Mental Health Legislation Committee

Tue 26 August 2025, 10:00 - 12:00

MS Teams

Agenda

10:00 - 10:05
5 min

1. Standing Items

1.1. Welcomes, Introductions & Apologies

Ceri Phillips

1.2. Declarations of Interest

Ceri Phillips

1.3. Minutes of the Meeting held on 29.04.2025

Ceri Phillips

1.3 - Draft MH Committee Minutes 29.04.2025.pdf (9 pages)

1.4. Actions from the meeting held on 29.04.2025

Ceri Phillips

1.4 - MH Committee Action Log from April 2025.pdf (2 pages)

1.5. Chair's Action taken since last meeting

Ceri Phillips

10:05 - 10:20
15 min

2. Mental Capacity Act

2.1. Mental Health Act Monitoring Exception Report

15 mins *Chloe Evans*

2.1 - MHLMCA Report Apr - Jun 2025 v2.pdf (9 pages)

10:20 - 11:10
50 min

3. Mental Health Act

3.1. Mental Health Act Monitoring Exception Report

10 mins *David Seward*

3.1.1 - Exception Report August 2025.pdf (6 pages)
3.1.2 - Mental Health Act Monitoring Report April - June 2025.pdf (37 pages)

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

5 mins *Dan Crossland*

3.3. DoLS and MHA Interface

10 mins *Dan Crossland*

3.4. Section 12 Challenges and Futureproofing

10 mins *Dan Crossland*

3.5. Board Assurance Framework – verbal update

5 mins *Matt Phillips*

3.6. Mental Health Bill Update

10 mins *Dan Crossland*

11:10 - 11:10
0 min

4. Mental Health Measure

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

15 mins *Dan Crossland / Samuel Barratt*

11:10 - 11:15
5 min

5. Items for Noting / Information

5.1. Sub-Committee Meeting Minutes:

5.1.1. Hospital Managers Power of Discharge Sub Committee Minutes

Amanda Morgan / Alex Nute

5.1.1 - PoD minutes July 2025.pdf (3 pages)

5.1.2. Mental Health Legislation and Governance Group Minutes

Julian Willett

5.1.2 - MHLGG minutes and action log July 2025.pdf (7 pages)

11:15 - 11:25
10 min

6. Items for Approval / Ratification

6.1. Policies

5 mins *Chloe Evans*

6.1.1. Court of Protection Procedure & Guidance

6.1.1 - CoP Process and Guidance Board & Committee Covering Report 2025-26.pdf (2 pages)
6.1.2 - CoP Procedure and Guidance August 2025.pdf (15 pages)

6.1.2. Memorandum of Understanding: MHA/DoLS Interface Guidance

6.1.3 - MHA-DoLS Interface Guidance Board & Committee Covering Report 2025-26.pdf (2 pages)
6.1.4 - CAV - MoU MHA-DoLS - Aug 25.pdf (22 pages)

11:25 - 11:25
0 min

7. Items for Noting and Information

Ceri Phillips

No items.

11:25 - 11:25
0 min

8. Any Other Business

Ceri Phillips

11:25 - 11:25
0 min

9. Review of the Meeting

Ceri Phillips

11:25 - 11:25
0 min

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

Ceri Phillips

21st October 2025 via MS Teams

Minutes of the Mental Health Legislation Committee
Held on 29th April 2025 via MS Teams

To view the meeting: CAVUHB Mental Health Legislation Committee 29.04.2025 - YouTube

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
In Attendance:		
Rim Al-Samsam	RAS	Clinical Board Director – Mental Health
Samuel Barratt	SB	Deputy Director of Operations Children & Women's Clinical Board
Daniel Crossland	DC	Director of Operations - Mental Health
Chloe Evans	CE	MCA & Consent Lead
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Jason Roberts	JR	Executive Director of Nursing
David Seward	DS	Mental Health Act Manager
Matt Phillips	MP	Director of Corporate Governance
Amanda Morgan	AM	Chair of the Power of Discharge Group
Radhika Oruganti	RO	Consultant Psychiatrist
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		

Item No	Agenda Item	Action
MHL 29/04/001	**Welcome & Introductions** The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHL 29/04/002	**Apologies for Absence** Apologies for Absence were noted. **The Committee Resolved that:** a) The Apologies for Absence were noted.	
MHL 29/04/003	**Declarations of Interest** *No declarations of interest were declared*.	
MHL 29/04/004	**Minutes of the Meeting held on 28th January 2025** The Minutes of the Meeting held on 28th January 2025 were received and approved. **The Committee Resolved that:** a) The minutes of the meeting held on 28.01.2025 were agreed as a true and accurate record.	

MHL 29/04/005	**Action Log from the meeting held on 28th January 2025** The Action Log was received and discussed. **The Committee Resolved that:** a) The Action Log was noted.	
MHL 29/04/006	**Committee Chair's Actions** *No Chair's Actions were taken since the last meeting.*	
MHL 29/04/007	**Any Other Urgent Business Agreed with the Chair** *No other urgent business was agreed with the Chair.*	
	Mental Health Act	
MHL 29/04/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring** 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: • MCA Team Audit 2024/25 • Mental Capacity Act Monitoring Actions (January – March 2025) • Mental Capacity IMCA Referral type • Awareness Raising / Training Sessions • Mandatory MCA Training • MCA Practitioner Led Training – 2024/25 • MCA Team Advice and Support • MCA Team Resources for Staff • Deprivation of Liberty Safeguards Monitoring Actions • Referrals and Assessments The Independent Member – General (IM-G) sought assurance that the proformas being used were effectively capturing the necessary data for both internal monitoring and auditing, whilst also serving as an informed decision-making tool for clinicians. In addition, the IM-G asked for more detail around the DoLS withdrawal rate of 274, specifically: • The number of inappropriate referrals. • Cases resolved before assessment • Cases where the DoLS expired before the assessment took place. The MCA-CL responded that the new proforma was more detailed and followed the MCA process. It prompted essential questions and included the guidance note as an appendix to help users complete it accurately. This ensured a robust capacity assessment, and it was supported by optional training on the practical application of the Act. The updated form was being finalised and would be shared at the following meeting. In terms of withdrawals, the MCA-CL responded that there was no detailed breakdown of withdrawal types. Withdrawals often occurred when patients were discharged or moved between wards. The DoLS team were working on reusing assessments for similar ward moves. Detailed breakdowns could be requested for future reports. The IM-G sought confirmation that elderly care wards were being targeted to promote the necessity of DoLS assessments, as referrals seemed more prevalent in this group.	

The MCA-CL responded that the aim was to ensure that there was a focus on patients who may lack capacity to consent to their admission. Their administrator logged issues with referrals, which were addressed with wards and used to help target training. DoLS resources would be sent to all inpatient wards to encourage discussions and improve understanding.

The Independent Member – Local Authority (IM-LA) expressed concern that there was a lack of significant overall improvement from the MCA audit. She highlighted the first recommendation for each area to develop an action plan to address concerns and asked whether this was a new requirement.

The MCA-CL responded that MCA team felt that clinical boards needed to take more direct responsibility for improving practices. The Directors of Nursing had been supportive which had led to recent improvement. Developing their own action plans would give clinical boards control and help with implementation.

The IM-LA asked how, given capacity issues, would the action plans be followed up to ensure they were effective and achieving improvements.

The MCA-CL responded that the MCA team would have oversight of the action plans to ensure they addressed the issues. An audit would be conducted in the summer, and it was hoped that areas would perform mini audits throughout the year to monitor practices.

The CC suggested that the MCA-CL report back in Q3 on how the action plans are progressing.

Regarding the Court of Protection (COP), the Clinical Board Director – Mental Health (CBD-MH) noted the reluctance from some senior decision-makers in mental health and medicine to take risky decisions, preferring to defer responsibility to the COP. The Head of Corporate Governance (HCG) sent a guidance document in January 2025 on when to go to the COP, but suggested it needed to include scenarios for borderline decisions. The lack of distribution of this guidance was causing delayed discharges and back-and-forth between senior teams and legal about going to the COP.

The Director of Corporate Governance (DCG) acknowledged the issue of risk aversion which led to decisions being delegated to the Court, even in non-mental health matters, where disciplinary teams should be making these decisions. He would address the issue with the HCG and provide feedback.

The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) suggested the inclusion of raw figures on Section 49 requests in the report to better understand the volume and origin.

The ICDPPT asked whether the MCA team were getting enough support digitally.

The MCA-CL responded with the following:

- There had been very few Section 49 requests corporately, with only around two the previous year. However, some requests may be handled within individual clinical areas without broader awareness.
- The All-Wales Group for DoLS, along with the medical illustration department, had developed digital forms to streamline the process and reduce paper use. These forms would soon be circulated and can be emailed directly to the DoLS team.

	• The forms would be shared at the following meeting, with positive feedback already received from the legal team. The CC noted that whilst the report mentioned improvement in mandatory training for medical and dental staff, the figure was still below 50%. The low compliance rate was significantly affecting the UHB's overall compliance rate and emphasised this should not be seen as an accomplishment. He asked that relevant colleagues be informed that there was still a lot more work to be done. The MCA-CL agreed and noted the issue had been raised with the Executive Medical Director (EMD) and was being addressed as part of a broader approach to all mandatory training. Compliance figures were shared monthly with clinical boards and highlighted that medical and dental staff were significantly behind other professionals. **The Committee resolved that**: a) The contents of the report were noted.	
	Mental Capacity Act	
MHL 29/04/009	**Mental Health Act Monitoring Exception Report** 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 MHA • 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 following reported during the quarter: • Two fundamentally defective reports • The use of Section 136s had decreased The Committee Vice Chair (CVC) asked about the conclusions being drawn regarding the reasons behind the observed divergence in the data presented in the first graph on Mental Health Inpatient Legal Status. The MHAM responded that often the reasons for increased detentions were unclear. The ICDPPT explained that the team was examining changes in guidance on using DoLS or the MHA, particularly for older people. There was a shift towards formally using the MHA due to changes in the DoLS criteria. The goal was to be as least restrictive as possible whilst ensuring safeguards through independent review. The CVC asked for the figures on Section 117 aftercare, as there could be a correlation between the current data and Section 117 figures. The MHAM responded that the full monitoring report showed the detention rate in the Mental Health Services for Older People (MHSOP) directorate had increased, possibly due to changes in the DoLS and MHA. Section 117 aftercare figures had also risen, but the clinical board had been reviewing out of area patients, leading to an increase in discharge rates. Financially there were more cases due to not using DoLS, but teams were	

	proactively identifying and discharging individuals who did not meet the criteria for Section 117. The IM-G asked whether the increase in detentions under the MHA could be related to seasonal issues. The Director of Operations - Mental Health (DO-MH) responded with the following: • Seasonal variation in mental health was seen mainly in Part One patients (mild to moderate), with spikes in October and March, likely due to student influxes and family challenges around holidays. • Research showed no consistent pattern in fluctuations for formal patients and Part Two patients, making it difficult to predict trends. • The RCRP initiative aimed to reduce admission rates for Section 136 cases, with additional sanctuary provisions working with the police as alternatives. • Cardiff and Vale had the highest Section 136 rates in Wales, accounting for 28% of all cases in 2023. • Current data showed a small drop in admission rates, but it was too early to definitively link this to the RCRP initiative. Monitoring would continue to observe trends. **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.	
MHL 29/04/010	**Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy** The DO-MH provided the following verbal update to the Committee: • Both strategies were expected to be launched on the same date, however Welsh Government (WG) decided to launch the Suicide and Self-Harm Prevention Strategy early to give it its own parity. • The Suicide and Self-Harm strategy emphasised six key areas: listening and learning, involving lived experiences, prevention, empowerment, support, equipping services, and responding. A distinct focus was on giving self-harm equal importance with suicide. • The Mental Health and Wellbeing Strategy was expected to launch by the end of the month. • The last local strategy meeting for the previous Suicide and Self-Harm Strategy was held recently, and implementation of the new strategy would begin soon. • A significant challenge was the lack of third-sector provision for self-harm, which would be addressed through a commissioning strategy with various partners. • A detailed briefing would be provided at the following meeting. The CVC requested an assessment of the progress and changes from the previous strategy. **The Committee resolved that:** a) The verbal update was noted.	
MHL 29/04/011	**MHA / DoLS Interface** The Consultant Psychiatrist (CP) presented the report to the Committee which discussed the interface issues between the MHA and DoLS, including the impact on patient flow, transfer requests, and Section 117 aftercare costs.	

The CBD-MH asked whether the MHA was intended solely for the assessment and treatment of mental health, not physical health. She referred to cases where the MHA was applied for physical treatment.

The CP explained that if a physical health issue arose because of a mental health condition, it could be treated under the MHA.

The CBD-MH highlighted instances where patients under the MHA, who had physical issues like diabetes, needed court intervention to make decisions about their treatment because they were not receiving mental health treatment.

The CP noted that the case law focused on determining whether a mental disorder was causing a physical health problem. If it was, treatment could be provided under the MHA. In cases of disagreement or differing opinions, the COP is consulted to decide.

The CVC highlighted the significant issue of increasing elderly patients and dementia rates, particularly in medical wards. There were strategic implications for how to best care for these patients and ensure the right staff were assigned. Additionally, she noted the need for effective care patterns to enable rapid discharge and addressed both legal and structural consideration for the medium and long term, given the changing population dynamics.

The CC noted the issue would be addressed and shared with other committees. Further work was needed to understand the full extent of the implications for the organisation.

The CP noted the case law from 2021/23 was relatively new and reached clinicians around 2024. This change highlighted the need for awareness regarding the interpretation of objections. This new legal framework would impact the number of beds and resources available.

The DO-MH highlighted three major issues for the Mental Health Clinical Board:

1. Rising CHC costs and limited CHC provision created a challenging position. It was crucial to avoid rerouting patients quickly to avoid costs and ensure patient care was appropriate. This situation could significantly impact mental health services.
2. The capacity to meet and deliver additional requirements was a concern – these included obligations under Section 117 for care and treatment planning allocations.
3. The overall system was under considerable pressure, and any additional demands would only increase this. Balancing finances, patient safety, governance, and meaningful delivery of services under new rules was a significant challenge.

The IM-G noted concern about the financial impact of patients moving from Section 2 to Section 3 under new case law. She asked if any preliminary calculations had been done to quantify the costs associated with this transition, including the implications of Section 117.

The CP responded that there were four dementia wards, each with 14-15 beds. Patients admitted for mental disorder assessment and treatment were typically under Section 2, which lasted 28 days. The first 2-3 weeks were used for assessment, after which decisions were made about moving to Section 3 or 4. With the new standard DoLS authorisation, most patients would likely move to Section 3 unless they became compliant and non-objecting. The exact numbers were not available, but the impact was expected to be significant.

	The DO-MH explained it was more of a process change which involved deciding whether patients should follow the DoLS or the MHA route. Key metrics to monitor included the detention rate and Section 117 activity, particularly in care homes. Data would be gathered to understand the impact of more patients transitioning to Section 3 and the associated costs. Monitoring these metrics would help assess the overall impact and facilitate discussions. The CC suggested bringing this back to a future committee for discussion. The DO-MH responded that the CHC data was gathered monthly and could be easily accessed. Whilst diagnostic data wasn't available, age ranges could be used as a rough tool to capture the mental health services for older people, though it may miss early-onset dementia cases under 65. Data from the 65+ cohort would be examined for changes and included in the exception report. The ICDPPT noted that in the previous MHLAGG meeting, the graphs showing detained and undetained patients by service area was discussed and provided valuable insights into age demographics. It was agreed this analysis would be done more routinely going forward. The ICDPPT acknowledged the anxiety around the issue but noted that the UK Government was reforming the MHA, and there may be amendments to the DoLS process during this process. This could lead to a more optimistic future in the medium term. The CC asked for an update at a future committee meeting on the potential impact of the new case law for DoLS and MHA. The IM-LA asked for more information on the following: 1. The process for timely dissemination of case law implications to the UHB. 2. The effectiveness of the COP given the timescales and potential pressure on patients and resources. 3. On national level discussions regarding the issue's impact. The DCG explained the reliance on professional networks and sectors to disseminate information, rather than a comprehensive legal system, and suggested that he would consult with Legal and Risk departments to understand if relevant updates were being communicated to the appropriate teams. The DO-MH noted that legal updates often percolated through UHBs and Local Authorities (LAs) rather than being formally communicated. Monthly meetings with LA colleagues helped share significant legal changes. Sometimes, direct instructions came from WG. The DO-MH suggested raising this issue with the NHS Executives. **The Committee resolved that:** a. The contents of the report was noted.	
	Mental Health Measure	
MHL 29/04/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** The DO-MH and the Deputy Director of Operations Children & Women's Clinical Board	

	(DDOCWCB) 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 CVC highlighted the level of need in Part 1a. She suggested reviewing commissioning arrangements and considering whether assessments could be conducted closer to primary care or within the community. Additionally, she requested the volume of people applying for self-referral assessments rather than percentages. The DO-MH responded that the plan was to invest more into the 111 Press 2 national helpline to provide rapid access to mental health services, aiming to reduce demand on other services. Whilst Part 1 assessment provisions were satisfactory and successful, CAV were experiencing an unusual rise in referrals, unlike other areas in Wales. This increase may require additional investment. The DO-MH suggested providing a breakdown of the Part 3 figures for the following meeting. The CC asked whether there was any intelligence surrounding why CAV were experiencing the increased demand compared to the rest of Wales. The DO-MH responded with the following: • There weren't specific reasons identified for the rise in referrals, though structural changes in the primary care liaison service may have contributed. • Socioeconomic factors such as benefits, finances, and community connections were likely to influence the increase. • The focus on future commissioning work would be on addressing these socioeconomic challenges, allowing services to concentrate more on care and treatment. • Further detail would be sought from discussions with stakeholders across Cardiff. **The Committee Resolved that:** a) The contents of the report was noted.	
	Items to bring to the attention of the Committee for Noting / Information	
MHL 29/04/013	**Sub-Committee Meeting Minutes:** Hospital Managers Power of Discharge Sub-Committee Minutes – 8th April 2025 The Chair of the Power of Discharge Group (CPDG) took the minutes as read, and highlighted that the MCA and Dols Interface and split decision issues were discussed. Mental Health Legislation and Governance Group (MHLGG) - 10th April 2025 The ICDPPT took the minutes as read and highlighted the following: • The activity report was reviewed, and they discussed breaking up graphs on informal and formal detention by service areas • The MHA / DoLS Interface topic was discussed • Discussion with AMHP colleagues was had around relative merits of Section 2 versus Section 3. This was likely to be ongoing debate.	

	• Discussion was had about the St John's Ambulance contract and their transportation cut-off times. • There were difficulties for advocacy colleagues in joining ward rounds of detained patients. • They would keep an eye on the MHA reforms and noted tabled amendments regarding who can receive Section 136s. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
HL 29/04/014	**Annual Report of the Mental Health Legislation Committee 2024/25** **The Committee Resolved that:** a. The MHL Annual Report 2024/25 was noted.	
	Items for Approval / Ratification	
MHL 29/04/015	*No items.*	
	Any Other Business	
MHL 29/04/016	The DO-MH suggested bringing a paper around the challenges of access to Section 12s and the future proofing of the provision.	
MHL 29/04/017	**To note the date, time and venue of the next meeting:** 29th July 2025 via MS Teams	

Action Log
Mental Health Legislation Committee – 29.04.2025
(Updated for 29th July 2025 Meeting).

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
ACTIONS COMPLETED					
MHL 29/04/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring**	For an update to be brought back to the Committee on how the clinical board action plans are progressing.	**21.10.2025**	Chloe Evans / Jason Roberts	**COMPLETED** *Added to the Forward Plan for October 2025's MHL Committee.*
MHL 29/04/008	**Mental Capacity Act Monitoring Report and DoLS Monitoring**	For the Director of Corporate Governance (DCG) to discuss with the Head of Corporate Governance (HCG) around the finalisation and distribution of the Court of Protection (COP) guidance.	**29.07.2025**	Francesca Thomas / Chloe Evans	COP Procedure scheduled to come to July Mental Health Committee for approval.
MHL 29/04/011	**MHA / DoLS Interface**	For an update on the potential impact of the new case law for DoLS and MHA.	**29.07.2025**	Dan Crossland	**COMPLETED** *Added to the Forward Plan for July 2025's MHL Committee.*
MHL 29/04/011	**MHA / DoLS Interface**	For the DCG to discuss with Legal and Risk departments to understand how relevant information was disseminated and communicated to the appropriate teams.	**29.07.2025**	Matt Phillips	*Update to be provided in the following Committee's 'Action Log' section.*
MHL 29/04/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report**	For a breakdown of Part 3 figures to be included in the report for the following Committee.	**29.07.2025**	Dan Crossland	**COMPLETED** *To be incorporated into the following Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update report.*
MHL 29/04/015	**Any Other Business**	For a paper on the challenges of access to Section 12s and the future proofing of the provision to be brought to the following Committee.	**29.07.2025**	Dan Crossland	**COMPLETED** *Added to the Forward Plan for July 2025's MHL Committee.*
Actions in Progress					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
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:	26.08.2025
			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, over the last quarter. As previously, there is additional information contained within this report outlining the additional training and support provided by the MCA Team.

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

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

<u>Mental Capacity Act Monitoring Actions (January – March 2025):</u>

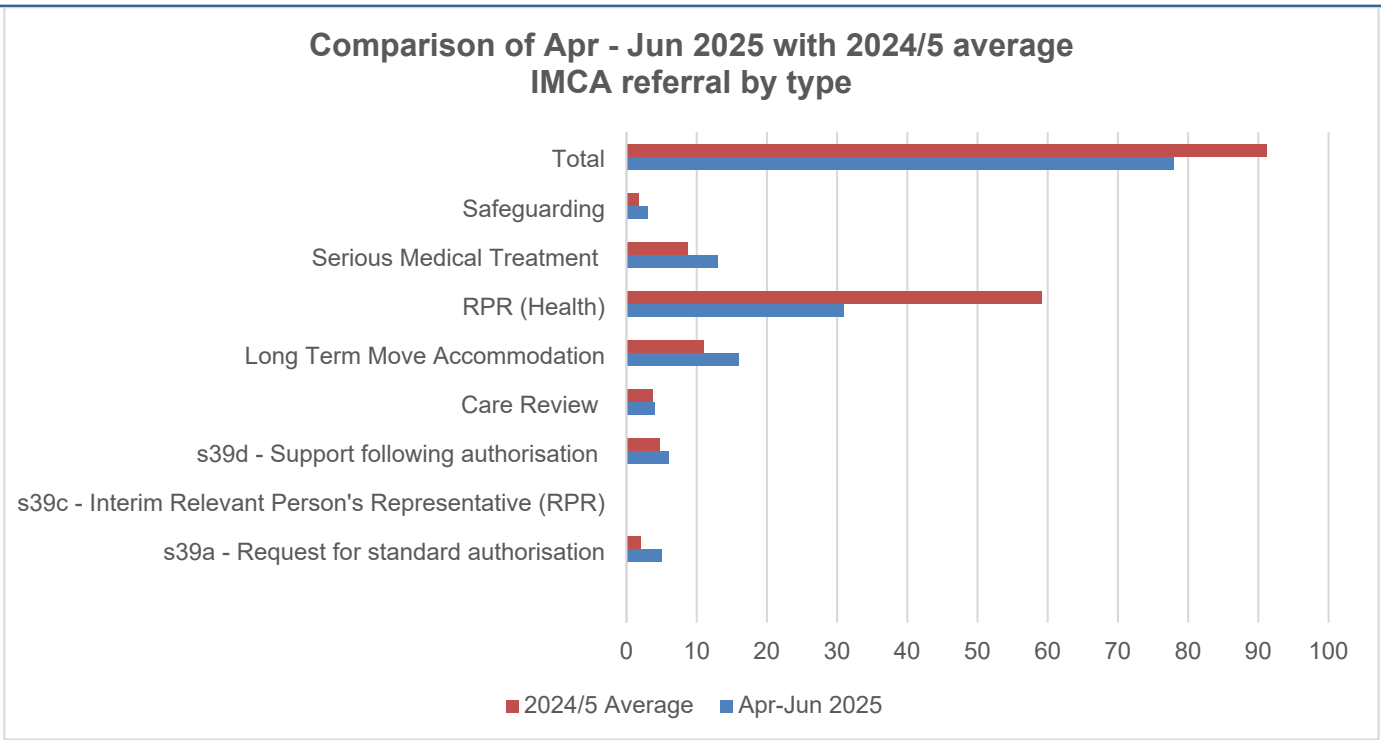
Mental Capacity IMCA Referral type

The MCA Indicators outline the breakdown of IMCA referrals for the period from April – June 2025 with a comparison of the 2024/5 mean average.

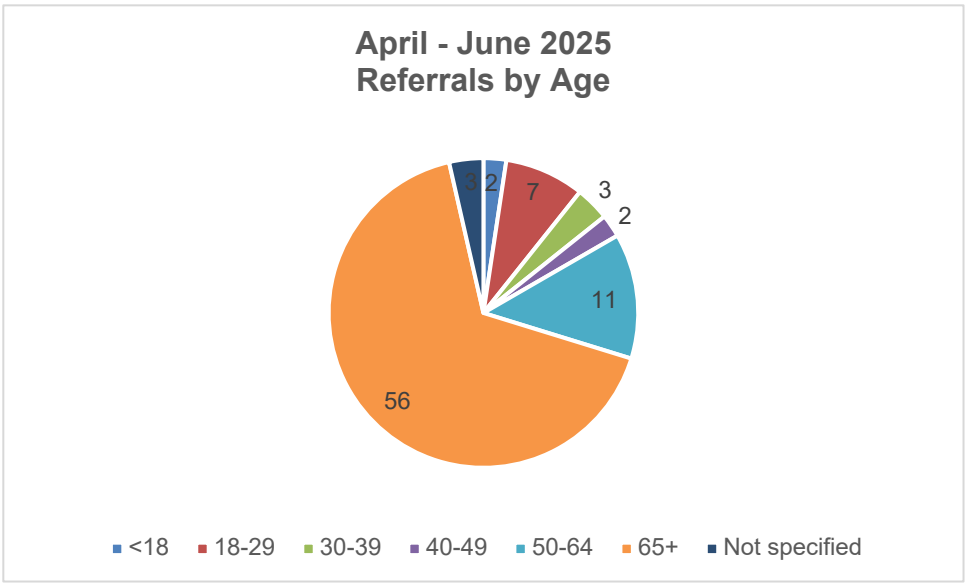
Overall referral rates are noted to be slightly reduced from Q4 (99) but higher than this time last year, up from 72 to 78 referrals. There has been more than a 40% decrease in referrals for Relevant Persons Representatives (RPR) since the last quarter however, this could be linked to improved engagement with families and discussion around the DoLS process which has been a focus of the DoLS Team in recent months. An RPR will be instructed where there is no suitable family member or friend who can act as an advocate for the person and instigate an appeal if the person is displaying signs of objection to their admission and care arrangements.

Referrals under s39d have reduced to 6, from 14 last quarter. This remains above average but again this can potentially be linked to better engagement and discussion with family and friends to identify a known person to advocate for the individual concerned.

Other types of referral are in keeping with previous quarters.



The below pie chart provides a breakdown of referrals for the last quarter by age. As the chart outlines, the majority of referrals were for people over the age of 65 (56 referrals), with the 50-64 age category coming in second (11 referrals). There were 7 referrals for the 18-29 age group and 2-3 for all other age groups.



In terms of gender, referrals were more heavily weighted towards males (61 %) than females (39%)

Awareness Raising / Training Sessions

Advocacy Support Cymru continue to offer informal training sessions when visiting patient areas, with 35 sessions delivered across all sites within the UHB and external units.

