Public Mental Health Legislation Committee

Tue 28 January 2025, 09:00 - 16:00

MS Teams

Agenda

09:00 - 09:05
5 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 of the Meeting held on 29th October 2024

Ceri Phillips

1.4 - CP - Unconfirmed MH Committee Minutes 29.10.2024 (1).pdf (7 pages)

1.5. Actions from the meeting held on 29th October 2024

Ceri Phillips

1.5 - Public MH Committee Action Log 29.10.2024 (1).pdf (1 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

1.7. Any Other Urgent Business Agreed with the Chair

Ceri Phillips

09:05 - 09:20
15 min

2. Mental Capacity Act

2.1. Mental Capacity Act Monitoring Report and DoLS monitoring

15 mins *Jason Roberts / Chloe Evans*

2.1 - MHLMCA Report Oct - Dec 2024 (1).pdf (9 pages)

09:20 - 09:35
15 min

3. Mental Health Act

3.1. Mental Health Act Monitoring Exception Report

10 mins *David Seward*

3.1.1 - Mental Health Act Monitoring Exception Report January 2025.pdf (7 pages)
3.1.2 - Mental Health Act Monitoring Report October - December 2024.pdf (36 pages)

3.2. Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy

5 mins *Daniel Crossland*

3.2 - Mental Health and Wellbeing Strategy Suicide and Self-Harm Prevention Strategy.pdf (3 pages)

09:35 - 09:50
15 min

4. Mental Health Measure

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

15 mins *Daniel Crossland*

4.1 - MHLC - Mental Health Measure January 2025 AMS and CAMHS.pdf (11 pages)

09:50 - 09:55
5 min

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

5.1. Sub-Committee Meeting Minutes:

5 mins

i) Hospital Managers Power of Discharge Sub Committee Minutes

ii) Mental Health Legislation and Governance Group Minutes

5.1.1 - PoD minutes January 2025 (1).pdf (3 pages)
5.1.2 - MHLGG minutes and action log January 2025.pdf (7 pages)

09:55 - 10:00
5 min

6. Items for Approval / Ratification

6.1. Policies:

5 mins *Chloe Evans*

i) Cardiff and Vale Mental Capacity Act (MCA) Policy

6.1.1 - MCA Policy - Board & Committee Covering Report 2024-25 (1).pdf (3 pages)
6.1.2 - Mental Capacity Act MCA Policy CV Jan 25.pdf (37 pages)
6.1.3 - MCA Policy EHIA Dec 24.pdf (22 pages)

10:00 - 10:15
15 min

7. Any Other Business

Ceri Phillips

7.1. Section 117 Verbal Update

10 mins *Daniel Crossland*

7.2. Funding for Increased Resource for DoLS Paper

5 mins *Jason Roberts / Chloe Evans*

10:15 - 10:15

8. Items for Private Committee Meeting:

0 min

Ceri Phillips

i) Unlawful Detentions

10:15 - 10:15
0 min

9. Review of the Meeting

Ceri Phillips

10:15 - 10:15
0 min

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

Ceri Phillips

29th April 2025 via MS Teams

10:15 - 10:15
0 min

11. Declaration

Ceri Phillips

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 29th October 2024
Via MS Teams

To view the meeting: CAVUHB Mental Health Legislation & Mental Capacity Act Committee Meeting 29.10.2024 (youtube.com)

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Rhian Thomas	RT	Independent Member – Capital & Estates
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
In Attendance:		
Francesca Thomas	FT	Head of Corporate Governance
Daniel Crossland	DC	Director of Operations - Mental Health
David Seward	DS	Mental Health Act Manager
Neil Jones	NJ	Clinical Board Director – Mental Health
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Chloe Evans	CE	MCA & Consent Lead
Katie Simpson	KS	Deputy General Manager – Children, Young People & Family Health Services
Jason Roberts	JR	Executive Director of Nursing
Paul Bostock	PB	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge Sub-Committee
Suzanne Rankin	SR	Chief Executive
David Fluck	DF	Executive Medical Director
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Richard Skone	RS	Interim Executive Medical Director
Matt Phillips	MP	Director of Corporate Governance

Item No	Agenda Item	Action
MHLMCA 29/10/001	**Welcome & Introductions** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=86 The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHLMCA 29/10/002	**Apologies for Absence** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=103 Apologies for Absence were noted. **The Committee Resolved that:** a) The Apologies for Absence were noted.	
MHLMCA 29/10/003	**Declarations of Interest** No declarations of interest were declared.	

MHLMCA 29/10/004	**Minutes of the Meeting held on 6th August 2024** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=127 The Minutes of the Meeting held on 6th August 2024 were received and approved. **The Committee Resolved that:** a) The minutes of the meeting held on 06.08.2024 were agreed as a true and accurate record.	
MHLMCA 29/10/005	**Action Log from the meeting held on 6th August 2024** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=170 The Action Log was received and discussed. **The Committee Resolved that:** a) The Action Log was noted.	
MHLMCA 29/10/006	**Committee Chair's Actions** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 29/10/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
	Mental Health Act	
MHLMCA 29/10/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=508 The MCA & Consent Lead (MCA-CL) 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 which included the following: • Mandatory MCA Training • MCA Practitioner Led Training • Assessing Decision Making Capacity MSc Module • MCA Team Advice and Support • DoLS Signatories • Referrals and Assessments The Committee Vice Chair (CVC) asked for clarification on the advocacy funding, specifically what it entailed, how it related to legislation, and how it impacted on patients' understanding of their own positions.	

	The MCA-CL responded that: • The advocacy funding contract was renewed in June 2024. • WG had provided increased advocacy funds due to the Liberty of Protection Safeguards, which expanded the need for advocacy to include individuals aged 16-18 and those in the community. • Despite the additional funds, they had not been fully utilised due to the new contract • A six-month review was scheduled for December to assess if the contract needed adjustments. They would ensure that the £63,000 remained available to potentially increase the contract if needed for this financial year. The CVC asked who the advocacy provider was. The MCA-CL responded that it was Advocacy Support Cymru. The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) asked whether it was necessary to increase the number of Best Interest Assessors (BIAs) and how to facilitate those discussions. The MCA-CL responded that this had been discussed with the Executive Nursing Director (END) over the past few months. They had identified funding for this year, but this had been used for agency staff which was more expensive. She agreed that it would be better to have something embedded into the team to increase the capacity of BIAs and get more value for money. The ICDPPT asked to see the Self-Neglect Protocol. The MCA-CL responded that the Regional Safeguarding Board had developed and released an assessment tool to support individuals who were self-neglecting, regardless of their capacity. A member of their team had delivered training on self-neglect to complement the release of this tool, and this training would also be offered to UHB staff. The MCA-CL agreed to share a poster with the ICDPPT. The END agreed for a paper on Funding for Increased Resource for DoLS to be brought to the following Committee for discussion. The Independent Member – Local Authority (IM-LA) asked about the prioritisation process for BIAs, particularly the four individuals who had waited over 81 days. The MCA-CL responded due to recruitment delays the team had struggled with the administrative workload of the DoLS process. However, the four individuals identified would be prioritised this month to be seen. With additional funding from WG and a potential permanent funding stream, the aim was to prevent such delays in the future. **The Committee resolved that**: a) The contents of the report were noted.	
	Mental Capacity Act	
MHLMCA 29/10/009	**Mental Health Act Monitoring Exception Report** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=1652	

The Mental Health Act Manager (MHAM) presented the Mental Health Act Manager (MHAM) presented the Mental Health Act (MHA) Monitoring Exception Report to the Committee which provided a summary of the below:

- Use of the Mental Health Act
- Fundamentally defective applications and reports
- Section 136 - A&E and CAMHS
- Nearest relatives discharge requests
- Development sessions
- Audits

The MHAM provided a summary of the no fundamentally defective applications, and the two fundamentally defective reports reported, and the two lapses reported during this quarter.

The Chief Executive Officer (CEO) asked about the administrative challenges in busy ward areas, particularly in Hafan Y Coed, and whether there were routine mechanisms in place to routinely check and ensure that staff were appropriately trained on the MHA.

The Director of Operations - Mental Health (DO-MH) responded that:

- In wards, staff were clear about who was detained, their leave status, and whether they were formal/informal.
- The main challenges arose from the short turnaround for 5(2) processes, high observation levels, and staffing issues.
- Junior staff needed to ensure that they followed the process and consulted with the MHAM
- The MHA office worked closely with clinicians, and high-quality training was provided to all staff.

The MHAM discussed the challenges of providing training on the MHA, in particular the lack of resources to conduct this training extensively. However, information on Section (2)s had started to be integrated into training for junior doctors, and shift coordinators were undergoing their annual refresher training. Information on Section 5(2)s was also available on their SharePoint page for easy access.

The IM-LA asked if the current process ensured that everybody who needed to know about a patient's detention under Section 5(2) was properly informed, and whether their system supported appropriate information sharing. In addition, she asked whether patients and their families were informed when timescales (particularly the 72hr requirement) were not met.

The MHAM responded that efforts were being made to ensure that people were aware of the necessary information through training, resources, and the MHA office for advice. However, there was currently no capacity to provide in-person training on the wards.

The MHAM also explained that wards were advised to inform patients of any fundamentally defective applications or 5(2) reports if deemed appropriate based on the patient's presentation.

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 29/10/010	**Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=2628 The DO-MH provided the following summary: • There had been no updates on the consultation phase – however some consultation responses on the draft Suicide and Self-Harm Prevention Strategy had been published recently • There was a limited number of responses, likely due to collective submissions from Health Boards, Local Authorities and other providers. • A recent strategy refresh conference had been attended by the DO-MH and the CBD-MH • Once the strategy was published, they would look at how to implement the strategy locally. The DO-MH offered to provide a brief on the Suicide and Self-Harm Prevention Strategy to be presented at the following Committee. **The Committee resolved that:** a) The update was noted.	
	Mental Health Measure	
MHLMCA 29/10/011	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=2717 The DO-MH and the Deputy General Manager – Children, Young People & Family Health Services (DGM-CYPFHS) presented the Mental Health Measure Report which outlined the performance of CAVUHB against the various mental health specific targets, which included: • 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 The Executive Medical Director (EMD) noted that whilst national waiting times for young people's assessment and treatment were poor, the local figures looked much better in comparison. The DGM-CYPFHS thanked her team's hard work and innovative approaches, however acknowledged that increasing demand would continue to pose challenges in maintaining service times for children and young people. The CVC asked what the strategy was to improve Part 1a compliance, and whether there were risk assessments in terms of compliance.	

	In addition, the CVC asked how much of Part 1b's compliance was done through referral to online provision, and whether they had an indication of the outcomes of these interventions. The DO-MH responded with the following: • The team faced a backlog of assessments due to sickness and maternity leave. To address this, three additional posts were being created based on extensive modelling of capacity and demand to maintain the target compliance. • During COVID, they accurately predicted the volume of Part 1 referrals but underestimated the sustained demand post-COVID. • The planned care funding and restructuring should increase the number of assessments being undertaken. The additional positions should help to clear the backlog by increasing weekly referrals by 36. • The highly-person focused and therapeutic assessments helped to maintain high compliance rates with Part 1b. They provided a range of services including immediate help, information provision and referrals for highly specialised therapy. **The Committee Resolved that:** a) The contents of the Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was noted.	
	Items to bring to the attention of the Committee for Noting / Information	
MHLMCA 29/10/012	**Sub-Committee Meeting Minutes:** To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=3961 Hospital Managers Power of Discharge Sub-Committee Minutes – 08.10.2024 The Chair of the Power of Discharge Sub-Committee (C-PDSC) took the minutes as read and informed the Committee that this was his last meeting as Chair of the C-PDSC. Mental Health Legislation and Governance Group (MHLGG) – 11.10.2024 The ICDPPT highlighted the following: • Nearest Relative Discharge Requests – this issue was specific to CAV. • Voluntary Assessments – there was a need to improve the recording of voluntary assessments (particularly Section 136s). • Staff Attendance at Hearings – the importance of staff attending hearings and being able to comprehensively speak to the reports being examined by the Tribunal or hospital managers was discussed. • Informal Patients and Deprivation of Liberty – progress was being made with the revised DoLS structure in psychiatric settings. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
	Items for Approval / Ratification	
MHLMCA 29/10/013	*No items for approval.*	
MHLMCA 29/10/014	**Any Other Business**	

	To view the minute: https://youtu.be/UKnZRDk3pjY?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4220 <u>Right Care, Right Person Verbal Update</u> The DO-MH provided the following summary: • They were currently in the phase of managing AWOLs and walkouts from hospital settings. Coordination with police, local authorities, Welsh Ambulance and other providers was going smoothly. • An issue where the police asked the hospital security to attend and convey was flagged and deemed to be resolved. • The next phase around conveyancing was expected to be more challenging. • The most challenging phase would be managing Section 136 cases in February 2025 - CAV were overrepresented in Section 136 cases (e.g. CAV had 28% of all cases in Wales the previous year, however 72% of them were not converted into further action). <u>Section 117 Verbal Update</u> The DO-MH provided the following summary: • Following the Worcestershire judgement, challenges arose around the duty to provide aftercare for Section 117 patients – e.g. where the local authority had Section 117 responsibility, but the health provision was held by another ICB/UHB. • Confusion existed around containing this within health records, which presented the risk of appearing as an open referral. • A meeting was due with both local authorities to work through challenges. • There were similar issues with other Health Boards, as English ICBs often moved quite large volumes of patients into placements in/around Wales for which they held Section 117 responsibility and would try to transfer the care over to local Health Boards. • They were seeking legal advice, and they hoped to start developing local policies. The CC asked to what extent WG were involved. The DO-MH responded that they had written to WG and advised them of one of their legal approaches taken with an English ICB. He noted that another challenge was that their Responsible Clinical Guidance had not been updated since 2014, which caused difficulty in making sure Wales was not disadvantaged. At present, they were waiting for this guidance to be developed and updated to be concordant with who paid in England.	
MHLMCA 29/10/015	**To note the date, time and venue of the next meeting:** 28th January 2025 via MS Teams	

Action Log
Mental Health Legislation and Mental Capacity Act Committee – 29th October 2024
(Updated For 28th January 2025 Meeting).

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
ACTIONS COMPLETED					
MHLMCA 06/08/009	**Mental Capacity Act Monitoring Report and DoLS Monitoring**	For the END and DCG to clarify the Court of Protection process and to provide an update at the following Committee.	**28.01.2025**	Jason Roberts / Matt Phillips / Chloe Evans	*Further update to be provided in January 2025's Action Log section.*
MHLMCA 29/10/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring**	For a paper on Funding for Increased Resource for DoLS to be brought to the following Committee.	**28.01.2025**	Jason Roberts / Chloe Evans	**COMPLETED** *Added to the Forward Plan for January 2025's MH Committee.*
MHLMCA 29/10/010	**Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy**	For a brief on the Suicide and Self-Harm Prevention Strategy to be presented at the following Committee.	**28.01.2025**	Daniel Crossland	**COMPLETED** *Added to the Forward Plan for January 2025's MH Committee.*
MHLMCA 29/10/014	**Any Other Business – Section 117 Verbal Update**	For a more detailed update on Section 117 to be presented at the following Committee.	**28.01.2025**	Daniel Crossland	**COMPLETED** *Added to the Forward Plan for January 2025's MH Committee.*
Actions in Progress					
ACTIONS REFERRED TO COMMITTEES OF THE BOARD / OTHER					

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring**				Agenda Item no.	*2.1*	
Meeting:	**Mental Health Legislation Committee**		Public	X	Meeting Date:	28.01.2025	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	Jason Roberts, Executive Nurse Director						
Report Author (Title):	Chloe Evans, MCA Project Lead						

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 MCA activity and training compliance across the UHB. As previously, there is additional information contained within this report outlining the additional training and support provided by the MCA Team. The second Mental Capacity Specialist Practitioner post was filled at the start of October so the team will be looking to expand upon available training offerings.

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

The increased funding provided to address the DoLS backlog and work carried out on cleansing referrals has proved successful, with no breaches for new standard requests in the last quarter.

The additional DoLS Signatories are now actively reviewing and signing off authorisations with ongoing support provided as required.

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

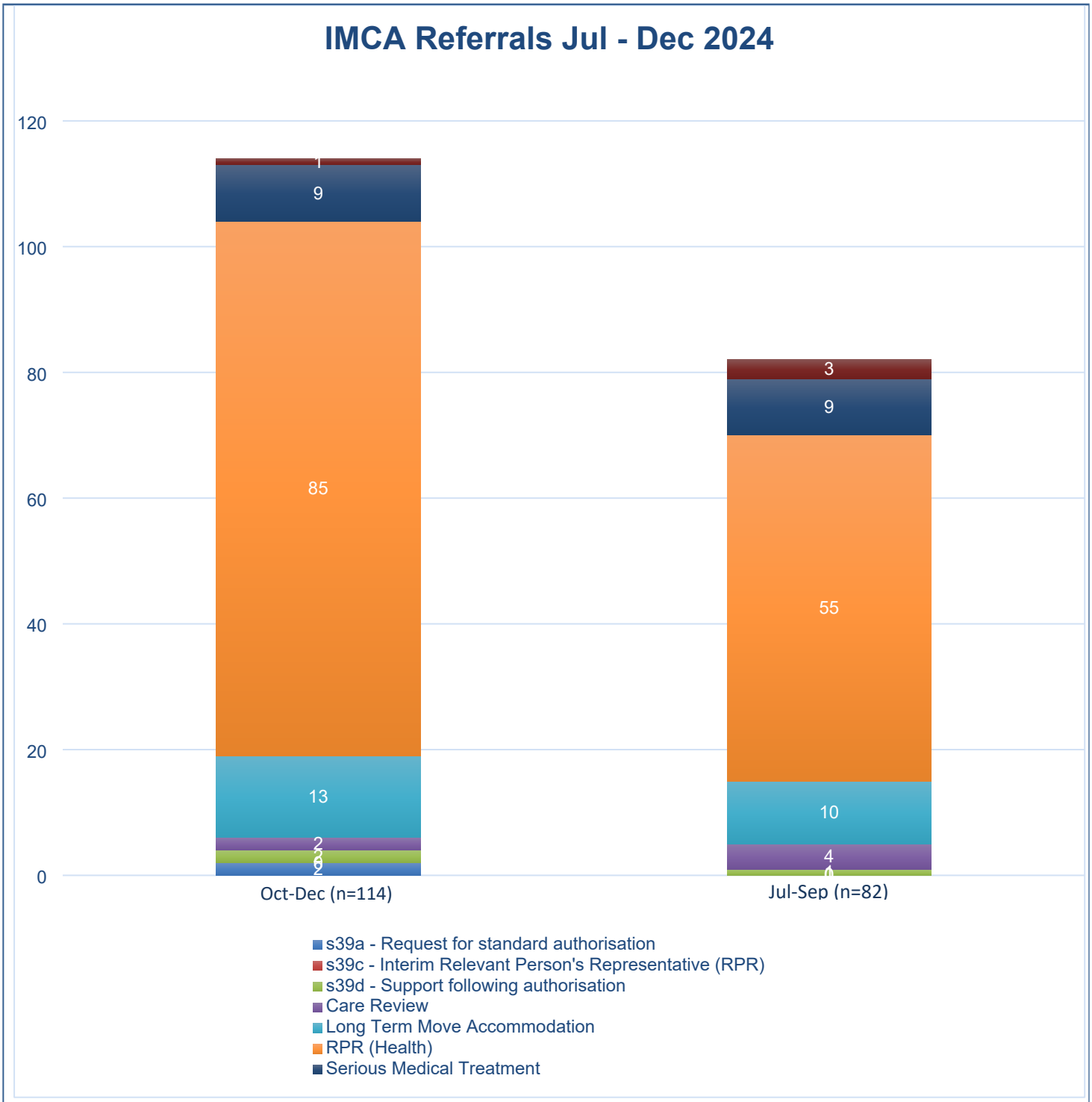
<u>Mental Capacity Act Monitoring Actions (July – December 2024):</u>

Mental Capacity IMCA Referral type

The MCA Indicators outline the breakdown of IMCA referrals for the period from June to September and October to December 2024, as the information for Quarter 2 was not available at the time of reporting for the last Committee meeting.

Overall referral rates are noted to have increased significantly over the last two quarters up from 72 (Q1) to 82 (Q2) and 114 (Q3). The greatest increases have been seen in referrals for RPR (Health), shown in orange, which have more than doubled from the same time last year when there were 26 referrals for Q2 and Q3. This was expected and is in keeping with the improved awareness around DoLS and work to address the backlog which means that an increased number of referrals have been processed within a more compressed time period.

Referrals for Serious Medical Treatment were 9 for both quarters, which is keeping with previous years. Similarly, long term move of accommodation were around average for this period.



Awareness Raising / Training Sessions

Our advocacy provider has also delivered a significant number of informal training sessions across the UHB during the last quarter, with the following areas covered:

University Hospital of Wales – Lakeside IACU A & B, Ward 1, B7, C7, ICU

University Hospital Llandough – East 6, East 7, East 8, West 1, West 10

St David's Hopsital – Rhydlafar, Landsdowne, Elizabeth

Mental Health – St Barrucs, East 10, East 12, East 14, East 16, East 18, Willow and Ash

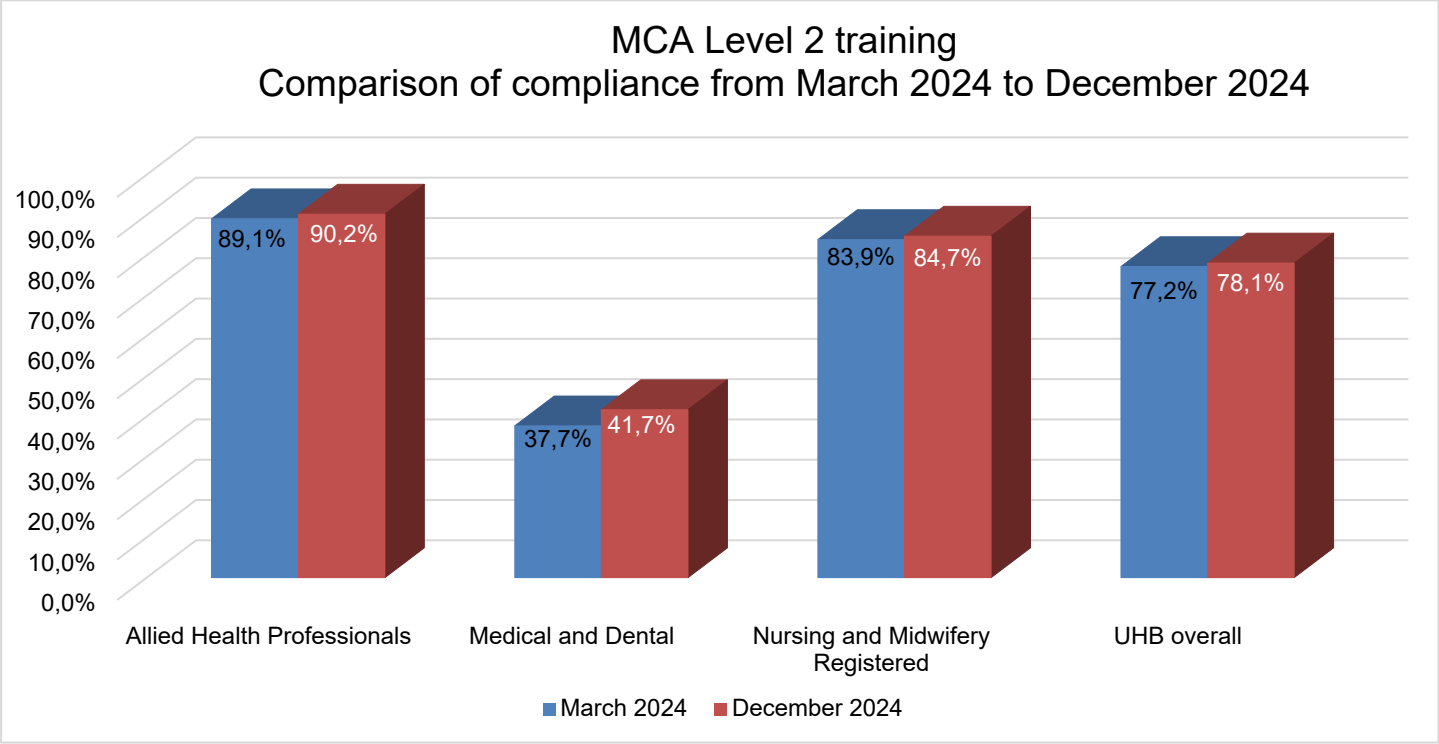
Learning Disability – Llety Newydd, Laurels and Briary

They also kindly presented at the UHB's MCA Focus Group meeting in November.

Mental Capacity Training

Mandatory MCA Training

The following graph demonstrates overall compliance by staff group over the last quarter. This appears to have remained stable, though there has been a marginal increase in the last 6 months.



The compliance of Nursing and Midwifery and Allied Health Professionals remains at an appropriate level taking account of staff changes. Medical and Dental continues to be far below target; though there has been a more significant improvement in the last quarter than previously, this remains minimal progress. Mandatory training of this professional group is being addressed corporately so it is expected that improvement should increase further over the next quarter.

In order to take a proactive approach to awareness raising of training, the MCA Team continue to advertise training dates regularly when presenting and attending meetings. In addition, the team have begun circulating a poster with the latest training dates to all ward managers on a monthly basis; this is also available on the MCA Team Training page on SharePoint.

The new and updated ESR Training is due for launch in early 2025 and the team will look to advertise this through UHB wide communications.

MCA Practitioner led training: October to December 2024

The Practical Application of the MCA training continues to be well received by staff but booking numbers have reduced significantly in the latter part of this quarter with three sessions being cancelled due to low uptake. This is felt to be due to limited capacity for staff to be released for training and it is hoped that this will increase in the new year as winter pressures ease however, as outlined above, the MCA Team are taking a proactive approach to advertising training so it is expected that this will help to raise staff awareness of what offerings are available.

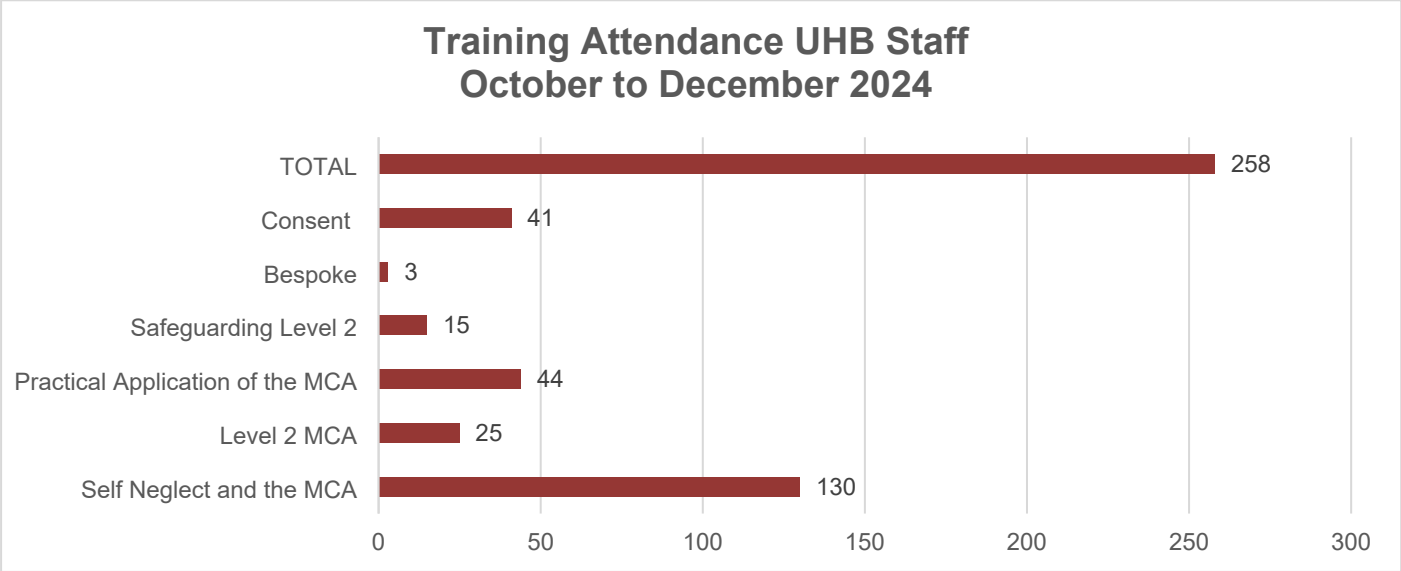
The MCA team have delivered 6 sessions this quarter, with a total of 44 staff trained; compared with 92 last quarter. Due to the reduced uptake over the last two quarters the third session per month has now been stopped and will be reconsidered in line with demand.

The MCA Team supported National Safeguarding Week in November with the provision of a stand in UHW for awareness raising for the public and to provide access to relevant resources. In addition, a bespoke training entitled 'Self Neglect and the MCA' was also delivered for the UHB and partner agencies. This was extremely well received and a further three sessions were delivered over Teams as 'Lunch and Learn' style training for UHB staff in November and December.

MCA Level 2 taught sessions achieved better booking rates but there were a high number of last minute cancellations, therefore the decision has been made to reduce this offering to once every two months going forward, rotated across the UHW and UHL sites.

A new DoLS training package is currently under development with a view to this being available to staff in the next quarter.

The below chart outlines attendance figures for the various training sessions offered by the MCA Team this quarter.



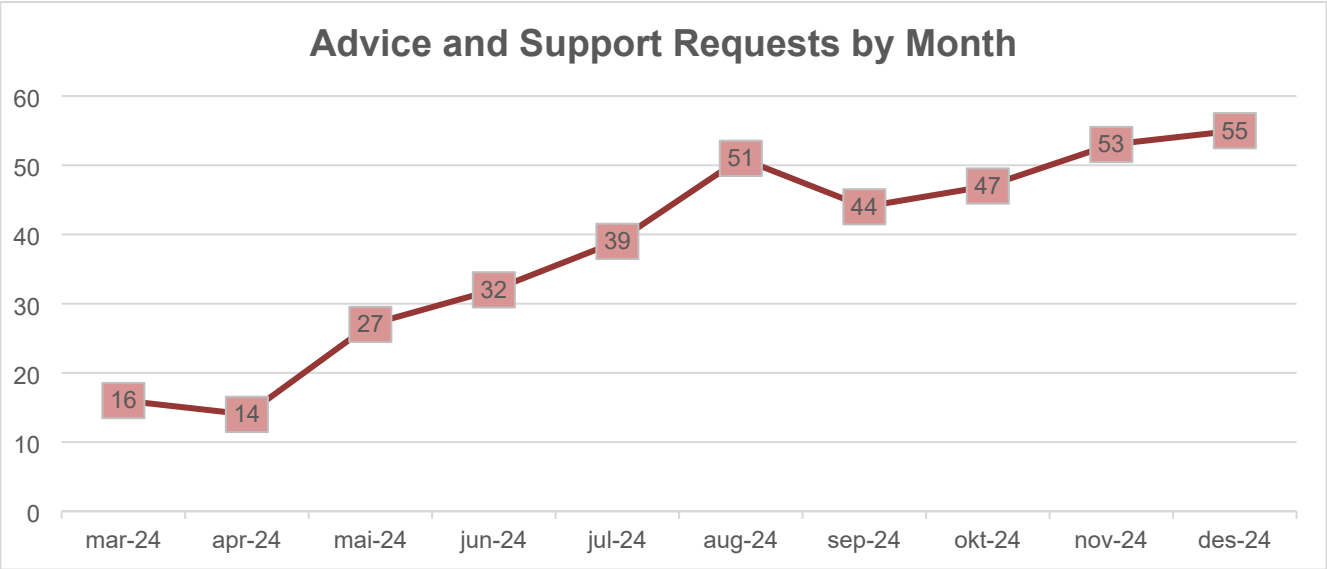
Despite lower attendance figures, feedback for the Practical Application of the MCA continues to be extremely positive, as outlined below.

Training Feedback	% Agree or strongly agree	% Neutral, disagree or strongly disagree
My learning outcomes were met	99%	1%
Training was effective and easy to understand	98%	2%
I feel confident about applying principles of MCA to practice	94%	6%
Helped with practical application of MCA as well as theory	96%	4%
I feel confident in knowing how to access MCA support	97%	3%

MCA Team Advice and Support

Requests for advice and support from the MCA Team have remained stable over the last quarter, though the average time per query has reduced from 2.11 hours to 1.7 hours.

The below chart outlines the number of referrals received by month, from the start of this financial year, for advice and support in relation to specific individuals. There have been a further 13 requests for advice and support more generally, such as questions about the MCA, DoLS or Court of Protection processes.



Deprivation of Liberty Safeguards Monitoring Actions:

Headline figures as at 8/1/2025:

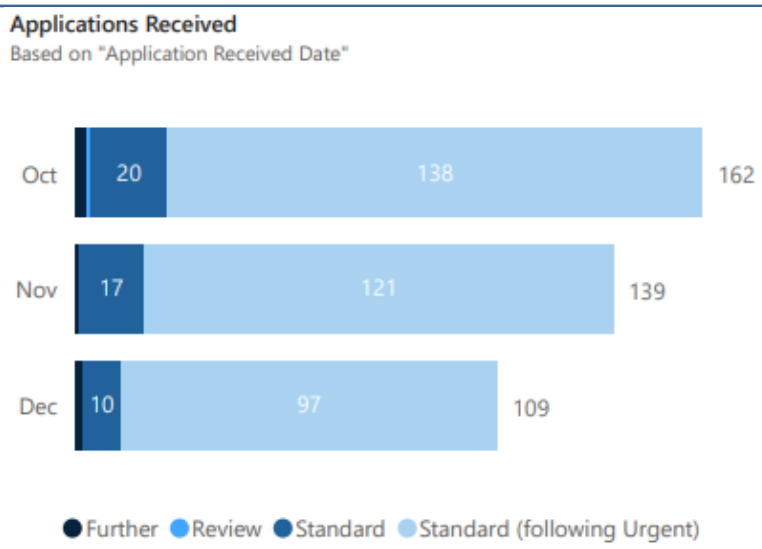
Total Waiting List	Breach: Urgent	Breach: Standard	Applications Received	Assessments Carried out	Authorisations Granted
46	18	0	410	116	93

Quarterly overview from July to September 2024

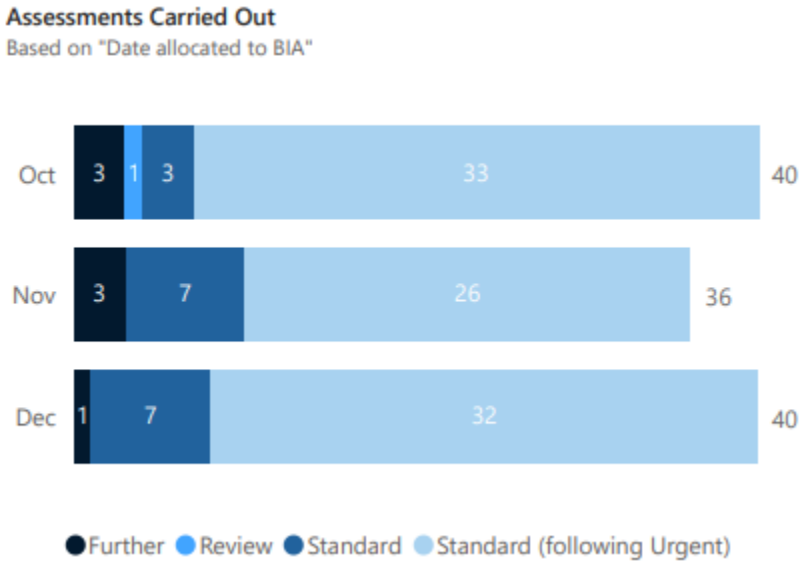
Following extensive work to address the DoLS backlog with a large scale cleansing exercise to identify withdrawn applications, where individuals had moved ward, passed away or been discharged, there were no breaches for new standard requests this quarter which is a notable improvement. There were 18 breaches for urgent requests which is largely due to the limited timeframe in which the team have to process the referrals and assess. During this period the deprivation is self authorised by the Managing Authority (the UHB) so efforts will continue to focus upon standard requests unless otherwise indicated, to ensure that no individuals are detained in hospital without an appropriate framework to authorise this.

Referrals and Assessment

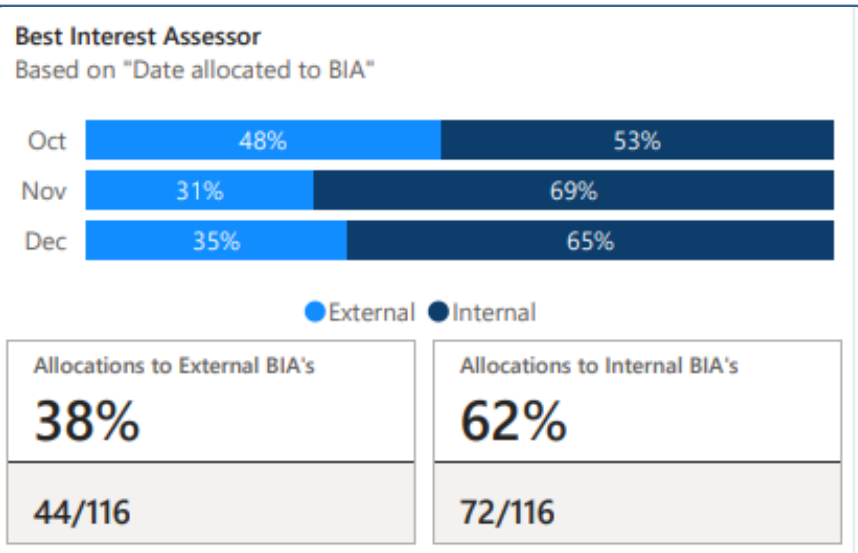
The referral figures for the last quarter are outlined below.



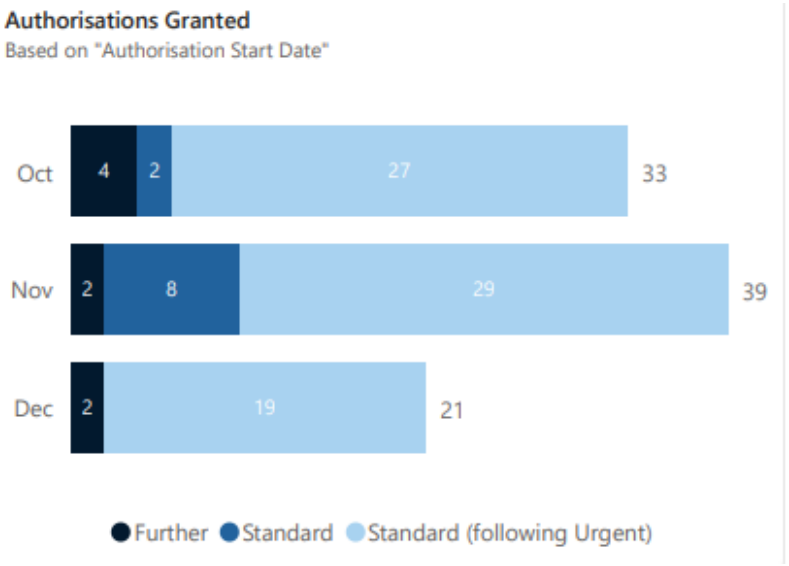
The below chart outlines the number of assessments carried out per month by type. This includes assessments using both existing funding and additional backlog monies.



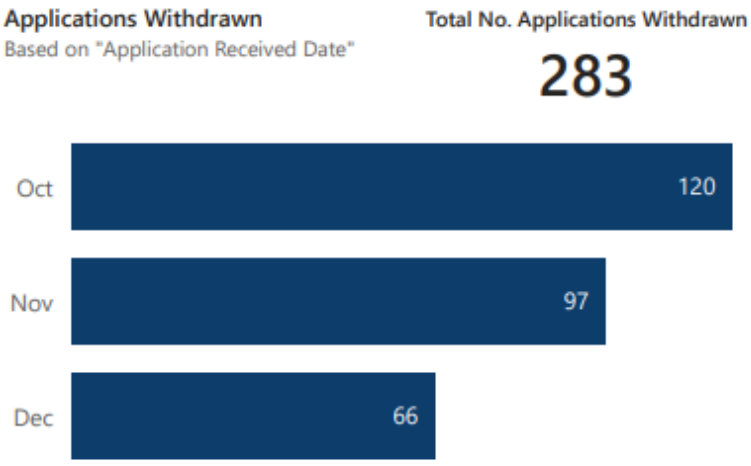
The below figures provide a breakdown outlining the number of assessments carried out within existing provision and the number carried out by external Best Interest Assessors using the additional backlog funding.



A total of 93 authorisations have been granted this quarter, with the highest level of activity seen in November.



A total of 283 applications were withdrawn this quarter, compared with 281 last quarter.



The below table outlines the current waiting list for allocation of a BIA to assess. These figures are improved from last quarter where there had been 4 individuals waiting over 81+ days and 17

individuals within the 22-80 day category. It is expected this should be further reduced next quarter as the increased assessment capacity allows.

Waiting List
As at 08/01/25

No. Waiting List (No BIA Allocation)	Avg Days Waiting for BIA allocation	Total Days Waiting	Max Wait (days)
46	11	514	51

Wait Day Groups	Further	Standard	Standard (following Urgent)	Total
0-7 Days	2	1	24	27
8-21 Days			11	11
22-80 Days	1		7	8
Total	**3**	**1**	**42**	**46**

Recommendation:

The Committee is requested to:

a) Note the contents of this paper

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	X
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	*Not required*

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 *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

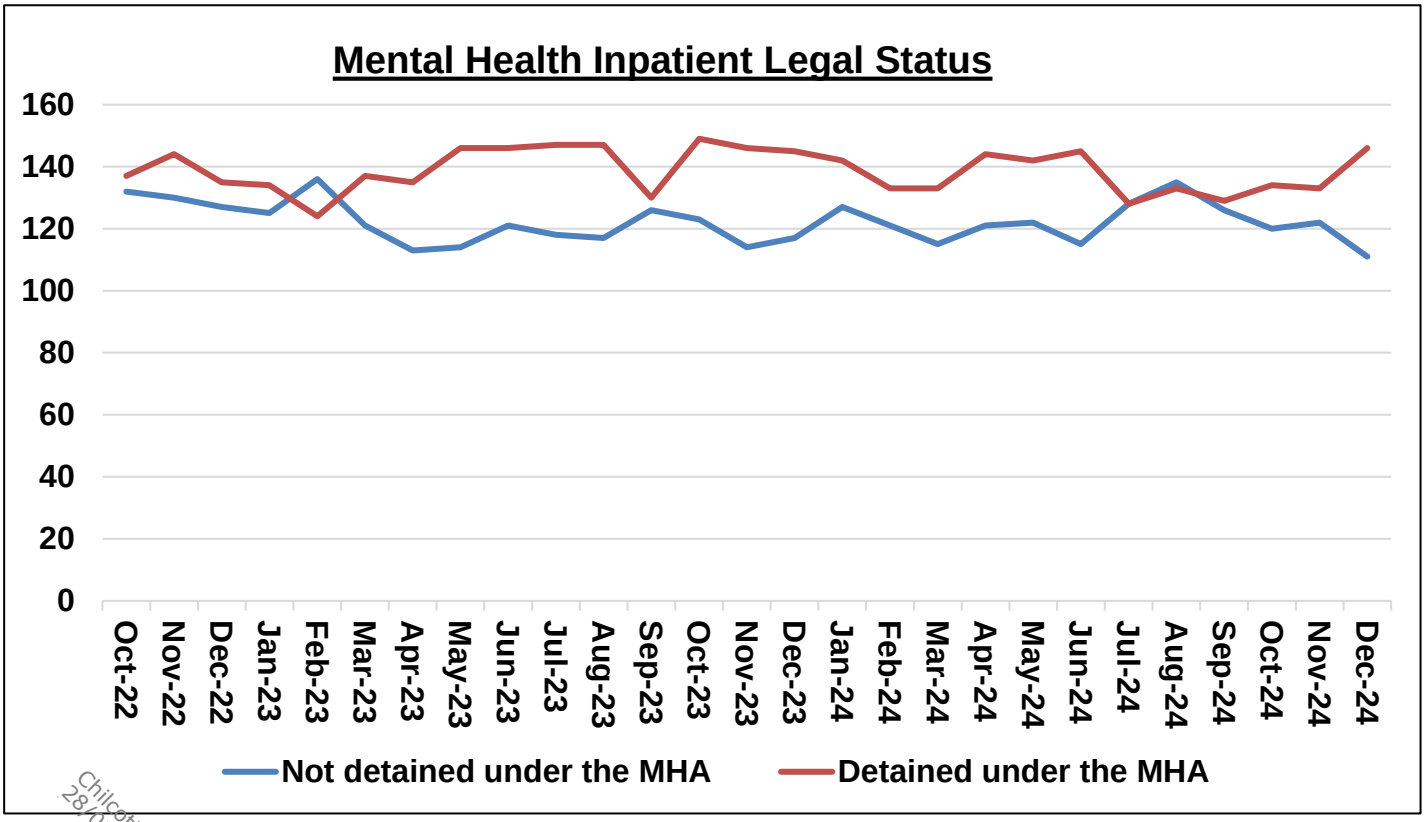
Report Title:	Mental Health Act Monitoring Exception Report			Agenda Item no.	3.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	28 January 2025
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Interim Chief Operating Officer				
Report Author (Title):	Mental Health Clinical Board Director of Opertations				

Main Report
Background and current situation:

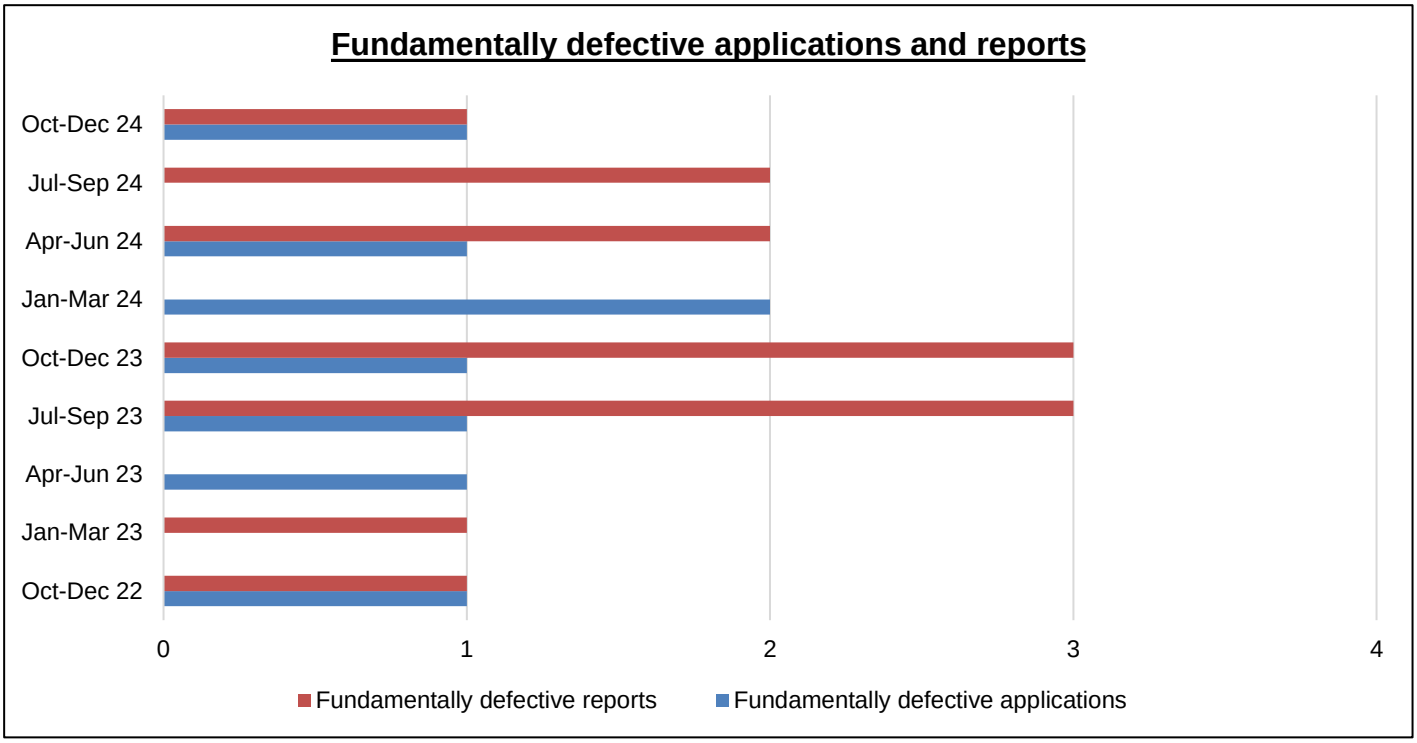
This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that 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 was 1 fundamentally defective application.
P was detained on a Section 2, assessed and detained under Section 3. The medical recommendations were sent for medical scrutiny where they both failed, which rendered the application fundamentally defective. The ward was advised and a new MHA assessment was arranged. As the Section 2 hadn't expired yet, the patient was still able to be detained under this Section until a new Section 3 application was completed.

