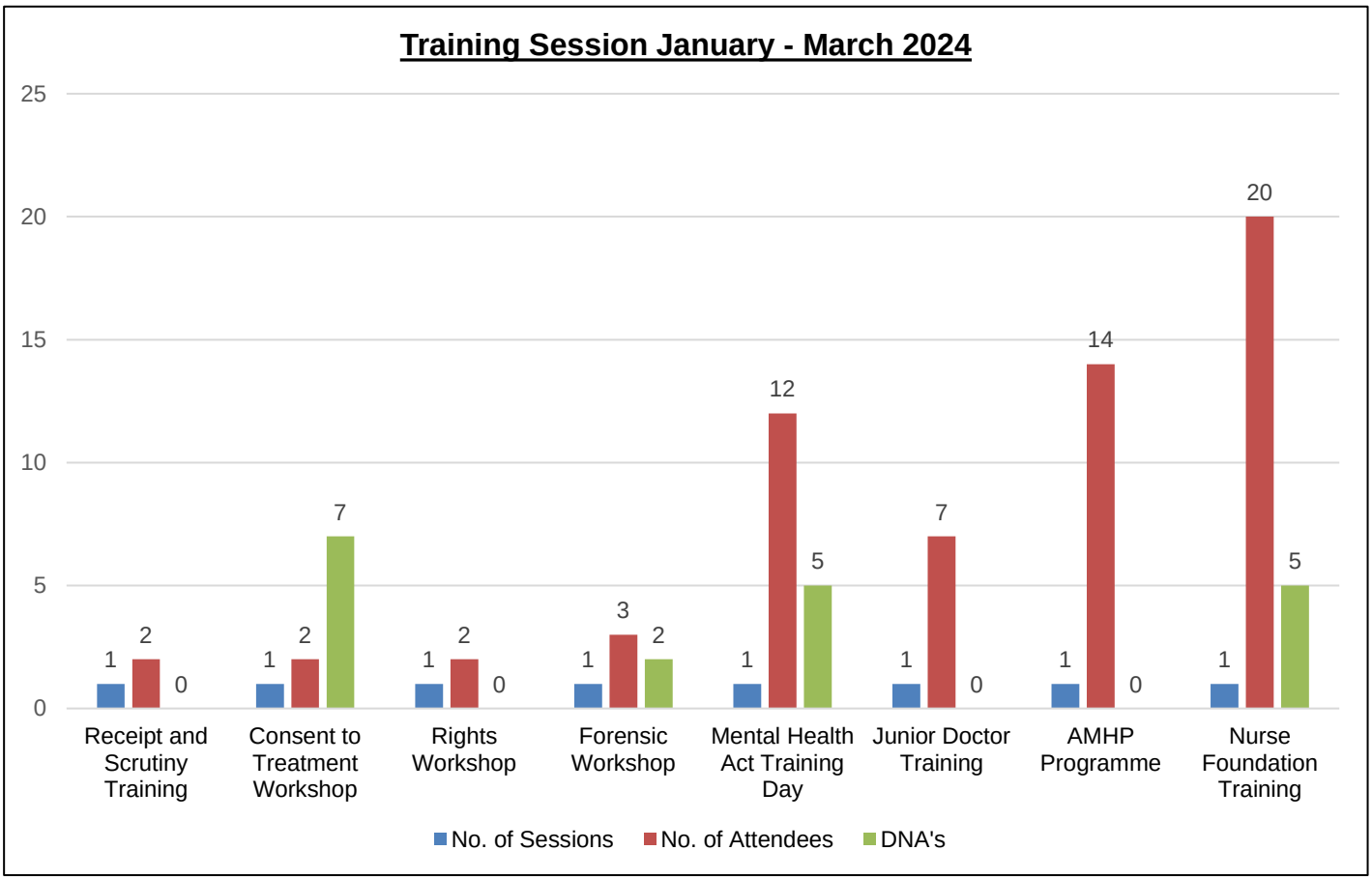
Development Sessions

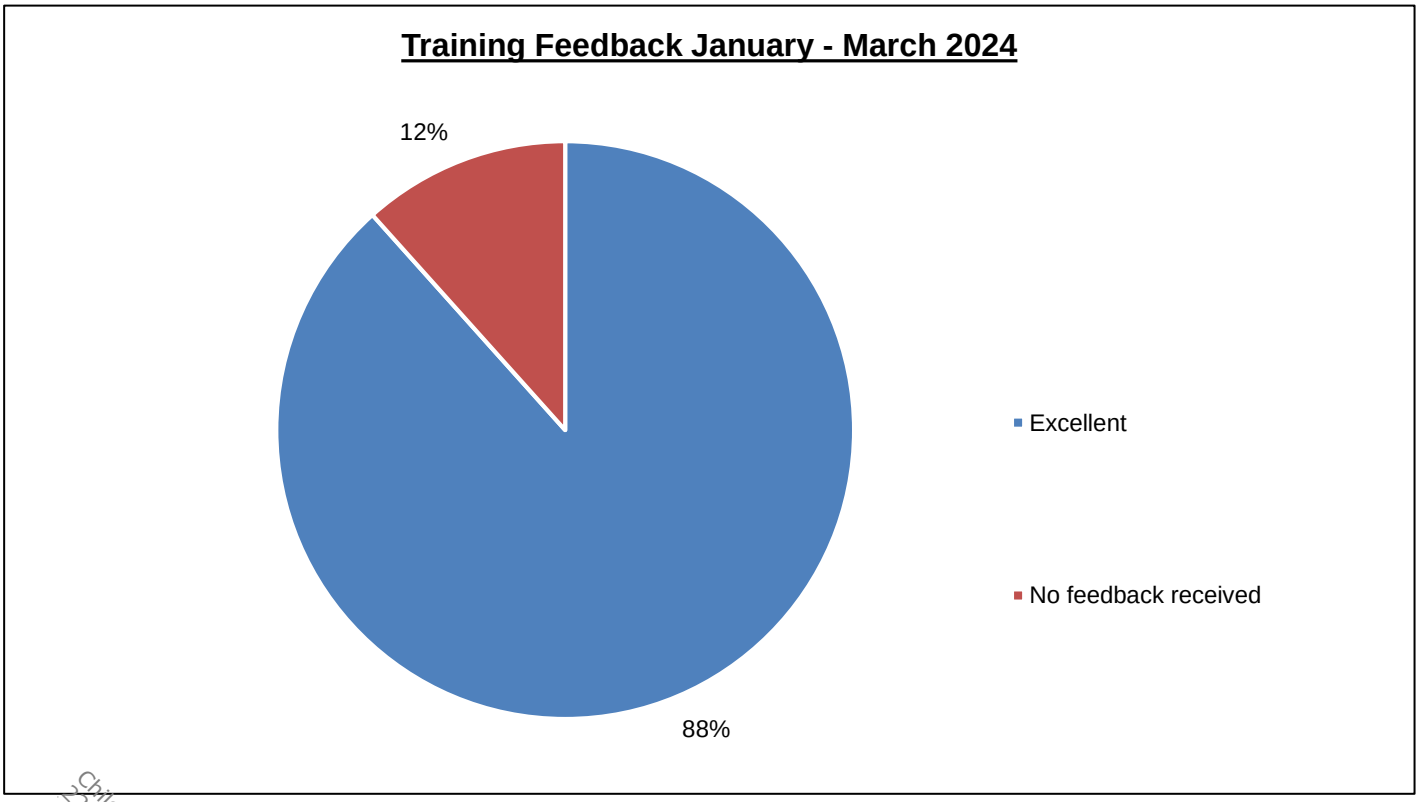
The MHA office continues to run the below awareness sessions available to all staff within the Health Board:

- Bi monthly MHA training day
- Quarterly consent to treatment, rights and forensic workshops
- Yearly refresher receipt and scrutiny training for all shift coordinators

We also continue to support the below training programmes as and when required:

- Nurse foundation programme
- Junior Doctor's MHA inductions
- AMHP programme





Audits

The MHA office continue to audit all the wards and CMHT's within the UHB. This is to ensure compliance with the MHA and best practices are maintained. If any issues are found during the audit we will follow up with an e-mail to the ward manager and/or responsible clinician confirming what is needed to rectify the issue and re-audit within 4-6 weeks.

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

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

Fundamentally defective reports
Continue to ensure effective communication across the UHB and promote MHA training.

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

Section 136
Continue to monitor with colleagues in South Wales Police and ensure any incidents related to an assessment not being completed within the 24/36-hour period due to physical health issues are reported accordingly.

Section 136 – CAMHS
Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal
Continue to work with the MHRT for Wales to find suitable resolutions to any issues, to ensure that appropriate action is taken to protect the patients' right to a fair hearing and ensure any incidents are reported accordingly.

Development sessions
Continue to develop a robust training rota to ensure that development sessions in relation to all areas of the MHA are available and easily accessible. This will be provided by creating an MHA e-learning module.

Audits
Continue to audit wards and CMHT's, while providing support and guidance on maintaining compliance with the MHA and best practices.

Recommendation:

The Committee is requested to:

a) NOTE the approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report.

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

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

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

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

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

Yes – there is a potential risk that if a 136 lapses with no assessment being completed the patient will be allowed to leave and could harm themselves or others.

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – communication between the UHB, Local Authority and South Wales Police needs to continue to be monitored to ensure all risks regarding detaining someone without authority are mitigated.

Reputational: Yes/No

No

Socio Economic: Yes/No

No

Equality and Health: Yes/No

No

Decarbonisation: Yes/No

No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Chilcott Rachel
22/04/2024 16:14:37

Report to the

Mental Health Legislation and Mental Capacity Act Committee

on the use of The Mental Health Act, 1983

January- March 2024

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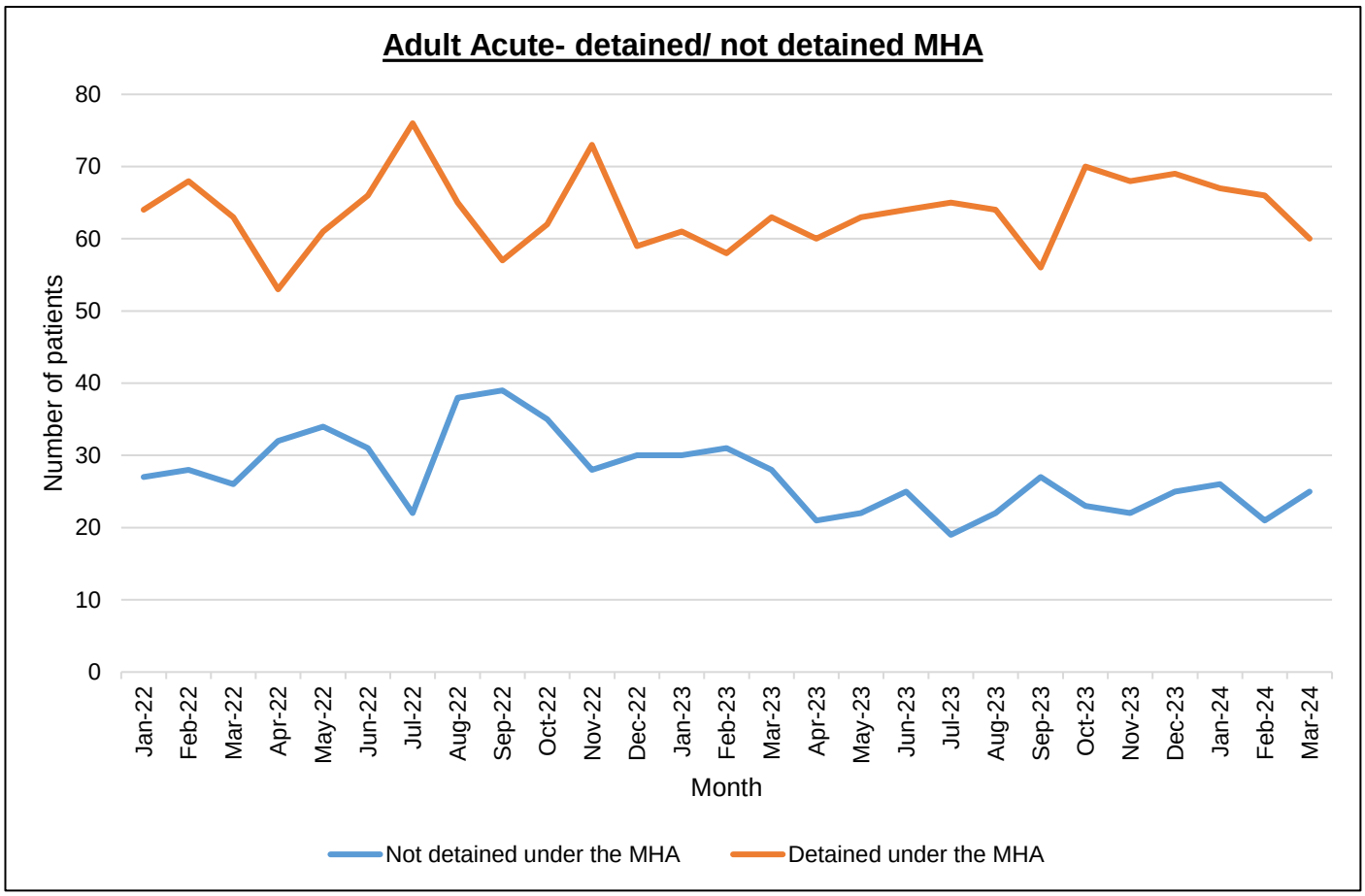
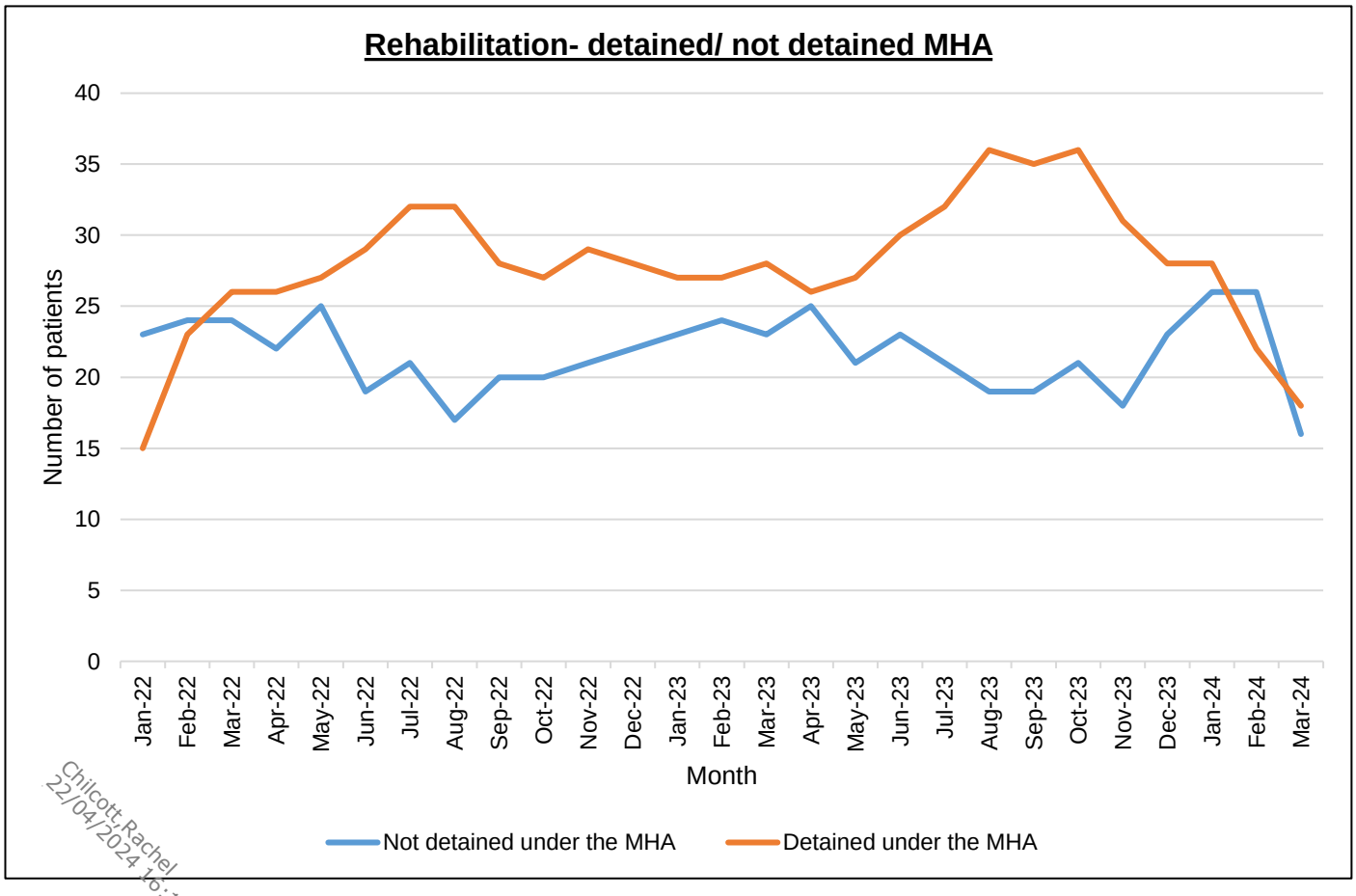
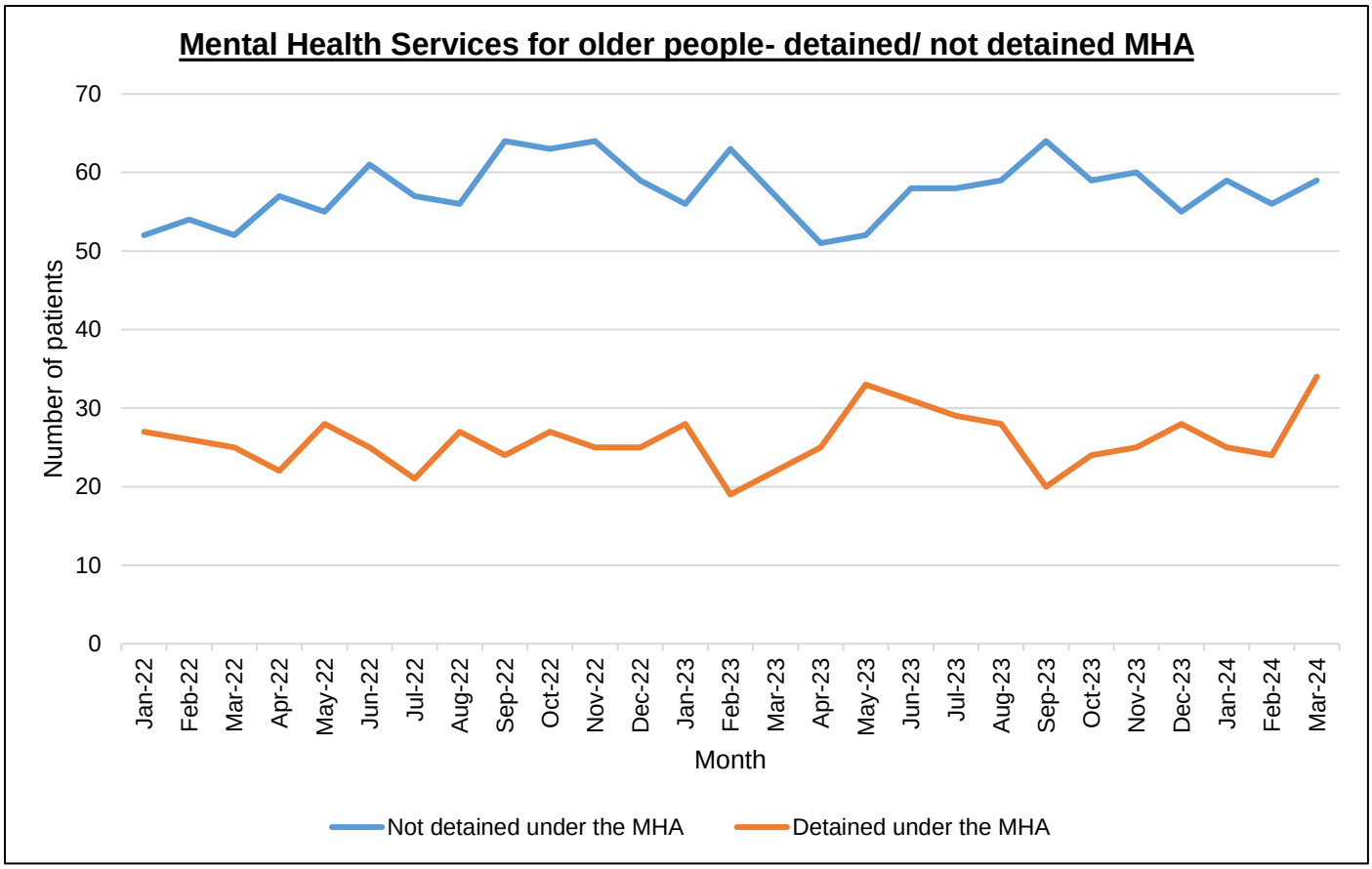
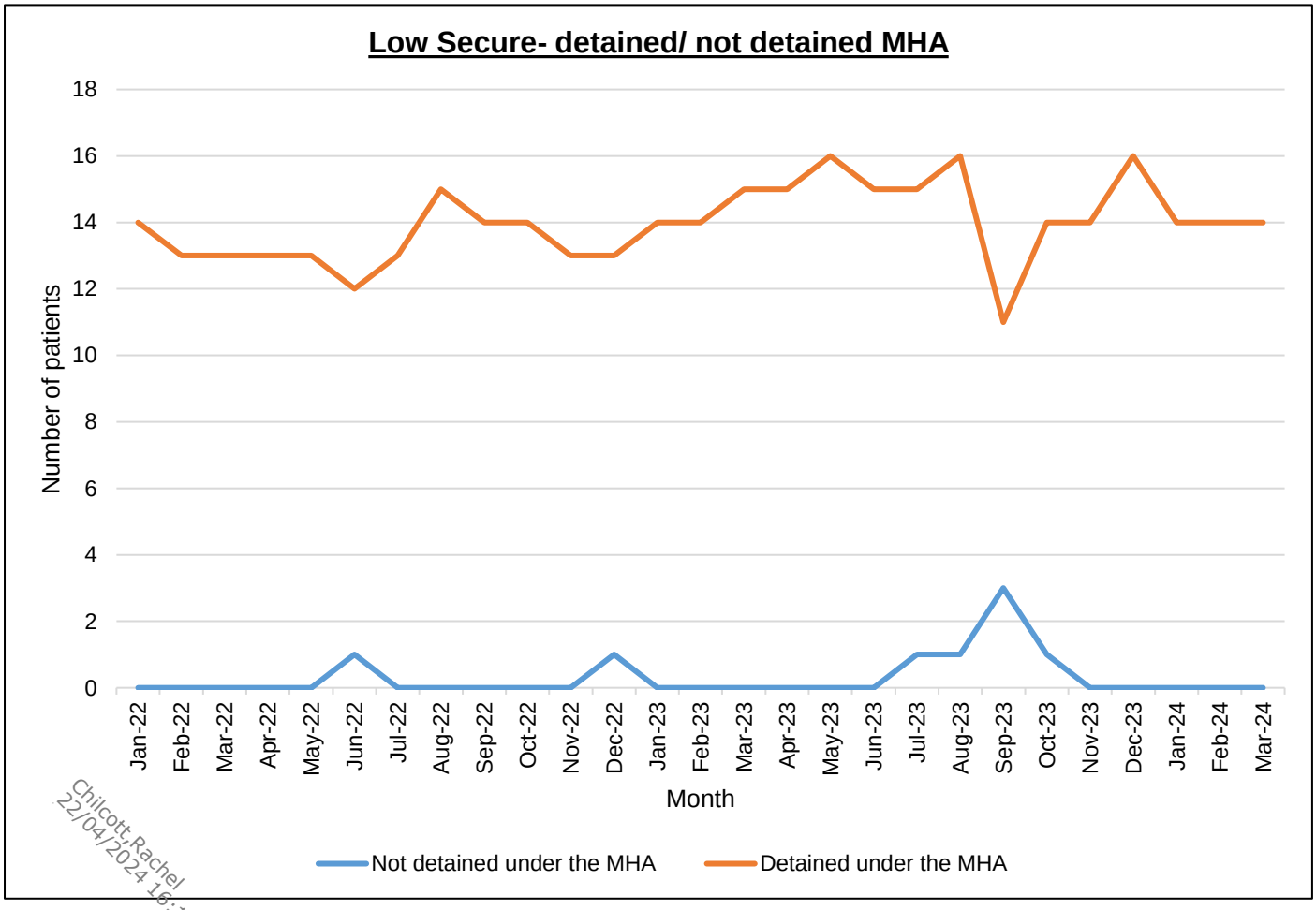
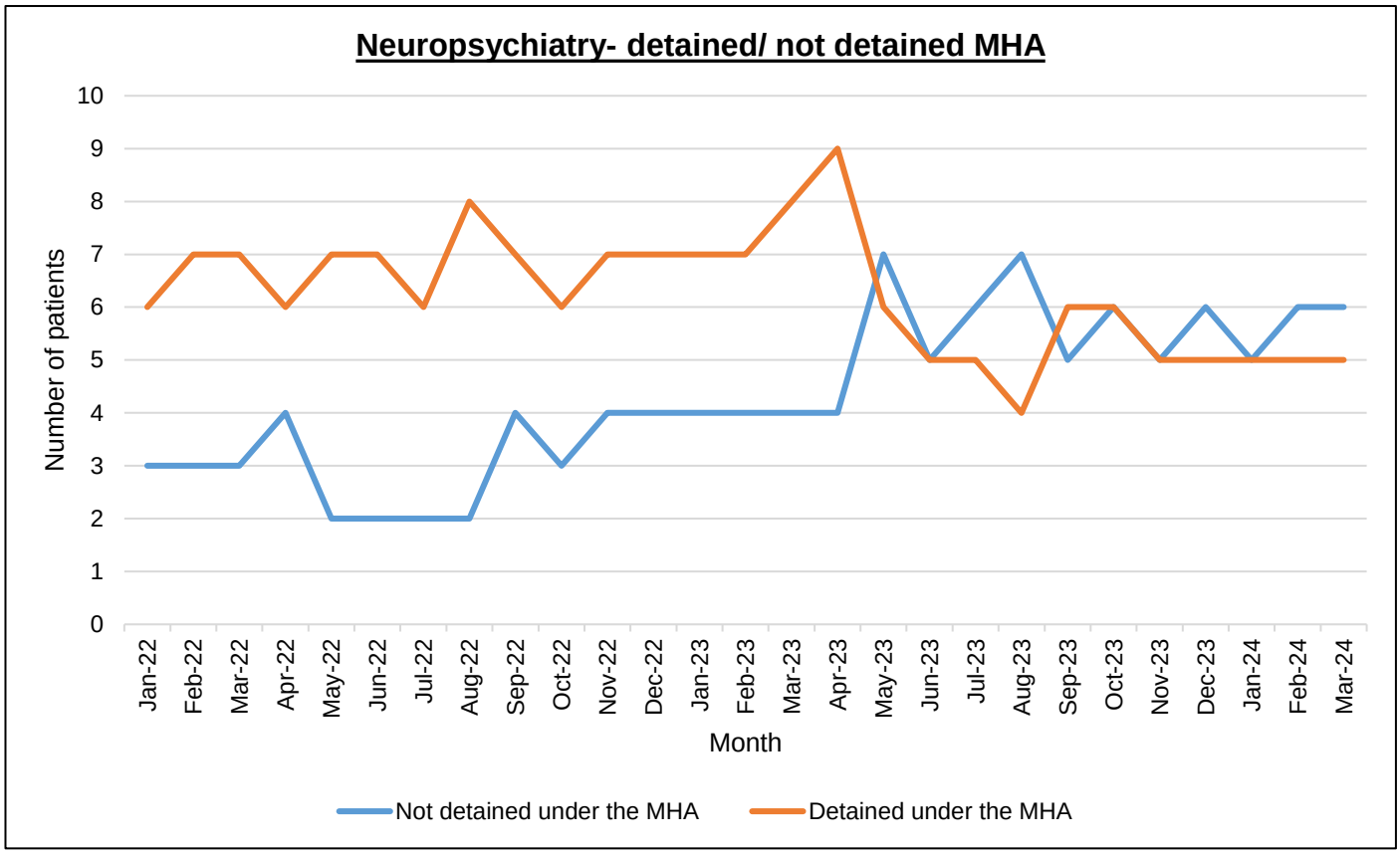
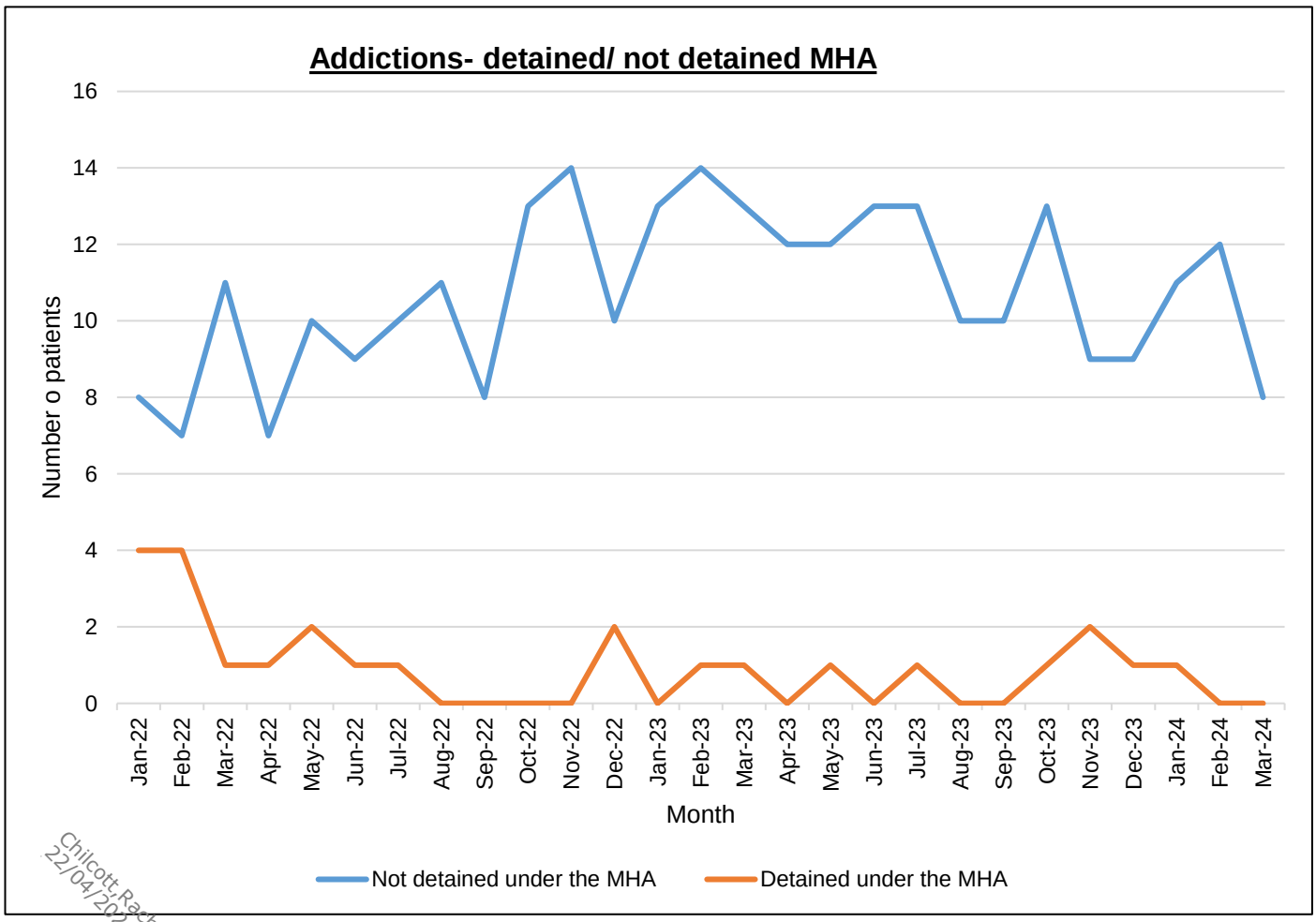








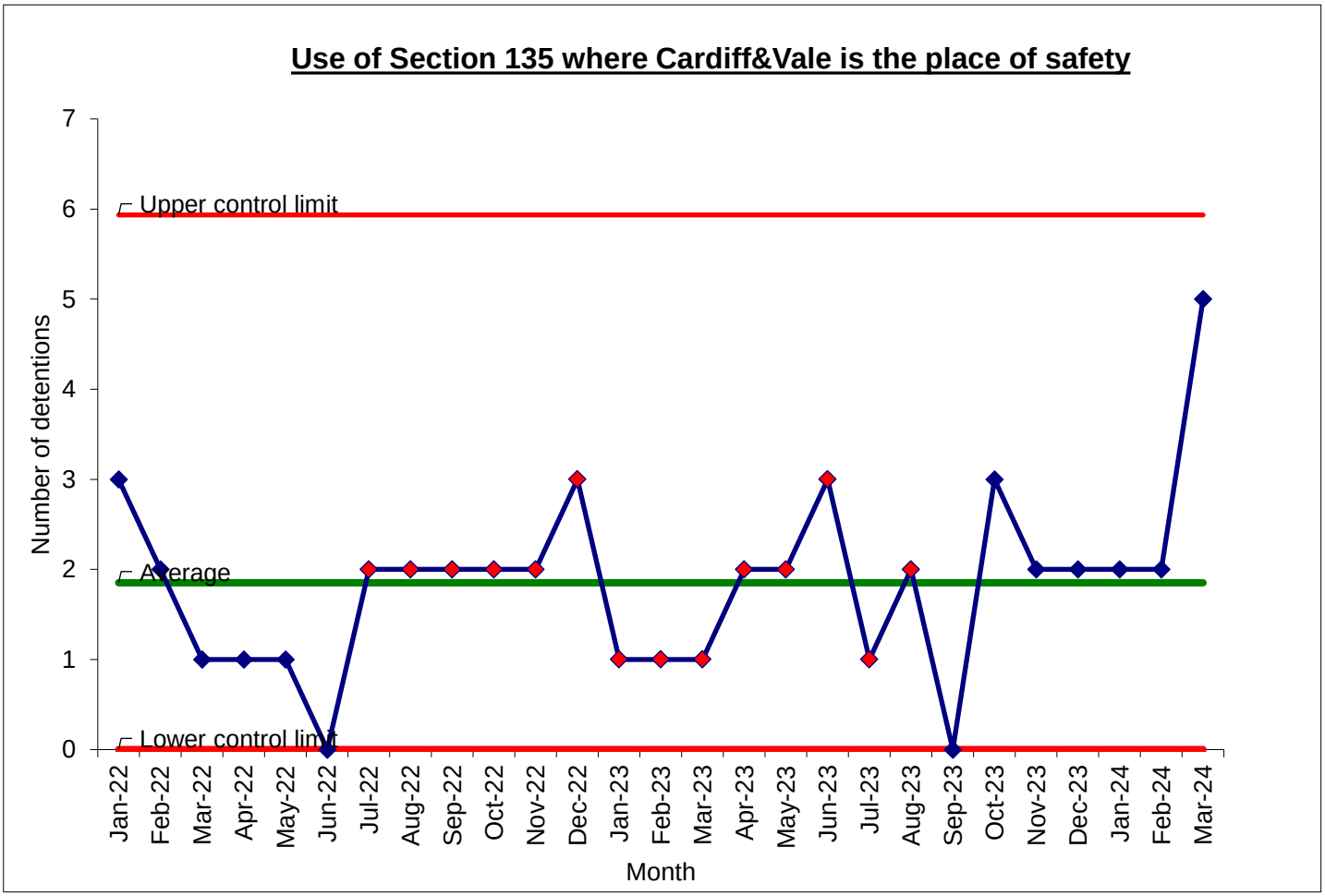




Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on nine occasions. During the period there were no uses of Section 135(2).

- Detained under Section 2 x 5
- Patient AWOL when warrant executed x 1
- Detained to out of area bed x 1
- Detained under Section 3 x 1
- Discharged to community services x 1



Voluntary Assessment

During Summer 2020, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

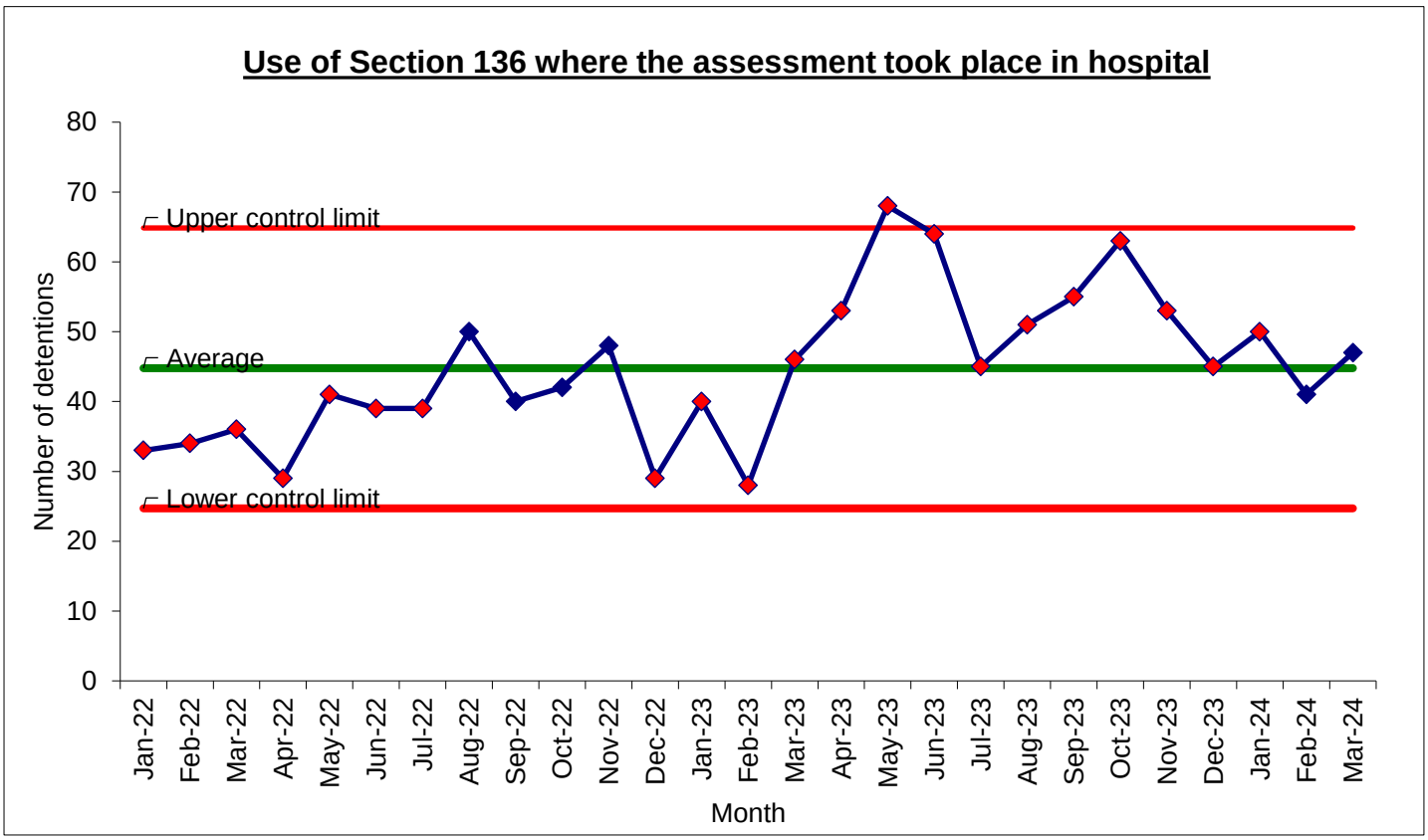
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

We continue to work with South Wales police to ensure the AWMF is completed each time a person is brought to hospital for an assessment and hope to see an improvement in the use of the electronic form going forward.