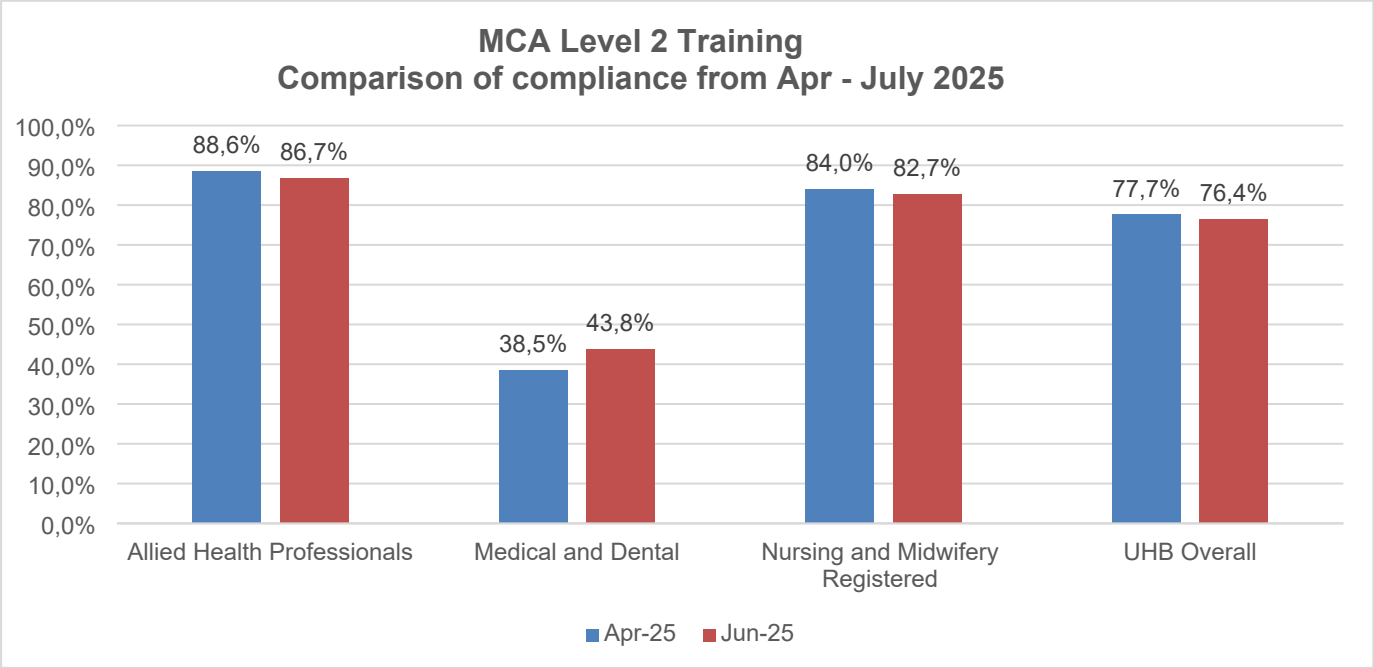
Mental Capacity Training

Mandatory MCA Training

The following graph provides a comparison of overall compliance by staff group from April to July 2025. Although there has been marginal improvement from Medical and Dental there has been a

slight decrease in overall UHB compliance, due to reductions in compliance from Allied Health Professionals and Nursing and Midwifery; which is likely the result of existing competencies expiring and requiring renewal.

There have been recent discussions with the Executive Medical Director regarding Medical and Dental compliance with mandatory training and a plan has been put in place to address this with Clinical Directors. It is expected that an update can be provided at the next Committee meeting.



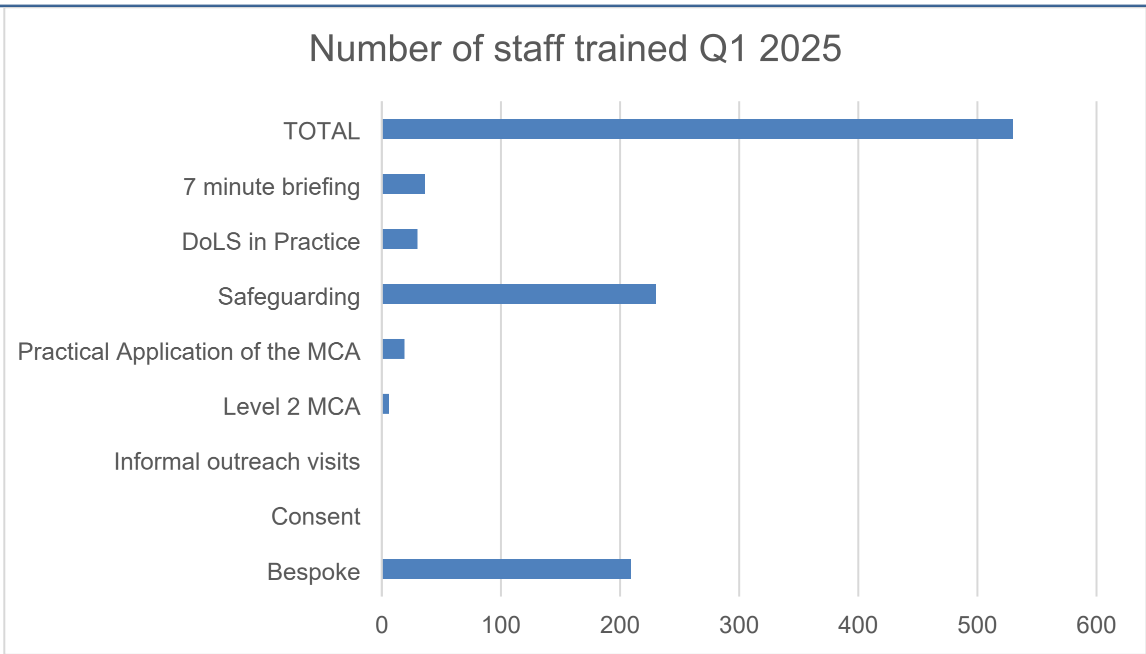
The updated All Wales Mental Capacity ESR training for Levels 1 and 2 is now available on ESR. This appears to be the preferred method of achieving the required competency for mandatory training, although the MCA Team continue to offer face to face training on a bi-monthly basis for those that prefer to attend in person.

MCA Practitioner led training: 2024/5

Training attendance remains lower than hoped although booking numbers for the next two quarters indicate improvement. The MCA Team is due to meet with medical education again in August to plan the training program for resident doctors. It is hoped that this will enable the team to reach a greater number of medics going forward and the MCA Team continue to take a proactive approach to raise awareness of the training available, sharing training posters at meetings and when delivering presentations.

The MCA team have delivered 14 training sessions during the last quarter, with a total of 530 staff trained across our various offerings.

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



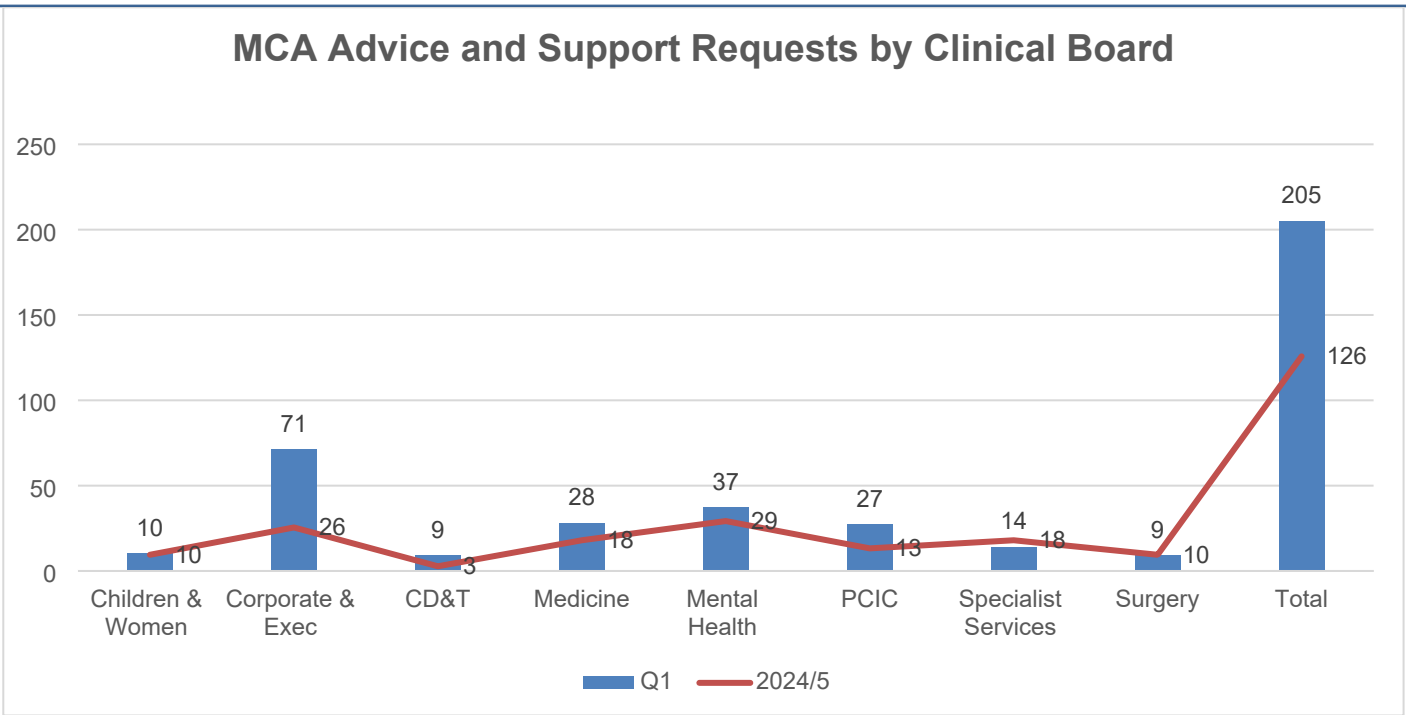
Training feedback is requested following each session of the Practical Application of the MCA, DoLS in Practice and MCA Level 2 face to face training and continues to demonstrate that the training is extremely well received by those that do attend.

Training Feedback	% Agree or strongly agree	% Neutral, disagree or strongly disagree
My learning outcomes were met	98%	2%
Training was effective and easy to understand	98%	2%
I feel confident about applying principles of MCA to practice	90%	10%
Helped with practical application of MCA as well as theory	98%	2%
I feel confident in knowing how to access MCA support	98%	2%

MCA Team Advice and Support

The below chart outlines the number of referrals received by each Clinical Board over the last quarter with a comparison of the mean average for 2024/5 to highlight the increase in requests. As shown, there has been a significant increase in the number of cases from Corporate & Executives as this captures all of the reviews that are identified as a result of the work the team do to support Mortality Screening Panel and referrals via the Corporate Safeguarding Team and Adult Safeguarding in the Local Authority. The largest number of clinical requests have come from Mental Health, closely followed by Medicine and Specialist Services. This is to be expected as these are the core inpatient areas however, the figures for PCIC also demonstrate the contacts received for people within the community; with most of these referrals being raised by district nurses.

We have seen a significant increase in the number of requests from district nurses in relation to individuals showing signs of moderate to severe self-neglect within the community. This support often takes the form of advice, review of mental capacity assessments and providing direction for the use of the team's new proformas. The increase in cases of this type has also led to the MCA Team working in conjunction with the Corporate Safeguarding Team to develop a Level 3 Safeguarding 'Self Neglect' study day; with the first session due to take place in December.



MCA Team Resources for staff

The MCA Team have developed the following resources for staff over the last quarter, which are available on the MCA Team's SharePoint page.

7 minute briefings: Restraint to facilitate care and treatment under the MCA

Proformas: New proformas developed for documenting mental capacity assessments and making best interests decisions now available and being promoted for use.

Policies and procedures: Court of Protection Process and Guidance, Memorandum of Understanding MHA/DoLS Interface brought for approval at this meeting.

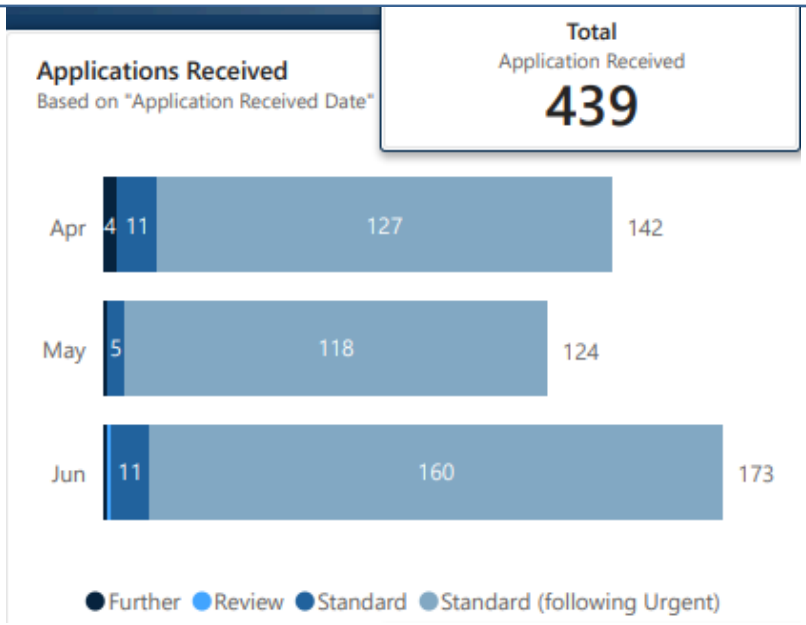
Deprivation of Liberty Safeguards Monitoring Actions:

Quarterly overview from April - June 2025

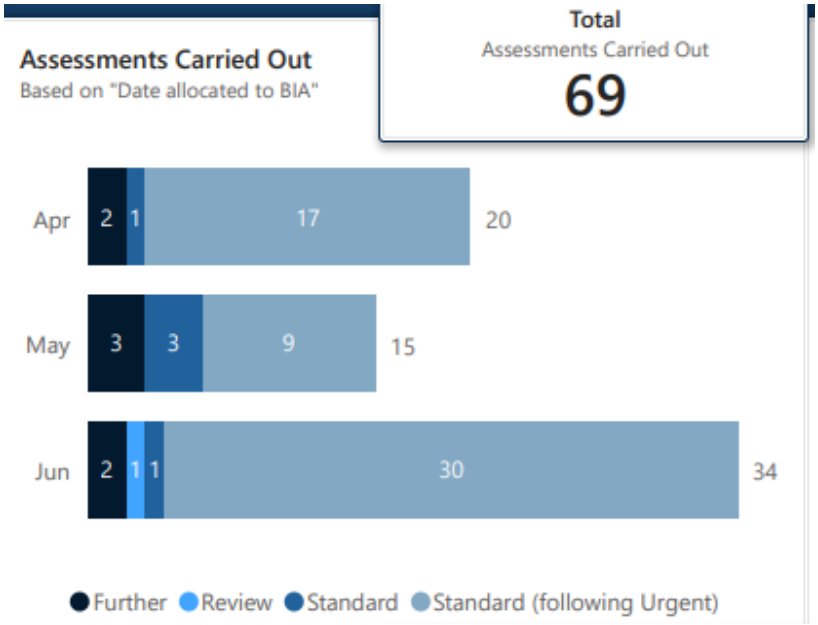
Applications Received	Assessments Carried out	Authorisations Granted	Total Waiting List	Applications Withdrawn
439	69	55	69	311

Referrals and Assessment

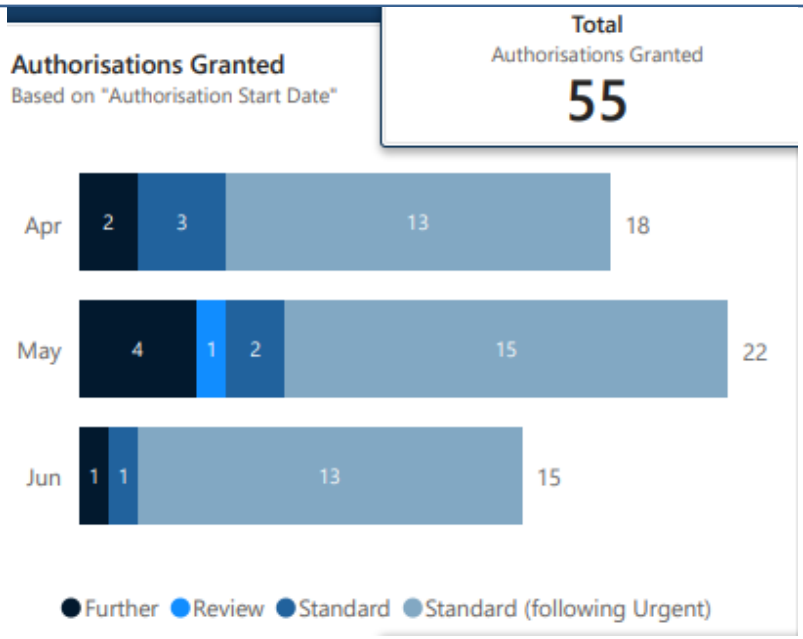
The referral figures for the last quarter are outlined below.



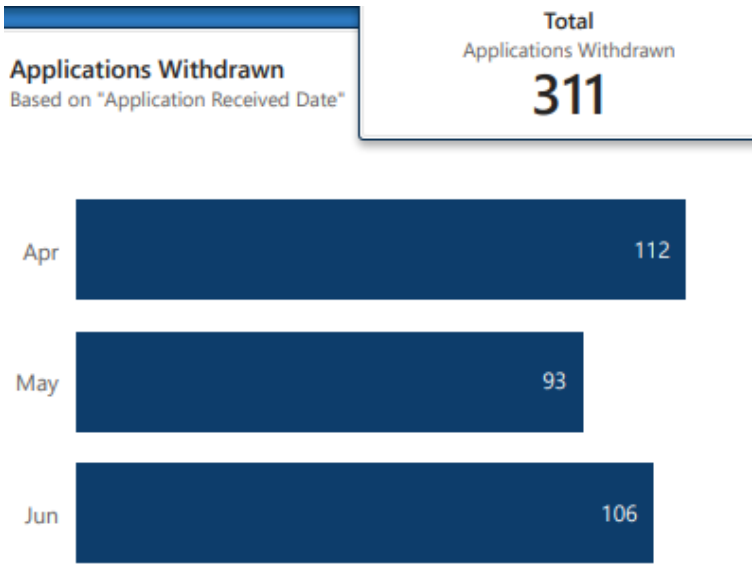
The below chart outlines the number of assessments carried out per month by type. It is important to note that there was no additional funding available for increased assessment capacity in Q1 however, additional assessments have been agreed by the Executive Nurse Director at a rate of 5 per week from July; as an interim measure whilst awaiting a decision regarding longer term funding. Based on Q1's referral figures, taking account of withdrawals (128 for the quarter) this should mean that the UHB will be in a position to meet demand for assessments and minimise the risk of any breaches.



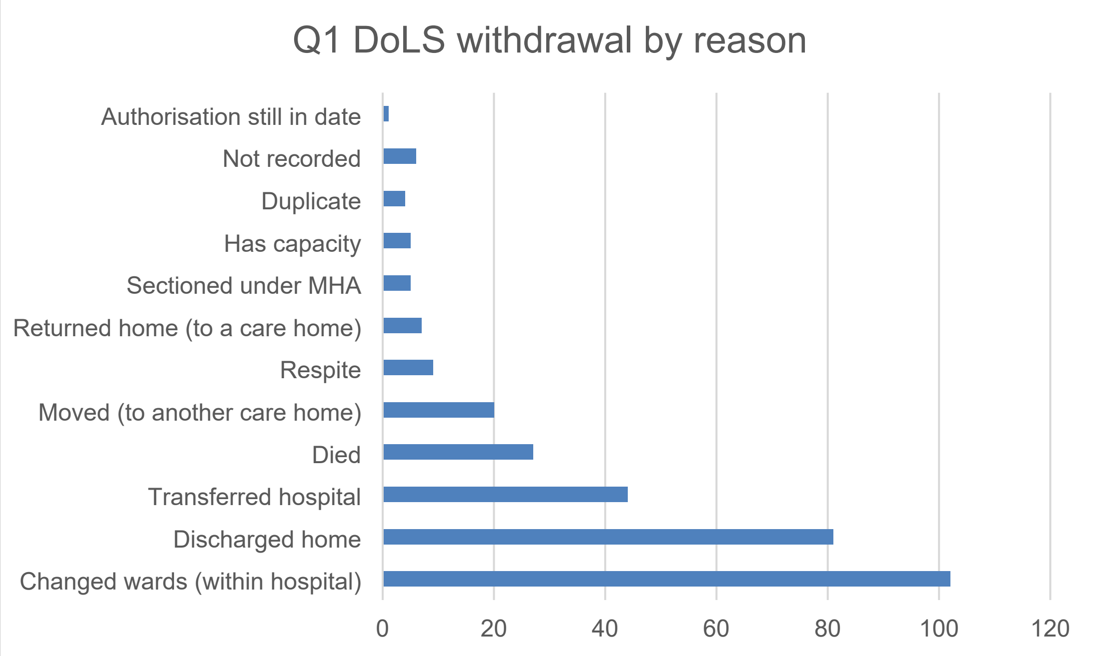
A total of 55 authorisations have been granted this quarter, with an average of 18 authorisations per month.



A total of 311 applications were withdrawn this quarter, compared with 274 last quarter.



Below is a chart outlining the reason for withdrawal of DoLS applications for the last quarter. The most common reasons reported are: change of ward (102), discharge home from hospital (81), transfer to a different hospital site (44) and death (27).



Other business

NWSSP are currently undertaking an audit of DoLS processes across the UHB with their report due to published in September. The results and recommendations of this audit will be shared at the next Committee meeting.

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.

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

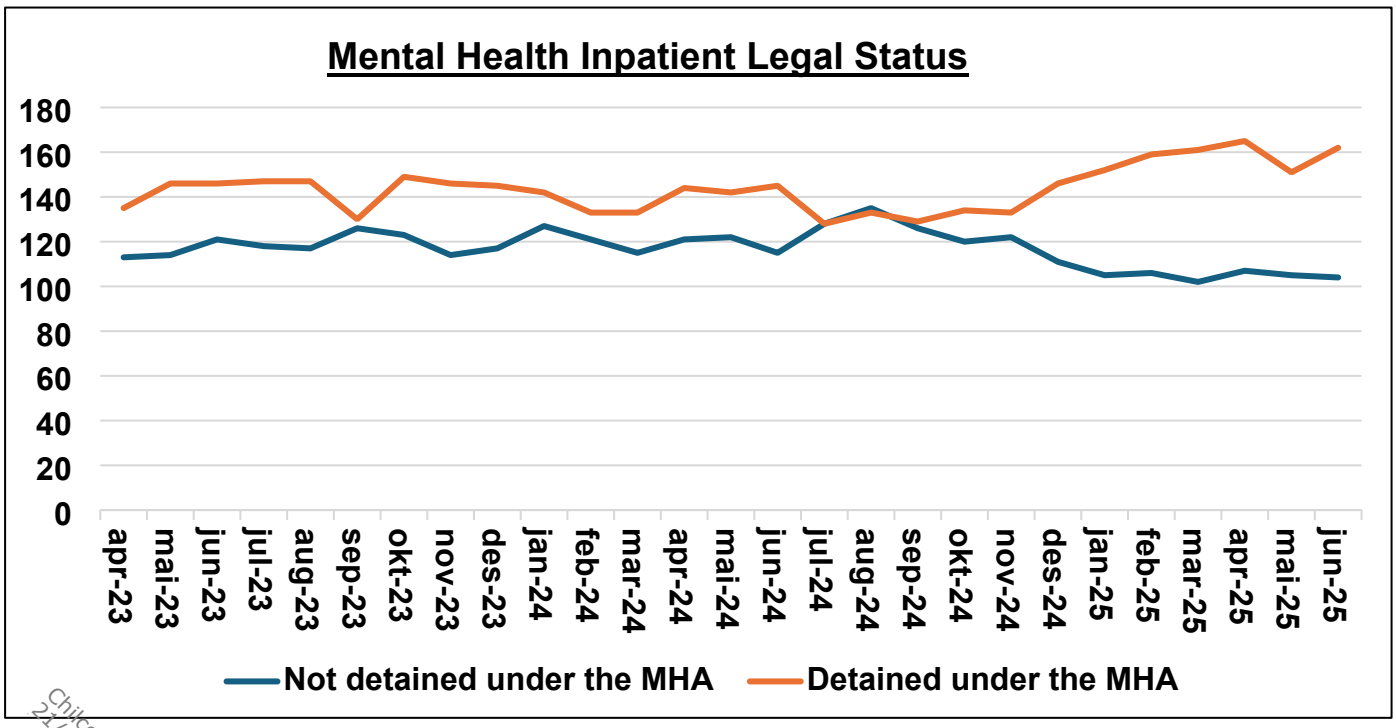
Report Title:	Mental Health Act Monitoring Exception Report				Agenda Item No:	3.1	
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	26th August 2025	
			Private				
Status (please only tick one)	Assurance	X	Approval		Information/Noting		
Lead Executive Title:	Chief Operating Officer						
Report Author Title:	Mental Health Act Manager						

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 & Key Issues to bring to the attention of the Committee

Use of the MHA



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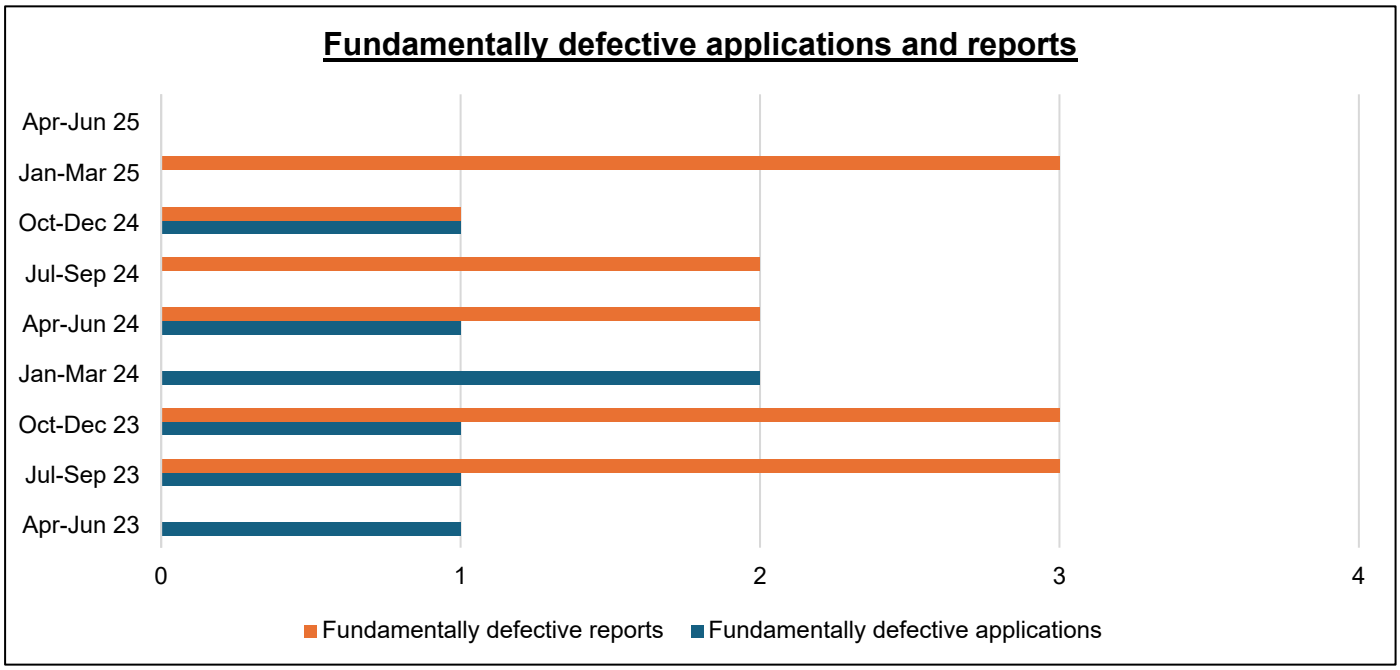
Fundamentally defective applications and reports



During the quarter there were no fundamentally defective applications or reports.