During the quarter there was one fundamentally defective report.
P was in HYC and a 5(2) completed on a Friday evening however, the form was not signed by the doctor who had completed it. It had been sent to the shift coordinator to accept and unfortunately, they had not picked up that it wasn't signed. MHAO chased the doctor on the Monday morning to see if they had a signed copy but were unable to get in touch. The ward was advised that the 5(2) was fundamentally defective and the patient was happy to stay informally in reviewed by RC the following day.

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,

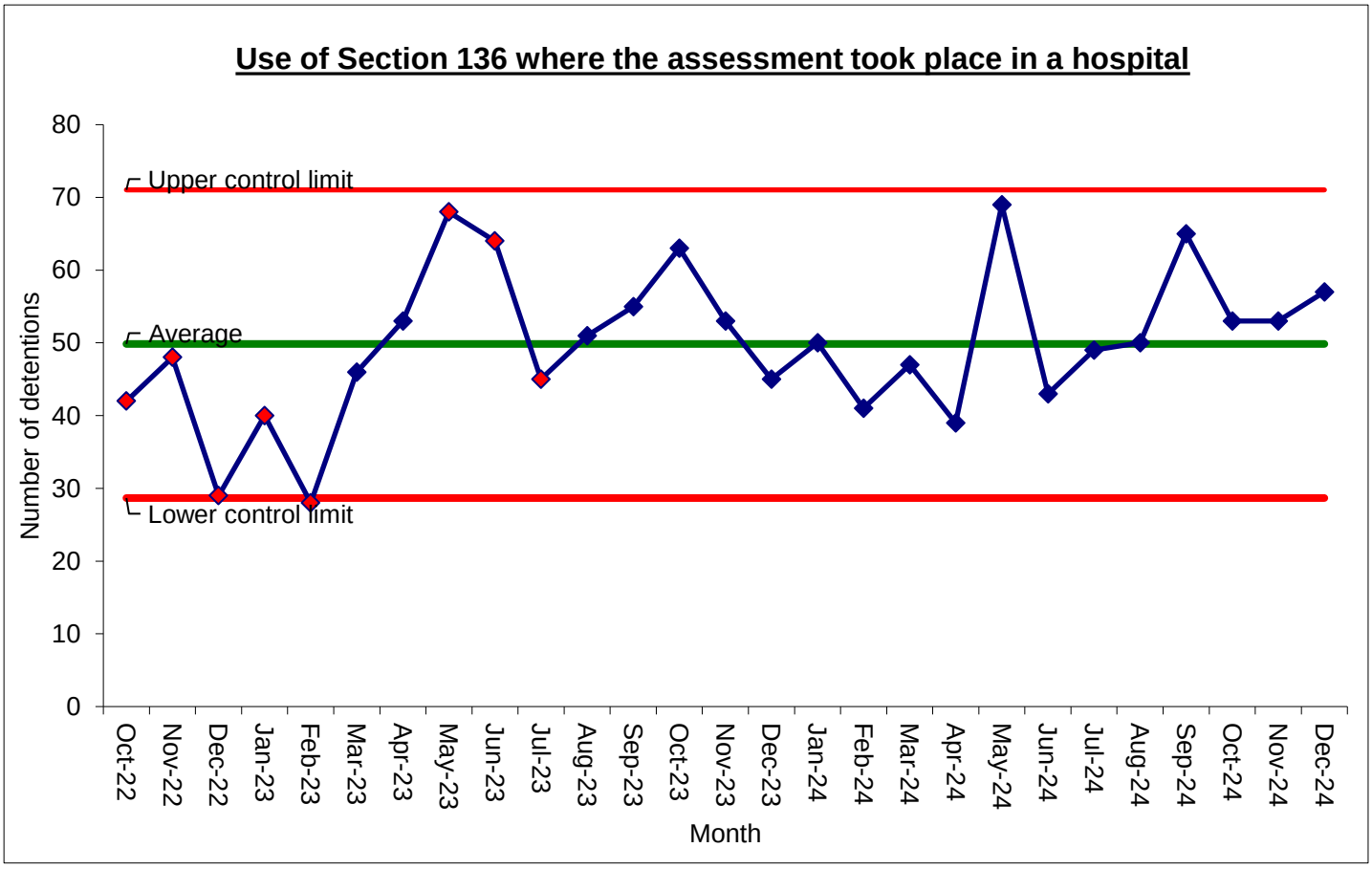
> *Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.*

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.

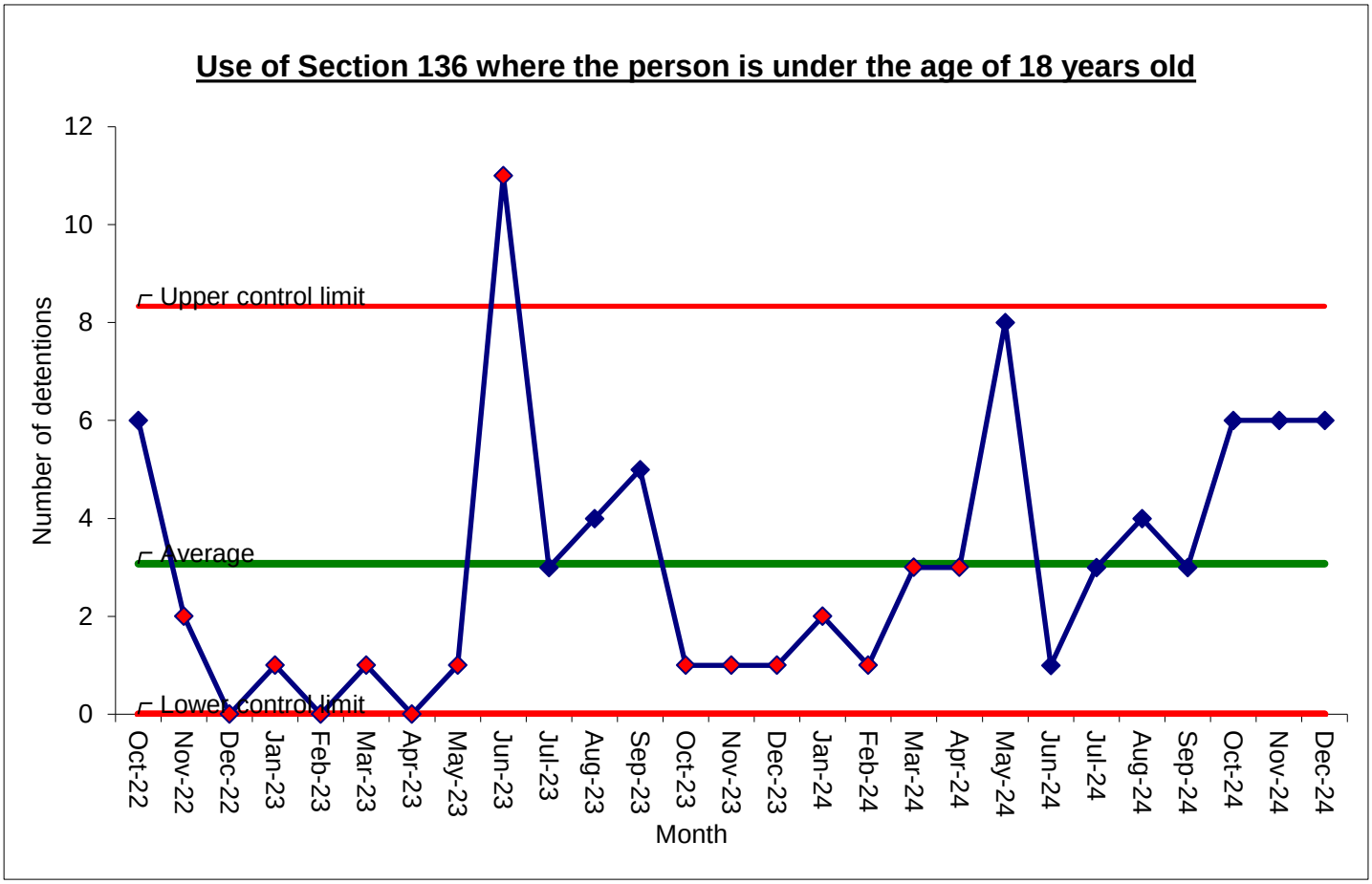
It was noted that 78.6% of individuals assessed were not admitted to hospital, with 44.2% being discharged to community services and 34.4% were discharged with no follow up. Overall during the period 18.3% of patients were admitted to hospital following a 136 assessment which is lower than the previous quarter at 26.6%.
Four 136's lapsed with no assessment taking place.
One 136 was unlawful.

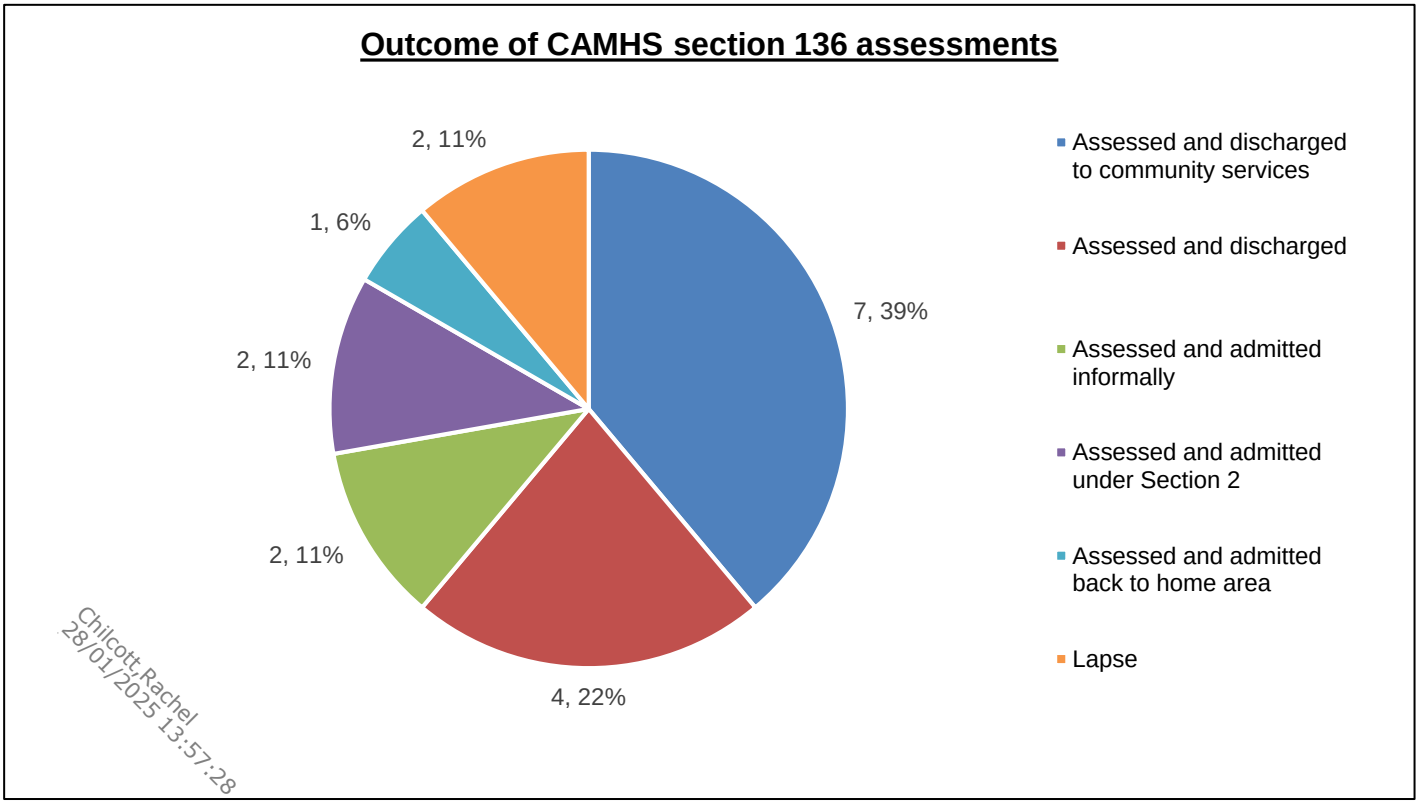
Period	% not admitted to hospital
October – December 2024	78.6%
July – September 2024	72.7%
April – June 2024	79.5%
January – March 2024	83.3%
October – December 2023	80.1%
July – September 2023	83.5%
April – June 2023	80.4%
January – March 2023	71.1%
October – December 2022	73.9%



Section 136 - CAMHS

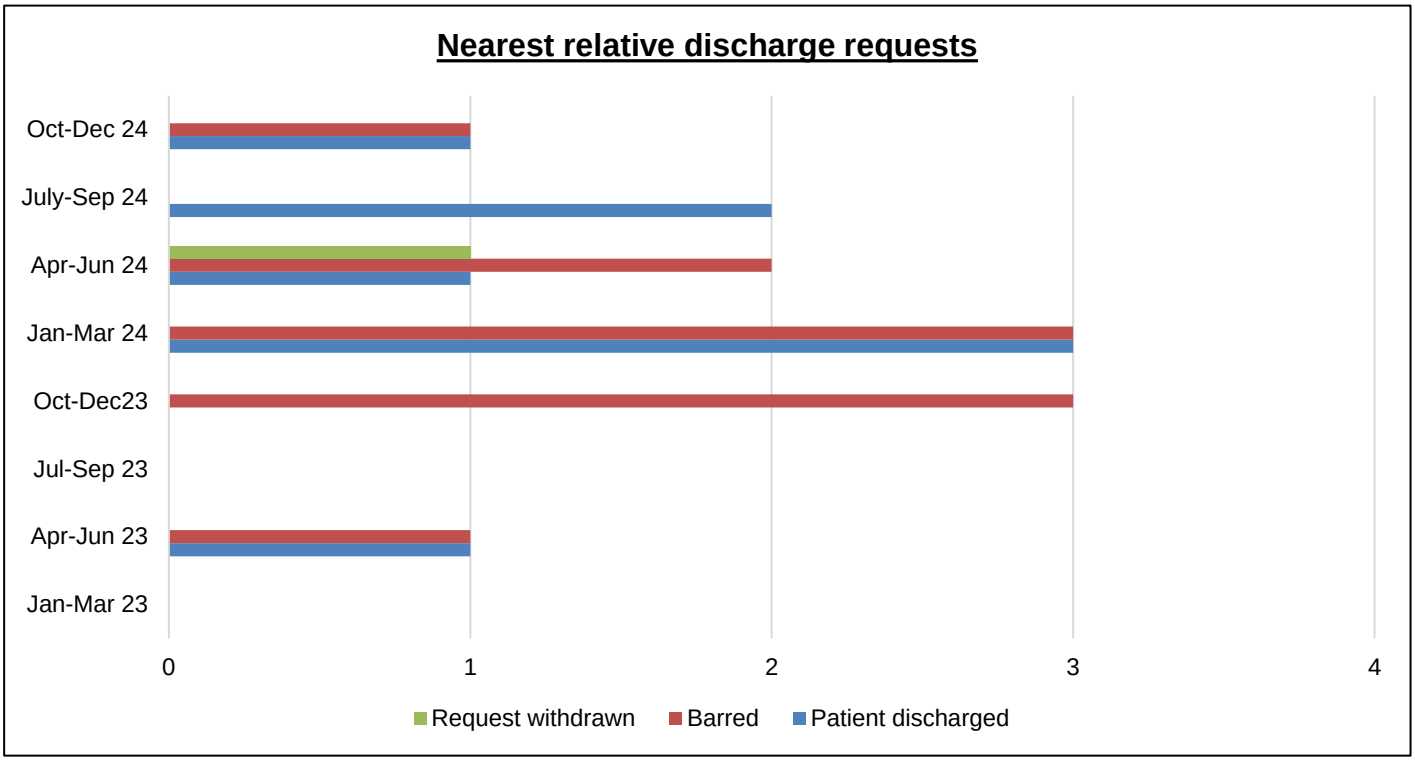
The number of those under 18 assessed under section 136 has increased from 10 in the previous quarter to 18 in this quarter. 3 users had repeat presentations.





Nearest relatives discharge requests

There has been a rise in the number of nearest relative discharge requests over the past few months with seemingly no reason for this increase. I have investigated to see whether professionals are giving nearest relative's more information regarding their rights but they are still providing them the same leaflet/information.



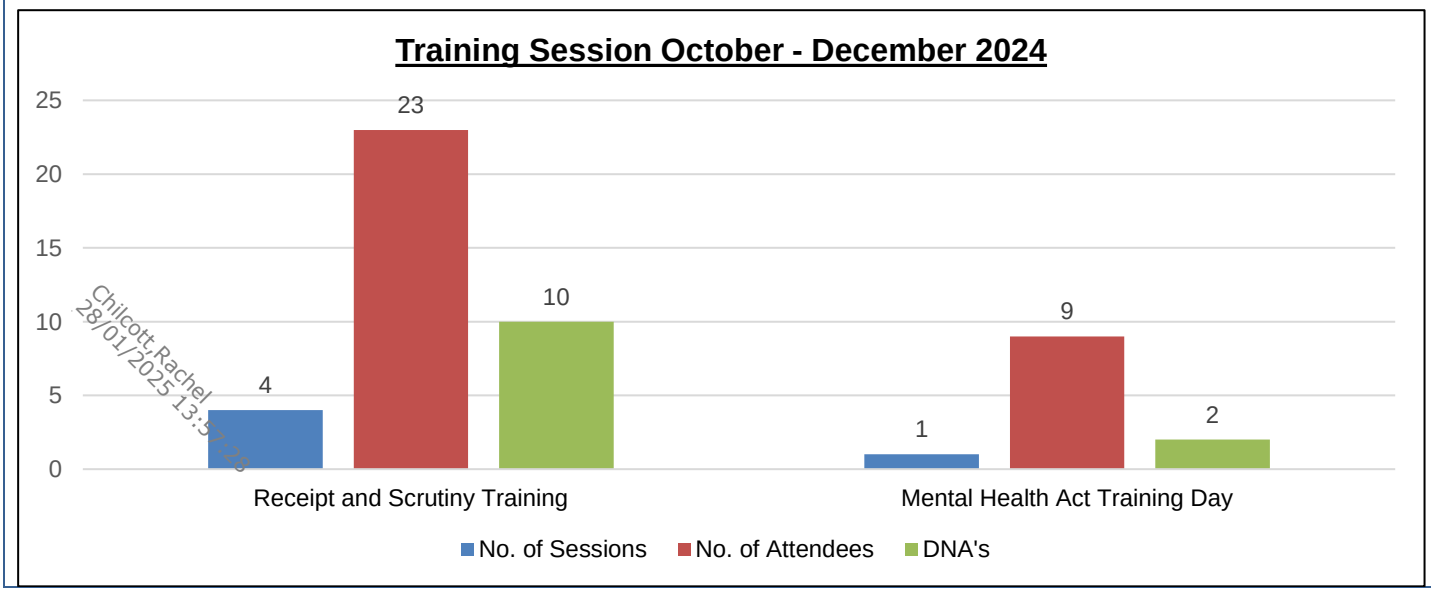
Development Sessions

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:

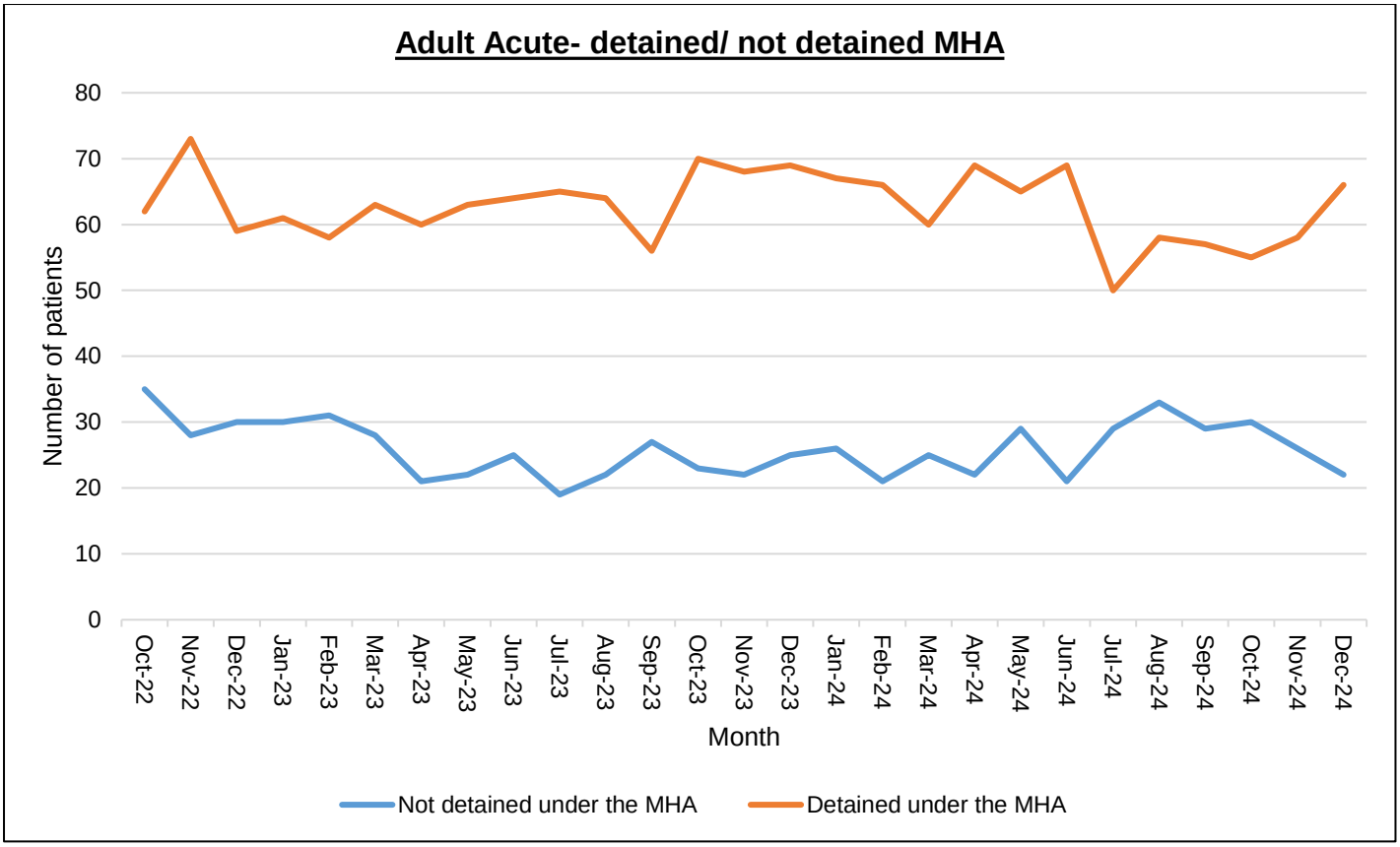
Report to the

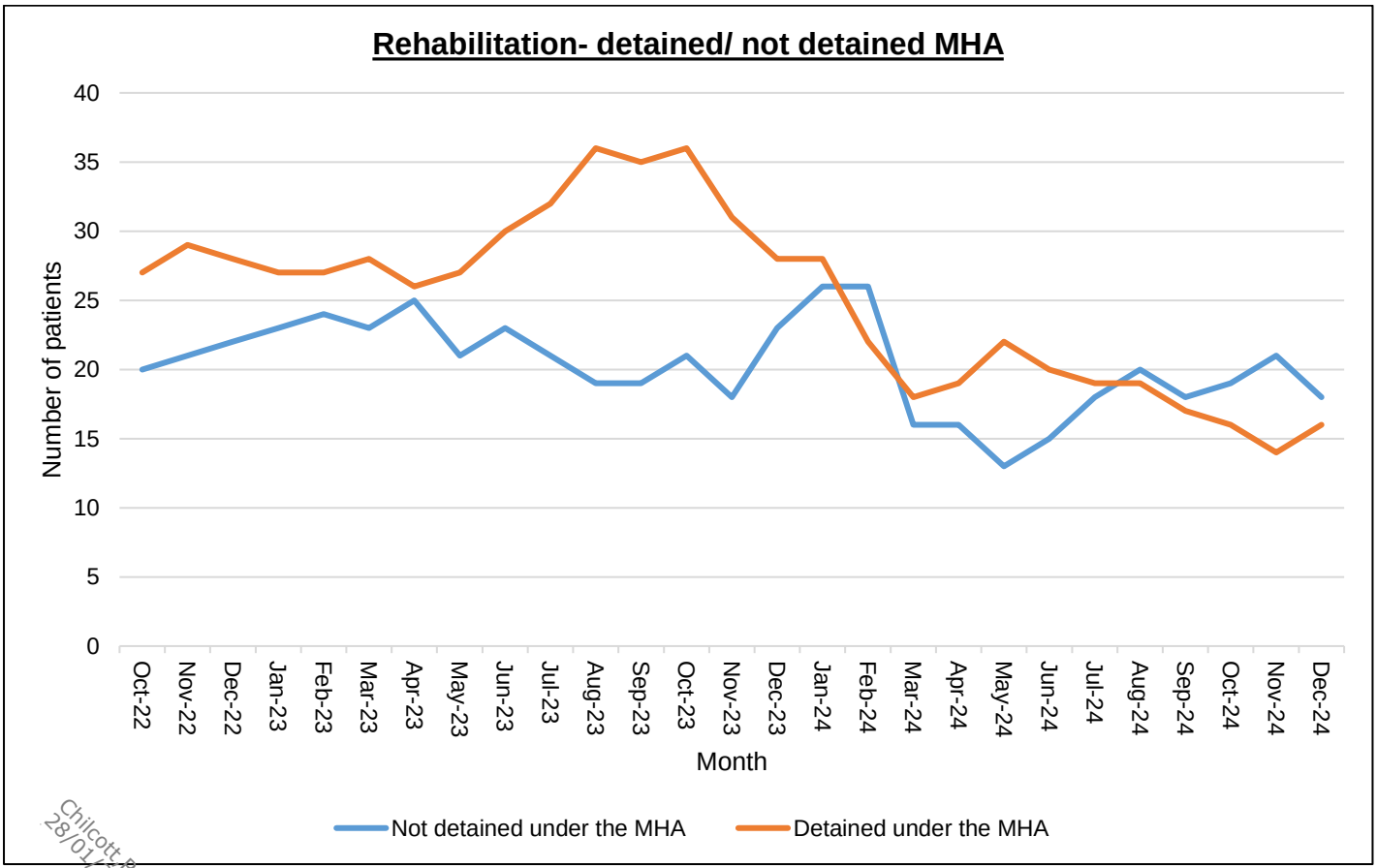
Mental Health Legislation and Mental Capacity Act Committee

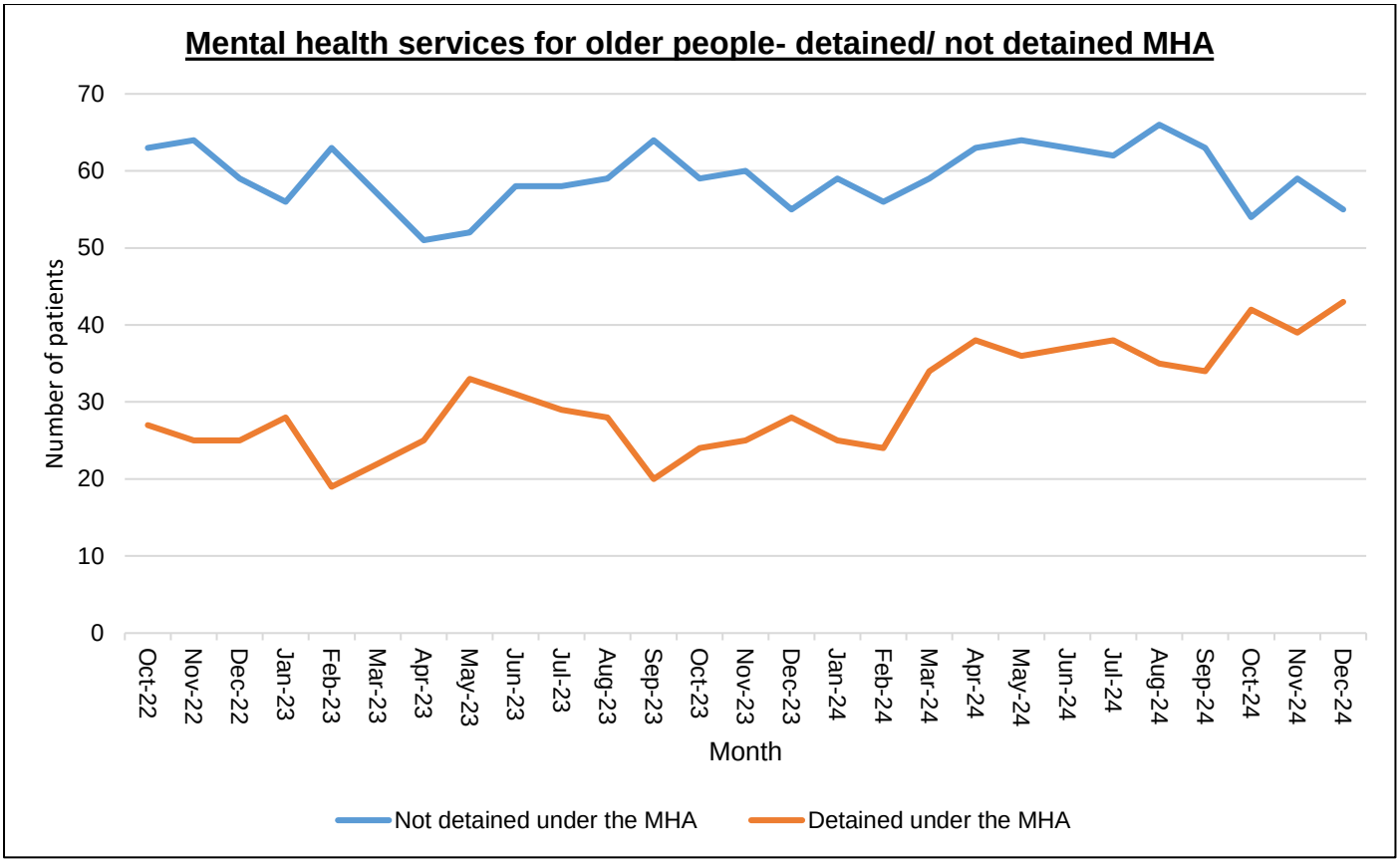
on the use of The Mental Health Act, 1983

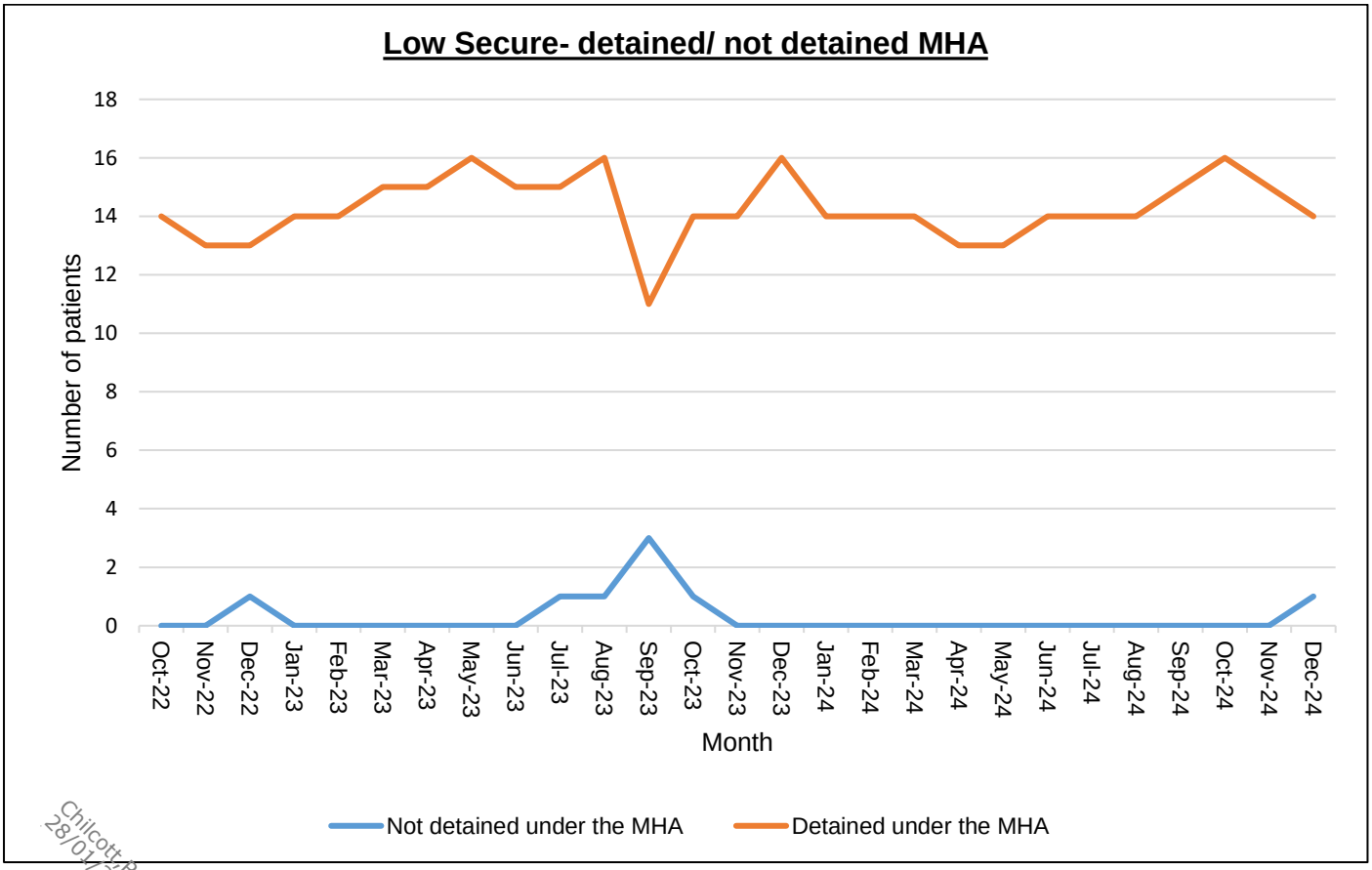
October - December 2024

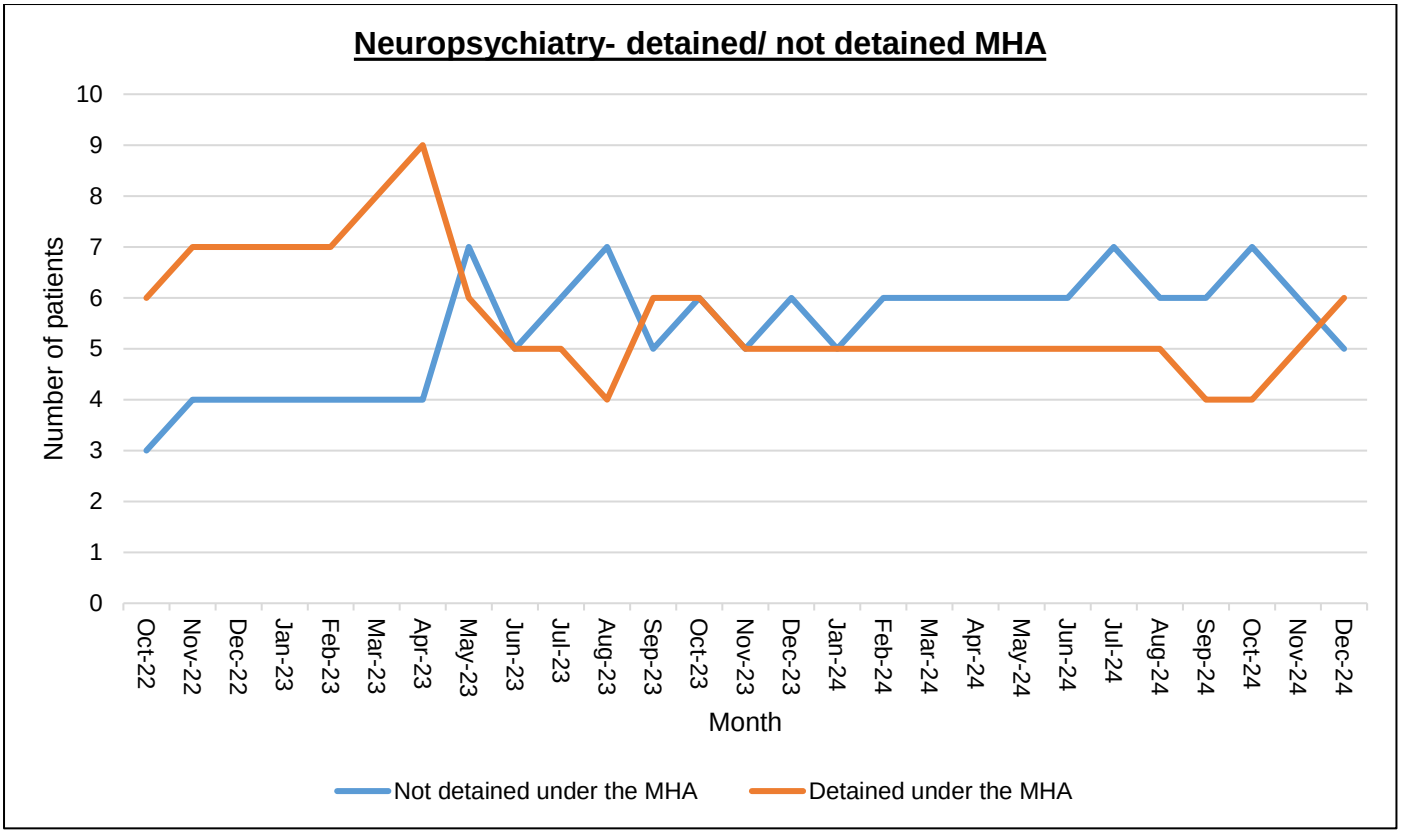
Contents **Page**

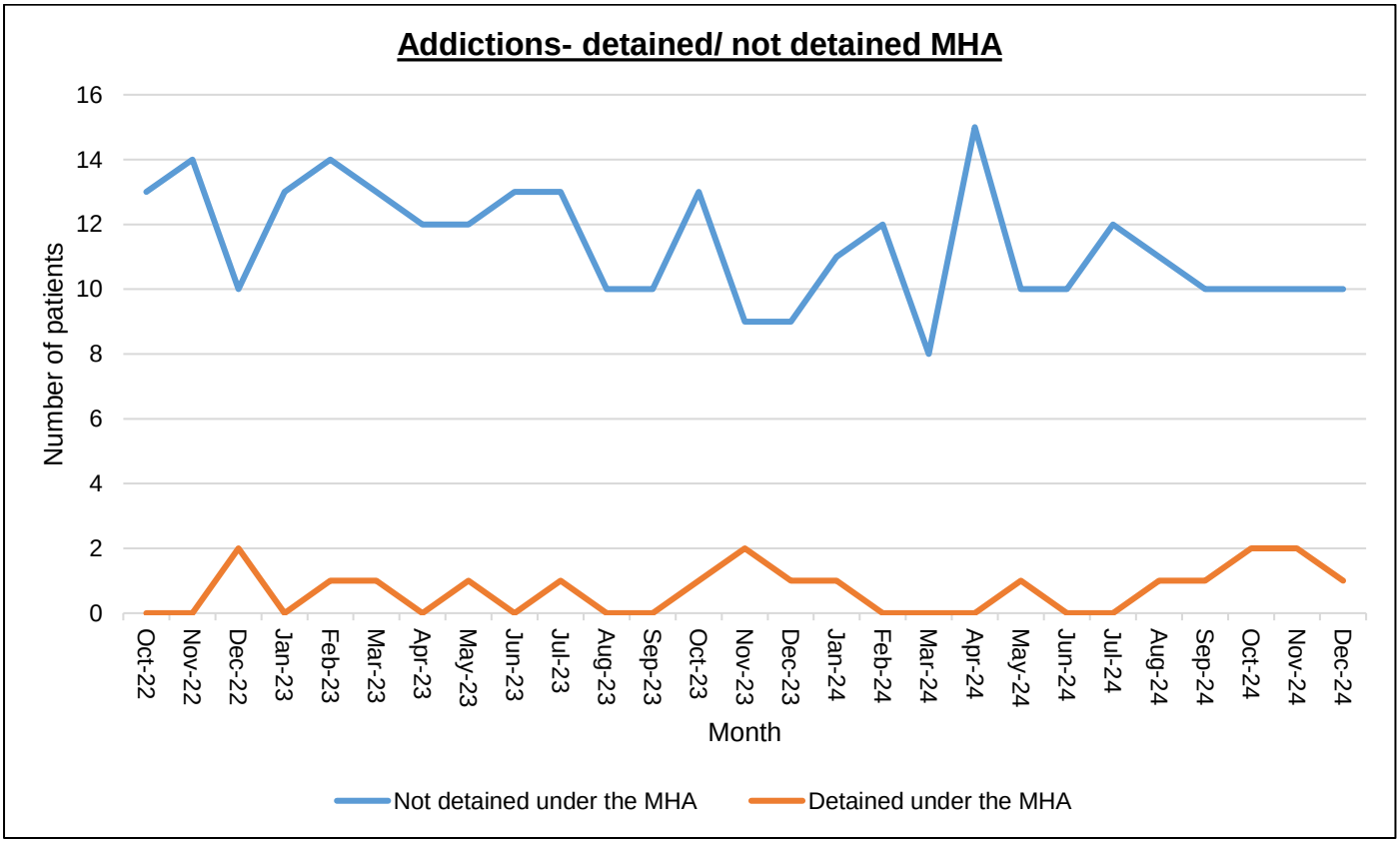












There have been no CAMHS learning disability patients detained in Hafan Y Coed during the period.

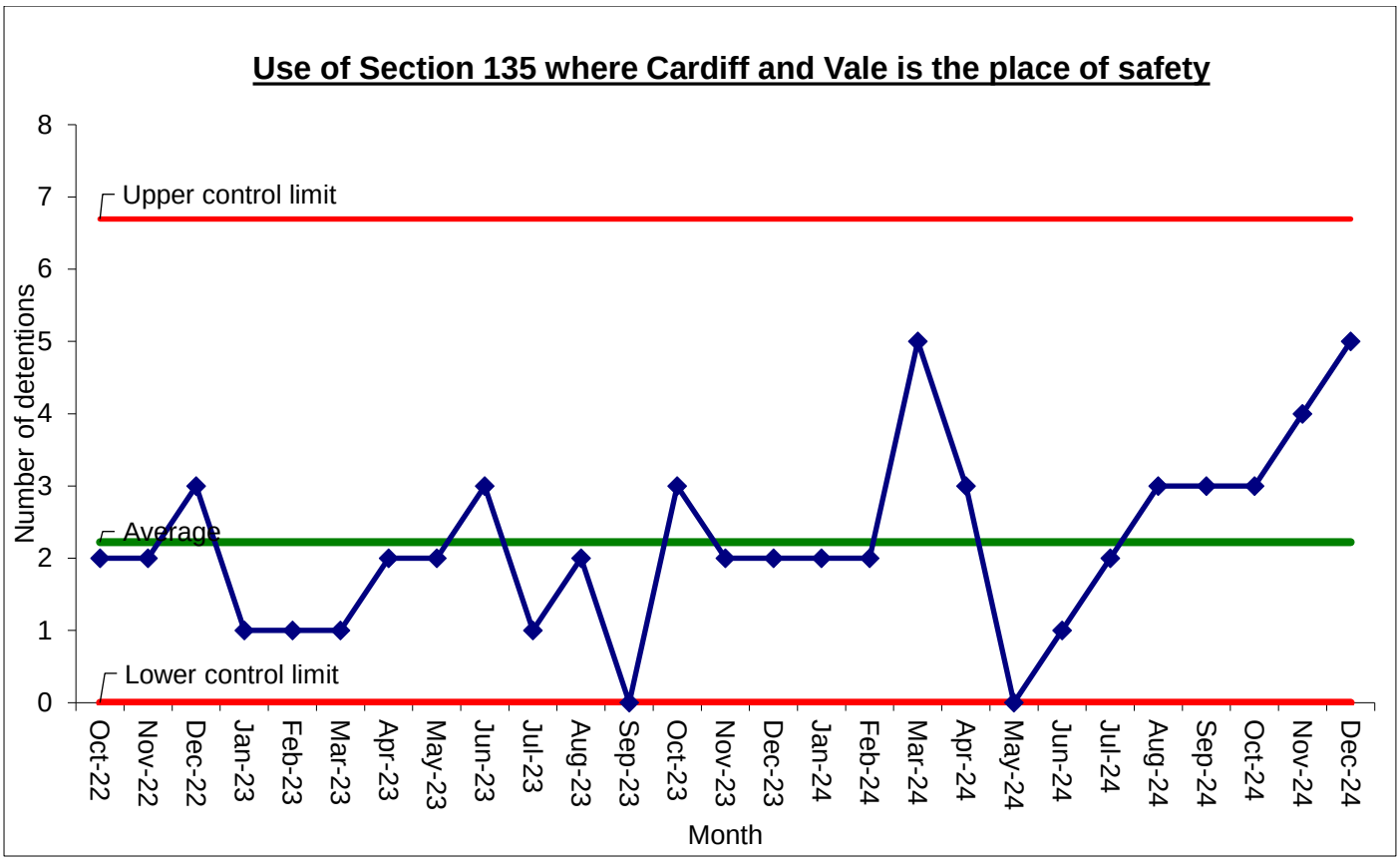
Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on nine occasions.