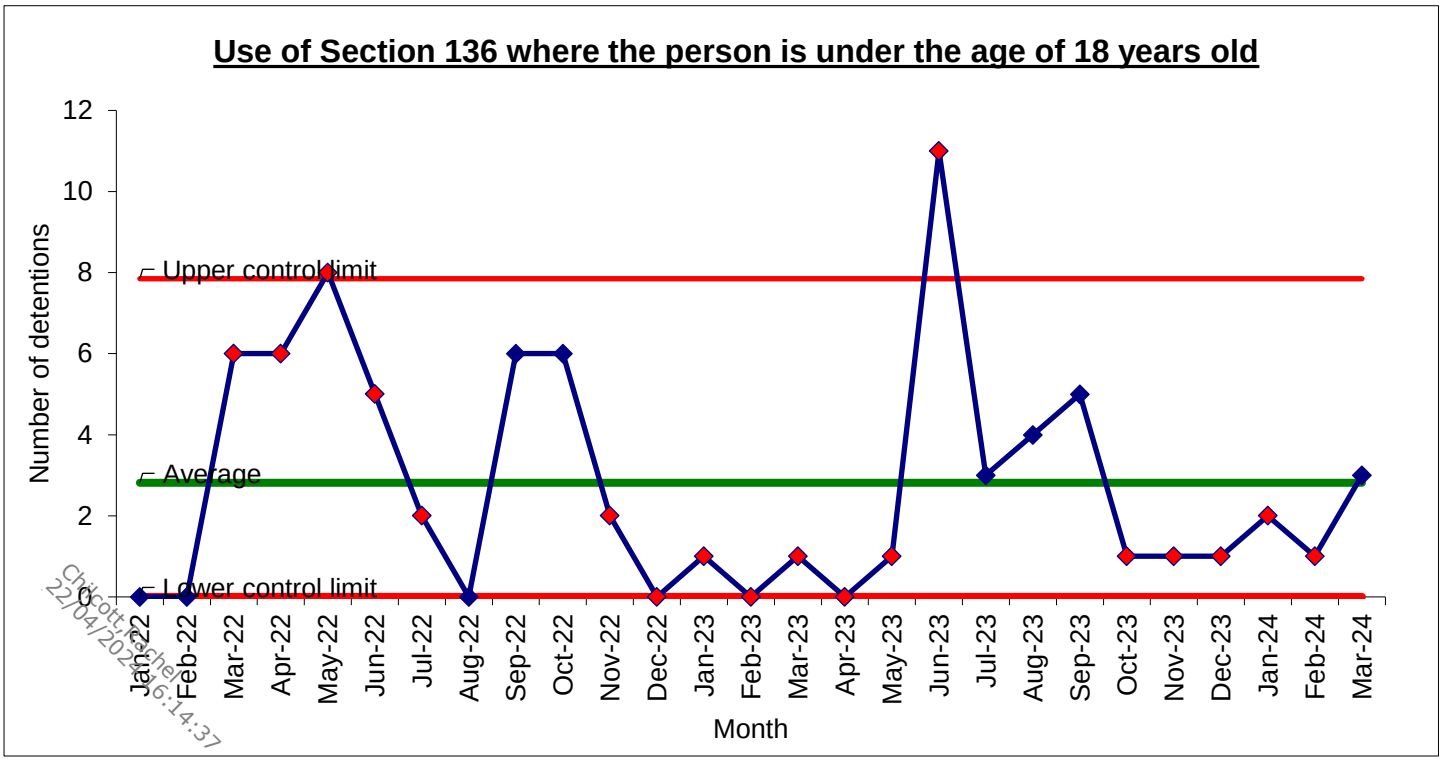
For this period, we have seen three people for a Voluntary Assessment and no one was brought into hospital under the Mental Capacity Act.

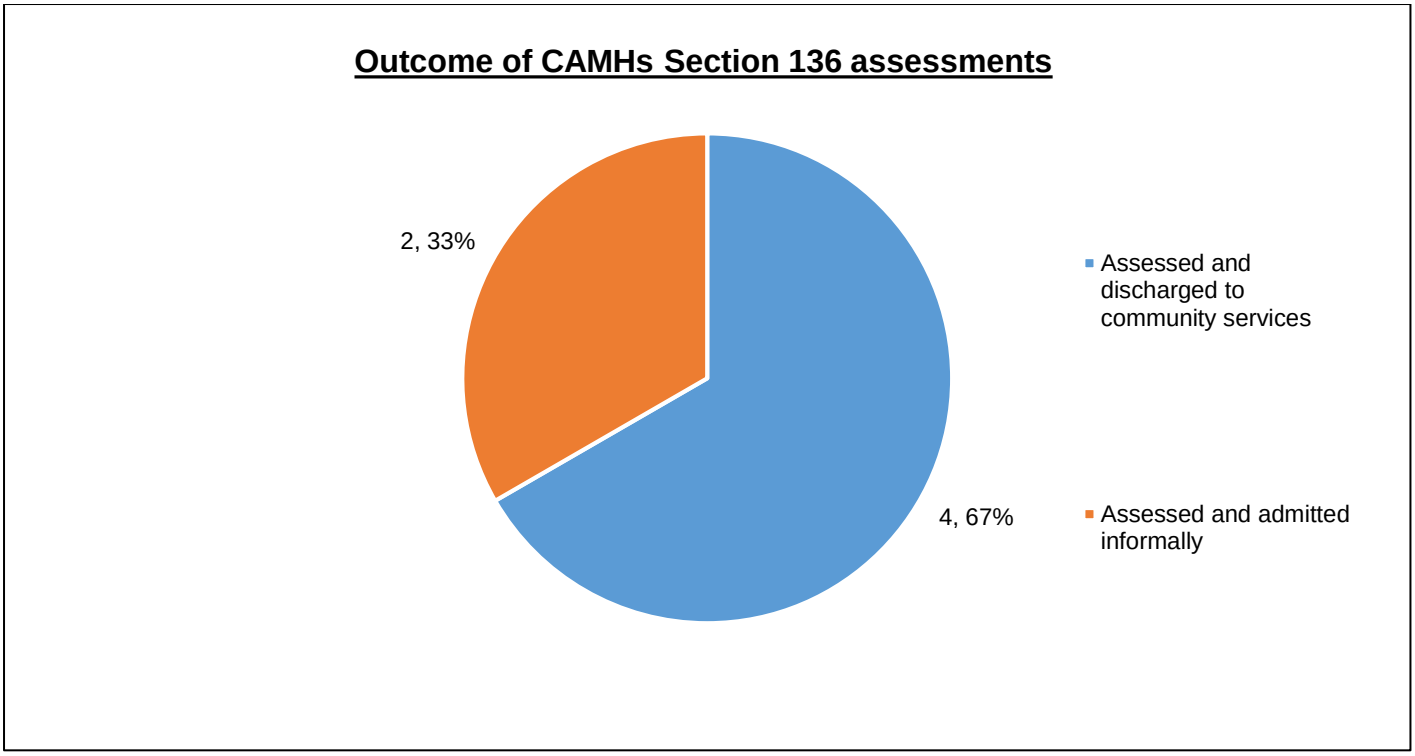
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

During the period a total of 138 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

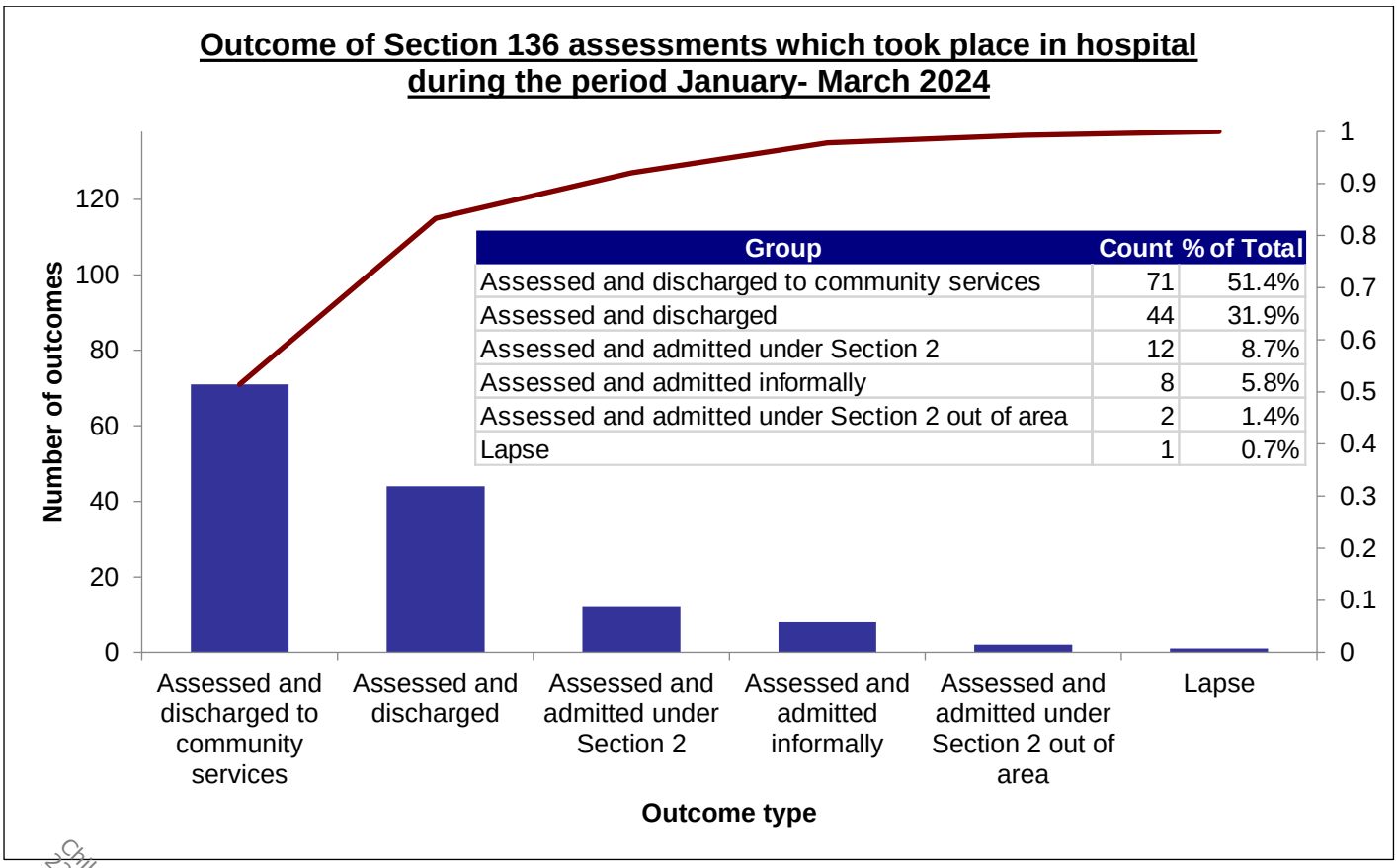


Six of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. None of these were repeat presentations This is extracted below;-





The pareto chart highlights that 83.3% 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.

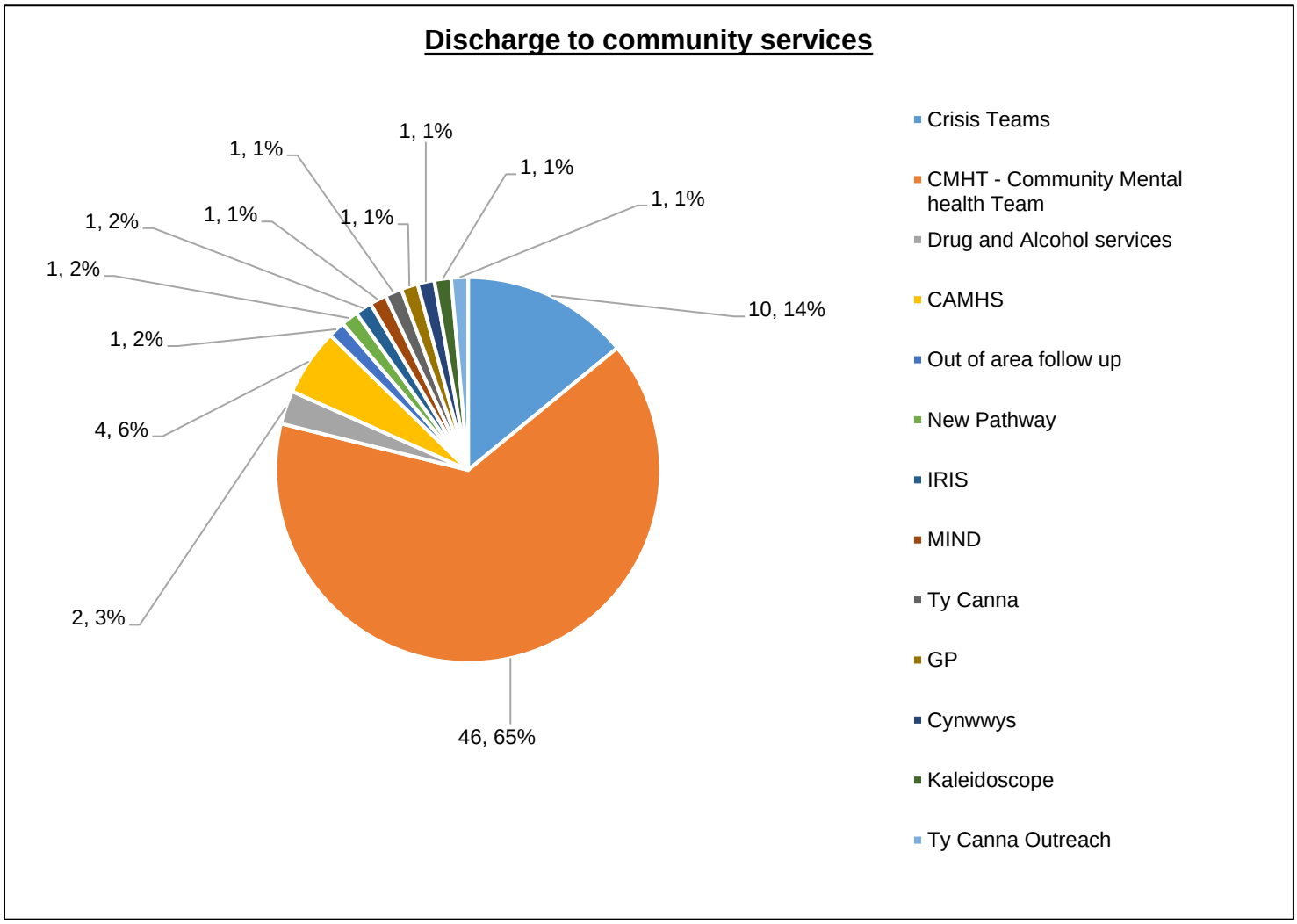


Group	Count	% of Total
Assessed and discharged to community services	71	51.4%
Assessed and discharged	44	31.9%
Assessed and admitted under Section 2	12	8.7%
Assessed and admitted informally	8	5.8%
Assessed and admitted under Section 2 out of area	2	1.4%
Lapse	1	0.7%

Included in the above data are the outcomes for those under 18 years of age.

The one lapsed detention was due to the patient not being fit for assessment during the detention period.

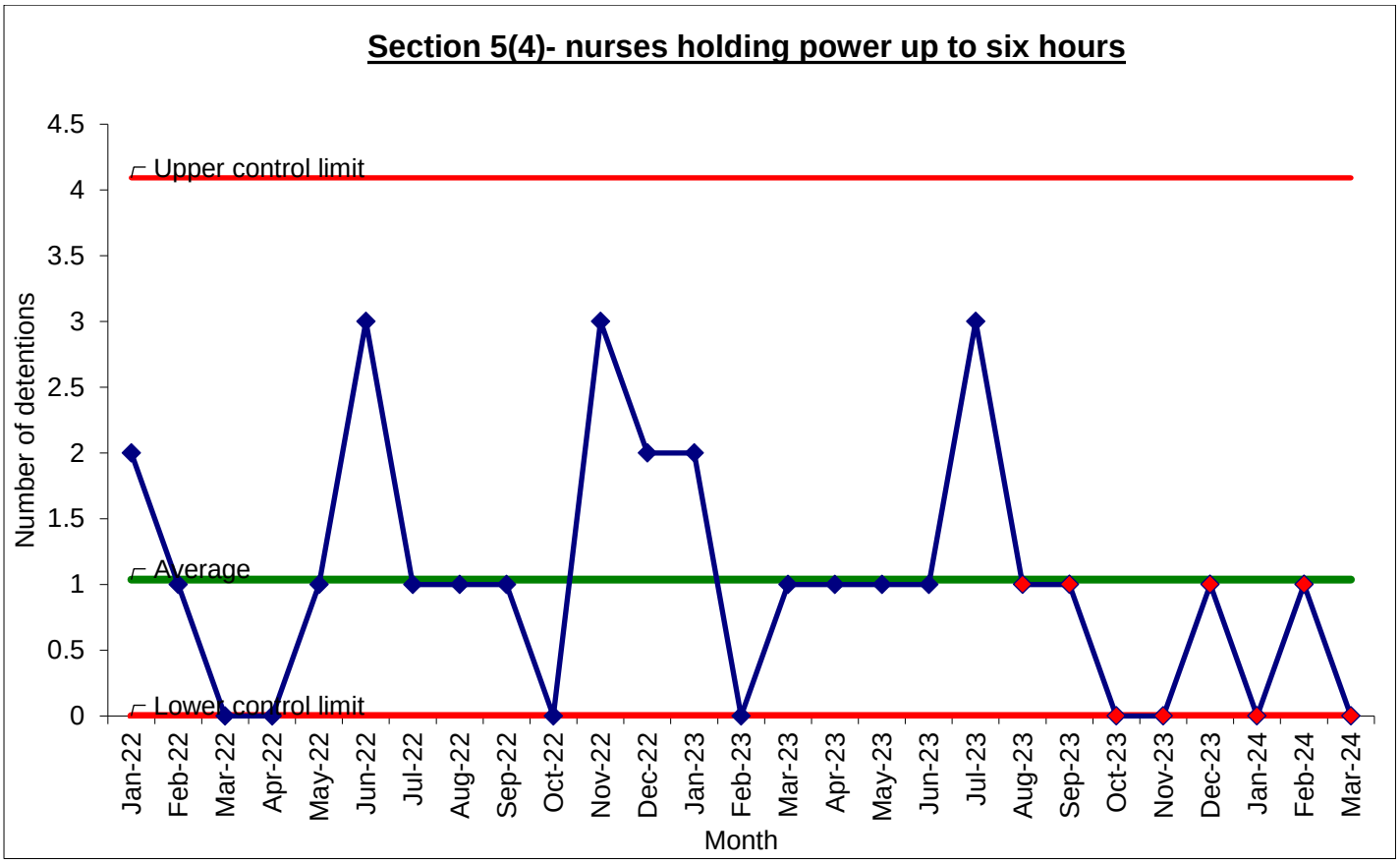
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.



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

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

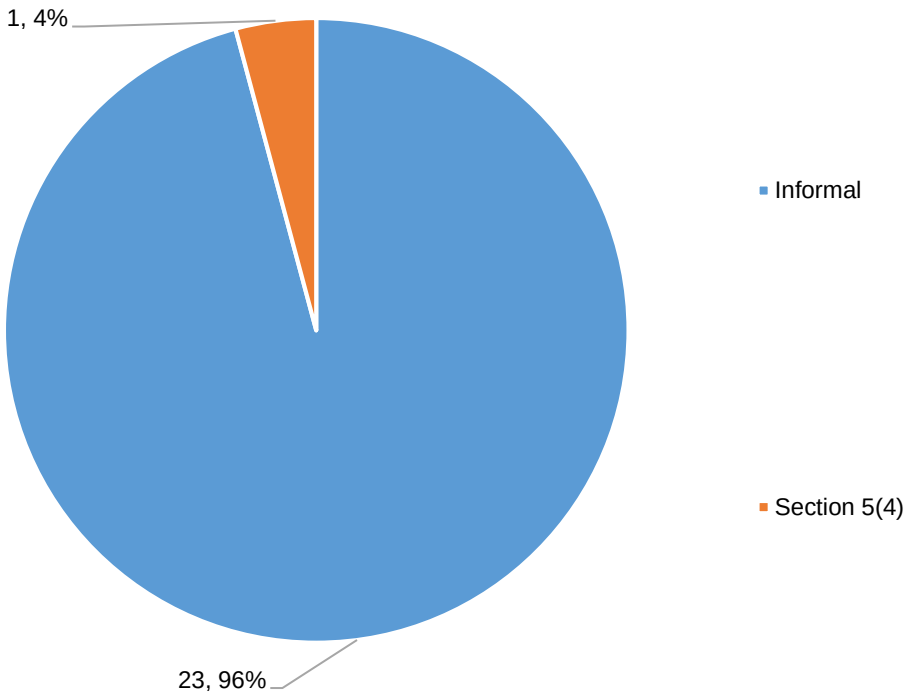
Section 5(4) - Nurses Holding Power



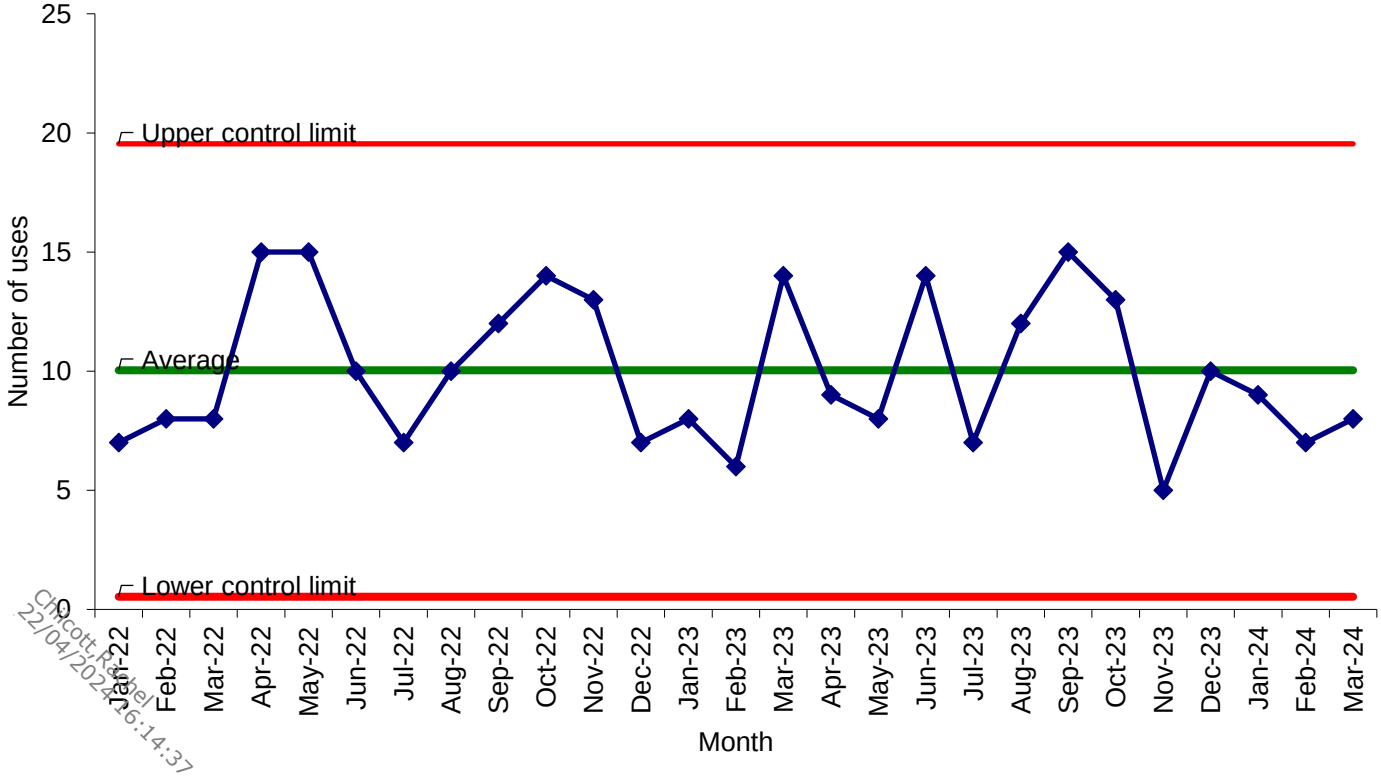
Section 5(4) was used once during the period. This was followed on by the person being held under Section 5(2).

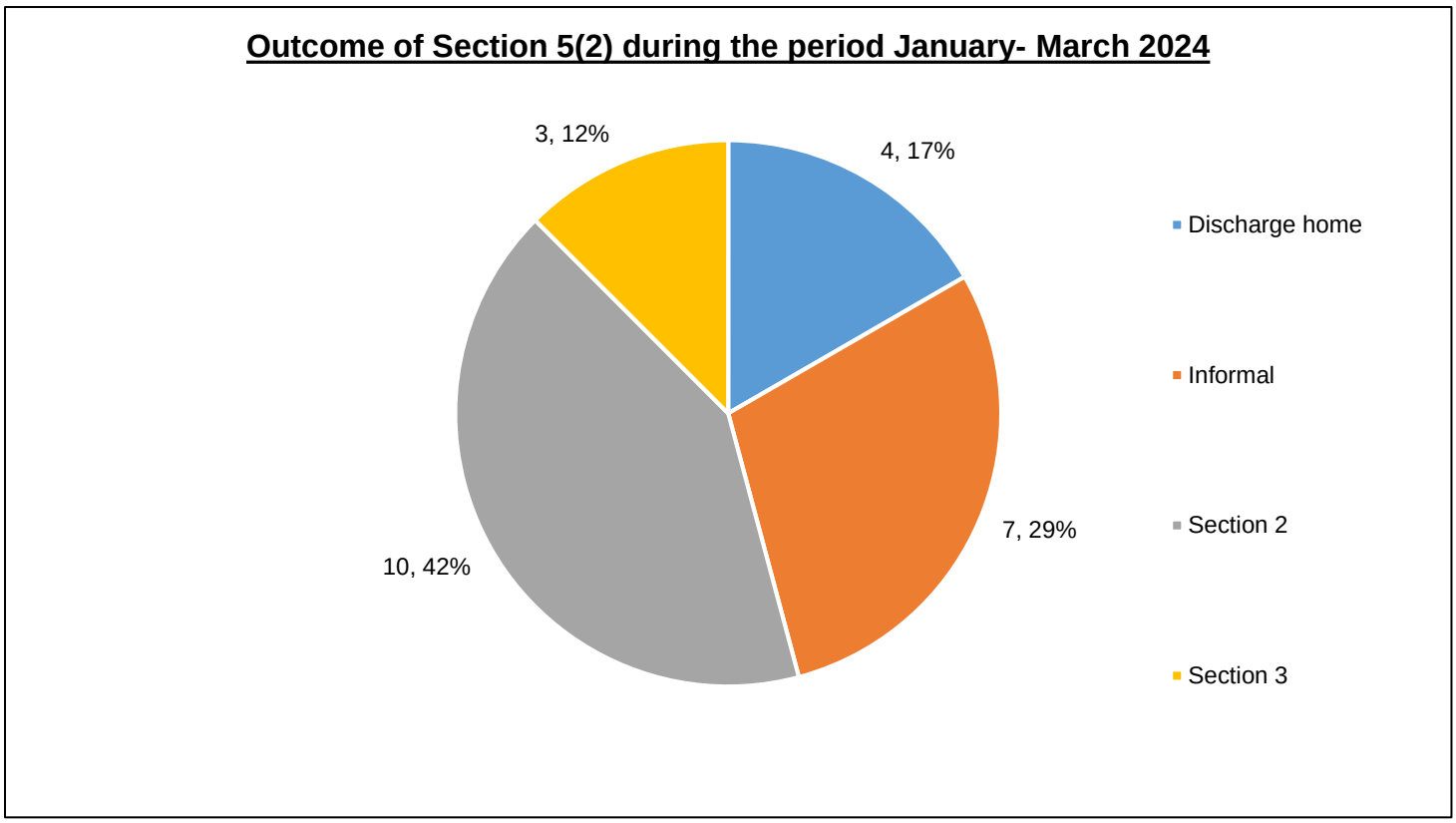
Section 5(2) - Doctors holding power

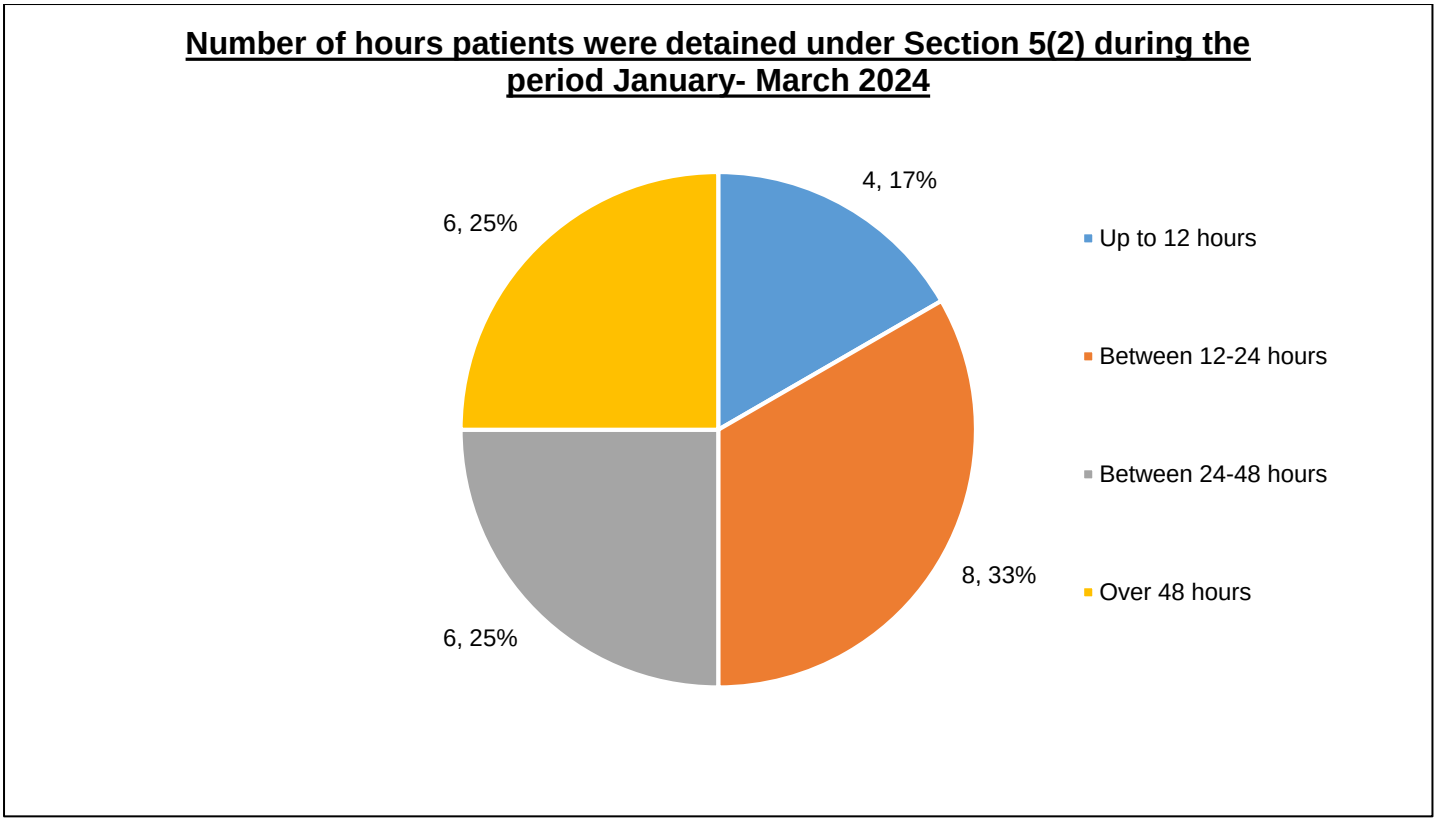
Legal status prior to Section 5(2) during the period January- March 2024



Section 5(2)- doctors holding power up to 72 hours



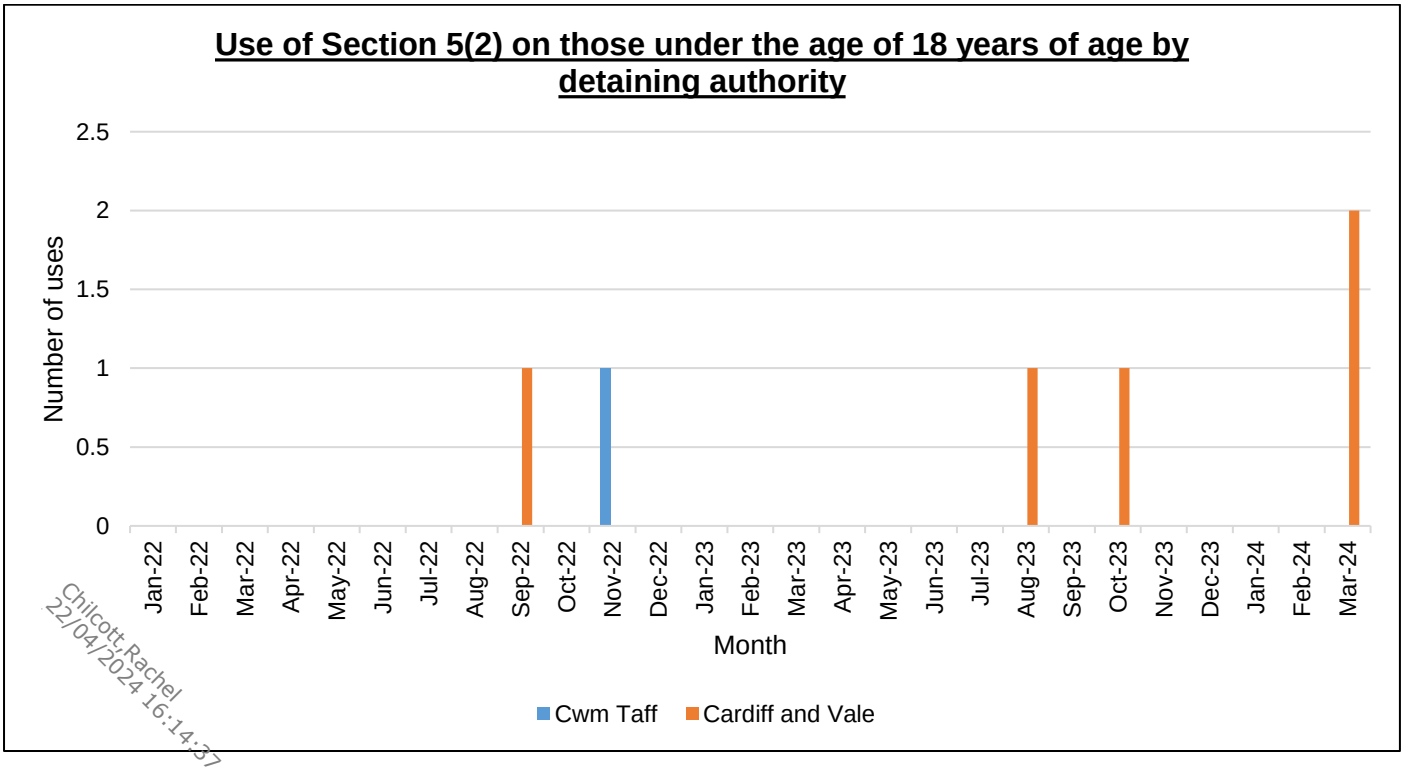




CAMHS Commissioned Inpatient Data

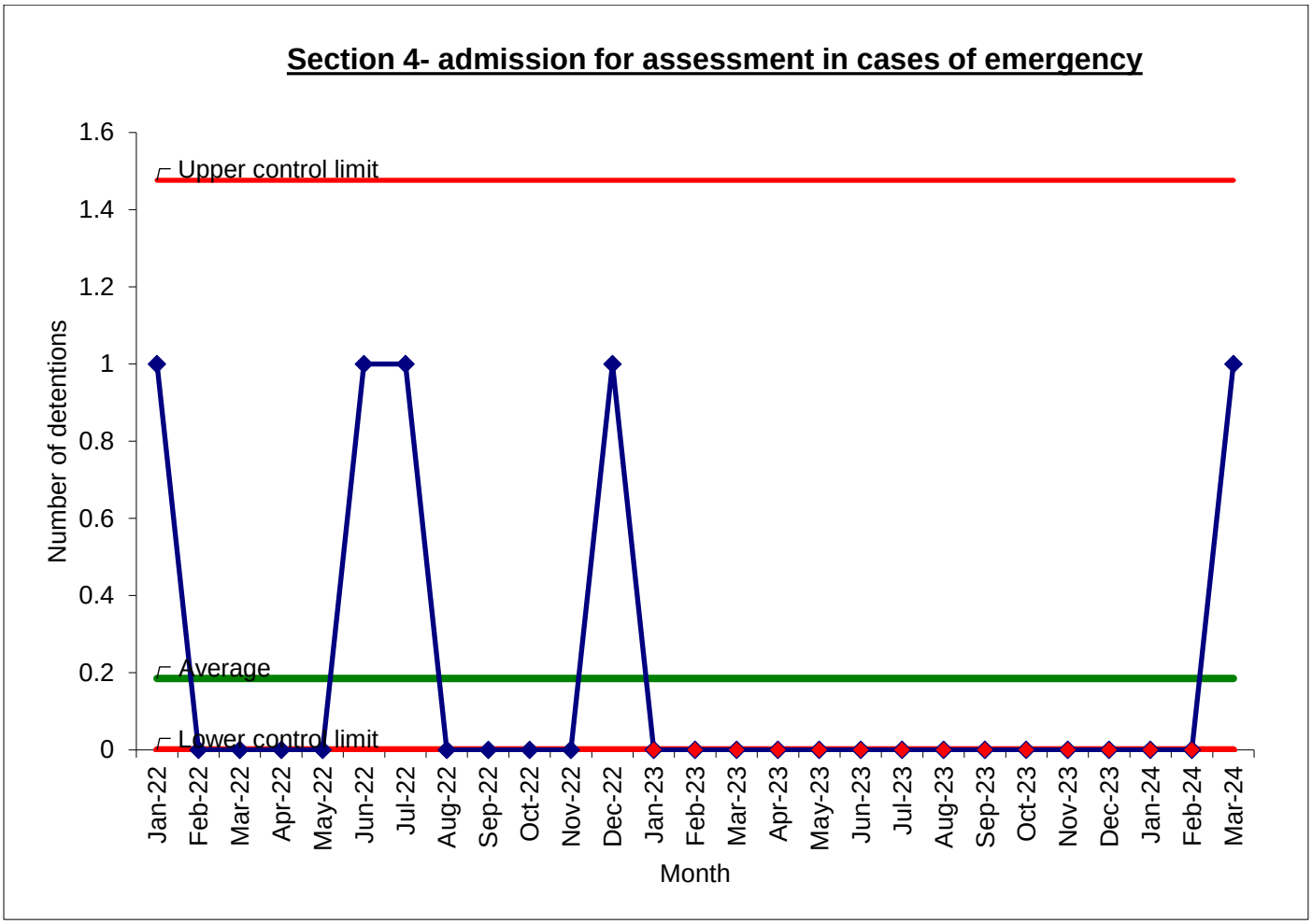
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During the period there were two uses of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB. The outcome of one of the holding powers was that the person stayed in hospital informally. The outcome of one of the holding powers was that the person was discharged home.