During the quarter there was one lapse.
P was detained in HYC under a section 5(4) due to the SHO being in UHW and unable to complete a section 5(2). The SHO was unable to get to HYC before the 5(4) expired therefore the section lapsed. The SHO did assess the patient 20 mins after the expiry, but P was agreeing to stay informally.

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.

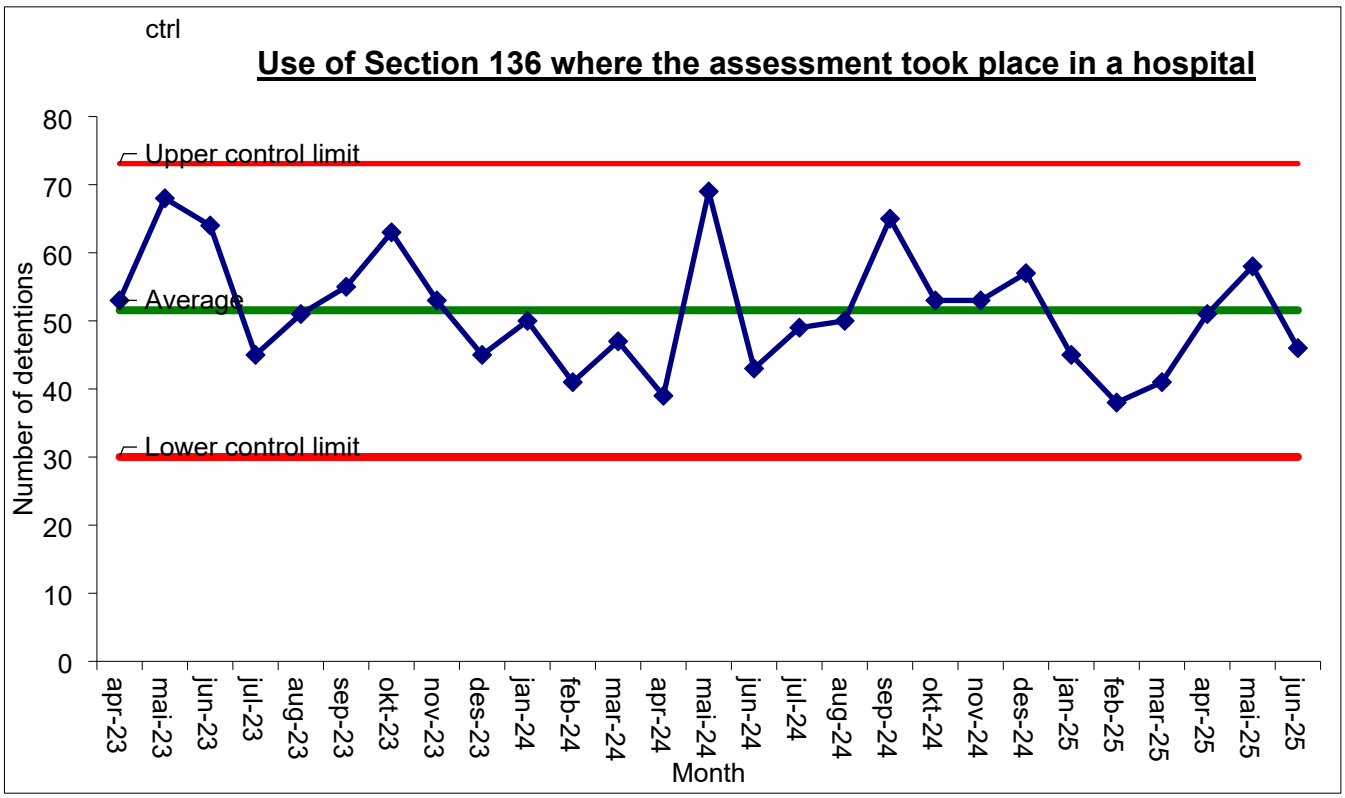
Section 136
During the period, the use of section 136 has increased.

It was noted that 77.4% of individuals assessed were not admitted to hospital, with 51.0% being discharged to community services and 25.8% were discharged with no follow up. Overall, during the period 22.5% of patients were admitted to hospital following a 136 assessment which is higher than the previous quarter at 21.7%.

One 136 lapsed with no assessment taking place due to not being medically fit.

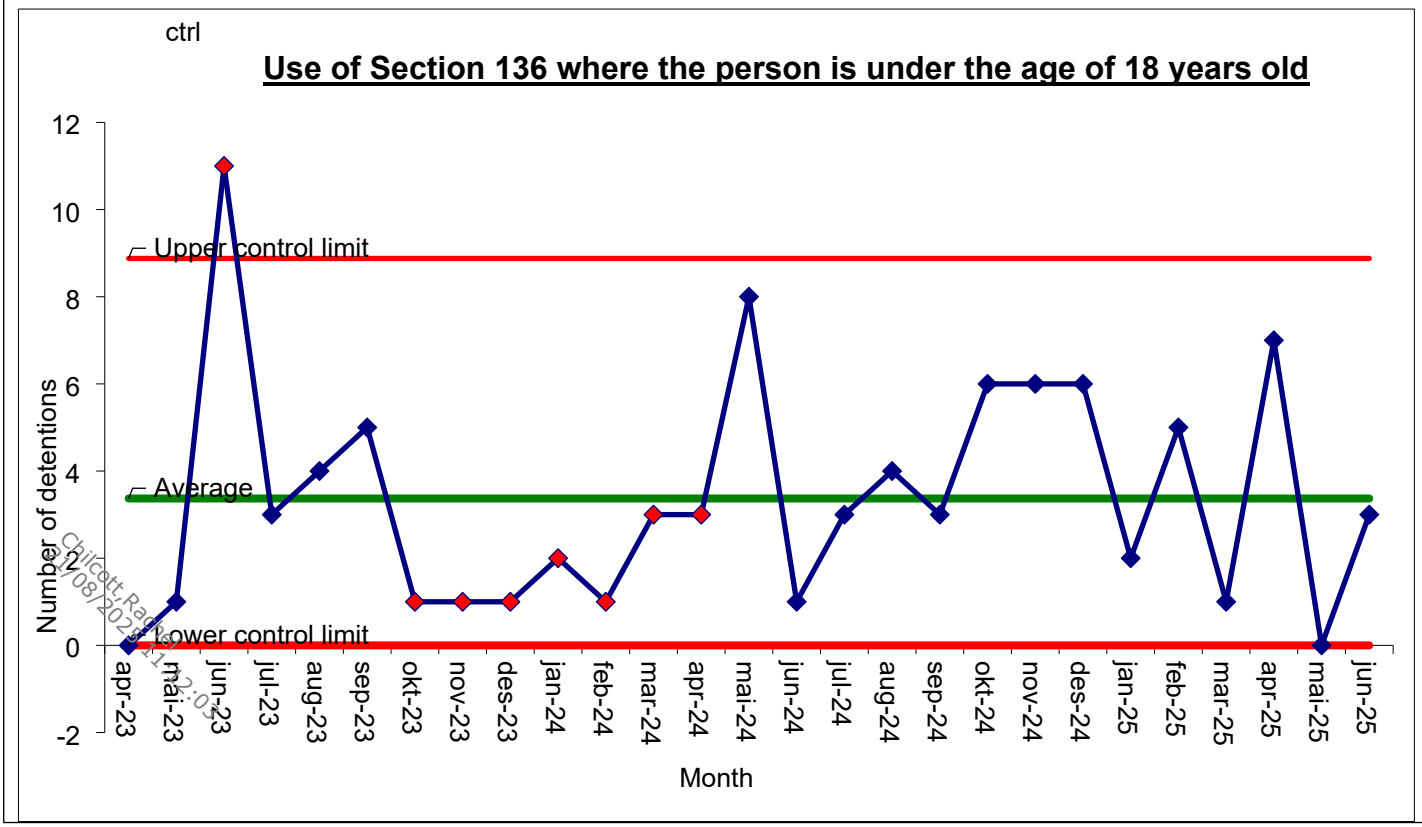
Period	% not admitted to hospital
April – June 2025	77.4%
January – March 2025	77.4%
October – December 2024	78.6%
July – September 2024	72.7%
April – June 2024	79.5%

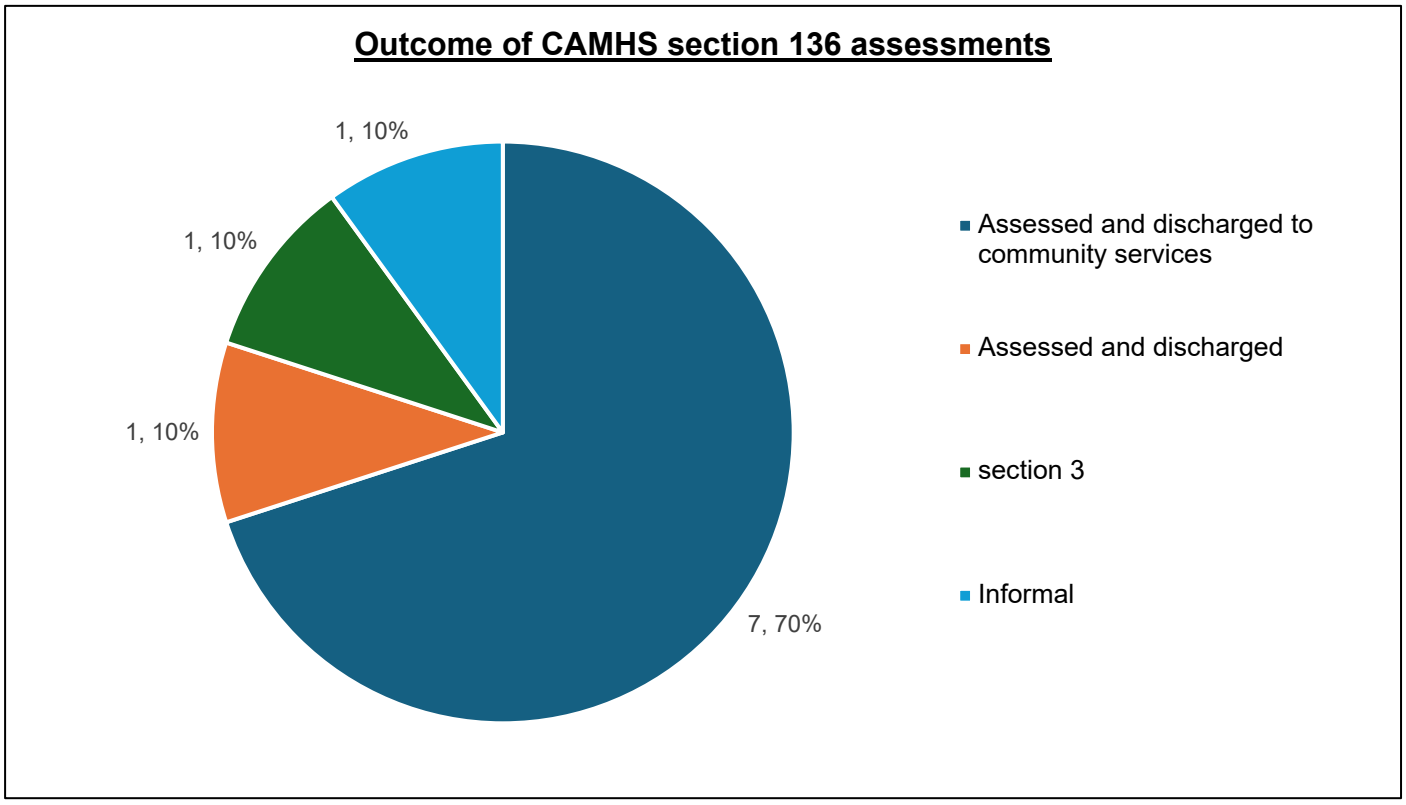
January – March 2024	83.3%
October – December 2023	80.1%
July – September 2023	83.5%
April – June 2023	80.4%



Section 136 - CAMHS

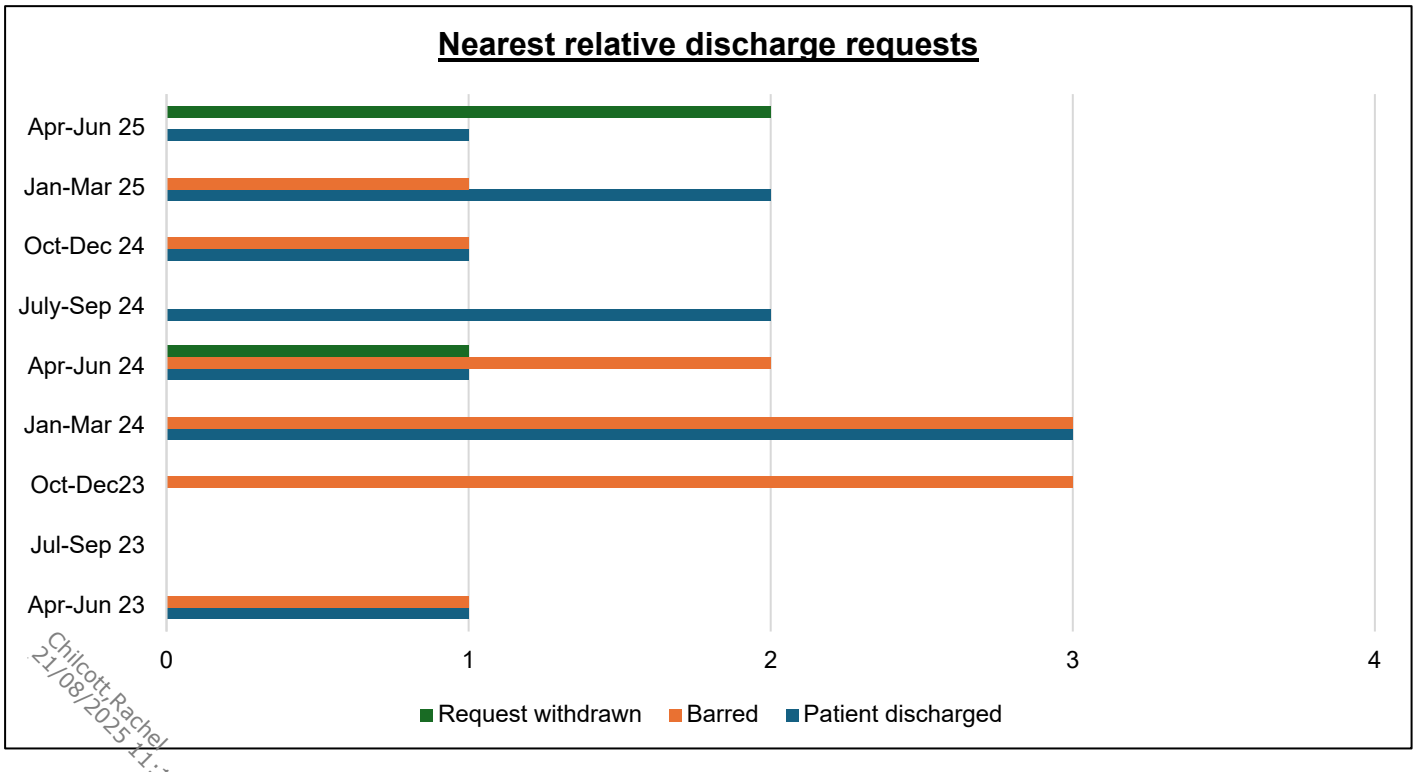
The number of those under 18 assessed under section 136 has increased from 8 in the previous quarter to 10 in this quarter. 3 users had repeat presentations.





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

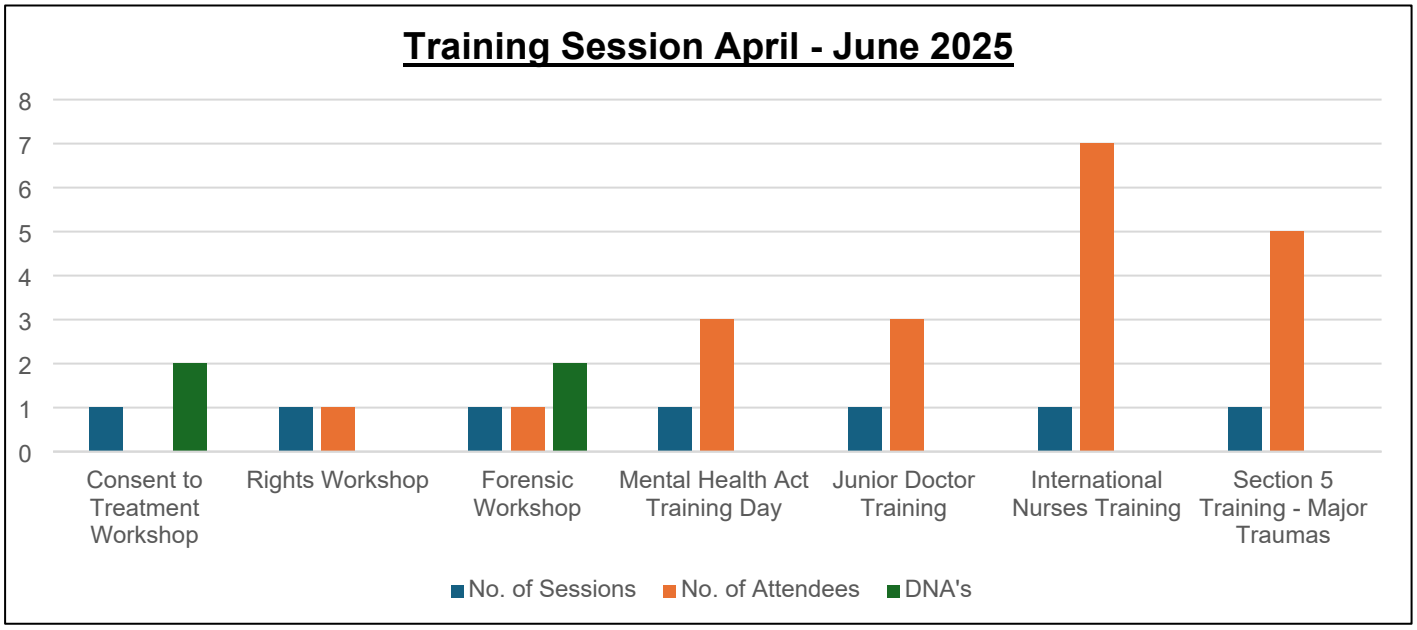
The MHA office continues to run the below awareness sessions available to all staff within the Health Board:

- 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.

Appendices (please list all appendices that accompany this report. Do **not** embed)

Attachment 3.1.2 - Mental Health Act Monitoring Report April - June 2025

Recommendations:

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 place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prev	X	Long Term	X	Integration	X	Collaboration	X	Involvement	X

e nt io n									

Quality Impact Assessment Completed? Please place an “x” in the below boxes where relevant				
Yes (please include the complete QIA document)	X	No (please provide reasoning e.g. not required		n/a

Impact Assessment Please place an “x” in the below boxes where relevant
Risk: No
Safety: Yes
Identified in the main body of the report
Financial: No
Workforce: No
Legal: 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: No
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Mental Health Legislation and Governance Group	31/07/2025

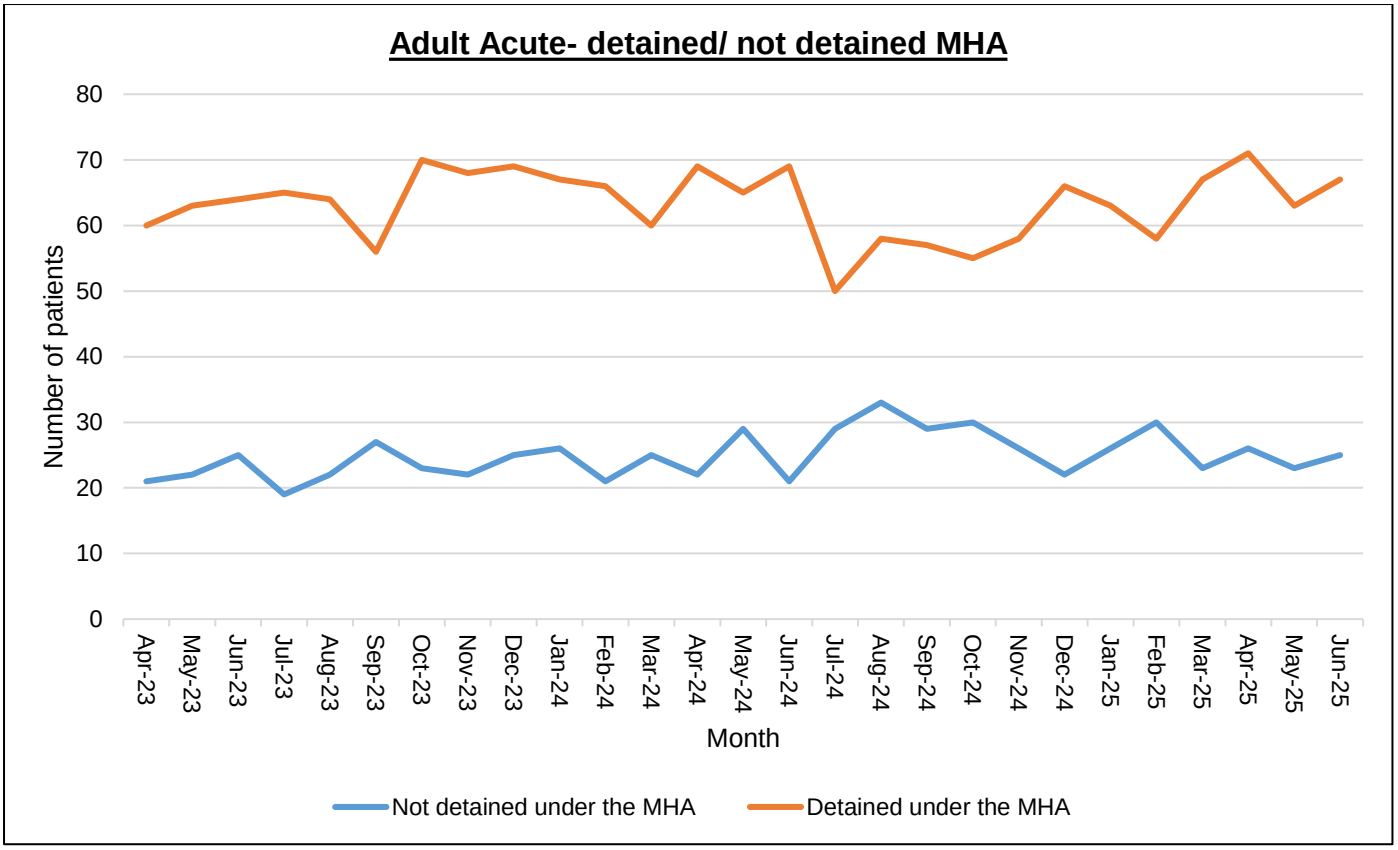
Report to the

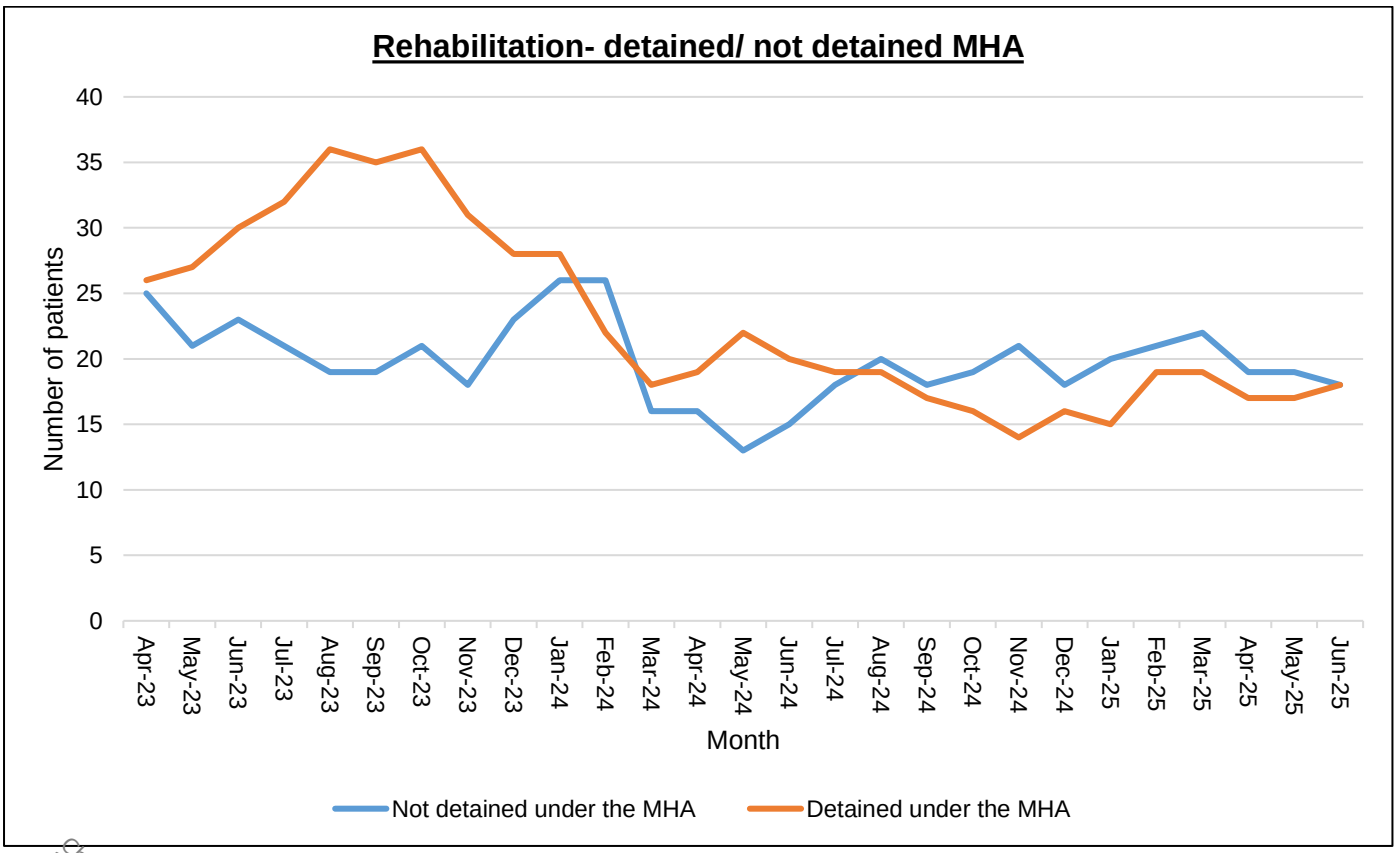
Mental Health Legislation Committee

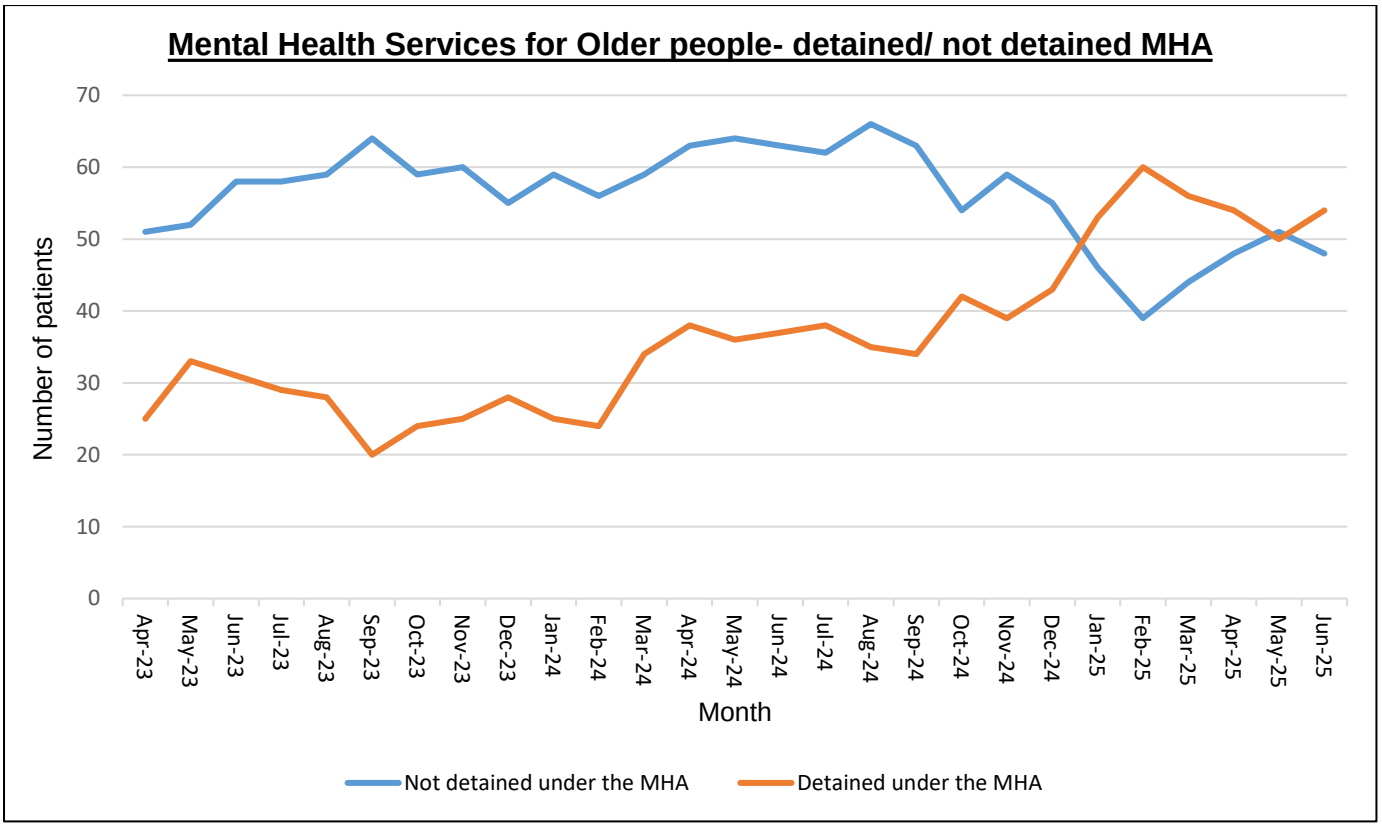
on the use of The Mental Health Act, 1983