- detained under Section 2 x7
- detained under Section 3 x1
- absconded x1

During the period Section 135 (2) powers were used on three occasions.

- Detained under Section 2 OOA x1
- Brought back to HYC under Section 3 x1
- Brought back to HYC under Section 2 x1



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;-

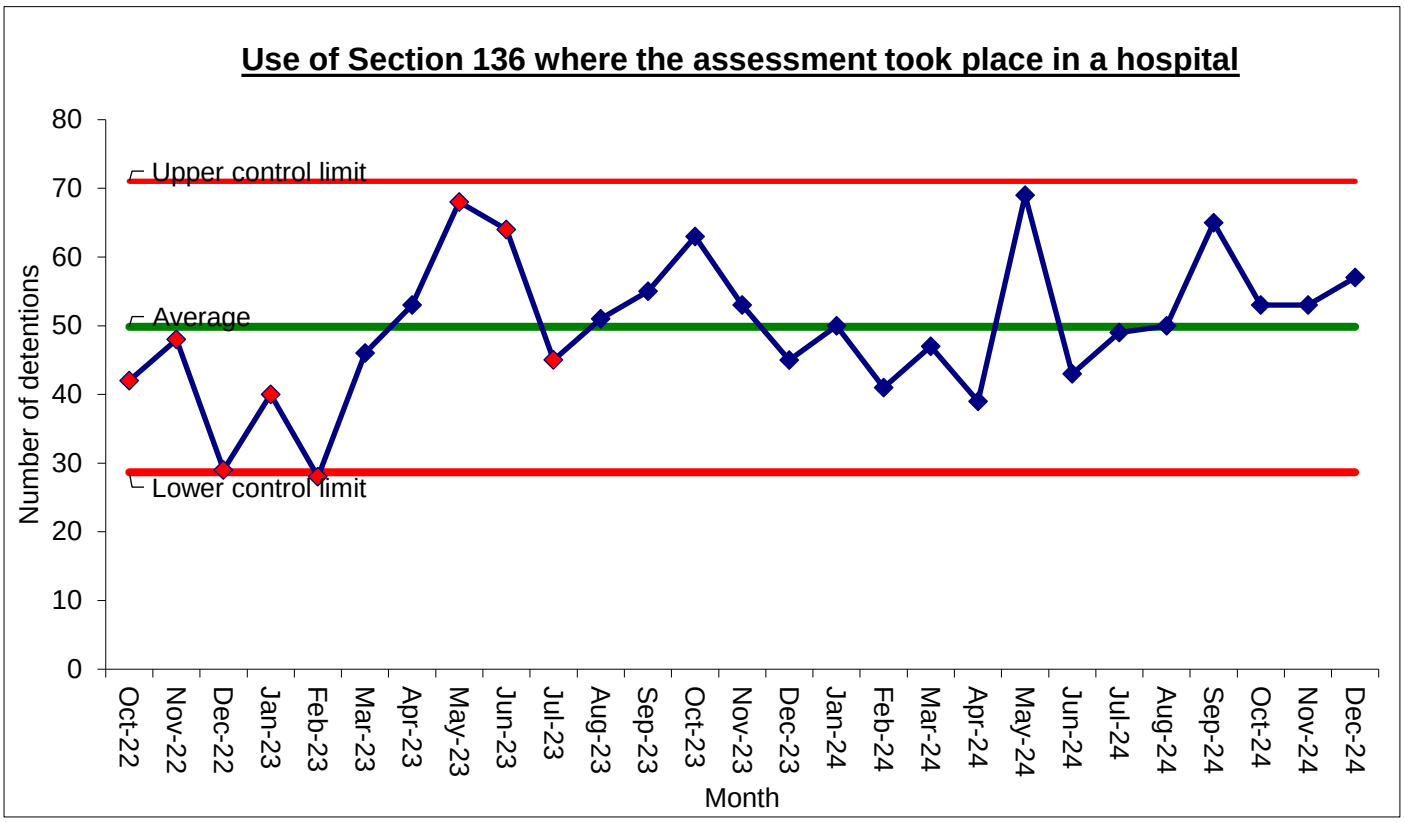
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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.

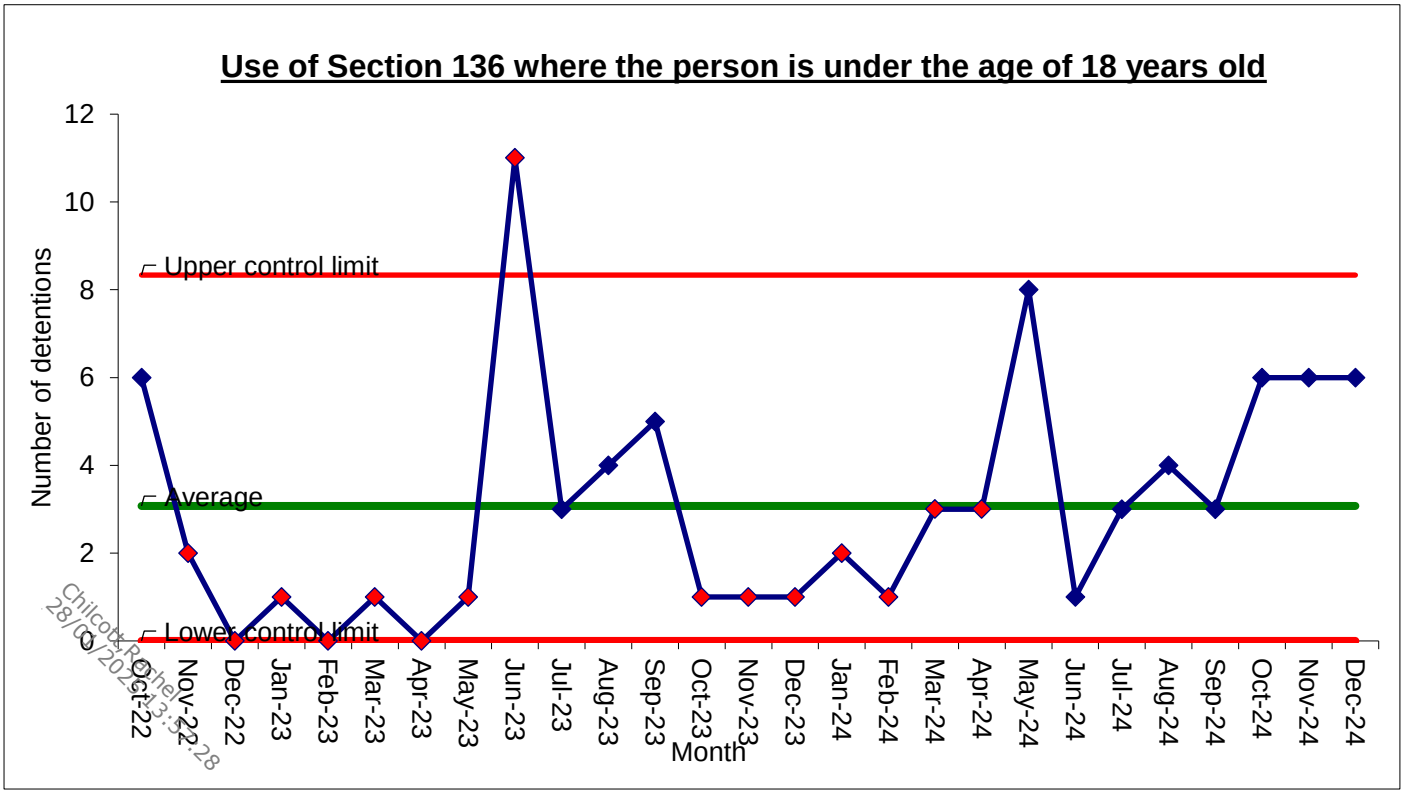
For this period, we have seen nine people for a Voluntary Assessment. No one was brought into hospital under the Mental Capacity Act.-

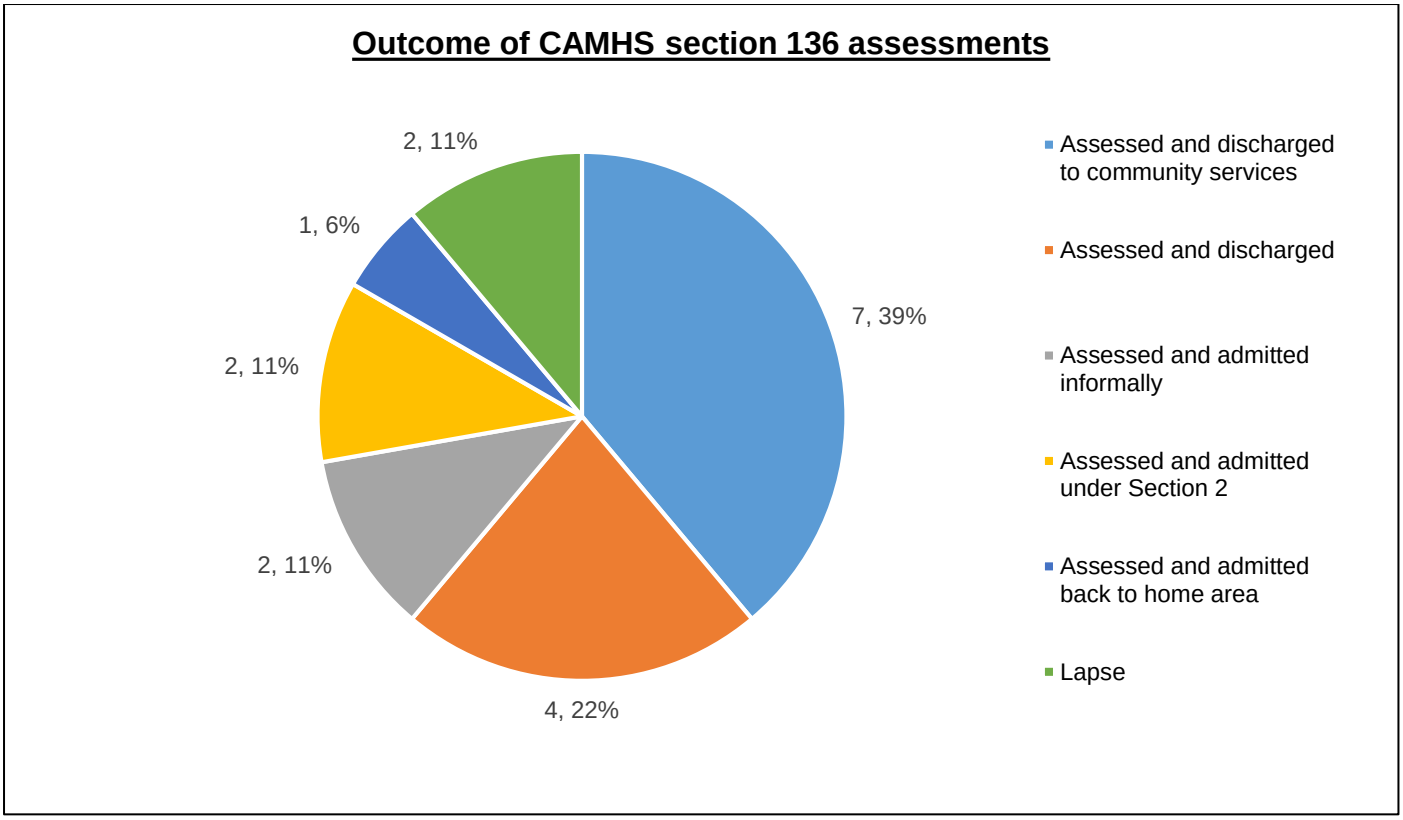
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

During the period a total of 163 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

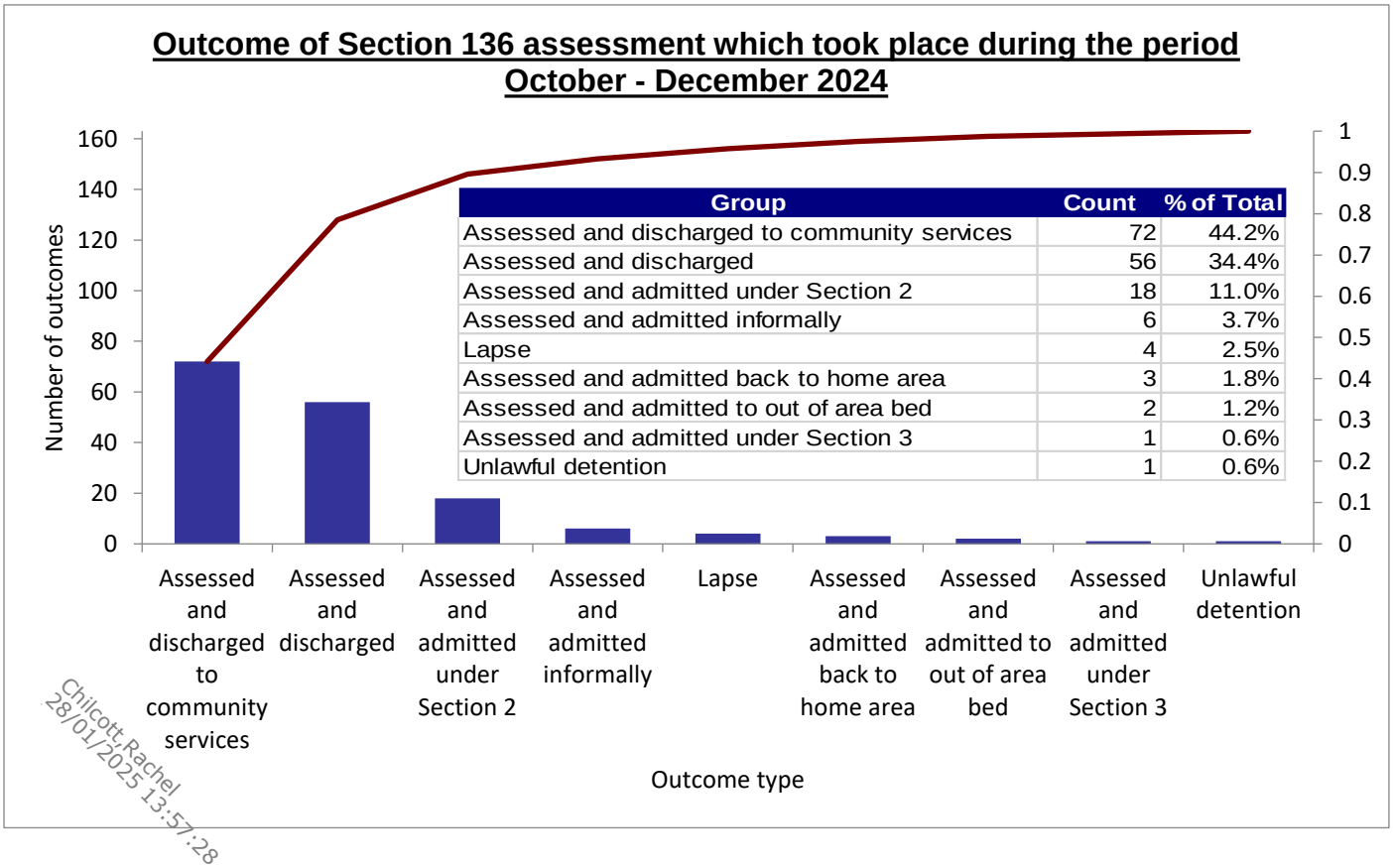


Eighteen of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. Three service users had repeat presentations. This is extracted below;-





The pareto chart highlights that 78.6% 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	72	44.2%
Assessed and discharged	56	34.4%
Assessed and admitted under Section 2	18	11.0%
Assessed and admitted informally	6	3.7%
Lapse	4	2.5%
Assessed and admitted back to home area	3	1.8%
Assessed and admitted to out of area bed	2	1.2%
Assessed and admitted under Section 3	1	0.6%
Unlawful detention	1	0.6%

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

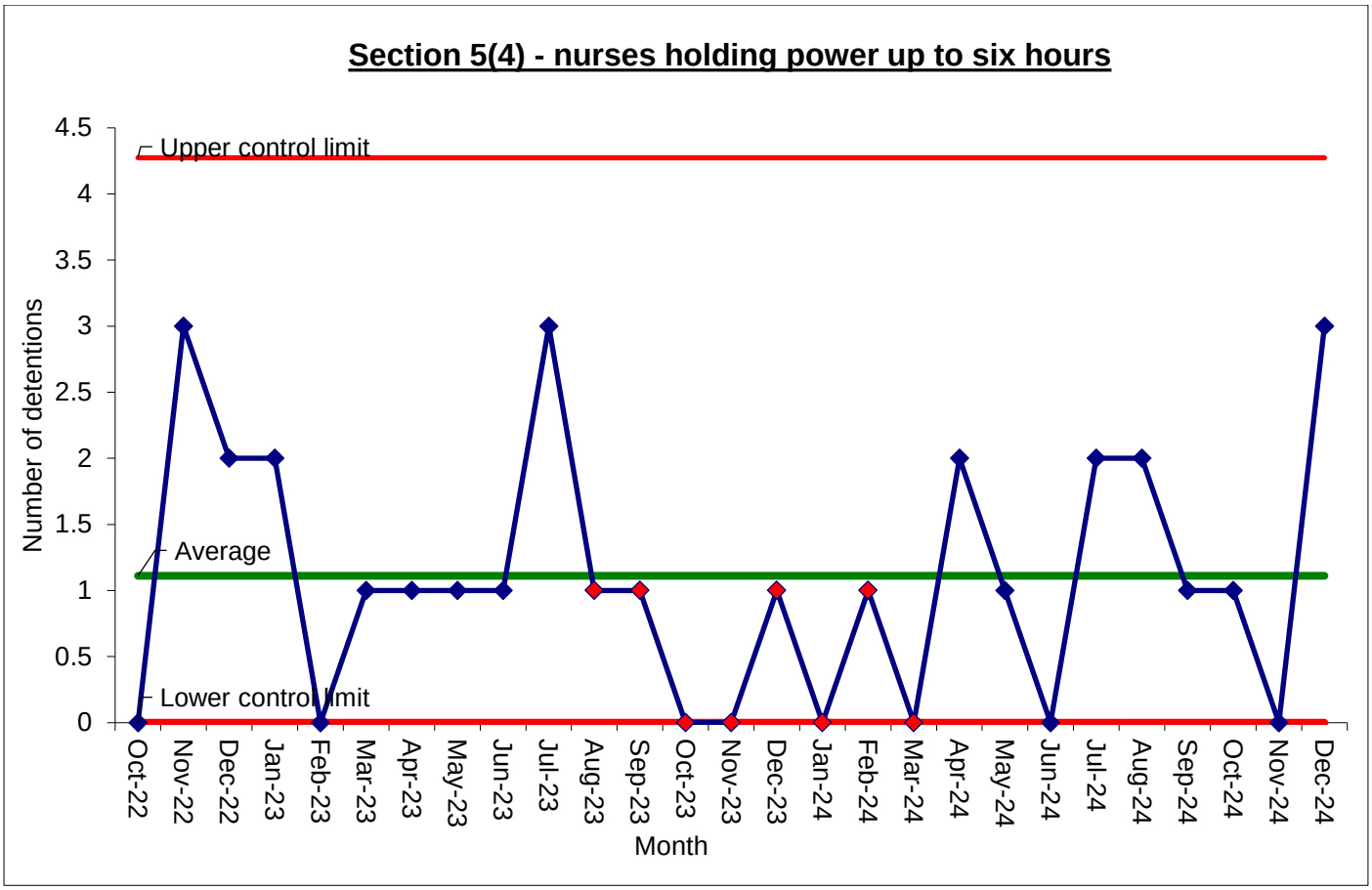
Out of the four lapsed detentions, 2 were due to the patient not being fit for assessment, 1 was due to the patient absconding from A&E and 1 was due to the patient being allowed to leave A&E before an assessment took place.

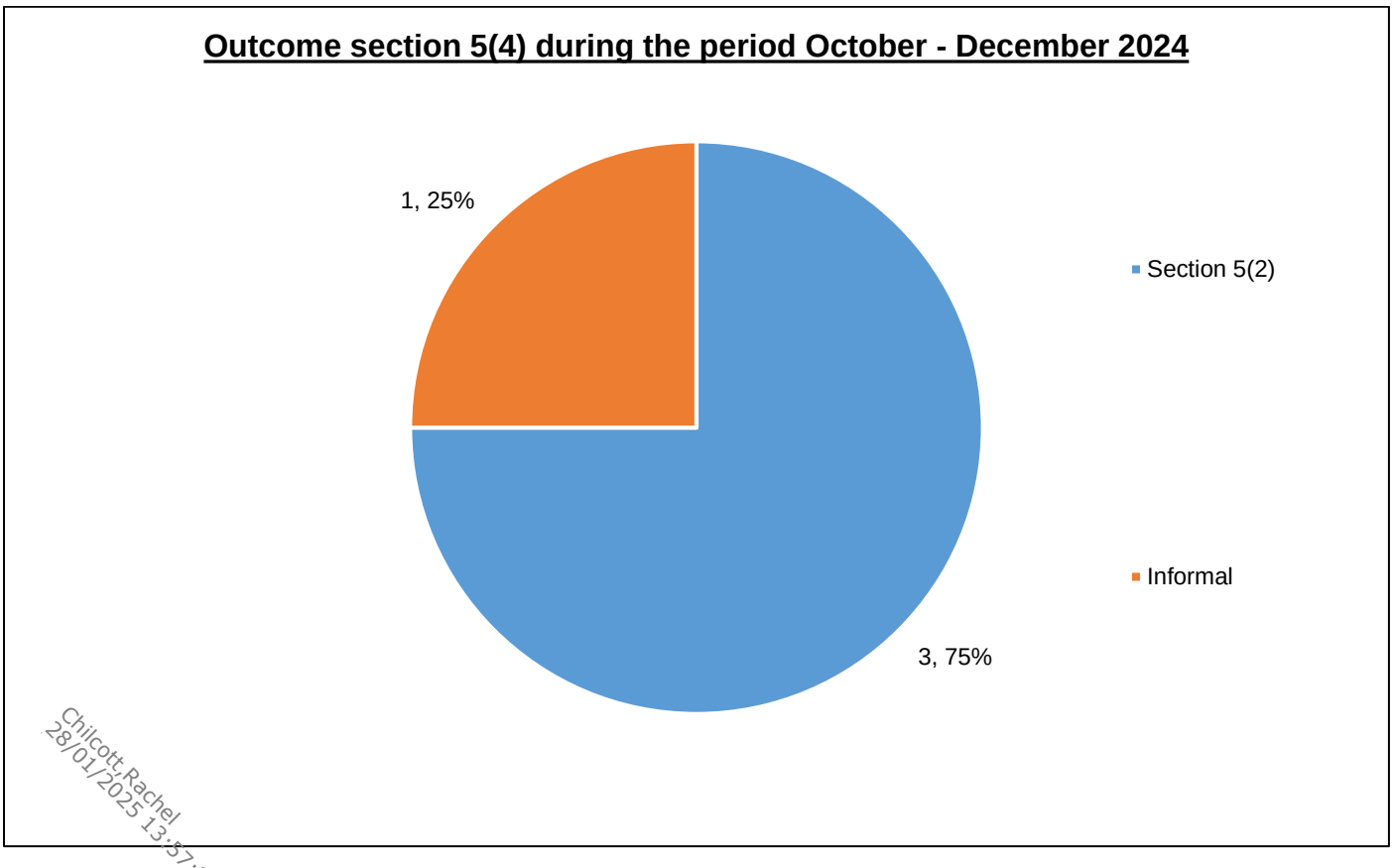
One 136 was an unlawful detention as the patient was detained in their garden.

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

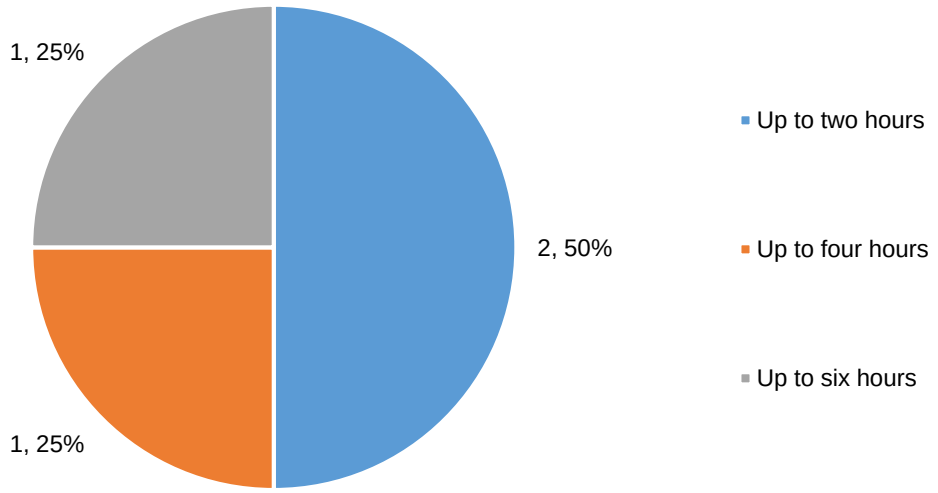
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

Section 5(4) - Nurses Holding Power

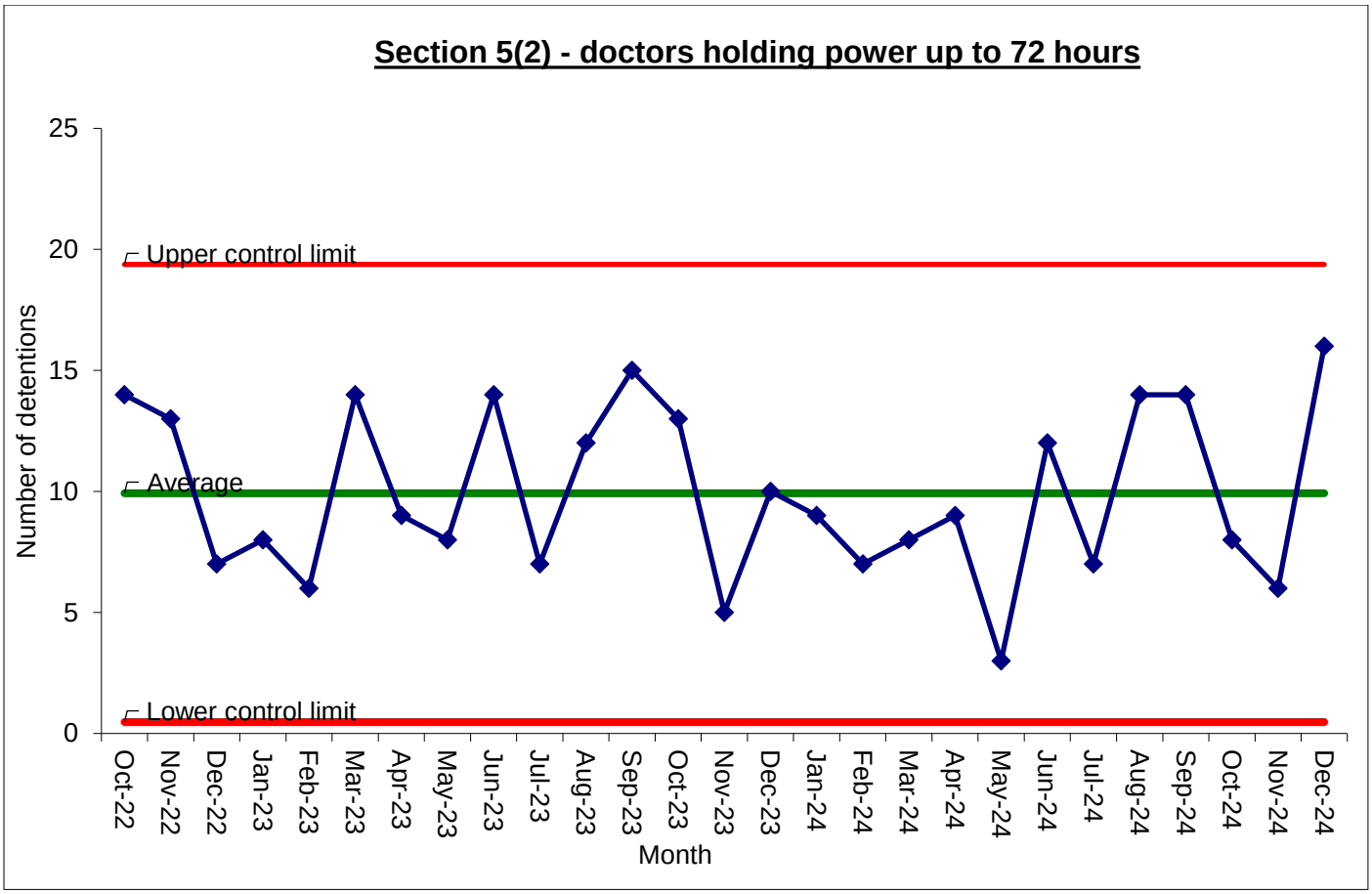


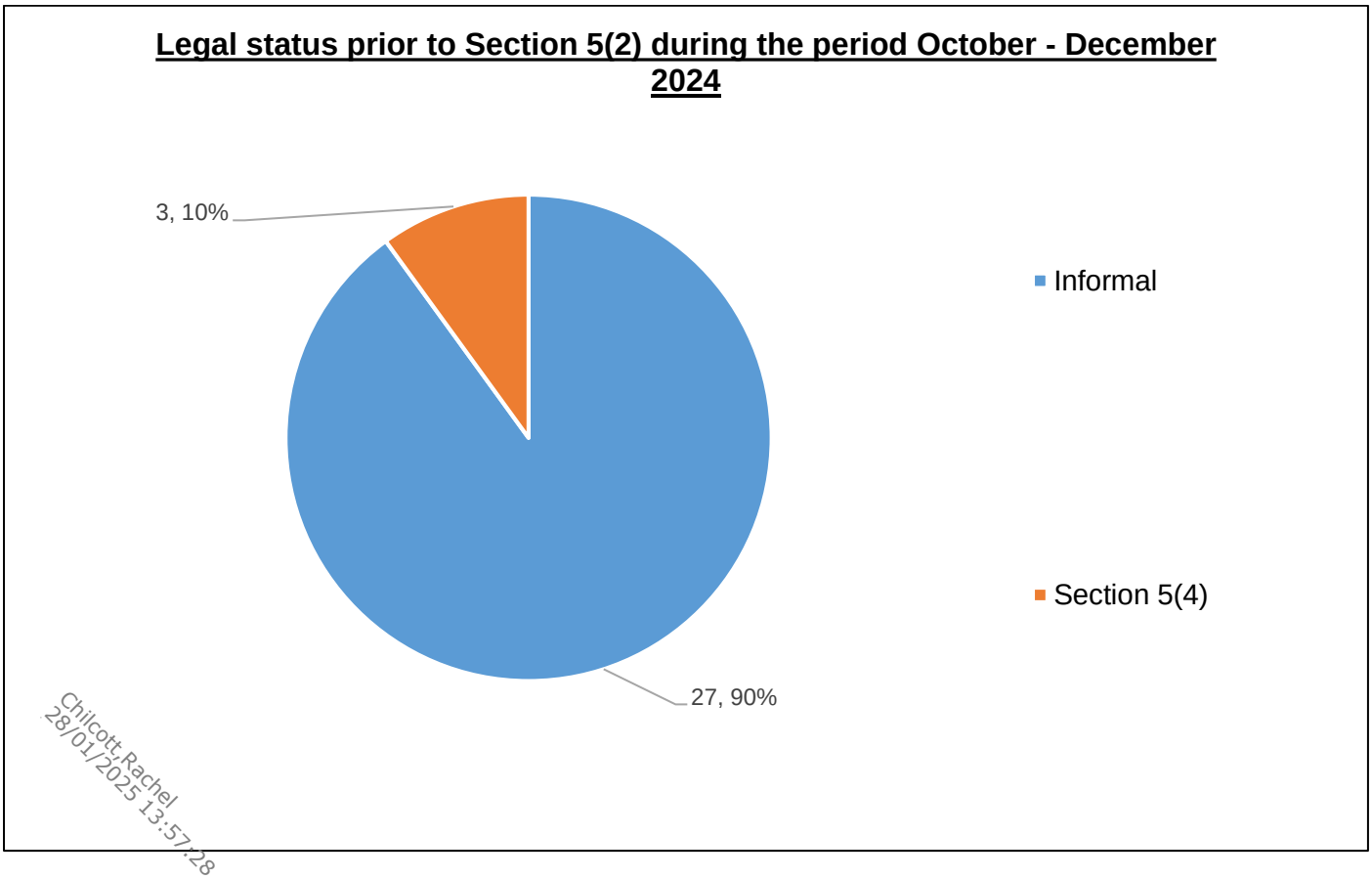


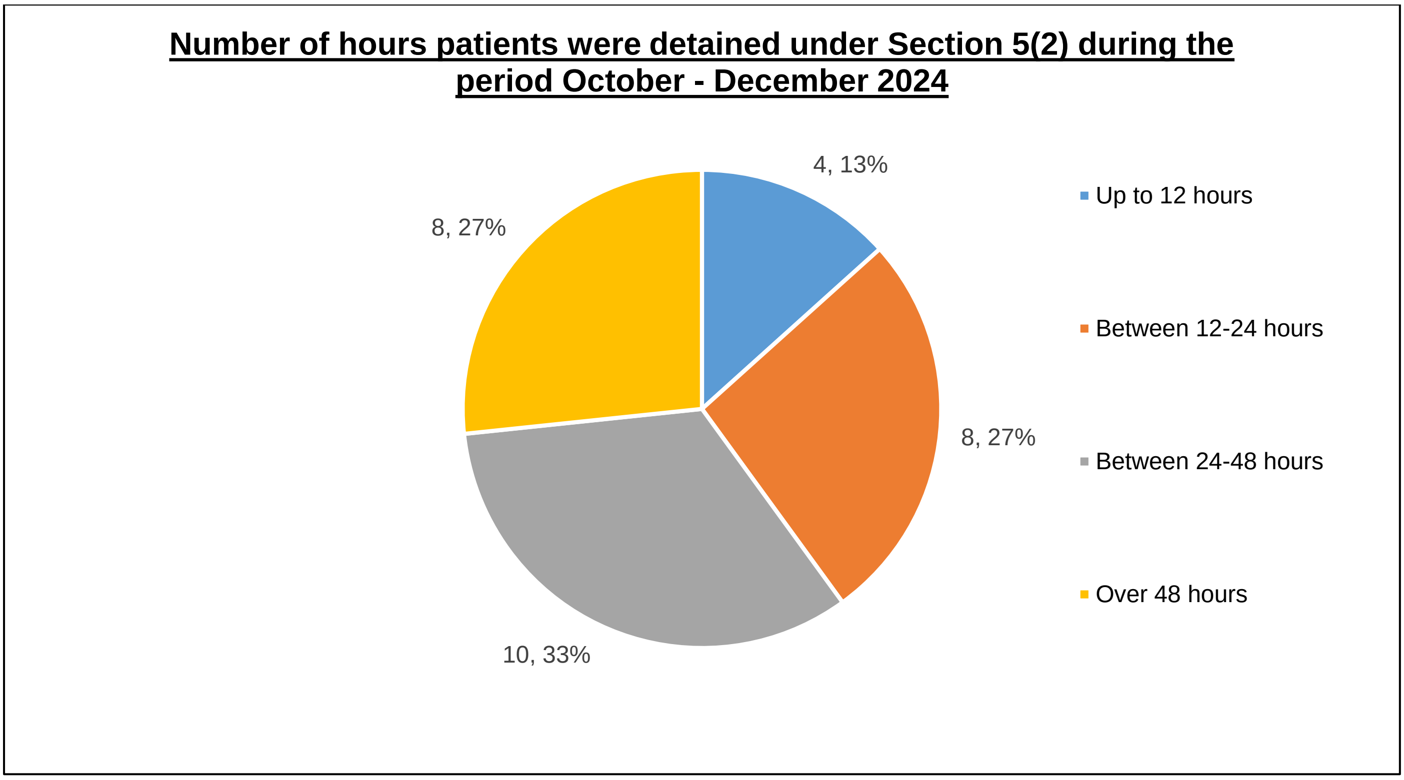
Number of hours patients were detained under Section 5(4) during the period October - December 2024

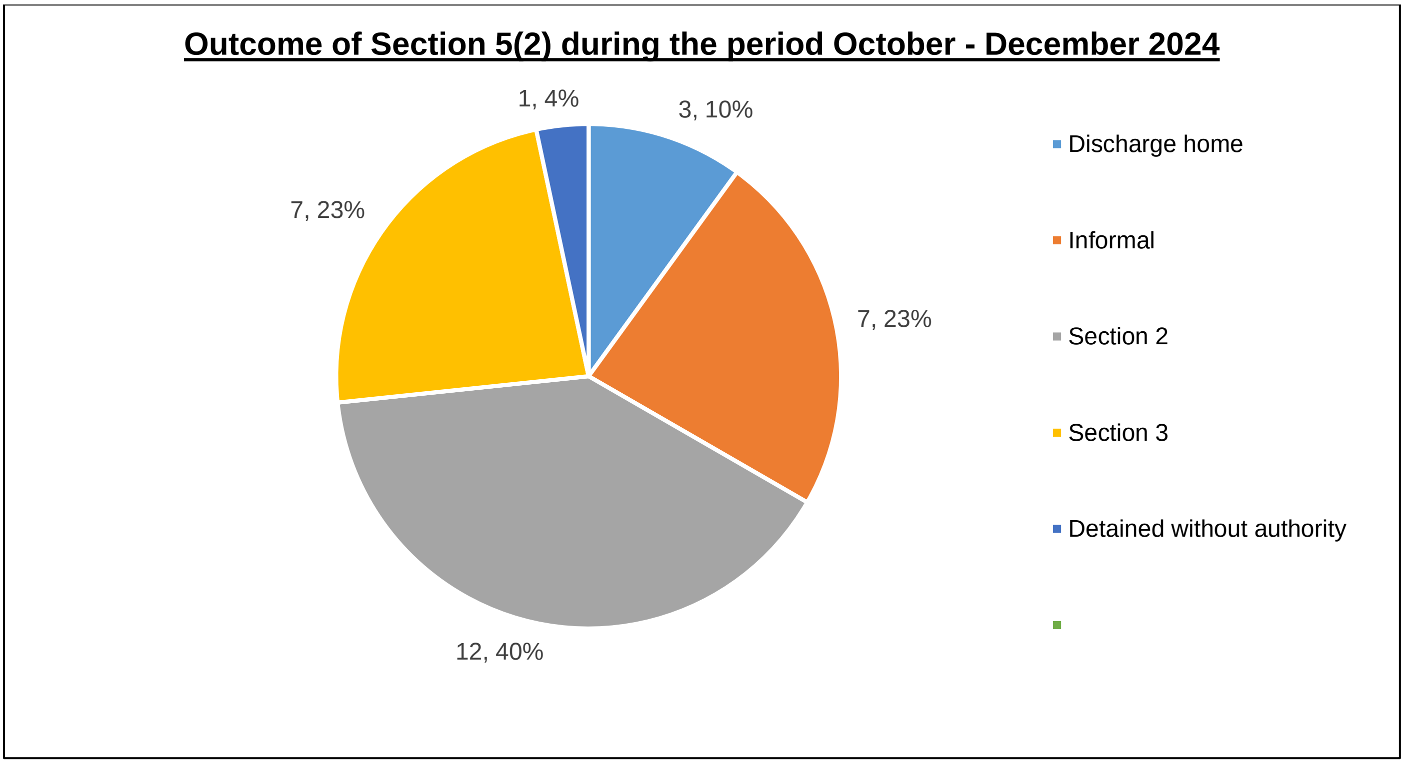


Section 5(2) - Doctors holding power









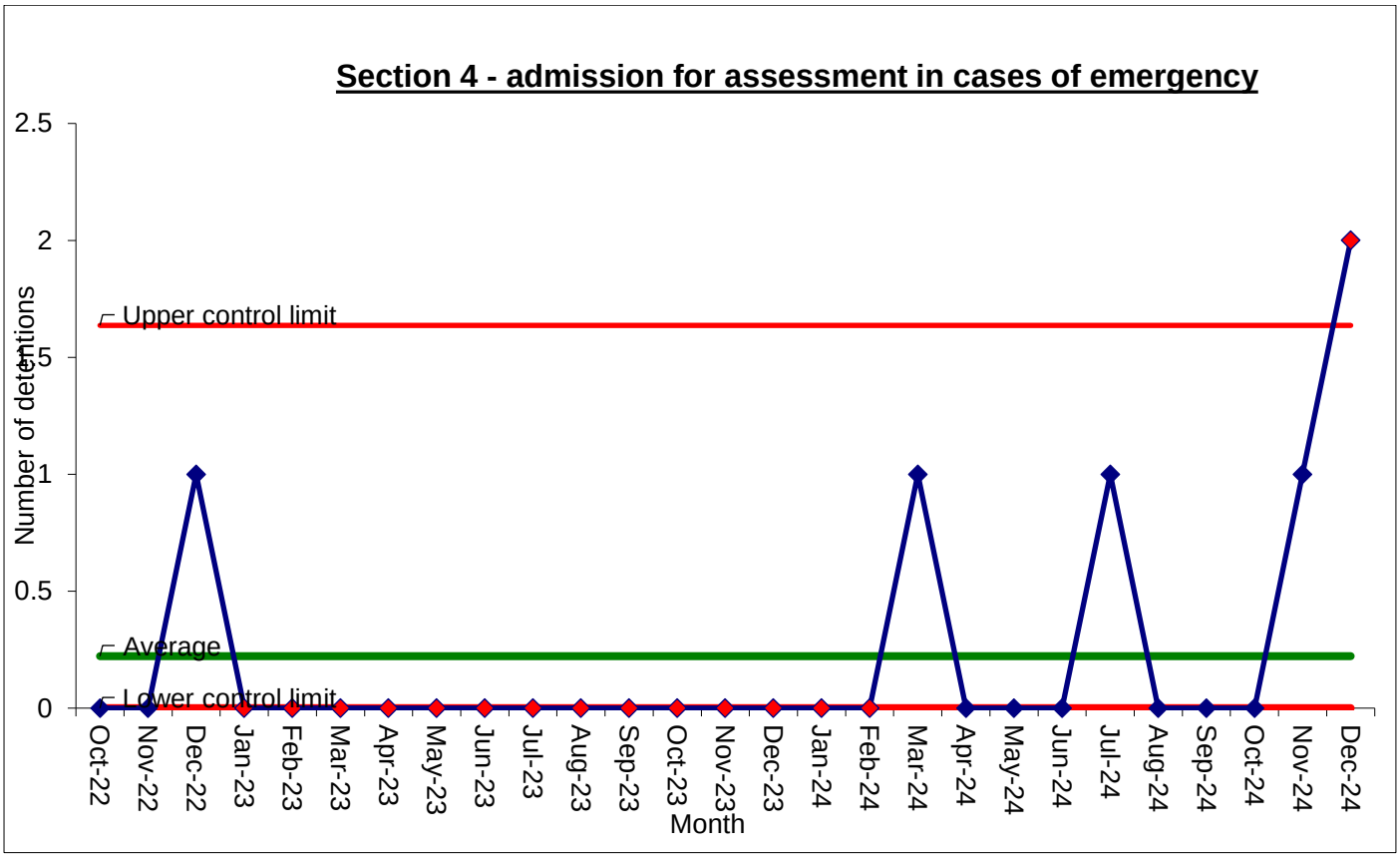
CAMHS Commissioned Inpatient Data

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

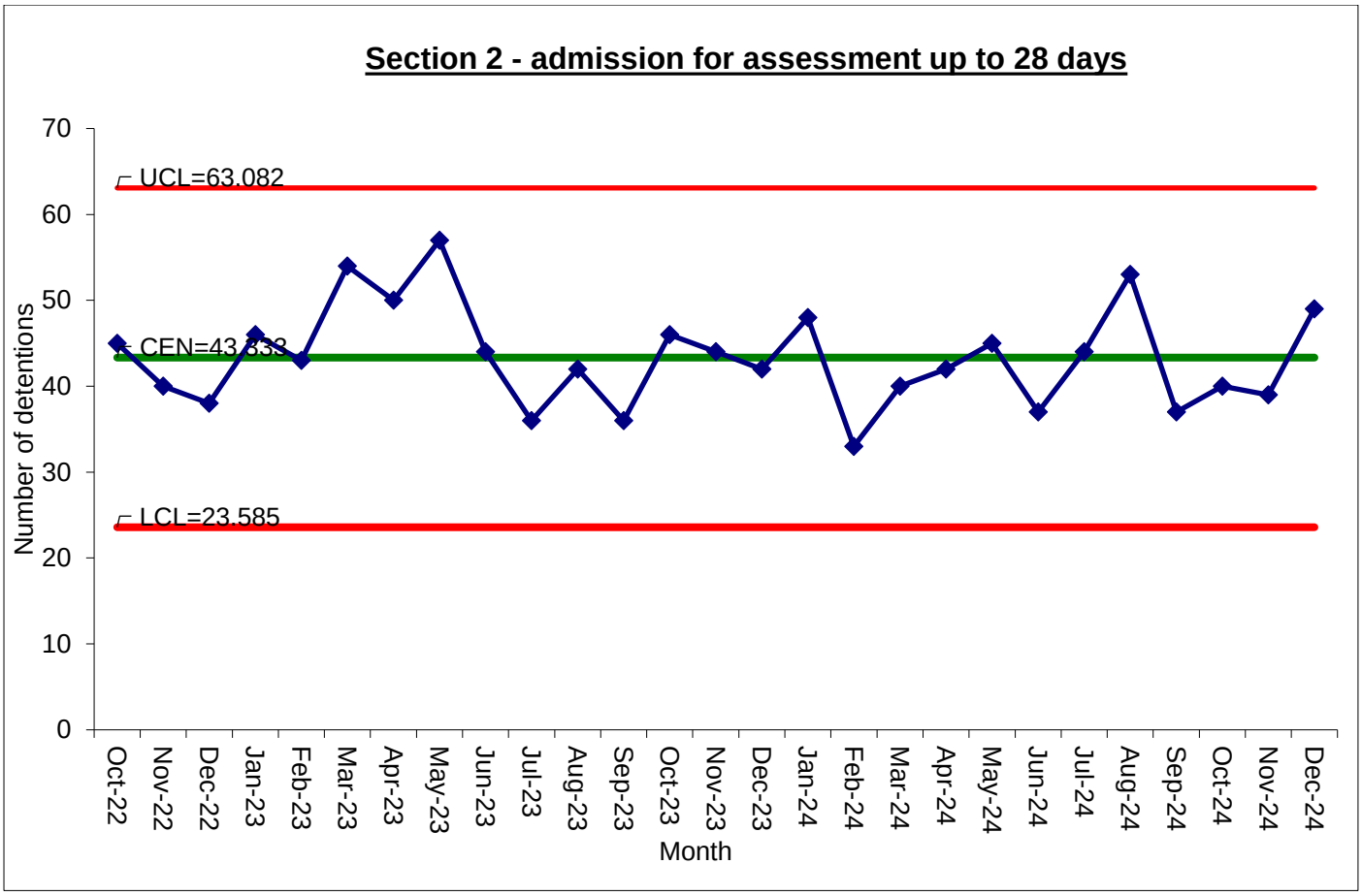
During the period there were no uses of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB.