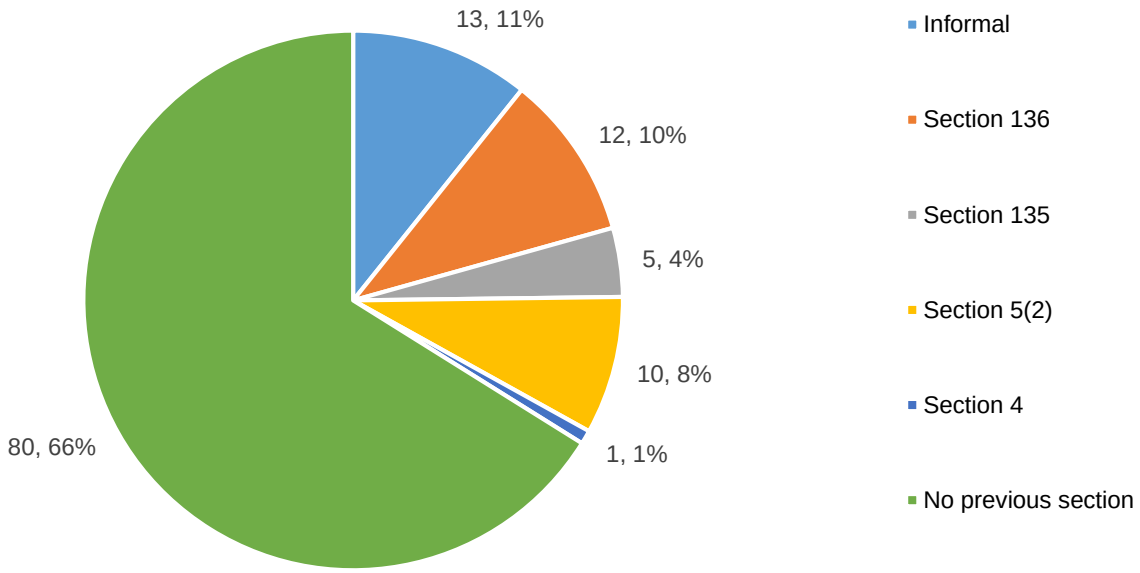
Section 4 - Admission for Assessment in Cases of Emergency

Section 4 was used once during the period. The section 4 was converted into a Section 2.

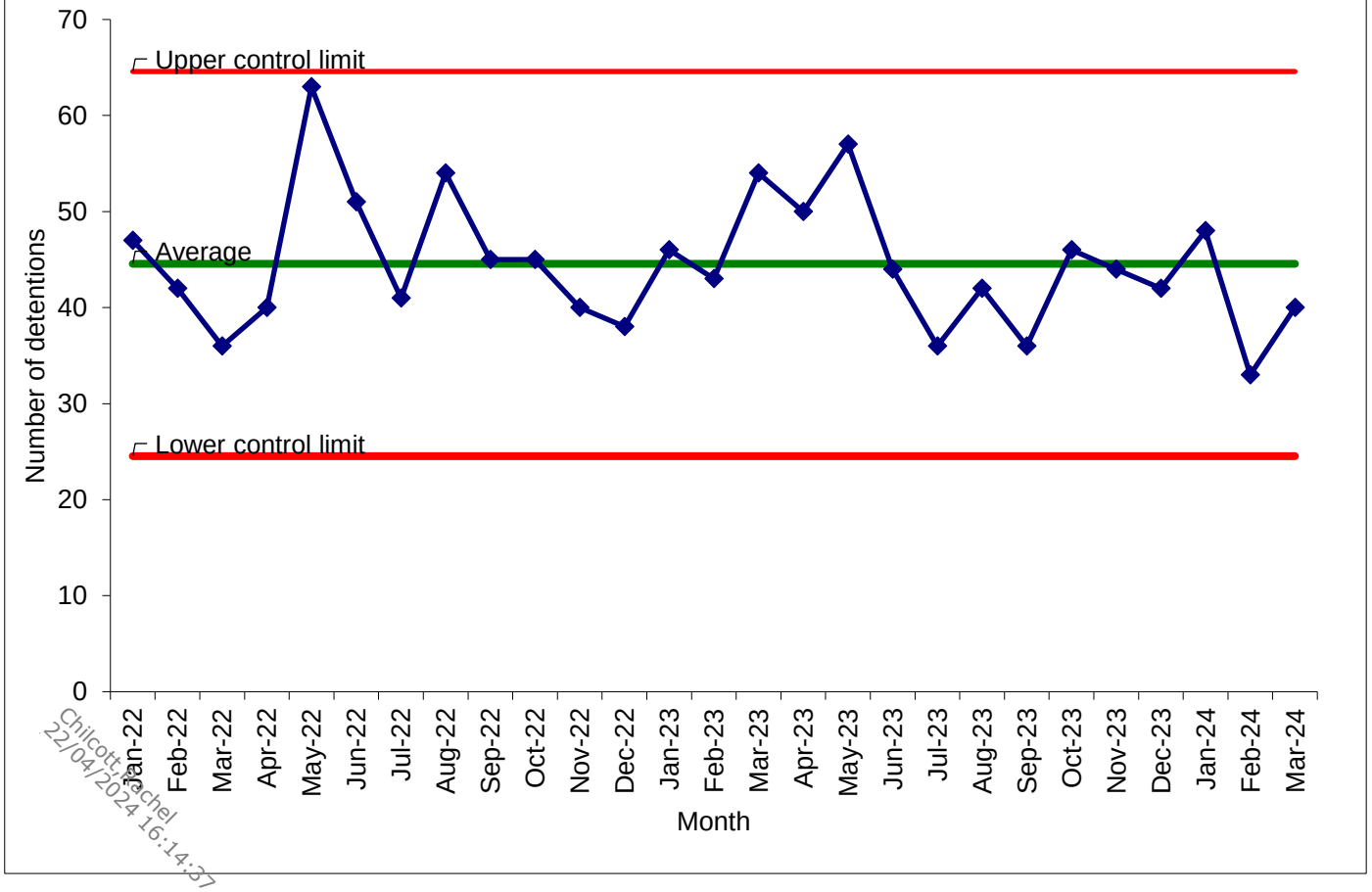


Section 2 – Admission for Assessment

Legal status prior to Section 2 during the period January- March 2024



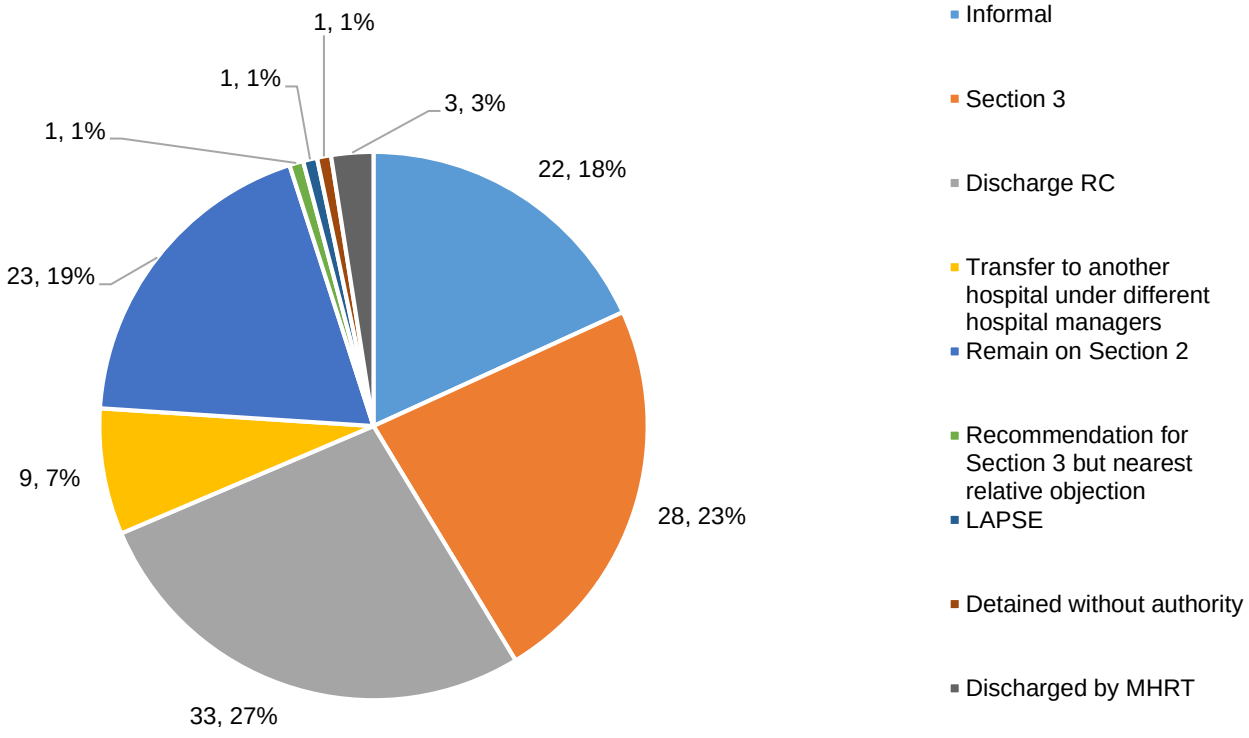
Section 2- admission for assessment for up to 28 days



During the period one use of Section 2 lapsed due to the patient being AWOL when the assessment period ended and therefore couldn't be assessed.

During the period one person was detained without authority due to the detentions papers not having been signed in line with Welsh regulations.

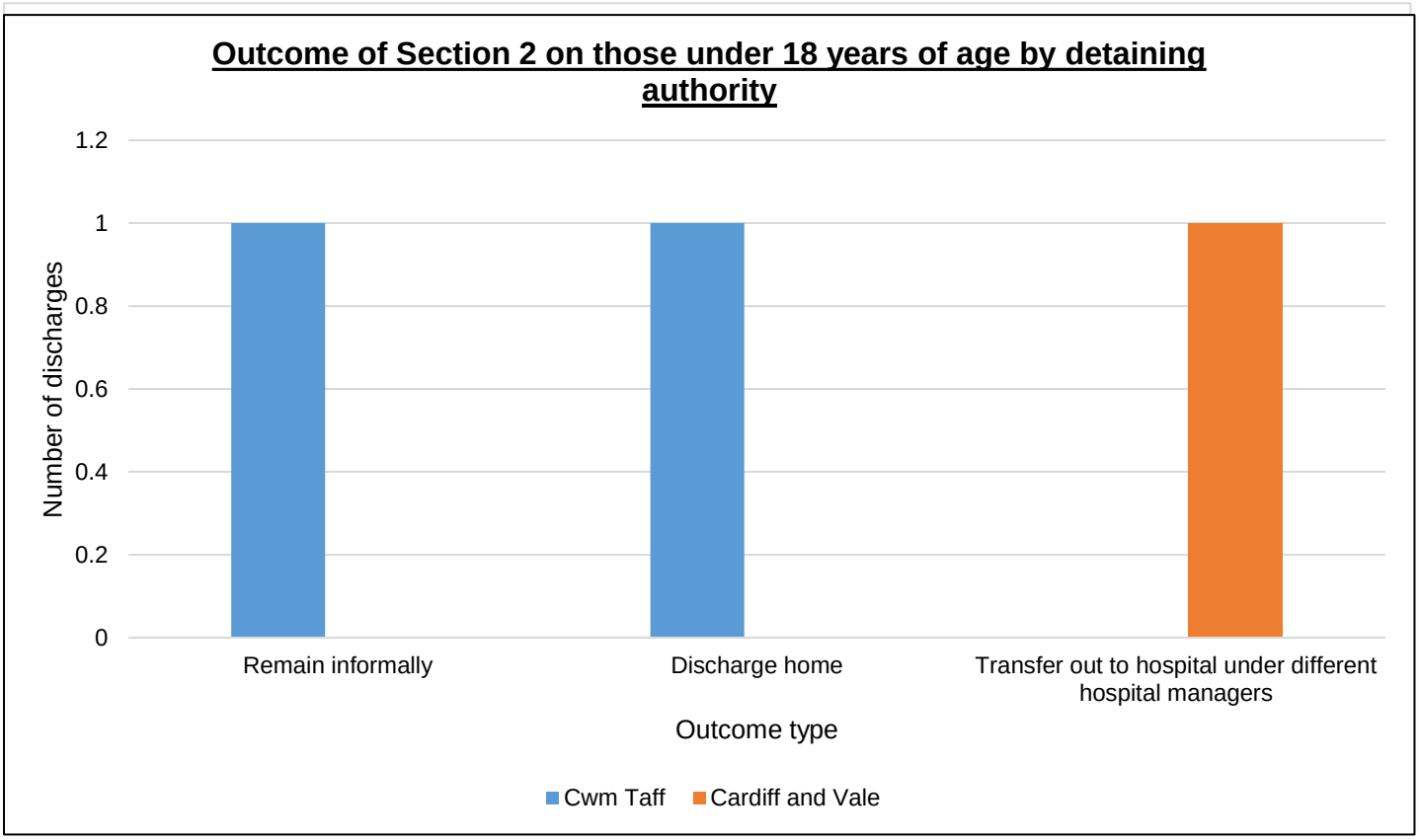
Outcome following Section 2 during the period January- March 2024



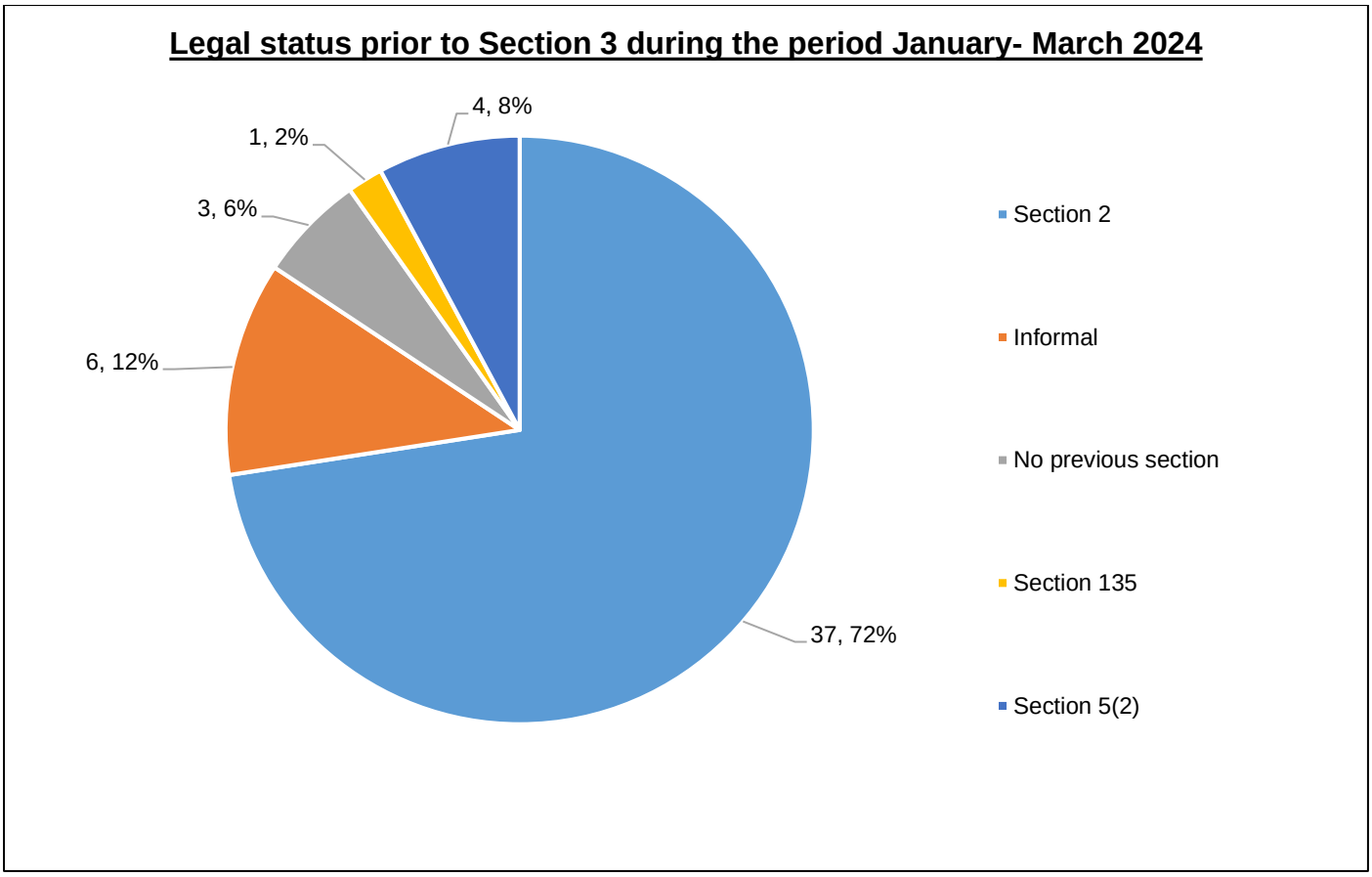
CAMHS Commissioned Inpatient Data

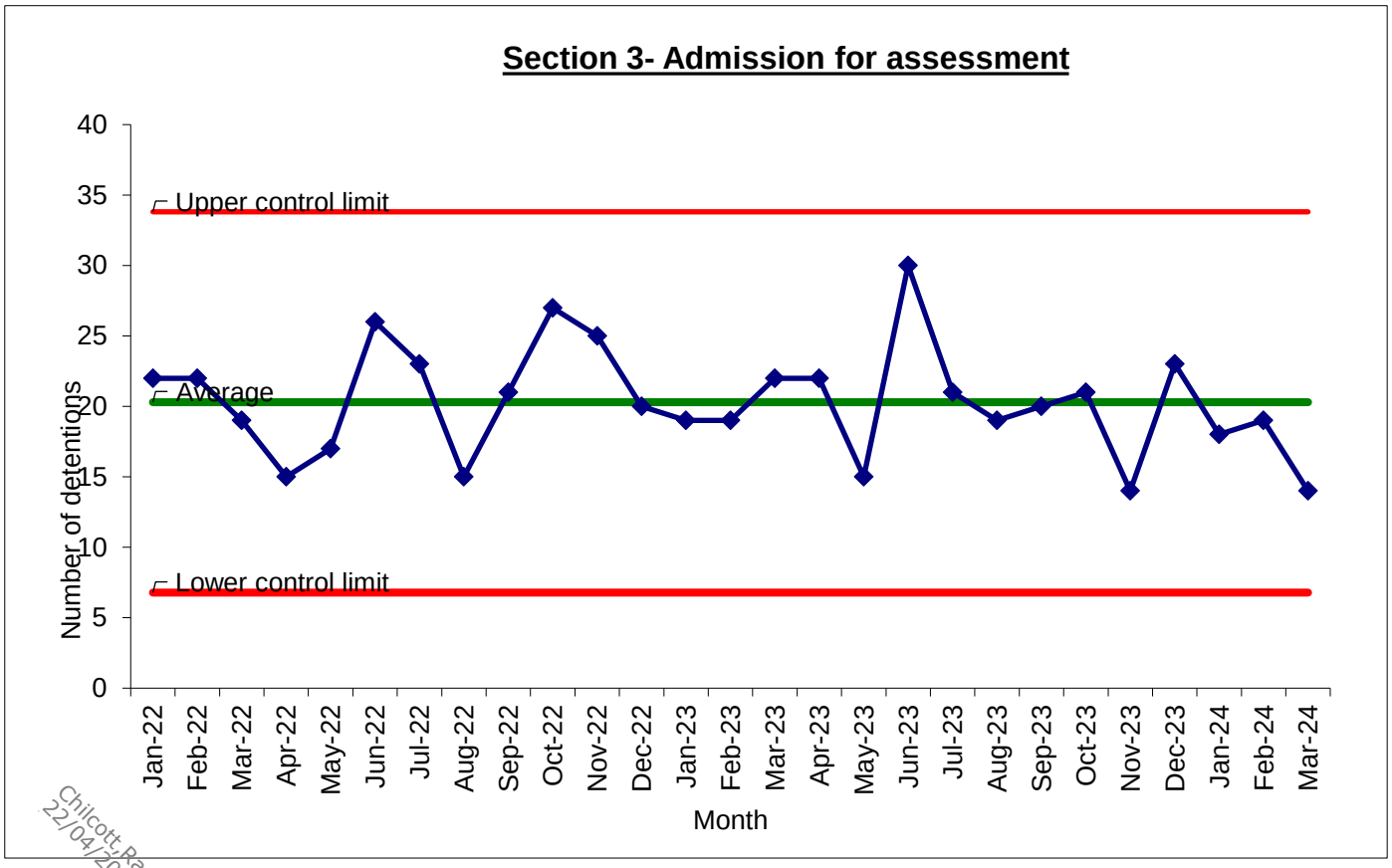
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

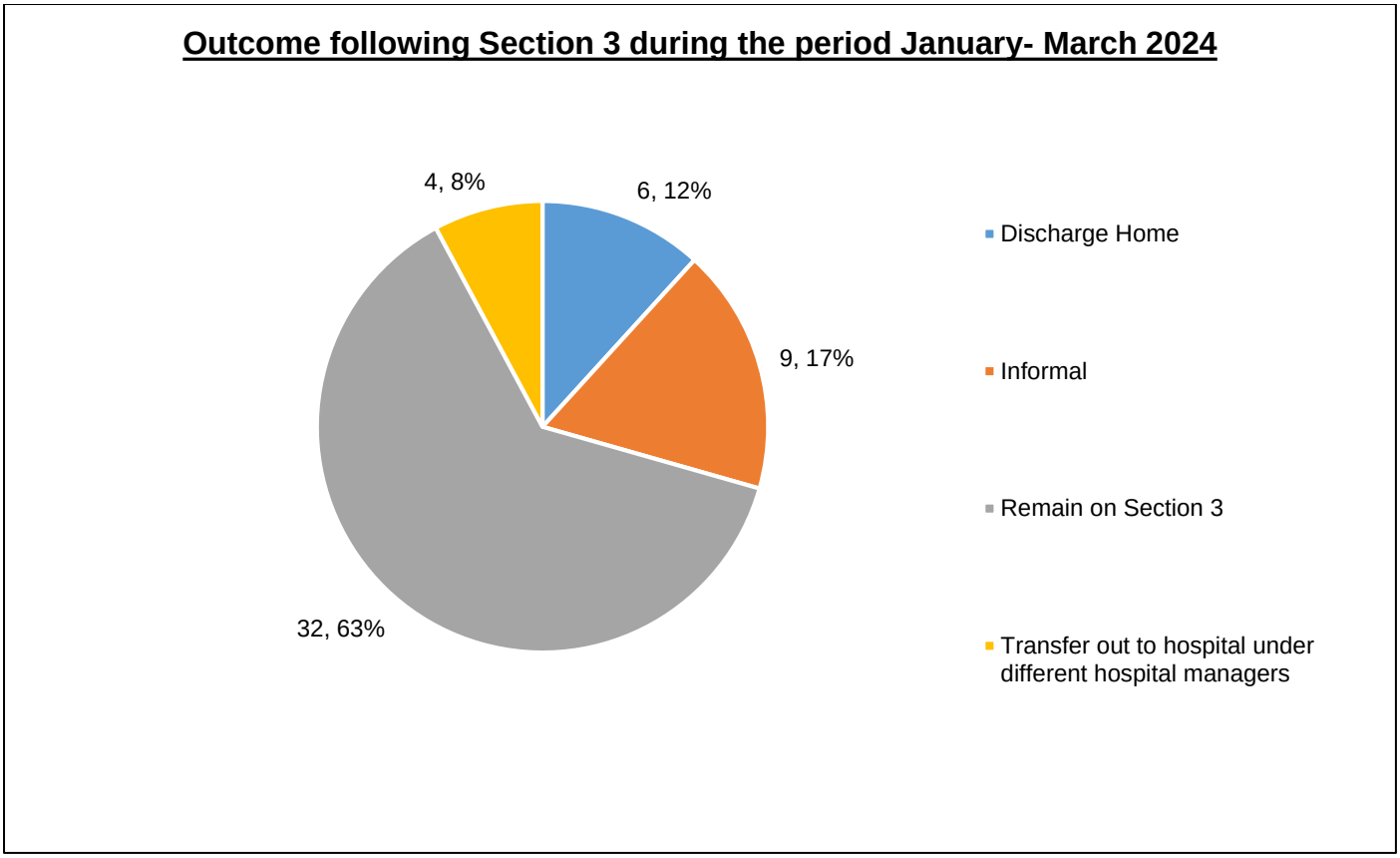


Section 3 – Admission for Treatment



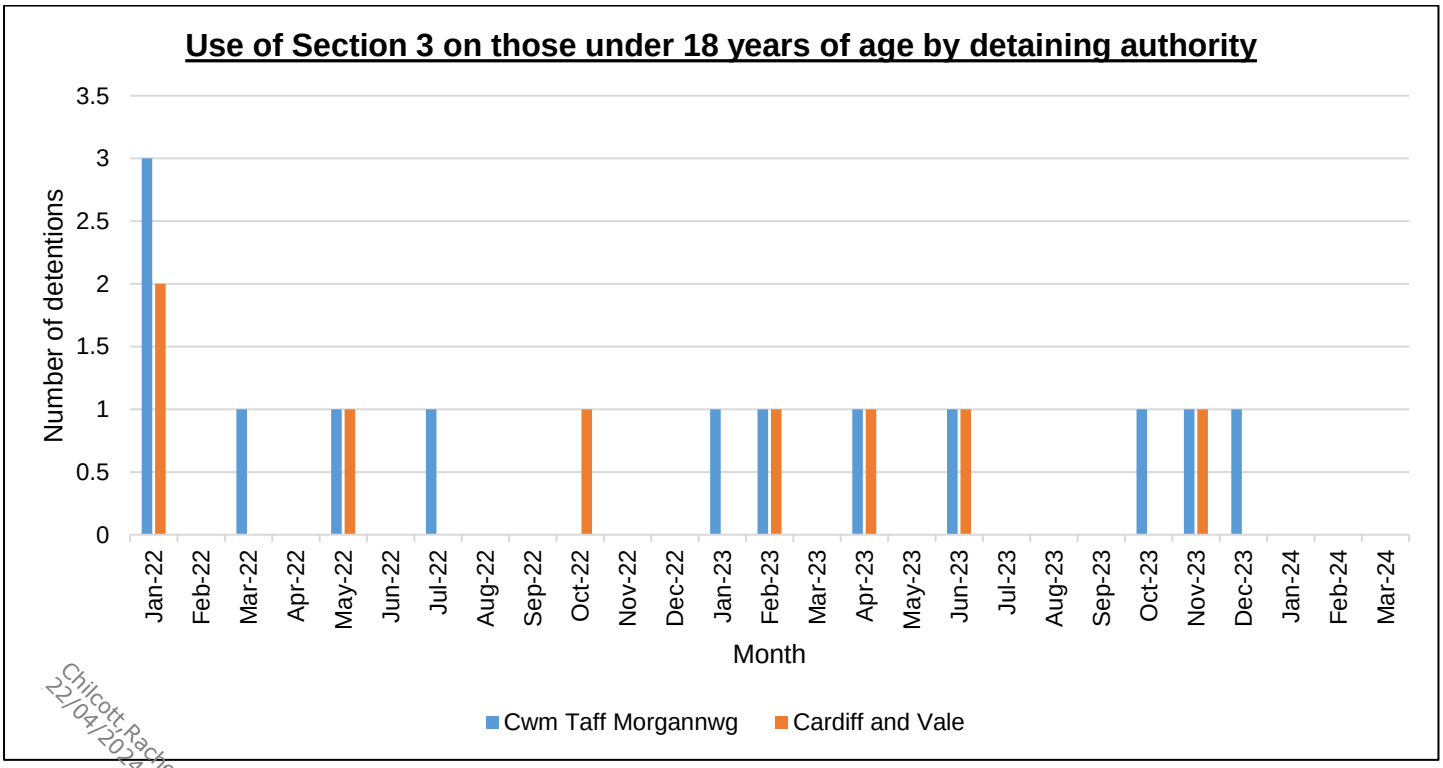


The above data would include those under 18 years of age.



CAMHS Commissioned Inpatient Data

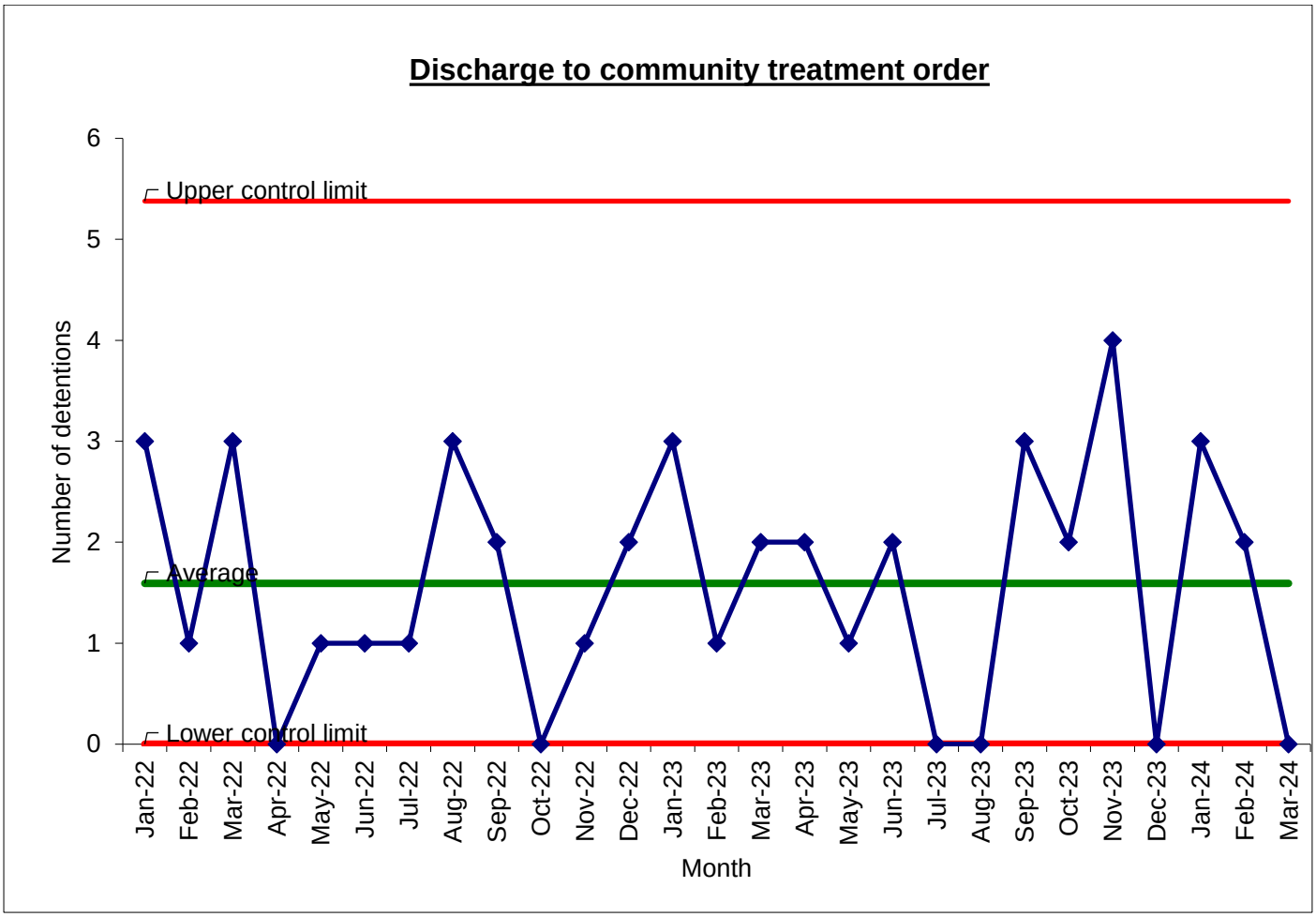
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients. There were no uses of Section 3 during the period.

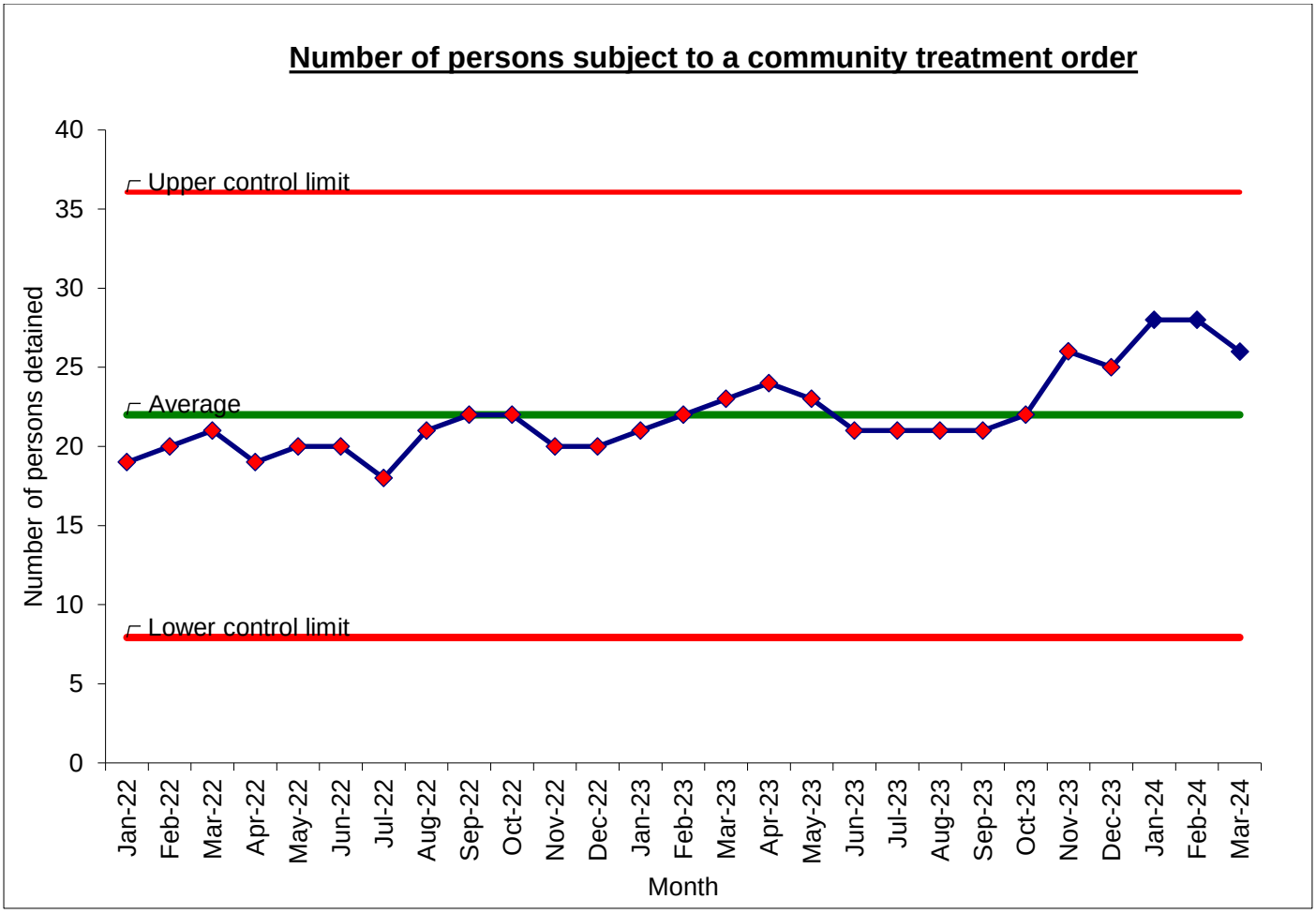


Community Treatment Order

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

As at 31st March 2024, twenty-six 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 three times. Two uses resulted in the persons CTO being revoked. One use resulted in the person remaining on their CTO.

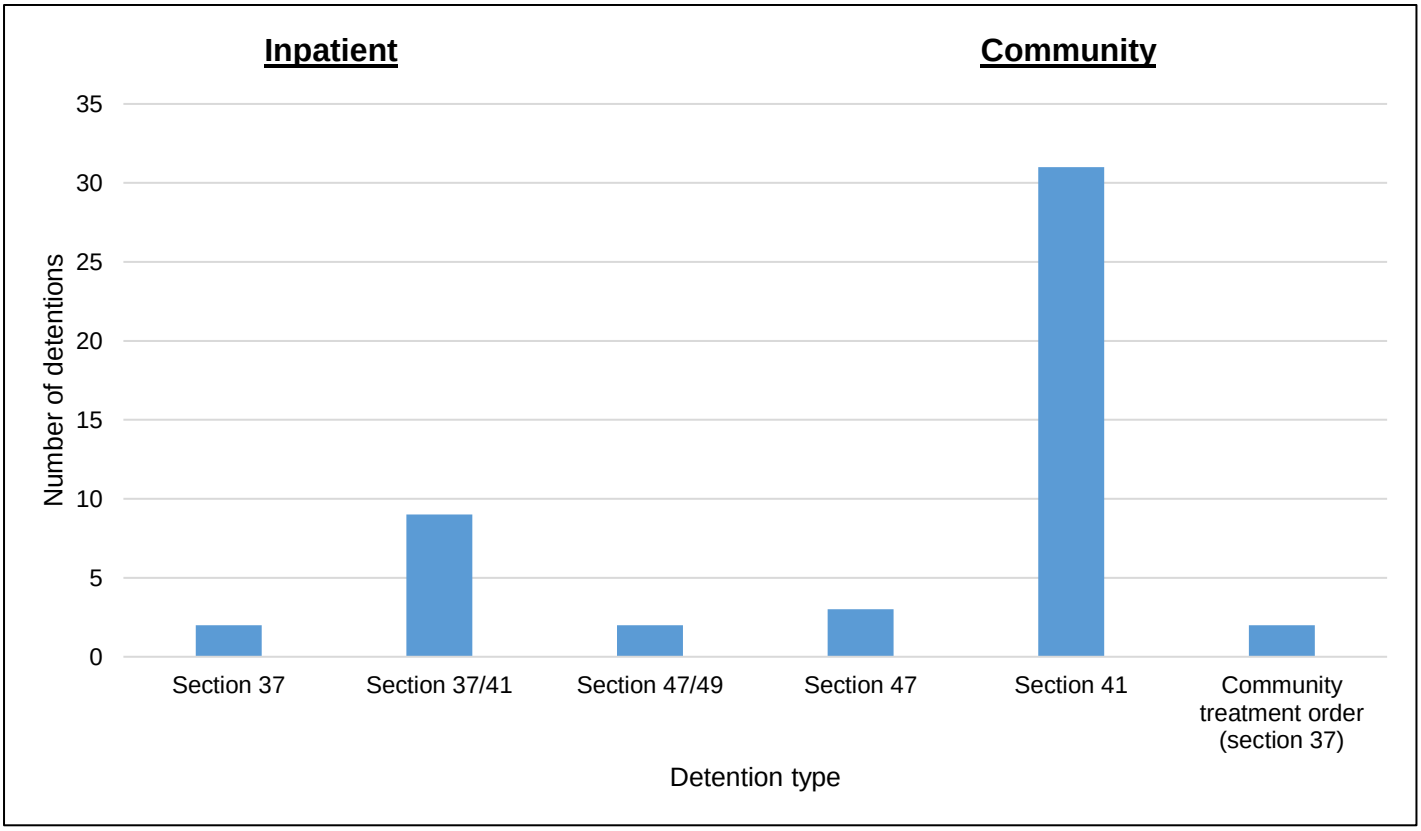
CAMHS Commissioned Inpatient Data

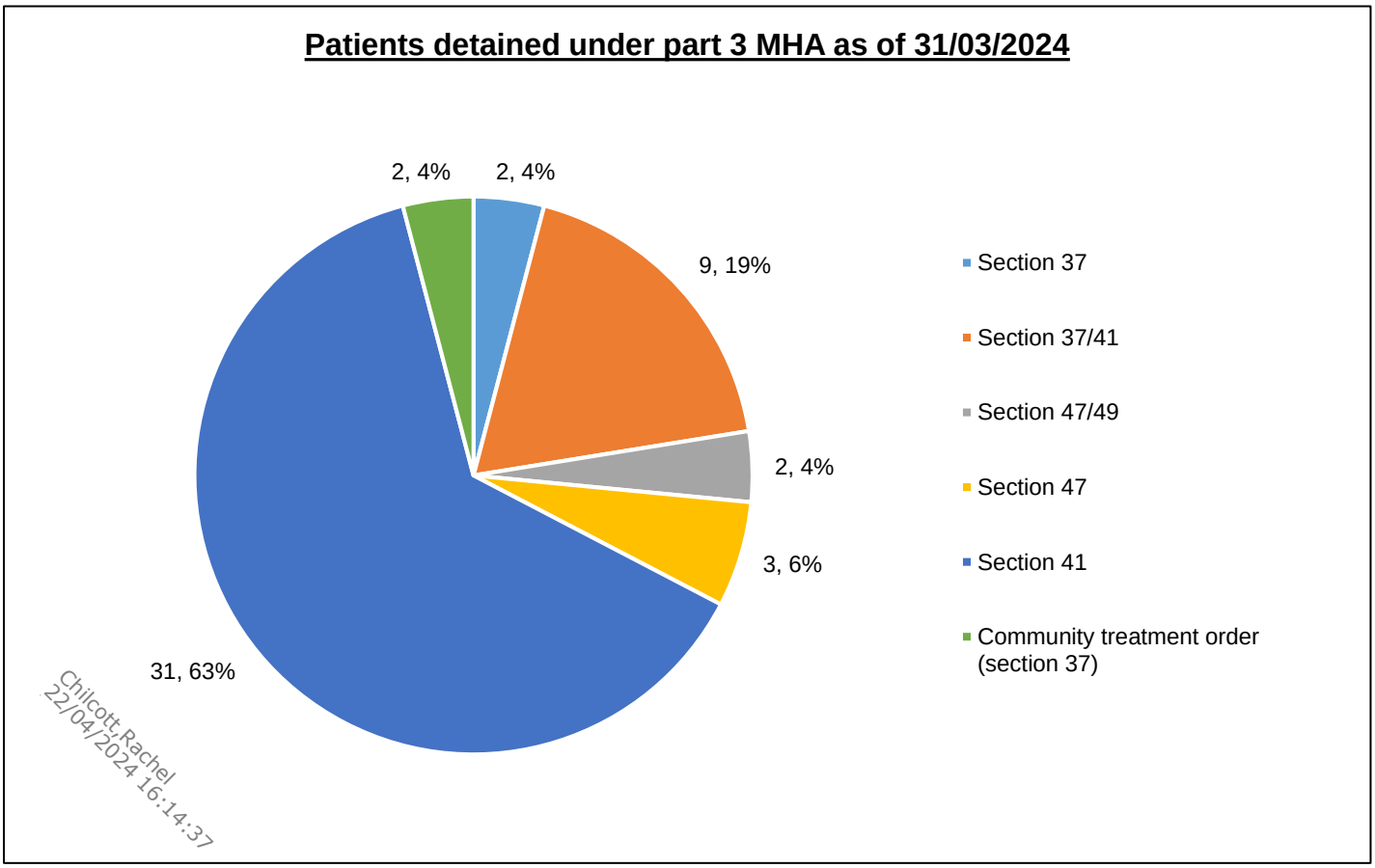
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During this period there no uses of Community Treatment Orders for persons under the age of 18 years of age.