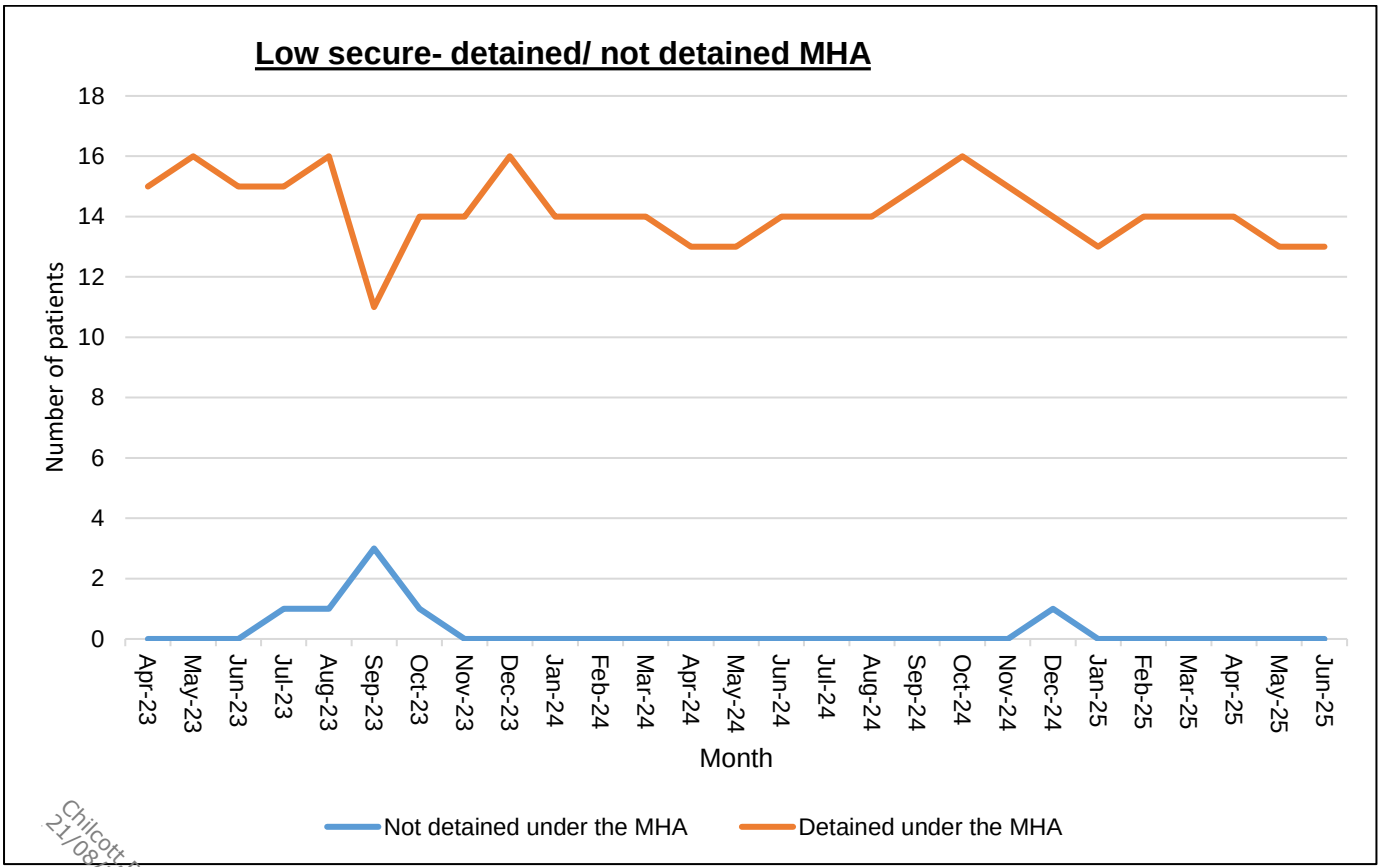
April – June 2025

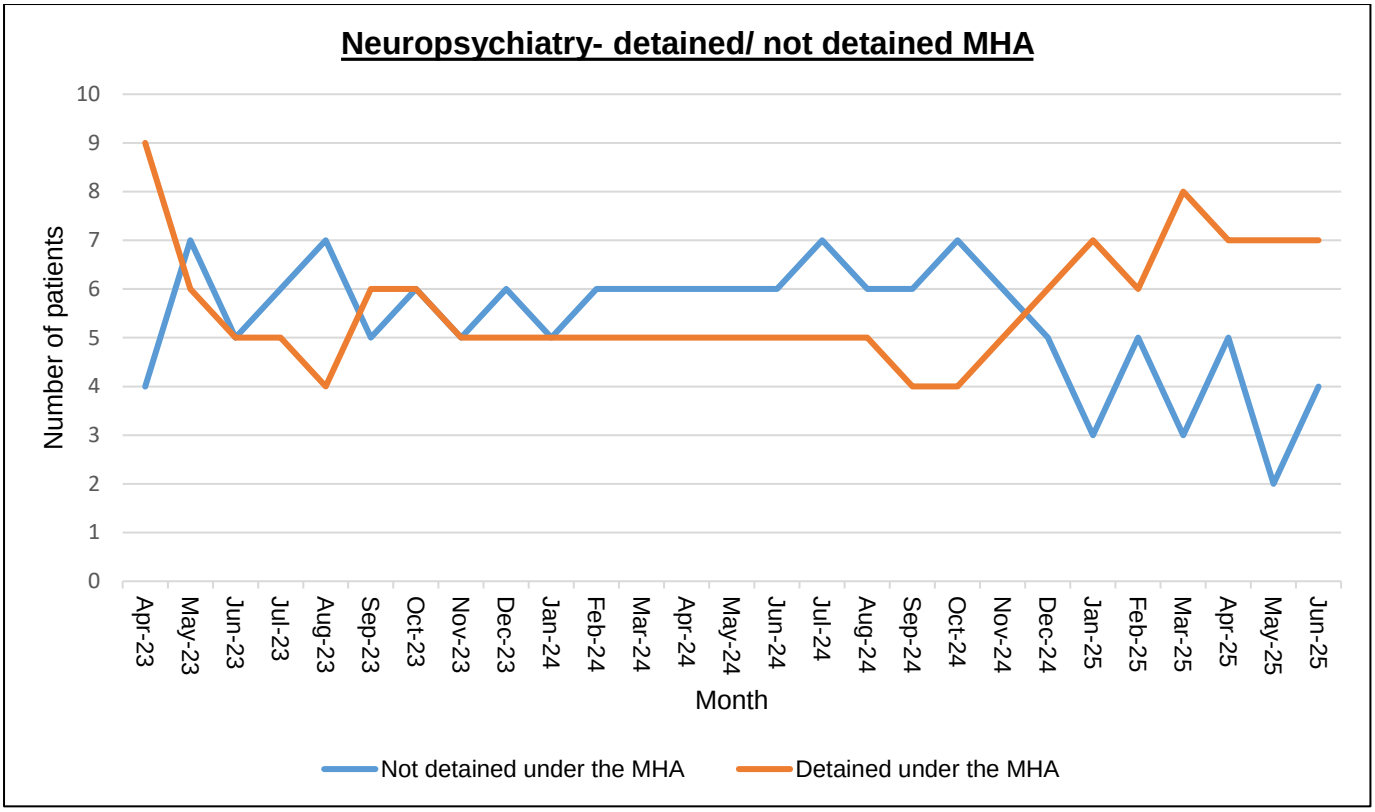
Contents **Page**

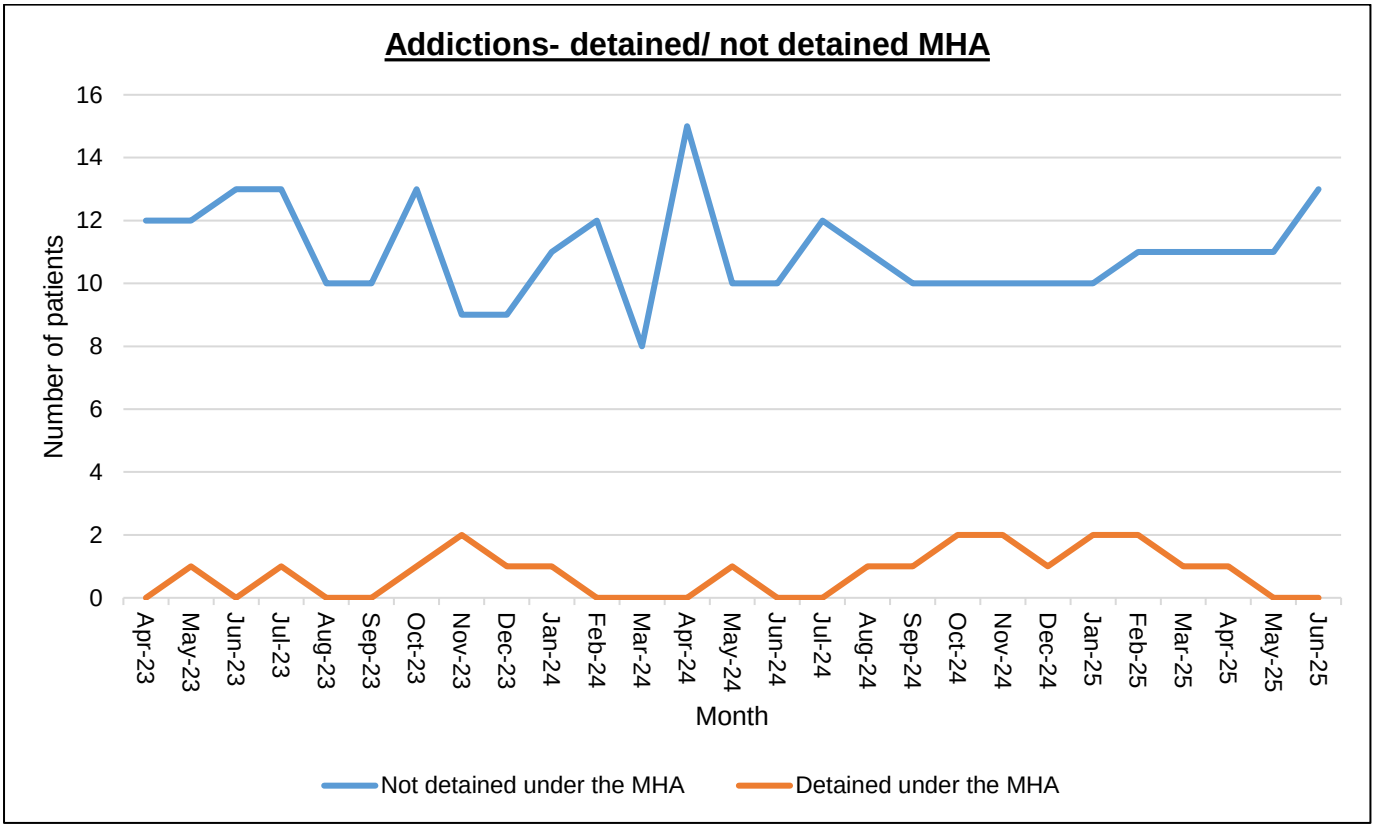












There has been one CAMHS patient detained in Hafan Y Coed during the period.

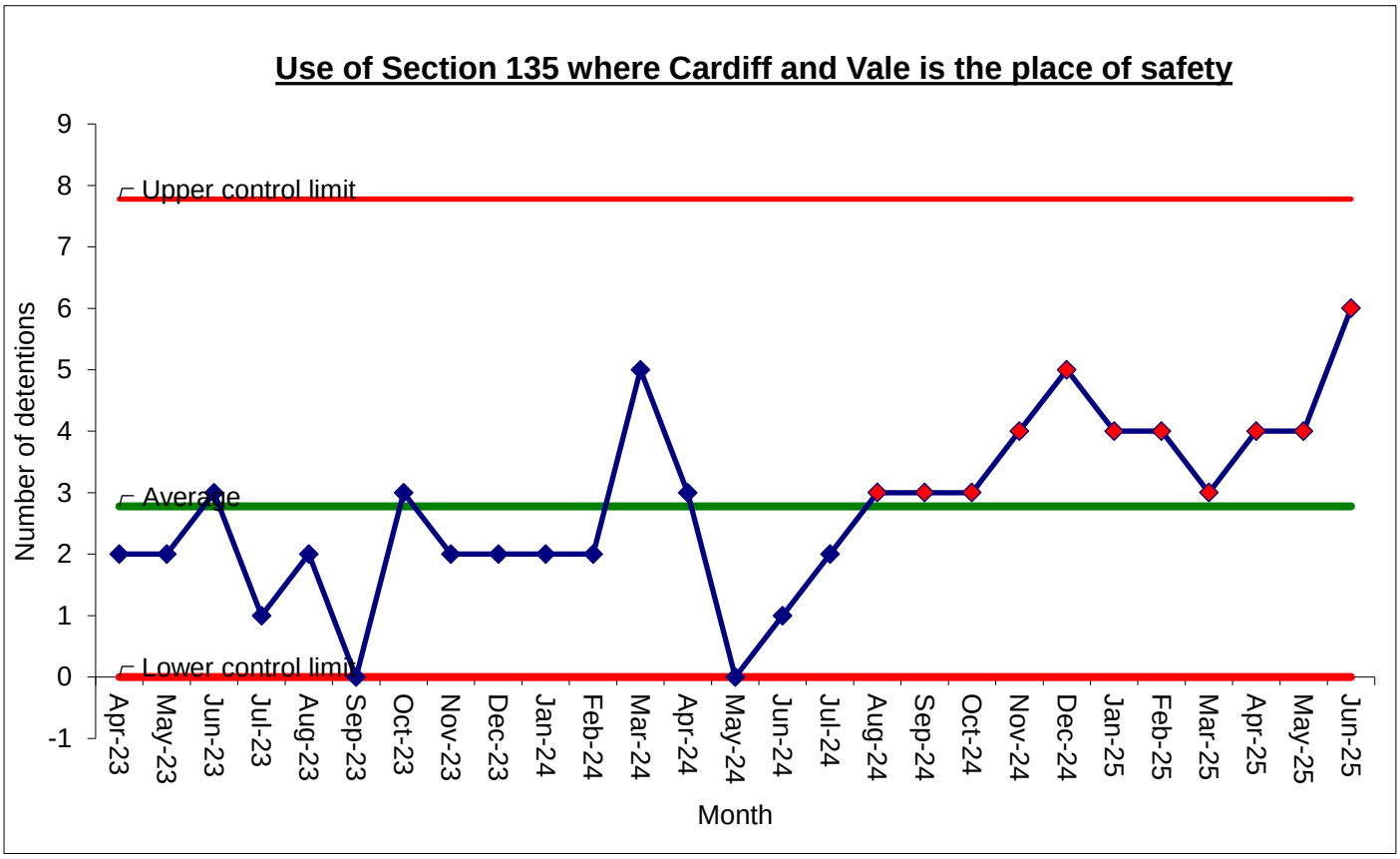
There have been no learning disability patients detained in Hafan Y Coed during the period.

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 fourteen occasions.

- detained under Section 2 x8
- admitted informally x1
- detained under Section 3x 3
- Discharged home x 2

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



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;-

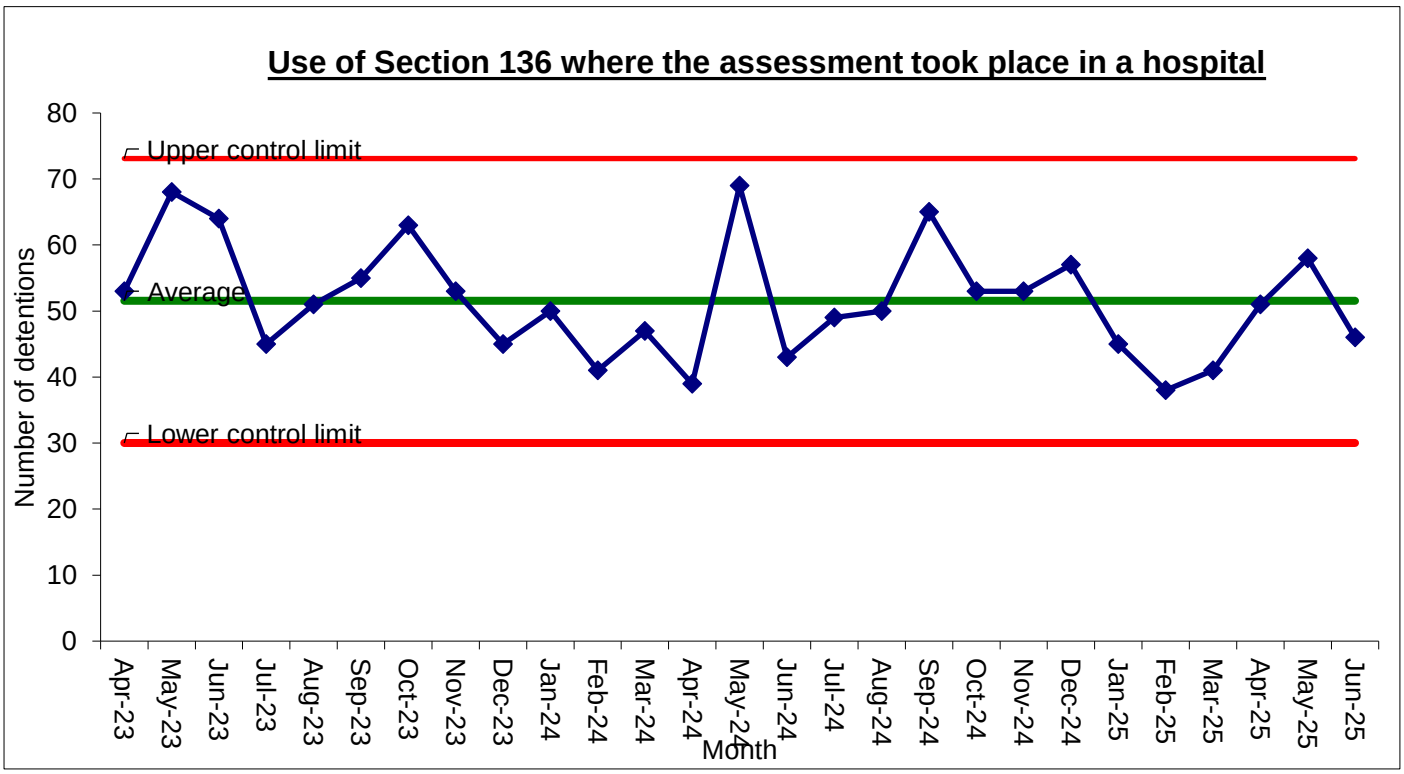
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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.

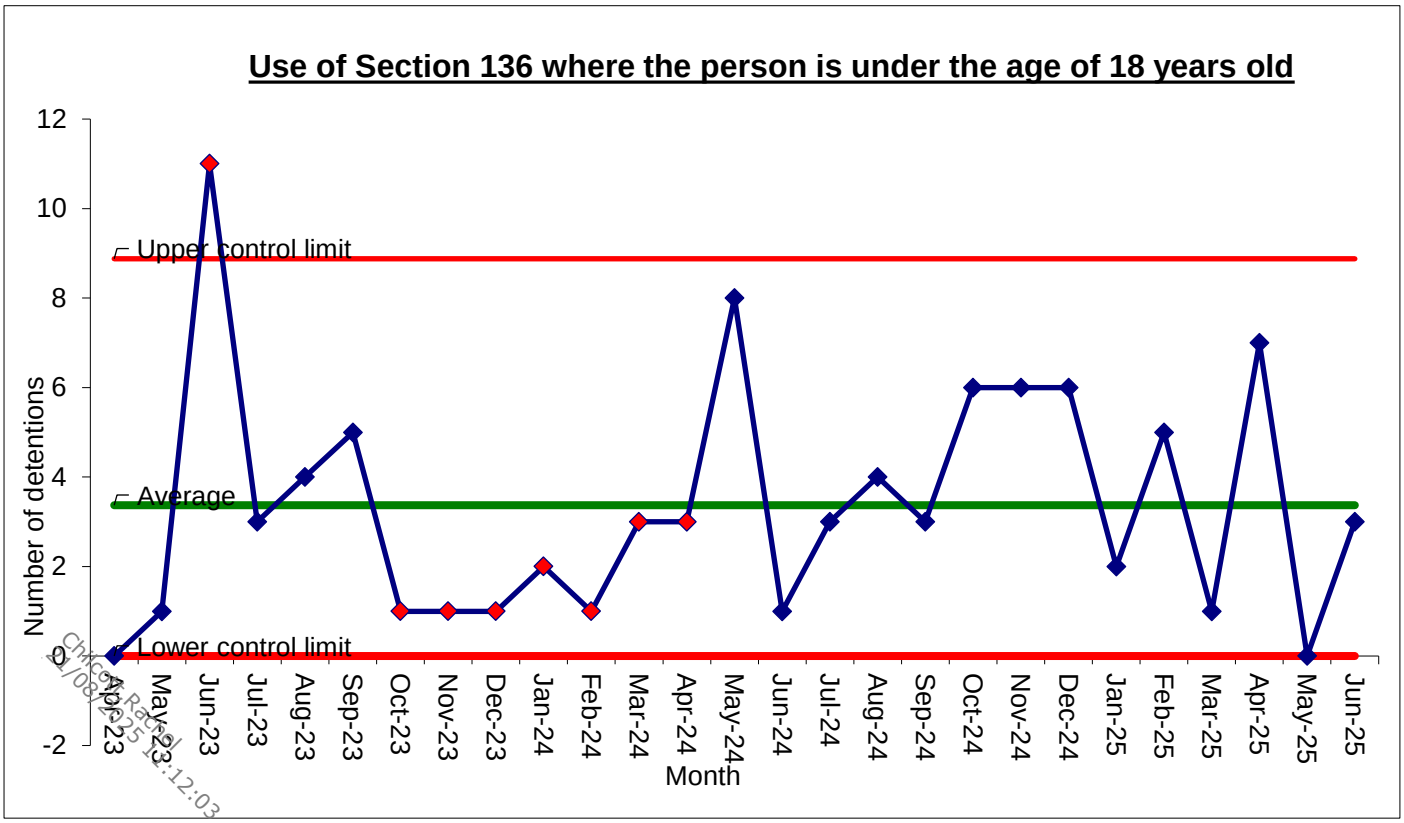
For this period, we have seen sixteen Voluntary Assessments. No one was brought into hospital under the Mental Capacity Act.-