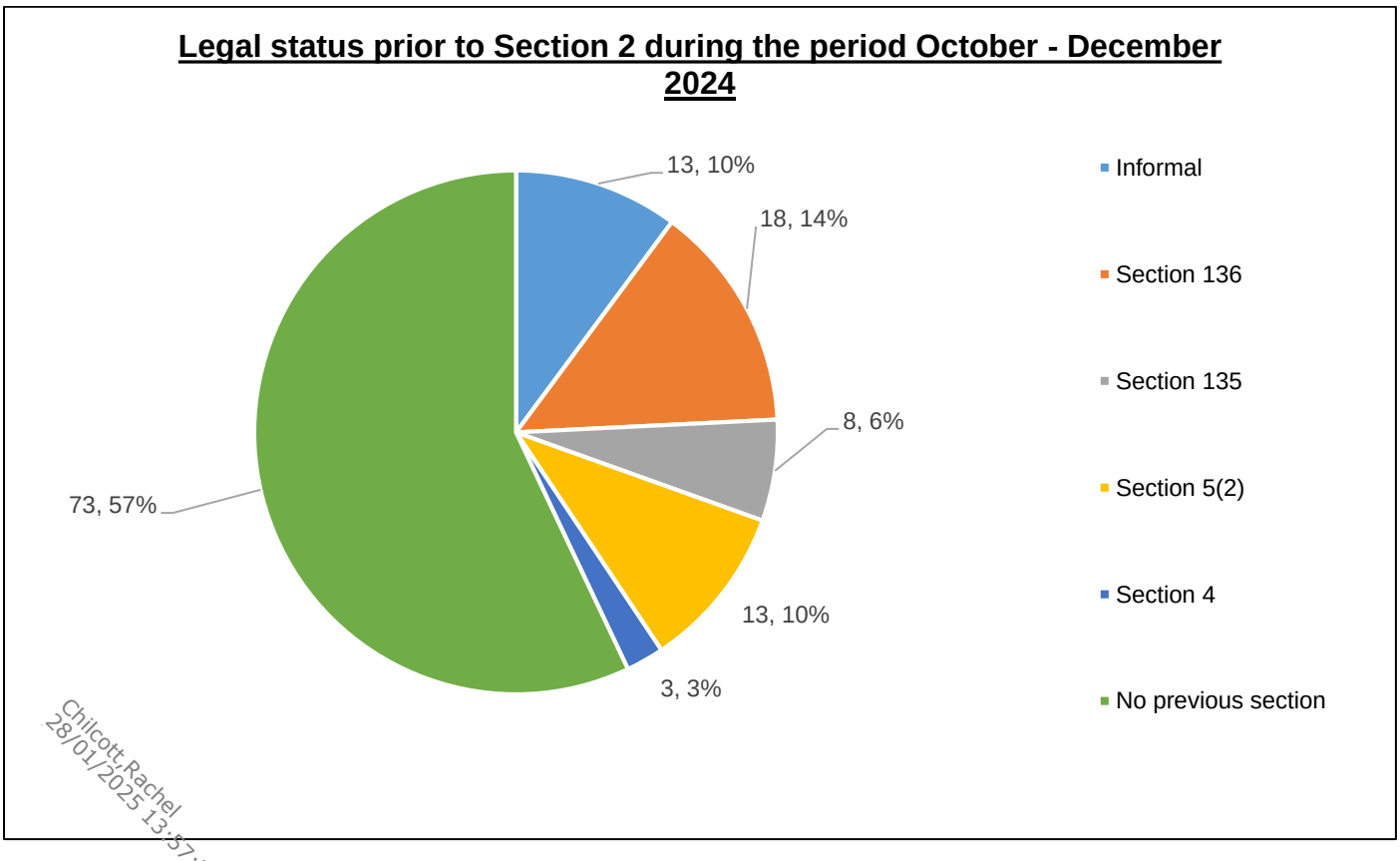
Section 4 - Admission for Assessment in Cases of Emergency

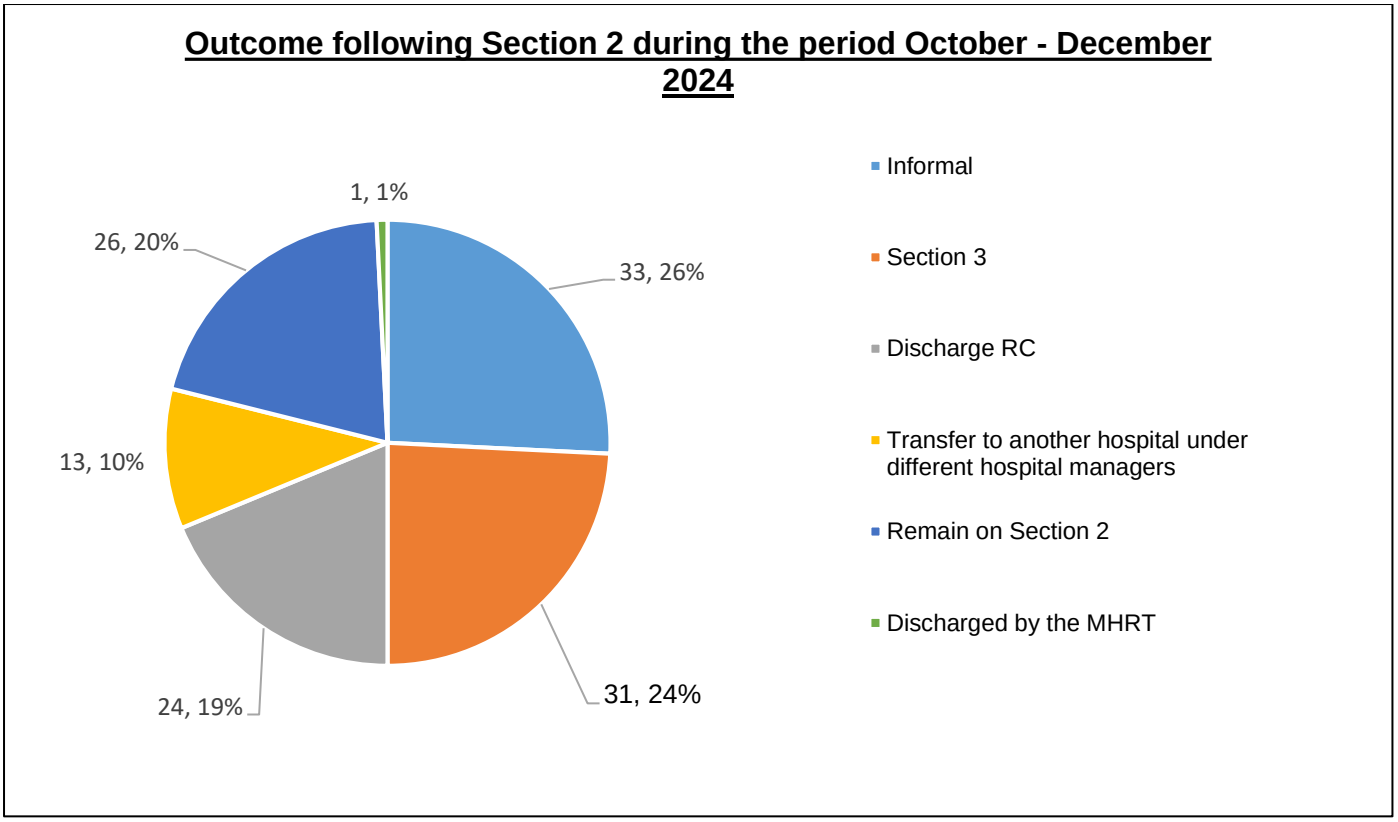
Section 4 was used three times during the period. All were subsequently placed on Section 2.



Section 2 – Admission for Assessment



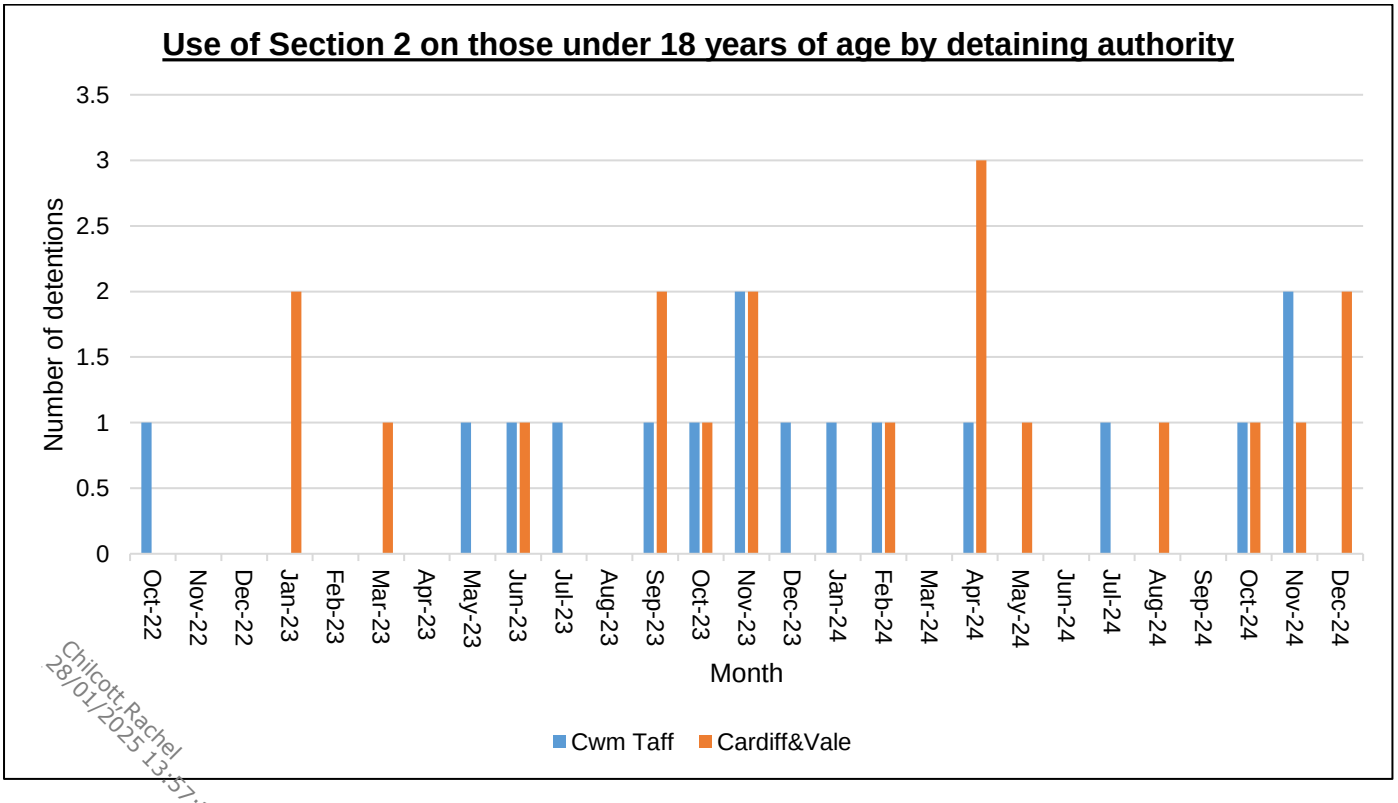


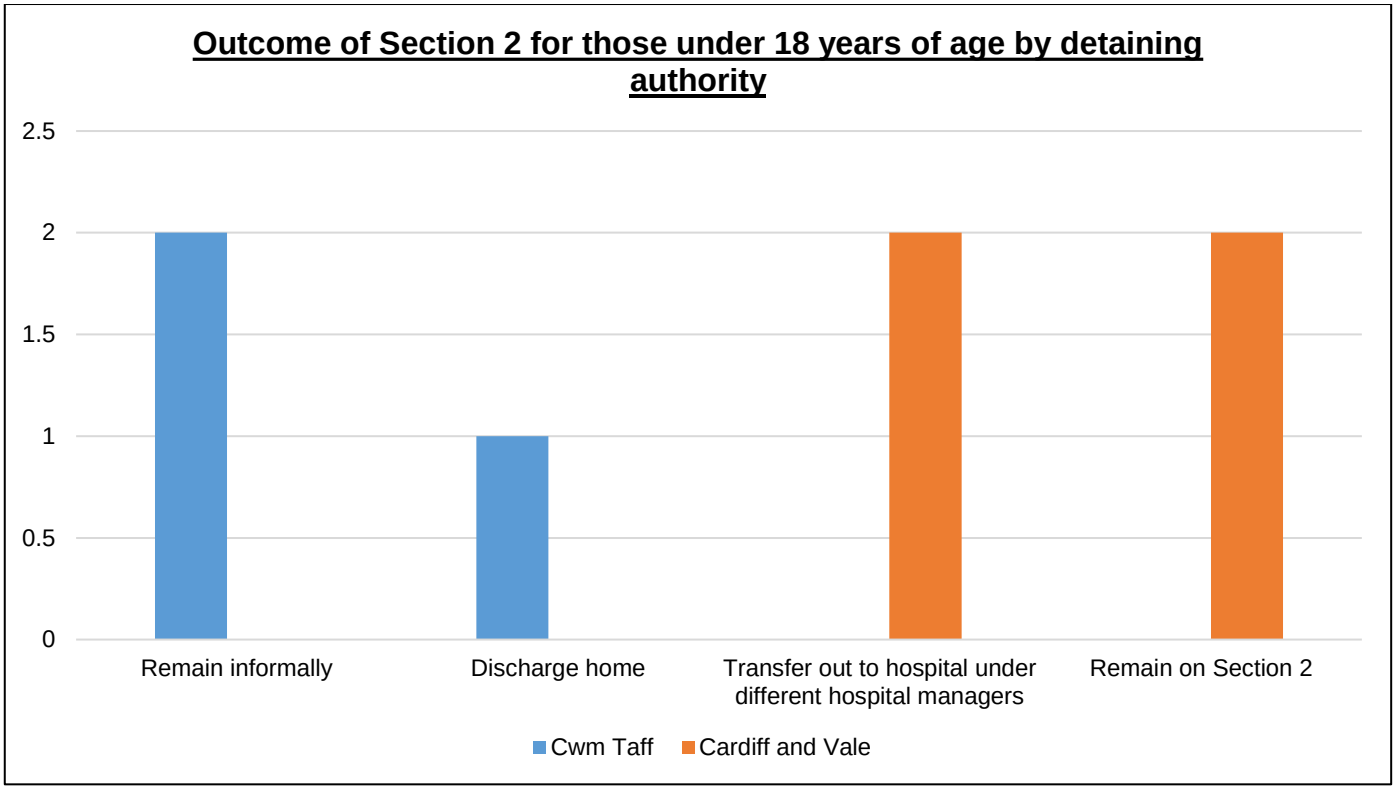


CAMHS Commissioned Inpatient Data

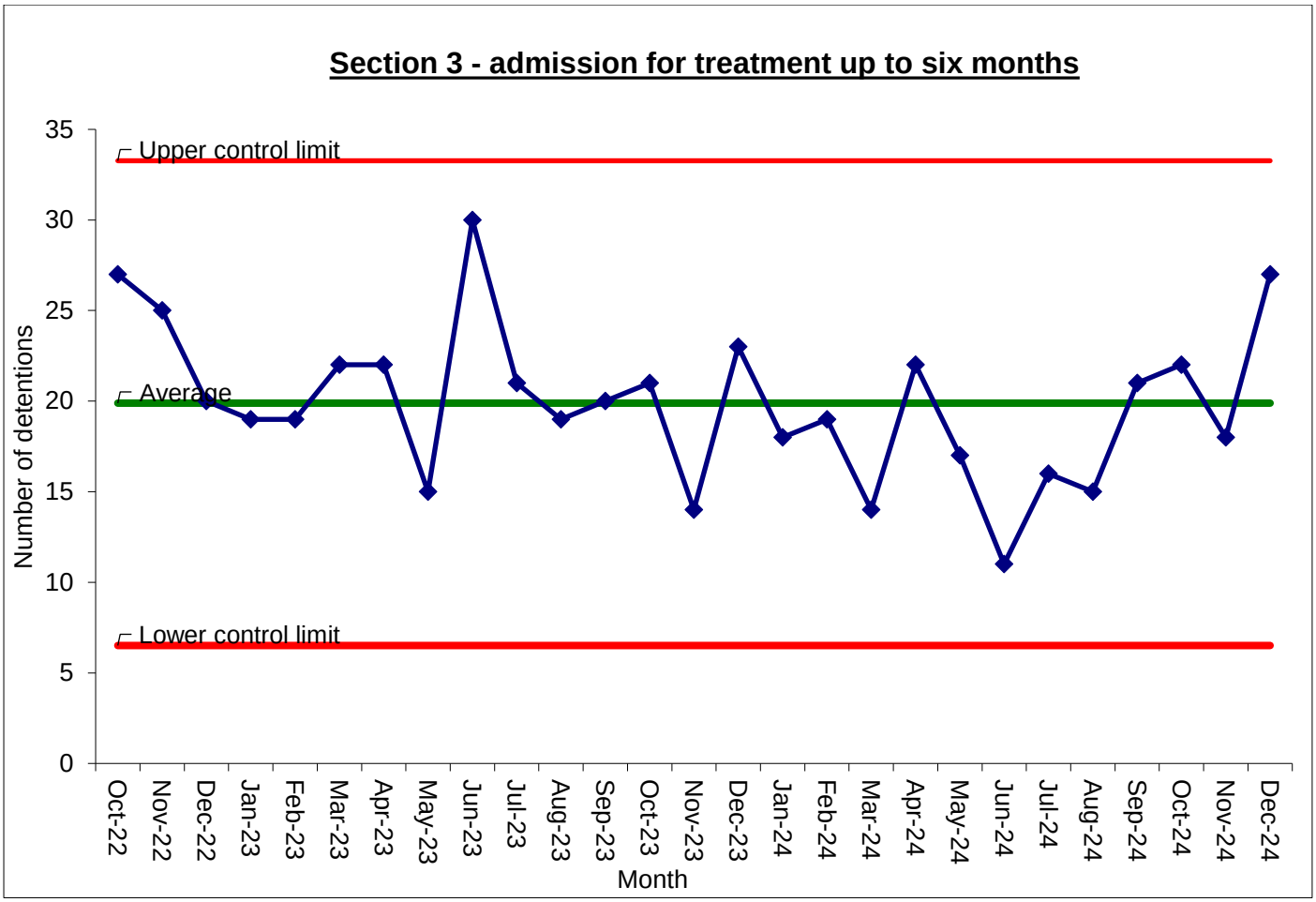
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

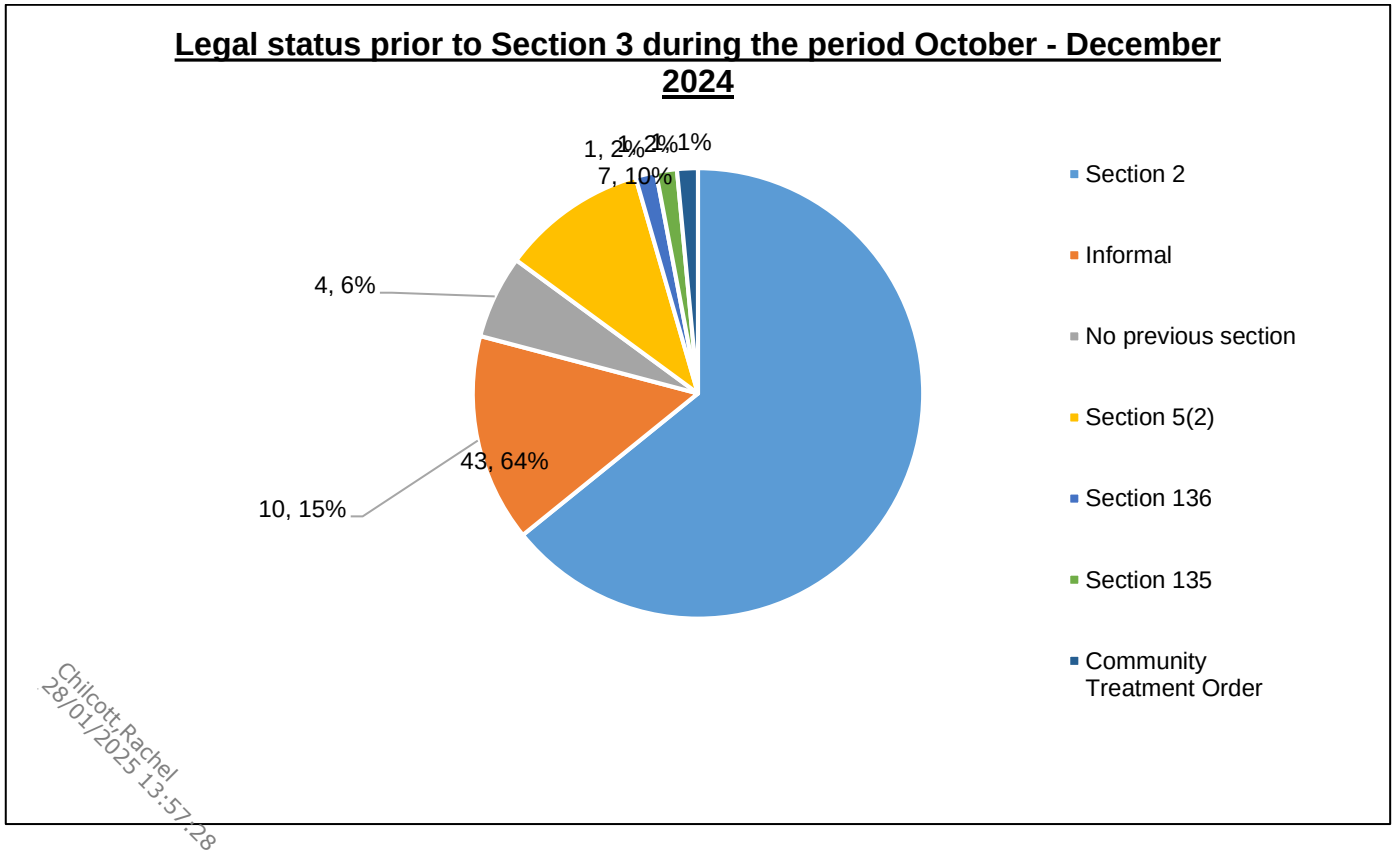
Included in the above data are those under 18 years of age. This is extracted below;-



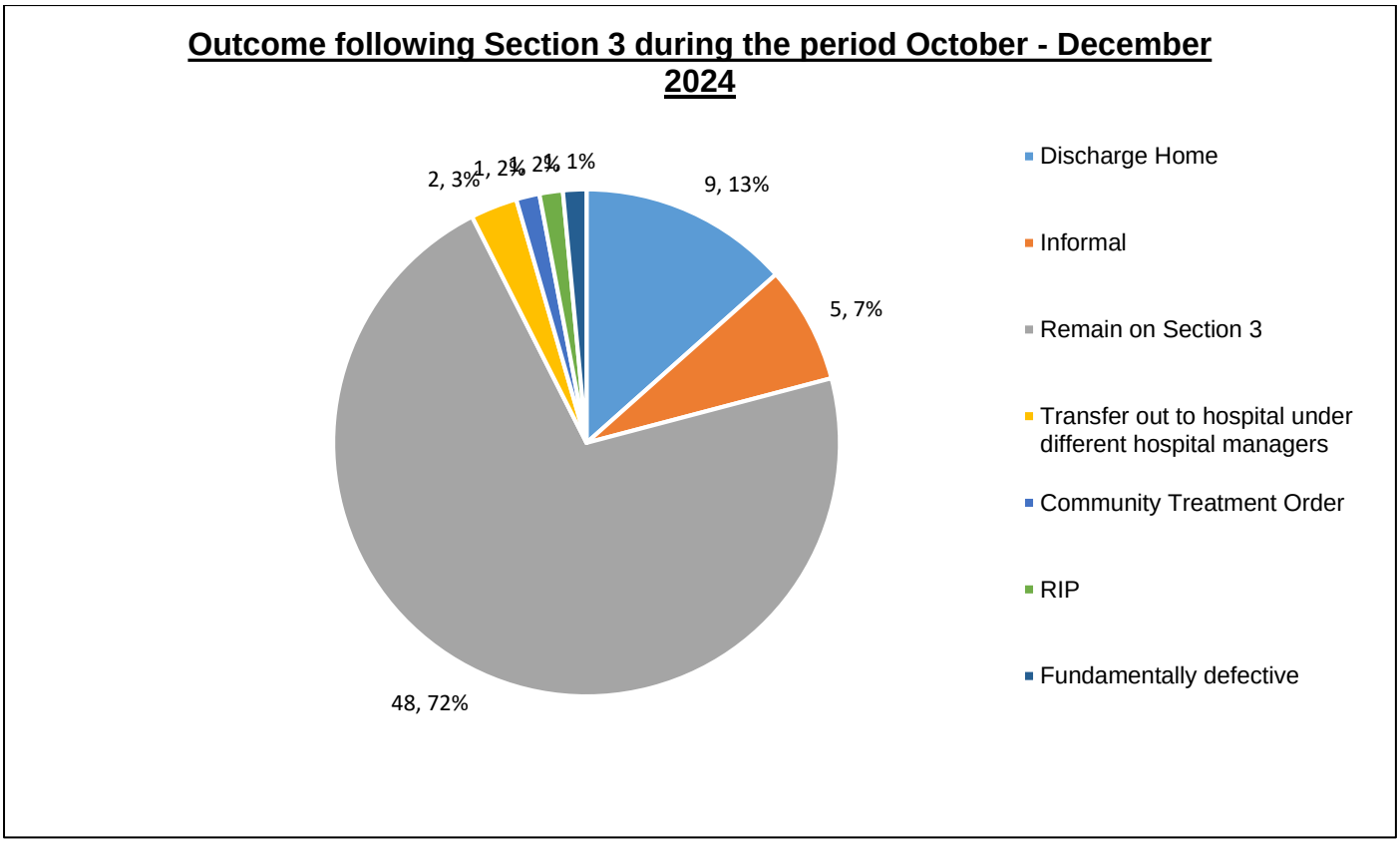


Section 3 – Admission for Treatment



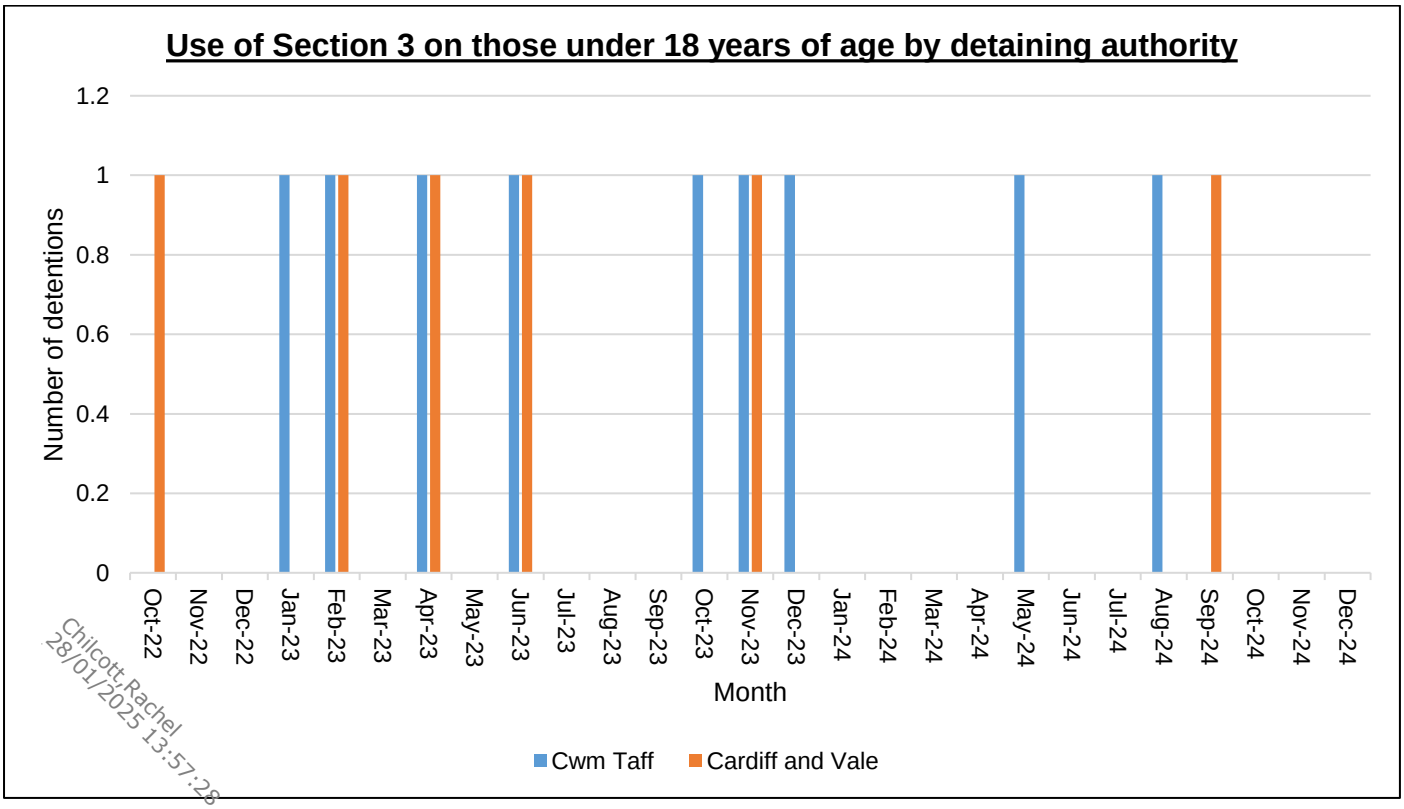


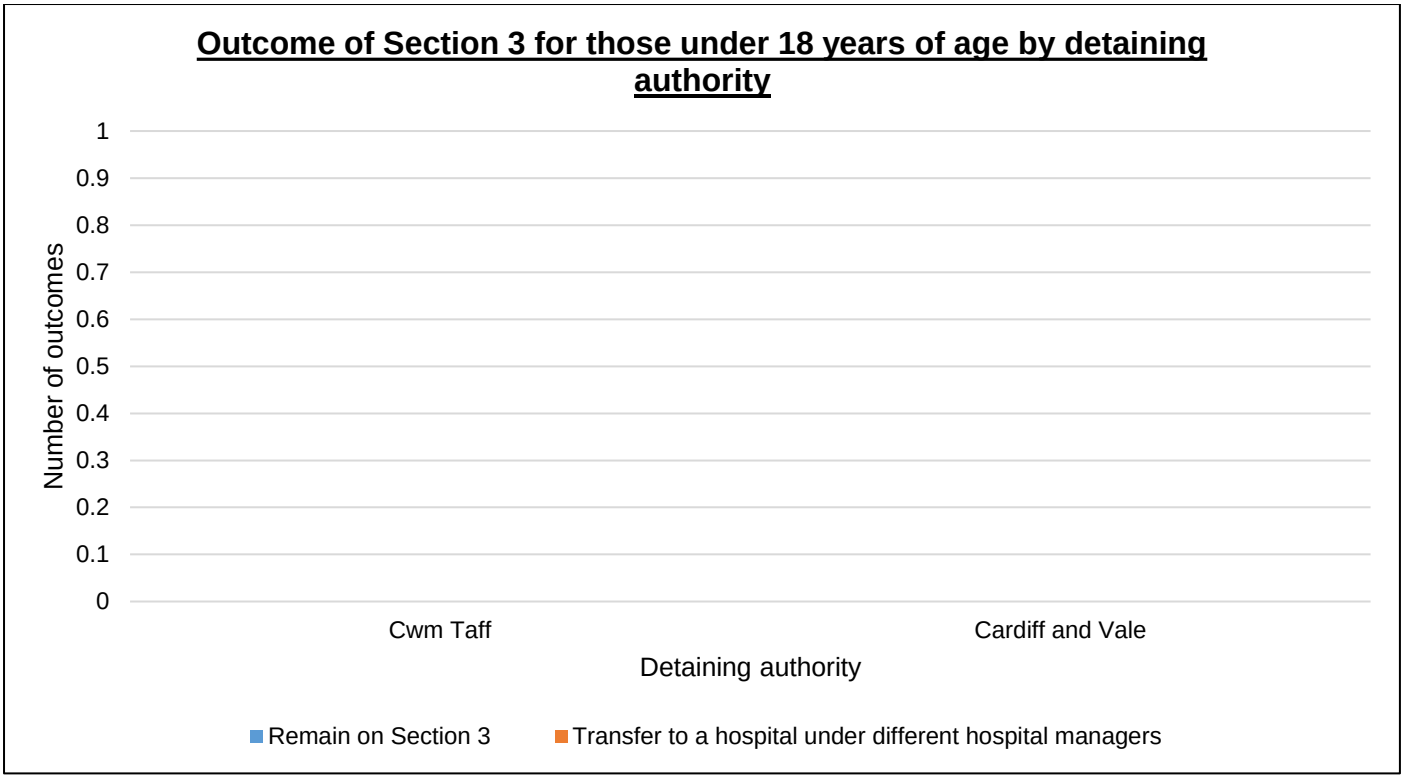
The above data would include those under 18 years of age.



CAMHS Commissioned Inpatient Data

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

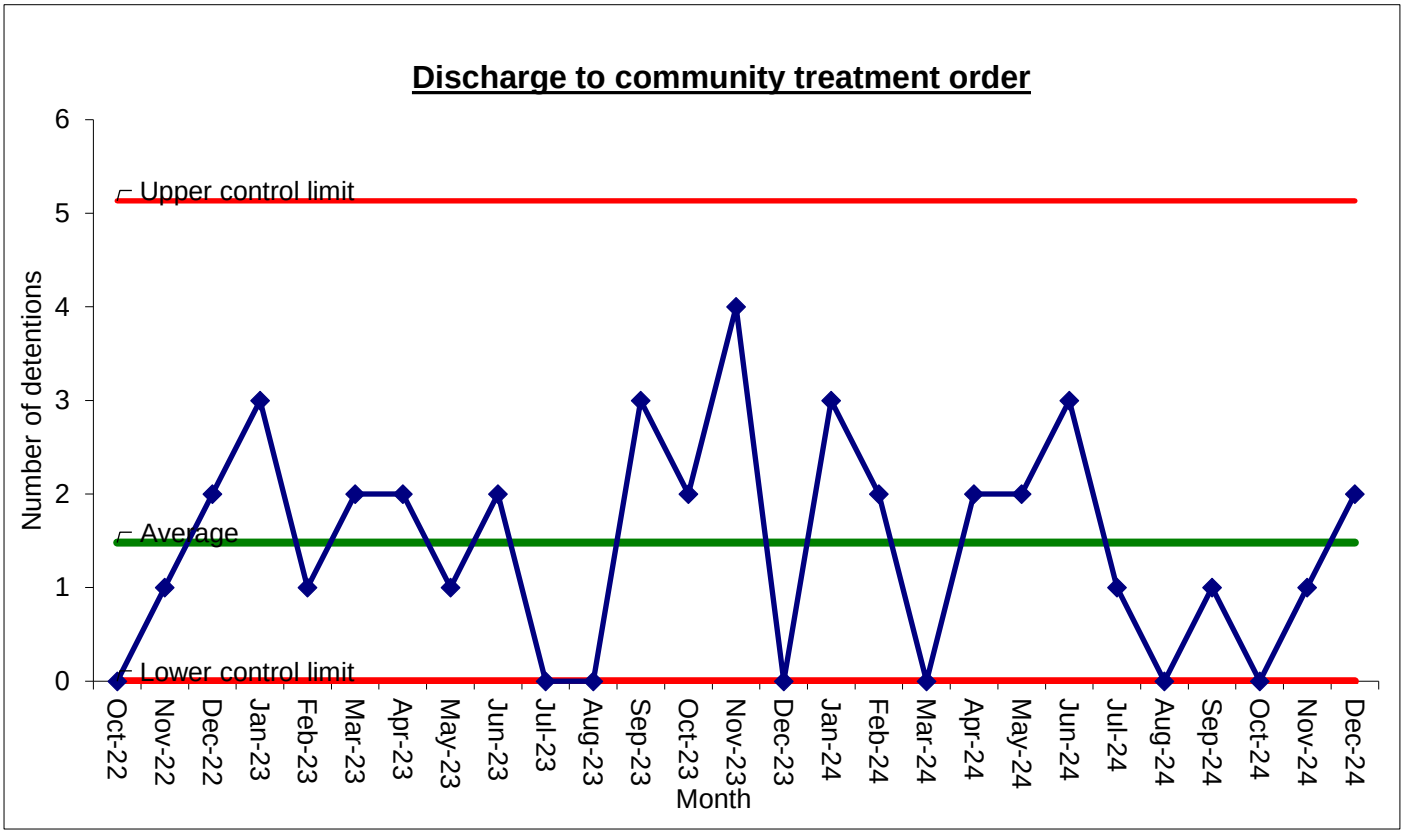


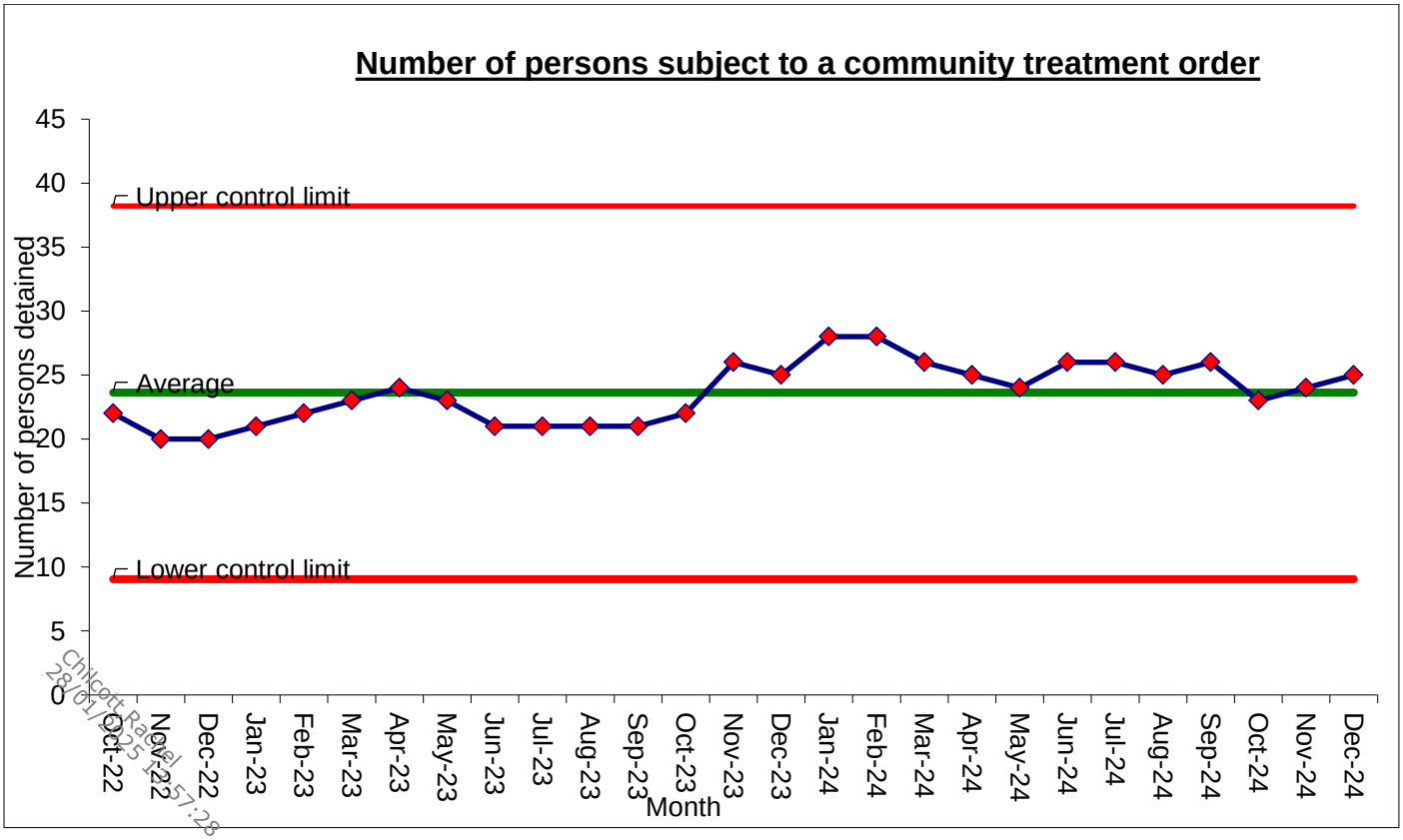


Community Treatment Order

During the period October - December three patients were discharged to Community Treatment Order.

As at 31st December 2024, twenty-five 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 once. One use did not end with the person being brought back to hospital. One use from the previous quarter resulted in the persons CTO being revoked in this quarter.