Part 3 of the Mental Health Act 1983

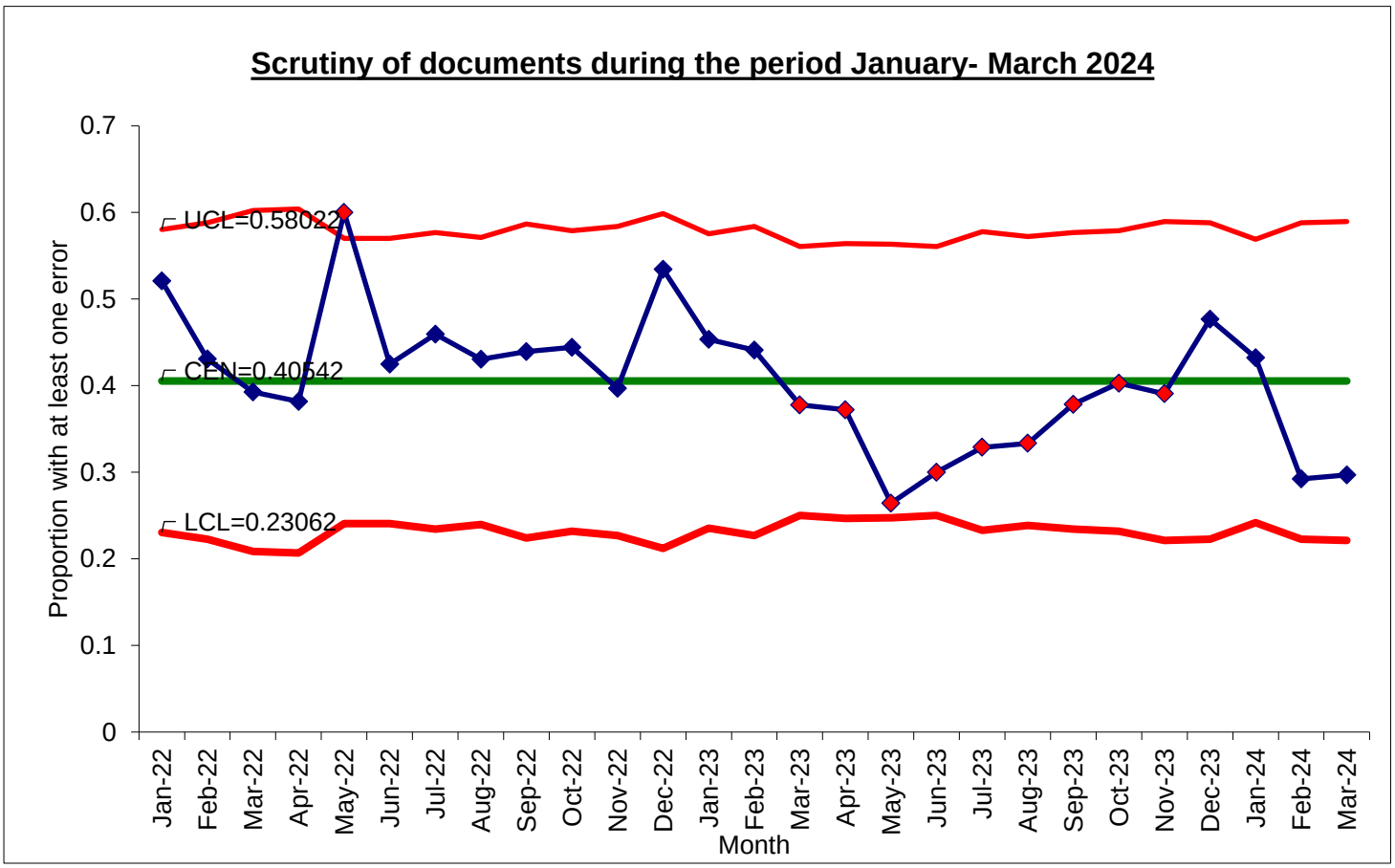
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st March 2024.

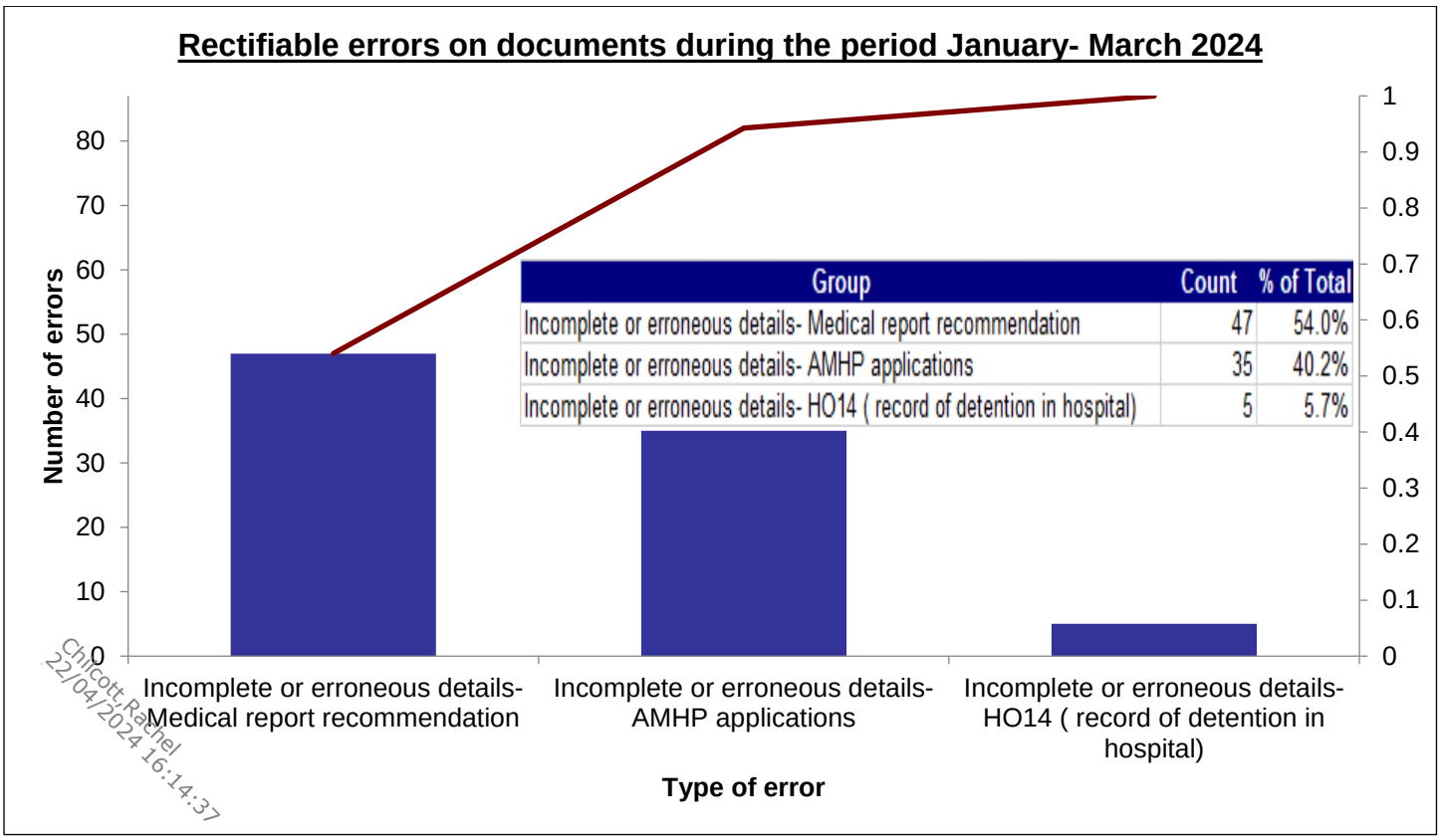




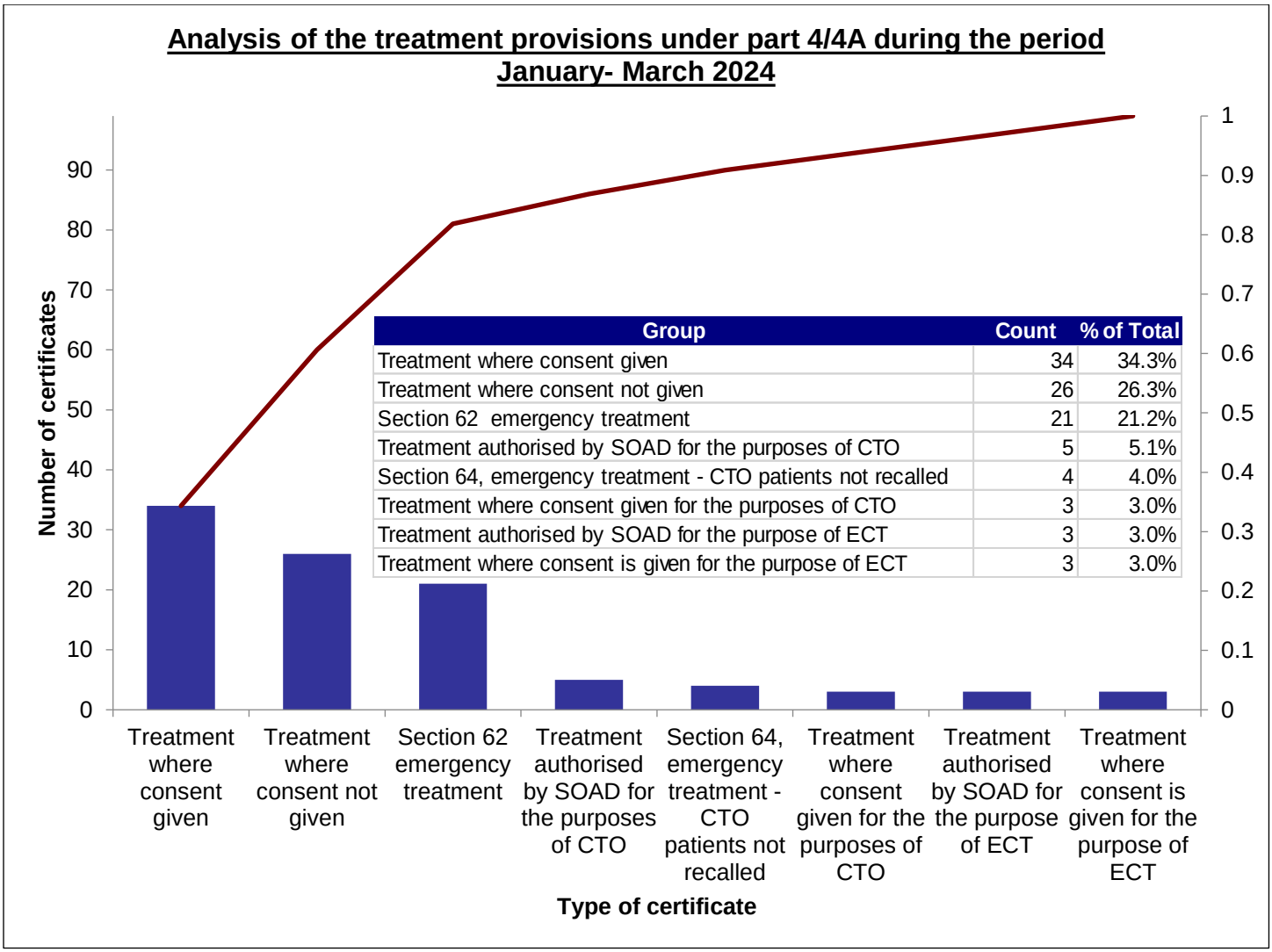
Scrutiny of documents during the period

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





Consent to Treatment



Group	Count	% of Total
Treatment where consent given	34	34.3%
Treatment where consent not given	26	26.3%
Section 62 emergency treatment	21	21.2%
Treatment authorised by SOAD for the purposes of CTO	5	5.1%
Section 64, emergency treatment - CTO patients not recalled	4	4.0%
Treatment where consent given for the purposes of CTO	3	3.0%
Treatment authorised by SOAD for the purpose of ECT	3	3.0%
Treatment where consent is given for the purpose of ECT	3	3.0%

Urgent Treatment

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

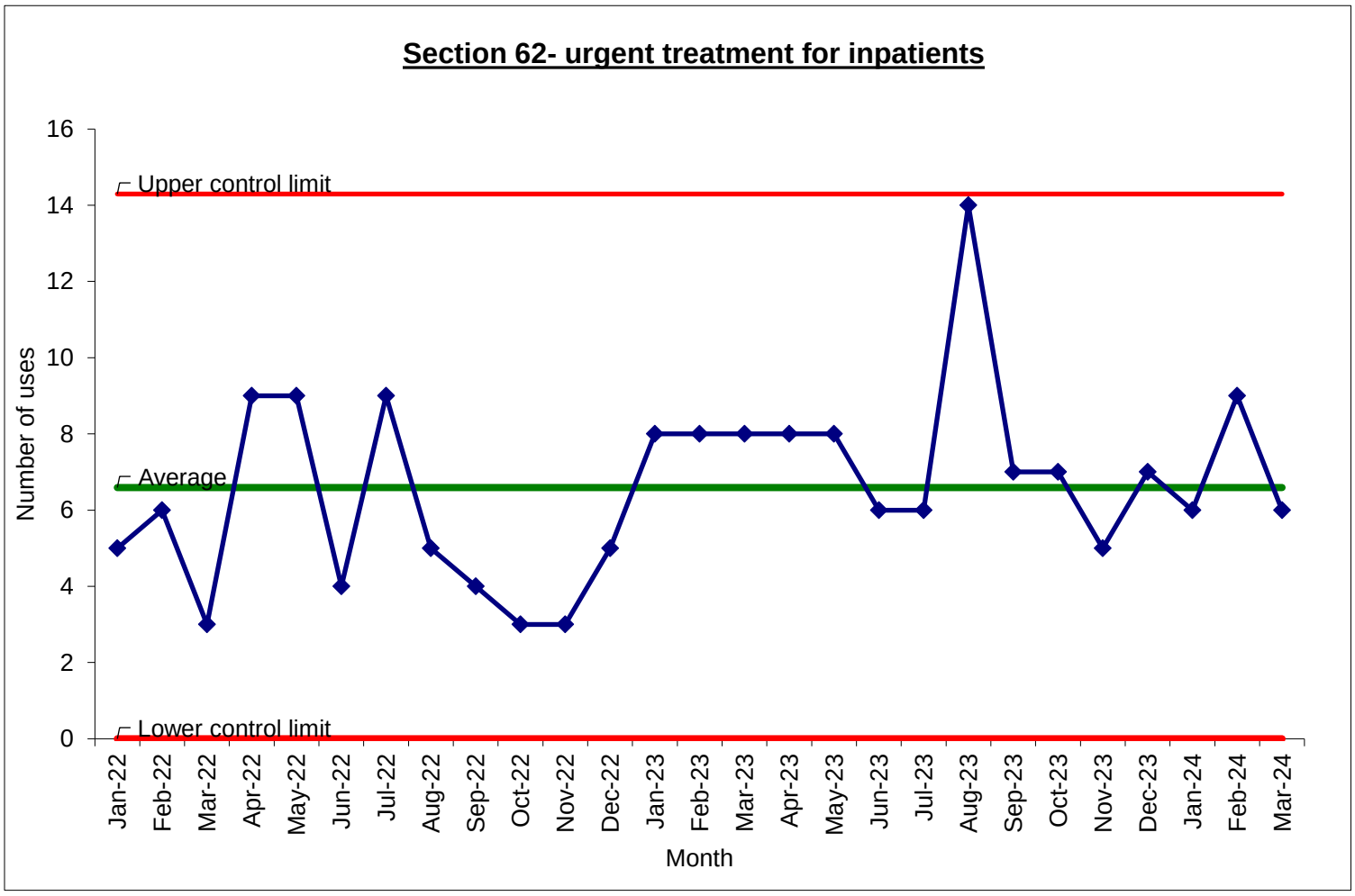
Urgent treatment is defined as treatment that is:

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

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

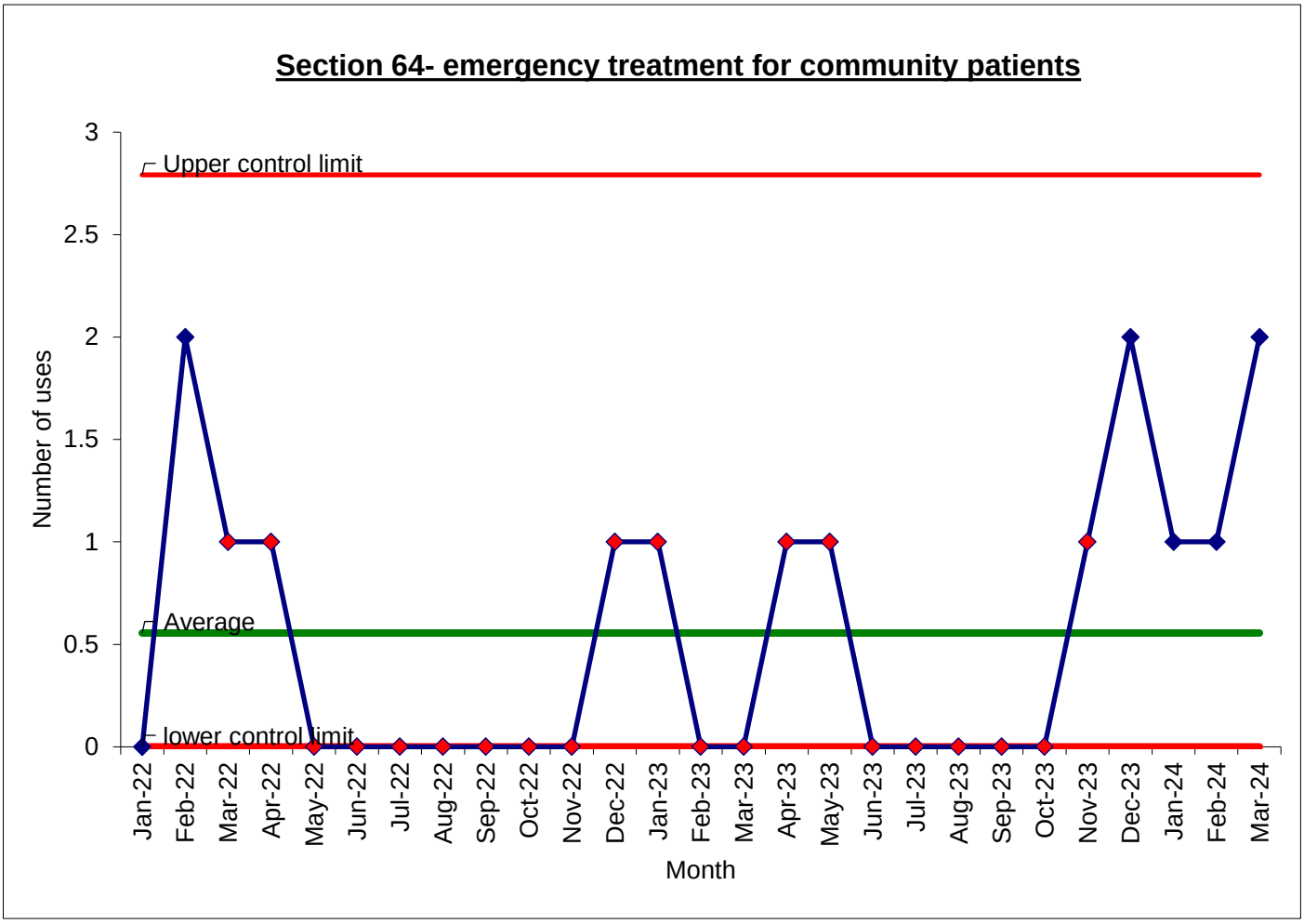
Urgent treatment can be used in any of the following instances:

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



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

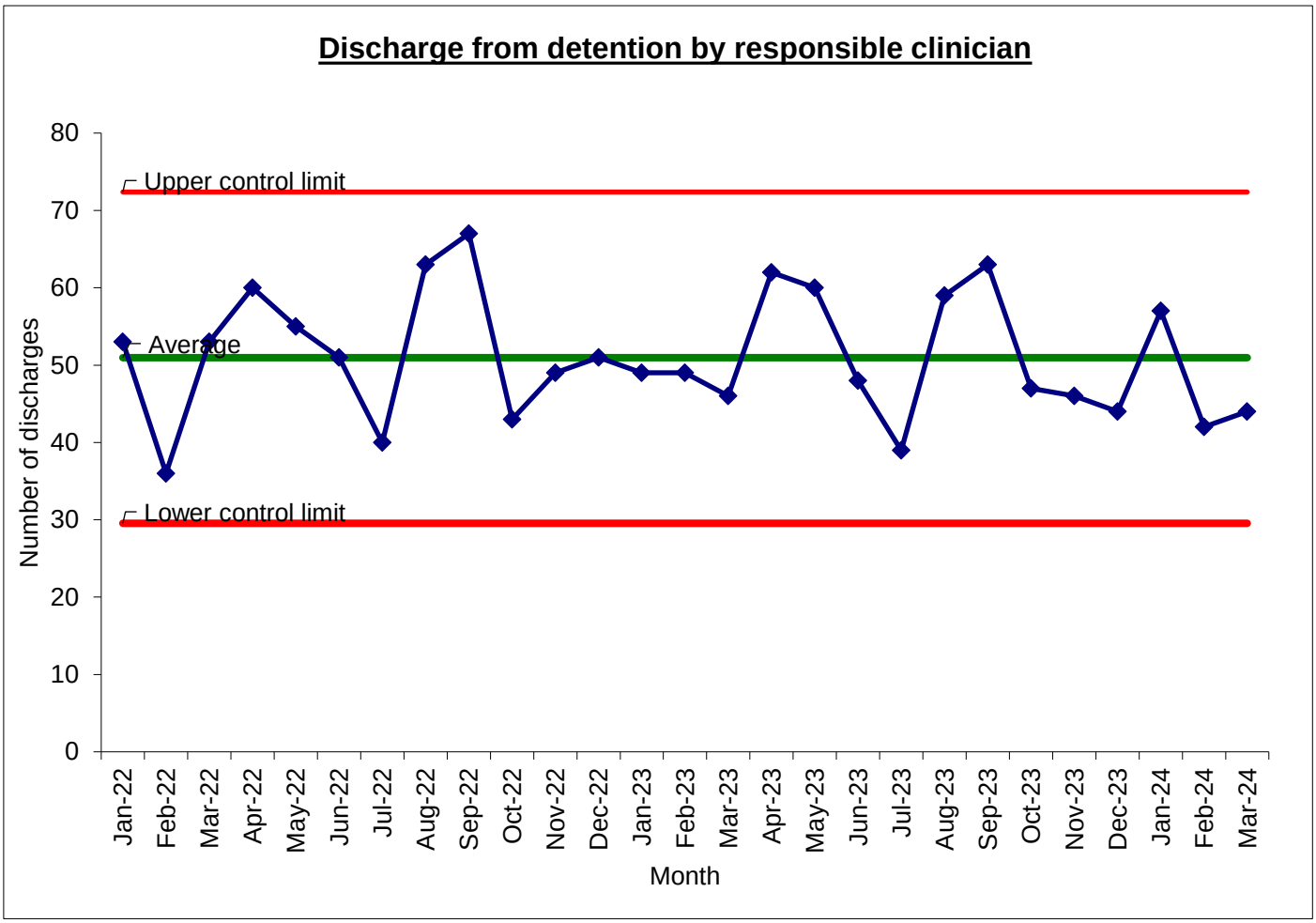
- Pending SOAD 3-month rule x 11
- Change of medication x 4
- Pending SOAD authorisation for ECT x 1
- Time limited certificate expired- waiting new SOAD authorisation x 1
- Change of capacity x 1
- Patient lacked capacity upon revoke x 3

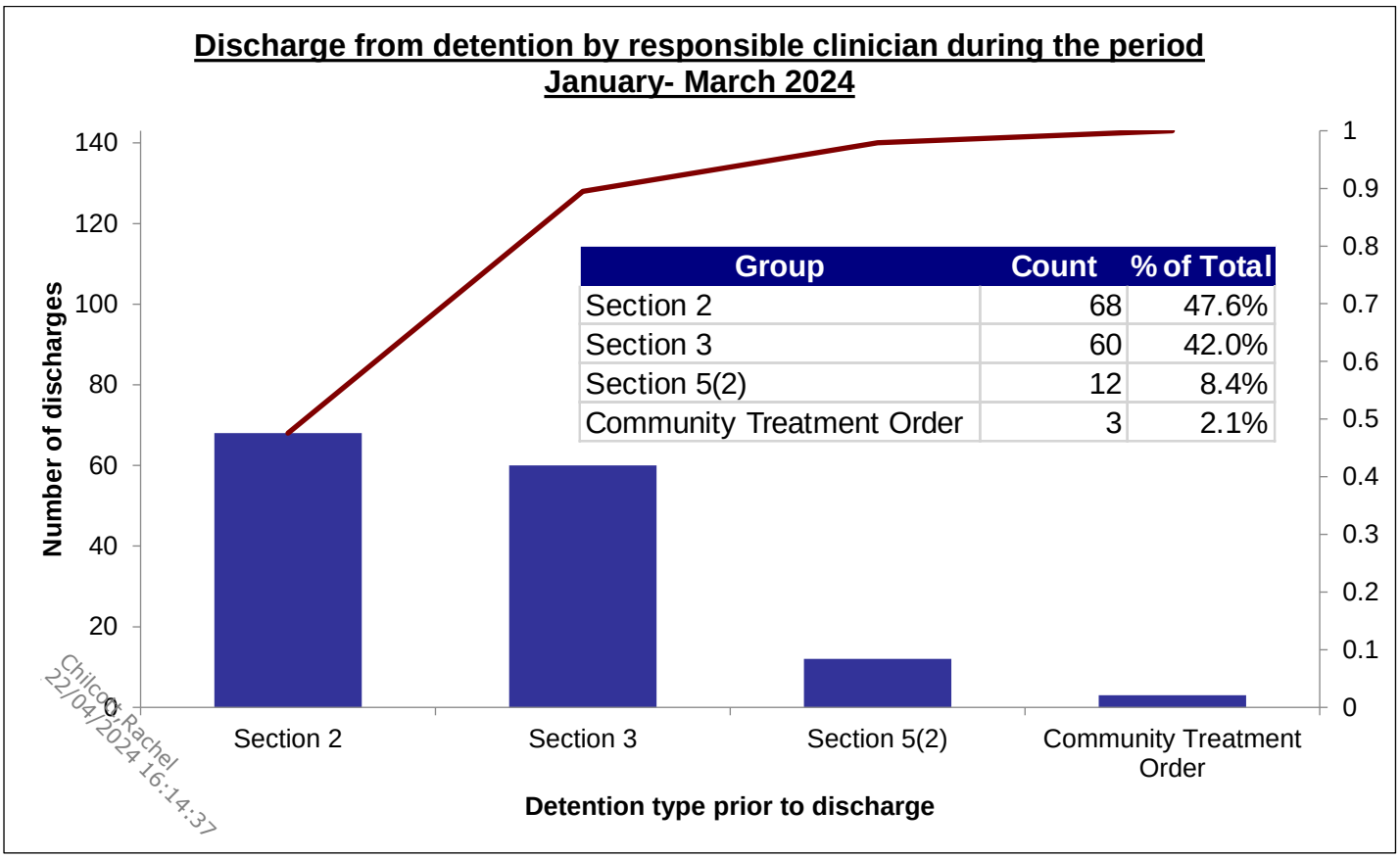


The above chart highlights that Section 64 was used four times during this period.

- Change of medication x 2
- Upon recall of CTO- extra medication needed x 1
- One month rule x 1

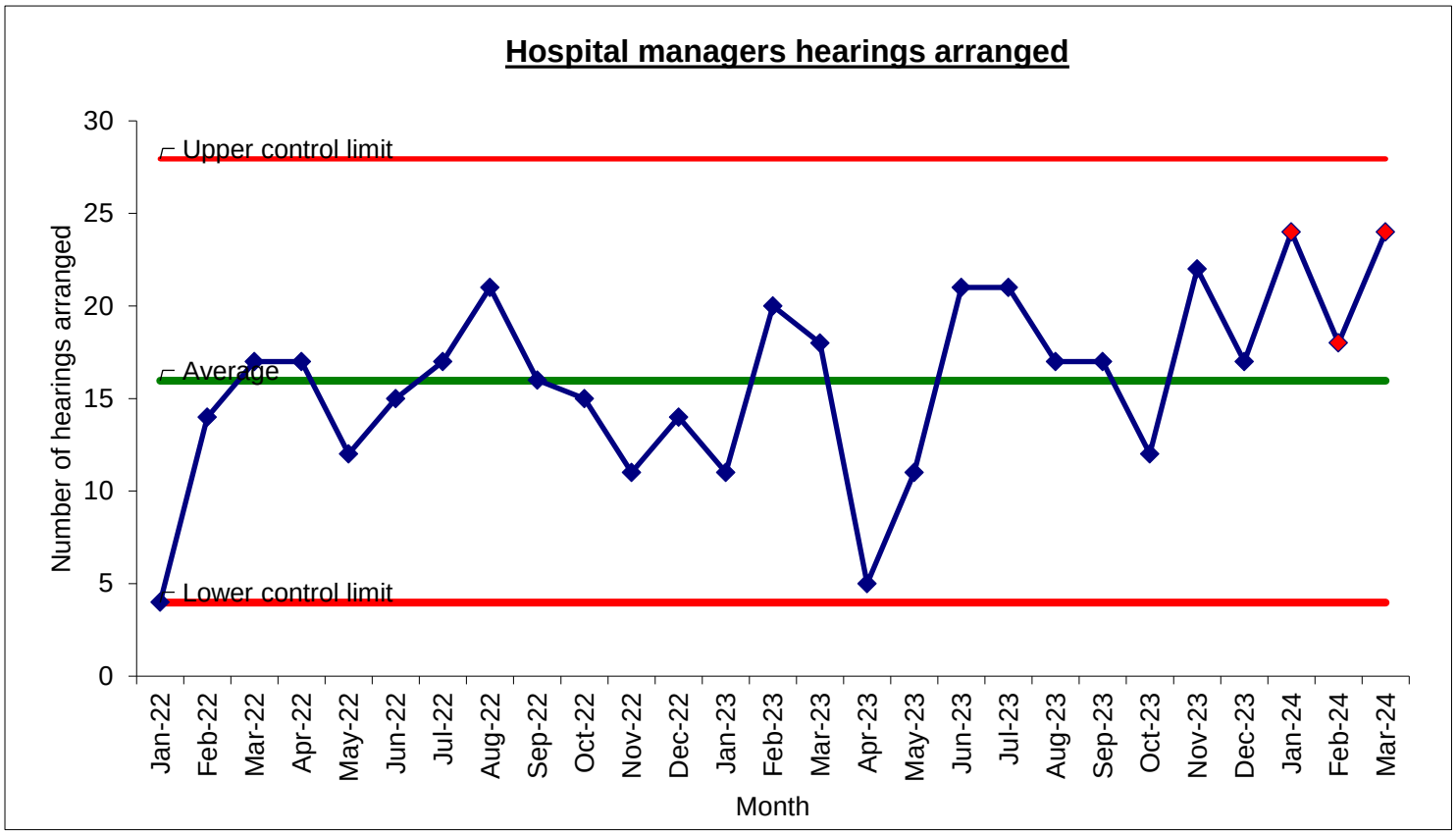
Discharge

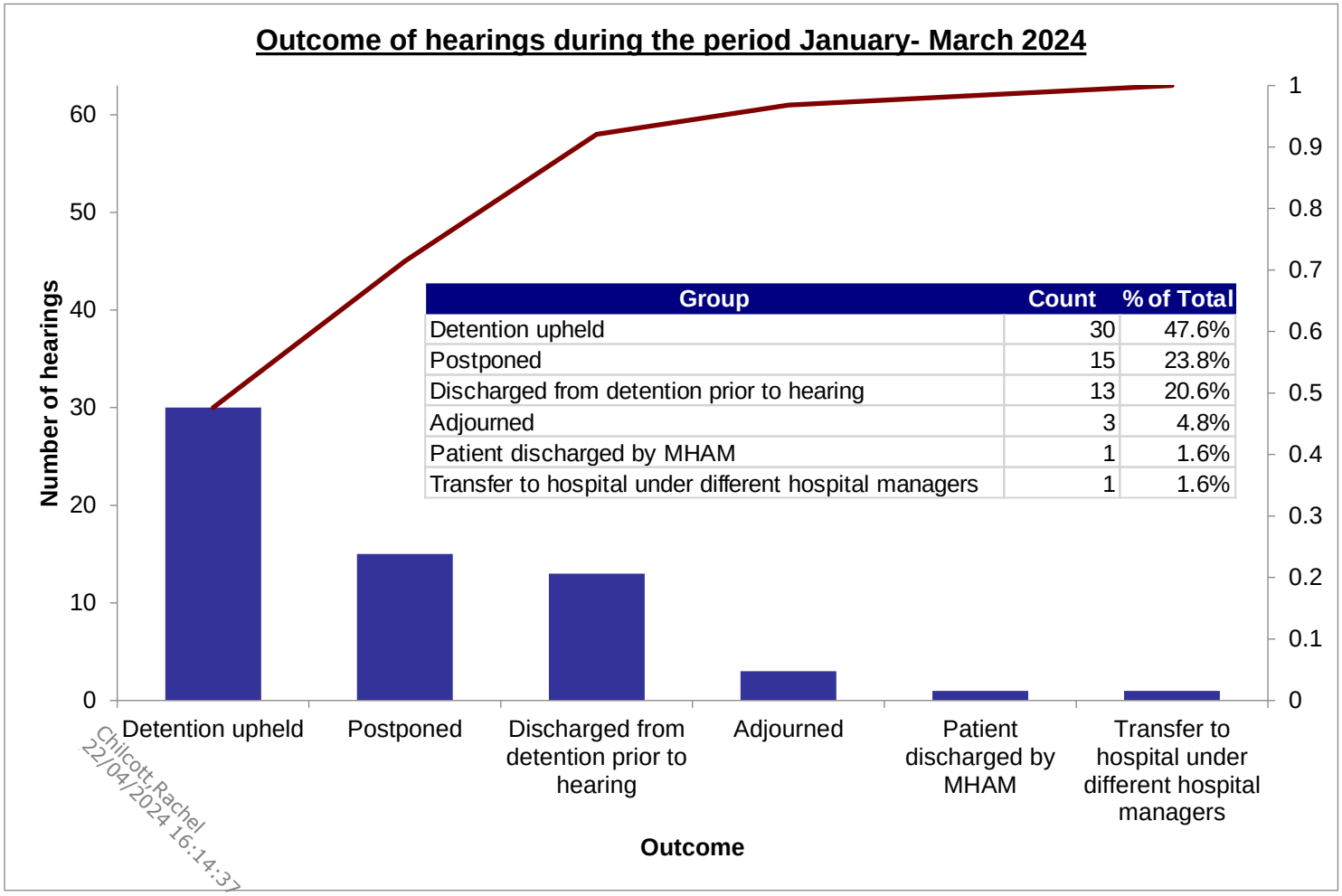




Group	Count	% of Total
Section 2	68	47.6%
Section 3	60	42.0%
Section 5(2)	12	8.4%
Community Treatment Order	3	2.1%

Hospital Managers – Power of Discharge





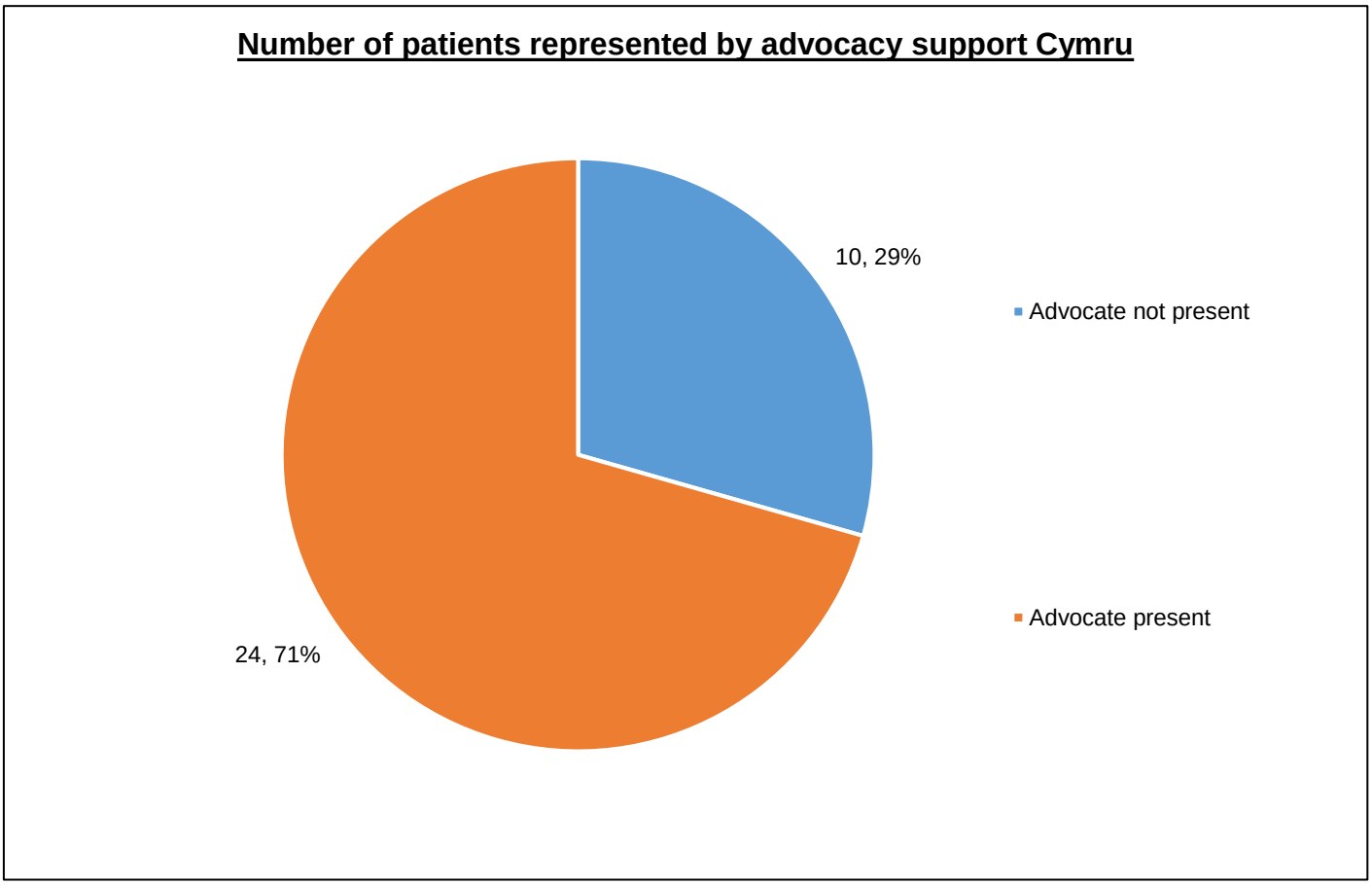
Group	Count	% of Total
Detention upheld	30	47.6%
Postponed	15	23.8%
Discharged from detention prior to hearing	13	20.6%
Adjourned	3	4.8%
Patient discharged by MHAM	1	1.6%
Transfer to hospital under different hospital managers	1	1.6%