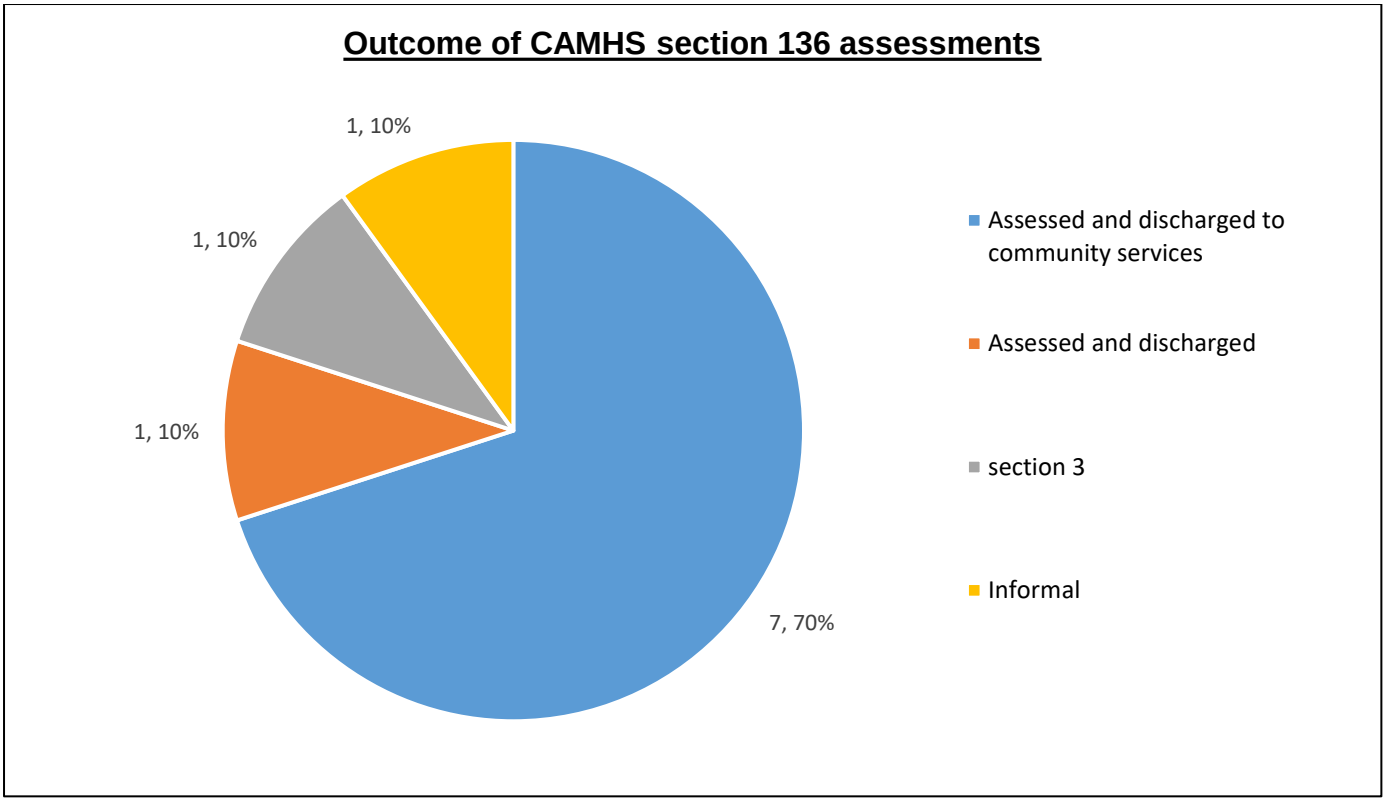
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

During the period a total of 155 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

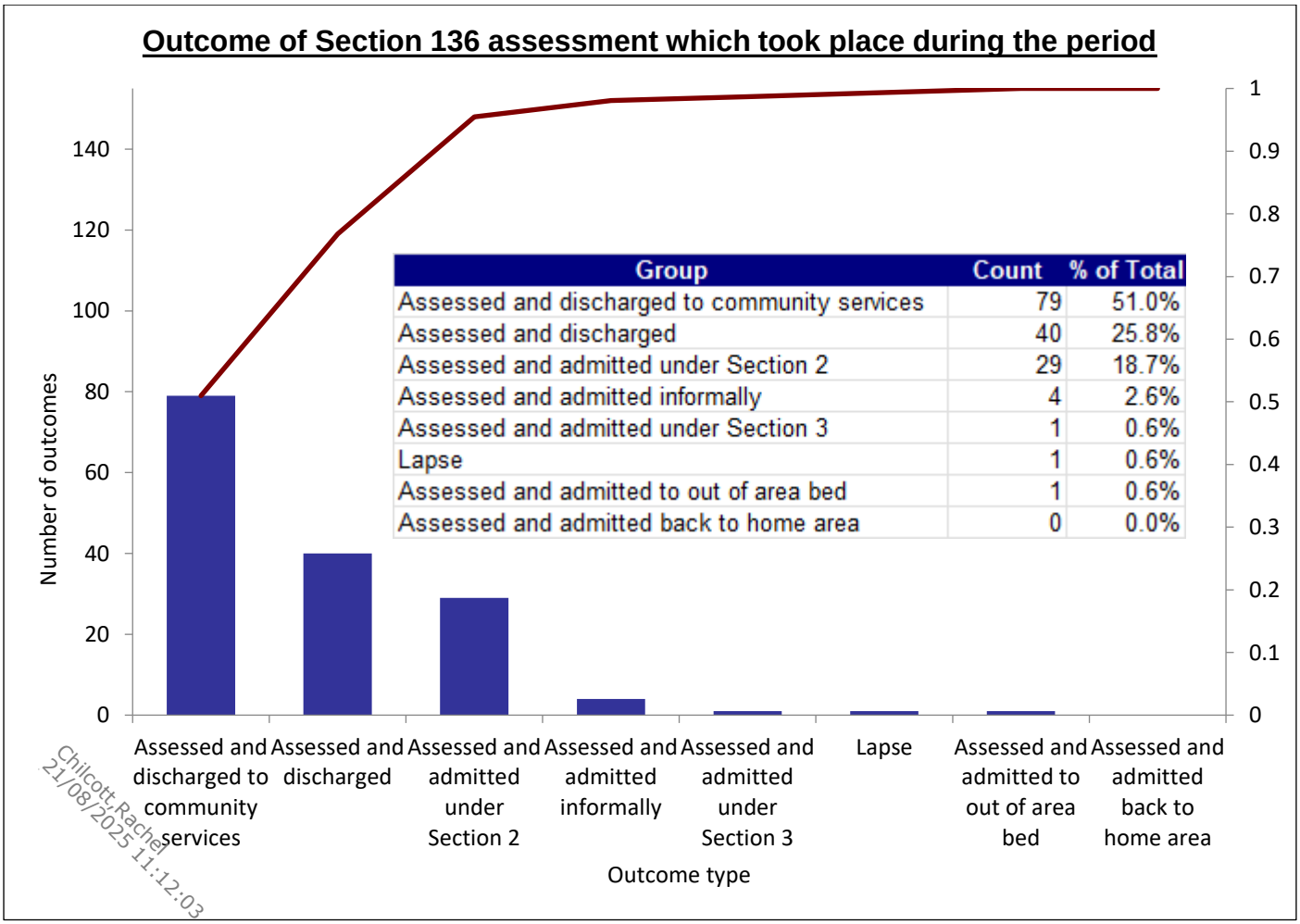


Ten of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. Three service users had repeat presentations. This is extracted below;-





The pareto chart highlights that 76.8% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.



Group	Count	% of Total
Assessed and discharged to community services	79	51.0%
Assessed and discharged	40	25.8%
Assessed and admitted under Section 2	29	18.7%
Assessed and admitted informally	4	2.6%
Assessed and admitted under Section 3	1	0.6%
Lapse	1	0.6%
Assessed and admitted to out of area bed	1	0.6%
Assessed and admitted back to home area	0	0.0%

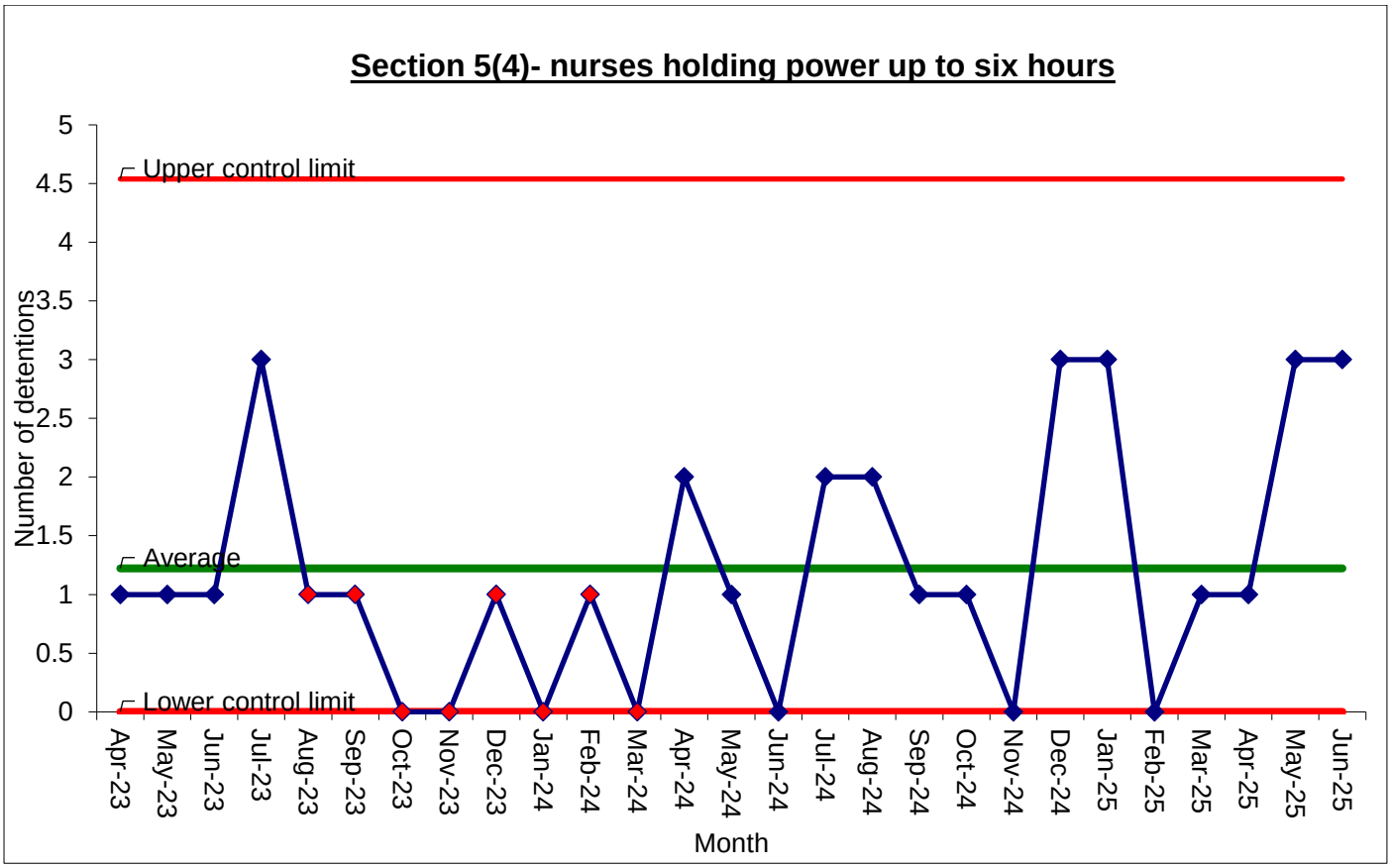
Included in the above data are the outcomes for those under 18 years of age.

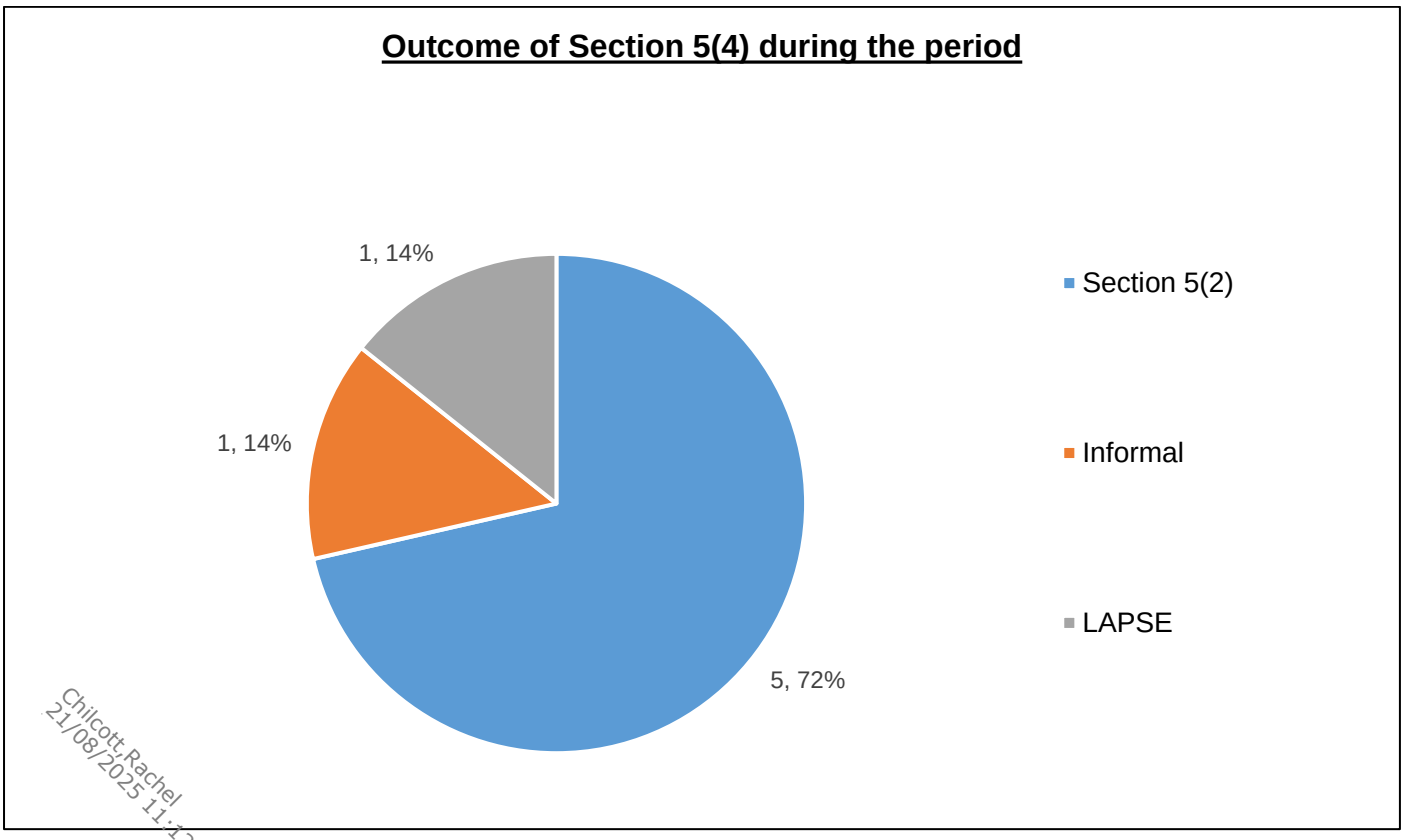
Out of the one lapsed detention, 1 was due to the patient not being fit for assessment.

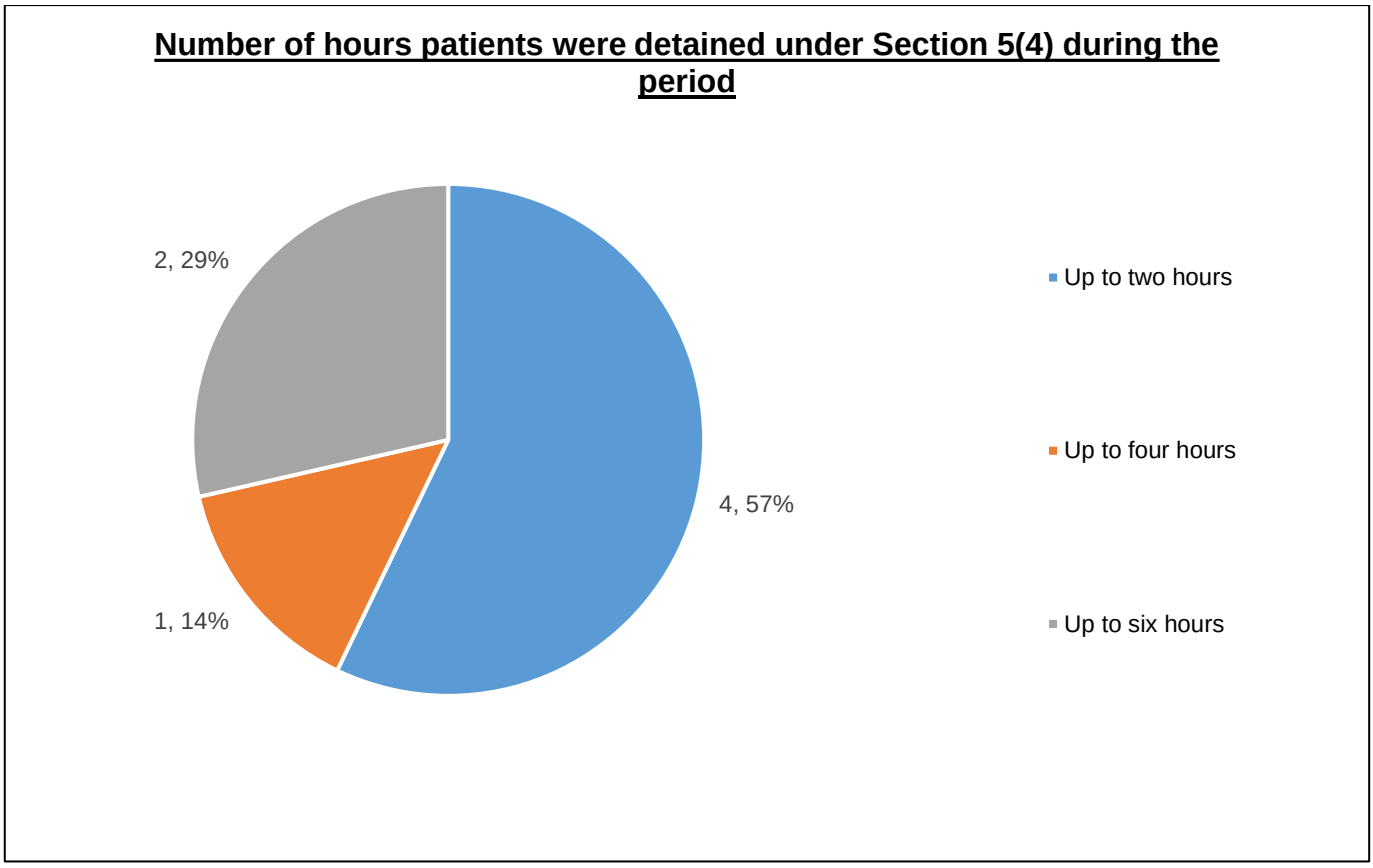
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