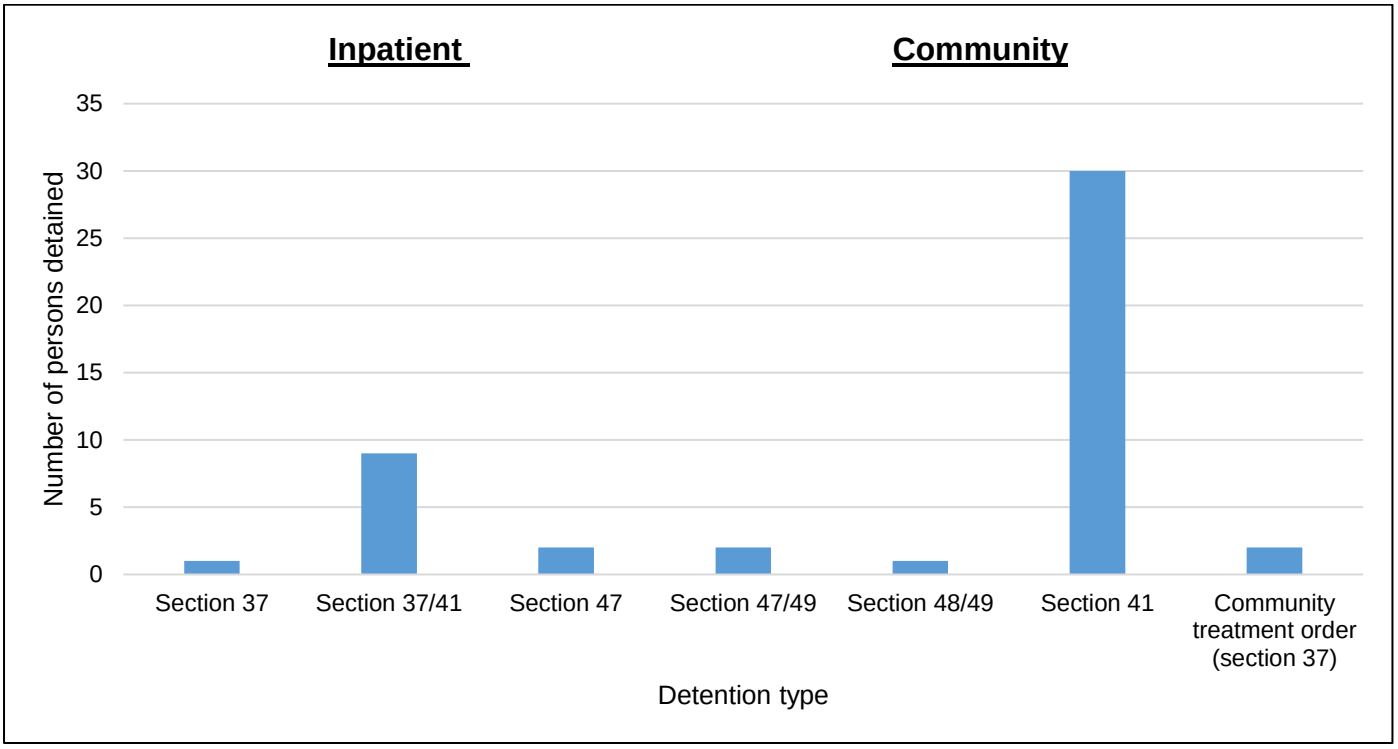
CAMHS Commissioned Inpatient Data

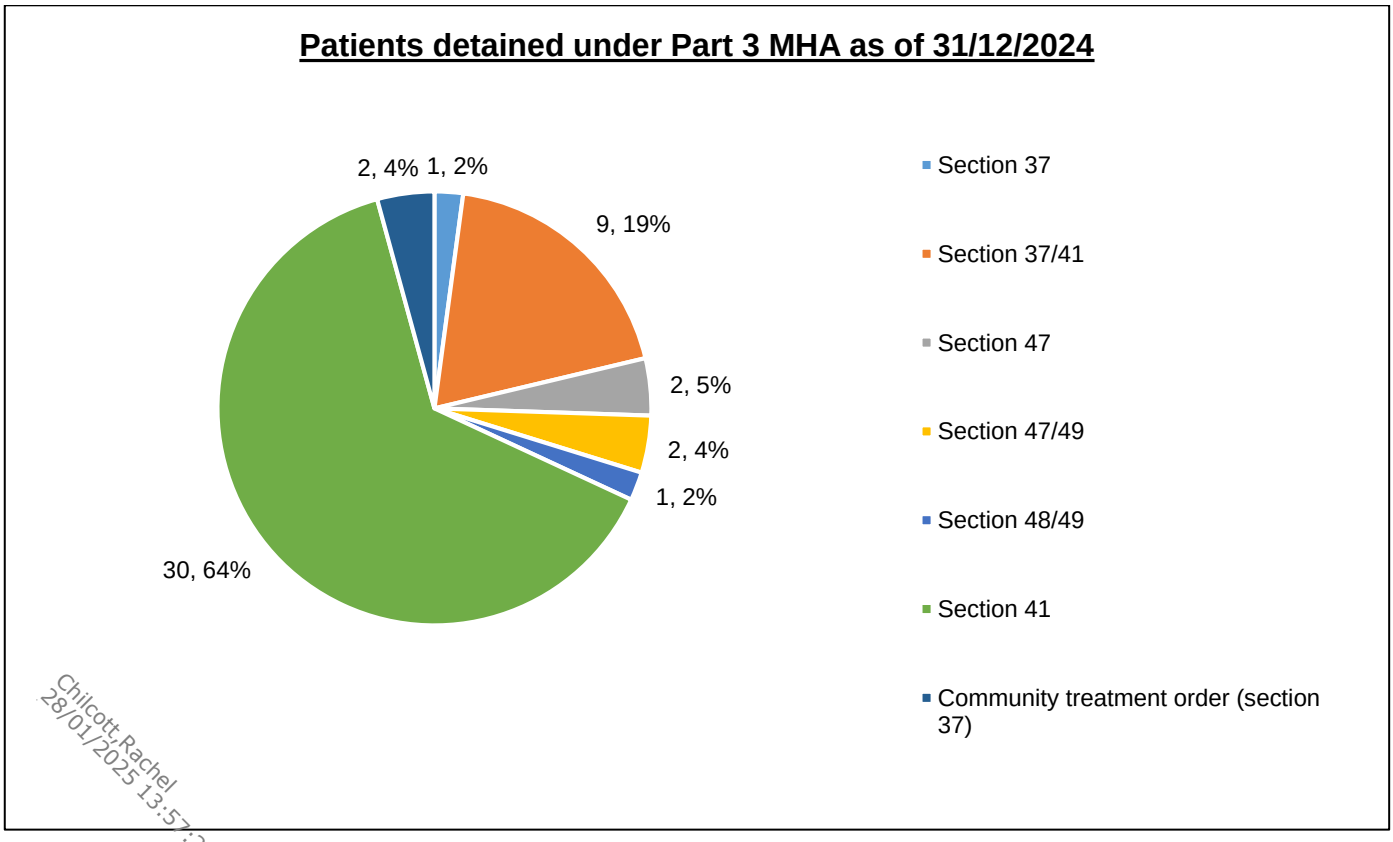
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

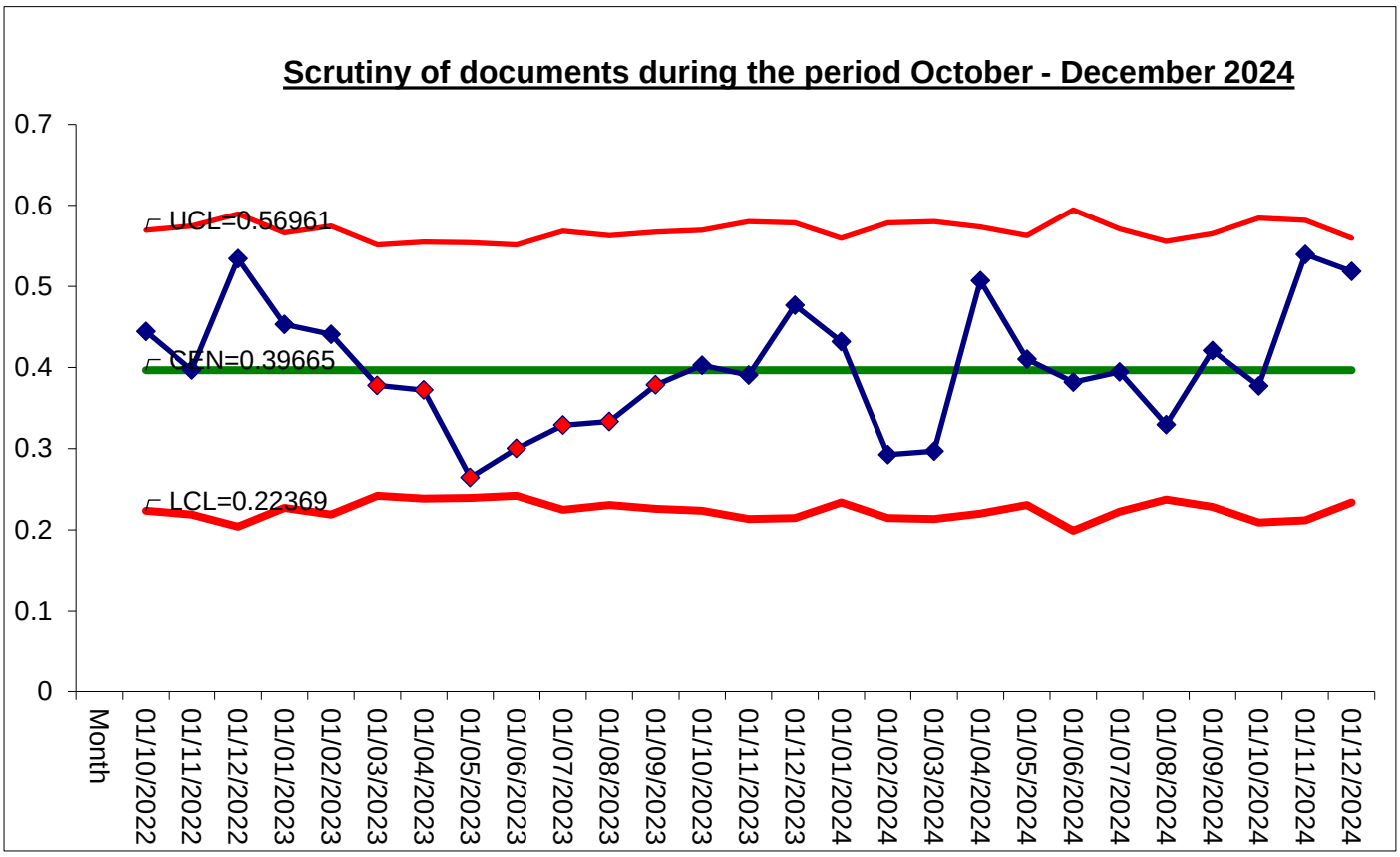
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st December 2024.

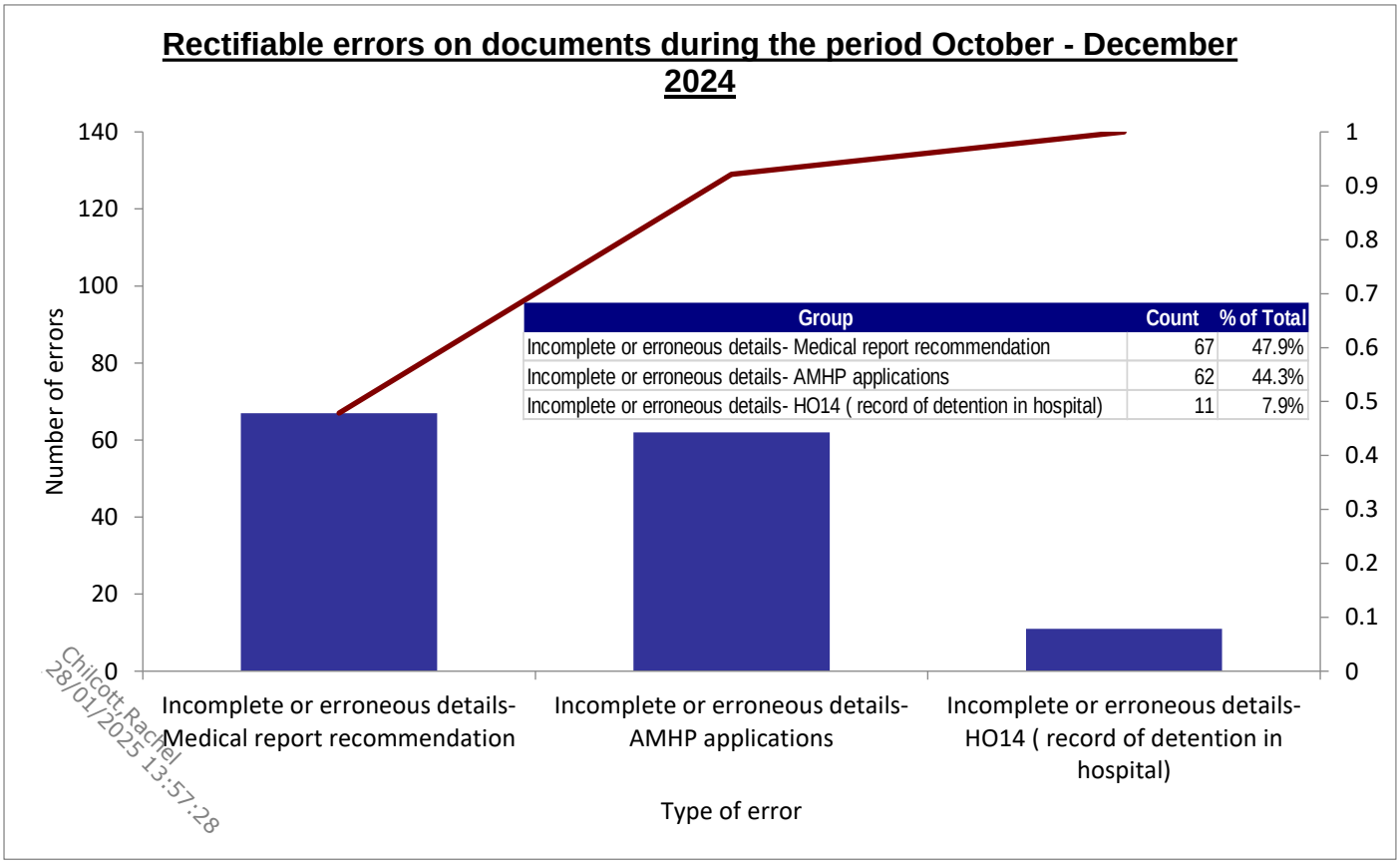




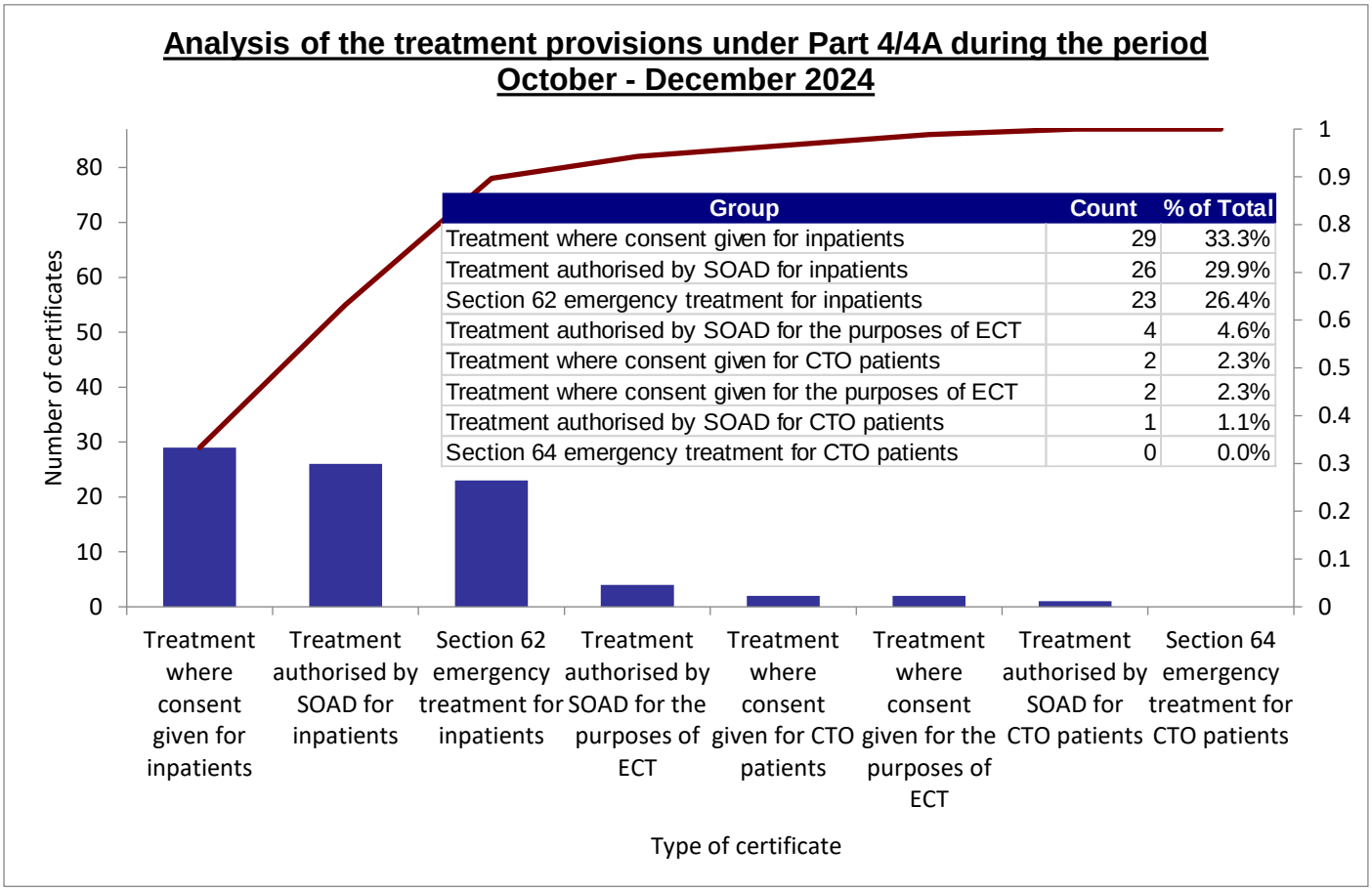
Scrutiny of documents during the period

The chart below 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 for inpatients	29	33.3%
Treatment authorised by SOAD for inpatients	26	29.9%
Section 62 emergency treatment for inpatients	23	26.4%
Treatment authorised by SOAD for the purposes of ECT	4	4.6%
Treatment where consent given for CTO patients	2	2.3%
Treatment where consent given for the purposes of ECT	2	2.3%
Treatment authorised by SOAD for CTO patients	1	1.1%
Section 64 emergency treatment for CTO patients	0	0.0%

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.

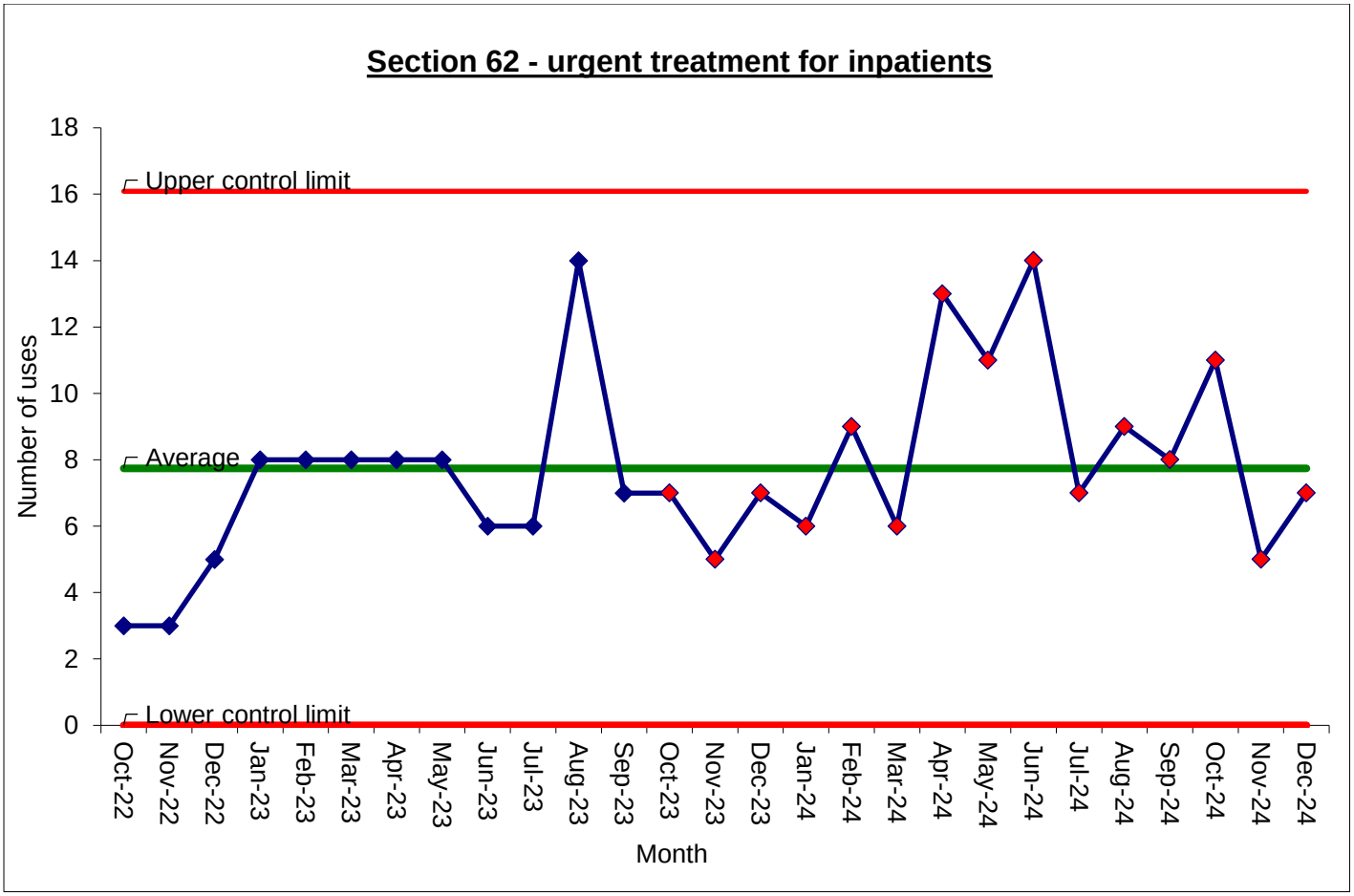
Urgent treatment is defined as treatment that is:

- 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.

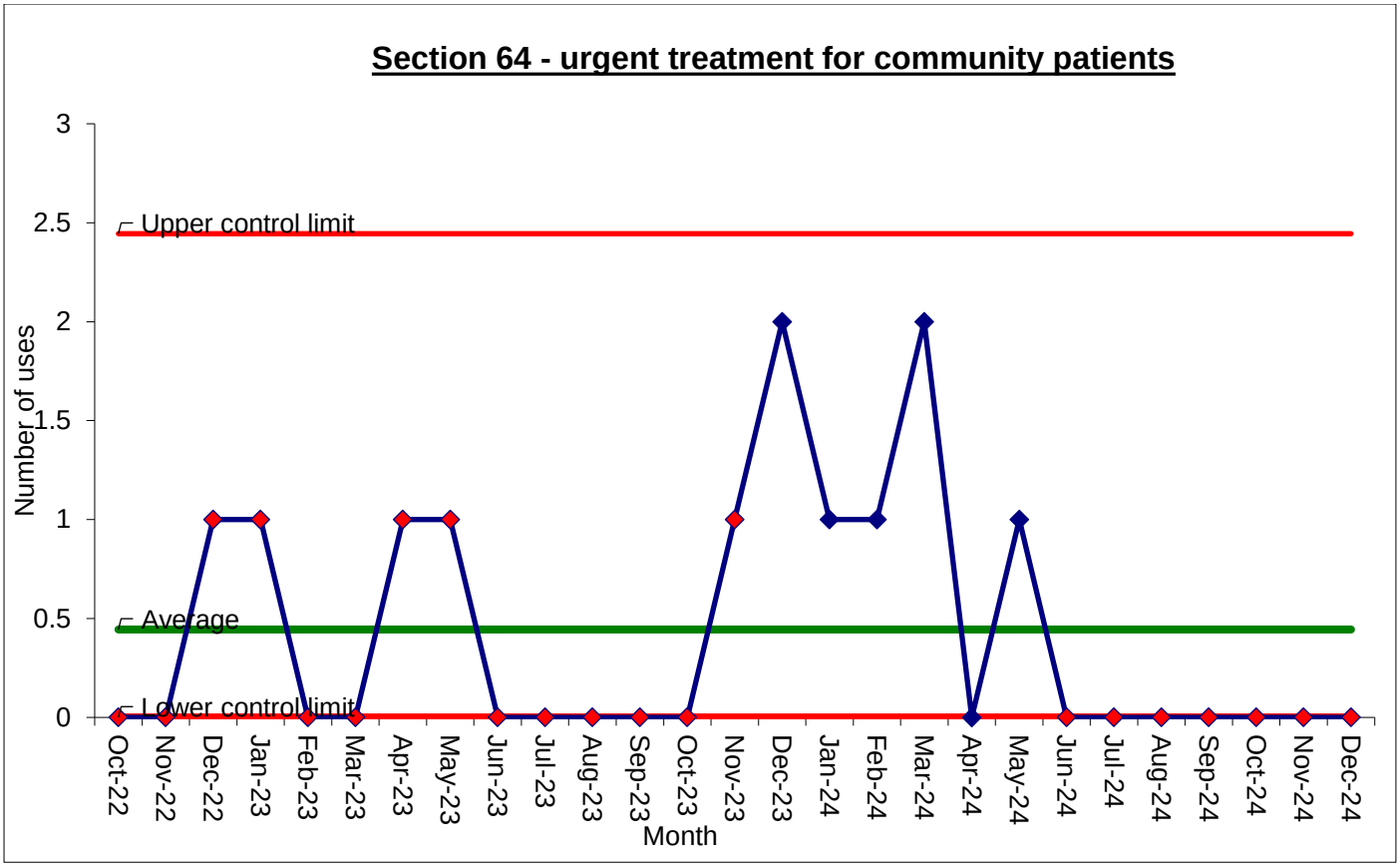
Urgent treatment can be used in any of the following instances:

- 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.



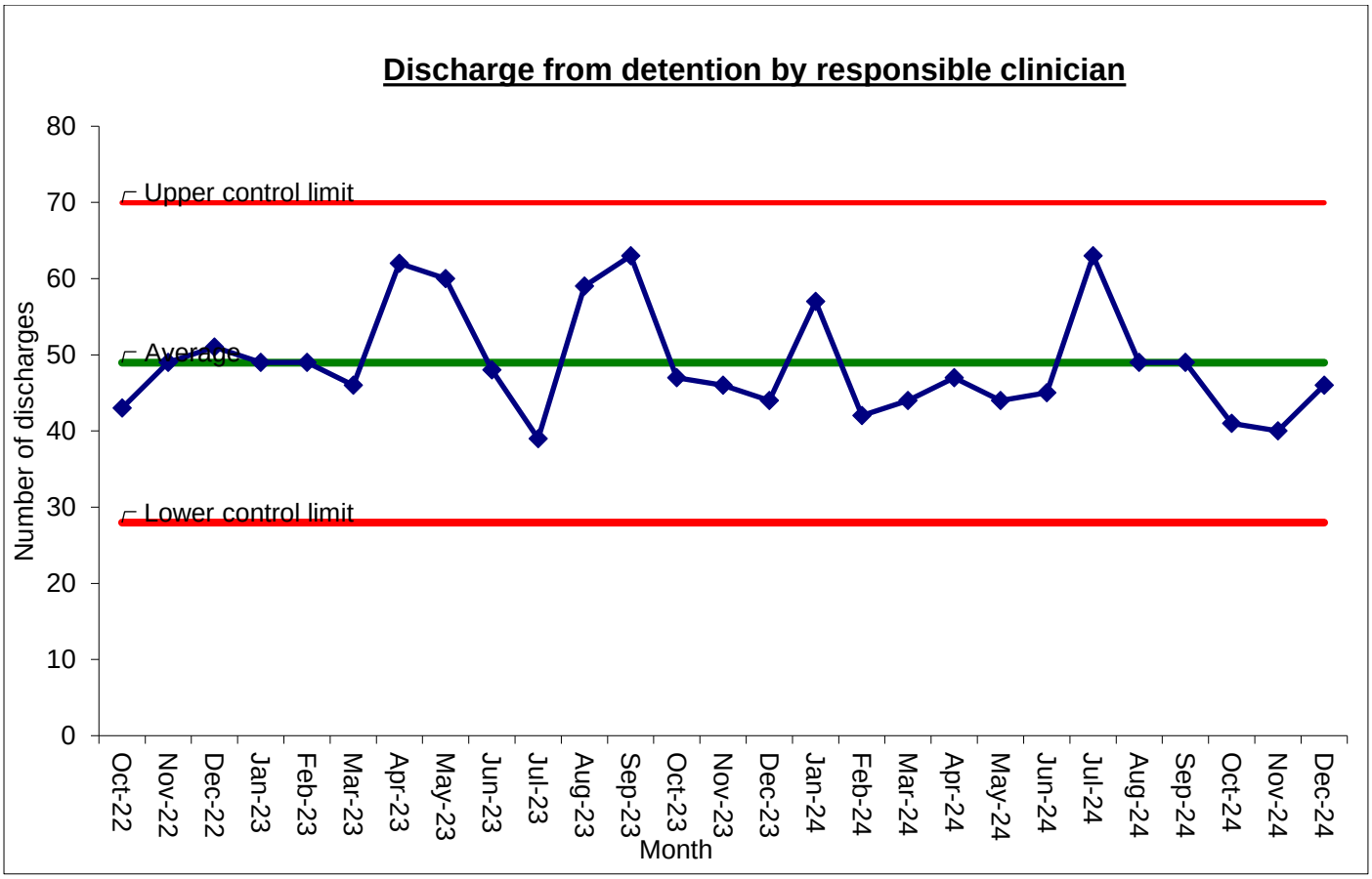
The above chart highlights that Section 62 was used on twenty-three occasions for the following reasons:

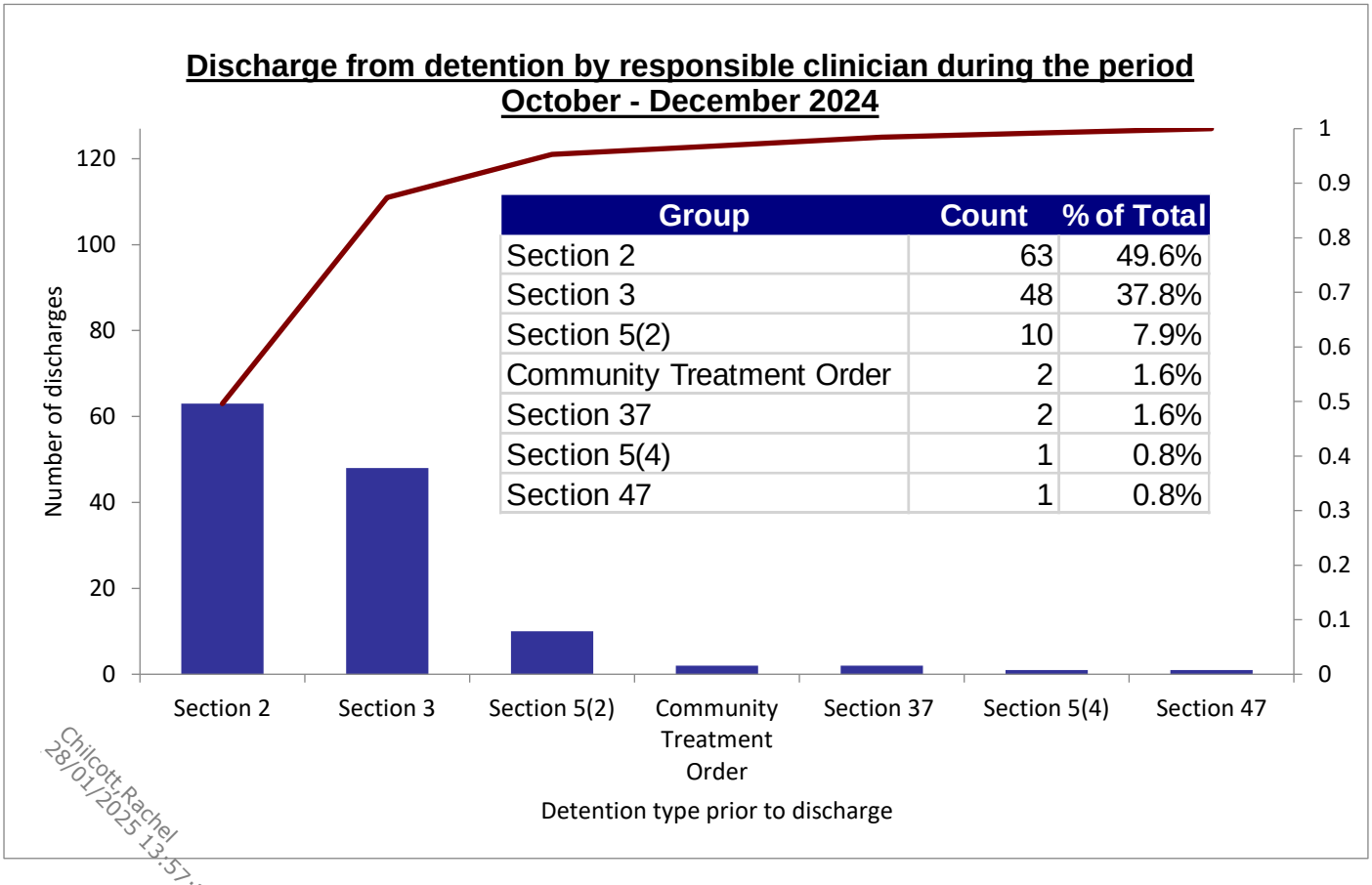
- Time limited certificate x1
- Change of medication x3
- Three month rule x11
- Emergency ECT x5
- CTO revoke x3



The above chart highlights that Section 64 was not used during this period.

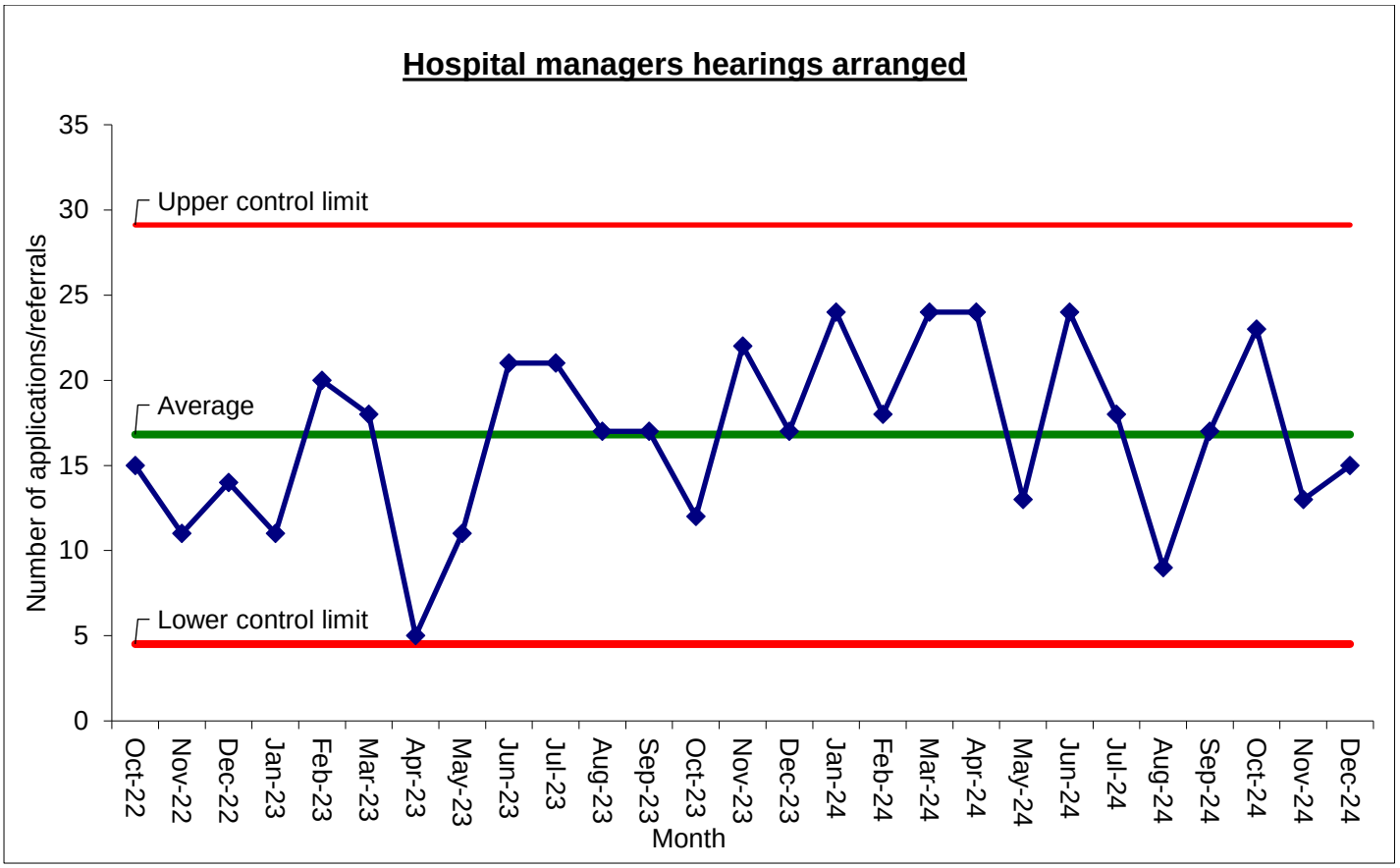
Discharge

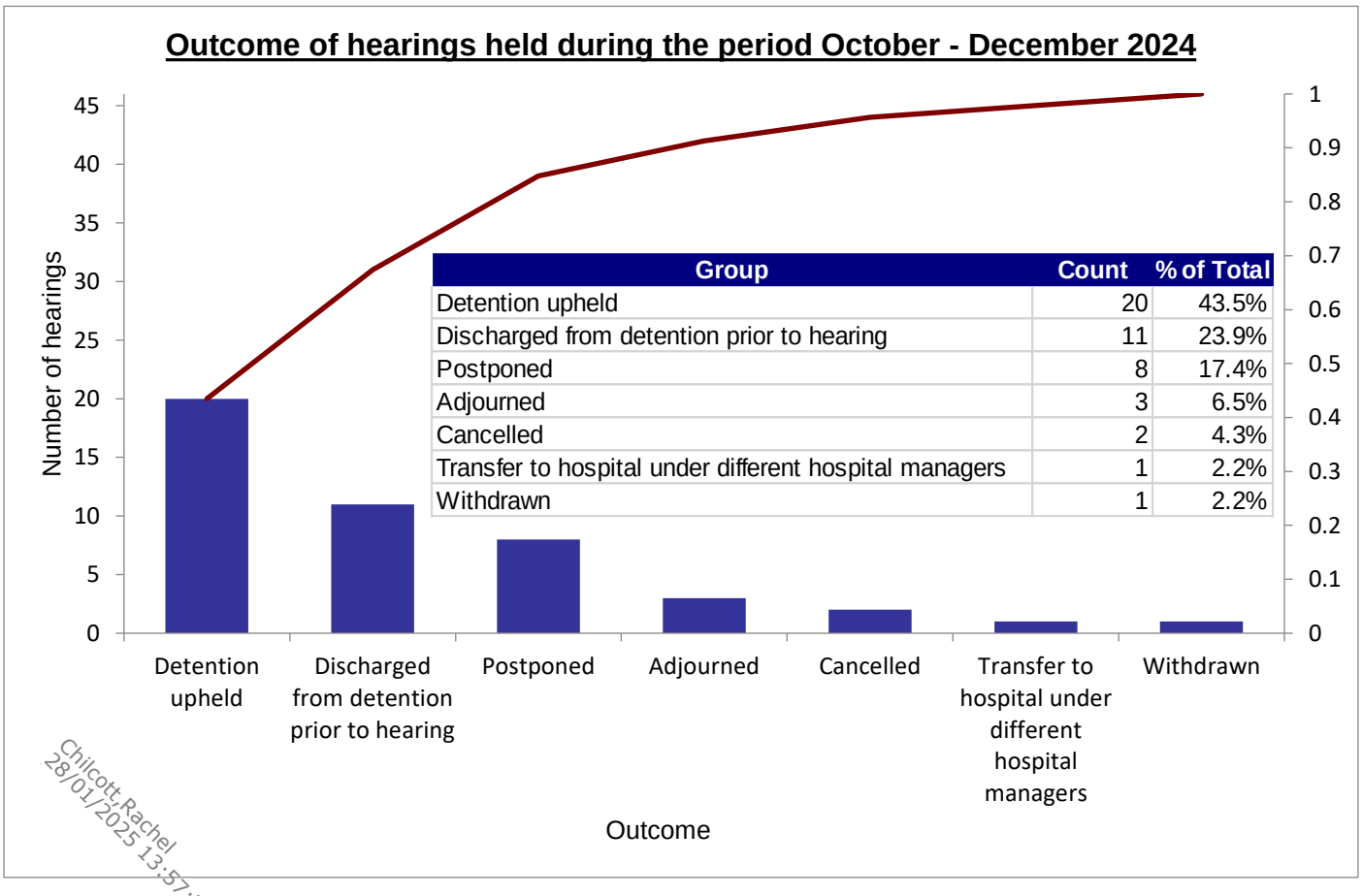




Group	Count	% of Total
Section 2	63	49.6%
Section 3	48	37.8%
Section 5(2)	10	7.9%
Community Treatment Order	2	1.6%
Section 37	2	1.6%
Section 5(4)	1	0.8%
Section 47	1	0.8%

Hospital Managers – Power of Discharge





Group	Count	% of Total
Detention upheld	20	43.5%
Discharged from detention prior to hearing	11	23.9%
Postponed	8	17.4%
Adjourned	3	6.5%
Cancelled	2	4.3%
Transfer to hospital under different hospital managers	1	2.2%
Withdrawn	1	2.2%

Three hearings were adjourned for the following reasons:

- Staff did not attend x1
- Advocate required x1
- Report needed updating x1

Eight hearings were postponed for the following reasons:

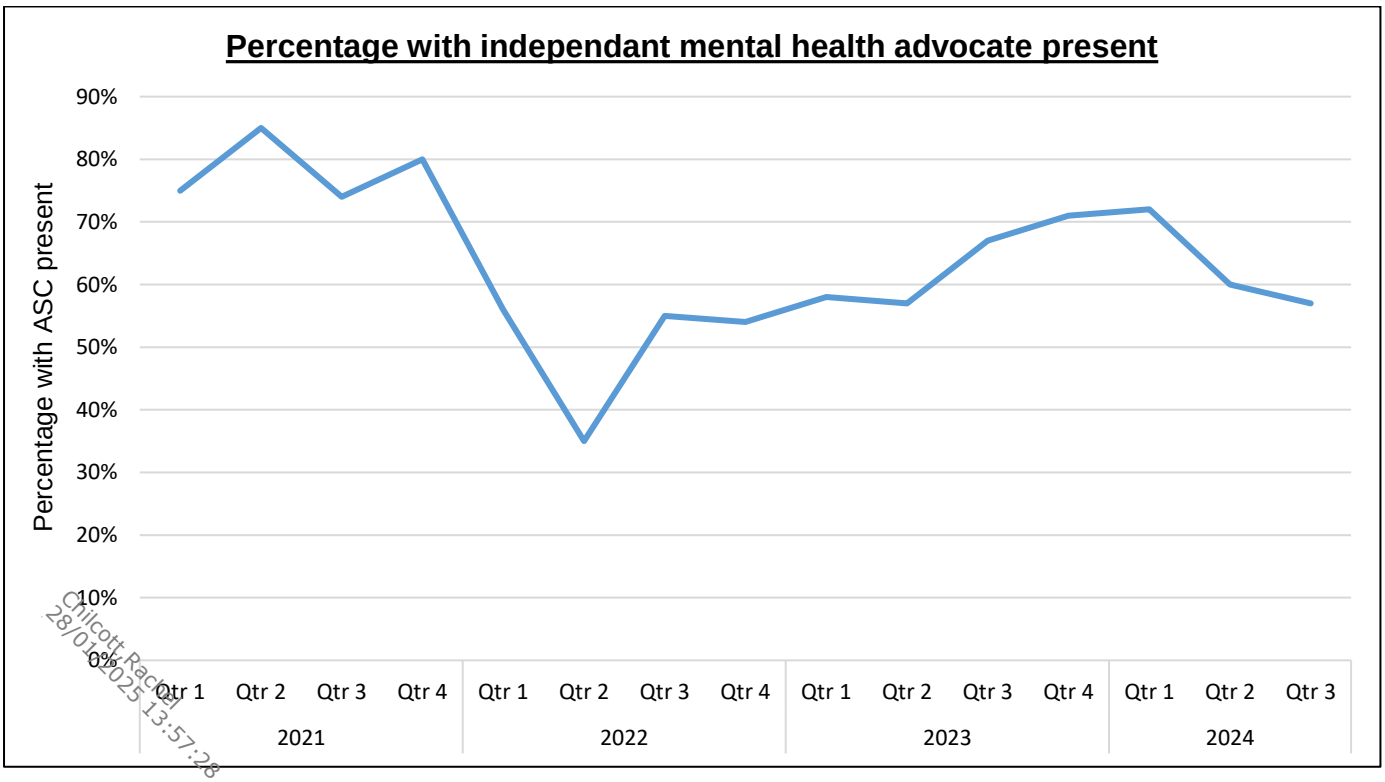
- RC unavailable x5
- Staff unavailable x1
- Patient unwell x1
- New RC unavailable x1

Advocacy referrals:

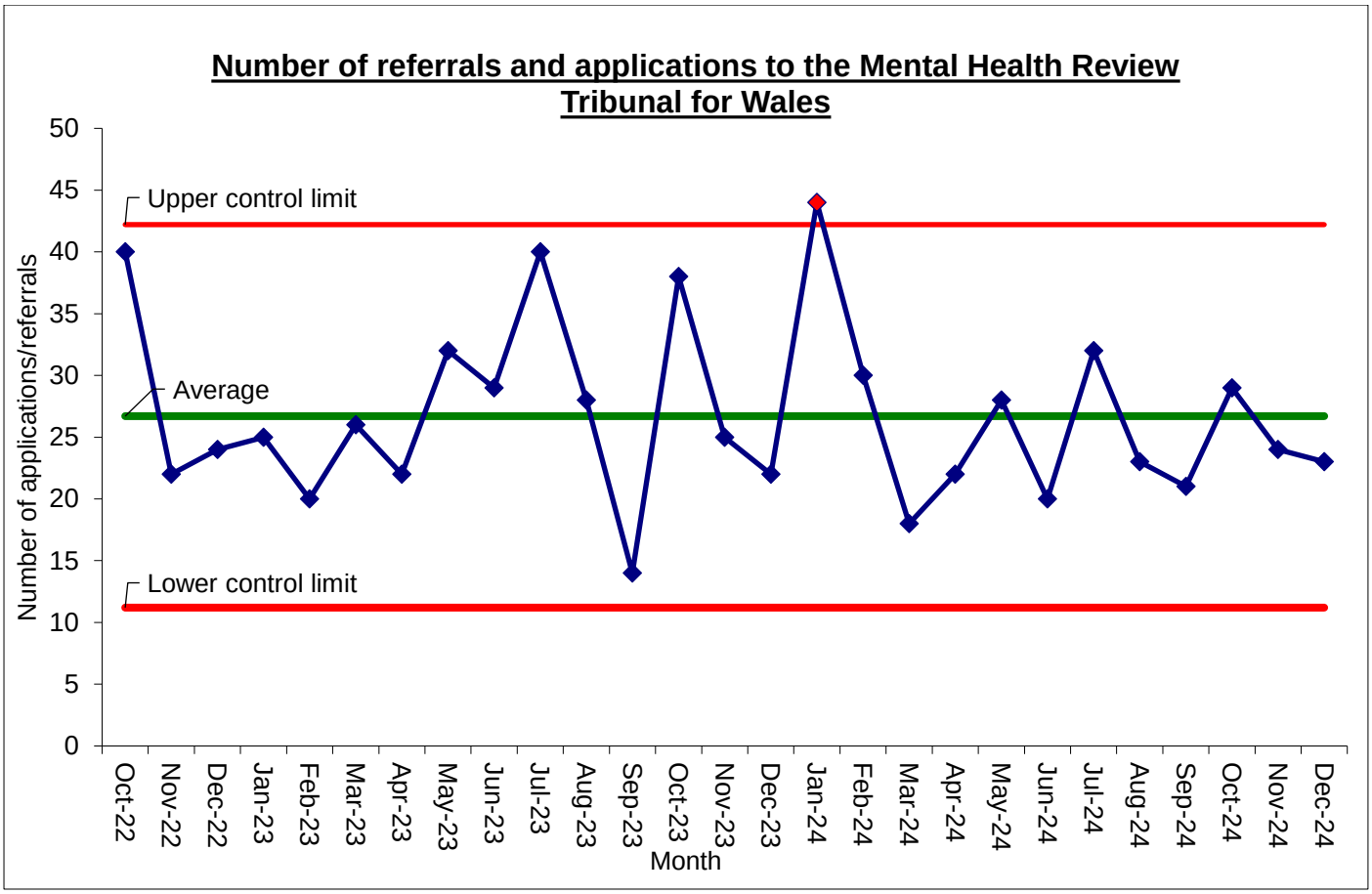
Out of 46 hearings that could have gone ahead during the quarter, 37 of those had been referred for an advocate and advocates attended 12 of those.