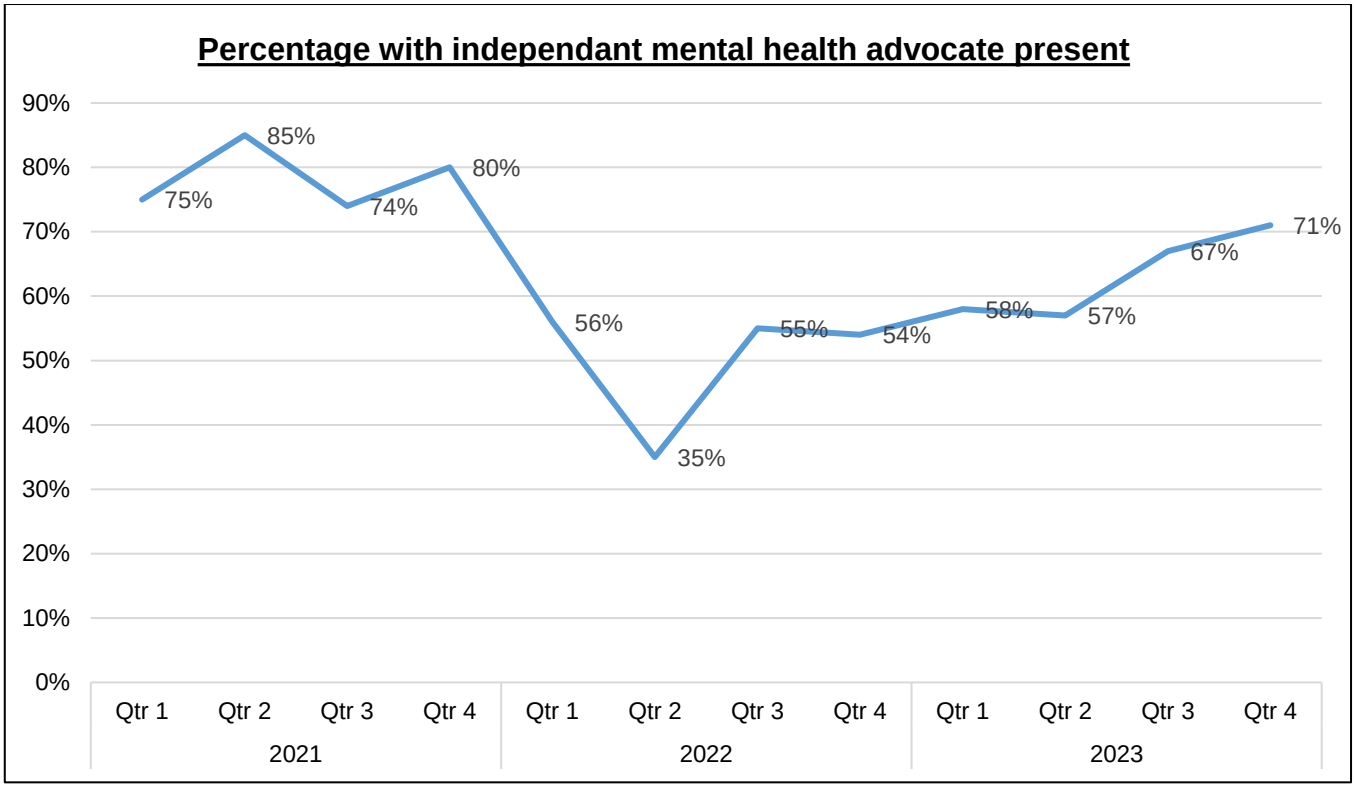
Three hearings were adjourned for the following reasons:

- Responsible clinician availability x 1
- Care and treatment plan needed x 1
- Patient hadn't accessed reports x1

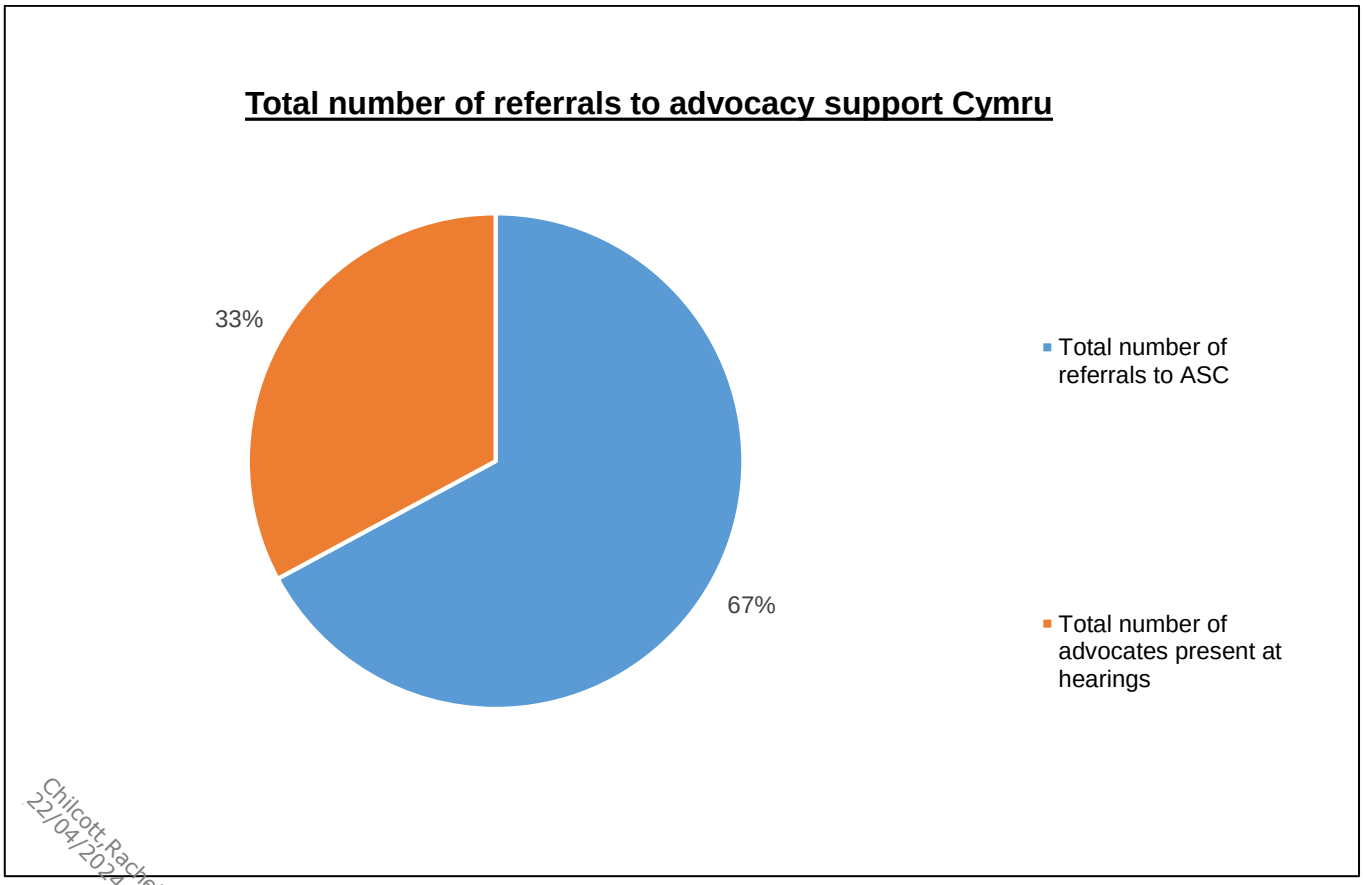
Fifteen hearings were postponed for the following reasons:

- Responsible Clinician unavailable x 11
- Patient physically unwell in general hospital x 2
- Advocacy Support Cymru x 1
- Patient disengaged from services x 1



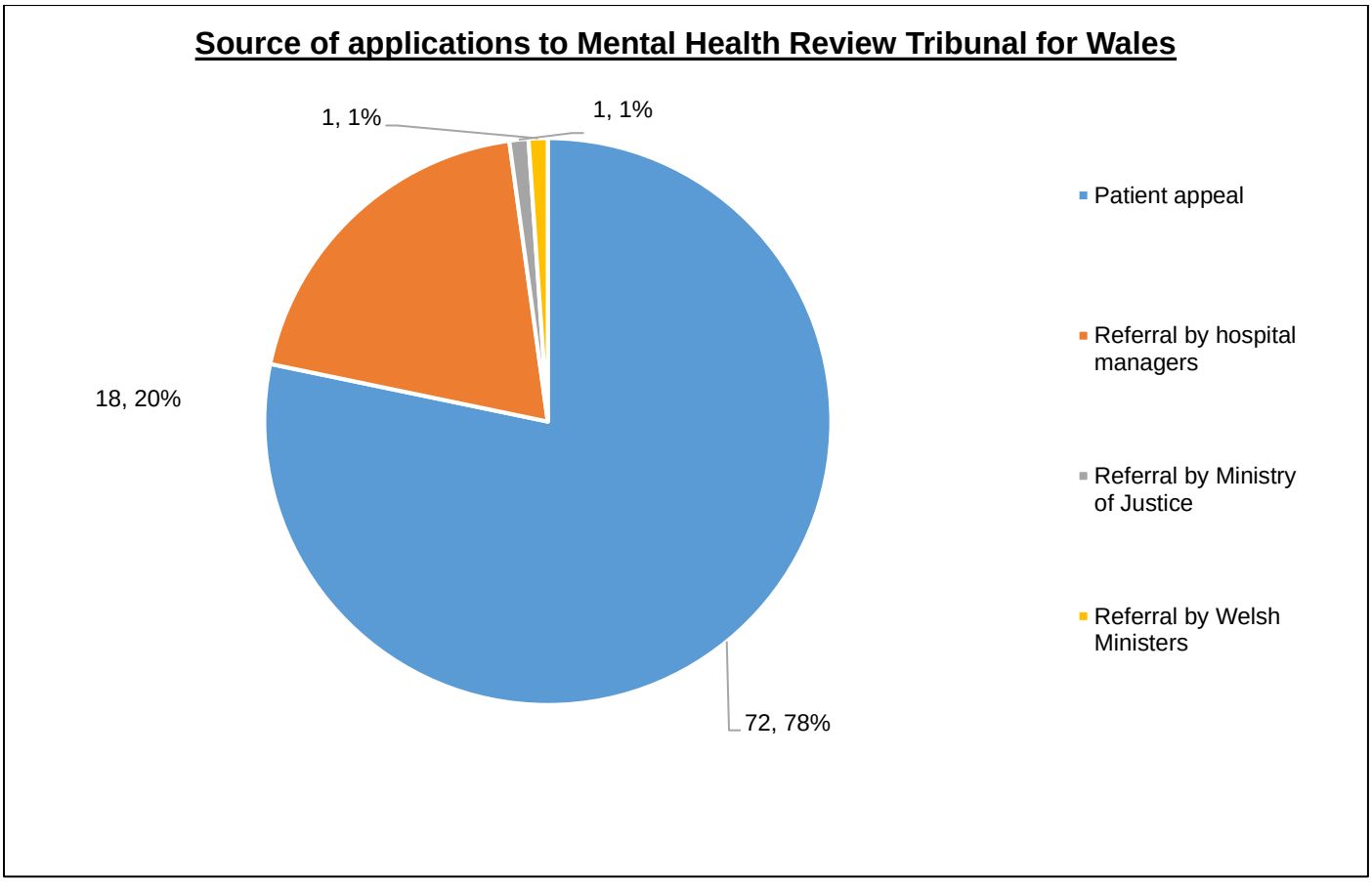


During the period the Mental Health Act Office made forty nine referrals to Advocacy Support Cymru where the patient was deemed not to have capacity to make this decision. Twenty five of the hearings of the hearings were either postponed/cancelled and therefore weren't attended by an advocate.

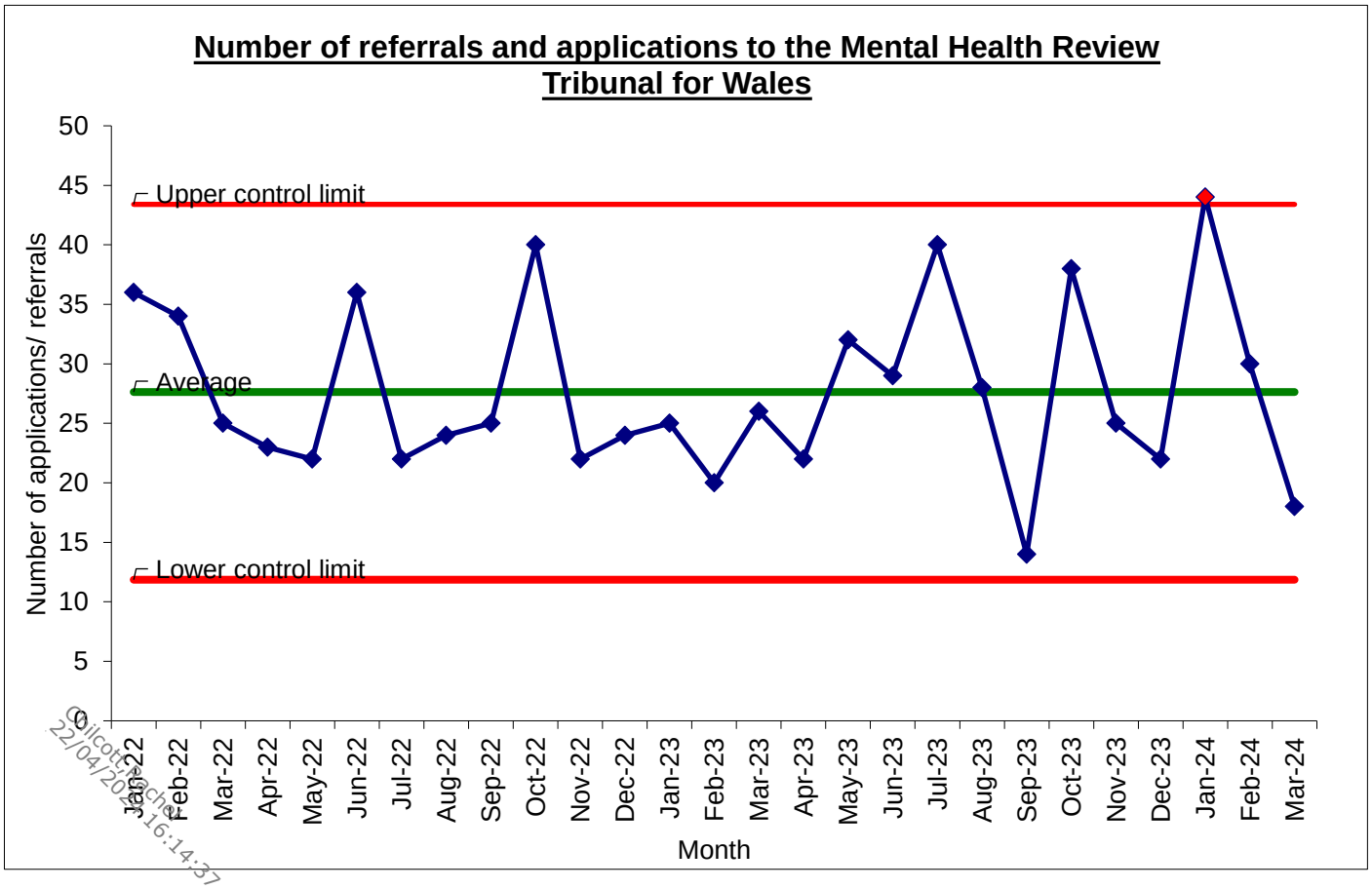


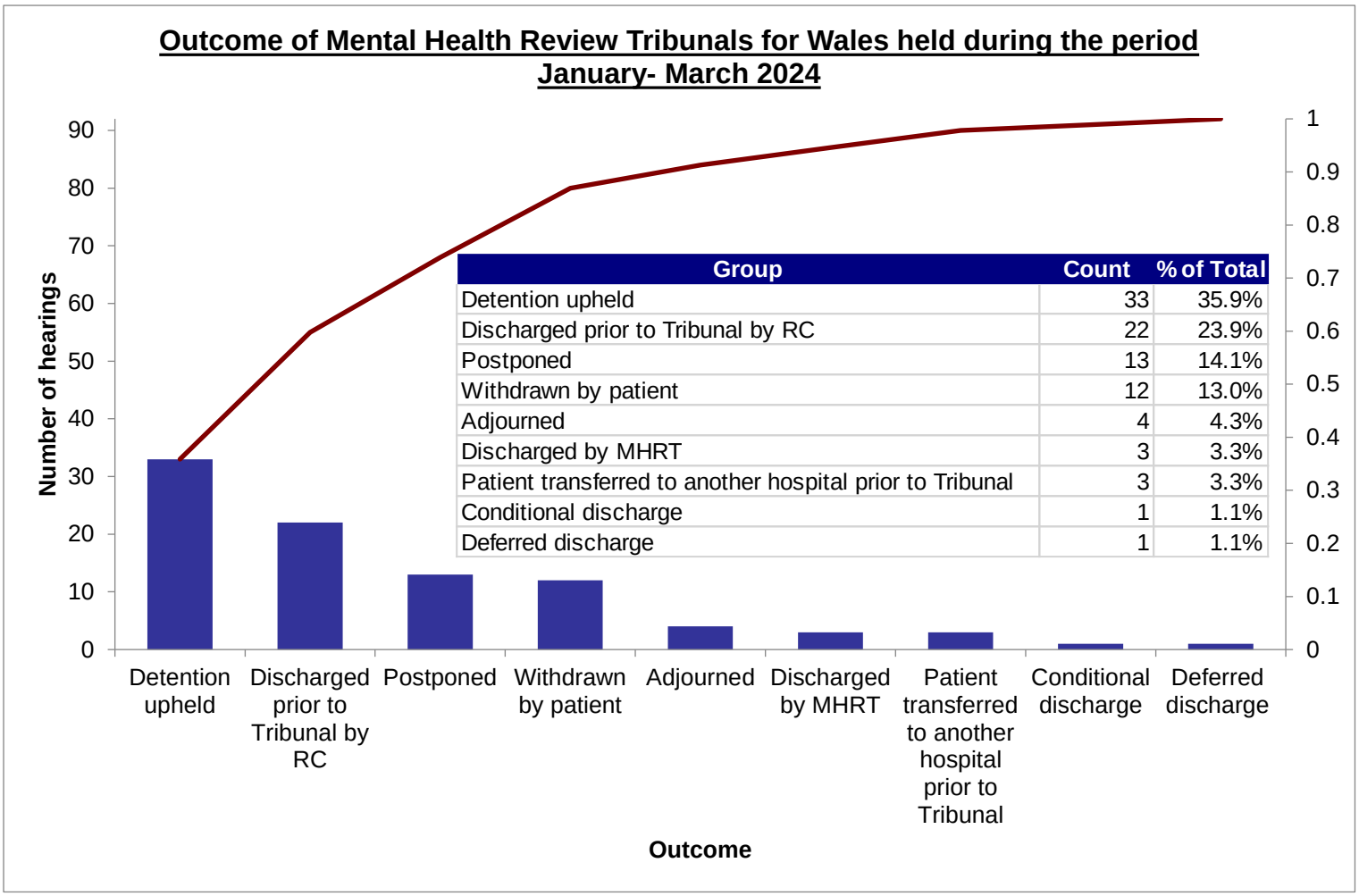
Mental Health Review Tribunal (MHRT) for Wales

Source of applications to Mental Health Review Tribunal for Wales



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





Group	Count	% of Total
Detention upheld	33	35.9%
Discharged prior to Tribunal by RC	22	23.9%
Postponed	13	14.1%
Withdrawn by patient	12	13.0%
Adjourned	4	4.3%
Discharged by MHRT	3	3.3%
Patient transferred to another hospital prior to Tribunal	3	3.3%
Conditional discharge	1	1.1%
Deferred discharge	1	1.1%

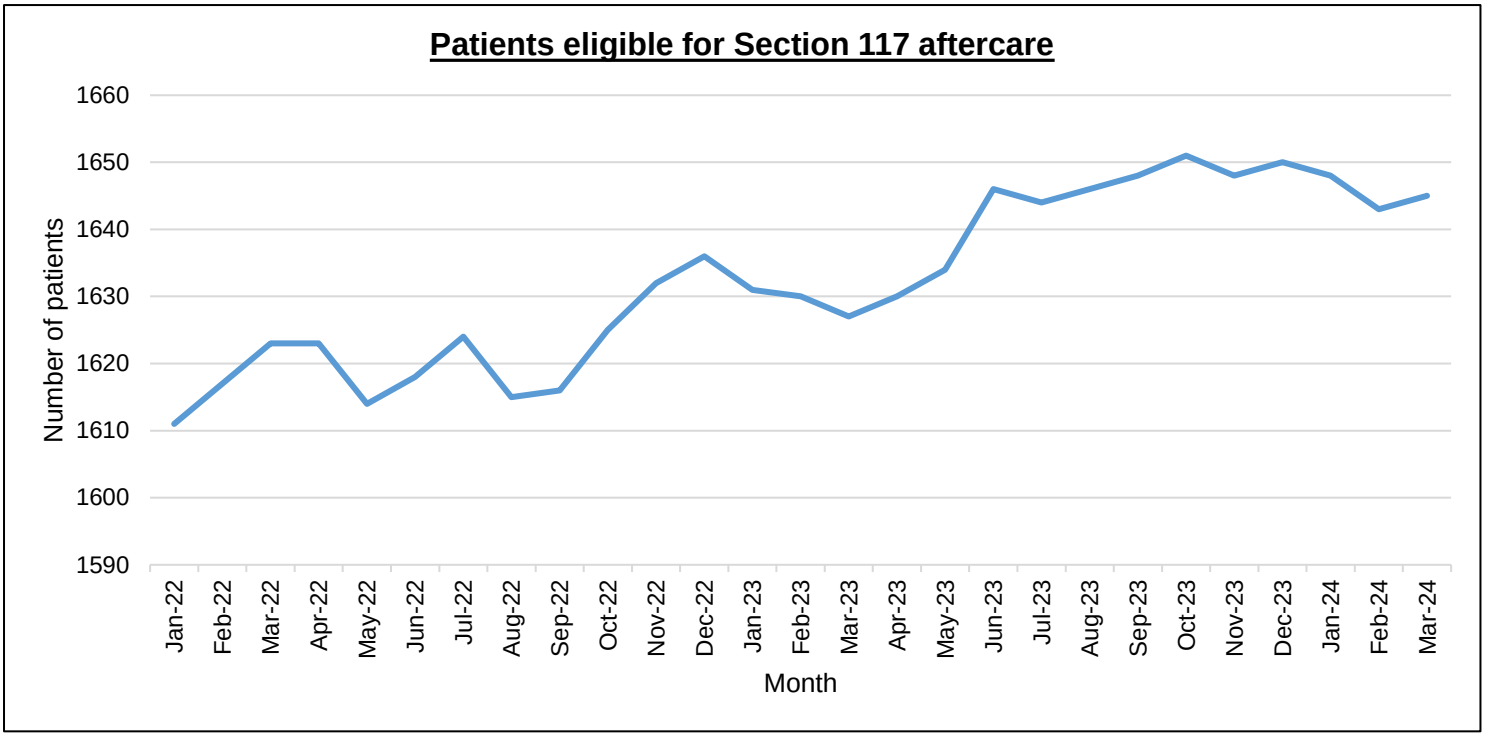
Four hearings were adjourned for the following reasons:

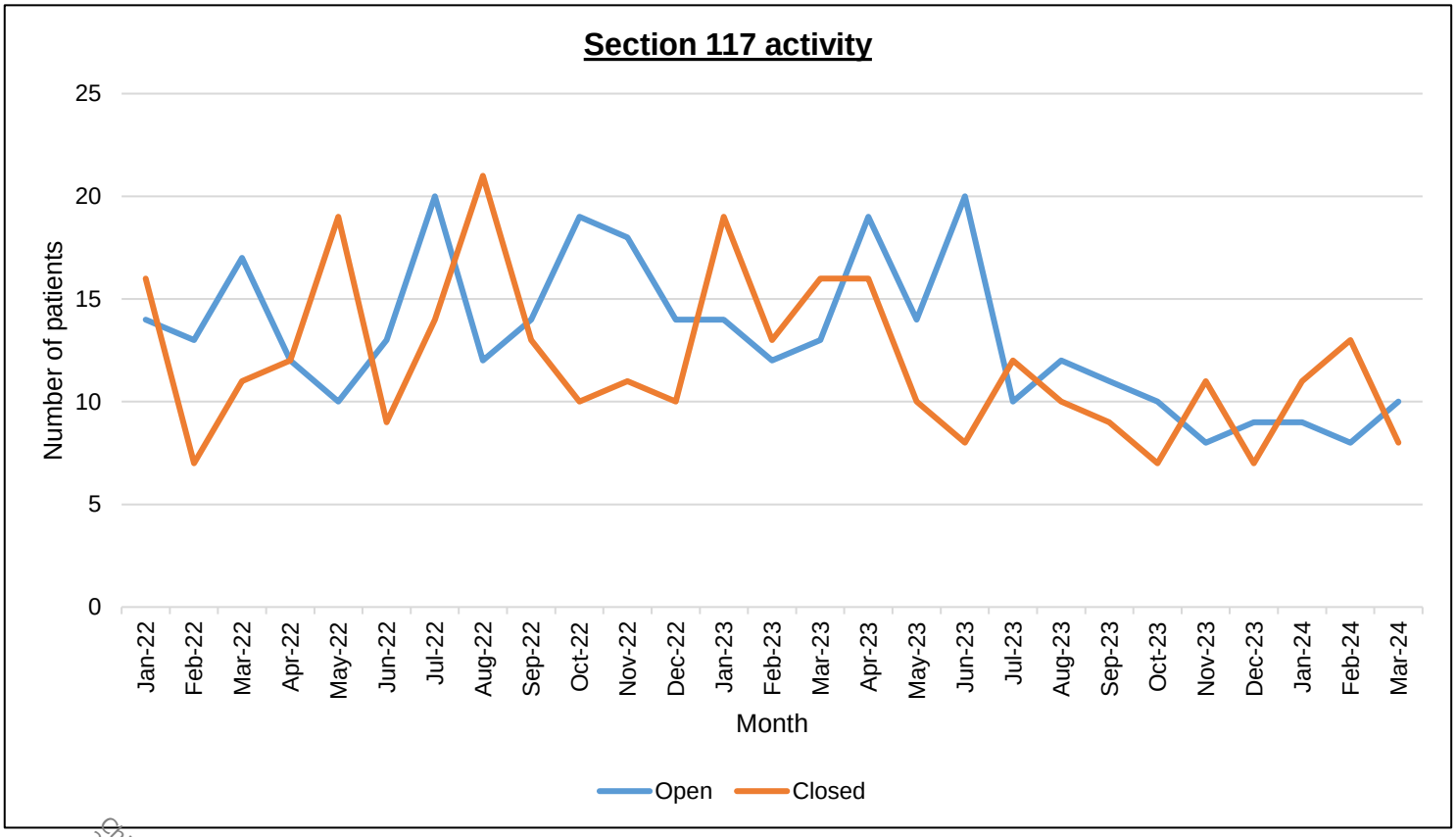
- Additional information needed x 1
- Care coordinator unavailable x1
- Reports unavailable x 1
- Discharge planning meeting needed x 1

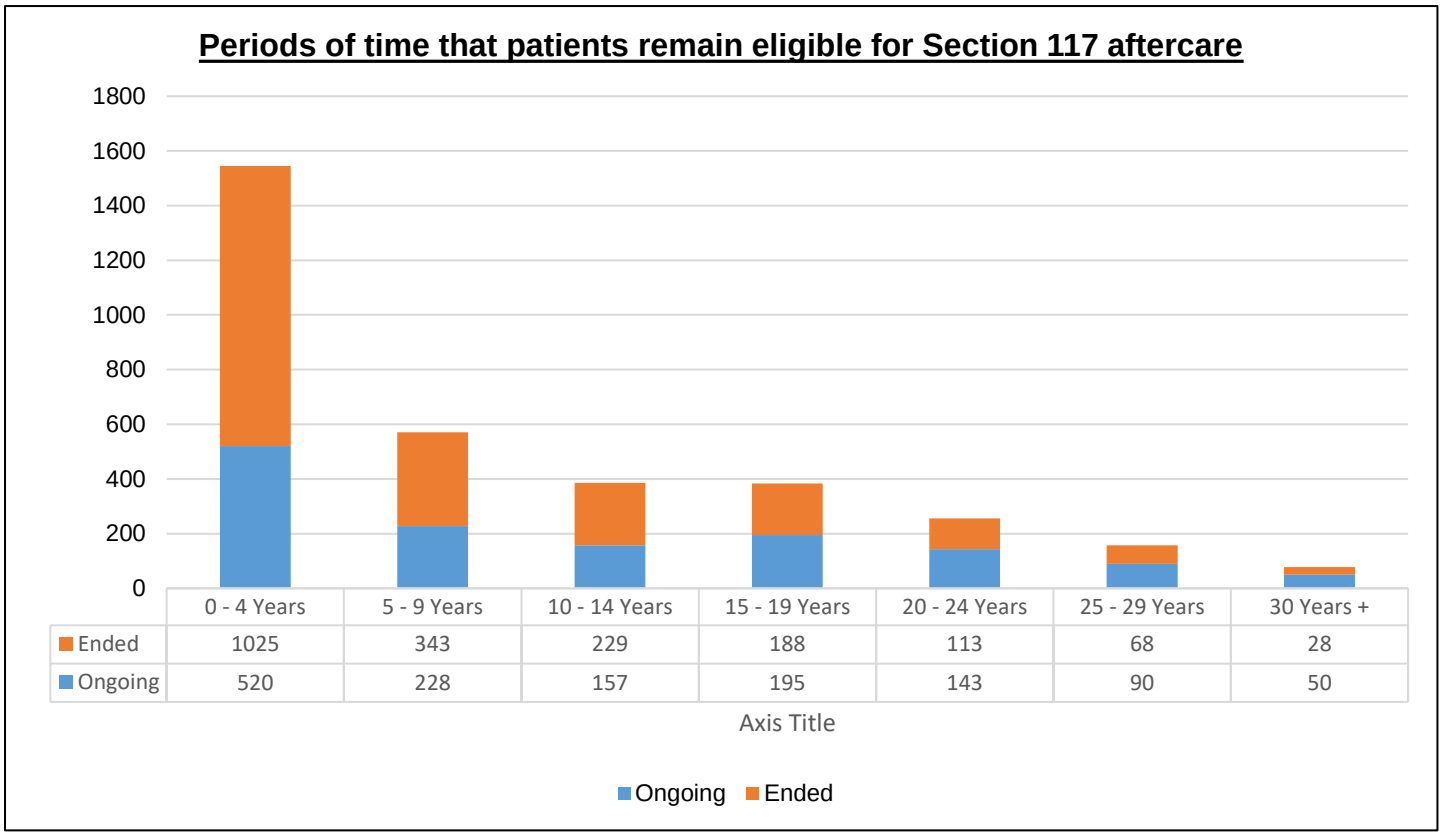
Thirteen hearings were postponed for the following reasons:

- RC availability x 3
- Social worker availability x 4
- Legal representative x 4
- Panel member unavailable x1
- Room not available x 1

Section 117 Aftercare







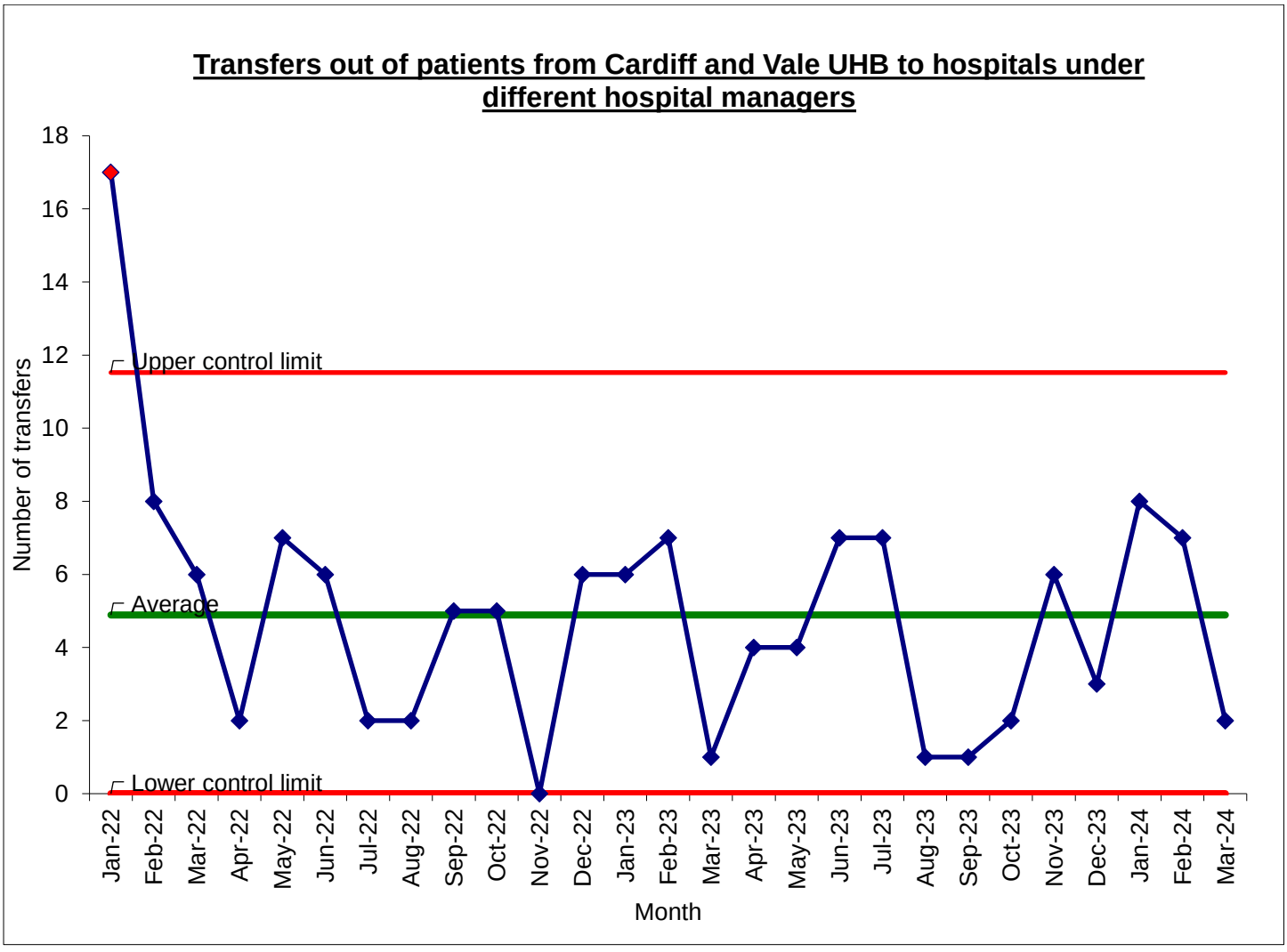
Section 19 transfers to and from Cardiff and Vale UHB

During the period:

Sixteen 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:

- Nine to PICU beds out of area
- Four to specialist placements
- Three back to their home area

One patient detained under Part 3 of the Mental Health Act was transferred from Cardiff and Vale UHB to a medium secure unit.



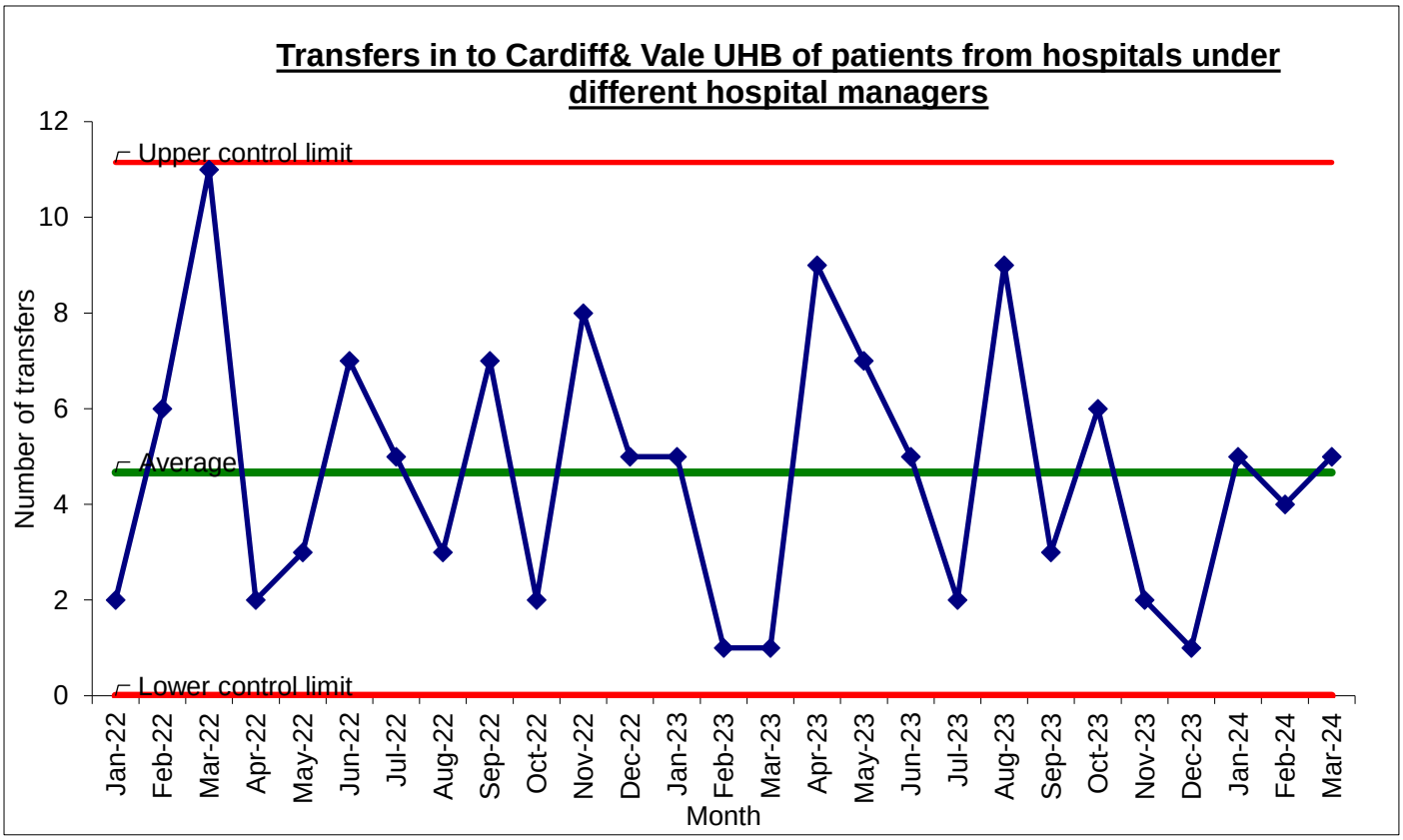
Eleven patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- From out of area PICU beds to home PICU x 7
- One from out of area beds to home area x 4

Two patients detained under Part 3 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- From out of area beds to home area x 2

One person detained under a Community Treatment Order was transferred back into Cardiff and Vale UHB due to reaching the age of 18 years old.