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

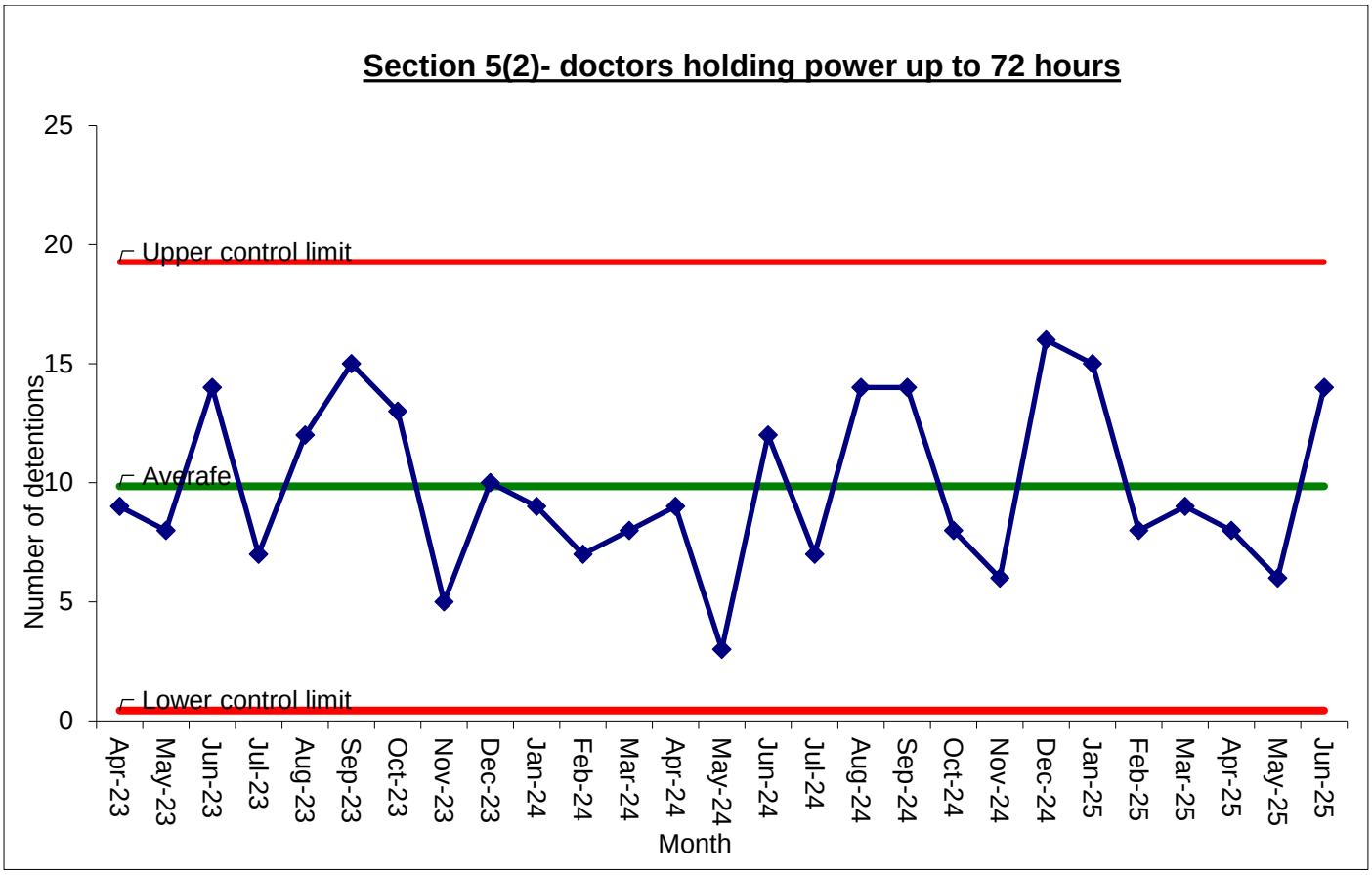
Section 5(4) - Nurses Holding Power

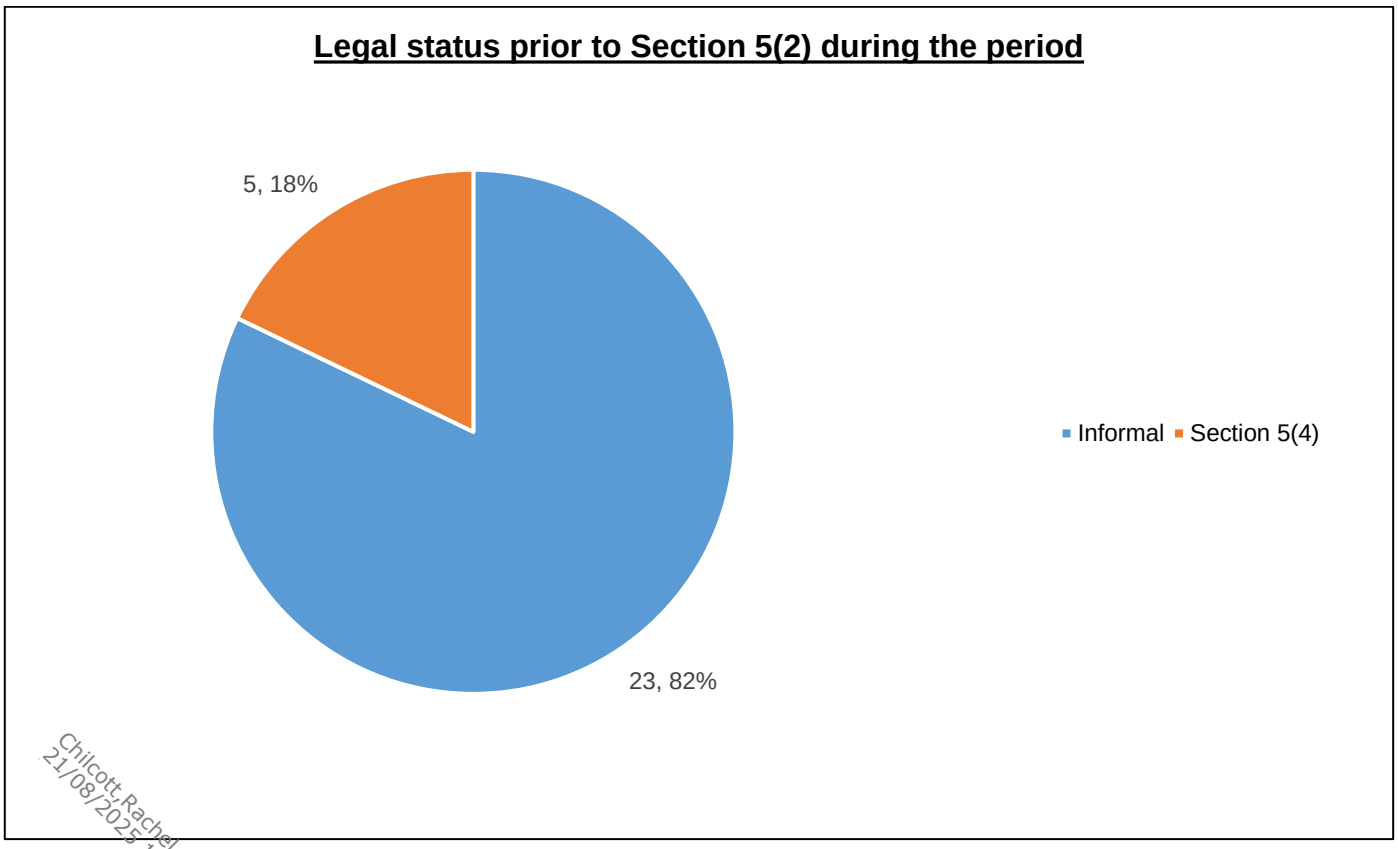






Section 5(2) - Doctors holding power





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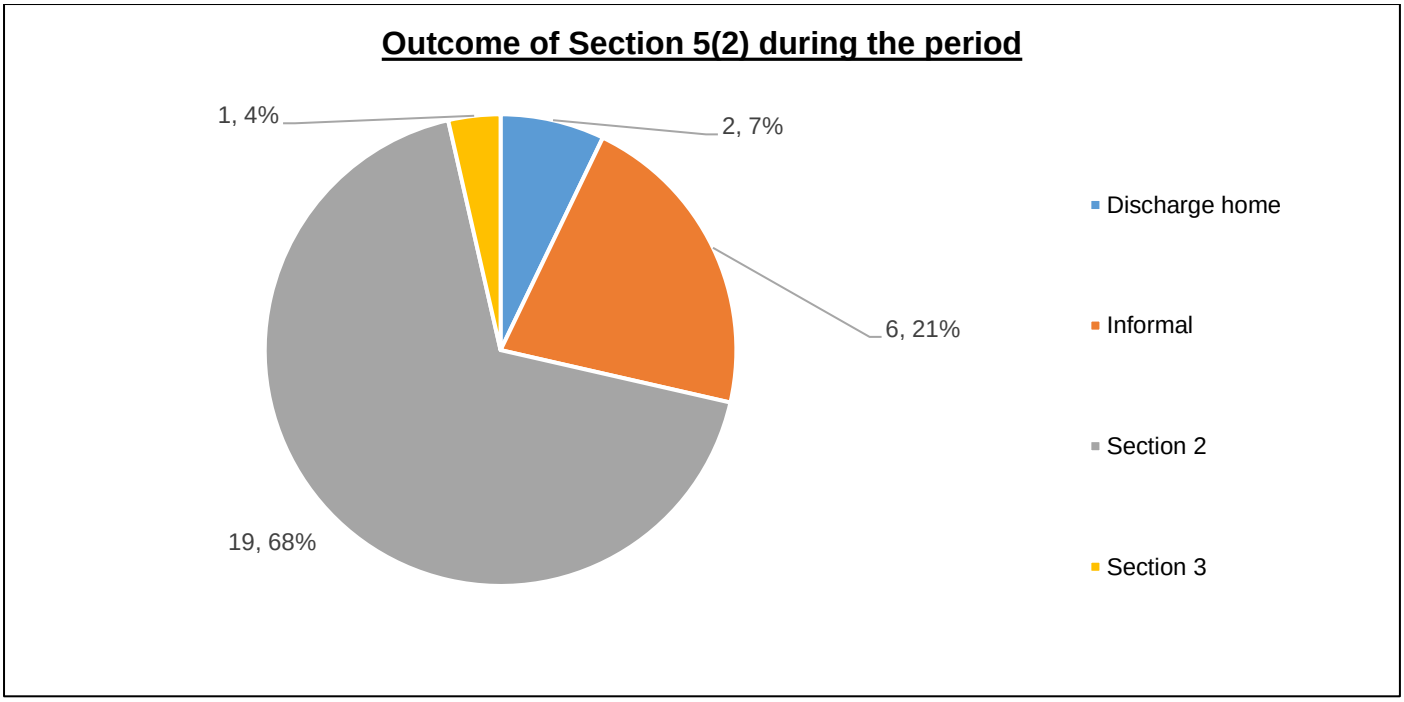
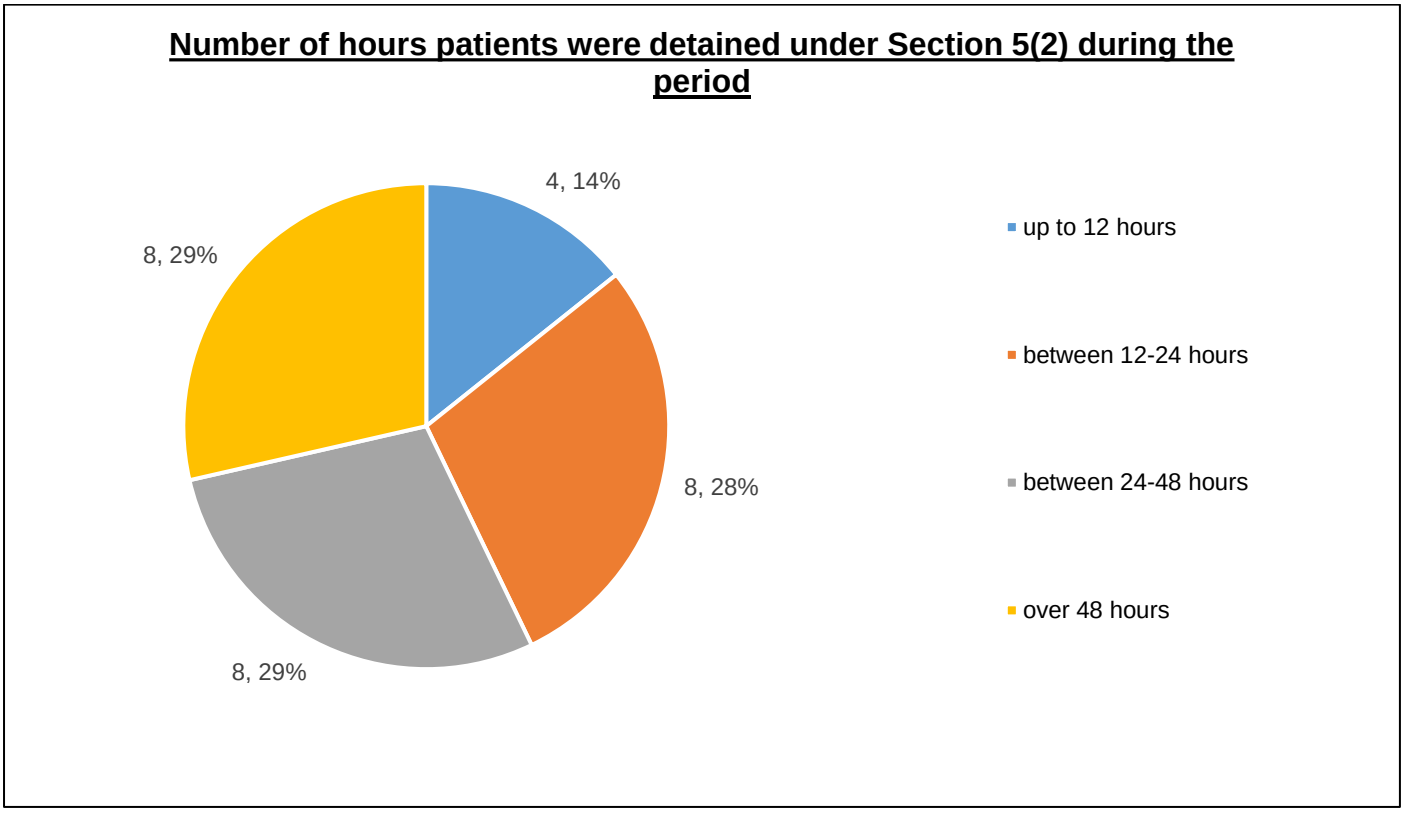




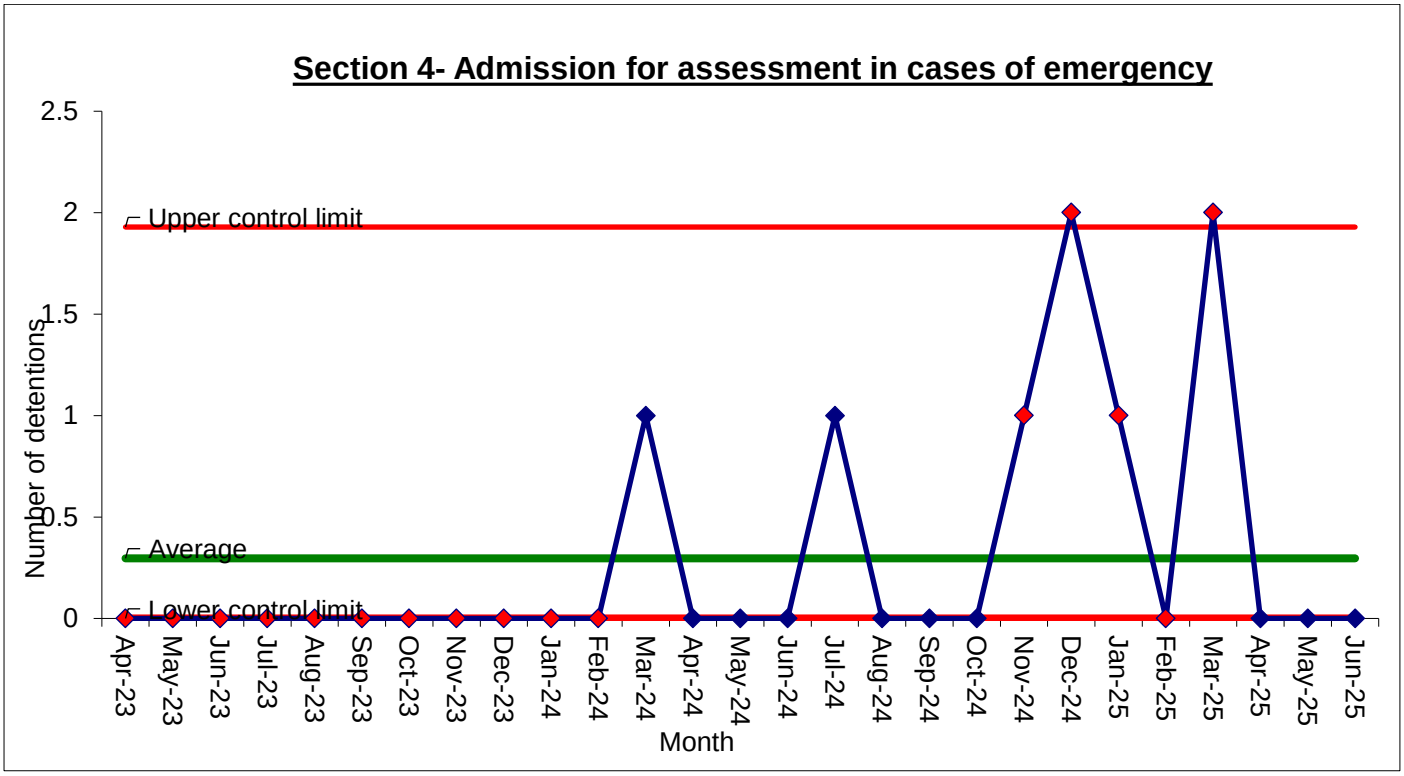
CAMHS Commissioned Inpatient Data

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

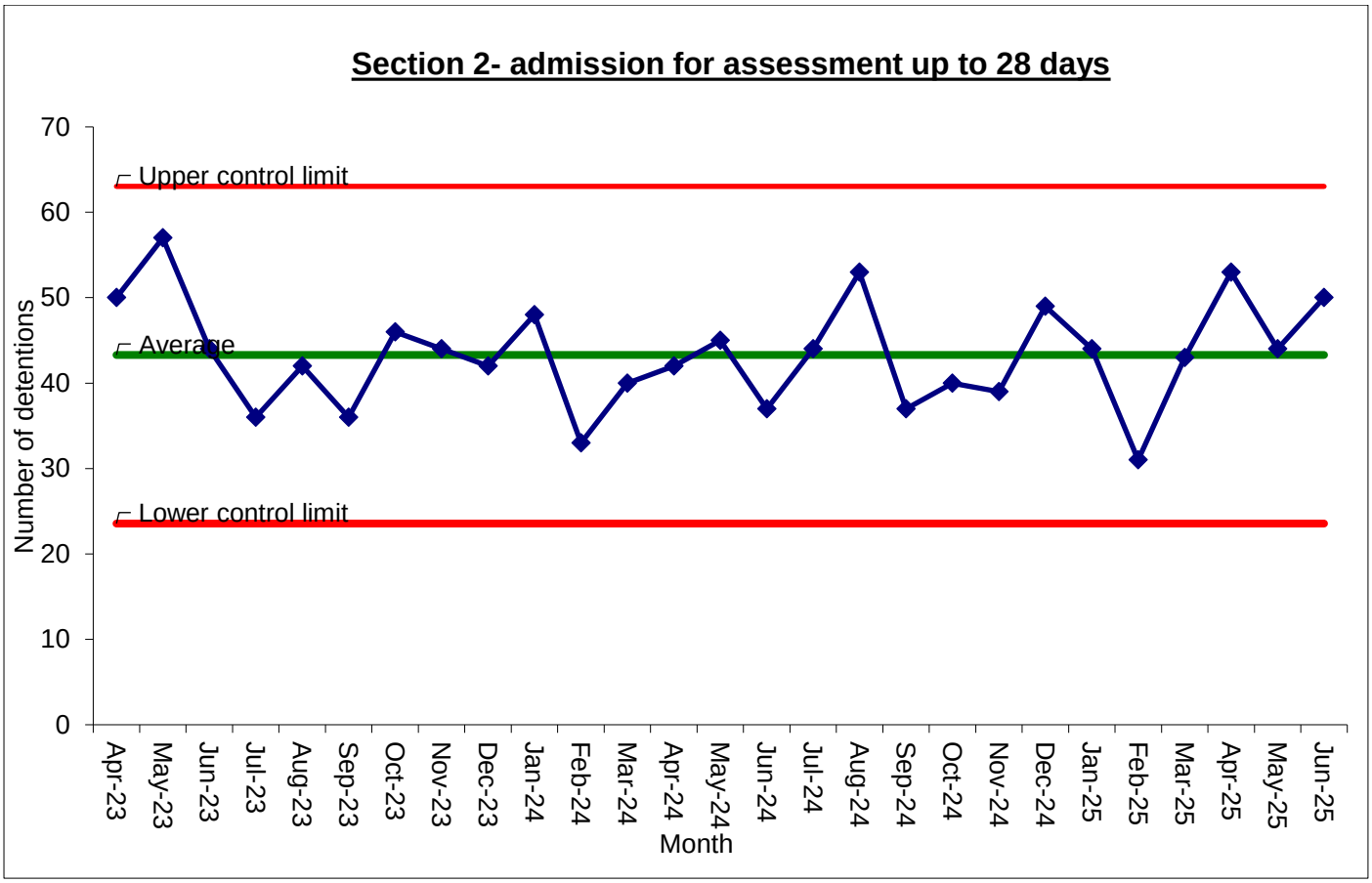
During the period there was one use of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB. The person was subsequently detained under Section 2.

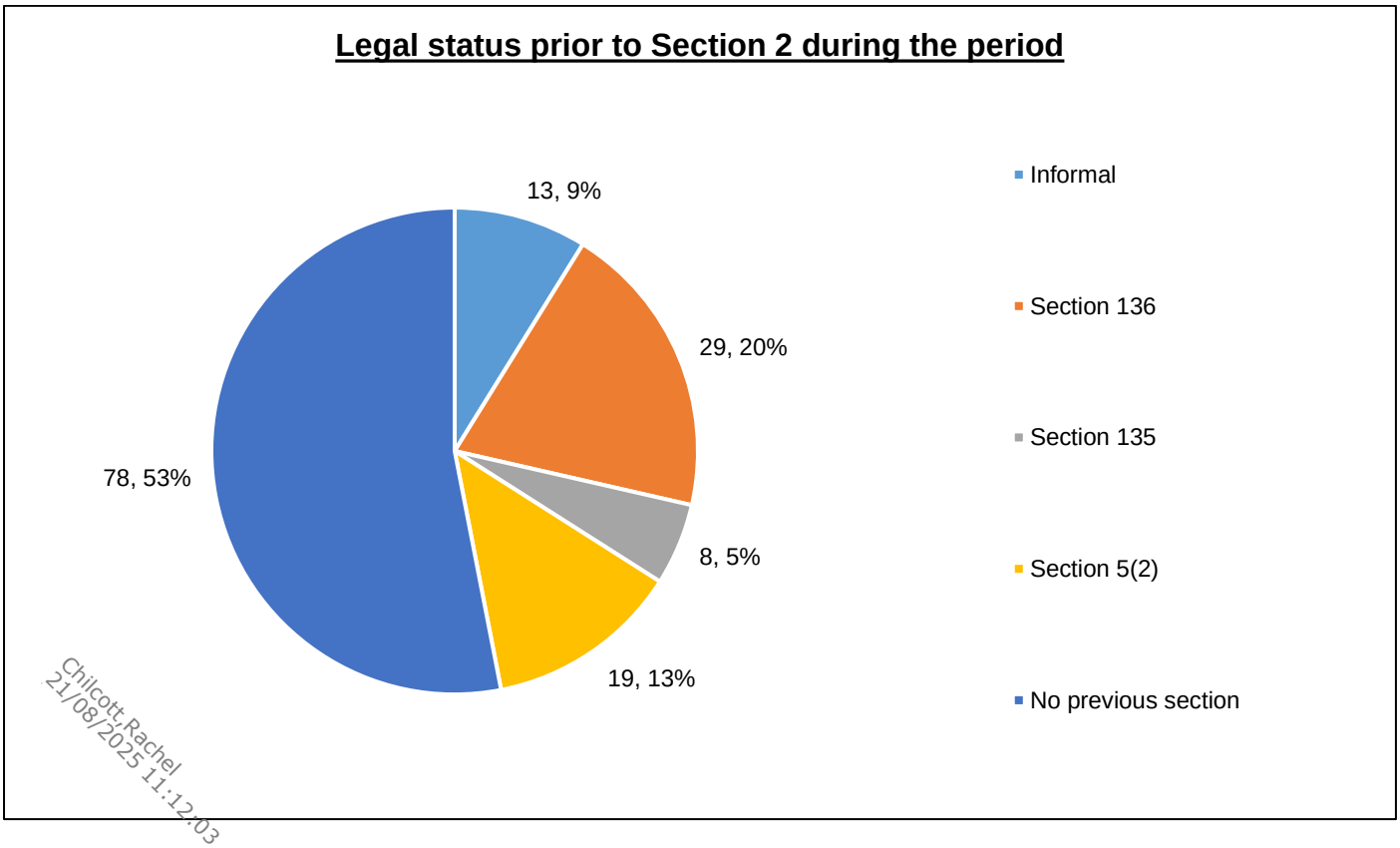
Section 4 - Admission for Assessment in Cases of Emergency

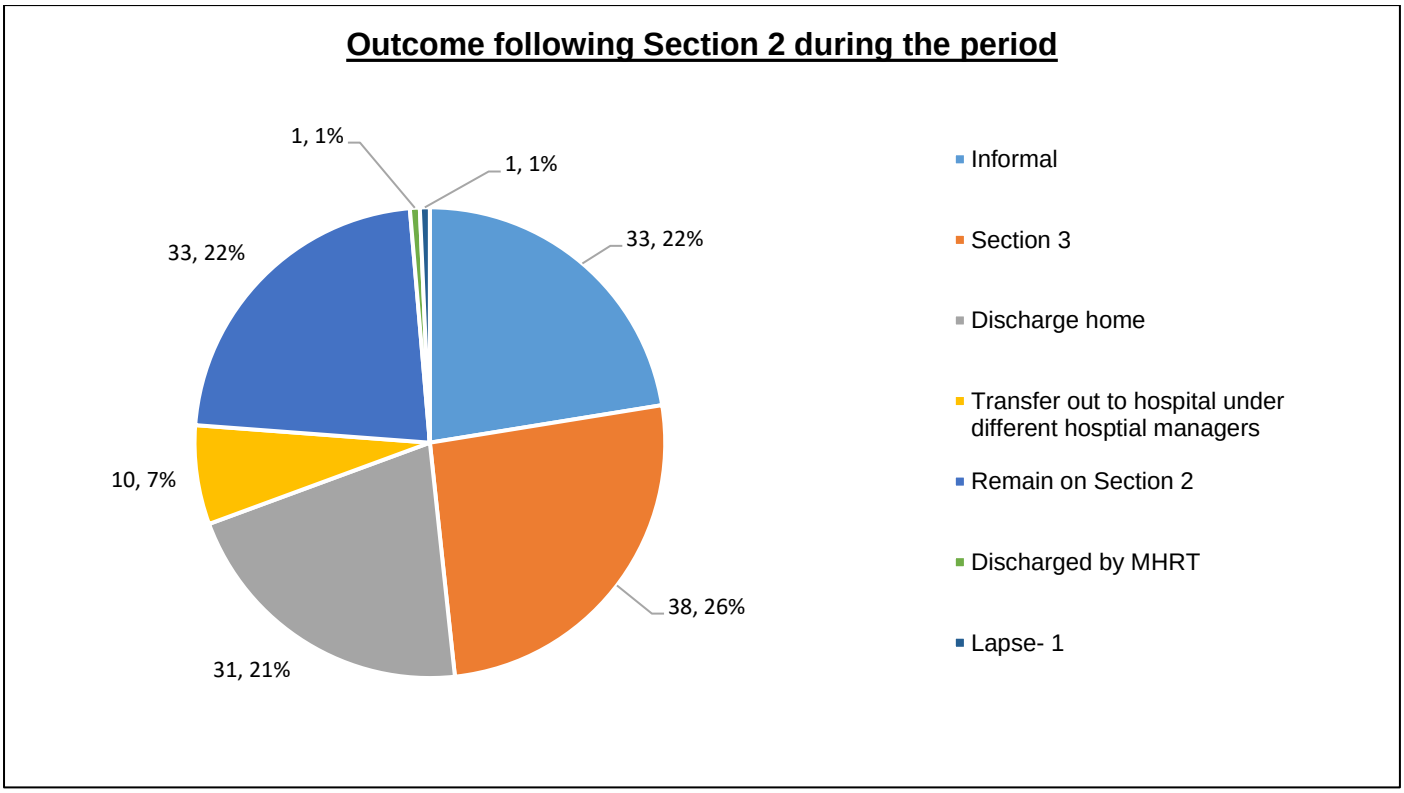
Section 4 was not used during the period.



Section 2 – Admission for Assessment



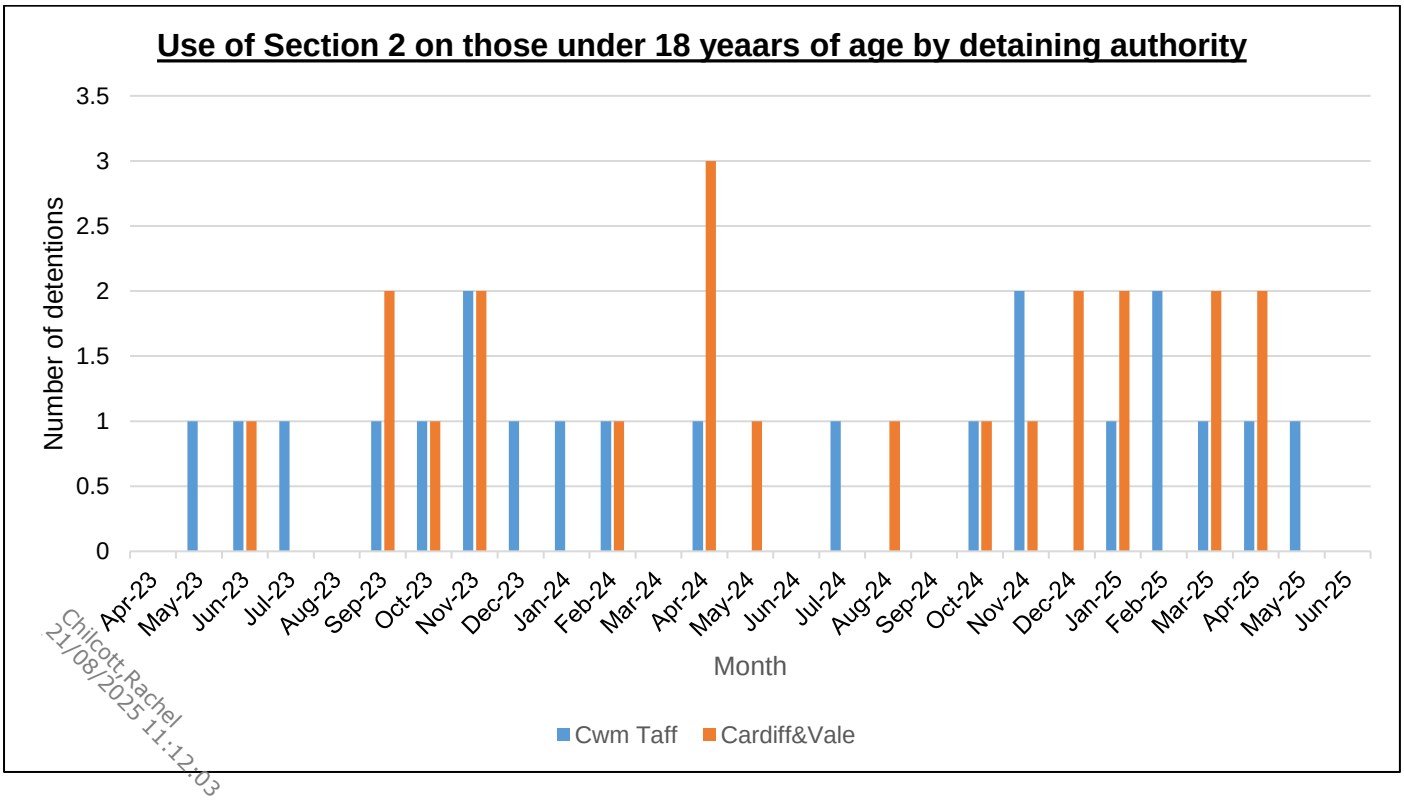


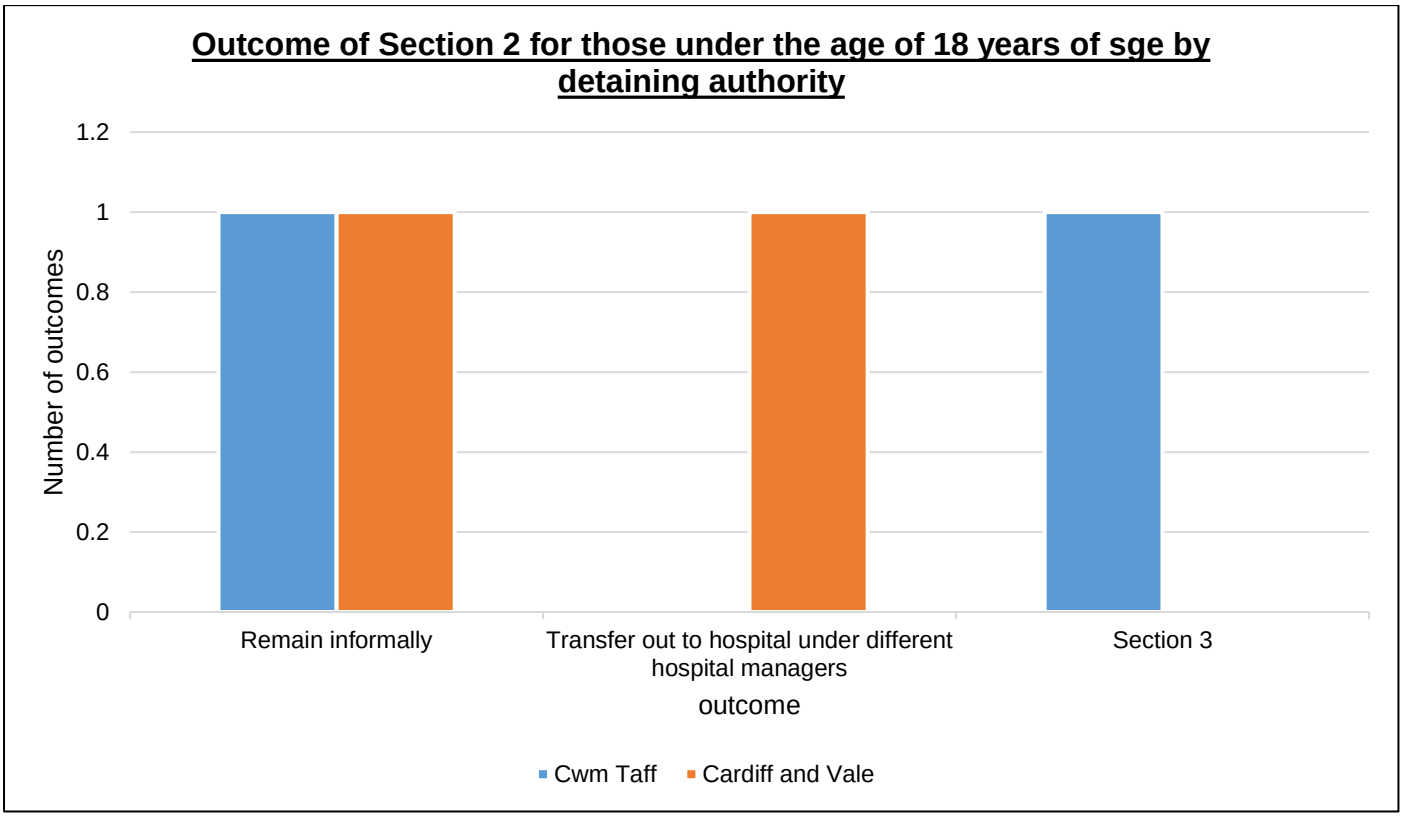


CAMHS Commissioned Inpatient Data

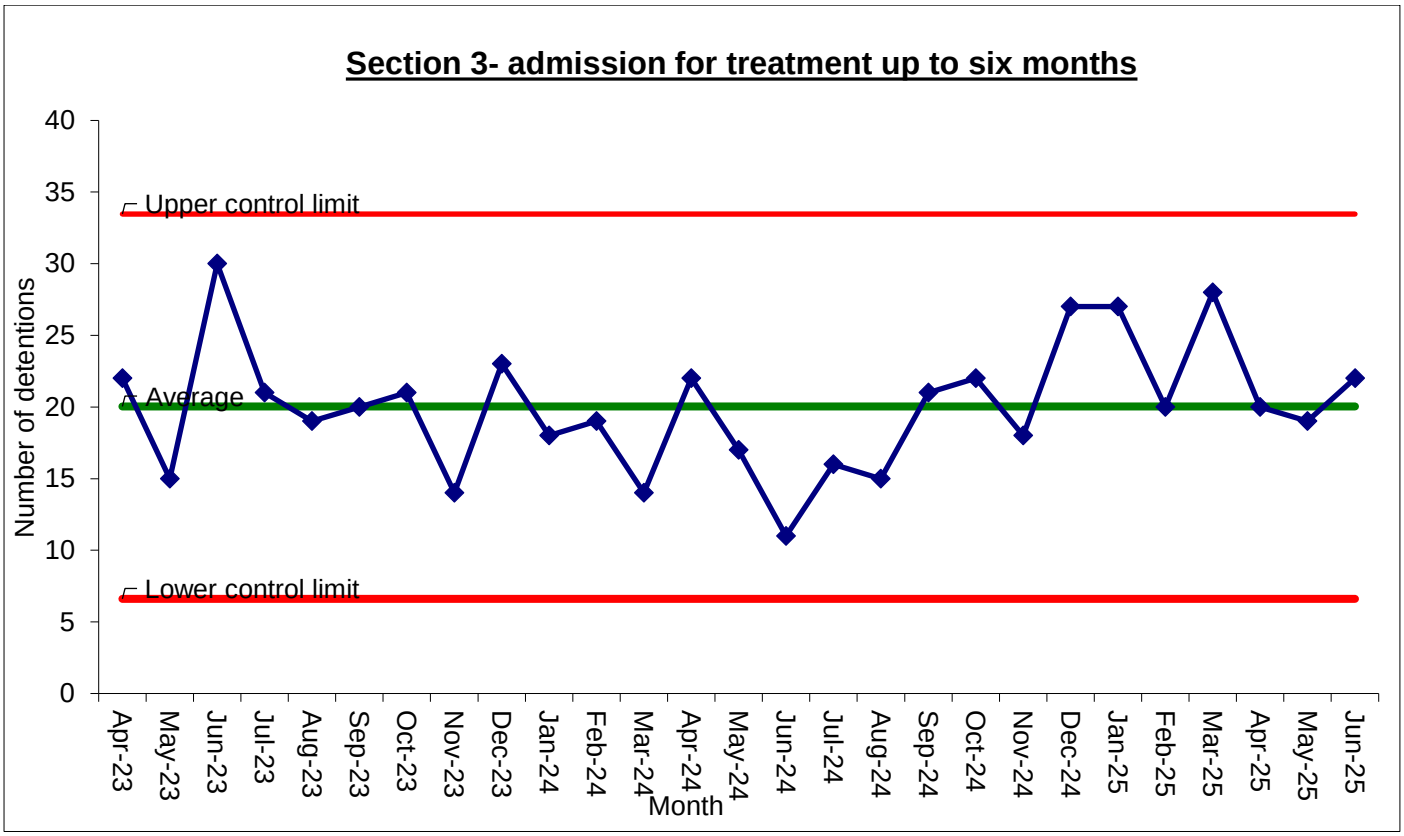
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