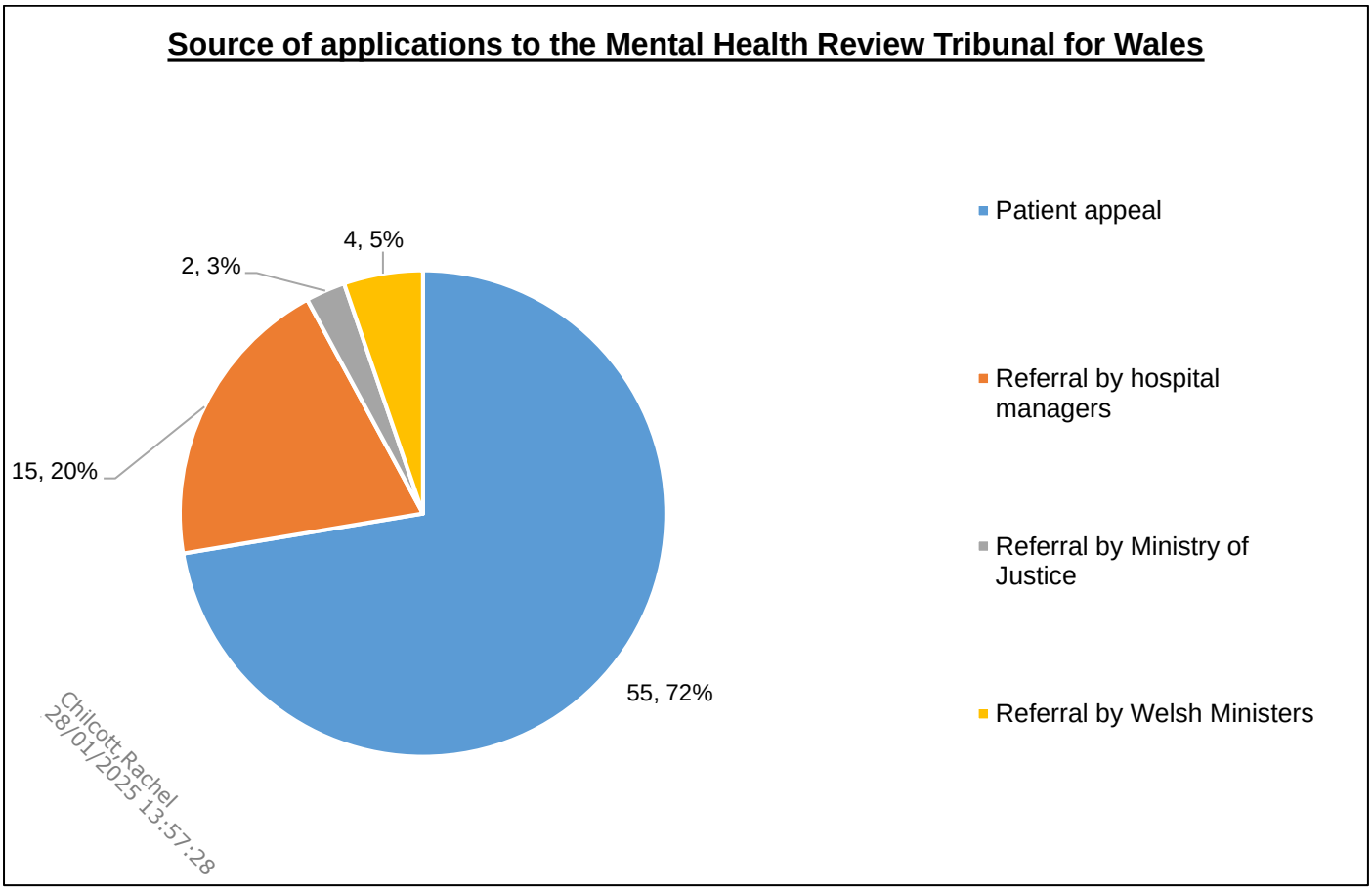
Advocates present:

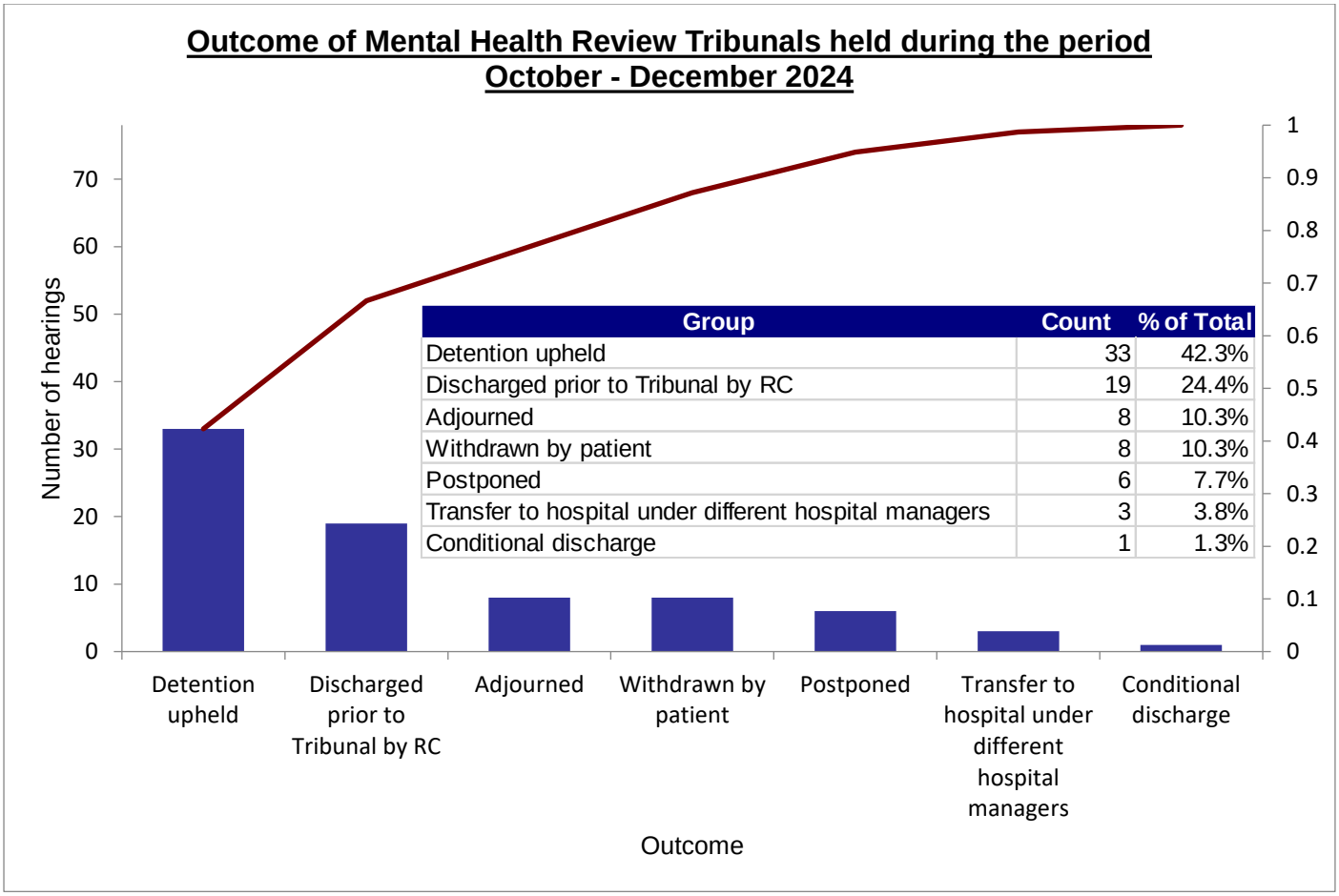
Out of the 46 hearings, only 23 hearings went ahead. Out of that 23, 13 had an advocate present and 10 didn't have an advocate.



Mental Health Review Tribunal (MHRT) for Wales







Group	Count	% of Total
Detention upheld	33	42.3%
Discharged prior to Tribunal by RC	19	24.4%
Adjourned	8	10.3%
Withdrawn by patient	8	10.3%
Postponed	6	7.7%
Transfer to hospital under different hospital managers	3	3.8%
Conditional discharge	1	1.3%

Eight hearings were adjourned for the following reasons:

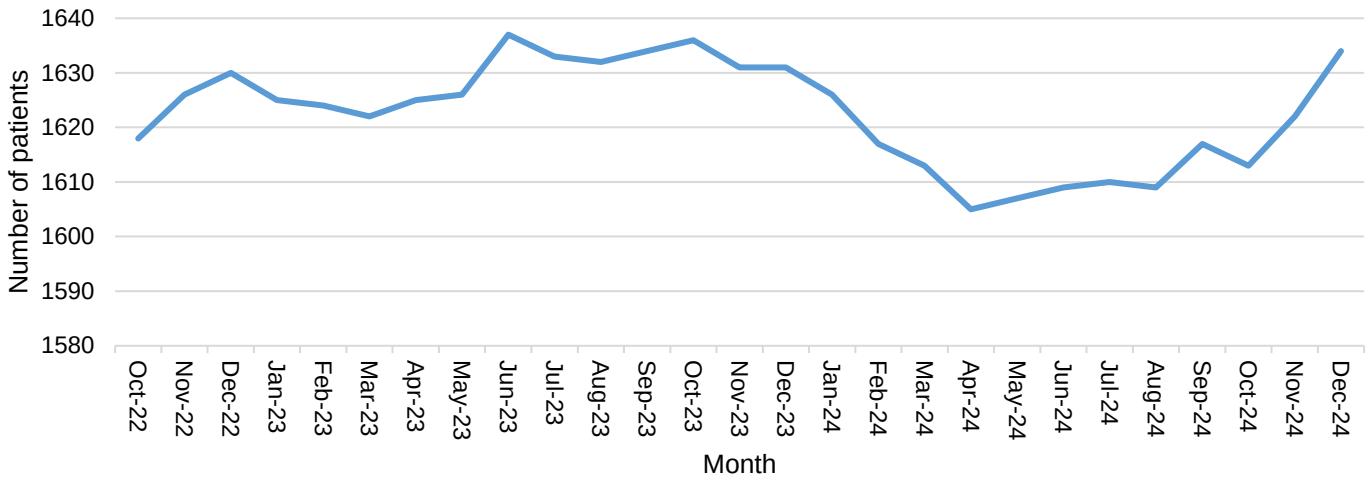
- For patient to read reports x1
- Patient unwell x1
- Capacity query x1
- Needed further reports x2
- RC unavailable x1
- CTP needed updating x1
- Nursing report unavailable x1

Six hearings were postponed for the following reasons:

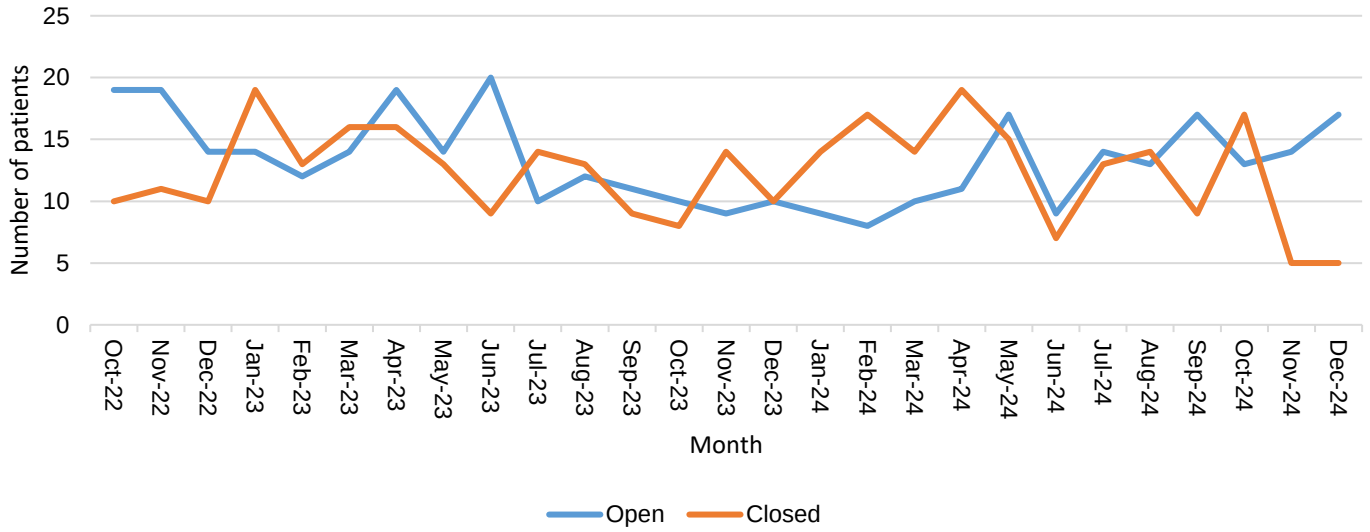
- Patient unwell x2
- Legal representative unavailable x2
- RC unavailable x2

Section 117 Aftercare

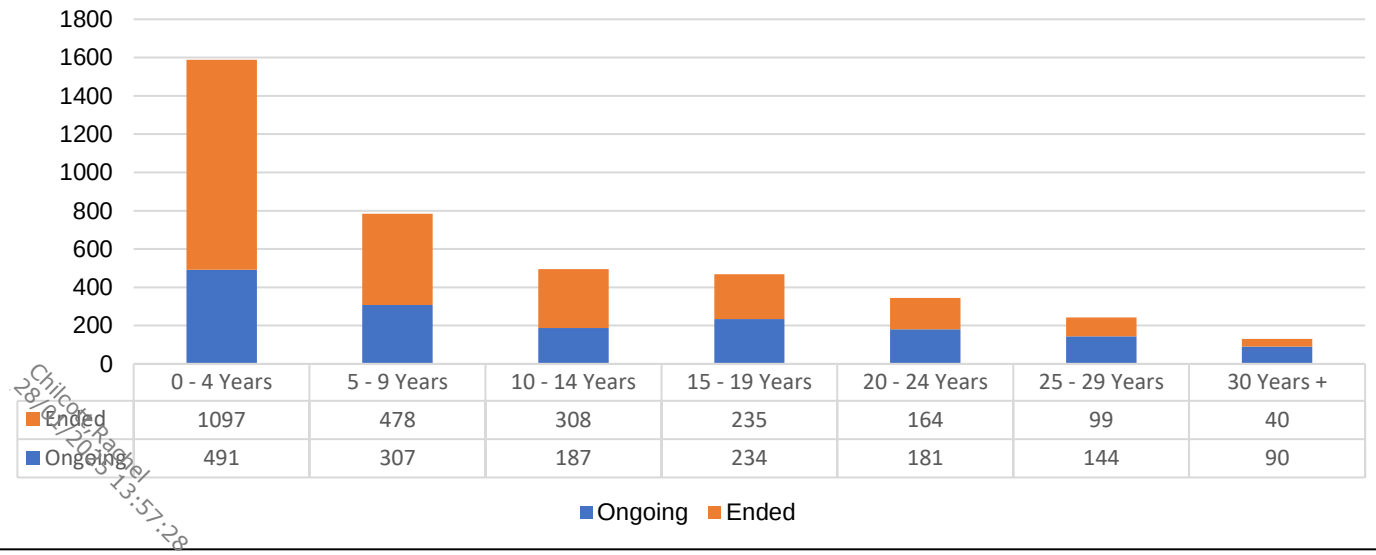
Patients eligible for section 117 aftercare



Section 117 Activity



Periods of time that patients remain eligible for Section 117 aftercare



	0 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	20 - 24 Years	25 - 29 Years	30 Years +
Ended	1097	478	308	235	164	99	40
Ongoing	491	307	187	234	181	144	90

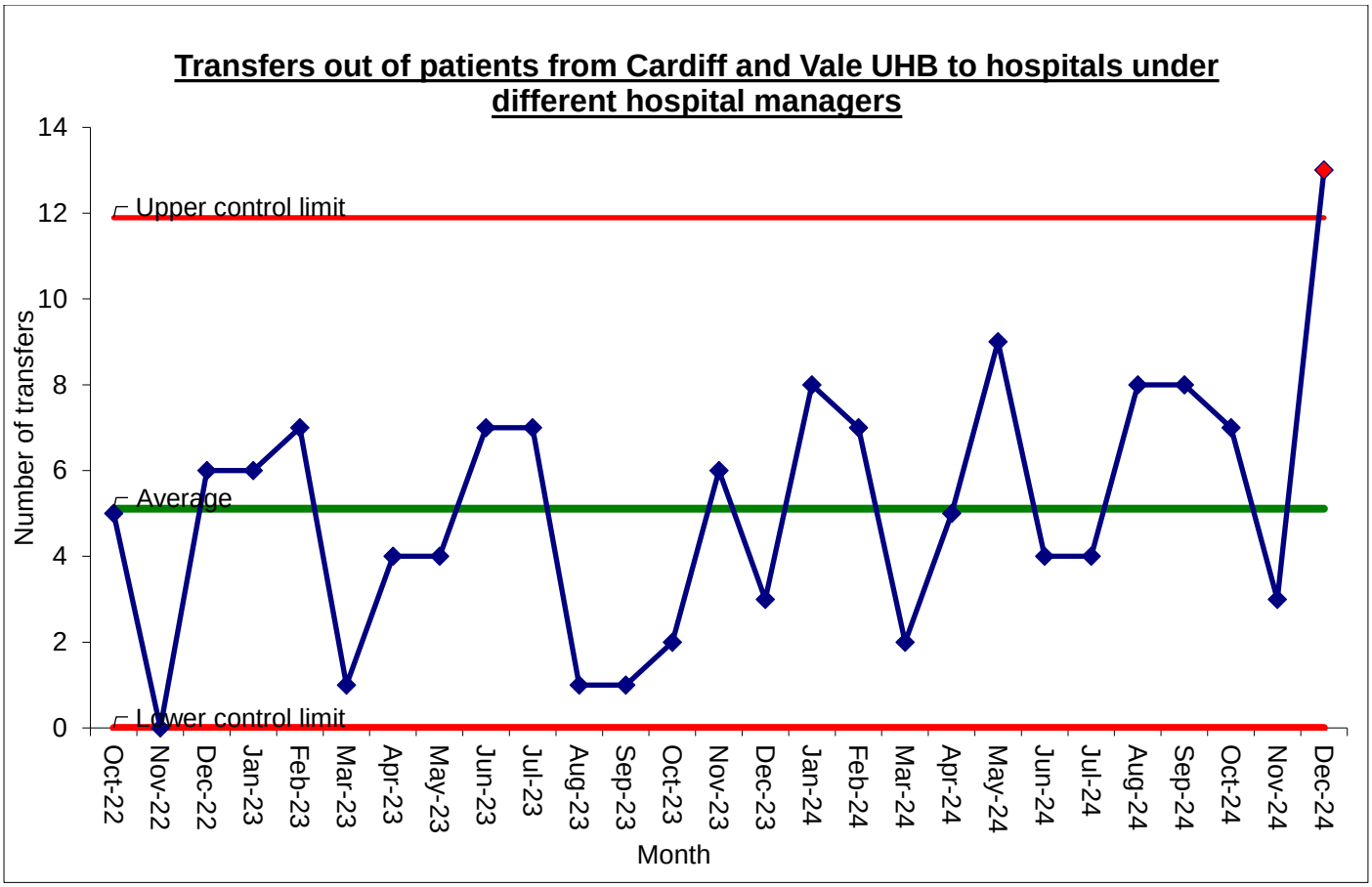
Section 19 transfers to and from Cardiff and Vale UHB

During the period:

Twenty-two 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:

- To PICU beds out of area x11
- To a specialist placement x2
- Back to their home area x6
- To a female low secure unit x1
- CAMHs beds x2

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

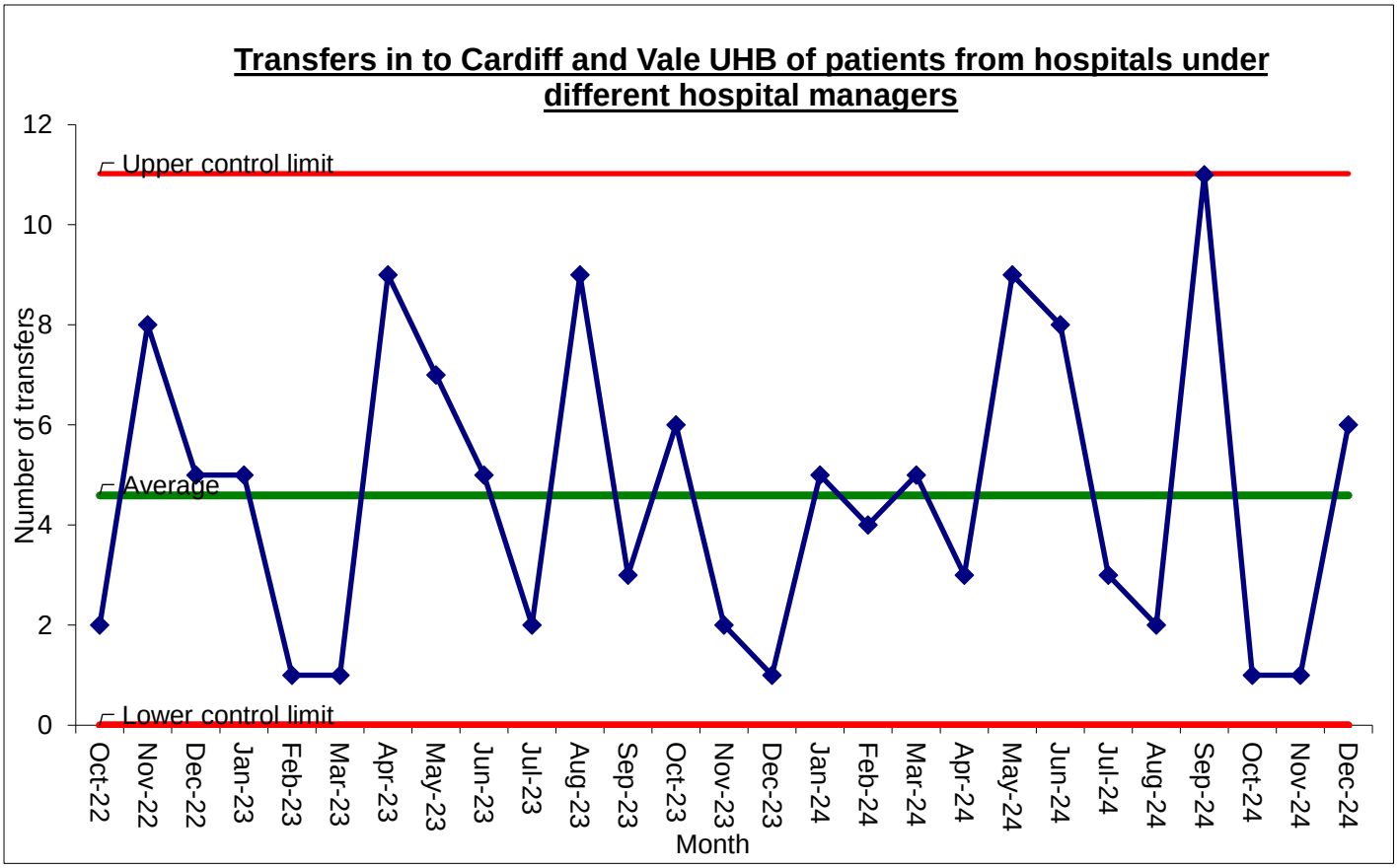


During the period:

Eight 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 x4
- One from out of area beds to home area x4

No 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:



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

October - December 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 patient

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

Report Title:	Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy			Agenda Item no.		3.1
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	28.01.2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Chief Operating Officer					
Report Author:	Dan Crossland Director of Operations Mental Health Clinical Board					

Background and current situation:

On 20th February 2024, the Welsh Government launched a public consultation on the draft 10-year suicide and self-harm prevention strategy. A summary of the consultation responses was published in October 2024. The new strategy will replace the previous strategy – Talk to me 2 (2015-2022)

The draft Suicide and Self Harm Prevention Strategy consultation closed in June 2024. A summary of the 126 responses was published by the Welsh Government in October 2024. This replaces the 2015 five-year strategy that has been in place for nearly 10 years (Talk to Me 2).
The draft Mental Health and Wellbeing Strategy also closed in June 2024 with a summary of responses published in October 2024. The Strategy aims to replace Together for Mental Health.

Both strategies will be reviewed in light of the feedback with a future publication of each. There is currently no published timescale for this. National leads have been advised the target for publication is March 2025.

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

Mental Health and Wellbeing Strategy:
The key themes and 4 vision statements within the Mental Health and Wellbeing Strategy were largely supported. There were particular comments from stakeholders that are pertinent to Health service providers in the long-term:

- More focus on Social Care Providers within the strategy
- More service-user voice and co-production in the planning and delivery of services
- More focus on prevention and the wider determinants of health and wellbeing, including community assets and the buildings from which providers operate
- More training for all providers in delivering effectively to under-served groups
- Services to be more needs led and trauma informed
- More commitment within the strategy to reference neurodiversity
- Seamless MH Pathways

Suicide and Self-Harm Prevention Strategy:
The Suicide and Self Harm prevention strategy aims to reduce the number and rates of death by suicide. It also aims to establish a pathway to support people who self-harm and to improve support for those bereaved by suicide. The draft strategy outlined an overarching vision for suicide and self-harm prevention in Wales. It included 6 underpinning principles, six high level objectives and several supporting sub objectives. The consultation highlights the following should be considered for future planning:

- The strategy is disproportionally weighted towards suicide and highlights the need for clear and specific objectives for self-harm including safe self-harming and harm reduction.
- Greater focus on governance and accountability
- An overreliance on data with a need for greater focus on lived experience and coproduction
- A need for focus on investment in services that are timely, relevant and accessible to all including alternatives to admission.
- An emphasis on education to improve knowledge and awareness.

The implication is that the two strategies are being more closely aligned, this means there will need to be more joined up planning about how services deliver to the two strategies.

There is greater focus on self-harm which will likely require different responses from services and a higher expectation of delivery and outcomes. This is likely to be very challenging locally as there is now less provision from Third Sector Providers with the closure of the Amber Project (a project dedicated to young people who self-harm). Where procurement and grant opportunities had been explored and offered to Third Sector agencies specifically to cover the gaps in provision around self-harm, there was a reluctance to run or set up services due to the perceived high risk nature of self-harm service provision. This gap in service can only be picked up by Mental Health services- advice is that people with these needs need to be referred onto 111 Press 2, but there is a gap to where these service users are directed post-assessment. This risks transferring increased demand onto Emergency Departments. The UHB will need to consider how the preventative and treatment agenda is delivered across Mental Health teams.

There are likely to be new assurances and responsibilities for the UHB Public Health Health Teams to provide clearer data and possibly outcome measures demonstrating improvements that are not currently in place.

Recommendation:

- A mapping and scoping exercise needs to be undertaken locally in conjunction with Public Health Teams, Third Sector, Mental Health Clinical Board, Local Authorities and Regional Suicide and Self Harm Lead to properly understand the demand and current landscape.
- Key elements of the published strategies will need to be communicated widely to teams to understand the implications locally.

The Committee are requested to:

a) Note the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First		Providing Outstanding Quality
1.		2.
Click the objective above to view more detail.		**Click the objective above to view more detail.**

 Delivering in the Right Places 3. **Click the objective above to view more detail.**		 Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?				
Yes –		No – ***(Please provide reasoning, e.g. not required)***		n/a

Impact Assessment:
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
Welsh Language: Yes/No - n/a

Approval/Scrutiny Route	
Committee/Group/ Exec	Date:

Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2				Agenda Item no.	**4.1**	
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	January 28th 2025	
			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.

Part 1: PMHSS

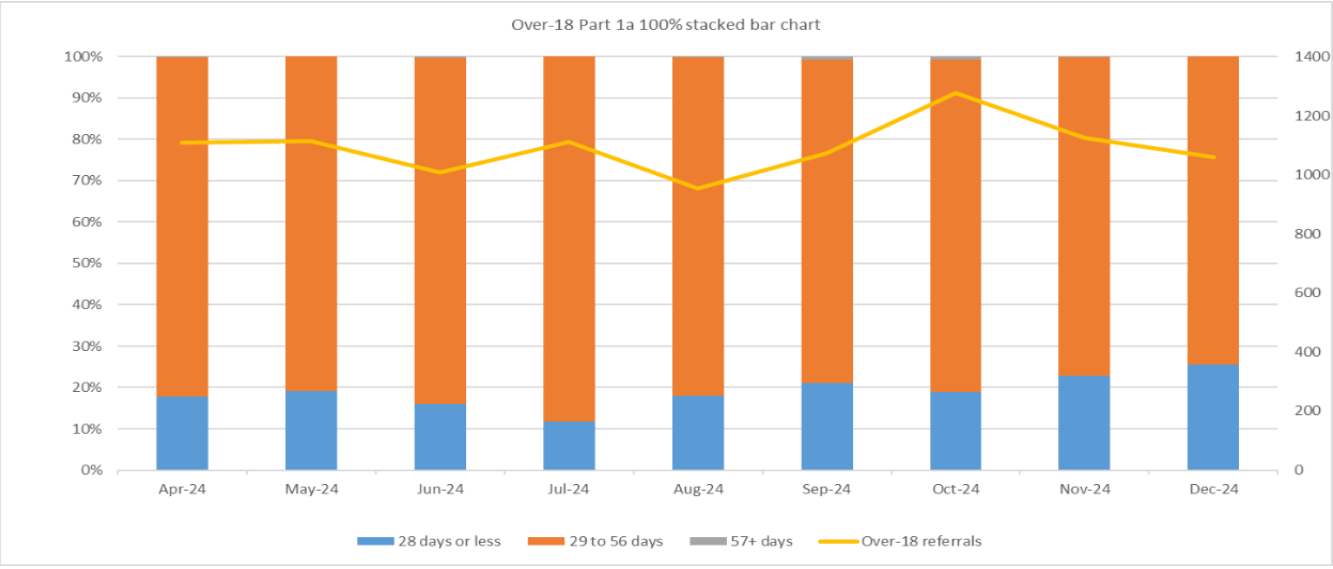
Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)
Part 1a was 26% compliant on 31/12 /24. This is a slightly increasing position month on month.
Compliance was 23% on 30/11/24, and 19% on 30/10/24
The last month of full target compliance was February 2024.
As of January 3/1/25, 2024 the average waiting time is 35 days with the longest wait being 44 days.
In December 2024 there were 1,060 referrals.
In terms of outcomes outside of the target, recent three Civica reports highlighted high quality interactions between service users and PMHSS:

“Rhiannon was professional, friendly and caring during our conversation. She signposted me to many services that may be able to help”.
“I felt I was being listened to and was made to feel comfortable within the conversation”.

The gentleman I spoke to Jim was reassuring, made me feel at ease during the appointment and made me feel understood that I wasn't alone. He is a massive help to the service".
"This latest help I received has been good I've only had the 1st assessment and there will be more to follow. The lady who called me was kind and understanding and easy to speak to. Informed me of the next step going forward."
"I explained how I was feeling, and she did everything she could to help"
"My issues have been addressed promptly and are ongoing. The people I have delt with have been a big help."
"Calm and understanding by the person carrying out my assessment".
"When I did not understand, things were explained to me in a way I did clearly in a caring non-judgmental way".
"The person listened to me very well and was very understanding of what I was going through."
"This is the first time I've had a mental health assessment with the NHS as my previous GP surgery did not offer me this. I have however had assessments with other organisations such as mind and this is the first assessment where I've been given a whole heap of options available to me whilst being given a huge amount of empathy and acknowledgement of what I'm experiencing and how it affects me. I hope that as I move through the process, the level of support provided is on par with this initial assessment. It's the first time I've come away from an appointment where I've felt compassion and understanding (and I had weekly private counselling for 3+ months)."
"The referral process was well managed."

Actions to restore compliance:
Additional staffing 2.0 WTE band 6 practitioners have been in position since 3rd December. A secondment has been recruited for a practitioner taking a career break and will be in post by February 1st. One member of staff is on long-term sick.

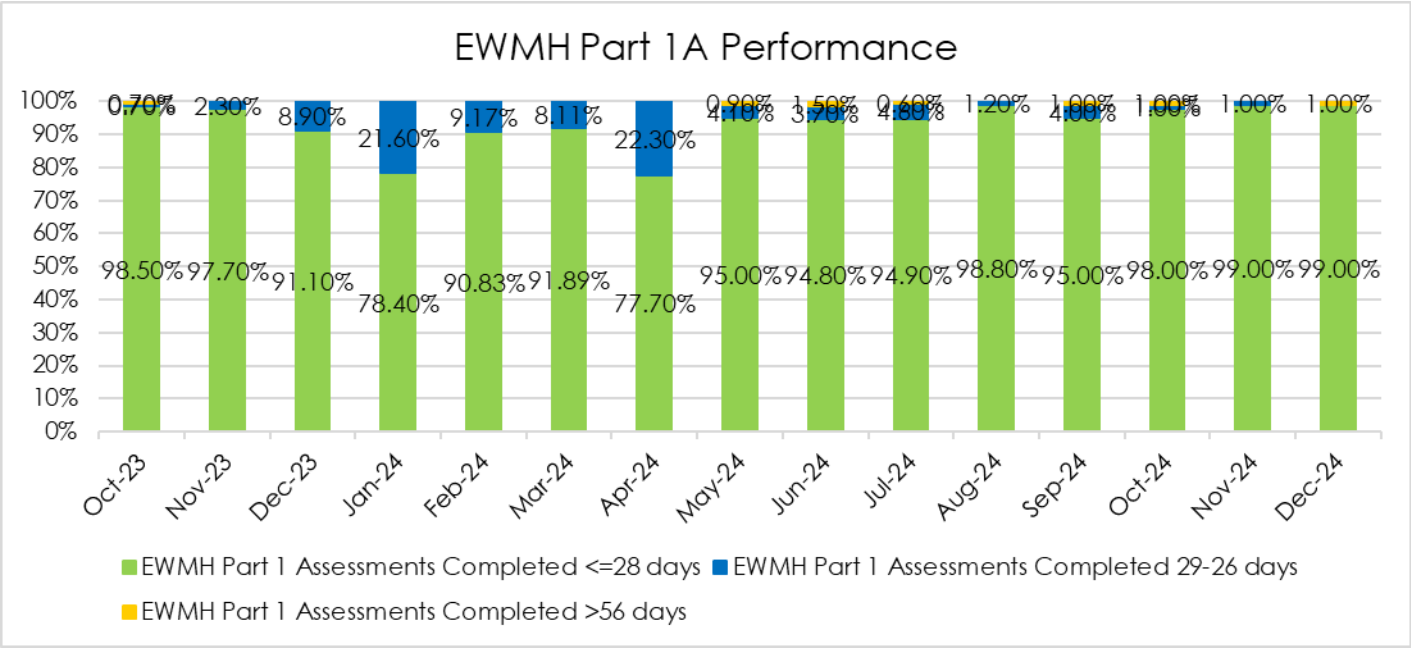
Graph 1:



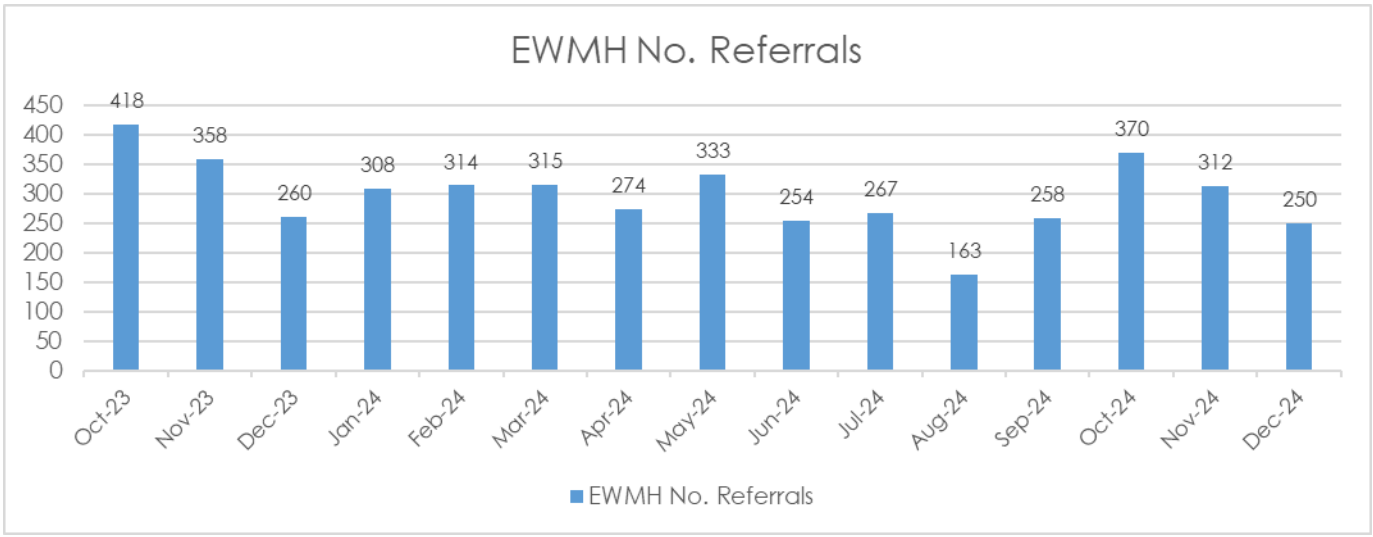
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

Compliance has been maintained and exceeded for all months in the past quarter. 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.

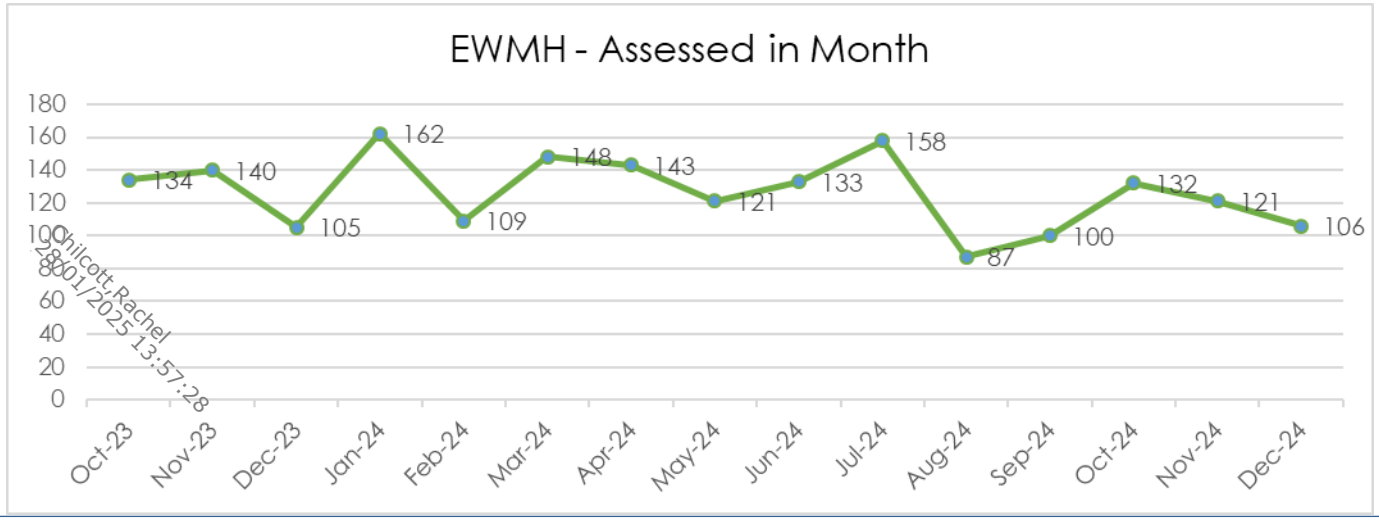
Graph 2



Graph 3



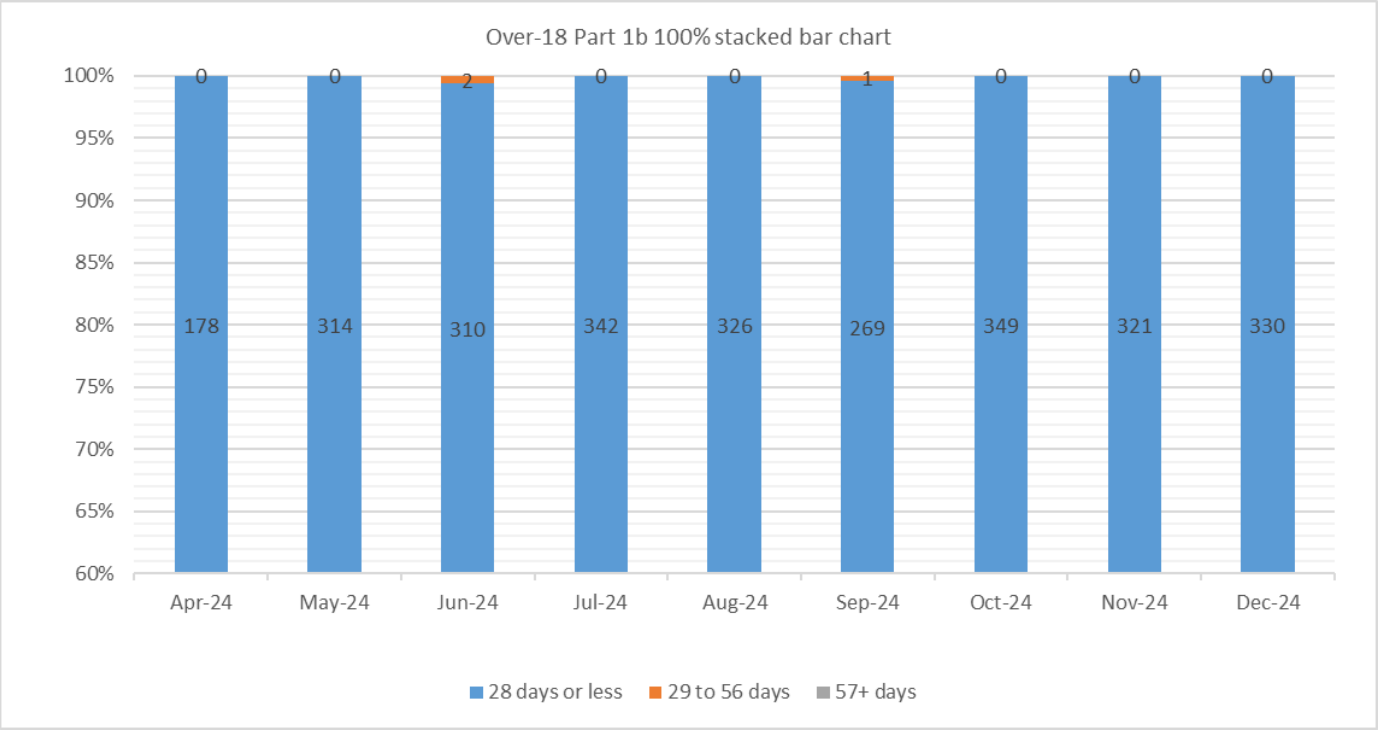
Graph 4



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

Part 1b remains compliant (Graph 5). The same professionals delivering Part 1a assessments also deliver the interventions in Part 1b.

Graph 5:



The PMHSS team continue to deliver group interventions for:

-Living Life to the Full
-Behavioural Activation
-ACT for Wellbeing

Feedback for Living Life to the Full this quarter is as follows:

-'It would be good to have a quick 'refreshment' course after a while'

'Thank you for being so friendly and supportive'

-'I find sharing and being open in the group extremely helpful. It made me feel I wasn't alone and other people understood me. The facilitators created a safe space for us'

-'Very insightful course; normalised thoughts I thought were only mine'

-'Very helpful content and exercises. The course practitioners were understanding, kind and gave good insight and experience of the content we covered. I've very much enjoyed the practical homework tasks'

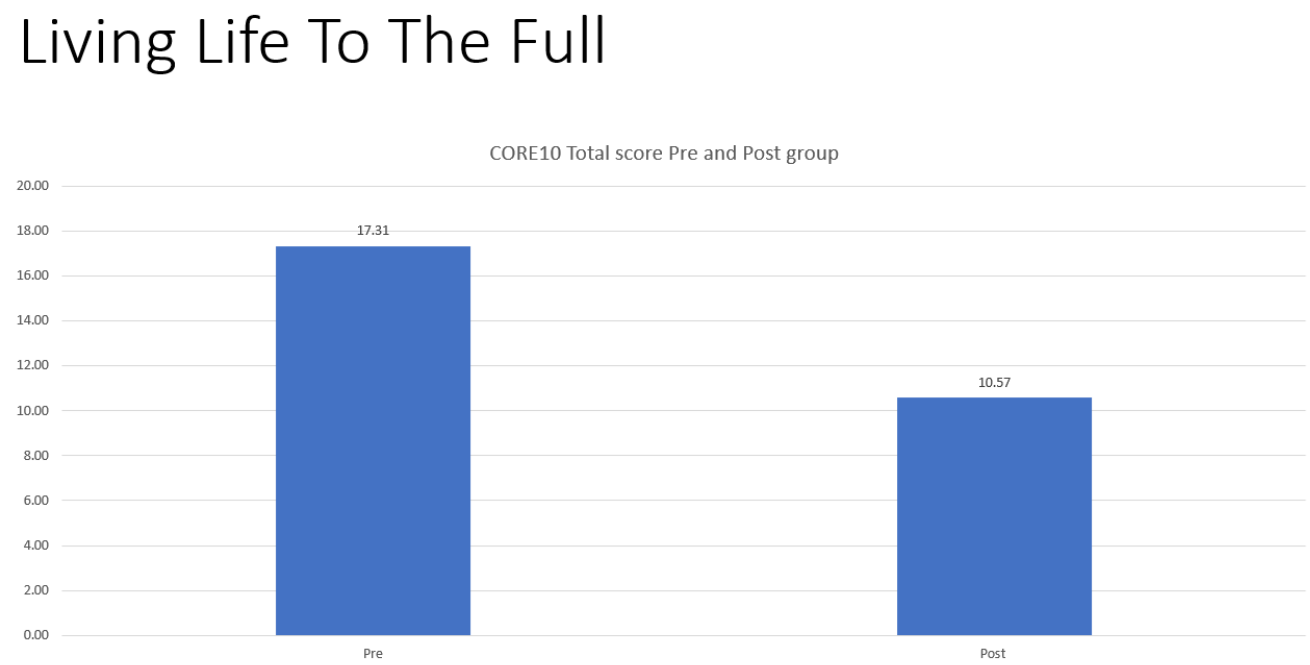
-'To make the course more lengthy as I feel we have only just started'

-'I would like some of the material on the website printed and brought to sessions. Make sure everyone gets the time to speak'

-'very lovely hosts. I found it very helpful. Helped me to cope, break things down and come out of my vicious cycle'

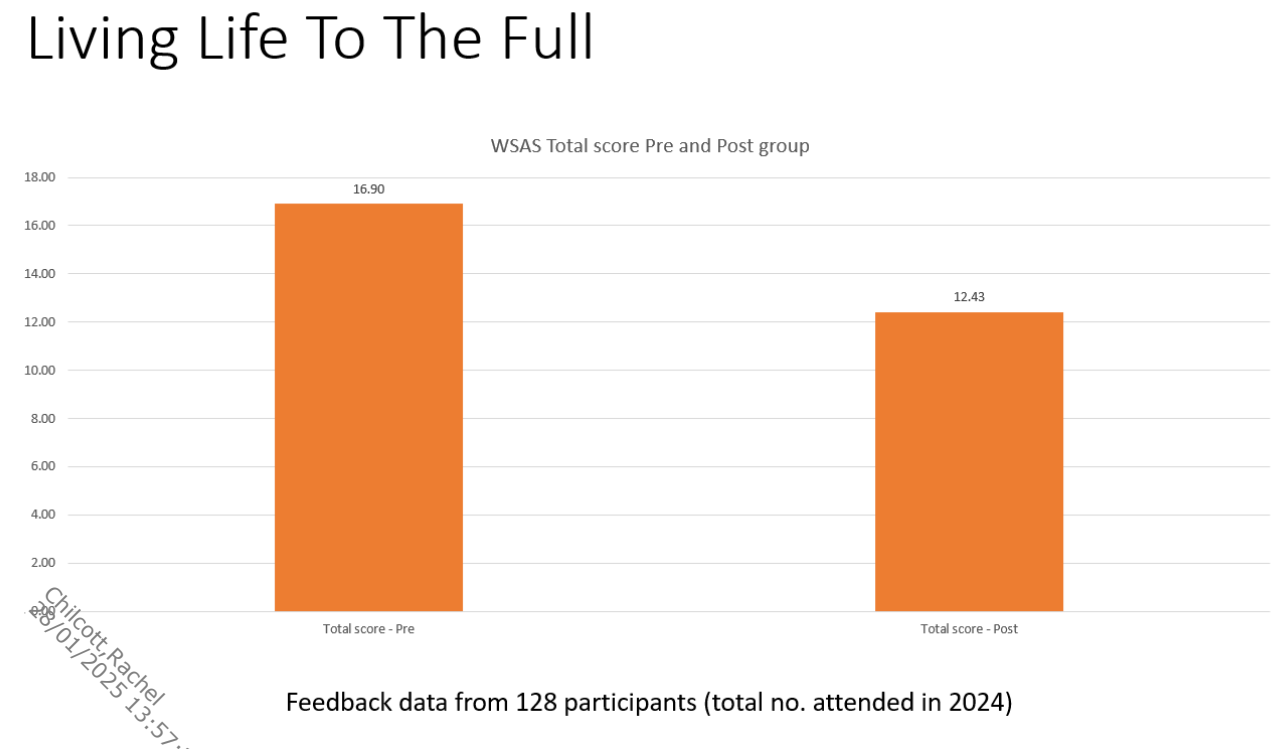
Various Outcome Measurement tools are used to gather outcomes for all groups. Core 10 Outcome measure data is below (Graph 6) for 128 participants showing a reduction in psychological distress for people following completion of the group. The Work and Social Adjustment Scale (WSAS) measures impairment in functioning (Graph 7) and shows improved function following group.