One of the transfers of patients detained under Part 2 of the Act was subsequently discovered to be invalid therefore the patient was discharged.

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

January- March 2024

Exclusion of visitors

Visiting on wards at Hafan Y Coed are allowed but by appointment only. This is managed through a booking in system.

Death of detained patients

During the period there was one death of a detained patient.

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety initially for up to 24 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care. The detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place

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

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

	Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.

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

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

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

Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion. If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for mental disorder. If the patient lacks capacity to consent SOAD authorisation is required.
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is:

	• To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and

	conditionally discharged patients as well as those who have been absolutely discharged.

Report Title:	UHB Response to the Consultation on the Mental Health Standards of Care (Wales) Bill: **Covering report**			Agenda Item no.	3.3
Meeting:	Mental Health Legislation & Mental Capacity Act Committee	Public	X	Meeting Date:	30.04.2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive Title:	Chief Operating Officer				
Report Author (Title):	Dan Crossland Director of Operations Mental Health Clinical Board				

Main Report
Background and current situation:

The Proposed Mental Health Standards of Care (Wales) Bill is a Private Member's Bill brought to the Senedd by James Evans MS.
The consultation asked organisations and individuals to give their views on the policy objectives of the proposed law.
The purpose is to update mental health legislation, improve delivery plans for CAMHS and Adult services and improve accountability of Welsh Public Sector organisations.

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

The Bill proposes changes to key areas of the Mental Health Act 1983 and the Mental Health (Wales) Measure 2010.
These are:
-replacing Nearest Relative with the new role of *Nominated Person*
-changing the criteria for detention to ensure the prospect of *therapeutic benefit*
-introduce remote (virtual) assessment under specific provisions for Second Opinion Appointed Doctors (SOADs) and Independent Mental Health Advocates (IMHAs)
-remove age limits for Part 3 of the MHM
-Extend Part 3 requests to include people specified by the patient

There was broad support for the Bill but concern expressed about the integration with English and Scottish Mental Health Act implications and cross-border transfers which do not recognise these amendments- in particular the Nominated Person and Therapeutic Benefit changes. There were questions about forensic sections and public protection considerations and how viable it is to implement and quantify the therapeutic benefit implications.
There was less support for promoting virtual SOAD and IMHA appointments as it was strongly felt that there was value in seeing the patients face to face for both clinical assessment and relationship building.
The Mental Health Measure amedments were felt to be broadly viable and in context with existing supporting guidance.

Recommendation:

The Committee is requested to:

a) NOTE the submission of the consultation on behalf of the UHB.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	

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

Five Ways of Working (Sustainable Development Principles) considered *Please place an "X" in the below boxes as relevant*									
Prevention		Long term	X	Integration		Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category.* ***If yes please provide further details.***
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

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

/Reference Number: *TBA* **Version Number: 01.9**	**Date of Next Review:** **Previous Trust/LHB Reference Number: NA**

Adult Mental Health Services (AMHS)
Recovery and Maintenance Programme (RAMP) Procedure

Summary

C&V UHB's AMHS have re-developed strictly limited parts of current AMHS provision in Community Mental Health Teams (CMHTs) to support a uniform step down provision, referred to as RAMP. This is provided under Part 1 of the Mental Health (Wales) Measure 2010. The service is likely to best suit a recovering service user in need of ongoing medication, either not currently made available through the service user's GP surgery or practitioner, or needing a GP Shared Care scheme. RAMP may also prove the most appropriate service for other service users.

The following criteria should normally be met before RAMP consideration:

1. A service user's mental health is sufficiently stable that:
   - appointments are needed less frequently than approx. every 12 weeks and,
   - an elementary maintenance schedule is all that is required

and either:

2. Full Mental Health Services discharge is not yet appropriate

or

3. No other specific pathway or Part 1 service exists.

Any move to Part 1 service, for an existing Part 2 service user, must be supported by a recorded CMHT MDT decision agreed with the service user.
Decisions by the MDT should be guided by consideration of:

- The best interests of the patient
- The level of clinical need
- Ensuring no reduction in access to evidence-based treatments required.

Following a move to RAMP, at least annual service user contact is needed, with subsequent written communication to service user, and GP.

CMHTs will monitor use of any aligned stepdown Part 1 provision, considering impact on their Part 2 work, and options for future specific Part 1 alternatives.

Aims

To provide, under Part 1 of the Mental Health (Wales) Measure 2010, a scheme to step down mental health support service, ensuring uniform transition into primary care, and elementary maintenance provision, if necessary.

Objectives

- To provide a part 1 scheme, within the legal framework of the Mental Health (Wales) Measure 2010 and associated legislation and code of practice
- To describe which practitioners, may utilise RAMP - part 1 scheme, and how
- To provide guidance on suitability of CMHT service users for RAMP
- To ensure MDT discussion before a service user enters the scheme
- To provide minimum standards of ongoing contact within RAMP
- To ensure adequate written communication with service user and GP
- To provide guidance on weekly time limits for CMHT based practitioner involvement in part 1 work
- To define audit standards
- To define the PARIS electronic service user record (EPR) recording standards and PARIS reports
- To clarify future self-referral access to CMHTs
- To describe a return to Part 2 care, for service users whose mental health related needs change

Scope
This protocol applies to the Adult Mental Health Services (AMHS) Directorate; and is designed specifically for service users stepping down from MDT working in AMHS - CMHTs, but may have relevance to other MHCB service areas.

Equality Impact Assessment	*An Equality Impact Assessment has not yet been completed.*
Health Impact Assessment	*Not required*
Documents to read alongside this Procedure	See references Mental Health Measure (2010) Part 1 Scheme
Approved by	*Committee/Group*

Accountable Executive or Clinical Board Director	*Mental Health Clinical Board*
Author(s)	**Neil Jones**

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
	Date of Committee or Group Approval	*TBA*	*New Document*

Contents Page

1) Introduction

Individuals receiving services from locality or community mental health teams (CMHTs) are expected to do so under part 2 of the Measure, utilising a stipulated care and treatment plan template (Mental Health (Wales) Measure 2010, The Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011) with further guidance described in the relevant Code of Practice (Welsh Government, 2012)

However, some service users remain under the care of a CMHT, even though treatment is feasible in primary care facing services. There are various logistical reasons why a discharge from a CMHT does not take place. Most often this is due to medication not being currently available through a service user's GP, but may also relate to simple individual components of treatment not currently being available through other defined Part 1 services.

This document describes a broad-spectrum Part 1 scheme, referred to as Recovery and Maintenance Programme (or its acronym RAMP) operating alongside CMHTs, for such individuals, allowing suitable 'step down' in treatment intensity for most qualifying individuals, with "stable severe and enduring mental health problems"(Cardiff and Vale UHB et al 2012, The Mental Health (Secondary Mental Health Services) (Wales) Order, 2012) as part of a recovery journey. RAMP operates within the principles of the current local Part 1 provision articulated within the Part 1 Scheme, Section 10.

Over time, it is the aim within AMHS to provide a greater range of condition specific stepdown pathways in co-operation with partners inside the NHS, local authorities and third sector partners. To this end Cardiff and Vale UHB will monitor use of this RAMP provision, and consider alternatives.

The protocol includes standards expected in operating the scheme.

2) RAMP: set up and management

RAMP participation, by team (usually a CMHT), and subsequently for individual team members, should be decided by the relevant team itself through the integrated manager. Each CMHT will be expected to provide staffing input to the aligned RAMP, depending on demand.

Any team wishing to participate must have an MDT as part of its components. Within the team, existing Part 2 service users, can be considered for a stepdown to RAMP, or any other Part 1 scheme. Service users MUST be discussed and a Part 1 move agreed and recorded on PARIS, prior to a change of PARIS allocation.

Any CMHT supporting RAMP provision is expected to monitor demand and use, and report to the directorate. Monitoring should be through PARIS and include monthly data on:

- Which staff are allocated, and number of sessions per practitioner
- Number of Part 1 service users aligned to the team, and Part 1 allocations per staff member
- Follow up rate
- Communication with service user and GP.

RAMP practitioner eligibility is open to any professional group, but is designed from the outset to have specific relevance to practitioners overseeing longer term medication regimes.

For CMHT based practitioners, Part 1 work with the aligned RAMP, MUST form a minority of any weekly timetable – as guidance - usually equivalent to no more than one session per week. Staff operating as RAMP practitioners MUST define that regular clinical session as RAMP work, and limit their Part 1 work to the allocated session. They may undertake other non-Part 1 service user contact in the allocated session as necessary, no matter where the RAMP session takes place.

If a CMHT based practitioner's RAMP work cannot be contained within a single session, the CMHT should support a review of the practitioner's overall caseload and if necessary job plan.

3) Service user Entry to RAMP:

Service users newly referred to CMHTs, and accepted as suitable for CMHT input, can enter RAMP at intake providing all needs are fully assessed at initial assessment.

For Part 2 allocated patients, after a period (usually no less than 12 weeks), and with sufficient progress made (often signalled by appointment frequency dropping below every 12 weeks, and an elementary maintenance schedule being all that is required), the care co-ordinator may make a RAMP referral. The referral must be discussed with a functioning and quorate MDT, and a decision made on which option is most appropriate for the service user: RAMP (Part 1), existing Part 2 services, or full discharge with Part 3 self-referral option. Decisions by the MDT should have consider:

- The best interests of the service user
- The level of clinical need,

ensuring no reduction in access to evidence-based treatments required

N.B. A move to any Part 1 provision may only be undertaken with both MDT and service user (and their significant others') agreement.

A leaflet explaining the scheme, and what is means for service users, is included as appendix 1 – and copies should be provided if a RAMP move is being considered.

Service users, subject to Section 117 aftercare, are presently adjudged not to meet the criteria for CMHT-Part 1 by virtue of the multiagency / professional nature of the review process alone, even though local 117 aftercare legal interpretation regularly necessitates CMHT follow up into periods of extended recovery.

4) Ongoing Review

If longer term service user's RAMP Part 1 provision is necessary, it should be reviewed no less than annually. A letter, detailing the review and justifying ongoing provision, must then be sent to the service user's GP, with a copy demonstrably sent to the service user. Any significant deterioration should trigger a return to Part 2 and full MDT working.

5) Discharge and Re-referral

The Mental Health Measure, states that a move away from Part 2 provision will begin the Part 3 self-referral 'clock', allowing a three year window for self re-referral. (*The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011)*

It is unworkable for service users, to try to differentiate between Part 2 and aligned RAMP Part 1 work, when contacting for extra support. In practice for RAMP service users, CMHTs should write with Part 3 letters from the moment of full service discharge, not when an agreed move to RAMP takes place in the spirit of the Measure.

As a matter of principle, CMHTs are encouraged to always take a flexible and balanced approach to later self re-referral, remembering self-referrals constitute less than 20% of CMHT referrals.

In practice, RAMP discharge is no different to other areas – where possible it should be planned, include discussion of return of symptoms, where and how to seek support, and include letters to GP and other service partners, copying in the service user.

6) Use of PARIS

RAMP (PART 1) entry
The CMHT - MDT discussion and decision should be captured on the PARIS electronic service user record (EPR) – this is an audit standard.

When moving to RAMP – part 1, staff allocation type should change on PARIS to RAMP practitioner.

Under RAMP, PARIS – CTP documentation is not compulsory - any irrelevant PARIS CTP documentation can be closed; pre-existing elementary plans should form part of ongoing reviews, with details included in letters to GP and service user (a suggested format for the letter is described in appendix 2).

Ongoing
Letters should be captured as RAMP part 1 letter type – a subtype of the Letter case note writer – where a second copy is generated automatically for the service user. There is an option box to delete this extra copy.

PARIS - Clinic booking should be used where possible to diarise appointments and outcomes.

Transfer back to CMHT
If significant new mental health care planning is deemed necessary e.g. following e.g. a CMHT duty assessment, or mental health admission, then a move back to Part 2 provision is advised, with a care co-ordinator allocated on PARIS, and ending the RAMP practitioner allocation.

Discharge
Discharge is no different to other areas – and should include the same PARIS procedures and trigger a Part 3 letter.

Reporting

The following PARIS reports are in place:

- Individual RAMP Part 1 list:

Current service user names, allocation CMHT part 1 date, last three appts, date of last letter

- Team RAMP part 1 list:

As above but to include all practitioners with one or more suitable allocation.

CTP reporting is altered to exclude RAMP allocated service users.

7) Equality Impact Assessment

Cardiff and the Vale Health UHB are committed to providing an environment where staff, service users and carers are provided with consistent equality of opportunity.

8) Concerns

All concerns should be dealt with in accordance with Wales wide 'Putting Things Right'. All complaints regarding the service should be directed to the UHB concerns team.

9) References:

Cardiff and Vale UHB (2012)Mental Health (Wales) Measure 2010 Part 1 Scheme for Local Primary Mental Health Support Services for Cardiff & Vale University Health Board and Partner Local Authority areas of Cardiff and Vale of Glamorgan May 2012
Available at:
http://www.cavamh.org.uk/system/resources/W1siZiIsIjIwMTQvMDMvMjEvMTZfNTdfMDNfODg5X0xvY2FsX1ByaW1hcnlfTWVudGFsX0hlYWx0aF9TdXBwb3J0X1NlcnZpY2VzX2Zvcl9DYXJkaWZmX1ZhbGVfVW5pdmVyc2l0eV9IZWFsdGhfQm9hcmRfc2NoZW1lX2luZm9ybWF0aW9uLnBkZiJdXQ/Local%20Primary%20Mental%20Health%20Support%20Services%20for%20Cardiff%20%26%20Vale%20University%20Health%20Board-%20scheme%20information.pdf
(accessed 12/03/2019)

The Mental Health (Wales) Measure 2010
Available at:
http://legislation.go.uk/wma/2010/7/pdfs/mwa_20100007_en.pdf
(accessed 12/03/2019)

The Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011
Available at:
http://www.legislation.gov.uk/wsi/2011/2942/pdfs/wsi_20112942_mi.pdf
(accessed 12/03/2019)

The Mental Health (Secondary Mental Health Services) (Wales) Order 2012
Available at:
http://www.legislation.gov.uk/wsi/2012/1428/pdfs/wsi_20121428_mi.pdf

The *Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011*
Available at:
https://www.legislation.gov.uk/wsi//2011/2500/pdfs/wsi_20112500_mi.pdf
(accessed 12/03/2019)

Welsh Government (2012) Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
Available at:
http://www.assembly.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf
Add here
(accessed 12/03/2019)

Welsh Government (2012) the Mental Health (Wales) Measure 2010 (public leaflet)
Available at:
https://gov.wales/docs/dhss/publications/121017measureency.pdf

Accessed 12/03/2019)

APPENDIX 1: Service user Information Leaflet

The Recovery and Maintenance Programme – Part 1 scheme

This leaflet explains options for your future mental health treatment and support.

Up until this point, you have worked with a care co-ordinator, and an agreed care and treatment plan (CTP). That plan may have had a few, or lots of, elements of support and treatment.

Over time you may have progressed in your recovery to a point where you no longer require high levels of care and support to maintain and improve your wellbeing. This leaflet supports the discussion, with your care co-ordinator, about what comes next: how to best meet any ongoing support needs.

So what are those options?

A. You may decide, with your care co-ordinator, to keep things as they are – and work with your current care and treatment plan. As they say " if it ain't broken…."

B. You may opt for discharge, with ongoing support available through your GP. If so, you'll be pleased to know you can self-refer back to a Cardiff and Vale CMHT for up to three years after discharge. This is described as your Part 3 right, under the Welsh Government's Mental Health Measure. At the point of discharge, your care co-ordinator will write to your GP and explain any ongoing support and medication needs, and when, if necessary to consider re-referral. We'll also write to you explaining your discharge and 'part 3 rights'.

C. Alternatively, you and your care co-ordinator may decide on something in between: a form of support we call RAMP (and the Welsh Government refer to as a Part 1 Mental Health scheme). Together, you may both feel the initial intensity of contact with the CMHT is no longer required, but some ongoing mental health service contact remains necessary. For example, RAMP may help, when the sort of help needed - perhaps a specific medication - is not offered by your GP, without extra support.

Within the RAMP scheme, you will usually see a single allocated staff member. You will meet up with that person as necessary, but usually no more than a few times per year. If possible we'll try and maintain that contact with a staff member you already know.

We'll send you copies of all the letters we write to your GP, ensuring you are kept informed of all that we discuss and agree with you.

If you choose to enter the RAMP scheme (option C), and later feel you need more support, simply call us. We'll try and connect you to the person you normally see, or failing that, a duty worker. It maybe we can quickly help sort things out over the phone with you. If not, and things are more difficult, we'll arrange to see you and reassess your situation fully. Following that assessment, and if needed, we'll return to a detailed CMHT care and treatment plan, with a care co-ordinator.

If you want to know more about the Mental Health Measure, and what it means for you, the Welsh Government have a leaflet online:

https://gov.wales/sites/default/files/publications/2019-03/the-mental-health-wales-measure-2010.pdf

Appendix 2 (suggested RAMP GP letter format)

CMHT HEADER
DATE of letter

Dear (GP)

Recovery and Maintenance Programme (RAMP) at --------- (enter the team name)

Date of entry to the Programme: (enter the allocation date here)
Date of most recent meeting:

Diagnosis (and / or brief summary of mental health concerns)

Medication prescribed by this service: (and any changes)

GP prescribed mental health medications: (and any recommendations for change)

SUMMARY OF Review Meeting:

Any intended plans / recommendations:

Date / timescale for next review meeting

Yours sincerely

Name
(position)

Cc – service user

RAMP is a part 1 (Mental Health Measure) scheme currently operating from Cardiff and Vale CMHT locations.
To qualify service users will have stable ongoing or improving mental health needs:
- not requiring detailed mental health care planning, but not yet ready for full Mental Health Services discharge.

Service users needing a fuller review, or to contact between appointments, should contact the above number, stating they are treated under RAMP.

Mental Health (Wales) Measure 2010
Part 1 Scheme

for

Local Primary Mental Health Support Services

for

Cardiff & Vale University Health Board

and

Partner Local Authority areas

of

Cardiff and Vale of Glamorgan

April 2024

Contents

1. Introduction

This joint scheme for the provision of local primary mental health support services is a regional scheme for the local authority areas covered by the Cardiff & Vale University Health Board. It has been developed under the provisions of section 2 of the Mental Health (Wales) Measure 2010 which require that the local mental health partners for a local authority area must take all reasonable steps to agree a scheme:

(a) which identifies the treatment which is to be made available for the area (local primary mental health treatment), and

(b) for securing the provision for that area of the local primary mental health support services (described in section 5 of the Measure)

Secondary legislation in the form of the mental health (Regional Provisions) (Wales) regulations 2012 provide for the development of a regional scheme which includes more than one local authority area

This joint scheme seeks to assist the delivery of local primary mental health support services across the University Health Board area. It provides a framework for the provision of the local primary mental health support services that the University Health Board and local authorities have a duty to deliver for their populations under Part 1 of the Mental Health (Wales) Measure 2010 (the Measure). Local primary mental health support services must:

(a) carry out primary mental health assessments in accordance with Part 1 of the Measure;

(b) provide local primary mental health treatment (interventions), following assessment;

(c) make referrals concerning services which might improve or prevent a deterioration in the individual's mental health;

(d) provide information for patients (of the service) and carers and advice about services that are available to them; and

(e) provide information, advice and other assistance for primary care providers (GPs) so as to improve the services related to mental health which they provide or arrange.

The aim of these services is to improve access to mental health care within primary care settings, and to improve the outcomes for individuals accessing these services. This will be achieved by increasing the availability of mental health services in primary care, providing support for individuals in meeting their non-medical needs and increasing the support available to primary care providers to help them improve the health and well-being of people with mental health problems.

The Scheme is an enabling agreement which identifies the mental health partners who are responsible for ensuring the provision of local primary mental health support services. It sets out the local vision for these services, the responsibilities of the partners, eligibility, and the treatments that will be provided and on what basis they will be provided for specific groups, and addresses governance issues. It builds on the guidance set out in the National Service Model (ref) and the agreement of the local services model.

The local Primary Mental Health Support Services (PMHSS), which this scheme supports, have been in effect since 1 October 2012. This 2024 document represents the latest update to the scheme since its 2012 inception and sees the planned introduction of three new elements:

-Mental Health University Liaison Service including planned CBT clinic

-Recovery and Maintenance Protocol

-Neurodevelopmental service provision

2. Partners

As permitted by the Mental Health (Regional Provision) (Wales) Regulations 2012 this is a regional scheme for the local authority areas covered by the Cardiff & Vale University Local Health Board and the local mental health partners are:

- Cardiff & Vale University Health Board
- Cardiff Council
- Vale of Glamorgan Council

The joint mental health partners will operate in partnership with local primary care practitioners to ensure the primary care mental health support service. Local primary care practitioners are represented on implementation and steering groups for primary care mental health support services and kept informed via Local Medical Committee and the Primary Care and Localities team within the health boards Primary Care and Intermediate Care, Mental Health and Llais.

A range of local Third Sector organisations will also be involved in the provision of services and interventions that the scheme will support.

3. Purpose/Scope of the Scheme

The scheme will support and secure the provision of local primary mental health support services for people of all ages across the local authority areas of Cardiff and Vale of Glamorgan including the Western Vale. A key purpose of the scheme is to identify the local primary mental health treatments which are to be provided for these populations and the arrangements for securing the provision of these services between Cardiff & Vale University Health Board and its Local Authority mental health partners, in accordance with section 2(1) of the Measure.

The scheme also identifies:

- The mental health partners
- The extent of the responsibilities of each of the mental health partners for the provision of the services
- Eligibility of individuals who are subject to the provisions of the Mental Health Act 1983 or who are in receipt of secondary mental health services, and categories of individuals who would not otherwise be entitled to an assessment, to be referred to the local primary mental health support services,
- Persons who can refer such individuals to these services
- Arrangements for altering the scheme

The purpose of Cardiff & Vale of Glamorgan's scheme under Part 1 of the Mental Health (Wales) Measure is to ensure that the following stipulated elements be delivered as part of local primary mental health support services:

(a) comprehensive mental health assessments for individuals who have first been seen by their GP, but for whom the GP considers a more detailed assessment is required and assessment of those individuals with stable severe and enduring mental health problems referred into the primary care mental health service from secondary care.

(b) treatment, by way of short-term interventions, either individually or through group work, if this has been identified as appropriate following assessment.

(c) provision of information and advice to individuals and their carers about treatment and care, including the options available to them, as well as 'signposting' them to other sources of support (such as support provided by third sector organisations);

(d) provision of support and advice to GPs and other primary care workers (such as practice nurses) to enable them to safely manage and care for people with mental health problems, and improve the mental health services they provide or arrange;

(e) supporting the onward referral to secondary mental health services, where this is felt to be appropriate for an individual, in accordance with Section 10(1)(b) of the Measure.

The service in Cardiff & Vale will be available to individuals of all ages who are experiencing common mild to moderate, or stable severe and enduring mental health problems for whom an appropriate referral is received and whose presentation is appropriate for treatment within a primary care setting.

Going forward, it is the intention of the Cardiff and Vale Part 1 scheme to expand Part 1 provision for stable and enduring mental health problems: by the re-positioning of that provision, and building element D above.

4. Vision for the Local Primary Mental Health Support Services

The aims of Local Primary Mental Health Support Services will be to provide local access to mental health support within primary care for people of all ages experiencing mild to moderate or stable severe and enduring mental health problems for whom an appropriate

referral is received. As set out in the National Service Model, the overall objectives of local primary mental health support services are to:

- Increase the availability and uptake of mental health services at the primary care level, in order to improve outcomes for individuals of all ages and to increase effectiveness, and efficiency in accessing secondary care, where this is indicated

- Provide for all people of all ages across Cardiff and Vale, effective primary mental health support services that are accessible and close to those who require them. These services should be appropriate, acceptable and outcome focused, with an emphasis on promotion of an individual's well-being, recovery and resilience;

- Work with and develop close relationships with GPs and practice staff, and to provide support, consultation, advice on clinical management, education, training and liaison in order to develop capacity for and approached to managing mental health problems in primary care.

For the populations of Cardiff and the Vale of Glamorgan, the mental health partners will seek to achieve this by ensuring the provision of services which:

- Increase the availability and uptake of mental health services in primary care settings.

- Promote recovery and resilience for people of all ages.

- Improve the interface between Primary and Secondary Care.

- Establish close working relationships with primary care including provision of advice and support.

- Support but do not supplant existing services.

The aim of the Primary Mental Health Support Service in particular and mental health services in general is to make the delivery of services to these groups as responsive as possible to their circumstances and needs by embracing the provisions of the Public Sector Equality Duties. The service aims to pro-actively address any misconceptions and discriminatory attitudes towards people with mental health problems.

5. Responsibilities

Sections 2(3) and 2(4)(a) of the Measure require this scheme to outline to what extent each of the partners within the Cardiff & Vale scheme are responsible for providing local primary mental health support services in each of the local authority areas. The Integrated Health and Social Care Partnership Board for the Cardiff and Vale 'region' are accountable for the delivery of the MH Measure on behalf of the Cardiff and Vale Health Board and the two Local Authorities. The Director of Operations for Mental Health Clinical Board within the Health Board has delegated responsibility for the delivery of the Mental Health (Wales) Measure for the population of Cardiff and the Vale of Glamorgan. This responsibility is delivered through the Mental Health Act Mental Capacity Act Legislation Committee (MHMCLC) chaired by the Health Board Vice Chair. In terms of Learning Disability services, these services are provided on a sub regional network basis, that the UHB is responsible for the commissioning of these services for the population of Cardiff and the Vale of Glamorgan. The MHMCLC has delegated representation and responsibility from these services in order to link the joint efforts of these services in delivering the Measure requirements.

The Health Board will work with the two local authorities in partnership with third sector organisations who deliver a wide range of community support services including health and well-being, education, day services, volunteering and employment opportunities, accommodation and information/advice/advocacy services.

The partners, as described above, are committed to meeting the requirements of the Measure in partnership but it is agreed that Cardiff & Vale University Health Board will be the lead agency for the scheme.

General Practitioners will remain responsible for providing the services to patients outlined within their general medical services contract. Provision of the local primary care mental health support service will not supplant general medical services but will enhance the range of services available to patients at a primary care level.

Clinical responsibility for a patient will be shared between the GP and the local primary care mental health support service in respect of individuals referred by the GP. GPs will require differing levels of support to manage or jointly manage patients with stable and enduring mental health, and support for GPs will need to be tailored.

6. Eligibility for assessment by the local primary mental health support service

Assessment by the local primary mental health support services will be available for individuals of all ages, from children and young people to older adults for whom an appropriate referral is received. The Measure does not allow for self-referral to local primary mental health support services. Referrals may be made in respect of individuals of any age who present with any form of mild to moderate and/or stable severe and enduring mental health problem, regardless of whether that individual may also be experiencing any co-occurring condition such as a learning disability or a substance misuse problem. This scheme provides that for Cardiff and the Vale UHB primary mental health assessments will be made available to individuals receiving secondary mental health services, including those subject to 117 of the Mental Health Act 1983, as per section 8(1) of the Measure, provided they are eligible via the referral route outlined below.

The National Service Model clarifies that referrals can only be made by:

- the GP with whom the individual is registered ; or

- a GP with whom the individual is not registered as proposed in the Mental Health (Primary Care Referrals and Eligibility to Conduct Primary Mental Health Assessments) (Wales) Regulations 2012; or

- a person working in secondary mental health services in respect of an individual subject to the provisions of the Mental Health Act 1983, or in receipt of secondary mental health services, but only if the local joint scheme prescribes that such individuals are eligible, and the person making the referral is eligible to do so. Eligibility criteria are the same as those set out in the Regulations made under Part 2 of the Measure for eligibility to act as a care coordinator. In this respect the professional requirements are;

    a) a qualified social worker (registered with either the Care Council for Wales or the General Social Care Council);
    b) a first or second level mental health or learning disabilities nurse (registered in Sub-part 1 or Sub-part 2 of the Register maintained under article 5 of the Nursing and Midwifery Order 20017);
    c) an occupational therapist (registered in Part 6 of the Register maintained under article 5 of the Health Professions Order 20018);
    d) a practitioner psychologist (registered in Part 14 of the Register maintained under article 5 of the Health Professions Order 2001);

e) a registered medical practitioner;
f) a dietician (registered in Part 4 of the Register maintained under article 5 of the Health Professions Order 2001);
g) a physiotherapist (registered in Part 9 of the Register maintained under article 5 of the Health Professions Order 2001); or
h) a speech and language therapist (registered in under Part 12 of the Register maintained under article 5 of the Health Professions Order 2001).

As the proposed service is based on a tiered whole-system model arrangements for the provision of services for individuals referred from secondary care will be agreed via a formally agreed referral pathway with a clear communications hub facilitating ease of referral from one to the other. Those eligible to refer from secondary care into primary care are those who fulfil under Section 14 of the Measure the requirement to be the relevant patient's care coordinator and to undertake the functions required of them.
Cardiff and Vale UHB will strive towards meeting The National Service Model target of a maximum of 28 calendar days between referral by a primary care practitioner or a care coordinator, as permitted under this scheme, and the assessment being carried out by the local primary mental health support services.

There will be regular reviews of referral protocols to ensure that they remain relevant to local need and to ensure skills of the local primary mental health support services staff are being utilised appropriately and the service provision is both efficient and effective.

7. Equality

The Equality and Human Rights Commission Wales has stated that people with experience of mental distress are among the most discriminated against in Wales. Many people experience multiple disadvantages through discrimination on the grounds of their mental health problems and also on the grounds of their sexuality, ethnicity and other characteristics. People from minority groups often find it difficult to access mental health services, or they find the services that are available to them are culturally inappropriate or insensitive to their needs.

Services across Cardiff & Vale UHB will be delivered which genuinely meet the needs of the people they serve. An Equality Impact Assessment is being undertaken to highlight and

address misconceptions and discriminatory attitudes towards people with mental health conditions in the area(s) covered by the scheme.

8. Provision of services in English and Welsh

Cardiff & Vale University Health Board, The City and County of Cardiff and the Vale of Glamorgan Council have Welsh Language Scheme Corporate Documents that outline their commitments and obligations under the Welsh Language Act 1993, and have adopted the principle that in the conduct of their public business, they will treat the English and Welsh languages on an equal basis.

9. Where services are to be provided

In keeping with the philosophy of the Measure, local primary mental health services will operate within or alongside GP practices. Cardiff & Vale UHB is composed of three primary care localities: The Vale of Glamorgan; Cardiff North, West & South West; and Cardiff South, East & City (68 practices in total, including Cardiff and Vale Health Inclusion Service), in 93 premises). The local primary mental health support services work to these three localities.

The service will be delivered via a mixture of centralised and locality-based static and peripatetic services which will be determined by local demand and demographics.

Arrangements for the provision of special groups such as the homeless, prisoners and asylum seekers and refugees within Cardiff & Vale UHB will be agreed in partnership with third sector providers.

As the proposed service is based on a tiered model arrangements for the provision of services for individuals referred from secondary care will be agreed via a formally agreed care pathway. A tiered care model allocates appropriate resources to ensure that expertise and interventions match complexity of need, and should minimise the necessity for multiple assessments of an individual.

10. Local primary mental health support services

(this list is not exhaustive)

These are planned scheduled services that sit within primary care. The following services are formally identified within this scheme as being primary mental health services and therefore do not require care and treatment planning under part 2 of the Measure:

- Primary Mental Health Support Service (assessment, treatment and onward referral).

- Primary Care Counselling Service.

- The Liaison Psychiatry service offers specialist psychiatric consultation and advice to secondary care services and a second opinion service to Community Mental Health Teams to help with management of patients whose mental health difficulties are being exacerbated by chronic physical difficulties. The majority of clients open to this service do not require levels of input which require a care co-ordinator and a Care and Treatment Plan (Part 2) but in the small number of cases that do, the service is in a position to provide this level of input itself without necessarily referring on to secondary care.

- The Traumatic Stress Service offers interventions for non-complex presentations. Should the complexity of an individual merit the involvement of more than one professional then the appropriate secondary care service will be involved.

- The Memory Team accessed by both GP's and the PMHSS but may be provided across more than one locality.

- The All Wales Veterans Health and Wellbeing Service (AWVHWS) provides information and advice to GP's/primary care staff and PMHSS staff and facilitate access to Veterans Support Groups.

- Children & Adolescent Mental Health Service (CAMHS) Primary Care Mental Health Service will operate with systems, policy and protocols in place to ensure GP referrals for children and young people are appropriately met. The service will be commissioned by the three partners as stated above but delivered by the existent Cwm Taf Local Health Board CAMHS Network.

- Eating Disorders Specialist Outpatient Treatment (EDSOT) team, including dietetics, will continue to provide consultancy, liaison, supervision, training, sign-posting and information to GP's / Primary Care staff and PMHSS colleagues regarding the care and treatment of individuals presenting with an eating disorder.

- Individuals, with stable and enduring mental health diagnoses or conditions that cannot currently be treated in GP surgeries may participate in recovery and

maintenance programmes (RAMP). Such programmes are intended to develop a more graduated move between service tiers as promoted in the Measure supporting guidance. Some patients may require some level of extra mental health support to be manageable by, or with, their GP. That support can include medication, and or medication support. The support will usually by provide by a single named mental health practitioner. The nature of 'enduring' mental health problem means mental health support to patient, and primary care team, may not be short term. Nevertheless, the aim remains to develop primary care capabilities, in line with the Measure guidance. For patients who become less stable – care and treatment should be stepped up to Part 2 provision without delay.

- Psychiatric Out-Patients will provide a liaison and consultation service to GPs within Cardiff & Vale UHB (including Cardiff and Vale Health Inclusion Service -CAVHIS) and face-to-face consultations for service users experiencing issues which relate to their mental health but not of a severity or complexity which would warrant referral to secondary care mental health services. This service will be provided to support GPs to maintain a patients' mental health not to provide ongoing treatment for unstable and complex mental illness.

- The Psychological Therapies Hub offers interventions, such as CBT, to those experiencing panic disorder, agoraphobia social phobia and other conditions where this is the primary problem. Should the complexity of an individual merit the involvement of more than one professional then the appropriate secondary care service will be involved.
- Neurodevelopmental provision in adult services (such as the Integrated Autism Service and the Attention Deficit Hyperactivity Disorder Service) are Primary Care provisions, the diagnosis is not an exclusion to secondary mental health care provision when there is an indication of co-morbidity or high complexity.

- Specialist Therapy teams including the Traumatic Stress Service and the University CBT Clinic Service may provide treatment at primary care level when there is no indication for the involvement of secondary care provision. This does not rule out a referral to secondary care should complexity or risk indications warrant additional support and care planning.

- Primary Care Liaison Services, Mental Health University Liaison Services and Primary Care Counselling Services all fall within primary care provision.

11. Joint working arrangements

The funding for the development and provision of the Primary Mental Health Support Service will be held and managed by the Cardiff & Vale UHB. The operational management of the service will be by the Mental Health Division of Cardiff & Vale UHB on behalf of the three partner organisations.

Throughout the duration of an individual's contact with the local Primary Mental Health Support Service, clinical responsibility will be shared between the service and the GP for those individuals referred to the service by a GP. For those accessing the service via secondary mental health services clinical, responsibility will remain with the secondary mental health services. However, individual practitioners are accountable for their own professional practice.

Section 42 of the Measure allows one partner in the scheme to supply to the other partner information which has been obtained in the discharge of functions under Part 1 of the Measure, and which relates to an individual for whom local primary mental health support services are being, or might be, provided.

12. Performance management of the local primary mental health support services

Key to ensuring best use of resources and good outcomes the service will have clear performance management arrangements. Standardised data collection and analysis and regular audit and service evaluation will be agreed and conducted via joint management structure. Service evaluation will take place on a yearly basis.

In addition to locally agreed performance management information, particularly with a focus on clinical outcomes, the mental health partners will be required to routinely collect information for the Welsh Government in relation to:

- The number of primary care practitioners per 20,000 population (all ages);

- The number of assessments undertaken

- Waiting times for assessments (in calendar days) against the target of 28 calendar days;
- Waiting times for interventions, where indicated (in calendar days);
- The number of completed interventions (to include treatment, referral or information);
- User, carer and GP satisfaction levels.

13. Governance of the local primary mental health support service

Governance arrangements will be agreed with partners and regularly monitored via formal use of outcome measurement, client satisfaction, supervision and audit.

Throughout the duration of an individual's contact with the local Primary Mental Health Support Service, clinical responsibility will be shared between the service and the GP for those individuals referred to the service by a GP. For those accessing the service via secondary mental health services clinical, responsibility will remain with the secondary mental health services. However, individual practitioners are accountable for their own professional practice. Patients remain under the normal care of their GP whilst in the Primary Care Mental Health Support Service.

Where services are delivered by a third sector organisation the provider will ensure that services are delivered to the standard as set out in the Health and Care Quality Standards for Wales (Welsh Assembly Government 2023). The full document can be found at:

English Version

Health and Care Quality Standards 2023 (WHC/2023/013) | GOV.WALES

Welsh Version

Safonau Ansawdd Iechyd a Gofal 2023 (WHC/2023/013) | LLYW.CYMRU

The local primary mental health support service will not be appropriate for all individuals with mental health problems who present to GPs. Where a GP considers that other services within the mental health care system would be appropriate to meet an individual's needs, the GP should continue to refer them to these services (e.g. Community Mental Health Teams, specialist CAMHS, substance misuse services, etc). The GP may wish to be guided and

supported in relation to the appropriate referral of individuals through consultation with, and/or advice from, the local primary mental health support service.

14. Promoting the local primary mental health support services

Arrangements for promotion of the service will be agreed with GP partners and third sector partners and monitored by the Mental Health Program Board. Local primary care mental health services across Wales are explained within an information leaflet developed by Welsh Government. The service seeks to be an integral part of implementing the *Setting the Direction* and the Carers Strategies (Wales) Measure 2010 agendas regarding the provision of advice and information to services users and their carers.

Commented [nj1]: Are they agreed?

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15. Arrangements for review of the Scheme

The development and progress of the scheme for Cardiff & Vale UHB will be monitored by the Mental Health Program Board on a bi-monthly basis and by the Expert Reference Group of local health partners at least quarterly.

16. Arrangements for altering a scheme

Where a review of the scheme has identified the need to alter the Cardiff & Vale UHB Part 1 scheme the proposed alterations will be presented to the Mental Health Program Board and (where relevant) the local Children and Young People's Partnerships for agreement before being presented to the Local Health Board and (where required) Local Service Boards before a revised and updated scheme is provided to Welsh Government.

In the event of a dispute all parties to the Agreement will use their reasonable endeavours to resolve the matter. In the event that is not possible the matter will be referred to Cardiff & Vale 'regional' Mental Health Measure Partnership Board who will attempt to resolve the matter. All parties agree that this is an agreement which is subject to section 7 NHS (Wales) Act 2006.

Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2			Agenda Item no.	**4.1**
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	30th April 2024
		Private			
Status *(please tick one only)*:	Assurance	X	Approval		Information	
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Director of Operations, Mental Health				

Main Report
Background and current situation:

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

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

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

Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance

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

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

<u>Part 1: PMHSS</u>

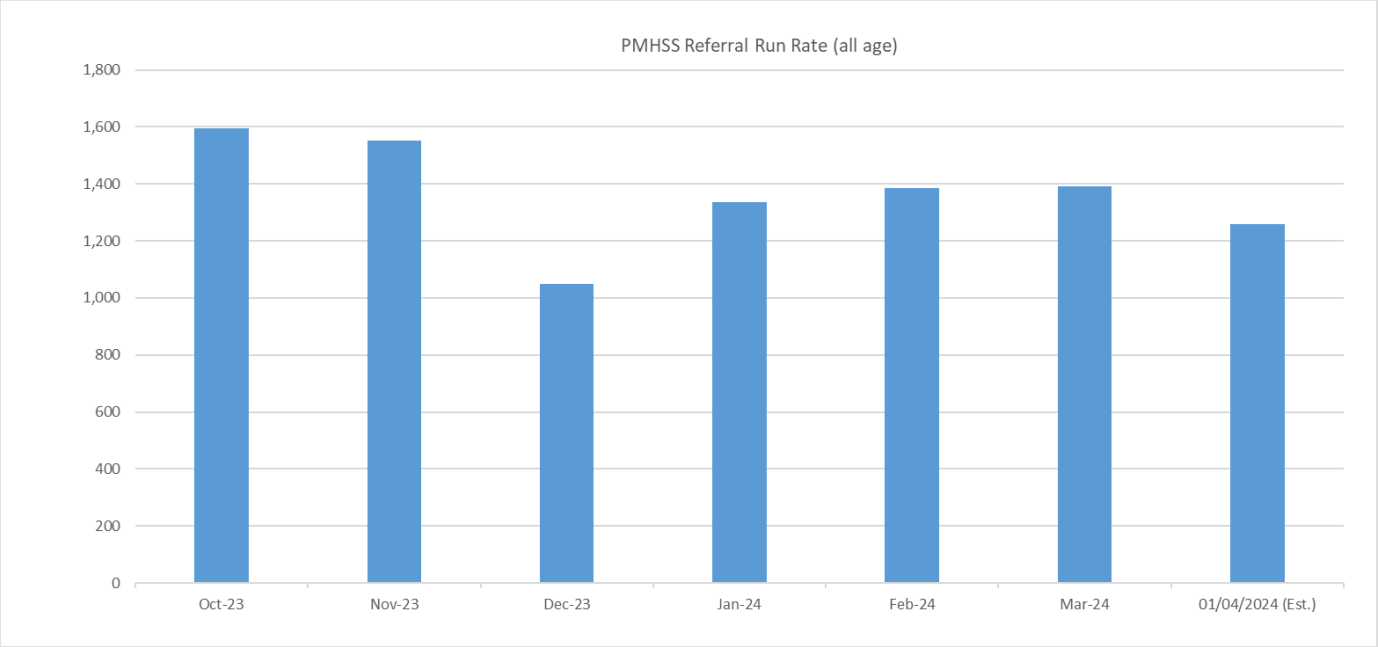
Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)
Part 1a is at 41% compliance on 4/4/24. This is a deteriorating picture as compliance on 23/3/24 was 63%.
As of 05/04 the average waiting time was 40 days with the longest waiting being 54 days.
Trajectory is deteriorating due to an upward trajectory of referrals from December 2023 to March 2024 (see Graph 1), with a slight decrease in assessments over the same period (see Graph 2). The fragility of compliance subsequent to busier periods with lower assessment capacity increases the wait time and reduces compliance (see Graph 3). Trajectories to restore compliance have been modelled with additional staffing complements of 1,2,3 and 4 additional whole-time equivalents to better understand what additionality is required to sustain compliance.

In terms of outcomes outside of the target, recent Civica report in March highlighted high quality interactions between service users and PMHSS:

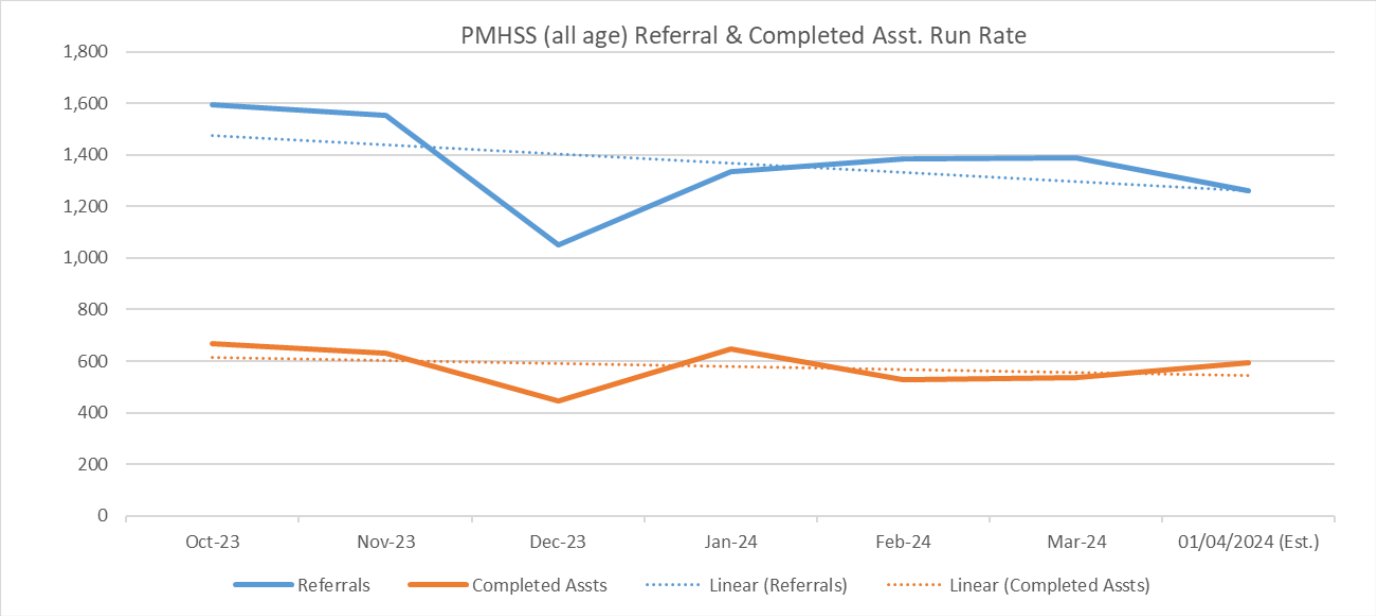
“Lovely lady I spoke to and other staff I spoke to.”
“Both Jim and sorry i can't recall the lady's name were fab. Very professional and compassionate.”
“The staff that I encountered were brilliant, very friendly and knowledgeable. They totally made a very stressful experience a very relaxing one. The recovery staff were equally supportive and friendly Thank you NHS you are fantastic.”
“Really listened to and everything I said validated as well as additional advice being given”
“The presence brightened my mood even more because they provide a fresh perspective and an excellent experience, and they genuinely listen to and care about me. I have hope that they can assist me in getting out of this sticky predicament.”
“Very empathetic and listened extremely well. Took time to understand and respond with support.”
“Very professional and the MH practitioner was very helpful and supportive towards my issue.”

In terms of areas of dissatisfaction, PMHSS waiting times were an area of concern:
“Reducing waiting times for examination and treatment is crucial, as is providing mental health patients with greater attention, particularly if they have had bad mood. It would be great if you could tend to the mental health of sick people more. I sincerely appreciate it.”
“Timescales but that is not the fault of NHS but the government.”
“Maybe shorter waiting time.”

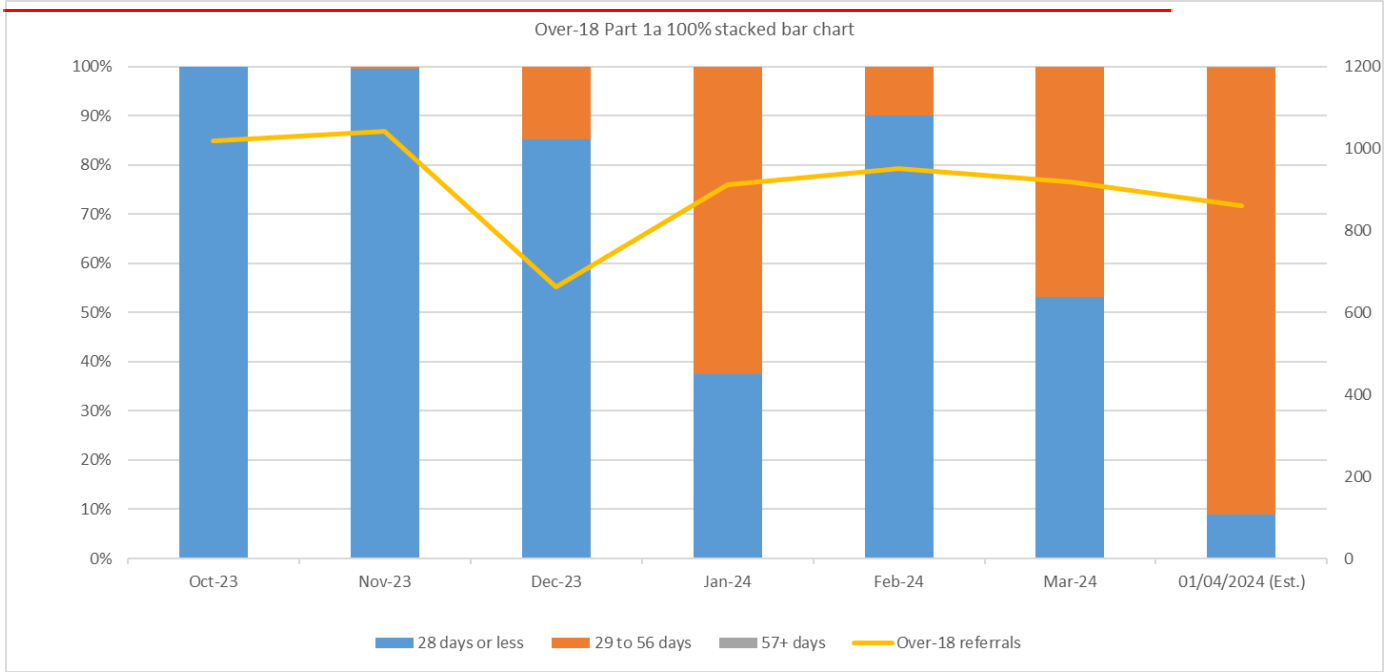
Graph 1:



Graph 2

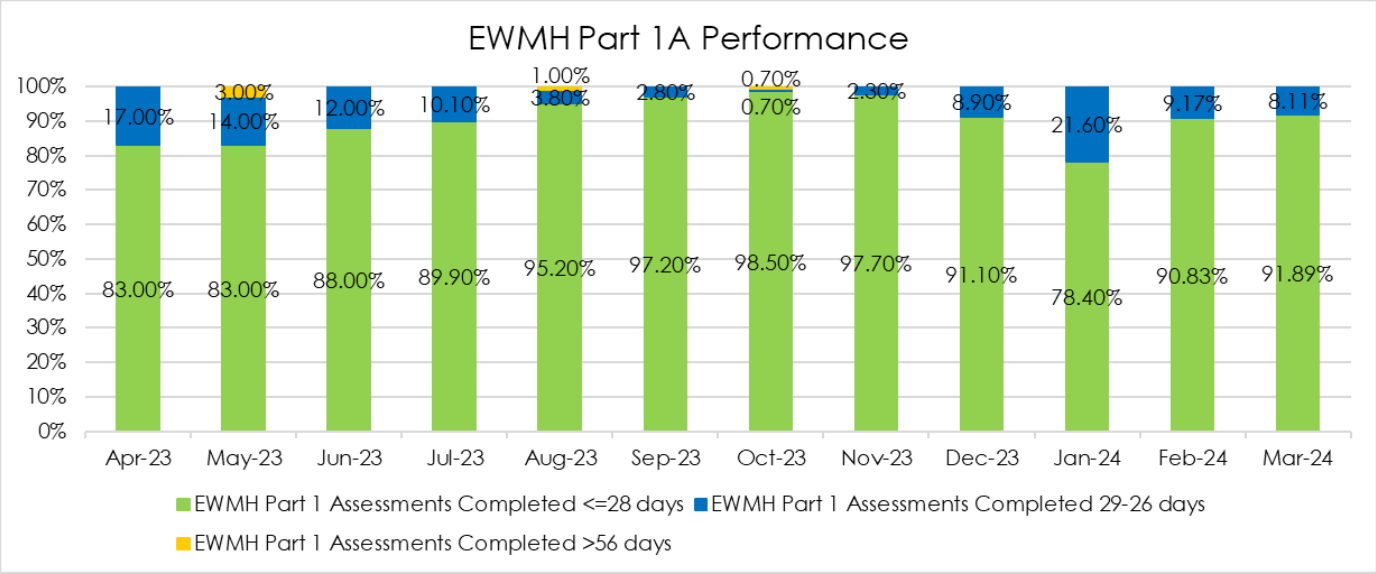


Graph 3



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

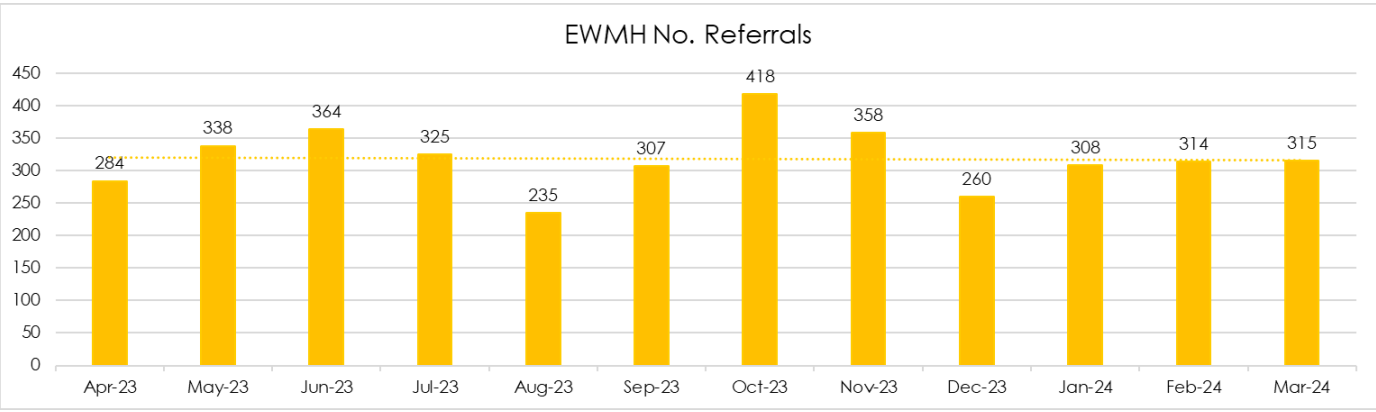
Graph 4



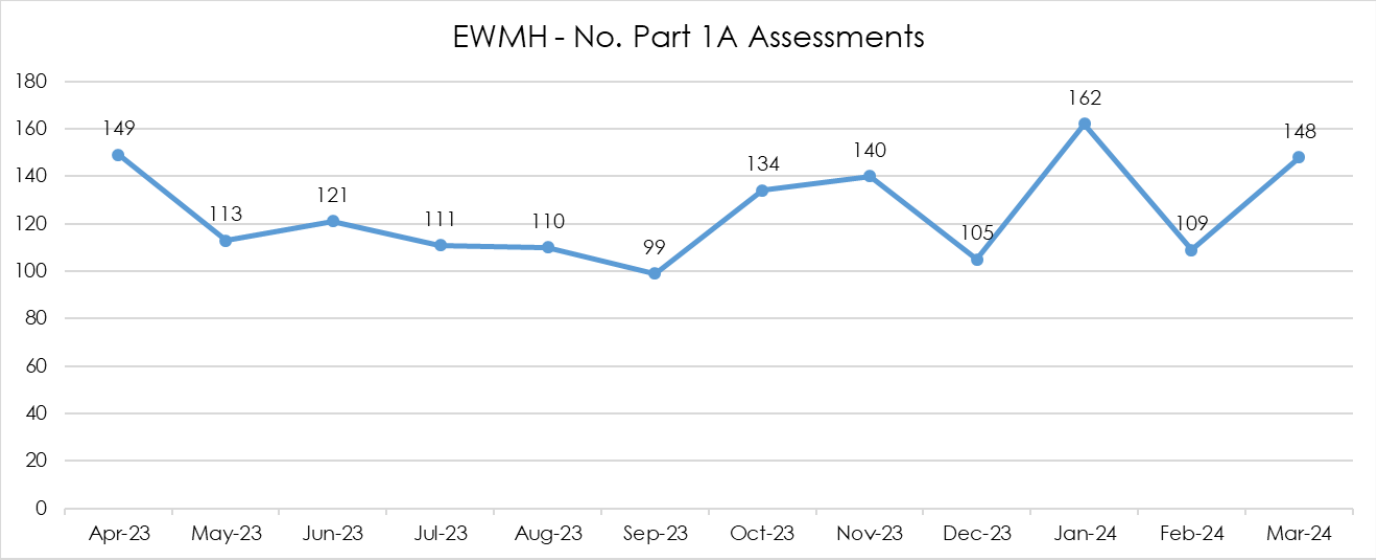
Despite a slight dip below the target in January, the service has since recovered and maintained compliance. In January 2024, the service unfortunately did not achieve compliance against the target as a result of reduced capacity due to long term sickness within the Assessment Team.

However, the establishment of the Assessment Team continues to support the service in providing sufficient capacity to meet incoming demand and the average wait for assessment currently fluctuates between 3-4 weeks.

Graph 5



Graph 6



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

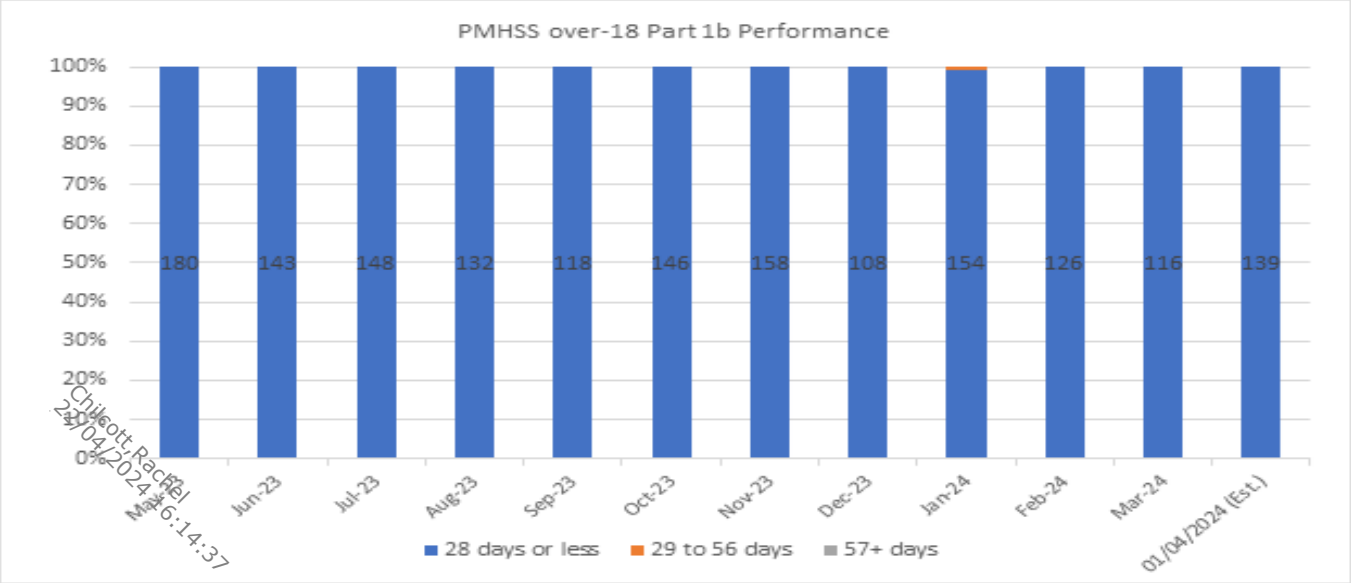
Part 1b remains 100% compliant (Graph 7). The same professionals delivering Part 1a assessments also deliver the interventions in Part 1b. The team have trained in the new Stress Control course which was procured for delivery in PMHSS. This large-scale, educative intervention uses lecture halls to deliver an evidence-based, high quality course to high numbers of people. This open access course is evaluated using clinical outcome measures (CORE 10) for attendees.

The PMHSS team continue to deliver group interventions for:

-Living Life to the Full
-Behavioural Activation
-ACT for Wellbeing
-Anger Awareness.

The *Understanding Me* course is currently under evaluation.

Graph 7:



Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)

There are ongoing issues with the achievement of the Part 1B target which is largely as a result of the volume of assessments which have been undertaken through the previous waiting list initiatives where the focus had been on the external waiting list. There has also been an additional impact as a result of the significant increase in referrals for assessment in March 23 and November 23 with increased numbers requiring follow on intervention.

The service has had ongoing capacity issues as a result of vacancies and sickness. Due to staff turnover as well as the bulk of the waiting list initiative and Healios intervention coming to an end, a number of young people on these caseloads remained in the service requiring treatment to be completed – this was prioritised, thus delaying treatment starts for those on the waiting list.

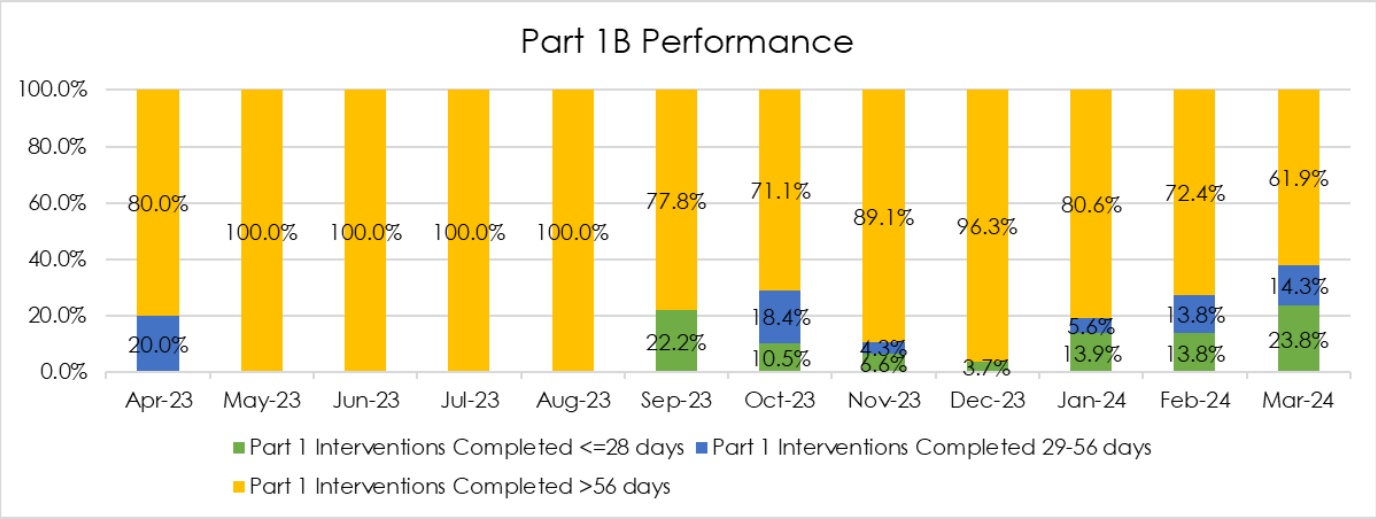
Additionally, during the last quarter we were unable to recruit to the 8a Psychology vacancy and the service now has four members of staff on long-term sick leave within the interventions team which support Part 1B. This has significantly impacted capacity and as a result, performance.

A full demand and capacity review has been completed and revised job plans for improved maximization of clinical activity against demand have been identified. New job plans have been mobilised with some improvement required and additional monitoring for caseload volumes has been implemented, as well as a system which highlights young people who have been receiving intervention for longer than expected to support with letting go and discharge.

Previous data quality and reporting issues have largely been addressed through the development of the new PARIS module for the team. We continue to work closely with the PARIS team to refine the reporting and proactively address any potential data quality issues, weekly internal monitoring remains in place to monitor capacity, demand and performance.

Additionally, the service is developing a psychoeducation offer which will be delivered as the initial intervention for children and young people and will support the delivery of the target against Part 1B.

Graph 8



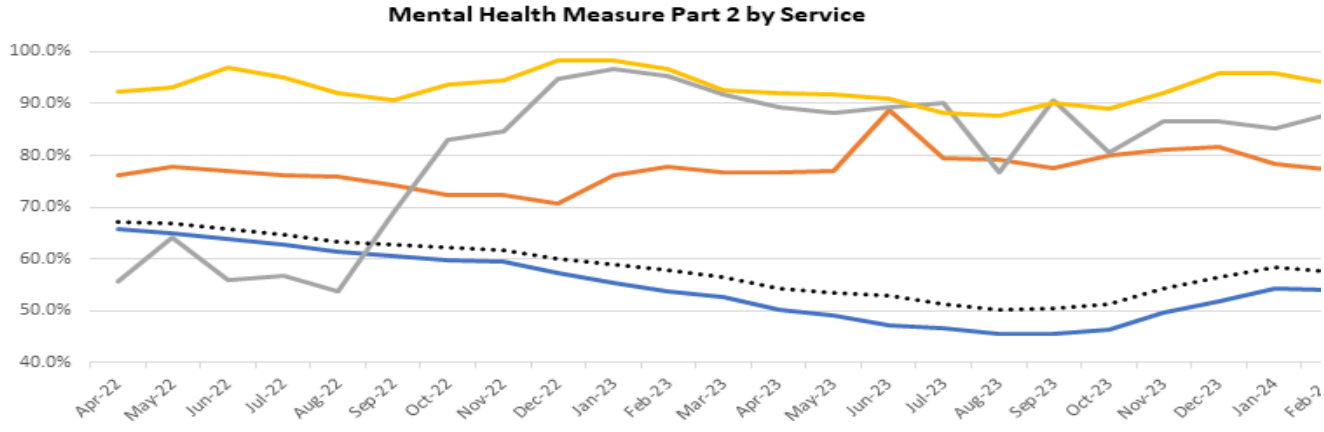
Actions to improve compliance against the target include:

- Recruitment to vacant posts – (1 x Band 8a Psychologist and 2 x Fixed Term Psychology Posts)
- Development of psychoeducation offer for children and young people
- Active sickness and absence monitoring and wellbeing support to the team – currently 3.80 WTE on LTS
- Supplementary capacity using agency staff to cover sickness/vacancies
- Active weekly monitoring of capacity and demand as well as caseloads and supporting the process of letting go through peer group
- Regular triage of the internal waiting list and waiting list validation
- Work with PARIS and clinical team to address data capture, recording and reporting quality
- Active work on clinical pathways to ensure a clear model that allows for clear capacity and demand planning
- Extension of the group offer which provides an alternative intervention offer for several children and young people, which will help meet demand
- Engagement with Silvercloud re developing the refer in offer for support offer for anxiety, depression and low mood
- Evaluation of acceptance criteria for referrals at SPOA to make sure we are consistent in decision making and maximising signposting opportunities.

Part 2 – Care and Treatment Planning (over 18)

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

Graph 10



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	F
Adult	65.7%	65.0%	64.0%	62.9%	61.5%	60.7%	59.9%	59.5%	57.2%	55.4%	53.8%	52.7%	50.3%	49.1%	47.3%	46.7%	45.7%	45.7%	46.3%	49.6%	52.0%	54.4%	54
MHSOP	76.3%	77.9%	77.0%	76.1%	76.0%	74.2%	72.4%	72.3%	70.8%	76.2%	77.7%	76.7%	76.6%	77.0%	88.8%	79.4%	79.1%	77.6%	80.0%	81.0%	81.5%	78.4%	77
CAMHS	55.6%	64.2%	56.0%	56.9%	53.7%	69.1%	83.1%	84.5%	94.6%	96.6%	95.2%	91.8%	89.4%	88.1%	89.2%	90.2%	76.6%	90.6%	80.5%	86.5%	86.5%	85.3%	88
LD	92.2%	93.2%	97.1%	95.0%	92.0%	90.8%	93.8%	94.6%	98.4%	98.4%	96.8%	92.6%	92.0%	91.8%	90.9%	88.3%	87.7%	90.2%	88.9%	92.0%	95.9%	95.7%	94
Total for UHB	67.1%	66.8%	65.8%	64.8%	63.4%	62.7%	62.2%	61.8%	60.0%	59.0%	57.8%	56.5%	54.4%	53.4%	52.9%	51.4%	50.3%	50.5%	51.3%	54.4%	56.5%	58.3%	57

There has been a steady improvement in compliance with Care and Treatment Plans since August 2023 but this improvement has started to level out during February 2024. The main challenge continues to be compliance within medical caseloads, specifically where the medic has:

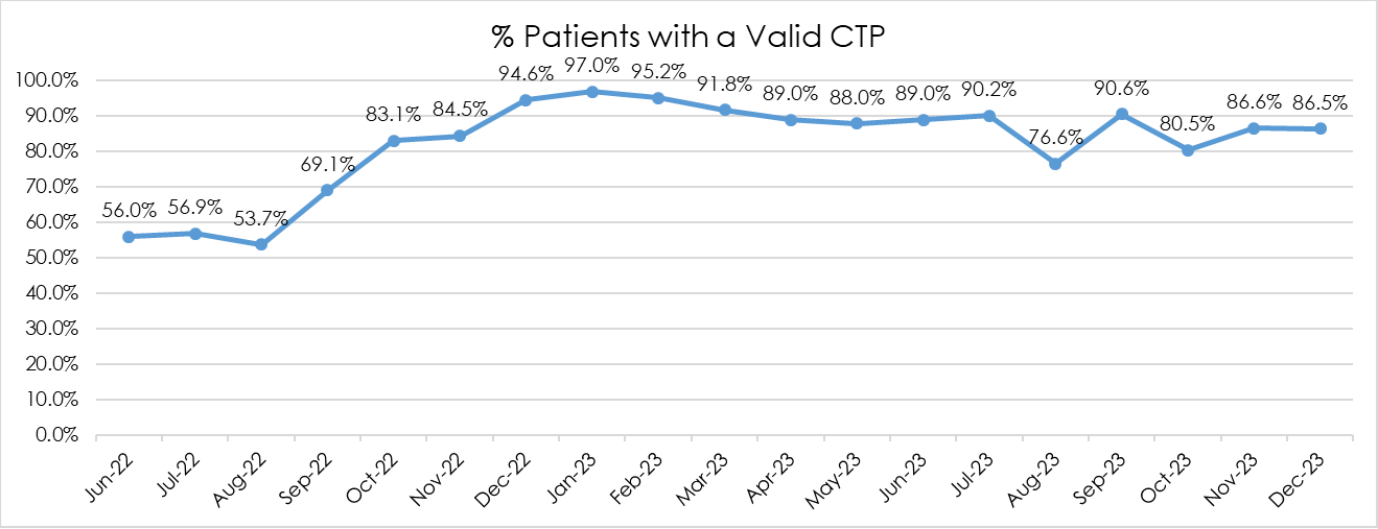
1. Large caseloads of patients (typically over 100)
2. Where the medic is the only professional involved in the care of the individual

The Recovery And Maintenance Programme (RAMP) Protocol has been submitted to the MHMCLC for ratification. A Equality Health Impact Assessment is approaching completion. Following ratification of the protocol, the Part 1 Scheme which articulates all of the Mental Health provision outside of Part 2 services will await ratification from the 30th April 2024 MHMCLC. The RAMP Protocol is designed for service users who only see a single clinician and where they cannot be discharged due to limits of provision in primary care (such as for medications where there is no shared care agreement). The expected benefits for compliance will be that this will create the first provision in line with the Measure for 'Stable Severe' service users. The benefit for service users will be that their care will continue to be delivered, Part 3 rights will be protected, access to usual services such as the CMHT Duty worker will continue and all letters to the GP from the Outpatient Clinic are mandated to be sent to the service user.
Where this is applied in Adult Mental Health services, we expect to see significant improvements in Care and Treatment Plan compliance month on month, as service users are transferred onto the RAMP Protocol.

The Recovery and Wellbeing College course *Preparing for Discharge* has commenced on the Wards and been evaluated, a further course has started on 19th March 2024 to improve the quality of Care and Treatment Plans. This course has been developed with Health Education and Improvement Wales, Social Care Wales and co-produced with staff, service users and carers in the usual manner.

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

Graph 11



For the last quarter, compliance has dipped slightly below target. The service continues to face challenges in relation to the CTP process including poor engagement from young people as a result of the paperwork having a more adult focus. This issue has been flagged to the All-Wales CAMHS Implementation Network in the hope a collective piece of work can be completed to make improvements to the paperwork for children and young people. The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate and in a supportive multi-agency approach.

It is anticipated that the implementation of the new clinical pathways, with clearer identification of those children and young people requiring a CTP will have a positive longer-term impact on the achievement of the target. All staff have received in-house Part 2 training to support with the identification of young people who should be on a CTP.

There are also now clearer mechanisms on PARIS to capture Part 2 data and sustaining compliance remains a priority for the service.

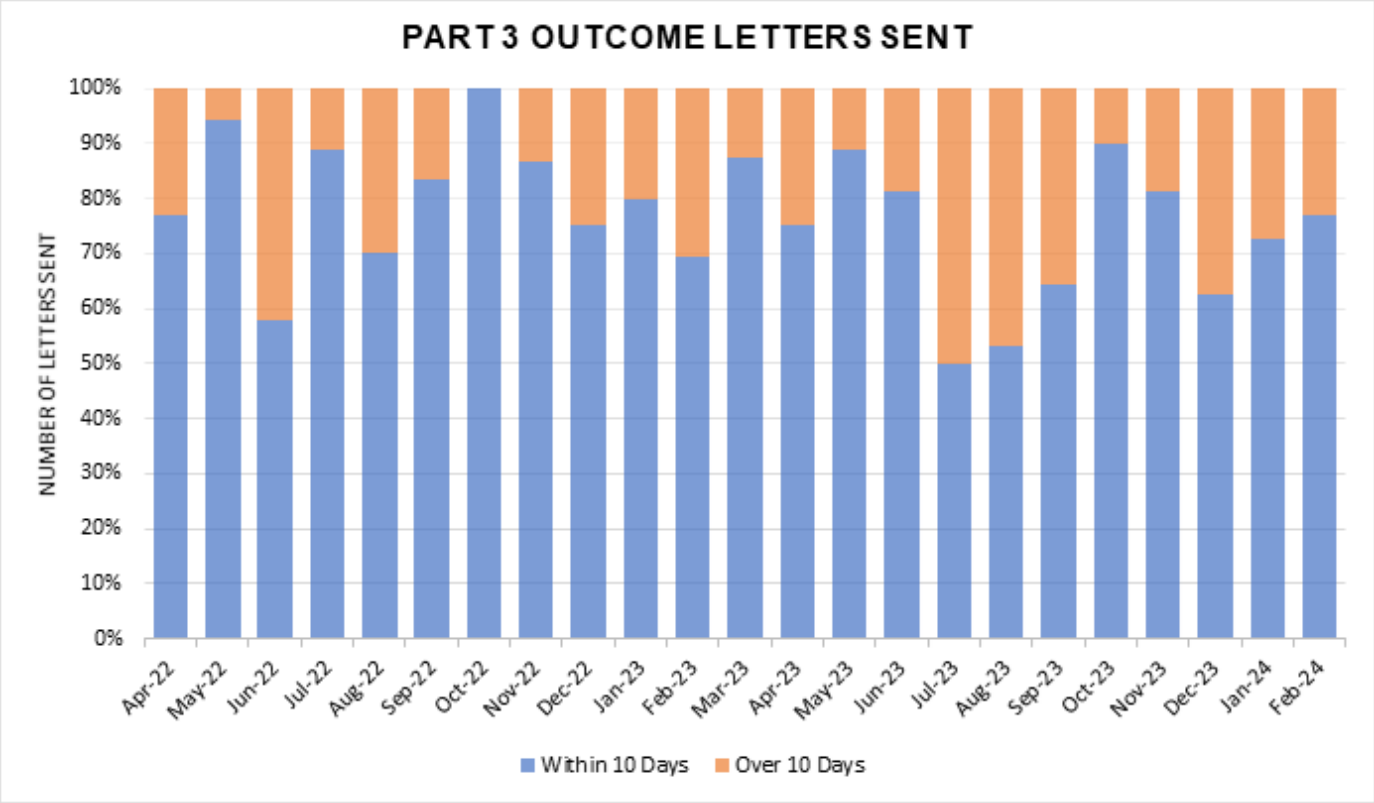
Actions to improve compliance against the target include:

- Embedding staff training
- Engagement with Youth Board re ensuring a child and young person friendly approach to the CTP process.
- Engagement with All Wales CAMHS Implementation Network to support a national improvement to the paperwork for CYP

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

The target relates to service users who have self-referred, having a confirmation letter regarding the outcome of their assessment within 10 days. Graph 12 details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 12



The Adult and Older people's directorates have dedicated time with the Mental Health Clinical Board to explore the various issues contributing to volatility of the target. There has been an improvement in the target and there has been exploration of the process issues contributing to the breaches in return. A new process map has been designed to sit alongside the new standard operating procedures for assessments in CMHTs though some dedicated digital time is required to ensure that the PARIS electronic record system supports this and is amended to ensure that manual reports are removed. 45.8% of referrals were accepted back onto the caseload in January and February 2024 compared to 45.2% in Q3.

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

100% compliance but asks the committee to note the following:-

The following observations for quarter 4 in the delivery of Advocacy services across Cardiff & Vale

- There have been some staffing issues within ASC over the last few months and 1 vacancy still outstanding. This is in common with all 3rd Sector organisations having difficulty recruiting to relatively low salary scales.
- There has been no increase in Welsh Government funding for Advocacy since inception of the Mental Health Measure 2010 and demand continues to rise.
- Some consultant psychiatrists have taken on board the IMHA role and tried to include the IMHA in arranging ward rounds if the client has asked for their support
- Continue to work with Doctors on the mental health elderly non instructed wards has resulted in a good working practice for the clients and still keeping the advocacy independent for the client but resulting in better outcomes for the clients.

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:
Part 1: Operational decisions about staffing numbers to maintain consistent compliance to be outlined at next meeting.

Part 2: RAMP goes live following MHMCLC

Part 3: Process mapping underway and PARIS development required to provide a reliable system to monitor and maintain compliance.

Part 4: Continue with ongoing progress.

Recommendation:

The Committee is requested to:
Committee to note the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Reduce health inequalities	X	Have a planned care system where demand and capacity are in balance	
Deliver outcomes that matter to people	X	Be a great place to work and learn	
All take responsibility for improving our health and wellbeing	X	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
Offer services that deliver the population health our citizens are entitled to expect	X	Reduce harm, waste and variation sustainably making best use of the resources available to us	
Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
Chilcott Rachel 22/04/2024 16:14:37
Safety: Yes/No
No
Financial: Yes/No
No

Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
Yes
Socio Economic: Yes/No
No
Equality and Health: Yes/No
Yes
Decarbonisation: Yes/No
n/a

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

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS
POWER OF DISCHARGE SUB COMMITTEE HELD AT 3 PM ON 9th April 2024
MENTAL
HEALTH ACT OFFICE AND VIA TEAMS

Present:
Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer - Vice Chair, PoD Group
Alex Nute - PoD member
Mair Rawle - PoD member
Alan Parker - PoD member
Gerrie Hughes – PoD member via TEAMS
Mike Lewis – PoD member
Wendy Hewitt-Sayer - PoD member
Margaret Jones – PoD member
Dr John Copley – PoD member via TEAMS
Sharon Dixon – PoD member

Apologies:
David Seward – MHA Manager
Professor Ceri Phillips - Vice Chair, Cardiff and Vale Health Board
Sarah Vetter - PoD member
Peter Kelly – PoD member
Rashpal Singh – PoD member
Amanda Morgan – PoD member
Sarah Vetter – PoD member

1. Welcome and Introductions
The meeting was held in the MHA office and via Teams and the Chair welcomed all to the meeting.