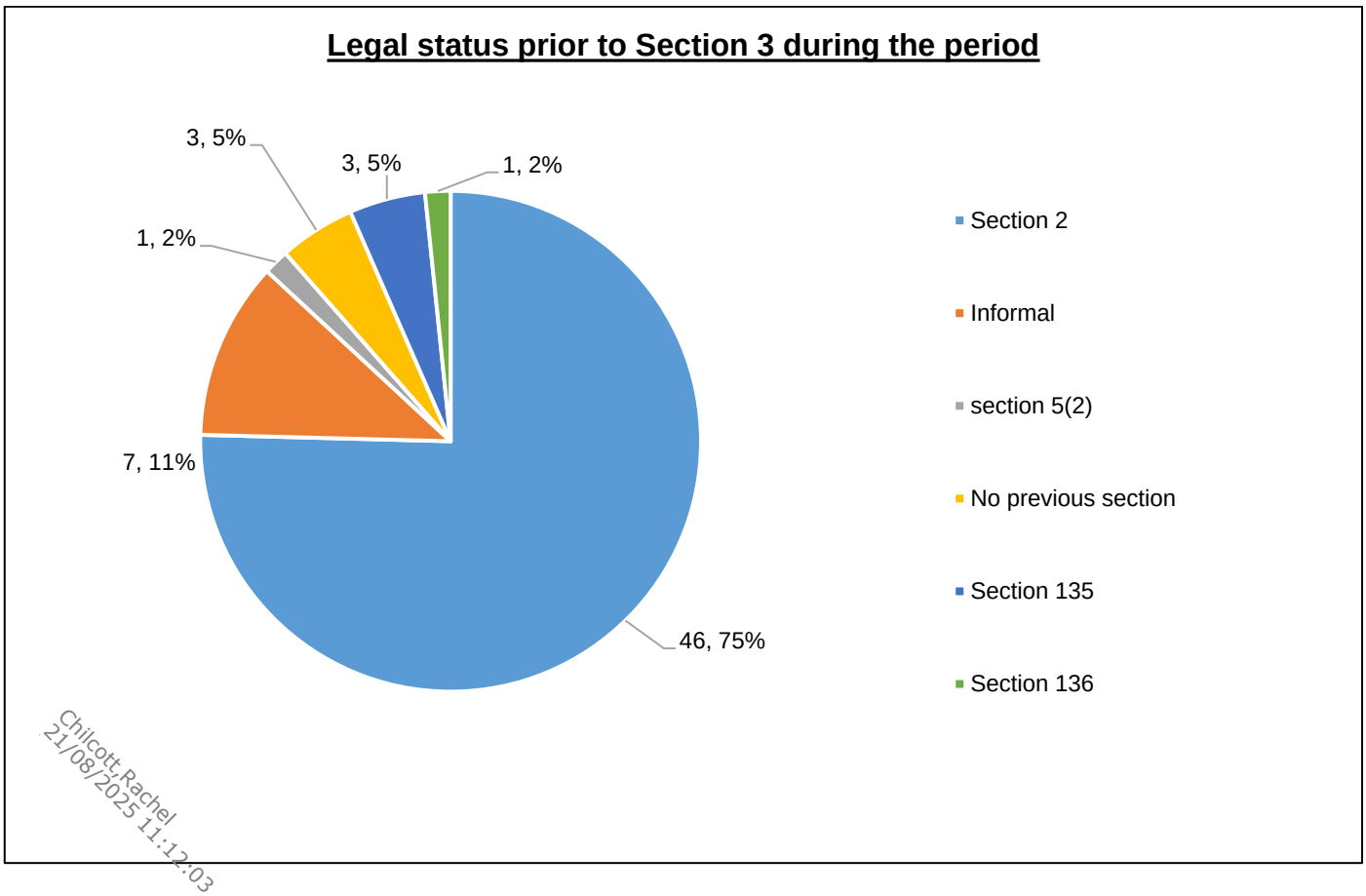
Included in the above data are those under 18 years of age. This is extracted below;-

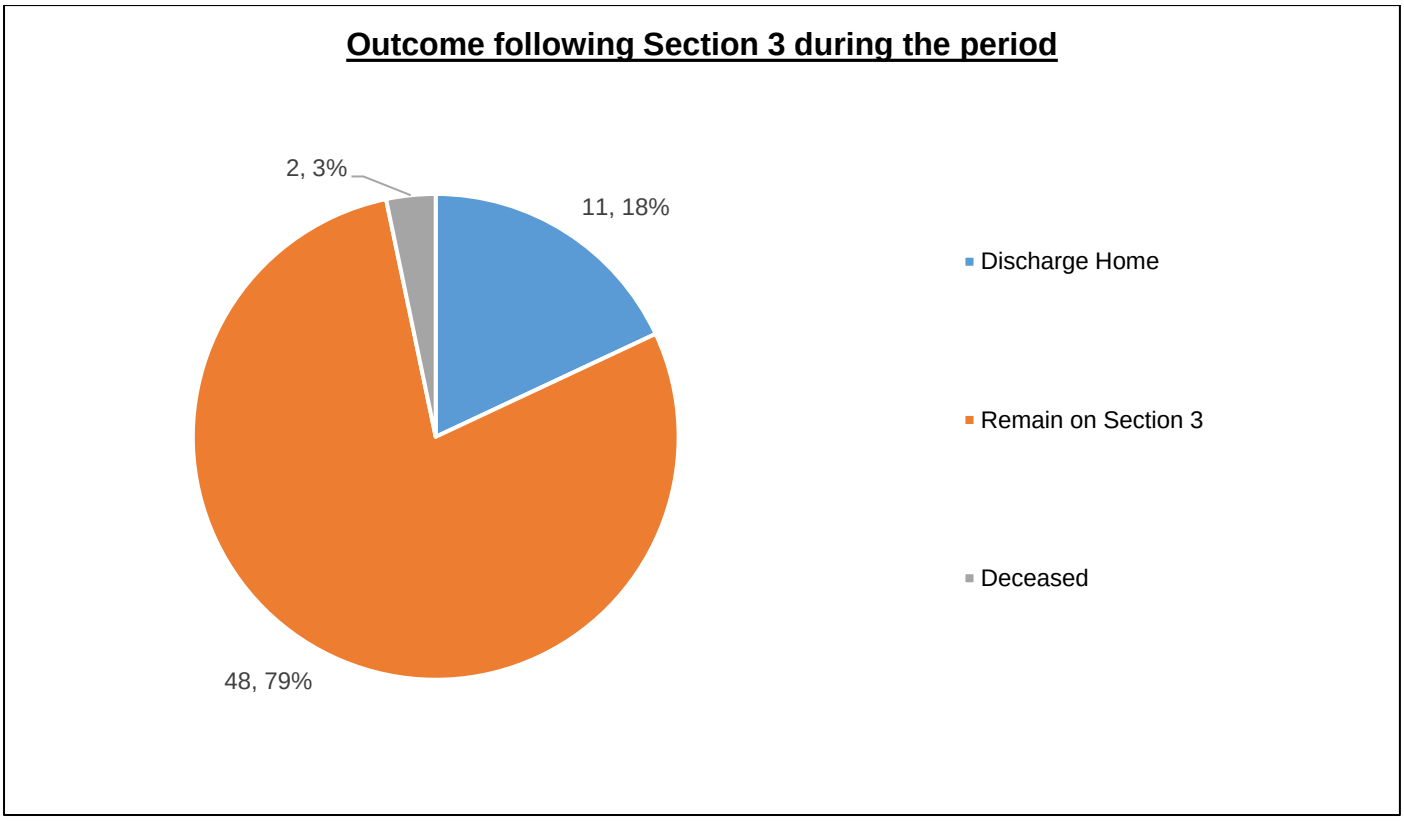




Section 3 – Admission for Treatment



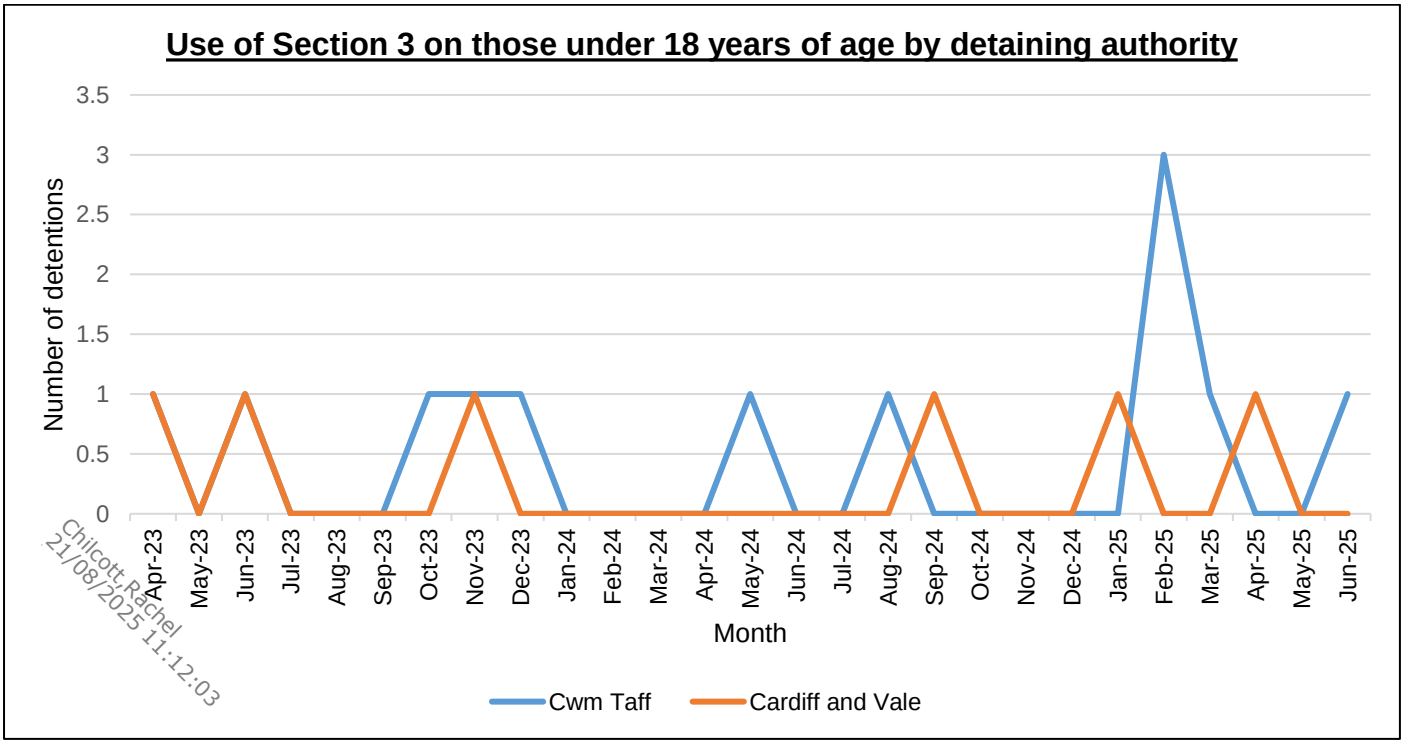


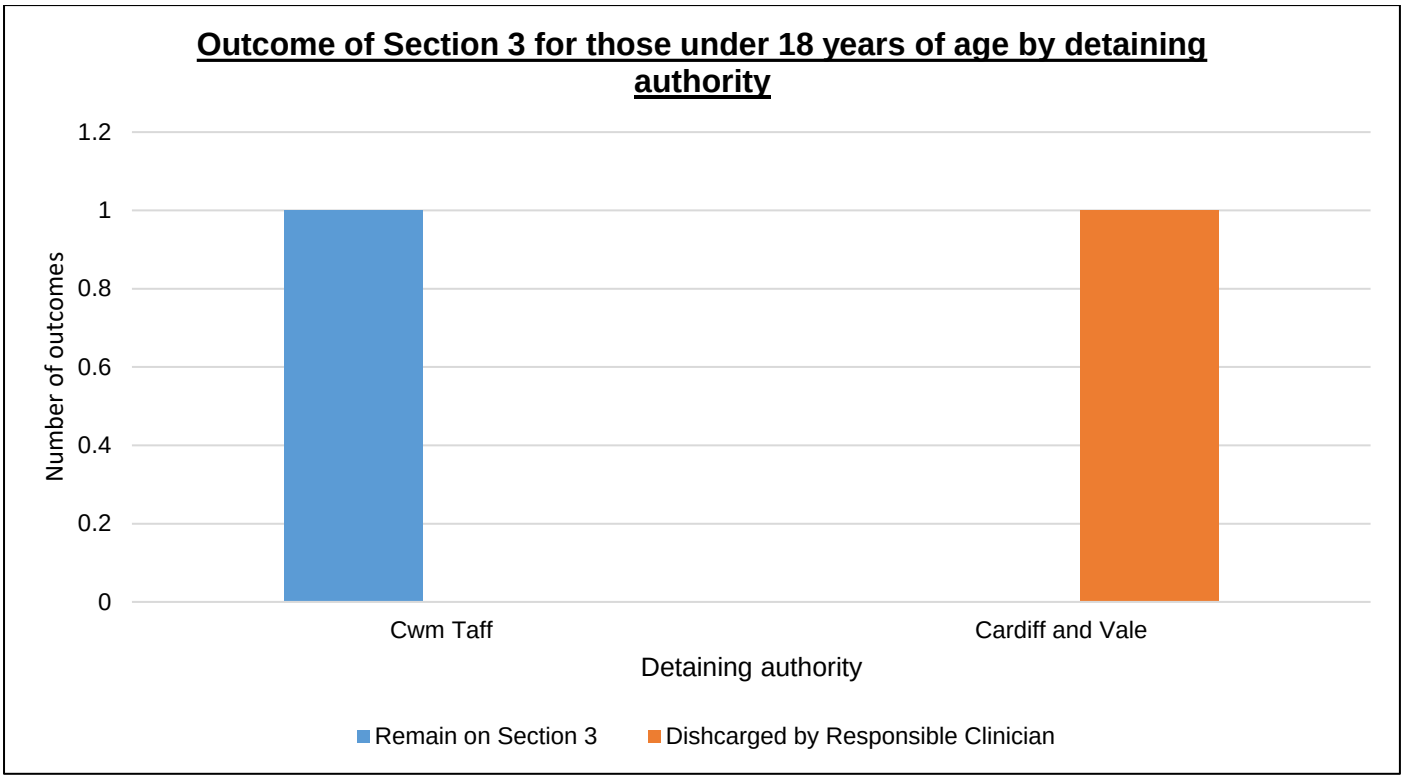


The above data would include those under 18 years of age.

CAMHS Commissioned Inpatient Data

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

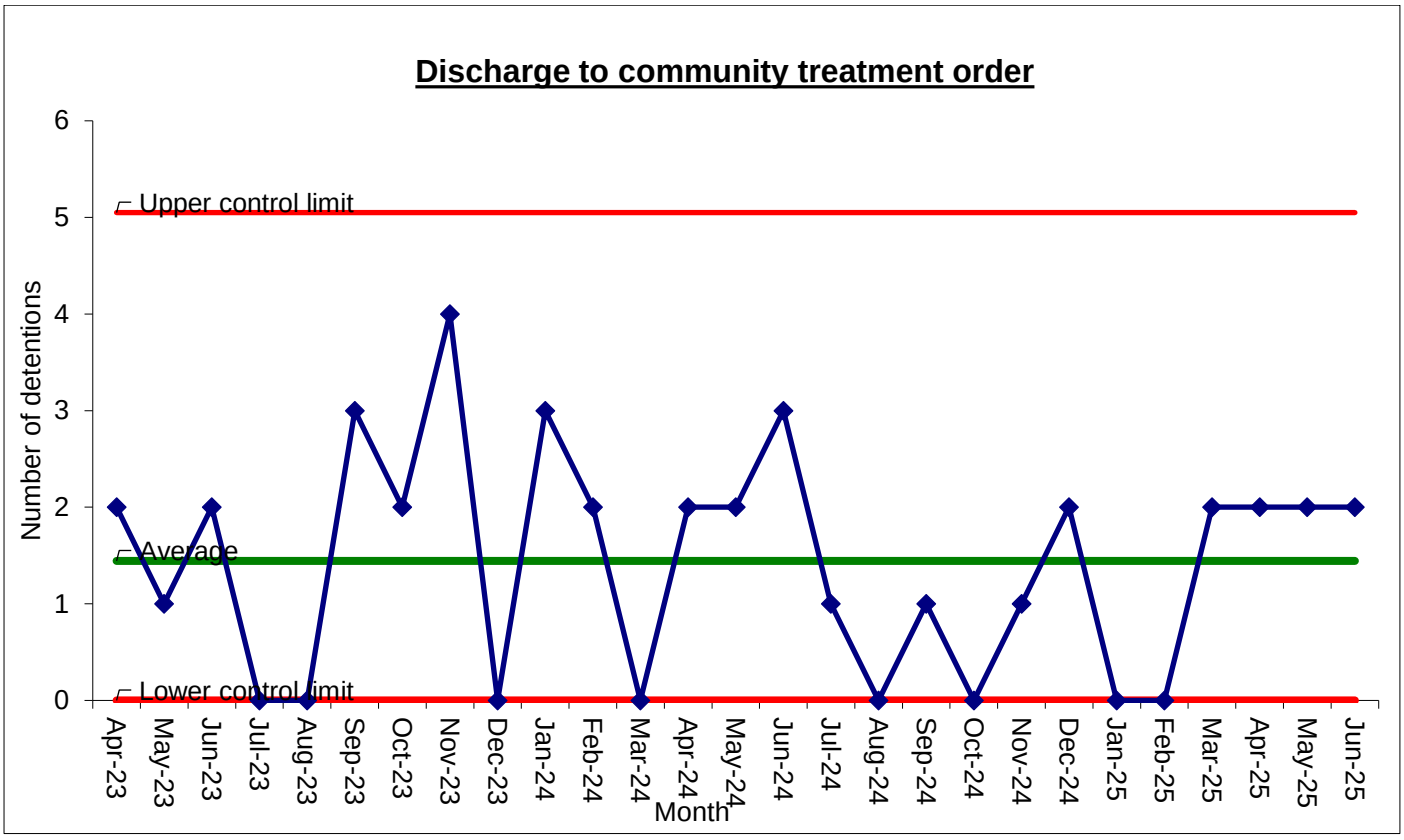


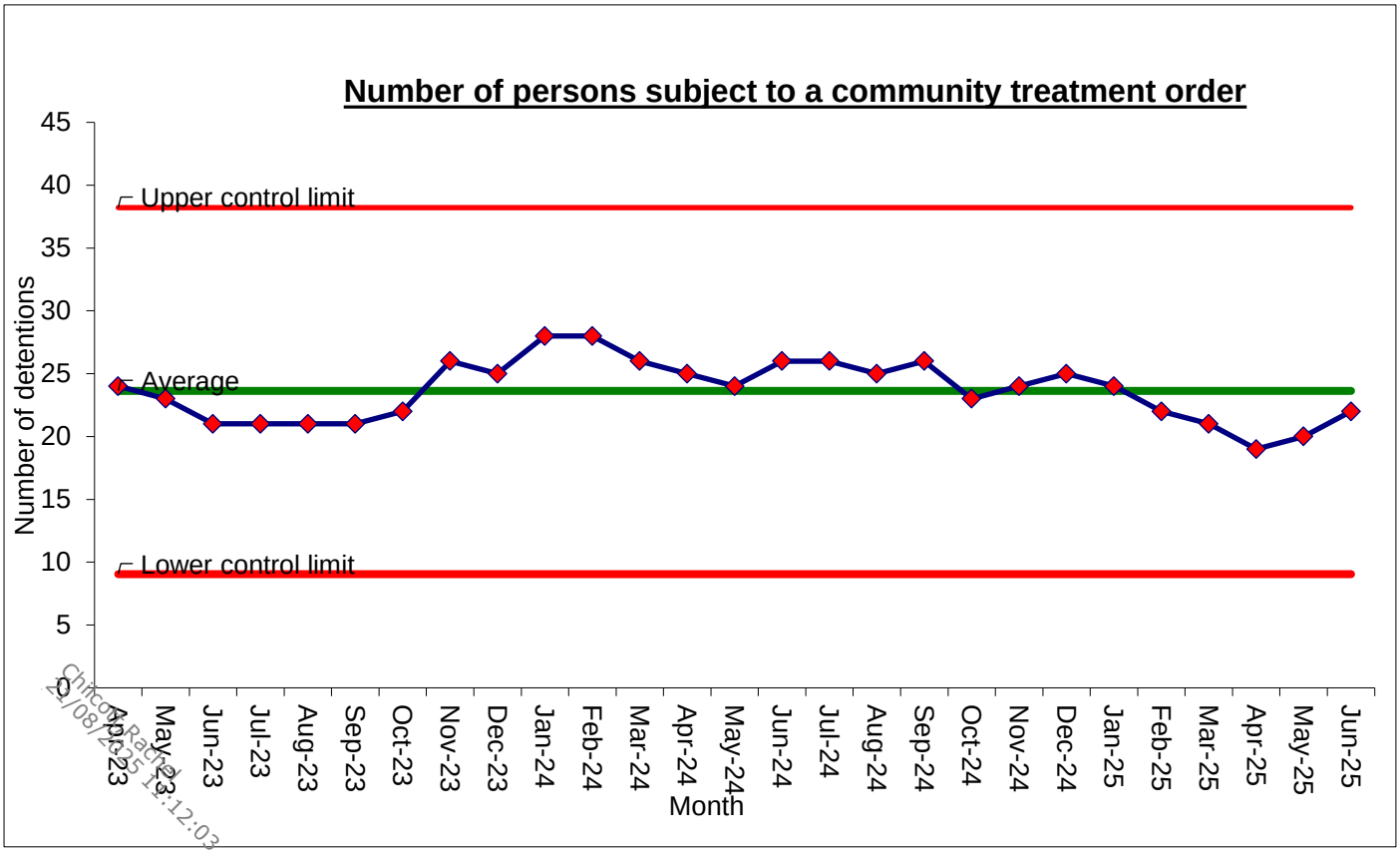


Community Treatment Order

During the period April - June six patients were discharged to a Community Treatment Order.

As of 30th June 2025, twenty-two 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 four times. Three ended with the person being revoked. One recall resulted in the person being released back onto their CTO.