Graph 6:



Feedback data from 128 participants (total no. attended in 2024)

Graph 7:

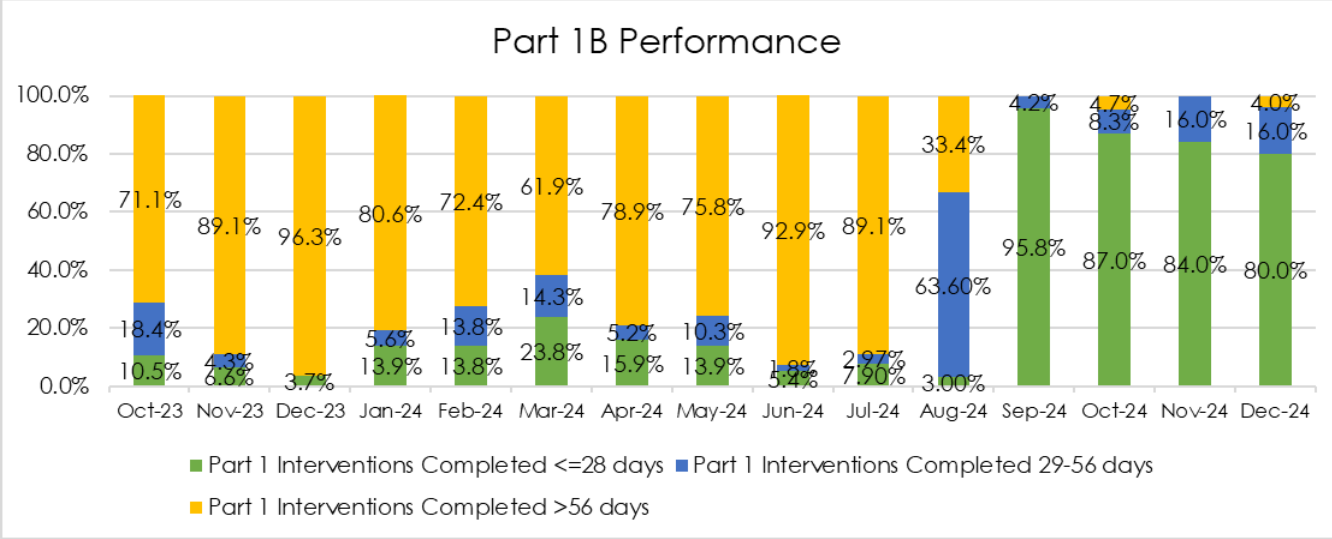


Feedback data from 128 participants (total no. attended in 2024)

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

Compliance has been achieved and maintained during the last quarter. The impact of the Psychoeducation and Group offer has been positive in meeting the needs of CYP in a timely manner. Both offers continue to be developed and enhanced, with a view to new groups coming online in this next quarter. A higher number of cancellations and DNAs experienced in the last quarter, as a result of school commitments and Christmas holidays.
Feedback from CYP and parents on the new offer is positive and we continue to work collaboratively with young people to inform the offer.
The service went live with the Silvercloud "refer in" service for online CBT at the beginning of December and the number of referrals into this offer is slowly increasing.
Ongoing weekly monitoring is in place to ensure compliance is maintained and wider work on managing capacity and demand for direct 1:1 intervention is underway.

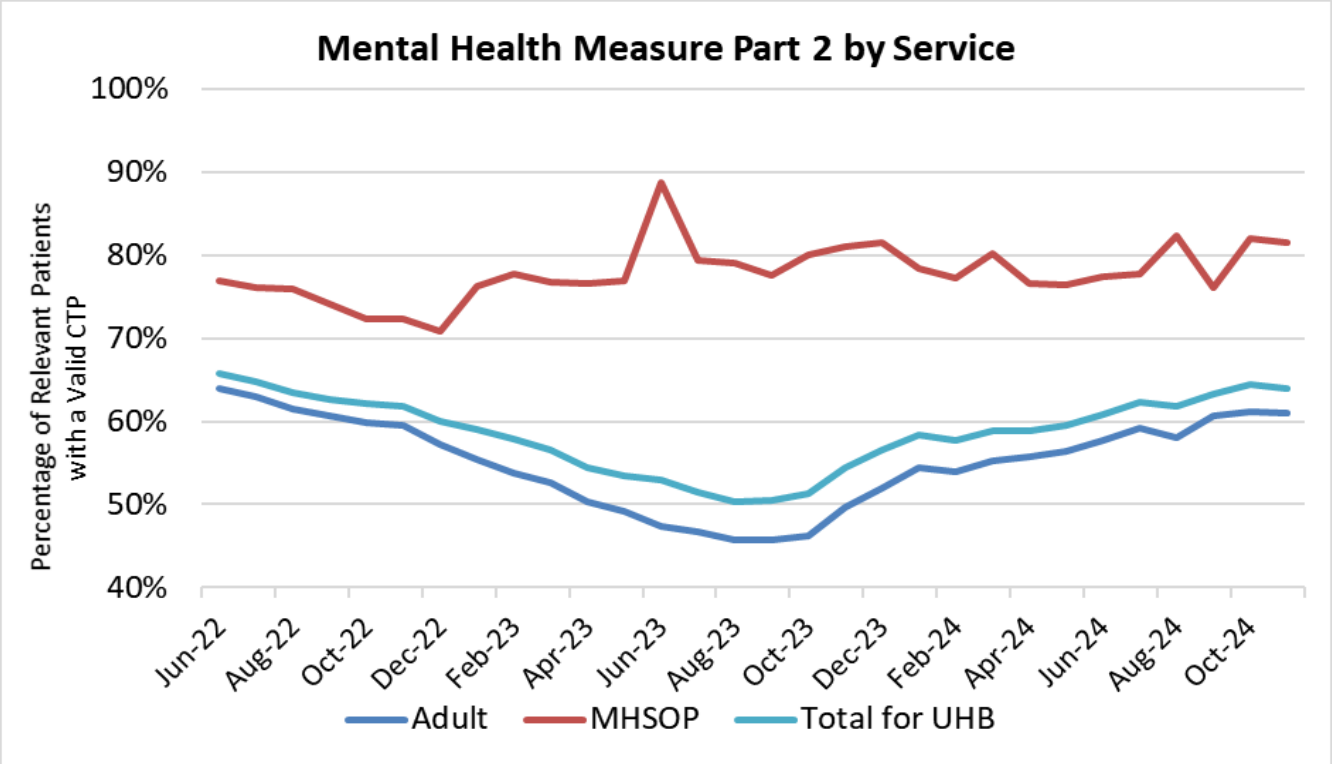
Graph 8



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 9



There has been a slight reduction in overall compliance with Care and Treatment Plans in September 2024 due to a small reduction in Adult compliance, which is outside of the trajectory of improvement since October 2023.

The Recovery And Maintenance Programme (RAMP) Protocol is being implemented but there is currently limited PARIS development time to implement this electronically to demonstrate impact. 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 current assessment for RAMP is that there are over 500 patients now on the scheme (a sample audit was undertaken indicating that of the 10% of patients assessed, all had a primary diagnosis of ADHD). This means that a reduction of the overall caseload will raise compliance with the target as intended, though the margins for improvement are likely to be modest (currently the caseload is 3500, indicating RAMP could reduce the whole caseload by 14%).

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.
When there is an electronic pathway, we expect to see large numbers transferring onto RAMP and consequently seeing an improvement in the performance.

Second to this there are conversations with a Community Mental Health Summit about providing both an ADHD Primary Care pathway and a Stable Severe pathway within Part 1. Both will required close engagement from the Local Medical Committee, the UHB, the Delivery and Assurance Unit and the NHS Executive. A recent stakeholder meeting with third sector agencies, service user representatives, Lived Experience professionals and carers was supportive of the transformation of care.

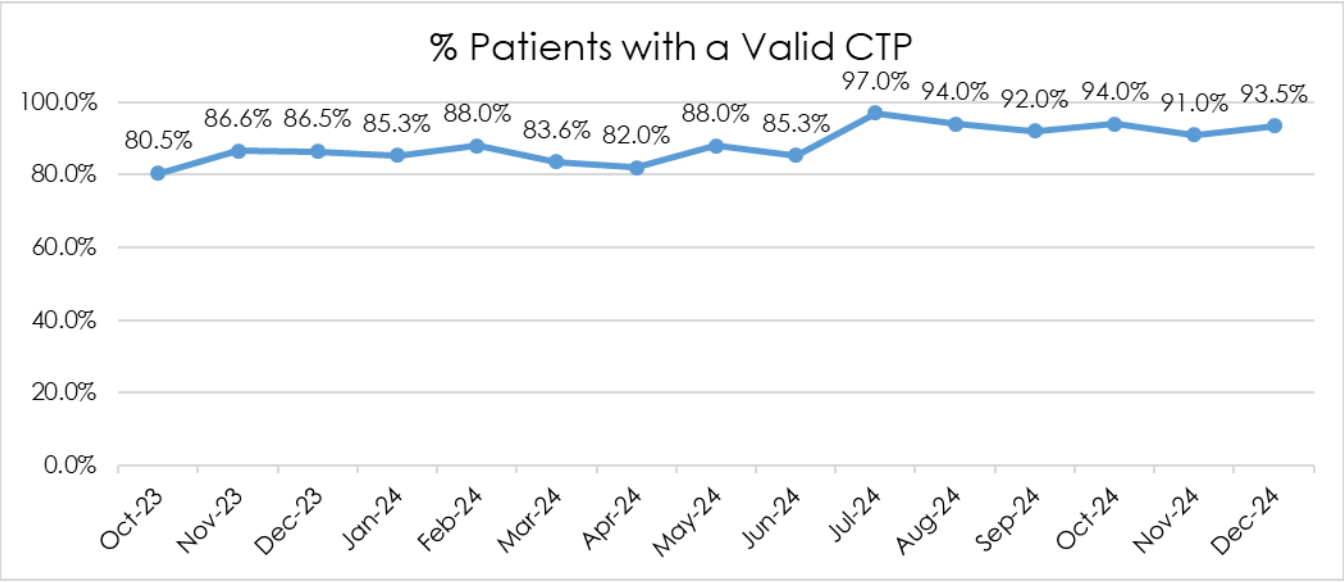
The Recovery and Wellbeing College course Care and Treatment Planning has running on the Adult Inpatient Wards, with Maple Ward having 25 attendees including all patients and staff on duty. This course has been developed with the Delivery and Assurance Unit and Health Education Improvement Wales (HEIW), Social Care Wales and co-produced with staff, service users and carers in the usual manner.

Actions to Improve Compliance:
-Care and Treatment Planning courses run across Inpatient Units
-RAMP protocol roll out
-Ongoing work in Community Summit towards Stable Severe and ADHD provisions
-Monthly directorate performance meetings with Integrated Managers with focus on Part 2 and 3 compliance.

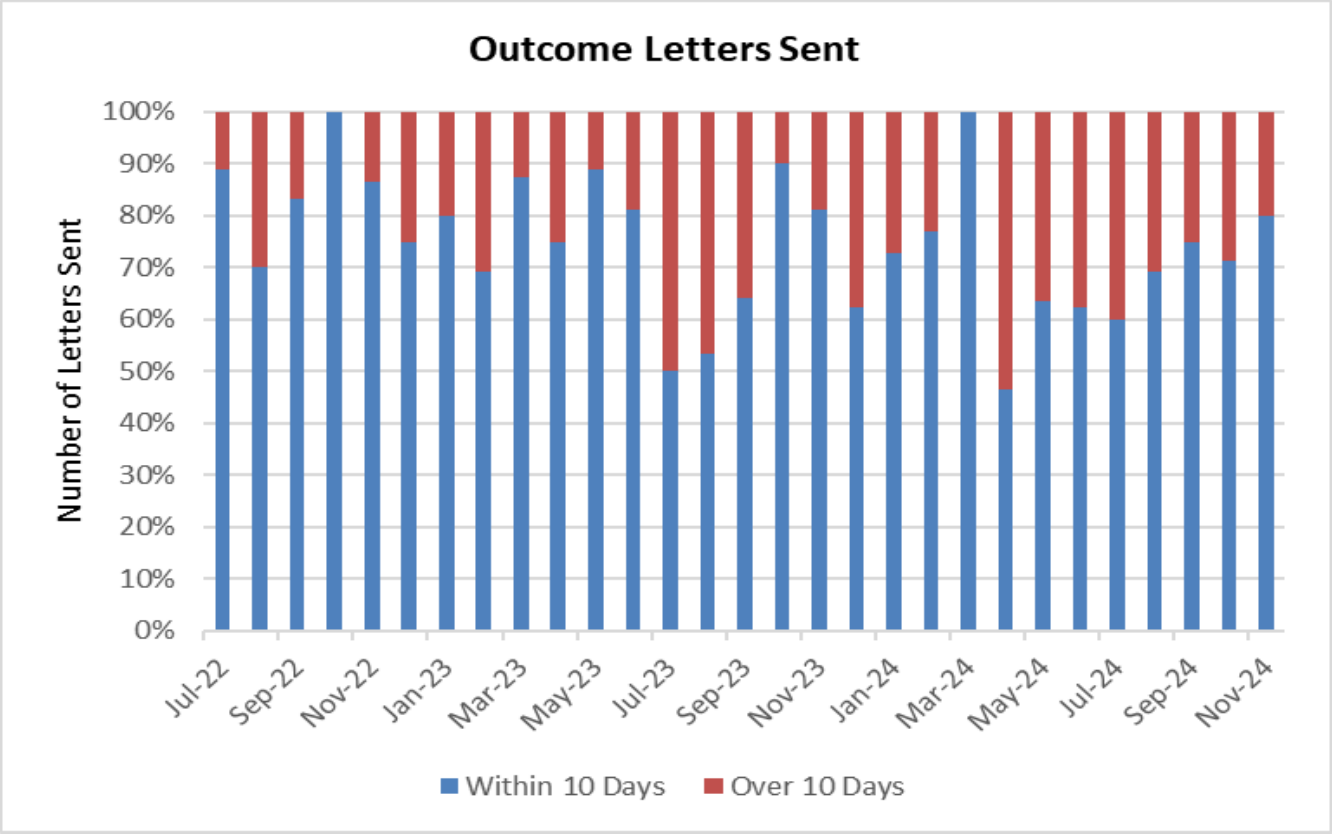
Part 2 – Care and Treatment Planning (Children & Young People)

Compliance has been achieved and maintained this quarter.
Challenges remain re engagement from CYP in the process due to the adult focus of the process and paperwork. This has been escalated to NHS Executive as a required action on the National CAMHS development workplan and a specific workshop to address the challenges on an all Wales level is to be planned.

Graph 10



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

Graph 11

There were two breaches in December 2024, both were one day over target. Total performance improved in December 2024 to 80% with additional scrutiny. Performance is under greater scrutiny from the Clinical Board and Directorate teams with performance reviewed at service, directorate and clinical board levels. Other reasons for breaching in the quarter were referrals on (and acceptance by) Crisis Services and a service user passing away between the point of assessment and letter. Greater scrutiny and validation is being applied, mainly due to some errors in the report which the Digital team are working to improve.

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

100% compliance.
ASC received 123 referrals this quarter, of which, 36 were unable to request advocacy, and were assisted on a non-instructed basis. ASC closed 115 cases, and had 108 cases open at the end of the quarter, meaning that 223 were assisted in this reporting period. New referrals consist of 87 qualifying compulsory patients, of which 100 percent of appropriate referrals were seen within 5 working days, and 36 informal patients, of which 100 percent of appropriate referrals were seen within 5 working days.

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:
Part 1: Recruitment increasing staff numbers above funded establishment to meet demand.

Part 2: Ongoing performance management and RAMP roll out

Part 3: Monthly performance management and implementation of process mapping.

Part 4: Continues to be 100% compliant with ongoing progress. Quarterly reports can be made available when requested.

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
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
Yes
Socio Economic: No
Equality and Health: Yes
Decarbonisation: 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 15:00 ON 14th JANUARY 2025 MENTAL HEALTH ACT OFFICE AND VIA TEAMS

Present
Jeff Champney-Smith Chair, PoD Group
Liz Singer - Vice Chair, PoD Group
Alex Nute - PoD member
Alan Parker - PoD member
Gerrie Hughes – PoD member via Teams
Mike Lewis – PoD member
Margaret Jones – PoD member
Dr John Copley – PoD member via Teams
David Seward – MHA Manager
Peter Kelly – PoD member
Amanda Morgan – PoD member
Mair Rawle - PoD member
Professor Ceri Phillips - Vice Chair, Cardiff and Vale Health Board via Teams
Rashpal Singh – PoD member
Carol Thomas – PoD member via Teams

Apologies for absence
Sharon Dixon - 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. There were no new members. The Chair provided an update on PoD members - good wishes were sent to Mary Williams. It was noted that Sarah Vetter and John Owen had resigned from the group, the group wished them well.

2. **Apologies**
Apologies were received and noted.

3. Members points for open discussion
Nothing to note.

4. **Minutes of Meeting held on 8th October 2024**
Slight amendment actioned to point 8, highlighted to high, otherwise the minutes were confirmed as an accurate record of the meeting.

5. Matters Arising
Interpreters for NR's - issue previously raised on whether it was the Health Board's responsibility to provide an interpreter for NR's for barring hearings. The MHA Manager has asked senior nurses to confirm but hasn't had a response as yet. **Action – MHA Manager**
Laptops – two members noted they had had issues with their laptops and saving minutes via Libre. They couldn't be open by the office or when opened no information was showing. The MHA Manager advised not to use Word as the PoD laptops don't have a licence it and to try re-installing Libre Office and see if that works and monitoring the situation.

6. Operational Issues

Split decisions – one member brought up a situation while sitting on a panel with another Health Board, the managers couldn't reach a unanimous decision about upholding the detention. The default position was that the patient wasn't discharged if it's a split decision, which is the same in CaV. It was noted that the wording in the Act was that three members had to agree as there is no limit to the amount of people that can sit on a panel. The two issues were a) whether a new hearing would be set up due to the split decision and b) whether the patient should be told about the split decision.
The legal advice from the other Health Board was that the legal decision by default is the patient is not discharged therefore, there is no need for a new hearing to be scheduled as a decision in law has been made. Although Hospital Managers have the discretion to hold a hearing at any time, it must be exercised reasonably, and a split decision is not a reasonable reason. The other Health Board's advice was that the patient should not be told about the split decision as the decision effectively is not discharged.
The group vocalised their thoughts that the advice goes against the openness and transparency that they strive for with patients and if the patient knew it was a split decision they might be more inclined to appeal to the Managers and have their case reviewed again, as is their right regardless of a split decision.
The consensus of the group was that we needed our own legal advice on the two issues.
Action – MHA Manager to seek legal advice

7. Lessons Learnt
Nothing to note.

8. MHA Activity Monitoring reports
Activity reports were provided for the periods October to December 2024 for both Hospital Managers and Tribunals. The contents of the reports were noted with the following issues highlighted: -

- There were still a high number of adjournments for both the Tribunal and the Hospital managers
  - For Hospital Managers there was one CMHT with a Dr on long term sick, so the hearings were all postponed hence the high number.
- After seeing an increased representation by advocacy at Hearings in the last quarter this had fallen again
- There had been two Nearest relative requests for discharge in the last quarter with one patient being discharged by the RC and one NR withdrawing their request
- There were no discretionary reviews this quarter
- Two hearings were cancelled – one due to the patient being happy on a CTO so no need for a review and one due to the patient going onto a DoLs.

9. **Comments/compliments**
Comments/compliments were provided for the period October – December 2024. The responses to the comments were noted. There was still one WIP due to the staff member involved was on long term sick. Point 5 was discussed as a potential training issue for ward staff.

10. Committee and Sub Committee feedback
The minutes from these meetings were attached. There was nothing further to add.

11. Training

Dr Fergus attended to discuss what training needs could be identified for her provided sessions going forward.

12. Any other business
Teams facilitation – the process of facilitation was discussed as all members of the MHAO are now helping with this process and that break out rooms haven't been used in a while as this helps MHAO from having to stay through the whole hearing. Some issues were raised where professionals were sometimes bypassing the lobby. The MHA Manager indicated this initially was due to the wrong permissions being saved. It was agreed that this would be monitored and if it continued, we would potentially go back to break out rooms. **Action – all to monitor and report any issues to MHA Manager**

Recruitment – due to illness and resignations our numbers have gone down and it was discussed whether we should recruit. The MHA Manager has a few people saved who have expressed an interest in the role he can reach out to as the group thought it would be beneficial to have more members. **Action – MHA Manager to recruit**

The group thanked Jeff and Liz for their excellent service and commitment to their roles over the years as they both step down and we welcome Alex and Amanda.

Date and time of the next meeting 8th April 2025 3pm Hafan Y Coed

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 16 January 2025 via Microsoft Teams

Present

Robert Kidd (RK)	(Chair) Consultant Psychologist
David Seward (DS)	Mental Health Act Manager
Alex Nute (AN)	Vice Chair, Power of Discharge Group
Ceri Phillips (CP)	Vice Chair, Cardiff & Vale University Health Board
Claire Thomas (CT)	South Wales Police Representative
Gemma Moeller (GM)	South Wales Police Representative
Gemma Lewis (GL)	Service Manager Adult MH, Cardiff LA
Beth Evans (BE)	EDT Service Lead
Gwilym Griffiths (GG)	Service Manager, Crisis, Psychiatric Liaison & Community MH Services
Casey Keegans (CK)	Shift Coordinator Representative
Chris Frayne (CF)	Senior Nurse for Low Secure & Specialist MH Services
Jayne Jennings (JJ)	Senior Nurse for Crisis & Liaison Services, Adult MH
Kath Lewis (KL)	Consultant Social Worker AMHP/DoLS
Samantha Kennedy (SK)	Integrated Team Manager, MHSOP
Alex Alegretto (AA)	Advocacy Support Cymru Manager
Rim Al-Samsam (RAS)	MHCB Director
Noel Martinez (NM)	Social Work/ AMHP Manager, Vale LA
Mohamed Marey (MM)	CAMHs Representative
Callista Hettiarachichi (CH)	CAMHs Representative
Linda Woodley (LW)	Operational Manager MH, Vale of Glamorgan LA
Adele Watkins (AW)	Mental Health CNS, Acute Child Health
Clare Davies (CD)	Consultant Representative, A&E
Chloe Evans (CE)	Mental Capacity Act Project Lead
Phil Ball (PB)	Senior Nurse, Community MH Teams, Adult MH

Apologies

Matthew Russell	Operational Manager MH, Cardiff LA
Rebekah Vincent Newson	DoLS Lead
Amanda Morgan	Chair, Power of Discharge Group

1 Welcome and Introductions

The Chair welcomed everyone to the meeting.

2 Apologies for absence

Apologies were noted.

3 Minutes of meeting held on 11 October 2024

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

4 MHA Activity

The MHA Monitoring report was gone through by DS who noted most of the activity remained stable this quarter. Section 135's were higher this quarter with 12 and previous at 8. GL confirmed that AMHP's felt the increase and potentially was because of the introduction of RCRP. CT confirmed that 135's will potentially increase as police are no longer willing to go to patients houses anymore if they've left hospital so 135(2)'s will go up as a result. GL noted that AMHP's do get requests to action a 135(2) warrant, but it isn't their role, it is Health's role, although AMHP's will assist where they can, but with RCRP they are going to need to consider how they move forward as they will need to concentrate on the roles they have a statutory duty to provide rather than roles they can help with.

Action – look at the process for 135(2) with Health colleagues

The use of Section 4 has increased, the last one being in July 2024 and this quarter there has been 3. Section 3 have slightly increased this quarter as the last couple of months they've been around 18-20 but December saw 27.

The exception report picked up the following that occurred within the last quarter –

There was one fundamentally defective application where patient was on a Section 2, assessed and put onto a Section 3. The medical recommendations were sent for scrutiny and both failed due to neither having a reason as to why informal admission was not possible. DS confirmed the process for failed scrutiny is for it to be sent to the Clinical Director for that directorate to confirm it fails and in this instance, we need to gain new medical recommendations but because the original AMHP was away so they couldn't just complete a new application, a new AMHP had to go out and complete a new assessment.

There was one fundamentally defective Section 5(2) report due to the form not being signed by the doctor completing the form. It was sent to shift coordinator on Friday evening and was accepted but the lack of signature wasn't picked up until we processed the form on the Monday morning. By the time we questioned the form, the patient was happy to stay informally until RC could review the following day.

136's had decreased this quarter by two. RK questioned whether 136 were due to decrease with RCRP. CT confirmed this as the premise of RCRP is that officers contact crisis teams etc prior to detention however, compliance with that at the moment is very low. It was noted that when RCRP fully comes into force supervisors will have to authorise a 136 detention and they'll have to make sure the officer has

consulted with someone first, if they're able to. GM confirmed that another level of triage will be expected before detention by asking who has been contacted and what was the advice.

Four 136's had lapsed due to two not being medically fit, one had absconded from A&E and one was allowed to go home before an assessment. One 136 was unlawful where the officer detained the patient in their garden, which isn't allowed.

CAMHs 136's were higher this quarter at eighteen with ten in the previous.

Nearest relative discharges are still being tracked with two this quarter – one resulting in being discharged as they didn't meet the dangerous criteria and the other being barred.

5 Matters for Action

Action log - this will be updated and sent separately.

6 Feedback on operational issues and incidents

Nothing to note.

7 Feedback from other meetings:

Vale of Glamorgan LA – NM confirmed the issue of completing Section 3 assessments with patients OOA and the cost implication this has but also the time constraints with an AMHP having to spend a whole day travelling etc and that impact on the service and the patient being so far away.

Cardiff LA – the issue of OOA beds was raised when AMHP's are getting requests to do Section 3 assessments the day before a Section 2 expires and it is difficult to keep track of OOA patients as sometimes they're detained straight to OOA rather than HYC first so they're not aware of them. The LA is having to contact the LA the hospital is in and ask for them to complete an assessment which some are refusing to do, and some are reluctant to do but if they do it is costing the LA up to £650 per assessment.

JJ stated that it isn't ideal having so many patients OOA and there are daily and weekly meetings to try and bring patients back, but it does depend on whether they need a treatment or PICU ward, whether they can come back to a mixed ward or do they need female only so there are lots of complexities in the decision making. JJ suggested that LA joins the weekly meetings so they're aware of patients who are OOA and might need a Section 3 assessment.

Action – JJ to send invite to KL/ GL

The issue of S12 doctors was raised by KL and MHA assessment not being able to be done overnight and they're being passed over to daytime services. Also, some SPR's are declining to do 136 assessments unless another doctor is present even when it's not required. LW advised a survey was being sent out by DS to try and get some feedback and data on the lack of S12 doctors. BE asked whether it could be added to the survey about over night availability. DS confirmed we hold the availability of the S12 doctors but if these change, he is reliant on being told by the S12 so it was agreed that a question would be added to the survey asking S12 to confirm their availability.

Action – DS to add availability question to survey and send out

KL stated that there was work being done on MHA/ DoLs and raising awareness of the need for a person to be under a legal framework if being deprived in hospital.

CAMHs – it was noted from AW that there are two patients currently detained in the children's hospital, and it was queried whether an RMN is required to assist as AW is the only person on the wards that has any MHA training. CK advised that if adult patients are detained on a medical ward, then it's staffed by healthcare rather than RMN's,

South Wales Police - No feedback or adverse incidents to be discussed.

Advocacy – AA confirmed things are going ok and referrals from self-referring or from MHAO are up from the previous quarter which they're pleased about. Advocacy have provided awareness sessions to a number of consultants within CaV.

8 Power of Discharge Group comments, compliments and feedback

AN raised an issue that was discussed in PoD regarding legal advice that had been shared from another Health Board about split decisions in hearings. They agreed there has to be a unanimous decision amongst the panel members, but the query was whether if the decision was split, could the panel adjourn and reconvene another hearing to review the case, as CaV has always done and whether the patient should be informed of that split decision. The advice from another Health Board contradicts what CaV do. Legal advice is being sought by DS for this issue.

Action – DS to obtain legal advice

9 External reviews

Nothing to note.

10 Interface MHA/MCA/DOLS

Nothing to note.

11 Quality indicators and audit activities

Nothing to note.

12 Mental Health Act Reform

It was noted that during the Kings Speech the Government advised they would be going ahead with the reform of the MHA. An invitation from the Health and Social Care Committee has been received for comments on the Mental Health Bill and to aid this, slides from the Department of Health, England were gone through with the group. These will also be sent out to the group with the minutes.

CF raised an issue that if they remove the option to 'remand for own protection' under the Bail Act, as this option is used quite frequently, it will put extra pressure on MH services as it will require a MHA assessment to be arranged in Court which will be difficult as it is a public space and a Court which is not a suitable place.

Concerns were raised by KL around the detention criteria being for ‘therapeutic benefit’ as when you’re assessing someone in the middle of night in an emergency it is difficult to understand that therapeutic benefit.

LW raised concerns about the extension of advocacy services in terms on capacity and funding. Nominated person could be difficult to manage and keep on top of for an AMHP. Also, it was raised about the potential cost implication for LD patients in private institutions with high level of care needed, as appropriate systems need to be created with investment behind it.

The questions from the Health and Social Care Committee were read out to the group for comment.

KL raised a concern around the ‘movement of patients across the Wales-England border, ensuring smooth collaboration between services’ as currently if a patient is put on a s2 in this area and needs a s3 OOA, as whoever does the s2 retains responsibility for organising the s3 and there is no process for this and is causing increased cost and impact on patients and NR consultations with lack of information.

CH brought up an issue with nominated person for young people and how we expect them to decide especially if they’re separated parents or strained relationships.

13 Any other business

Nothing to note.

14 Date of future meetings

16th January 2025

Mental Health Legislation & Governance Group Action Log

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

ACTIONS FROM PREVIOUS MEETINGS

STATUS			
	SPRs not calling on call consultant if they aren't available for assessments	Chair to raise the issue with Assistant Clinical Director to remind SPRs of the agreement and duty to call on call consultant Lead Nurse, Adult MH to advise shift coordinators for an extra reminder	**RK/EM** **RR**
	RC's completing and leaving single medical recommendations on ward/MHAO	MHA Manager to collate data and send to both LA once we have enough data to collate	**DS**
	Bed management/s140 policy	Has been approved by CDOG and is in the final 28-day consultation process	**SW**
	Locked doors – do informal patients know their rights	Lead Nurse, Adult MH advised information leaflets are being created. Update at next meeting	**RR**
	Advocacy continues to struggle to support clients at ward rounds as timetable isn't being adhered to	Lead Nurse, Adult MH to discuss with Clinical Director to establish a firmer timetable for all.	**RR/PY**
	Patients being detained in A&E	Senior Nurse, Crisis and Service Manager, Crisis completing SOP with EU Department	**GG/JW**
	Voluntary assessments figures	MHA Manager to liaise with Crisis Team re: figures and include in monthly audit to SWP	**DS**
	RC's reviewing s5(2) before AMHP being called	MHA Manager to raise at MAC and remind RC's.	**DS**
	Advocacy providing awareness sessions in MHSOP	MHA Manager to liaise with Advocacy and CD, MHSOP	**DS/DB/AC**

ACTIONS FROM THIS MEETING – 16th January 2025

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	135(2) warrants	DS to confirm the process for 135(2) warrants	**DS**
	OOA patients	JJ to invite KL/ GL to the weekly OOA bed management meetings	**JJ**
	S12 doctors survey	DS to add availability question to the S12 doctors survey and send out	**DS**
	Split decisions in Hospital Managers hearings	DS to obtain legal advice on whether a hearing can be reconvened after a split decision and whether we can advise the patient of that decision	**DS**

Report Title:	Request for approval of the ' Cardiff & Vale UHB Mental Capacity Act (MCA) Policy'			Agenda Item no.	*The Corporate Governance Team will complete this*
Meeting:	Mental Health Legislation and Mental Capacity Act Committee'	Public		Meeting Date:	
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Nurse Director				
Report Author (Title):	MCA Project Lead				

Main Report

Background and current situation:

The Mental Capacity Act 2005 (MCA) was introduced in 2007, in order to provide a statutory framework to empower and protect vulnerable people over the age of 16. It enables people to plan ahead for a possible loss of capacity and provides a legal framework for making decisions on behalf of those who are unable to make at least some decisions for themselves. It has two overarching aims:

- To promote autonomy of decision making for all
- To protect vulnerable adults from harm.

This policy sets out what is expected of staff and volunteers within the UHB, when working with people who may lack the mental capacity to make decisions within the meaning of the MCA. It provides guidance on the underlying principles, assessment of mental capacity and making best interests decisions on behalf of those who lack mental capacity.

It sets out what evidence is required to ensure healthcare staff are protected from liability when acting in a persons' best interests without their consent, including when using restraint and provides links to other useful documents and forms.

The policy also helps staff to identify when restraint of a person results in a Deprivation of Liberty, which requires additional procedural safeguards under the Mental Health Act or the Deprivation of Liberty Safeguards (DoLS).

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

Cardiff and Vale UHB is committed to ensuring that the MCA is properly embedded into clinical practice in order to safeguard the individuals that we care for.

This policy outlines the expectations of our staff and provides a framework for assessing mental capacity and managing decision making for people with cognitive impairments. It sets out how people should be supported to make decisions for themselves, how to identify those who are unable to make decisions for themselves and how to make decisions on their behalf.

Recommendation:

The Committee is requested to:

a) Review the contents of this policy and consider approval for publication

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	X
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	

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

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	*Not required*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: No
Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)
Safety: No
Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Financial: No
Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: No
Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Legal: No
Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)
Reputational: No
Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Socio Economic: No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

(If this has been addressed in the main body of the report, please confirm)

Equality and Health: No - *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)*

This procedure supports the UHB's Consent to Examination and Treatment Policy, for which an EHIA has been undertaken, in terms of ensuring that the UHB provides appropriate patient information to support the consent process where there is no EIDO or nationally recognized alternative available.

Decarbonisation: No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB. These include:

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions.*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated Follow Ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved?

Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Reference Number: Version Number: 1	Date of Next Review: Previous Trust/LHB Reference Number:

Cardiff & Vale UHB Mental Capacity Act (MCA) Policy

Policy Statement

To ensure that Cardiff and Vale UHB (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The UHB is committed to ensuring that adult patients are supported to make decisions and where they are found to have impaired mental capacity the appropriate process is followed, in accordance with the Mental Capacity Act 2005.

Policy Commitment

We are committed to ensuring that the Mental Capacity Act 2005 is understood and adhered to by our staff.

We support staff in this by

- Publishing this policy and keeping it updated
- Providing intranet pages containing useful information on mental capacity issues
- Providing training for staff on mental capacity
- Providing support to staff with queries on capacity issues

Supporting Procedures and Written Control Documents

This policy and the supporting procedures describe the following with regard to supporting adults with impaired capacity to make decisions.

- The process to follow when there are doubts regarding a person's ability to make decisions, including relevant documentation.
- Who to consult when decisions need to be made for a person who lacks mental capacity to decide
- When to consider the Deprivation of Liberties Safeguards (DoLS)

Relevant legislation and guidance to read alongside this policy include:

- Social Services and Wellbeing (Wales) Act 2014
- Mental Capacity Act 2005
- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Deprivation of Liberty Safeguards 2009
- The All Wales Safeguarding Procedures for Children and Adults at Risk or abuse and Neglect 2020.

- Domestic Abuse (Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015).

Other supporting documents are:

- Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, TSO London
- Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice HMSO (2005)
- Mental Capacity Act 2005, HMSO London
- Cardiff and Vale UHB, Consent to Examination or Treatment Policy, UHB 100
- Consent to Examination or Treatment Under the Mental Health Act 1983 (UHB 491)
- Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 186
- Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and procedure UHB 044
- Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005) UHB 113
- Research Consent and Capacity: Standard Operating Procedure, UHB 147
- Accessing Legal Advice Procedure UHB 469
- Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and Procedure (UHB 044)
- Jones, R. (2018) *Mental Capacity Act Manual* (8th Edition)

Scope

This policy applies to all of our staff in all locations including those with honorary contracts.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EHIA.

Policy Approved by	
Group with authority to approve procedures written to explain how this policy will be implemented	
Accountable Executive or Clinical Board Director	Executive Nurse Director

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 Review Approved**	**Date Published**	**Summary of Amendments**
1			New document

CONTENTS

1. EXECUTIVE SUMMARY

The Mental Capacity Act 2005 (MCA) was introduced in 2007, in order to provide a statutory framework to empower and protect vulnerable people over the age of 16. It enables people to plan ahead for a possible loss of capacity and provides a legal framework for making decisions on behalf of those who are unable to make at least some decisions for themselves. It has two overarching aims:

- To promote autonomy of decision making for all
- To protect vulnerable adults from harm.

The Act was amended in 2009 to provide safeguards for people who need to be cared for or treated under significant restrictions (the Deprivation of Liberty Safeguards). The Act reflects the development of case law relating to mental capacity and the European Convention on Human Rights (ECHR).

This policy sets out what is expected of staff and volunteers within the Health Board, when working with people who may lack the mental capacity to make decisions within the meaning of the MCA. It provides guidance on the underlying principles, assessment of mental capacity and making best interests decisions on behalf of those who lack mental capacity.

It sets out what evidence is required to ensure healthcare staff are protected from liability when acting in a persons' best interests without their consent, including when using restraint.

The policy helps staff to identify when restraint of a person results in a Deprivation of Liberty, which requires additional procedural safeguards under the Mental Health Act or the Deprivation of Liberty Safeguards (DoLS).

2. INTRODUCTION

This document is intended to assist all staff working with people with impaired mental capacity. It sets out what is expected of staff to ensure compliance with the principles of the MCA. It provides guidance on how to support people to make decisions, to identify those who are unable to make decisions and the principles to follow when acting in their best interests.

This guidance should be read alongside the Cardiff & Vale University Health Board's Consent and Adult Safeguarding policies and DoLS procedure. This policy is not intended to replace the Code of Practice to the Mental Capacity Act, which should be referred to for more detailed guidance.

3. DEFINITIONS

Advance Decision to Refuse Medical Treatment (ADRT)	Decision made by a person, which remains valid and binding after they lose the mental capacity to make decisions. An ADRT does not have to be in a specific format, but if it concerns life-sustaining treatment it must be in writing, include a statement that the person is aware their life is at risk and be signed and witnessed.
Advance Statement	Statement made by someone who has capacity setting out their views on aspects of lifestyle, care or treatment. If they later lack capacity for the decisions that they have discussed in their advanced statement, then the wishes set out in their statement should be followed as a guide.
Cognitive function/Cognition	The American Psychological Society defines cognition as "*all forms of knowing and awareness, such as perceiving, conceiving, remembering, reasoning, judging, imagining and problem-solving. The SAMPLE model outlines involved cognitive processes - Speed of processing, Attention, Memory, Perception, Language and Executive processing. These processes interact so an impairment in one area may affect another*." American Psychology Society 2018, SAMPLE Model of cognition. Measurement of impairment of cognitive functions involves assessment of the following elements of mental performance: orientation, registration, attention and calculation, recall, and language. Some forms of cognitive impairment affect other elements of a person's personality, while leaving the elements mentioned above, relatively intact. It may be less apparent that the person's decision making is impaired and careful assessment will be required to ascertain whether the impairment amounts to a lack of capacity to make specific decisions
Consent	The voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions
Critical Care / a vital act	Care that is needed to save someone's life or prevent a serious deterioration of their condition.
Carer	Person who provides unpaid care to an adult or disabled child.
Decision Maker	The person who makes a decision on behalf of a person who lacks mental capacity to make that decision. In the absence of any formally appointed authority (Lasting Power of Attorney or Court Appointed Deputy) this is usually the person who is requiring a decision to be made, for example the clinician proposing care and/or treatment for the person.
Deprivation of liberty	Being under continuous supervision and control and not free to leave
The Deprivation of Liberty Safeguards (DoLS)	Procedure which provides a legal framework where a person is detained within a hospital or care home for the purposes of receiving care and/or treatment. The safeguards provide protection for the individual by ensuring scrutiny of the care arrangements and the right of appeal.
DoLS Supervisory Body	The authority responsible for assessing and authorising requests for DoLS Authorisations, which is the Local Authority in whose area the person subject to deprivation of liberty resides or the Health Board if the person is in a hospital setting.
DoLs Managing Authority	the Care Home provider if person is a resident or the responsible Clinical Board if the person is in a hospital setting
Court Appointed Deputy	Person appointed by the Court of Protection to manage the affairs of a person who lacks the mental capacity to make decisions about such matters. Deputies can be appointed for financial matters and/or health and welfare matters
Donor of a Lasting Power of Attorney (LPA)	Person who has made the LPA to appoint a decision maker on their behalf
Lasting Power of Attorney (LPA)	This transfers decision making authority from the donor to the attorney. This can be for decisions relating to health and welfare and/or property and finance.
Enduring Powers of Attorney (EPA)	Made before the MCA came into force and cover financial decisions only (superseded by LPA)
The Office of the Public Guardian	Body that supervises deputies, keeps a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, checks on what attorneys are

	doing, and investigates any complaints about attorneys or deputies
Independent Mental Capacity Advocate (IMCA)	Qualified advocate who is appointed to represent the views of a person who lacks capacity in the decision-making process
Mental Capacity	The ability of an individual to make decisions about specific issues in their life. It is also sometimes referred to as 'competence'. Capacity is not an absolute concept: the level of understanding required will increase with the complexity of the decision and capacity can vary over time
Restraint	The use, or threatened use of force, to make someone do something, or prevent them from doing something, against their wish, or to restrict their movement, whether they resist or not.
Persons, People	Used in this policy to cover all patients, whether inpatients, outpatients and those receiving short-term or emergency contact, whether face-to-face, by phone or video link.
You	In this policy means any person, whether staff member or volunteer, who interacts with patients.

4. SCOPE

This guidance applies to all staff, including temporary staff (bank), agency and volunteers in the Cardiff & Vale University Health Board who have direct or indirect contact with people and/or their family or carers, who may have impaired mental capacity to make decisions.

The Mental Capacity Act applies to all persons over the age of 16 and to all decisions with the following exceptions:

- Decisions concerning family relationships, including marriage, sexual relationships etc. A person may have their capacity to make these decisions assessed, and you may be asked to contribute to this assessment. If the person is found to lack capacity for any of these decisions then the case must be referred to court rather than following the usual Best Interests process, so that what is in their best interests can be decided by a judge.
- Treatment under the Mental Health Act.
- Unlawful killing or assisted suicide.

5. PURPOSE

5.1. Overview

This policy provides a framework for assessing mental capacity and managing decision making for people with cognitive impairments. It sets out how people should be supported to make decisions for themselves, how to identify those who are unable to make decisions for themselves and how to make decisions on their behalf.

5.2. Principles

All staff who may come into contact with people who have impaired decision making and their family and/or carers must comply with this policy and in particular be aware of and follow the statutory principles of the MCA;

- **A person must be assumed to have capacity unless it is established that they lack capacity.**
- **A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.**
- **A person is not to be treated as unable to make a decision merely because he makes an unwise decision.**
- **An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.**
- **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action**.

***(Section 1, MCA 2005*)**

This policy is designed to support staff it finding the balance between protecting and empowering the people that we care for, by ensuring that they are involved in decisions about their care so far as they are able. Where a person is found to be unable to make a particular decision for themselves, it is important that those who know them best are consulted to enable staff to better understand the individual and their views.

6. ROLES AND RESPONSIBILITIES

6.1. The Health Board

The Health Board is responsible for ensuring that there is Board-level leadership, an overall policy and an organisational culture which promotes understanding of the MCA and embeds the principles of the MCA in everyday practice.

6.2. Designated Executive Director with responsibility for MCA

The Designated Executive Director for Cardiff & Vale University Health Board is the Executive Director of Nursing who is responsible for oversight of the MCA, executive leadership and reporting to the Board.

6.3. The Health Board Lead for the Mental Capacity Act

The Health Board Lead for the Mental Capacity Act will be responsible for the provision of expert guidance and leadership to support members of staff, and the organisation, to fulfil their obligations to people and their families and carers in relation to the MCA.

The Health Board Lead for the Mental Capacity Act is responsible for developing policies and monitoring practice relating to the MCA.

The Health Board Lead for the Mental Capacity Act will be responsible for the provision of training to support Health Board compliance with the mandatory training relating to the MCA.

The Health Board Lead for the Mental Capacity Act will monitor the use of the Deprivation of Liberty Safeguards and liaise with the Supervisory Body to ensure effective reporting and to resolve any issues.

6.4. Clinical Boards /Line Managers / Service Leads

The Clinical Boards /Line Managers/Service Leads are responsible for ensuring that staff are aware of the Health Board's policy.

They should also ensure that the level of responsibility for each staff member is explicit as a statement in all job descriptions, and actively review this via annual appraisal.

They should ensure that each staff member is able to access mandatory MCA training as appropriate to their role.