2. New Members and Independent Members
There had been no new appointments since the last meeting. The Chair provided an update on Sarah's situation as she had been in contact. Our best wishes to her and Norman. Mary was still not in a position to resume sittings at Hearings. The Chair asked Alan to convey our best wishes to her.

3. Apologies
Apologies were received and noted.

4. Members points for open discussion
Barring Hearing – there was a lengthy and wide-ranging discussion on Barring Hearings and the interpretation of dangerousness in light of a recent case before the managers. Barring hearings were infrequent and a number of manager's had yet to sit on a Barring Hearing although this was being addressed through the MHA office. It was agreed that the Chair and Vice Chair would pull together a reference sheet in respect of the wording to be considered in the minutes and decision recording. It was noted that if the barring was not upheld it wasn't possible for the Responsible Clinician to re-section unless there had been a change in circumstances.
Action - Chair and Vice Chair

5. Minutes of Meeting held on 9th January 2024
The minutes were confirmed as an accurate record of the meeting.

6. Matters Arising
The PoD member who had raised the issue of the Pie chart had discussed the issue with the Deputy MHA Manager.

The Chair confirmed that he had responded to the feedback raised by one of the professionals. There had been no further response. **Action completed**

It was unlikely that there would be changes to the Mental Capacity Act or a revised Mental Health Act. In view of that if panels were concerned regarding the capacity of a patients this should be recorded in the reasons. **Action - ALL**

The process of clearing the room in the MHA office to facilitate Hearings was well underway. The Chair did not anticipate the use of the seminar room on Beech ward would continue much longer. It was noted that since a return to face to face hearings that there had been no hearings held in either Barry Hospital of the Community Mental Health Teams Offices. **Action - Chair to discuss with the MHA Manager**

There had been one request for a discretionary review in the last quarter. No issues identified. The Chair will continue to monitor. **Action - Chair**

7. Operational Issues
No issues identified

8. Lessons Learnt
A recent Hearing, at which an interpreter was required, had been conducted via TEAMS. The panel felt that such Hearings should be face to face unless the patient objected. **Action - MHA Manager**

9. MHA Activity Monitoring Reports
Activity reports were provided for the periods January to March 2024 for both Hospital Managers and Tribunals. The contents of the reports were noted with the following issues highlighted:

- There had been a number of adjournments for both Manager's Hearings and Tribunals. It was unclear whether these were related to the on-going strikes by junior doctors.
- The writing on the bar charts weren't aligned
- It appeared that the Barring Hearing was held in January on one graph and March on another.
- The value of the PIE chart representing just two numbers was questioned
- The second pie chart on page 3 was measuring two different activities

Action - Chair to discuss with the MHA manager

10. Concerns/compliments from Power of Discharge group Hearings
These were noted and discussed. Concern was raised that a WARNN had not been updated to reflect a patient's three suicide attempts (number 14). Also, a CTP from January was noted as a WIP. **Action - Mental health Manager to chase.** Chair to raise the issue of the WARNN at the next Mental Health Legislation and Governance Committee Meeting. **Action - Mental Health manager and Chair**

11. Committee and Sub-Committee Feedback
The Chair had nothing further to add. The minutes from these meetings were attached.

12. Training
The All Wales Training day held on the 29th February 2024 in Builth Wells was discussed. Overall, the training had been well received although there were some concerns that the opportunity for

shared learning was lost as there was no verbal feedback from the group discussions. The numbers attending were again quite low and the question was asked as to whether this was due to the choice of venue. **Action - Chair to discuss with the MHA Manager**

Chair advised that Dan Crossland had further invited PoD members to join the feedback from the CTP training on 16th April– **Action –PoD members**
Training on Acquired Brain Injuries would follow the close of the business meeting.
There was a request for some training/information on the types of accommodation available for patients on discharge from hospital.

13. A.O.B
PoD members discussed the benefits for patients held under the Mental Capacity Act with regards to their choice of accommodation and their rights to challenge the accommodation identified for them.
Following a complaint, the Chair requested that all members be mindful of protective characteristics when discussing any patients whilst engaged in the HB's business. Further unconscious bias training will be provided at a later date. **Action - PoD members**

Future meetings to be held in the MHA office and via TEAMS on the following dates:

9th July 2024
8th October 2024
14th January 2025

As there was no further business the meeting was closed.

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 11 April 2024 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
Bianca Lepore	Deputy Mental Health Act Manager
Claire Ward	Consultant Social Worker DOLS/ AMHP Lead, Cardiff LA
Jeff Champney-Smith	Chair, PoD Group
Joshua Lusby	CAMHS Representative
Chloe Evans	Mental Capacity Act Manager
Noel Martinez Walsh	Lead Social Worker, Vale LA
Chris Frayne	Senior Nurse, Low Secure Services
Alex Allegretto	Advocacy Support Cymru Representative
Matthew Russell	Operational Manager, Cardiff LA
Gemma Lewis	Emergency Duty Team Lead, Cardiff LA
Bethan Evans	Emergency Duty Team Lead, Vale LA
Rebecca Lendon	Consultant Representative
Jayne Jennings	Senior Nurse, Inpatients
Marianne Seabright	Senior Nurse, MHSOP
Tim Crowston	Crisis Team Representative
Lynda Woodley	Operational manager, Vale of Glamorgan LA
Ceri Lovell	CAMHS representative

Apologies

Rachel Rushforth	Lead Nurse(Adult Mental Health)
Julia West	Senior Nurse, Complex Commissioning Team
Philip Ball	Senior Nurse, Community
David Seward	Mental Health Act Manager

1 Welcome and Introductions

The purpose of the meeting was explained to all those present for the benefit of new attendees. Terms of reference have been altered slightly along with the structures within the health board.

2 Apologies for absence

Apologies were noted.

3 Minutes of meeting held on 11 January 2024

No points of correction have been highlighted from the previous minutes.

4 MHA Activity

The monitoring report was gone through and the anomalies picked up within the last quarter were discussed. It was noted that there has been an increase in the use of Section 135(1) this quarter. Although the number hasn't breached the control limit it was not far off this. Its suggested that this increase may be partly due to the local authorities providing information more accurately to the MHA office and potentially as a result of the right care, right person initiative being launched by South Wales Police. It was agreed that although no discernible trend can be picked up on at this stage, that keeping our eyes on the use of S135 and S136 will be important going forward. The number of voluntary assessments hasn't changed to any degree during the last quarter either. It was noted that unfortunately at present there is no way of us accurately recording the number of voluntary assessments. The number of CAMHs S136s has also decreased and there has only been one repeat presentation. There was one use of Section 4- the nature of its use was appropriate. The role of the AMHP within the community treatment order process was briefly discussed. There has been a noticeable increase in the volume of both adjournments and postponements of both Hospital Managers and Mental Health Review Tribunal hearings. This was explained partly by the doctors strikes and partially due to ensuring that the correct people are in attendance at hearings in order to avoid adjournments which are more costly in terms of time and money. It was also noted by the chair of the PoD group that the importance of ensuring patients have had access to reports and opportunity to discuss them was perhaps overlooked on occasions. He would like professionals reminded of this requirement. Advocacy Representation has increased and it is felt that use of the advocacy is positive. The exception report was highlighted and the exceptions this quarter read out. We have had one transfer in that it transpired was unlawful. We have had one fundamentally defective application due to the Welsh regulations not having been complied with. We have also had two lapsed detentions- one due to a patient being AWOL and another due to communication issues between ourselves and the transferring hospital. During the period one S136 lapsed due to the patient not being fit for assessment during the required timescales.

Action- to remind professionals to offer and go through hospital managers reports with patients prior to hearings.

5 Matters for Action

EAS cover from Alder and Cedar has been added into the establishment- this can therefore be removed.

Bed management Section 140- CAMHS are looking at this at present. It was felt that the document could be more succinct in order for it to be more user friendly. Action log to be revised in accordance with this.

Consultants taking assessments after 4pm- this is still an area that needs movement and cooperation agreed between the Health Board and Local Authorities. It appears that there are still many challenges being faced by both the Health Board and the Local Authority when arranging assessments at this point in the working day. The Local Authorities do not feel the response from the Health Board is satisfactory. A trial has been progressed between SPRs and consultants during the last month which has proved to be successful but sadly this isn't tenable in the long term. Day time services are also affected by what is happening overnight due to potentially avoidable delays and therefore assessments and other work being passed on to others. Although at present discussions have only been held within adult services this problem could arise in older people's services. Discussions with the Clinical Board Director and Assistant Clinical Director are imminent.

It was agreed that when appropriate one doctor can be used for assessment for patients detained under S136. It was noted that there are two separate strands to this- one whereby a consultant deems the person to not be suffering from a mental disorder and therefore no AMHP involvement is necessary and another strand whereby a full assessment is needed including the use of a second doctor and an AMHP. It was noted that these are two separate circumstances and need to be treated as such. This needs to be forwarded back to the committee.

There is ongoing work surrounding ward rounds and their structure therefore this can be removed.

There hasn't been any response from children's services in relation to S117 but it was noted that thankfully we don't have many children entitled to S117. The Lead AMHP for Cardiff will keep this on her radar.

The Chair of the group has agreed to chase up the prison service in relation to the sentenced prisoner who was incorrectly placed on a Section 2.

The Section 135 with no place of safety will be discussed at a senior level- this can be removed from the log.

The apparent miscommunication between advocacy and nursing staff has been investigated and resolved and it was explained that nursing staff weren't hindering an advocate's ability to walk around a ward but were rather ensuring patients confidentiality by not allowing advocates to stay in the nursing offices for prolonged periods.

The footprint of A&E is changing and what constitutes A&E is being further investigated by the Mental Health Act Manager.

Action- amend action log as deemed appropriate- done in conjunction with the Chair of the group and the Mental Health Act Manager

6 Feedback on operational issues and incidents

No progress with regard to the locked door policy, however re-establishing the working group for this will need to be added to our action log. It is now likely that DOLs will continue to be used.

Action- re-establish working group

Section 140 procedure- this has been discussed and its felt that a more easy read format will be beneficial.

The Lead Nurse for MHSOP discussed one case whereby a patient was admitted onto a general ward and subsequently had a Mental Health Review Tribunal on this general ward. This is an unusual situation. The patient won the appeal and was discharged from detention by the Mental Health Review Tribunal and was then discharged back home under care of the react team. Concerns were raised by the Lead Nurse in regard to the way this discharge happened- it was felt to be rushed due to the MHRTs decision. Unfortunately, the discharge had adverse consequences for family members as well as the patient and the patient ended up being re-detained. It was explained that the Tribunal do have the power to make deferred discharges and do use this power. The lack of beds within mental health services for older people was also raised as this prevented the patient being transferred to a mental health ward at the desired time. The Lead AMHP for Cardiff queried whether we can challenge a Tribunals decision but it was agreed that this is a difficult process to follow. The Chair of the PoD group also highlighted that the PoD group are also aware of how important aftercare plans are within the decision-making process. It was agreed that there are regulations that ensure the team looking after the patient do need to know what aftercare would look like if a patient were to be discharged. The Lead AMHP in the Vale also raised concerns that some requests for MHA assessments are being made due to social care needs rather than a need for an assessment of a person's mental health. It was felt that carers pressure and inappropriate placements/ care packages are perhaps contributing to this trend. It was proposed that this is perhaps behind some of the bed pressures within MHSOP. The Chair of the group informed those present that the violence against women domestic abuse and sexual violence action plan has been agreed. Both Local Authorities and the Health Board are all part of this. This will need to be considered in terms of its interface within the Mental Health Act. The Operational Manager for the Vale reminded those present that the Tribunal make decisions both according to what is described to them on the day and what is contained within a patients reports. It is therefore very important to detail the risks involved/ aftercare available etc in order for the Tribunal to make a robust decision. The Code of Practice for Wales does suggest there is a structured assessment for risk. The Lead Nurse for MHSOP may well contact the Tribunal directly in regards to this. It was generally agreed that holding either Hospital Managers hearings or MHRTs on general wards is not ideal.

7 Feedback

AMHPs from Cardiff LA have noticed an increase in the number of medical recommendations being made in advance of the MHA assessment being arranged. The Code of Practice is clear that assessments should be held jointly unless a clear justification can be provided to deviate from this. It is felt that MHA assessment should be prioritised and that a patients' rights should be treated with the utmost importance. The Lead AMHP would like a discussion to be held with the doctors. The Deputy MHA Manager agreed to provide some stats around how many single medical recommendations we're receiving here without the MHA assessment being arranged. The Emergency Duty Team Manager reiterated these concerns as they can have ramifications further down the line in terms of nearest relatives etc.

Action- Deputy MHA Manager to provide statistics around single medical recommendations to Lead AMHP for Cardiff.

A Welsh mental health conveyance review is in the pipe line. There is an acknowledgment that WAST cannot provide the necessary service for mental health. It is hoped that a standard service from transport can be created. This is hoped to improve and expand on the service from St Johns ambulance.

The PoD group continue their discussion around dangerousness and the differences they need to consider when participating in a barring of nearest relative hearing compared to the more regularly used detention/ renewal criteria. There has been some difference of opinions between Hospital Managers and clinicians recently around this issue. Pleasingly there is a reduction in the volume of recommendations from PoD in relation to care and treatment plans. One specific issue about a patients WARRN was briefly discussed.

Ward rounds are still of concern to advocates as there is no clear time frames for ward rounds to happen- neither nursing staff or advocates are aware of precise times for doctors to see their patients. The advocacy service is currently recruiting and is one staff member down.

No feedback from the consultants meeting.

No feedback from the police.

No feedback from the approved clinicians' panel.

No feedback from Tribunal meeting.

8 Power of Discharge Group comments, compliments and feedback

Discussed above.

9 External reviews

None held this quarter.

10 Interface MHA/MCA/DOLS

No feedback.

11 Quality indicators and audit activities

No update on this.

12 Any other business

The Supreme Court Judgement Worcestershire V Swindon was discussed. The position as it stands is that the initial detaining authority retains responsibility for S117 even if the person moves elsewhere in the country. The intricacies of some jointly funded individuals were acknowledged to not fit into this judgement very easily and therefore agreements are likely to be a person by person basis. The “who pays” guidance also needs to be relooked at. It was noted that this Judgement is likely to cause a hinderance to cohesive working. This will be kept within the agenda.

The Chair of the group will email those present with the final version of the VAWDASV. It was proposed that discussing the impact of this on the use on the MHA may be on the agenda for the next meeting.

13 Date of future meetings

11th July 2024

10th October 2024

16th January 2025

Mental Health Legislation & Governance Group Action Log

Key:	Red: Outstanding	Amber: In progress	Green: Completed

ACTIONS FROM PREVIOUS MEETINGS

STATUS	SUBJECT	AGREED ACTION	ACTION BY
To be removed	~~Section 135 incident – no cover in EAS. SecureCare had to manage patient~~	~~Fact finding in order to establish the issues surrounding this incident – Lead Nurse to take forward~~	~~**RR**~~
Revised below	Bed management/s140 policy	Once finished, to be circulated for comment by Service Manager for Inpatients.	**SW**
	Supreme Court Ruling	Further discussions to be had regarding the impact of the ruling	**RK/DS**
Revised below	SPR's and consultants taking assessments after 4pm	Chair to discuss further with the Clinical Board Director and AMHP colleagues from the LA for an agreed position	**RK**
	136 assessment with one doctor	MHA Manager to discuss with Clinical Board Director whether one doctor is sufficient in CaV for a consistent approach	**DS**
To be removed	~~Lack of structure with ward reviews for Advocates~~	~~MHA Manager to liaise with Deepali Mahajan re: new ward round structure~~	~~**DS**~~
	117 knowledge gaps in CAMHs LA teams	Re-start discussions with CAMHs LA for training to be scheduled in	**CW/DS/CH**
	Sentenced prisoner being detained in HYC	Chair to liaise with Clinical Board about reaching out to Prison service re: review of incident	**RK**
To be removed	~~Section 135 incident where no PoS identified~~	~~Police Representative and Senior Nurse, Inpatients to investigate further and feed back~~	~~**JJ/CLT**~~
To be removed	~~Advocacy not allowed to walk around wards~~	~~Advocacy Representative to liaise with Senior Nurse, Inpatients for clarity~~	~~**JJ/DB**~~
	Patients being detained in A&E	MHA Manager to liaise with Senior Nurse, Crisis and Clinical Board about detaining patients in A&E	**DS**

ACTIONS FROM THIS MEETING – 11th April 2024

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	Bed management/s140 policy	Needs to be more succinct in order for it to be more user friendly	**SW/RK**
	SPR's and consultants taking assessments after 4pm	Further discussions between Clinical Board Director and Assistant Clinical Director are progressing the matter	**NJ/EM**
	Locked door policy	This working group needs to be re-established.	**RK**
	Single med recs being done	Deputy MHA Manager will provide data to the Cardiff LA around this.	**BL/CW**

Report Title:	Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act, 1983 Procedure			Agenda Item no.	6.1
Meeting:	Mental Health and Capacity Legislation Committee	Public	X	Meeting Date:	30th April 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Mental Health Clinical Board Director of Operations				
Report Author (Title):	Mental Health Act Manager – David Seward				

Main Report
Background and current situation:

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non-exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act 1983 Procedure sets out the requirements of the Mental Health Act 1983 (as amended by the MHA 2007) as to the purpose and process of identifying a Responsible Clinician and Nominated Deputy.

This document provides clear guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

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

The current procedure has been created to ensure statutory requirements under the Mental Health Act 1983 are met.

This includes key issues such as:

- The purpose of a Responsible Clinician and nominated deputy
- The process for identifying, allocating or changing the Responsible Clinician
- The process for identifying the nominated deputy
- The duties of the Responsible Clinician and nominated deputy

This procedure will ensure that the Health Board remains compliant with their statutory duty to allocate a Responsible Clinician to all detained patients under the Mental Health Act.

Wide consultation has taken place to ensure the procedure meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows: -

- The document was shared with the Mental Health Clinical Board Controlled Document Oversight Group, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager and the Principal Health Promotion Specialist.

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document, the Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act, 1983 Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Board / Committee are requested to:

- **APPROVE** the Allocation of Responsible Clinician and Nominated Deputy, Mental Health Act 1983 Procedure

and

- **APPROVE** the full publication of the Allocation of Responsible Clinician and Nominated Deputy, Mental Health Act 1983 Procedure in accordance with the UHB Publication Scheme

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
Yes – detail provided in the report regarding patients having an allocated Responsible Clinician.
Financial: Yes/No
No
Workforce: Yes/No
Yes – detail provided in the report regarding patients having an allocated Responsible Clinician.
Legal: Yes/No
Yes – detail provided in the report regarding compliance with the Mental Health Act
Reputational: Yes/No
No
Socio Economic: Yes/No

No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

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

Reference Number: TBC **Version Number:** 2	**Date of Next Review:** 23/02/2027 **Previous Trust/LHB Reference Number:** N/A

Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act, 1983

Introduction and Aim

This document supports the Allocation of Responsible Clinicians and Nominated Deputy, Mental Health Act, 1983 (MHA) Procedure.

Cardiff & Vale University Health Board are committed to providing appropriate services to detained patients being assessed and treated under the Mental Health Act 1983.

To ensure every patient has an allocated Responsible Clinician (RC), who will have overall responsibility for the patients care and treatment under the MHA.

To provide clear guidance in relation to identification of the nominated deputy, who is able to independently exercise section 5(2) powers in the absence of the RC.

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

Objectives

This procedure describes the following with regard to allocating or changing a Responsible Clinician and identification of the nominated deputy:

- The purpose of a Responsible Clinician and nominated deputy
- The process for identifying, allocating or changing the Responsible Clinician
- The process for identifying the nominated deputy
- The duties of the Responsible Clinician and nominated deputy

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

Scope

This procedure applies to all of our staff in any inpatient setting where a person is receiving compulsory treatment in hospital under the MHA or is subject to a community treatment order (CTO).

Equality and Health Impact Assessment Chilcott Rachel 22/04/2024 16:14:37	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental He Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • The Equality Act 2010 • Mental Health (Wales) Measure 2010 • Section 5(2) Doctors Holding Power Procedure All Cardiff and Vale Mental Health Act Policies and Procedures
Approved by	Mental Health Clinical Board Quality and Safety Committee

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

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*25/06/2020*	*27/07/2020*	*New document*
2	*23/02/2024*		*Mental Health Legislation & Mental Capacity Act Committee replaces Mental Health & Capacity Legislation Committee.* *Expanded on paragraphs throughout for easier reading and understanding.* *Added a paragraph around CAMHs, Learning Disabilities and PICU allocation for clarity.* *Expanded the section on 'patients admitted to a non-mental health ward' for clarity.*

CONTENTS

1 INTRODUCTION

1.1 This procedure sets out to describe the process of identifying, allocating or changing the Responsible Clinician (RC) responsible for the care and treatment of patients detained under the Mental Health Act 1983 (MHA). It also gives guidance on the duties of the Responsible Clinician and nominated deputy.

1.2 Under the MHA the RC is the Approved Clinician (AC) with overall responsibility for the patient's case.

1.3 An AC is a mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an AC for the purposes of the Act. In practice, local health boards take these decisions on behalf of the Welsh Ministers.

1.4 Certain decisions, such as the renewal of detention, authorisation of leave or placing a patient on a community treatment order (CTO) can only be taken by the RC.

2 PROCEDURE STATEMENT

2.1 Cardiff and Vale University Health Board are committed to providing an adequately resourced, safe and effective service that meets the needs of the patient and service delivery requirements. Whilst working within the framework that meets the legal requirements of the MHA, Code of Practice for Wales, Revised 2016 (CoP) and other associated legislation.

3 PURPOSE

3.1 This procedure has been developed to provide guidance to staff regarding the functions of the AC and RC.

3.2 The purpose of this procedure is to ensure that, for all those detained under the MHA, or subject to a CTO, there are clear and thorough arrangements in place to:

- Ensure that the patient's RC is the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs
- Ensure that it can be easily determined who a patient's RC is
- Ensure that cover arrangements are in place when the RC is not available (e.g. during non-working hours, annual leave or sickness)
- Include a system for keeping the appropriateness of the RC under review

3.3 This document does not attempt to describe all eventualities, but there are three basic principles which should be used to determine the correct course of action:

- All detained/CTO patients must have an RC at all times.
- A patient can only have one RC (but more than one AC may be involved in their care).
- The RC can change from time to time.

3.4 All staff should be familiar with the relevant sections in the Act, and Code of Practice for Wales, Revised 2016.

4 SCOPE

4.1 This procedure applies to all AC's employed by or have an honorary contract with Cardiff and Vale University Health Board.

4.2 All patients detained under Part 2 or Part 3 of the MHA must have an RC to perform various functions under the MHA.

4.3 The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the MHA on its behalf. The Mental Health Legislation & Mental Capacity Act Committee is specifically for this purpose.

5 ROLES AND RESPONSIBILITIES

5.1 The Mental Health Clinical Board Director is responsible for ensuring that there is a system in place to ensure that medical staff appointed to undertake RC roles have the necessary AC approval.

5.2 The Clinical Director for each directorate is responsible for ensuring that there is cover for RC's who are on sick or annual leave.

5.3 AC's are responsible for maintaining their approval, including necessary refresher training.

5.4 Any queries over RC allocations will be dealt with by the Clinical Director for the respective directorates.

5.5 Please check with the Mental Health Act office the AC approval status of any consultant to ensure they meet the requirements to perform the function of RC under the Act.

6 ALLOCATION OF THE RC

Adult

6.1 The RC for those admitted to Cedar ward for assessment will be the North or South crisis team inpatient consultant for Cedar ward depending on the patient's CMHT, or GP if they're not known to a CMHT. If there are other factors which consider the locality RC may be identified as having the most appropriate expertise, they will be the patient's RC.

6.2 Once the patient moves to their locality ward the RC will usually be the inpatient consultant responsible for that area.

6.3 Where there is more than one AC available for that area, the RC will be the available AC with the most appropriate skills and experience to meet the needs of the patient.

6.4 If a patient is admitted straight to the PICU ward, the North or South crisis team inpatient consultant will become the patient's RC, then after 7 days the PICU consultant will take over unless it is agreed otherwise.

6.5 If a patient transfers to the PICU ward from a treatment or crisis ward, the PICU consultant will become the patient's RC after 7 days, unless it is agreed otherwise.

6.6 If a patient transfers to the PICU ward from prison or is under the Headroom team, the PICU consultant will become the patients RC from point of admittance.

6.7 Wherever possible, the clinician responsible for the care and treatment of children should be a child and adolescent mental health services (CAMHS) specialist. If this is not possible clinical staff should have access to a CAMHS specialist for advice and consultation.

6.8 When a CAMHS patient is admitted to any hospital within Cardiff & Vale i.e. paeds wards, medical wards or Hafan Y Coed the following rules apply:

- If they are already open to a CAMHS consultant, that consultant will be the RC
- If they are a new patient, their RC will be determined by the day they are admitted
    - Sunday, Monday, Tuesday and Friday – RC will be Dr Callista Hettiarachchi
    - Wednesday, Thursday and Saturday – RC will be Dr Daniela Brazzo

6.9 Wherever possible, the clinician responsible for the care and treatment of a person with learning disabilities (LD) or autistic spectrum disorder (ASD) should be a specialist in that field. If this is not possible clinical staff should have access to a learning disability or ASD specialist for advice and consultation.

6.10 When an LD patient is admitted to any hospital within Cardiff & Vale, the following rules apply:

- If they are already open to an LD consultant, that consultant will be the RC. This is based on the consultant which covers that locality as below:
    - Vale of Glamorgan
    - Cardiff east
    - Cardiff west
    - Cardiff central

6.11 Please check with the Mental Health Act office whether an LD consultant has an active honorary contract with Cardiff & Vale, as only with this are they able to act as an RC for a detained patient.

6.12 If a patient is admitted as NFA but is registered with a GP, they will come under the appropriate CMHT with RC allocation as per CMHT/GP process.

6.13 If a patient is admitted with a home address but not registered with a GP, it will go to the closest CMHT to the home address.

6.14 If a patient is admitted as NFA and nor registered with a GP, they will be allocated an RC as per the NFA rota.

MHSOP

6.13 For patients admitted to MHSOP inpatient wards, the RC will be allocated based on which consultant covers that ward and the patient's locality.

6.14 For patients admitted to Barry Hospital under the Younger Onset Dementia (YOD) team, the YOD consultant will be their RC.

7 NON-MEDICAL ACs

7.1 If the most appropriate person identified to undertake the role of RC is not a doctor, it may be necessary to allocate an AC who is a doctor. For example, the most appropriate RC for a particular person is a psychologist who is not a prescriber.

7.2 The clinician in charge of the treatment must be an AC if treatment is being given:

- Without the patients consent
- With the patients consent but on the basis of a certificate issued under section 58 or 58A, MHA
- Pending compliance with section 58 and with the consent of a CTO patient who has been recalled to hospital, in order to avoid serious suffering

8 RECORDING RC ON PARIS

8.1 The correct RC must be recorded on PARIS.

8.2 It is the responsibility of the RC to ensure that this is done. However, this task can be delegated to another member of the community mental health team, i.e. an administrator or medical secretary. Ward staff are also able to record this if appropriate.

8.3 When the RC is changed, it is the responsibility of the RC taking over care of the patient to ensure that the change of RC is recorded on PARIS.

8.4 There is no need to change RC on PARIS for short-term changes, e.g. annual leave and sickness cover.

8.5 If applicable as above, the second AC must be recorded on PARIS. It is the responsibility of the second AC to ensure that this is done. If this AC is changed, it is the responsibility of the AC taking over to record the change of AC.

9 COMMUNITY TREATMENT ORDERS

9.1 The RC for those subject to a CTO will usually be the same RC as when the patient was in hospital although this would be determined by the Community Mental Health Team (CMHT) who will be responsible for providing care for the patient once discharged from hospital.

9.2 Where there is more than one AC available for that area, the RC will be the available AC with the most appropriate skills and experience to meet the needs of the patient.

9.3 Upon recall or revoke, unless there are other factors to be considered, the RC that was responsible for the patient while they were in the community will remain the RC unless a change of RC is agreed.

10 COVER ARRANGEMENTS FOR WHEN THE RC IS NOT AVAILABLE

10.1 The functions of RC cannot be delegated, but the patients RC can change from time to time and the role may be occupied on a temporary basis in the absence of the usual RC. This may be necessitated by:

- Annual, professional/study leave, maternity/paternity leave or unpaid leave
- Sickness
- Part-time working
- Out of hours cover

10.2 Any RC who works part time is responsible, in conjunction with their Clinical Director for ensuring that another AC can act as the RC for the hours when they are not at work. The cover arrangements described in this section do not constitute a transfer of RC.

10.3 For planned leave (including annual and study leave) the RC is responsible for making arrangements with a suitably qualified AC to act as RC in their absence.

10.4 The Clinical Director for each directorate should be responsible for arranging cover from an appropriately qualified AC for any period of sick leave. Where a period of sickness becomes long term then consideration should be given to a more formal transfer of RC.

11 OUT OF HOURS COVER

11.1 The Duty Consultant (on call consultant psychiatrist who must be an AC) will provide cover out of hours for RC functions. This will include providing any advice for nominated deputies (i.e. the nominated junior doctor on call) who are not AC's (or doctors approved under s12, MHA).

11.2 On occasions in hours where there is no identified RC the Duty Consultant will provide RC cover. It is good practice to keep to a minimum any of the RC functions that are exercised in this way.

11.3 RC's should not leave decisions that they are required to make or functions that they are required to undertake to the Duty Consultant. However, this should not prevent decisions being made when they are required out of hours.

11.4 For functions that can only be performed by the RC. For example, to recall a CTO patient or to authorise s17 leave in an emergency it is important to note that RC's are acting **AS** the RC and not acting **ON BEHALF OF** the RC.

12 PATIENTS ADMITTED TO A NON-MENTAL HEALTH WARD UNDER THE MHA

12.1 A patient admitted and detained under the MHA to a Cardiff and Vale UHB non-mental health ward will require an RC. In most cases this will be either the consultant for liaison psychiatry for adults or the consultant for liaison psychiatry for older people (LPOP) with the following applying:

For liaison psychiatry for adults:

- The team only cover University Hospital of Wales
- The patient must be under 65 years or graduate of adult service open to CMHT
- The team must have received and accepted a referral
- The patient must be detained under the MHA

For liaison psychiatry for older people (LPOP):

- The team covers University Hospital of Wales, University Hospital Llandough, St. David's Hospital, Barry Hospital (Sam Davies ward) and Holme Towers (Marie Curie Hospice)
- The patient must be 65 years or above
- No previous contact with Adult MH services in past 5 years
- The patient must be accepted by LPOP
- The patient must be detained under the MHA
- They cannot be from out of area

12.2 Once the patient has been transferred to Hafan Y Coed or MHSOP inpatient wards, the RC will change from a liaison psychiatry RC to one based on allocation stated in point 6 above.

12.3 Younger onset dementia (YOD) patients are the exception as these patients can often be under 65 years. If they're open to the YOD team and detained to a medical ward, the consultant for LPOP will become the RC. Once transferred to Barry Hospital, the YOD consultant will be their RC.

12.4 If an adult patient is detained in University Hospital Llandough, the RC will be provided by the locality consultant psychiatrist.

12.5 In the absence of a liaison psychiatry service, RC cover will be provided by the locality consultant psychiatrist.

12.6 Where a patient is well known to a particular CMHT it may be considered more appropriate for the RC from that team to be responsible.

12.7 A detained patient who is transferred to a general hospital should remain under the care of the existing RC unless a change of RC is agreed.

13 FUNCTIONS THAT CAN ONLY BE PERFORMED BY THE RC

13.1 Specific powers and duties that can only be performed by the RC include:

- Granting s17 leave
- Revoking a period of leave and recall
- Discharge from detention, guardianship or CTO
- Renewal of detention or extension of CTO
- Agreeing conditions and applying a CTO with an Approved Mental Health Professional (AMHP)
- Varying or suspending conditions of a CTO
- Recalling a patient from a CTO
- Barring a nearest relatives attempt to discharge a patient
- Providing certificates to authorise treatment under Part 4 (only for treatment they can professionally prescribe)
- Providing evidence to courts and the Ministry of Justice as required

13.2 Section 17 leave cannot be granted by the RC for those detained under s35, s36, or s38.

13.3 The RC can grant leave for restricted patients **but only with** prior approval from the Ministry of Justice.

14 CHANGE OF RC

14.1 As the needs of the patient may change over time, it is important that the appropriateness of the RC is kept under review throughout the care planning process. It may be appropriate for the patients RC to change during a period of care and treatment, if such a change enables the needs of the patient to be met more effectively.

14.2 For instance: -

- Where there may be an emphasis on pharmacological therapy, it may be appropriate for the RC to be an AC who is registered medical practitioner or a (Nurse Prescriber)
- Where the main therapy that is central to the patient's treatment is psychological, it may be more appropriate for the RC be a psychologist.
- Where the care plan's main emphasis is continuing mental health care and rehabilitation, it may be appropriate for the RC to be a nurse.
- Where the balance of activities is based around skill development and vocational rehabilitation, and this work forms the core of the patients care plan, then it may be more appropriate for an occupational therapist to be the RC.

14.3 Where a patient's treatment and rehabilitation require movement between different hospitals or to the community, successive RC's need to be identified in good time to enable movement to take place.

14.4 The existing RC is responsible for overseeing the patients progress through the system. If movement to another hospital is indicated, RC's should take the lead in identifying their successors.

14.5 If the patient requests a change of RC their reasons should be established. In considering such a change it is also important to take account of the need for continuity and continuing engagement with, and knowledge of the patient.

14.6 The process of considering a patient's request will be overseen by the Clinical Director for the respective directorate.

15 NOMINATED DEPUTY

15.1 Section 5(3) allows the doctor or approved clinician in charge of an inpatient's treatment to nominate a deputy to independently exercise section 5(2) powers in their absence.

15.2 Only a doctor or approved clinician on the staff of the same hospital may be a nominated deputy. The deputy does not have to be a member of the same profession as the person nominating them. Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.

15.3 Doctors and approved clinicians should only be nominated as a deputy if they are competent to perform the role. Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.

15.4 It is permissible for the RC to nominate the "doctor with responsibility for P's immediate care" providing that there would be no uncertainty about the identity of this doctor. In other words, ward staff would have immediate access to this information and would not have to make enquiries as to which doctor to contact.

15.5. Doctors and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. However, they may not leave instructions for their nominated deputy to use section 5(2), nor may they complete a section 5(2) report in advance to be used in their absence. The deputy must exercise their own professional judgment. Patients should not be admitted informally with the sole intention of then using the holding power.

16 TRAINING

16.1 All staff who work within Cardiff and Vale University Health Board are responsible for ensuring that they maintain an up to date knowledge of the Mental Health Act 1983 and associated legislation as it applies within their practice.

17 IMPLEMENTATION

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

18 RESPONSIBILITIES

18.1 Chief Executive - The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

18.2 Chief Operating Officer - The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

18.3 Clinical Directors/Service Managers - It is the responsibility of all clinical managers to:

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

19 REFERENCES

19.1 All staff will work within in accordance with:

- Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
- Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
- Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
- Domestic Violence, Crime and Victims Act 2004
- Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008
- Mental Health Wales Measure (2010)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of the Mental Health Legislation & Mental Capacity Act Committee 2023-24

1.0 INTRODUCTION

In accordance with best practice and good governance, the Mental Health Legislation & Mental Capacity Act Committee ("the 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 three Independent Members. During the financial year 2021/22 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), the Executive Nurse Director, the Director of Corporate Governance, the Clinical Board Director – Mental Health Clinical Board, the Director of Nursing – Mental Health Clinical Board, and the Director of Operations – Mental Health Clinical Board. 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 four times during the period 1 April 2023 to 31 March 2024. This is in line with its Terms of Reference. The Mental Health, Capacity and Legislation Committee achieved an attendance rate of 81.25% (80% is considered to be an acceptable attendance rate) during the period 1st April 2023 to 31st March 2024 as set out below:

	02.05.2023	01.08.2023	31.10.2023	30.01.2024	Attendance %
Ceri Phillips (Chair)	✓	✓	✓	✓	**100**
Sara Moseley (Vice Chair)	✓	✓	✓	✓	**100**
Rhian Thomas	✓	✓	X	✓	**75**
Susan Elsmore*	X	X	✓	N/A	**33.3**
Total	**75**	**75**	**75**	**100**	

*Susan Elsmore left the organisation on the 31.10.2023

4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed by the Committee on 31st January 2023. The Terms of Reference approved by the Board on the 30 March 2023.

5.0 WORK UNDERTAKEN

The principal remit of the Committee is to consider and monitor the use of the Mental Health Act 1983 ("MHA"), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards ("DoLS") and the Mental Health (Wales) Measure 2010 ("the Measure"). In particular, the Committee should seek and provide assurance to the Board or to escalate areas of concerns and advise on actions to be taken in relation to:

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

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

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

During the financial year 2022/23 the Mental Health, Capacity and Legislation Committee considered the following:

Mental Capacity Act Monitoring Report and DoLS Monitoring

The Committee received the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring report which provided a general update on current issues related to the MCA and DoLS. The MCA and DoLS indicators provided an overview of the following:

- Mental Capacity IMCA Referral type
- Mental Capacity Training
- Additional training provision
- Progress following the appointment of MCA Practitioners
- DoLS applications and assessments over the previous year
- Consent to Examination and Treatment

Liberty Protection Safeguards Monitoring Report

In 2023, the UK Government announced their decision to not progress the Liberty Protection Safeguards (LPS) or implement the Mental Capacity (Amendment) Act 2019 within Parliament. Further to that announcement, the Welsh Government expressed their disappointment in the decision and committed to continue to provide increased funding to protect the rights of those who lack mental capacity.

As such, the focus for the Health Board remained upon improving understanding and application of the MCA in clinical practice, strengthening the current Deprivation of Liberty Safeguards (DoLS) arrangements and improving ongoing monitoring and reporting.

Mental Health Act Monitoring Exception Report

The report 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.

The report provided an overview of the following:

- Use of the Mental Health Act
- Fundamentally defective applications
- Section 136 – A&E, CAMHS
- Mental Health Review Tribunal for Wales (MHRT)
- Development Sessions
- Audits

Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report

At all meetings, Members of the Committee were 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.

Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision, which included:

- Part 1: PMHSS
    - Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult) and (Children & Young People)
    - Part 1b – 28-day assessment to intervention compliance target of 80% (Adult) and (Children & Young People)
- Part 2 – Care and Treatment Planning (over 18) and (Children & Young People)
- Part 3 – Right to request an assessment by self-referral
- Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

Sub-Committee Meeting Minutes

Presented to the Committee were the minutes from the:

1. Hospital Managers Power of Discharge Minutes
2. Mental Health Legislation and Governance Group Minutes

Policies and Procedures

A number of policies and procedures were discussed & approved at the Committee as follows:

1. Receipt of Applications for Detention under the Mental Health Act Procedure
2. Mental Health Review Tribunal Procedure and Guidance

Other matters of business discussed during the year, included: -

- Health Inspectorate Wales (HIW) MHA Inspection Reports
- Draft Mental Health Bill – Joint Committee Report
- Committee Self-Assessment of Effectiveness
- Corporate Risk Register
- Hospital Managers Power of Discharge Sub-Committee Annual Report
- Public Service Ombudsman Wales Reports
- Feedback and Next Steps from the Community Mental Health Summit
- Section 117 Supreme Court Ruling Implications
- Development of a Recovery and Maintenance Protocol as part of a Part 1 Scheme under the Mental Health (Wales) Measure 2010
- Consent across the Welsh Health Boards
- Right Care, Right Person Update
- HIW Annual Report

6.0 REPORTING RESPONSIBILITIES

The Committee 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 Committee.

7.0 OPINION

The Committee is of the opinion that the draft Mental Health, Capacity and Legislation Committee Report 2023-24 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.

CERI PHILLIPS

Committee Chair

SARA MOSELEY

Vice Committee Chair