6.5. Responsible Clinicians

The Responsible Clinician must ensure that they are familiar with this policy and that appropriate steps are taken to establish a person's mental capacity to consent where there is any reason to doubt their ability to do so.

6.6. Ward Sisters and Senior Nurses on duty in inpatient wards

Nurses in charge of an inpatient unit must ensure that Mental Capacity and DoLS screening is undertaken for all inpatients.

They must ensure that the need for an urgent DoLS authorisation is considered and a request for a standard DoLS authorisation is made for every person who lacks capacity to consent to admission and treatment and who is deprived of liberty.

6.7. All Healthcare Staff and Volunteers

All employees and volunteers must be aware of and follow this policy.

They must apply the statutory principles of the MCA and the guidance in the Code of Practice when in contact with people with impaired mental capacity.

When discussing any intervention with a person staff must:

- take all reasonable steps to support the person to make decisions for themselves;
- assess a person's mental capacity when there is reason to doubt the presumption of capacity and record evidence to support a conclusion of a lack of mental capacity to make decisions;
- follow the best interests' checklist when making decisions on behalf of people who lack the mental capacity to make decisions.

7. POLICY DETAIL / COURSE OF ACTION

7.1 The Statutory Principles

These principles represent best practice and reflect a person-centred approach to supporting the two over-arching aims of the MCA;

7.2. Principle 1 - Presumption of capacity:

All adults over the age of 16 have the right to make their own decisions and you must assume that a person has the mental capacity to make a particular decision unless:

1) You have reason to doubt their decision-making ability
2) You have then assessed their capacity and can show that they lack the mental capacity to make the decision in question.

People do not have to prove that they have mental capacity.

If you conclude that a person lacks mental capacity you must provide evidence that the individual lacks mental capacity to make the decision in question at the time it needs to be made.

7.3. Principle 2 - Supported decision-making:

Before you conclude that a person lacks mental capacity for a decision, you must take all practicable steps, to help them make their own decision. You must explain

all the relevant information to the person and strike a balance between giving sufficient information to enable them to decide and giving too much information or too great detail, which could be confusing.

You must identify the most effective method of communication to help the person to understand the nature of the decision and the choices available:

- Use simple language avoiding jargon or technical language;
- Use pictures or diagrams to help the person visualise what you are explaining;
- Involve family, carers and others who know the person well, to advise on the most effective methods of communication;
- The presence of relatives, friends or other people who know the person, may reassure them and assist communication;
- Use communication aids such as an interpreter or professional with specific skills (e.g. Speech and Language Therapist) if the person has impaired communication;
- Consider the most appropriate location for the discussion to put the person at ease. If possible avoid noisy, busy environments;
- Consider the timing of the decision, as some people's functioning may vary between different times of the day, or may be affected by particular medication;
- The person may benefit from having the support of another person in making their decision;
- You must address any cultural and ethical issues that may affect communication.
- Where practicable, treat any ongoing medical issues that may be affecting their decision making
- Consider any therapeutic intervention needed to support the person's decision-making ability (for example, supporting a person with a learning disability to learn new skills)

7.4. Principle 3 - An unwise decision does not prove a lack of mental capacity:

You must not conclude that a person lacks mental capacity simply because they have made what you consider to be a bad or unwise decision that you disagree with.

An unwise decision or series of unwise decisions may be a warning sign that you need to assess whether the person does in fact have the mental capacity to make a decision, particularly if the decision involves significant risks or is new 'out of character' behaviour.

7.5. Principle 4 - Best interests:

When making a decision or acting for, or on behalf of a person who lacks the mental capacity to make a decision you must do so in their best interests.

You must consider the statutory "Best Interests Checklist" (see section 7.15) in deciding in the person's best interests.

7.6. Principle 5 - Less restrictive alternative:

When acting in the person's best interests you must consider whether you can achieve the desired outcome with less restrictions on their freedom of choice.

7.7. Who can make decisions?

Every person over the age of 16 years is entitled to make decisions for themselves, unless it has been established that they lack the mental capacity to make the required decision at the time it needs to be made (Principles 1-3).

For decision making relating to children under the age of 16 years please refer to the Health Board's *Consent to Examination or Treatment Policy*.

The decision maker:

A range of people may act as the **decision maker** on behalf of an individual who lacks the mental capacity to decide, depending on the type of decision that needs to be made.

For social care decisions, the decision maker may be a care manager or a staff member in day services or a care home or person/persons who hold relevant LPA.

- For medical treatment issues, a doctor, nurse or AHP will be the decision maker, or person/persons who hold relevant LPA
- For care and residence decisions, a social worker, person/persons who hold relevant LPA, family or clinical team; depending on the decision to be made
- For day-to-day decisions, a family member, friend or formal or informal carer may assist the individual to make a decision, or person/persons who hold relevant LPA.

If you are proposing or providing care or treatment for the person, you are likely to be the decision maker in respect of that care or treatment, unless someone has been given a formal authority to act on behalf of the person. See Table 1.

Where a person lacks capacity to make a decision for themselves, no one can give consent on their behalf except for:

- A valid and applicable Lasting Power of Attorney
- A valid and applicable Court Appointed Deputy
- A judge

Table 1: Identifying the Decision Maker

Decision level	Who should be involved in the assessment & decision-making process?	Recording
Simple e.g. day to day decisions about what to wear, what to eat, where to go during the day	**Decision maker –** paid carer whether formal (e.g. domiciliary or residential care staff member, support worker) or unpaid carer (family/friend)	With formal relationships, the person's care plan should be completed to show how the decision is made.
Procedures & Investigations e.g. scans, surgical procedures or medical investigations.	See section 20-22 within the consent to examination or treatment policy: Consent Policy	Welsh Risk Pool Consent Forms
Significant e.g. longer-term decisions involving care plans, arranging and reviewing packages of care.	**Decision Maker –** Allocated Worker (e.g. Care Manager, Nurse, OT, GP, Care Co-ordinator) who is managing the care. The decision maker must consult with relevant others (e.g. other involved professionals and family/friends).	**Use Forms at Appendices A and B to record:** Evidence that the person lacks capacity and outline who was consulted in making the decision. Factors considered in making the best interests decision.
Complex, high risk or contentious e.g. decisions about long term treatment, situations where risk levels are high, adult protection cases where there are disagreements between those involved.	**Decision maker** –Allocated Worker e.g. Care Manager, Nurse, Doctor) using a Multi-Disciplinary approach and consulting relevant others family/friends, and possibly an advocate. A team or Care Home Manager may be appropriate to chair a planning meeting if required. The Adult Protection framework should be used where relevant.	**Use Forms at Appendices A and B to record:** Evidence that the person lacks capacity and outline who was consulted in making the decision. Factors considered in making the best interests' decision. Additional reports/second opinions may also be required.

7.8. Lasting Power of Attorney (LPA)

Adults over the age of 18 years can authorise another adult over the age of 18 years to make decisions on their behalf in the event of a loss of capacity. Lasting Powers of Attorney (LPA) can be made for property and finances and / or for health and welfare matters.

Once the LPA has been registered with the Office of the Public Guardian (OPG) the appointed attorney will have authority to make a decision on behalf of the donor, if the donor lacks capacity to make the decision, including consenting to medical treatment.

The LPA document will specify what powers the attorney holds and any exceptions. If the attorney is asked to make any decisions about life sustaining treatment the LPA document must specify that they have this power, it is not automatically granted.

Sometimes people will make an Advance Decision to Refuse Treatment (ADRT) and also register to donate LPA. If the donor made an ADRT after they registered an LPA

then the LPA cannot overrule the ADRT. If the donor made an ADRT before they registered an LPA, the LPA's decision would overrule this ADRT although they should be expected to evidence why they are overruling the persons previously expressed wishes.

Professionals must ask to see evidence of any LPA, to check that the power has been registered and that the relevant decision falls within the scope of the power. A copy of the LPA should be taken and maintained in the medical record. The attorney must act in the donor's best interests and if professionals have concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian.

LPAs registered on or after 1st January 2016 in England and Wales can be accessed online with an access code provided by the LPA.

LPAs must formally request access to the person's notes via information governance.

For further guidance please see the UHB's Information Governance Policy

7.9. Court-Appointed Deputies

When a person has lost capacity without making a Lasting Power of Attorney, the Court of Protection can appoint a deputy to act on behalf of the person. This is normally only done for financial matters, but on rare occasions a welfare deputy may be appointed.

Deputies for personal welfare decisions will only be required in the most difficult cases where:

- a series of linked welfare decisions are required over time, or
- there is a history of disputes as to what is in the best interests of the person, or
- the person is thought to be at risk of harm if left in the care of family members.

Professionals must ask to see evidence of the appointment and scope of authority before acting on the decision of a deputy.

Deputies must act in the donor's best interests and if professionals have concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian.

A deputy cannot refuse consent to life sustaining treatment.

7.10. Advance Decisions to Refuse Treatment (ADRTs)

Adults over the age of 18 years who have capacity to make the decision can make an advance decision to refuse medical treatment at any time in the future when they have lost capacity to make that decision.

Advance decisions only apply to the refusal of medical treatment and do not cover basic care (warmth, food and drink by mouth, shelter, being kept clean etc.)

There are no legal requirements regarding format etc. for an ADRT, unless it concerns refusal of life-sustaining treatment, in which case it must be made in writing, including a statement that the person knows their life may be at risk, signed and witnessed. Any ADRT must also be specific about the treatment that would be refused and the circumstances in which it would be refused.

Clinicians must comply with an advance decision unless they have evidence that the decision is not valid or applicable in which case they should seek advice.

For further details see the Health Board's Advance Decision to Refuse Treatment policy and MCA Code of Practice.

Useful documents and guidance can be found on the MCA Team's SharePoint pages: Advance Decisions, Lasting Powers of Attorney (LPA) and Court Appointed Deputies

7.11. Assessment of Capacity – General points

You are responsible for assessing a person's mental capacity in respect of any decision you are asking them to make, such as consent to treatment or care interventions.

For complex or serious decisions or when the person's presentation is complex, you may ask others with specific expert knowledge to advise in relation to an assessment of capacity, although the final determination of capacity is for you to make.

You must consider the need to assess a person's capacity whenever a decision needs to be made and you have reason to doubt their ability to make this decision. Doubt may arise because:

- The person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision.
- Somebody else says they are concerned about the person's capacity.
- The person has been previously diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.
- Someone repeatedly makes unwise decisions that put them at significant risk of harm.
- Someone makes unwise decisions that are new and out of character.

The following is a non-exhaustive list of decisions or situations where you must assess and record a person's mental capacity if their decision-making is in doubt:

- at any clinical consultation in respect of care or treatment;

- on admission to hospital in respect of consent to admission and proposed treatment;
- on admission, in relation to the nursing needs assessment and care plan;
- whenever there is a significant change in the person's cognitive functioning;
- for any subsequent significant decision, such as additional or change in treatment;
- the provision of treatment or care in the community;
- whenever a patient disengages or is non-compliant with care or treatment;
- issues arising from a lack of mental capacity for decisions relating to day-to-day care interventions, including administration of regular medication, personal care, food and you must be aware of changes in the person's functioning and presentation that suggest that they may have re-gained mental capacity and reassess mental capacity whenever there is a change in the person's cognitive functioning.

Some individuals, for example those in the early stages of dementia, are able to retain information for a limited period only. This does not prevent them from being regarded as able to make the decision, even though they may forget having made a decision later. You should consider ways in which they can be reminded of decisions they have made.

When assessing a person's capacity, you should approach this as any clinical consultation, during which you try to understand how the person makes a decision, the difficulties they are having and help them to overcome those difficulties, concluding in a determination as to whether they have or don't have capacity for that decision.

7.12. The Test of Capacity

MCA Section 2:

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

Before assessing a person's capacity, the decision that needs to be made must be clearly formulated and the options identified, to ensure that the person is given the information that is relevant to that decision, is supported to make the decision themselves as far as possible and that their capacity is assessed in relation to the specific decision.

If a person's mental state is changeable, capacity should be assessed at a time when they are most likely to have capacity.

There are three elements to the test for capacity:

1) Functional Test: Are they unable to make a decision?

A person will be unable to make a decision if they are unable to do **any one** of the following:

- **understand** the information relevant to the decision, the reason it needs to be made, the options and consequences including the consequences of not making a decision at all;
- **remember** that information long enough to make a decision;
- **use or weigh** that information as part of the process of making a decision, or
- **communicate** that decision, by talking, sign language or any other means.

2) Diagnostic Test: Does the person have an impairment of, or disturbance in the functioning of, the mind or brain (cognitive impairment)?

This impairment can be temporary or permanent and can result from a number of conditions such as:

- dementia;
- mental illness;
- learning disabilities;
- brain injuries including stroke;
- physical or medical conditions such as infection causing delirium;
- the effect of alcohol, prescribed and illegal drugs.

The impairment or disturbance does not need to be 'formally diagnosed', you just need to have reasonable belief that one is present and be able to evidence why you think this is the case.

3) Is the inability to make a decision caused by the cognitive impairment?

For the MCA to apply, the inability to make a decision must be **caused** by the mental impairment, not by other factors such as indecision, vulnerability or undue influence.

7.13. Vulnerable Adults and Capacity

A person with or without a mental impairment may be unable to make a decision for other reasons, for example, because they feel overwhelmed by the situation. If this is the case, the person must be supported to make a decision and cannot be deemed to lack the mental capacity to make decisions.

A valid decision must be made free from undue influence as well as with mental capacity. A person with a cognitive impairment may be particularly vulnerable to undue influence, by others, including professionals, which would make any decision invalid.

You must consider what steps you can take to promote a person's decision making, including considering the effect of your and other's influence and the person's social

situation. This is particularly important where vulnerable adults may be in abusive relationships.

If concerns that a person is subject to undue influence cannot be resolved, you must refer the matter to Adult Safeguarding.

7.14. Recording assessments of capacity

In recording your assessment of capacity, you must take a proportionate approach. The level of detail to be recorded will depend on the type and seriousness of the decision, the role and qualifications of the decision maker and the urgency of making the decision.

To benefit from the protection from liability provided by Section 5 of the MCA you must record sufficient evidence to support a reasonable belief that the person lacked mental capacity.

The evidence should include:

- the decision and why it needs to be made;
- the relevant information that you have given the person, including the options and consequences;
- the help you have provided to them to make a decision;
- your decision 'on balance' as to whether they do, or do not, have the capacity to make this decision the evidence that they are able, or unable to make a decision;
- the evidence of the mental impairment and how it causes the inability to make the decision. See Appendix A for UHB form.

7.15. Making a Best Interests Decision

Once you have concluded that a person lacks the mental capacity to make a decision you must first check for the presence of a valid and applicable ADRT, LPA or Court Appointed Deputy. (Figure 2).

If the person has made an ADRT that is valid and applicable to the current decision for which they lack capacity, then this must be followed.

In any other circumstance if the person has appointed an LPA or Deputy that is valid and applicable to the current decision, then they will act as the decision maker.

If none of the above are in place, the clinician responsible for carrying out the act or intervention will be the decision maker.

The **'Best Interests' Checklist** for decision makers set out in Section 4 of the Act requires you to:

- **Avoid discrimination:** Your decision about the person's best interests must be based on assessment, consultation and the establishment of information about them and their circumstances, not on assumptions about their age, appearance, condition or behaviour, although all of these will be relevant considerations.
- **Encourage participation:** do whatever you can to support and encourage the person to take part in making the decision.
- **Consider all relevant circumstances relating to the decision:** the decision that needs to be made, why it needs to be made, what the options are, the outcomes, risks and benefits of each option, the impact it will have on the person etc.

You must also:

- **Consider the person's views:** their past and present wishes, values and beliefs and how these would influence their decision if they were able to make it.
- **Consult others** including anyone named by the person, anyone involved in their care or interested in their welfare, including family and friends and anyone with a Lasting Power of Attorney or Deputyship.
- **Assess whether the person may regain capacity:** can you delay the decision to enable the person to make their own decision?
- **Less restriction:** Any interference with the person's freedom of choice must be kept to a minimum consistent with achieving what is in their best interests

The avoidance of pre-conceived ideas is particularly important for decisions that involve the provision or withdrawal of life sustaining treatment, when your decision must not be based on your own views about the person's quality of life before treatment is given.

7.16. Consultation

In making a best interests decision you must consult in a "practical and appropriate" manner to the particular decision being considered. The more significant and complex the decision, the more formal and wide ranging the consultation process should be.

The following people must be included in a best interests consultation:

- Anyone named by the person lacking capacity as someone to be consulted;
- Anyone engaged in caring for the person or interested in their welfare;
- Any attorney appointed under a Lasting Power of Attorney;
- Any deputy appointed by the Court of Protection;
- An Independent Mental Capacity Advocate if the decision is about serious medical treatment or a change of residence and the person lacking capacity is unbefriended.

7.17. Best Interests Meetings:

If your consultation establishes that there is a clear consensus as to what is in the person's best interests, you do not need to arrange a best interest meeting. However, it is deemed best practice to arrange a meeting when there is a range of different views or any uncertainty or disagreement about what is in the person's best interests. The outcome of the meeting must be clearly recorded in all relevant documentation. You must consider whether it is appropriate to invite the person to this meeting or whether they should be represented by an advocate (for example an IMCA). All consultees listed above must be invited.

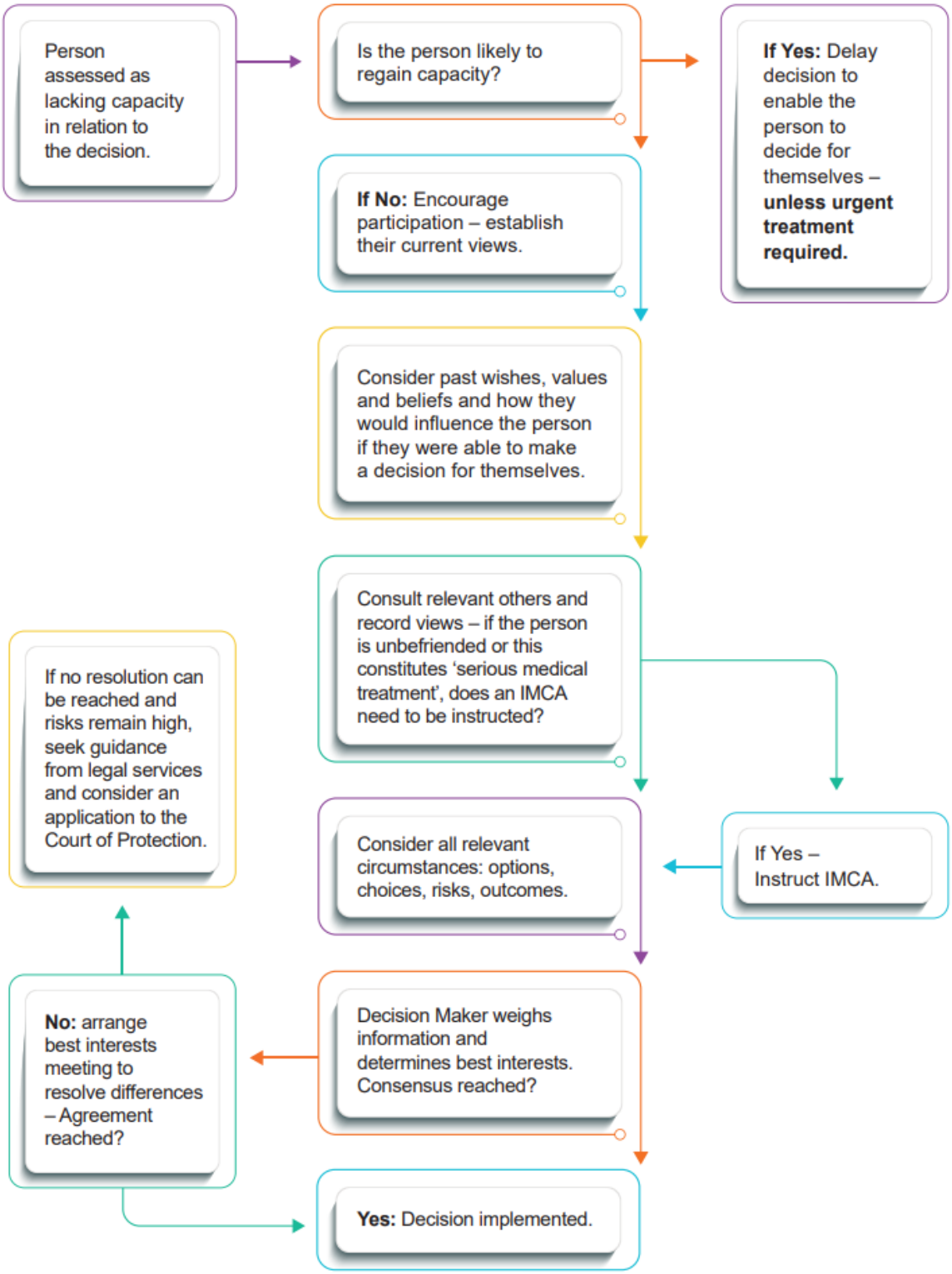
7.18. Recording a Best Interests Decision:

You must record the best interests decision making process and consultation, including any conflicting opinions in relation to any major decision or decision with potentially serious or significant consequences on the Best Interests Form. This form is also available

In an emergency it will almost always be in the person's best interests to give urgent treatment without delay, unless you are aware of a contrary ADRT.

If disagreements remain about what is in a person's best interests after consultation and these cannot be resolved you will have to make an interim decision and seek legal advice on referring the matter to the Court of Protection.

Figure 2: Best Interests Flowchart



7.19. Protection from Liability for Acts in Connection with Care and Treatment

Protection from liability: When making a decision or carrying out an act which could give rise to charges of assault or interference with the person, you will be protected from liability under Section 5 of the Mental Capacity Act provided you can evidence that you have:

- assessed whether the person has mental capacity in relation to the decision or action;
- a reasonable belief that the person lacks mental capacity, **and**
- acted in the person's best interests.

Resources are available on the MCA Team Sharepoint which are designed to help you record the required evidence to support the above.

However, see Sections 7.20 of this policy in relation to additional requirements should an action involve restraint.

7.20. Care and Treatment of Mental Disorder

The Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA) have different purposes. The MCA has a broad scope and provides a legal framework for decision-making which applies in many situations where adults are unable to make decisions and act for themselves. The MHA provides a much narrower legal authority for the admission to hospital and treatment (where appropriate without consent) of people with a mental disorder because of the risk to their health, to their safety or the safety of others.

People detained under the MHA can be treated without consent, without reference to mental capacity and such decisions are specifically excluded from the scope of the MCA. The procedural safeguards in Part IV of the MHA must be followed when treating people who are detained under the MHA.

The Mental Health Act 1983 only deals with treatment "for mental disorder". However, a person detained under the Mental Health Act may lack capacity in relation to some other form of medical treatment or some other issues. The MCA will apply to all decisions that are not the treatment and care of a mental disorder.

In some limited instances a person may be detained for treatment of mental disorder in hospital under the MCA/DoLS: the person must lack mental capacity and not be objecting to the admission and/or all or part of the treatment. Whether a person is 'objecting' must be considered in the round, including their behaviour, wishes, beliefs and values, both past and present, not just on verbally expressed objections. If in doubt, clinicians should assume the person is objecting (MHA Code of Practice 13.51/14.20).

Chapters 13 & 14 of the Code of Practice to the MHA (DH, 2015) contain detailed guidance for practitioners on the appropriate use of MHA and MCA, in relation to people who have a mental disorder (including the use of guardianship) and are assessed to lack capacity. Practitioners are recommended to refer to the Code for guidance on individual cases.

Table 2: Mental Health Act or Mental Capacity Act?

	MENTAL CAPACITY ACT 2005	MENTAL HEALTH ACT 1983
AGE	Must be over 16 years old For LPA, Advance Decisions and DoLS, over 18 years old	No age limits (except for Guardianship: over 16 years old)
CAPACITY	Applies only to those who lack capacity as defined by the Standard Test – although can plan ahead for loss of capacity.	Does not require lack of capacity.
BEST INTERESTS	Decisions must be made in the best interests of the incapacitated person. Protection of others is not part of best interests	Detention in hospital on the grounds of the person's health, safety or for the protection of others.
MEDICAL TREATMENT	Treatment decisions made in person's best interests (except for excluded decisions).	Treatment for mental disorder only – governed by Part IV of the Act.
RESTRICTION OF LIBERTY	Allows care and treatment including restraint when necessary to protect the person from harm, proportionate and not a deprivation of liberty. Deprivation of Liberty can be authorised using DoLS.	Broad range of compulsory powers to detain and treat without consent and in the face of resistance. Least restriction principle must be applied.
ADVANCE DECISIONS	Advance decisions that are "valid and applicable" are legally binding.	Part IV powers allow advance decisions to be overridden (NB except ECT).
POWERS OF ATTORNEY	LPA can make proxy decisions.	LPA have no authority over treatment of detained persons
SAFEGUARDS	No formal safeguards. Requires consultation with relatives, carers and IMCAs. DoLS has some safeguards (Personal Representative). Can apply to Court of Protection in disputed cases.	Formal independent appeals procedures (MHRT & Hospital Managers). Second Opinion Appointed Doctors.

7.21. The Use of Restraint

The MCA defines restraint as the;

- use of force or threat to use force, to make someone do something they are resisting, or
- restriction of a person's freedom of movement, whether they are resisting or not, including the use of sedating medication.

Acts of restraint can range from prompts and gentle verbal persuasion to physical force (hands-on and / or mechanical restraint) and medication (sedation).

Objections to particular actions can take many different forms, from physical resistance to verbal objections, passive resistance and other non-verbal responses. Clear communication and sensitive responses from the member of staff may still enable appropriate care to be given.

The effect of not providing the particular intervention will vary with the nature of the care or treatment. In some circumstances (e.g. cleaning or washing), the effect will be gradual and/or restricted to reducing the person's quality of life. In other situations, the refusal will have a faster and more drastic effect (such as declining food, drink or medication).

Whenever an incapacitated person is refusing or resisting care or treatment, and specific risks to their health or welfare are identified, discussions must be held with senior staff to consider how to ensure the appropriate care is delivered.

The protection from liability under section 5 (see 7.11) extends to the use of restraint, provided the following conditions are met:

- the person has been judged as lacking capacity to agree to the restraint and the restraint is in the person's best interests;
- restraint is necessary to prevent harm to the person being restrained; and
- the force used is proportionate to the likelihood and seriousness of the harm being prevented. *MCA 2005, Section 6*

Ultimately a balance has to be struck between a number of competing rights and duties, such as the person's civil liberties and staff's duty of care, with the key factor being the protection and enhancement of the vulnerable person's dignity.

Please see the UHB policy 'Restraint in the Care Management of Patients Aged 16 Years and Over with Impaired Mental Capacity' available on SharePoint.

7.22. Restriction of Movement and Deprivation of Liberty

Section 6 of the MCA permits restriction of movement that does not amount to a deprivation of liberty. Restrictions amounting to a deprivation of liberty requires a formal legal authorisation process (Mental Health Act, MCA Deprivation of Liberty Safeguards (DoLS) or Court Order).

This only applies to people over 18 who are in a hospital or living in a registered care home. If the inpatient is 16 -17 years old or resident in any other setting but you believe that they are being deprived of their liberty seek legal advice.

A *restriction of movement* (restraint) will become a *deprivation of liberty* when the restraint results in the person being ***"under continuous supervision and control and not free to leave".***

See guidance on DOLS Sharepoint:
Deprivation of Liberty Safeguards (DoLS) - Home (sharepoint.com)

7.23. Avoiding Deprivation of Liberty

Principle 5 of the MCA requires that any best interests intervention should involve no more interference with the person's freedoms than is necessary. The following elements of good practice will assist in avoiding 'deprivation of liberty':

- ensuring that decisions are taken, reviewed and recorded in a structured way, including a proper assessment of the person's capacity to consent to the proposed care;
- appropriate and documented involvement of the person, family, friends, carers and others interested in their welfare;
- ensuring that alternatives to admission to hospital or residential care are considered;
- ensuring that any restrictions placed on the person while in hospital or residential care are kept to the minimum necessary – meeting needs effectively and enhancing opportunities for choice and activity will often reduce the need for restraint;
- ensuring appropriate information is given to the person themselves and to family, friends and carers, including information about the purpose and reasons for the person's admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (e.g. through the relevant complaints procedure);
- ensuring both the assessment of capacity and the care plan are kept under regular review. It may well be helpful to include an independent element in the review, such as second opinion. This will be particularly important where family members, carers or friends do not agree with the authority's decisions.

7.24. Criminal Offence

Under the MCA it is a criminal offence to ill-treat or wilfully neglect a person who lacks capacity. The offence may apply to:

- anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff;
- an attorney appointed under an LPA or an EPA;
- a deputy appointed for the person by the court.

To be guilty of ill-treatment the ill-treatment must have been deliberate or reckless and the perpetrator must have known, or should have known, that the person lacked capacity. Neglect usually means the person deliberately failed to carry out an act they had a duty to do.

Penalties range from a fine to up to 5 years imprisonment.

If there is an indication of the above then please seek further advice from the MCA Team in the first instance.

7.25. Independent Mental Capacity Advocates (IMCAs)

The purpose of the IMCA service is to support particularly vulnerable person who lack the capacity to make certain far-reaching decisions. It is available to those people who have no family or friends with whom it would be appropriate to consult about those decisions.

In cases where a person who lacks capacity does not have friends or relatives to consult, you must consult an IMCA where the decision is about:

- serious medical treatment;
- a long-term change in accommodation arranged by the NHS or a local authority
- a care plan under All Wales Safeguarding Procedures
- a proposed deprivation of liberty under DoLS.

Serious medical treatment is defined as treatment that involves giving new treatment, stopping treatment that has already been started, or withholding treatment that could be offered in circumstances where:

- there is a fine balance between the likely benefits and the burdens to the person and the risks involved; or
- a decision between a choice of treatments is finely balanced; or
- what is proposed is likely to have serious consequences for the person.

If the treatment is urgent, you do not need to instruct an IMCA.

A long-term change of accommodation is defined as being for more than 28 days in hospital or more than 8 weeks in a care home. If the arrangements need to be made as a matter of urgency the move can proceed before an IMCA is instructed. However, if the person is then expected to be more than 28 days in hospital or 8 weeks in a care home or its equivalent then an IMCA must be instructed as soon as possible after the move.

When protective measures are being put in place to protect a vulnerable adult from abuse, an IMCA should be instructed even if there are friends or family members to consult. An IMCA must be instructed in the following situations:

- There is a reasonable belief that it is inappropriate to consult family or friends because they may not have the person ‘s best interests at heart;
- The proposed protection plan involves a serious life-changing decision or a serious exposure to risk which should not be agreed without consulting an independent advocate;
- The decision that the responsible body needs to make involves a potential conflict of interests between the responsible body and the vulnerable person and/or their family.

Once an IMCA has been instructed and until a best interests decision is taken, the decision maker must follow the Act’s five principles in relation to that decision-making process. NHS bodies and LAs must take into account any information given, or submissions made, by the IMCA. Any decision taken before proceeding with serious medical treatment or a move must also be made in the person’s best interests.

IMCAs have the following powers to enable them to carry out their role:

- to see the person concerned in private;
- to examine and take copies of any records that are relevant to the decision; however, they must apply to see records using the appropriate form: Independent Mental Capacity Advocate (IMCA) - AS Cymru

Details of the locally commissioned IMCA service can be found on the Health Board’s MCA/DoLS Intranet pages (IMCA Procedure.pdf (SharePoint.com).

8. OBTAINING LEGAL ADVICE

If you need advice about a mental capacity issue and/or you think a court application may be required, you should in the first instance contact your line manager.

Guidance on how to access legal advice can be found here.

9. CONSULTATION

The draft policy has been made available on the Health Board SharePoint site and comments invited via the Health Board e-Bulletin. It has been reviewed by the following committees prior to approval:

- Health Board Dementia Steering Group
- Health Board Safeguarding Steering Group
- Editorial Panel via Patient Experience
- MCA Focus Group
- Mental Health Legislation and Mental Capacity Act Committee

10. TRAINING

This Mental Capacity Act Policy has a mandatory training requirement which is detailed in the Health Boards mandatory training matrix and is reviewed on a yearly basis.

This policy will be cascaded via senior staff / team leaders in all areas and highlighted in all MCA Training.

MCA training is available to all staff, including;

- E-learning modules on ESR (MCA Level 1 + 2 and DoLS).
- Face to Face sessions offered for Level 2 MCA and DoLS
- Additional sessions devised by the MCA team for specialist training.

Training can be delivered to individual teams and departments – contact the MCA Team to discuss training requirements.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

Implementation of the MCA and DoLS is subject to a number of key performance indicators monitored quarterly and reported to the Mental Health Legislation and Mental Capacity Act Committee:

- Compliance with Mandatory Training requirements.
- Collation and monitoring of feedback from face to face training sessions.
- Annual Audit of Medical and Nursing records in relation to MCA and DoLS.

12. LINKS TO USEFUL TEMPLATES AND OTHER ORGANISATIONAL DOCUMENTS

Please note the latest templates for documenting assessments of mental capacity and making best interest decisions can be found on the 'Forms' section of the MCA Team SharePoint page.

All Wales DNACPR policy – "Sharing and Involving" A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults (18+) in Wales

Consent to Examination and Treatment Policy

Lasting Power of Attorney and Court Appointed Deputy Procedure

Information Governance Policy

All Wales Safeguarding Procedures

Restraint in Care Management of Patients Aged 16 Years and Over with Impaired Mental Capacity Policy and Procedure

13. REFERENCES

American Psychology Society 2018 [Accessed online 29.12.23] APA Dictionary of Psychology

Department of Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice

Department of Constitutional Affairs (2009) Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice

Department of Health (2015) Code of Practice to the Mental Health Act

Jones, R. (2018) Mental Capacity Act Manual. (8th Edition)

Letts, P. (ed) (2010) Assessment of Capacity – A Practical Guide for Doctors and Lawyers. British Medical Association and the Law Society

Office of the Public Guardian (2009) Mental Capacity Act Booklets:

- OPG601 Making Decisions about your health, welfare or finances. Who decides when you can't?
- OPG602 Making Decisions – A guide for family, friends and other unpaid carers.
- OPG603 Making Decisions – A guide for people who work in health and social care.
- OPG604 Making Decisions – A guide for advice workers.
- OPG605 Making Decisions – An easy read guide.
- OPG606 Making Decisions – The IMCA service.
- OPG607 Deprivation of Liberty Safeguards – A guide for primary care Health Boards and Local Authorities
- OPG608 Deprivation of Liberty safeguards – A guide for hospitals and care homes
- OPG609 Deprivation of Liberty Safeguards – A guide for relevant person's representatives

SAMPLE Model of cognition, referenced in Swansea University Masters Course 2023

Useful Links

Mental Capacity Act 2005 (sharepoint.com)

Consent (sharepoint.com)

Deprivation of Liberty Safeguards (sharepoint.com)

Accessing legal advice - CAV UHB

APPENDIX A IMCA Referral Form

SOUTH EAST WALES IMCA REFERRAL FORM

Please return completed form to :
Advocacy Support Cymru, Charterhouse 1, Links Business Park, Fortran Road,
St Mellons, Cardiff CF3 0LT

029 2054 0444 029 2073 5620 info@ascymru.org.uk

Advocacy Support Cymru
Empowering People to Speak Out

Reason For Referral (please only tick one box per form)	
Serious medical treatment [ ] **Safeguarding Vulnerable Adults [ ]** **Move of accommodation [ ]** **Care Review:** New **[ ]** Monitoring **[ ]**	**Deprivation of Liberty Safeguards (DoLs)** 39A **[ ]** 39C **[ ]** 39D **[ ]** **Relevant Person Representative (RPR)** ` Relevant Person **[ ]** Relevant Persons representative **[ ]** Relevant Persons and Relevant Persons Representative **[ ]**

Are there any family/friends? Yes [ ] No [ ] Have they been informed that an IMCA has been instructed? Yes [ ] No [ ]	Are they available/appropriate to consult with Yes [ ] No [ ]
Why are they not appropriate to consult with:	

Do you consider the person to lack capacity?	Yes [ ] No [ ]
Has a capacity assessment been completed?	Yes [ ] No [ ]
Date of Assessment:	Name of Assessor: .....
Is the person's capacity likely to change?	Yes [ ] No [ ]

CLIENT NAME	Male [ ] Female [ ] Date of Birth:
Current Address (where client is now)	Home Address

Postcode	Tel	Postcode	Tel

REFERRER	
Name:	Position:
Organisation:	
NHS Request [ ]	
Local Authority Request [ ]	Email:
Telephone number for confirmation of receipt of referral:	

DECISION MAKER (if not the referrer)	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

CONTACT PERSON FOR ACCESS TO RECORDS	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

Is the client in:

Hospital [ ] Name of Hospital ..... Ward .....

Independent Hospital [ ] Name of Hospital ..... Ward .....

Residential Home [ ] Nursing Home [ ] EMI Residential Home [ ] EMI Nursing Home [ ]

Supportive Living [ ] Care Home [ ] Own Home [ ]

Other: .....

Are there any risk issues that the IMCA should be aware of (e.g. risk to lone worker, infection control etc) ?

Client Group

Mental Health [ ] Learning Disability [ ] Older People [ ]

PSNI (Physical sensory neurological impairment) [ ] SPI (Serious/severe physical illness) [ ]

ASD (Autistic Spectrum Disorder) [ ] Dementia [ ] Combination [ ]
Brain Injury [ ] Cognitive Impairment [ ]

Other: .....

What is their primary communication method? (please tick the most appropriate box)

English [ ] Welsh [ ] Other spoken language [ ] No obvious means of communication [ ]
Words/Pictures/Makaton [ ] Gestures/vocalisations/facial expressions [ ] Sign language (e.g. BSL) [ ]
Sign Supported Makaton [ ]
▪
Other: .....

Ethnicity

White British [ ] White Irish [ ] White (other) [ ] Chinese [ ] Caribbean [ ]

Black African [ ] Black (other) [ ] Bangladeshi [ ] Indian [ ] Pakistani [ ]

Asian (other) [ ] Mixed Race [ ] Other: .....

Known religious/cultural beliefs

Additional Contacts – Relevant people to obtain information from.
Other people involved e.g. friends, family, LPA (Lasting Power of Attorney), GP, care home staff, lead nurse who may be able to indicate the wishes of the person being referred.

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Case overview:

Is there a date by which the decision must be made? YES [ ] NO [ ]

If 'YES', what is the date .....

Is there a deadline for a course of action? (Best interest or MDT meeting outcome) YES [ ] NO [ ]

If 'YES', what is the date, time and venue?

Is there a deadline for the required report? YES [ ] NO [ ]

If 'YES', what is the deadline date?

Has Serious Medical Treatment in an emergency already been carried out? YES [ ] NO [ ]

Details

I confirm that the IMCA has permission to access appropriate medical/social care records

I confirm that I am the Decision Maker/Person appointed by the Decision Maker on behalf of:

NHS body or local authority .....

Name (print) .....

Signature ..... Date .....

For decisions regarding (Client name) _____

GIG CYMRU NHS WALES

For any **MCA related queries** contact the MCA Team at **mca-lps.cav@wales.nhs.uk**

PRESUMPTION OF CAPACITY

SUPPORT TO MAKE DECISIONS

UNWISE DECISIONS

BEST INTERESTS

LESS RESTRICTIVE INTERVENTION

GIVE ME FIVE

Reference Number: Version Number: 1	Date of Next Review: Previous Trust/LHB Reference Number: N/A

Cardiff and Vale UHB Mental Capacity Act (MCA) Policy

Policy Statement

To ensure that Cardiff and Vale UHB (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The UHB is committed to ensuring that adult patients are supported to make decisions and where they are found to have impaired mental capacity the appropriate process is followed, in accordance with the Mental Capacity Act 2005.

Policy Commitment

The UHB is committed to working with patients, their families and partner organisations to support the robust assessment of capacity, if there is doubt in relation to patient's capacity to participate , consent and make decisions in relation to their care and care planning whilst in hospital .

To ensure the UHB delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will work in tandem with Social Care colleagues, and take all reasonable and practicable steps to provide individuals with a robust mental capacity assessment to ensure their safety and rights are upheld.

To ensure this commitment is met the UHB will ensure that these core principles are implemented :

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Supporting Procedures and Written Control Documents

This policy and the supporting procedures describe the following with regard to supporting adults with impaired capacity to make decisions.

- The process to follow when there are doubts regarding a person's ability to make decisions, including relevant documentation.
- Who to consult when decisions need to be made for a person who lacks mental capacity to decide
- When to consider the Deprivation of Liberties Safeguards (DoLS)

Relevant legislation and guidance to read alongside this policy include:

- Social Services and Wellbeing (Wales) Act 2014
- Mental Capacity Act 2005
- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Deprivation of Liberty Safeguards 2009
- The All Wales Safeguarding Procedures for Children and Adults at Risk or abuse and Neglect 2020.
- Domestic Abuse (Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015).

Other supporting documents are:

- Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, TSO London
- Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice HMSO (2005)
- Mental Capacity Act 2005, HMSO London
- Cardiff and Vale UHB, Consent to Examination or Treatment Policy, UHB 100
- Consent to Examination or Treatment Under the Mental Health Act 1983 (UHB 491)
- Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 186
- Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and procedure UHB 044
- Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005) UHB 113
- Research Consent and Capacity: Standard Operating Procedure, UHB 147
- Accessing Legal Advice Procedure UHB 469
- Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and Procedure (UHB 044)
- Jones, R. (2018) *Mental Capacity Act Manual* (8th Edition)

Scope

This policy applies to all staff working for Cardiff and Vale University Health Board in all locations including those with honorary contracts.

Equality and health impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a positive impact. Key actions have been identified and incorporated within this policy/supporting procedure.
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Quality, Safety and Experience Committee
Accountable Executive or Clinical Board Director	Executive Director of Nursing

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.

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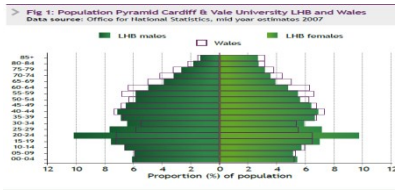
Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1			

Equality & Health Impact Assessment for

Mental Capacity Act Assessment

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Director of Nursing Rebecca Aylward Deputy Executive Director of Nursing Rebecca.Aylward@wales.nhs.uk MCA Team Lead Chloe Evans MCA Project Lead Chloe.Evans@wales.nhs.uk

3.	Objectives of strategy/ policy	To identify the **key principles** of assessment of mental capacity and understand the links with other policies and how they impact upon the assessment process • To provide a **standard framework** for staff to work within when considering assessment of patient's capacity whilst in hospital setting • To **clarify roles and responsibilities** of key staff associated with the assessment process • To promote a **coordinated multidisciplinary team approach** to assessment and subsequent care planning • To promote a **positive patient experience** by ensuring that patients receive the right care at the right time in the right place • Support **good communication** between clinical teams across the health community, patients and their families/carers / representatives and advocates

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively  The UHB's usual arrangement with regard to consultation was followed (i.e. 28 days on the intranet). All comments were considered and policy altered accordingly .Colleagues within Cardiff & Vale LA Social Services made extensive comments to numerous draft versions of policy. **A part of good practice, other policies from different organisations were considered.**

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf

	UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	• **Social Services and Wellbeing (Wales) Act 2014** • **Mental Capacity Act 2005** • **Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice** • **Mental Health Act 1983** • **Department of Health (2015) Code of Practice to the Mental Health Act**
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff involved at any stage in the process of safe, effective assessment including those who hold honorary contracts. There will be an impact on patients their carers as well as local authorities and partner agencies when planning care based on the outcome of the assessment.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age Suggest positive impact to have policy that provides a standard framework for the assessment of capacity across the UHB for anyone over the age of 16.	N/A	Quality ,Safety and Experience Committee Mental Health Legislation Management group Executive Director of Nursing Corporate Safeguarding Team

6.2 Persons with a disability as defined in the Equality Act 2010	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy has been made accessible to staff in both electronic and paper copy. Patients may have disabilities and their individual needs will be considered as part of the same assessment process within the framework of the policy	N/A	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where	N/A	

through any medical procedures. Sometimes referred to as Trans or Transgender	applied cause an adverse impact against any group of individuals in respect of gender. patients assessed will have their individual needs considered as part of the same capacity assessment process within the framework of the policy, irrespective of their gender		
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of	N/A	

	individuals in respect of sexual orientation. patients assessed will have their individual needs considered as part of the same assessment of capacity process within the framework of the policy, irrespective of whether married or civil partners		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact. patients assessed will have their individual needs considered as part of the same capacity assessment process within the framework of the policy,	N/A	

6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. All UHB patients must be treated in compliance with the law, regardless of their race.	N/A	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Whether patients have a religious faith or not, they cannot be treated without their consent, or outwith the Mental Capacity Act 2005 or the Mental Health Act 1983. The law is clear that people who have the mental capacity to do so, may refuse any treatment on any grounds, including religious beliefs, or for no clear reason. The Policy, in setting out the law, may have a positive impact.	N/A	

6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No evidence. All UHB patients must be treated in compliance with the law, regardless of their sexual orientation.		

6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	All UHB patients must be treated in compliance with the law, regardless of their being Welsh speakers or speakers of any other language. Bilingual patient information leaflets are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards. The	The policy prompts staff to ask patients which language the patient/service users would like to communicate in, either English or Welsh	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No evidence. All UHB patients must be treated in compliance with the law, regardless of their income.	N/A	

6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact in relation to this policy Policy is relevant to Cardiff and Vale residents but is also applied to residents from other areas who are currently in UHB beds	N/A	
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	People who speak other languages other than Welsh or English will be impacted positively as the policy refers to issues of language accessibility. There are no other groups including Carers or risk factors to take into account with regard to this Policy.	N/A	

7.HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No impact in relation to this policy		Policy put out for consultation within the organisation and ratified by ?

7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	No impact in relation to this policy		
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No impact in relation to this policy		

7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	For this policy, there will be no impact.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	For some individuals there may be positive impact on socialisation as a result of needs-based assessment		

7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No impact in relation to this policy		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	On reviewing the policy and writing the latest version, improvements have been made in people who communicate using the Welsh language, people with a religion or belief or with no religion or belief. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy. All assessments should be undertaken according to each person's individual circumstances

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	On reviewing the policy and writing the latest version, improvements have been made in people who communicate using the Welsh language, people with a religion or belief or with no religion or belief. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.		N/A	Action in accordance with UHB Employment Policies and Procedures.

8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified, it is unnecessary to undertake a more detailed assessment.		N/A	

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: •continues unchanged as there are no significant negative impacts •adjusts to account for the negative impacts •continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) •stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	On reviewing this policy minor positive changes have been made. The EHIA has been consulted. If there are any significant changes to the law associated with Mental Capacity Act the policy and EHIA will reviewed and revised accordingly .		This policy is to be ratified by the MHLMCA Committee. When this policy is reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	