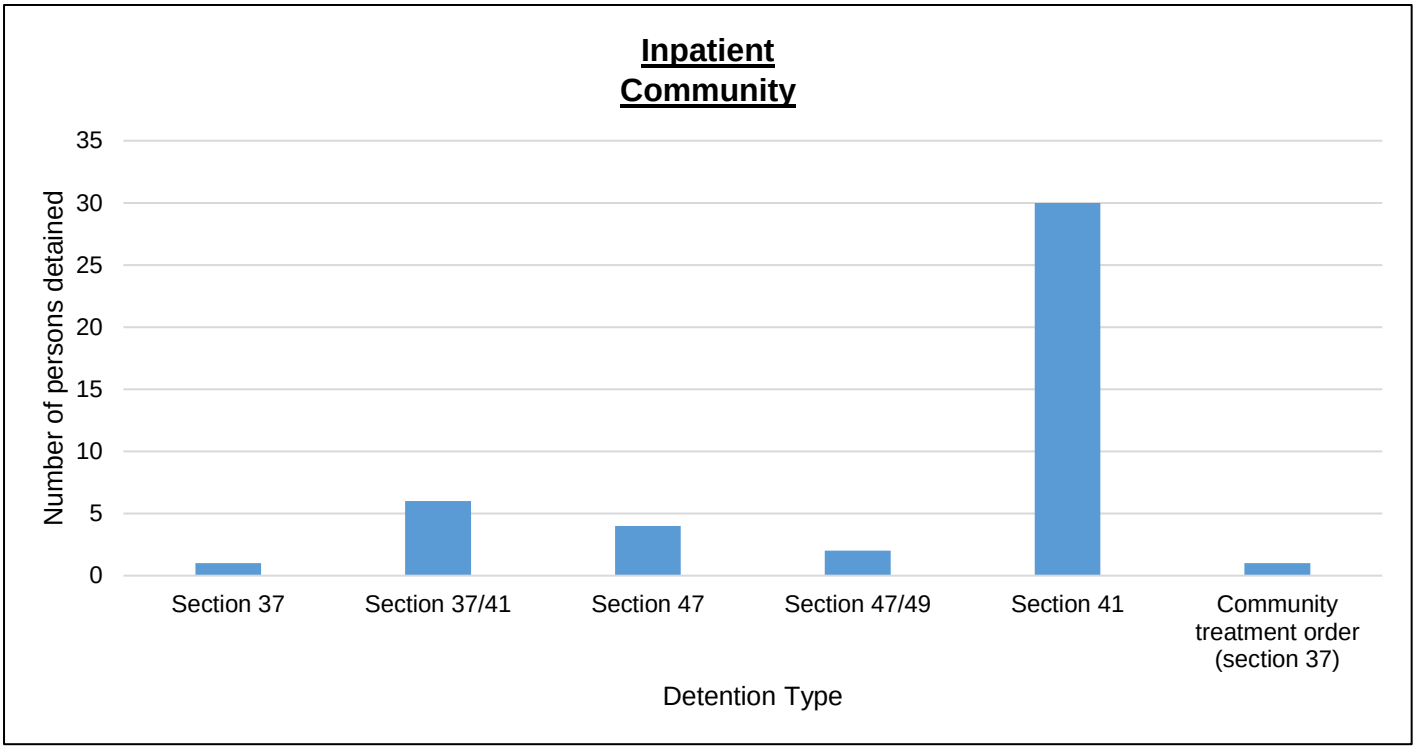
CAMHS Commissioned Inpatient Data

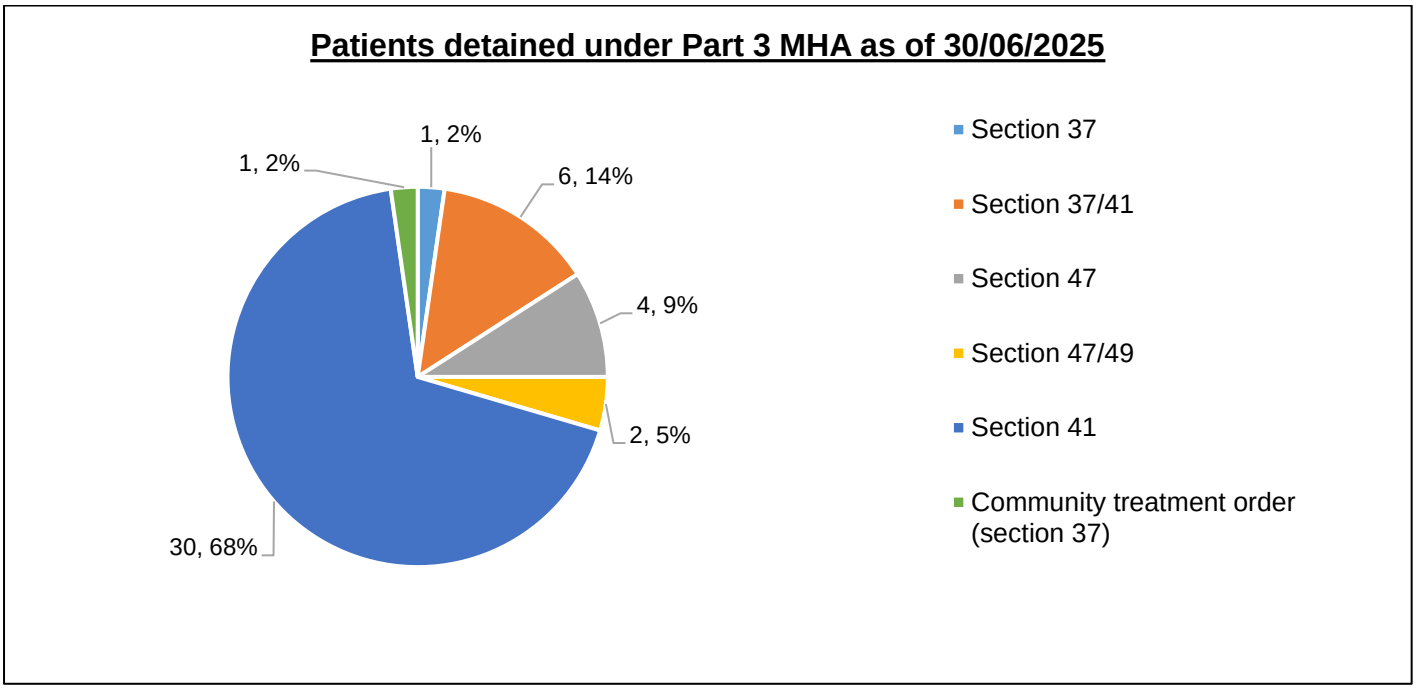
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

Part 3 of the Mental Health Act 1983

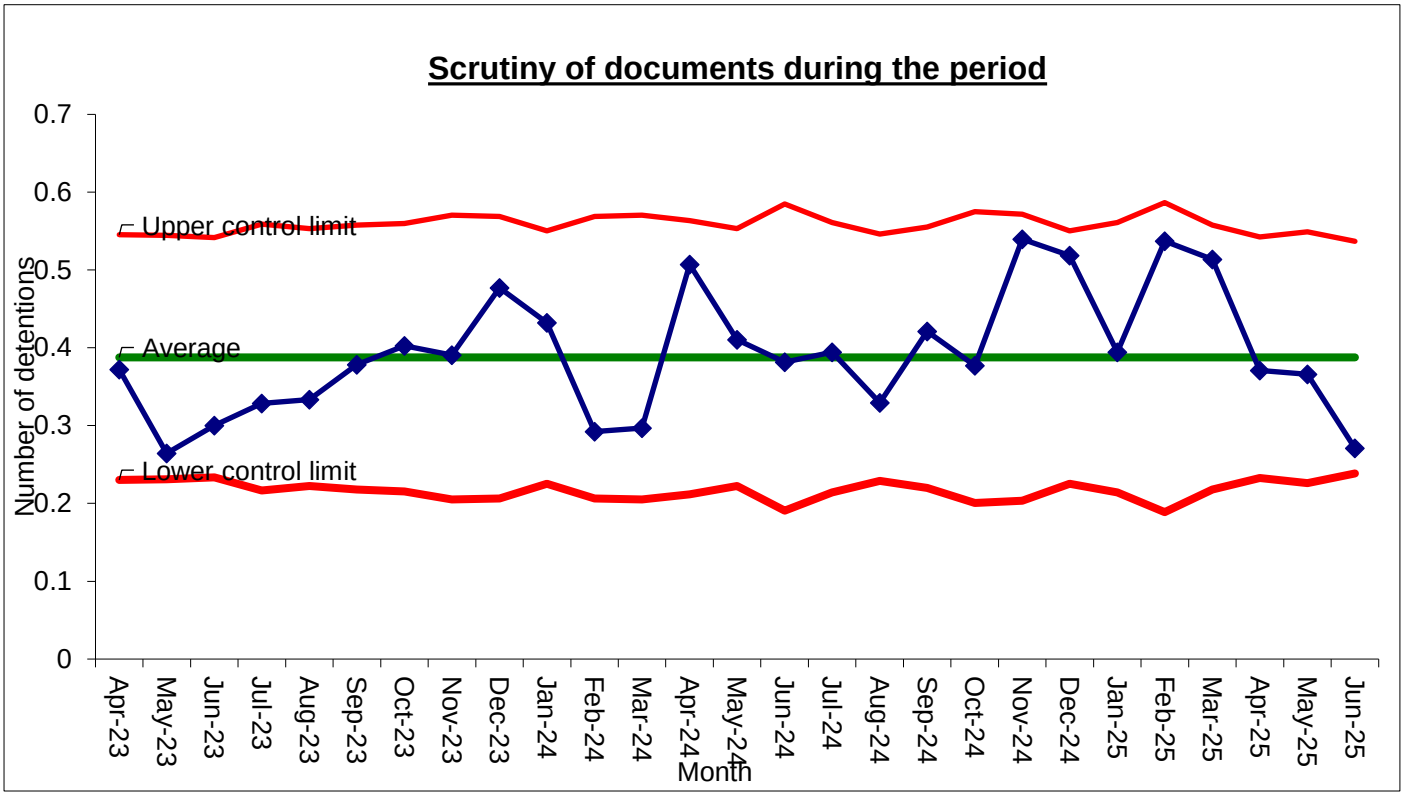
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as of 30th June 2025.

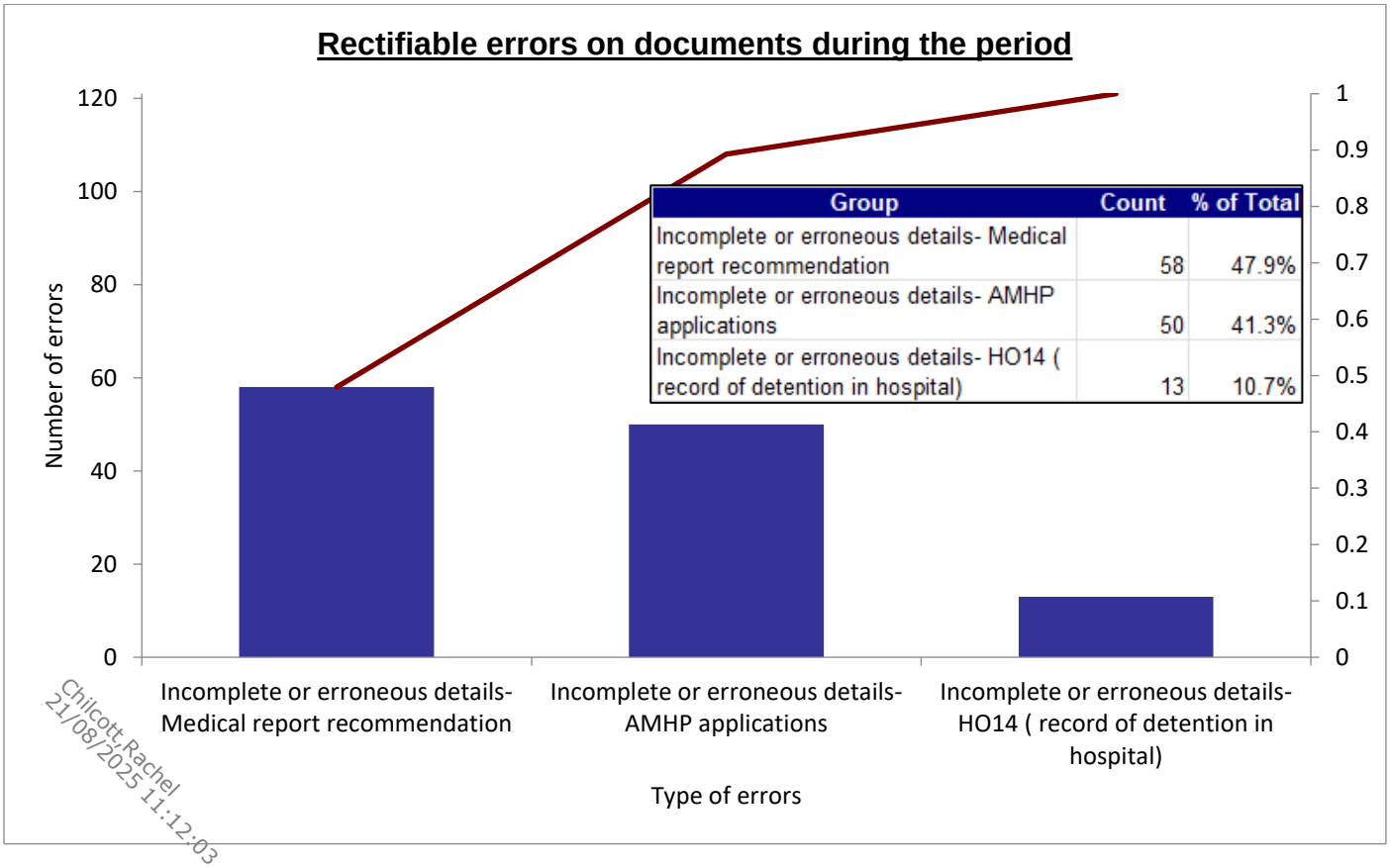




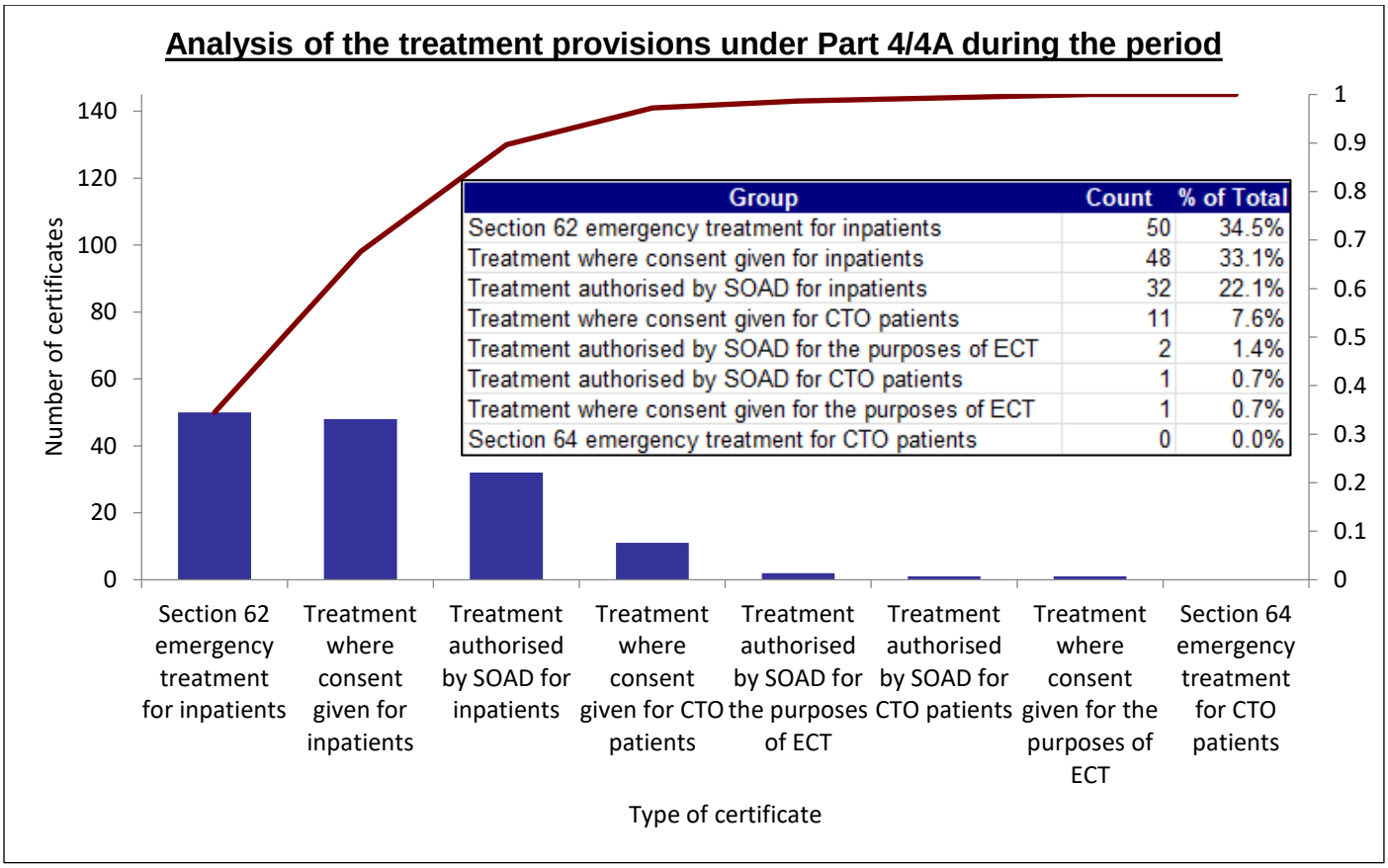
Scrutiny of documents during the period

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
Section 62 emergency treatment for inpatients	50	34.5%
Treatment where consent given for inpatients	48	33.1%
Treatment authorised by SOAD for inpatients	32	22.1%
Treatment where consent given for CTO patients	11	7.6%
Treatment authorised by SOAD for the purposes of ECT	2	1.4%
Treatment authorised by SOAD for CTO patients	1	0.7%
Treatment where consent given for the purposes of ECT	1	0.7%
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.

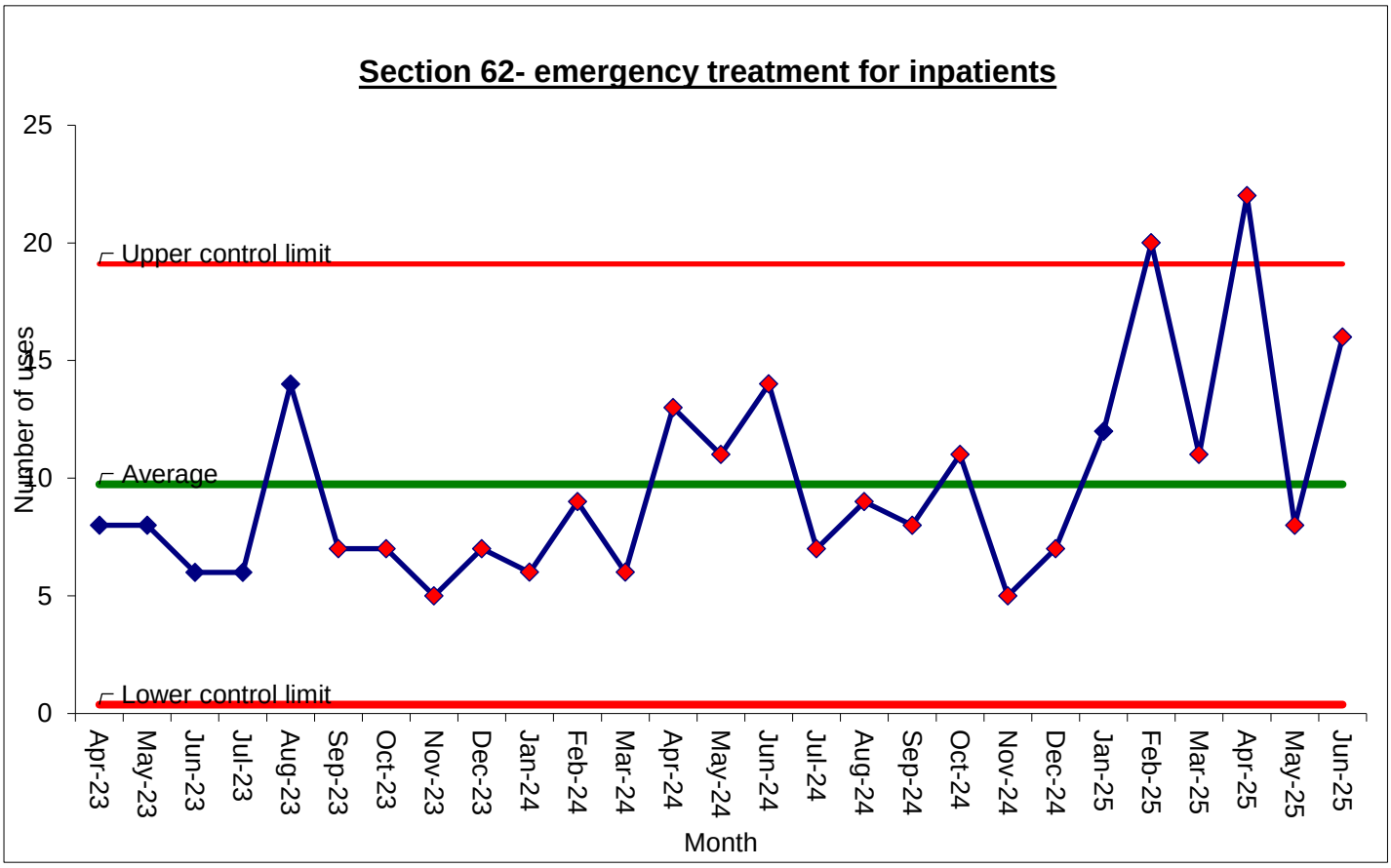
Urgent treatment is defined as treatment that is:

- 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.

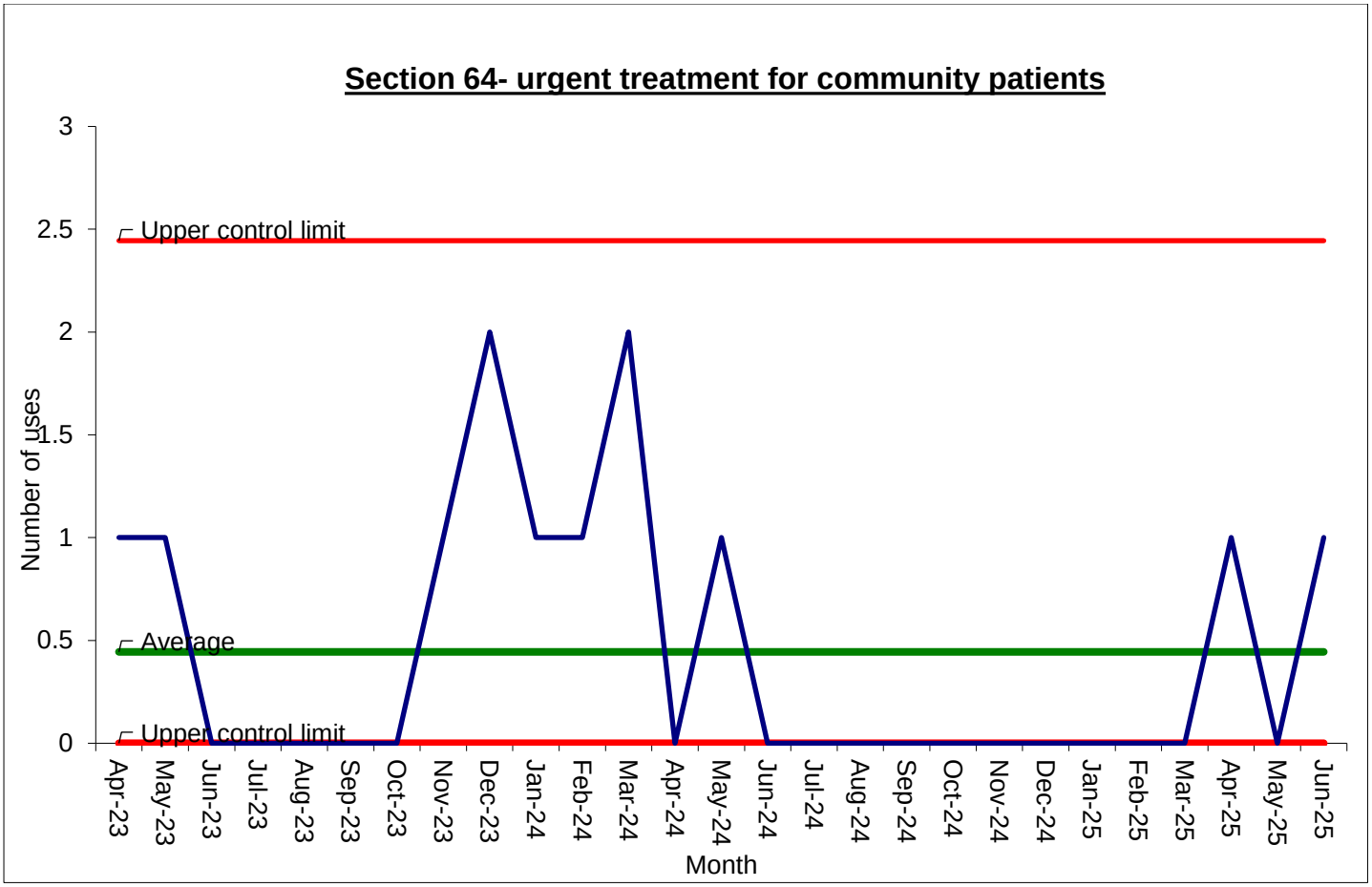
Urgent treatment can be used in any of the following instances:

- 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 forty-eight occasions for the following reasons:

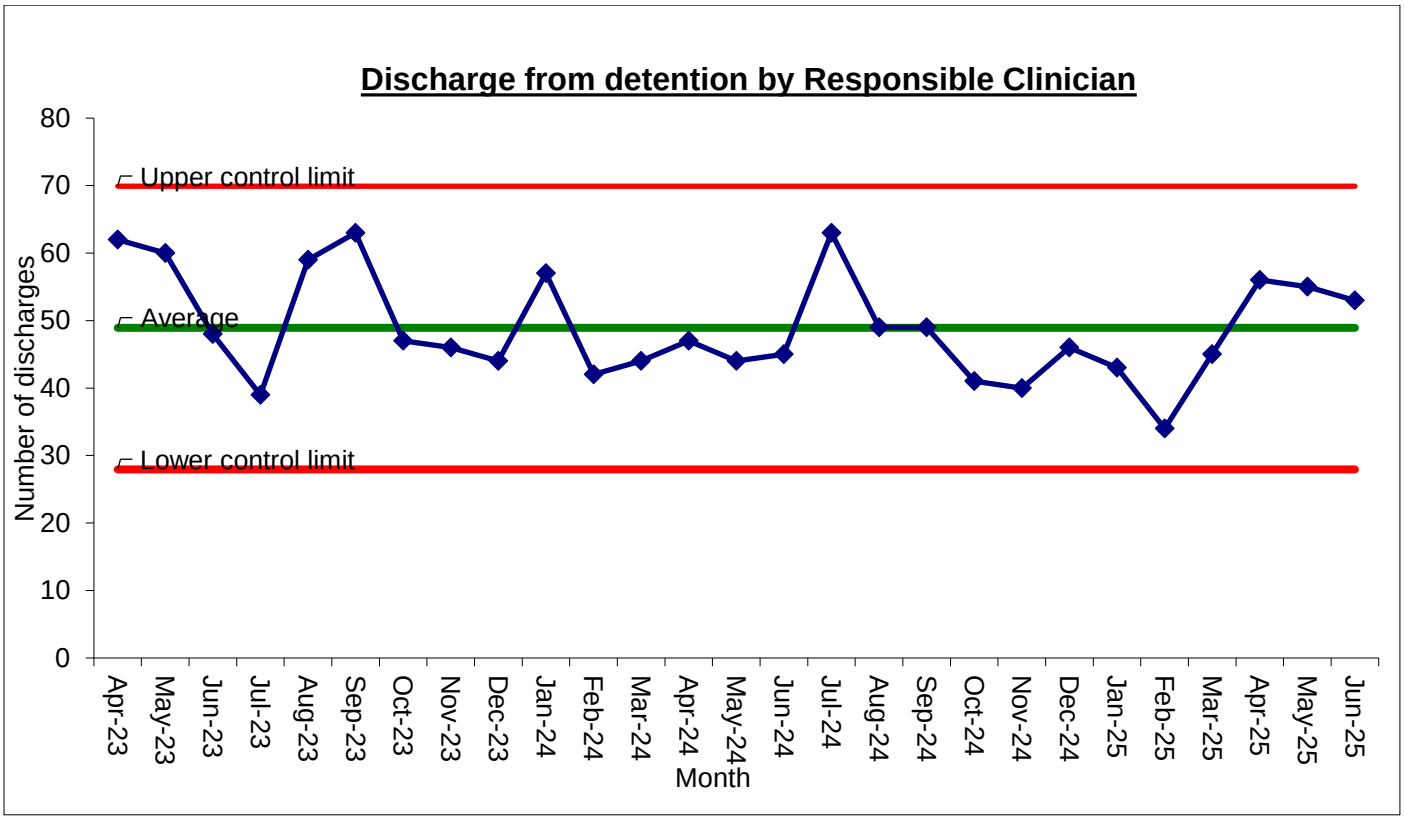
- Change of medication x9
- Three-month rule x21
- Emergency ECT x13
- CTO revoke x1
- Transfer in x2

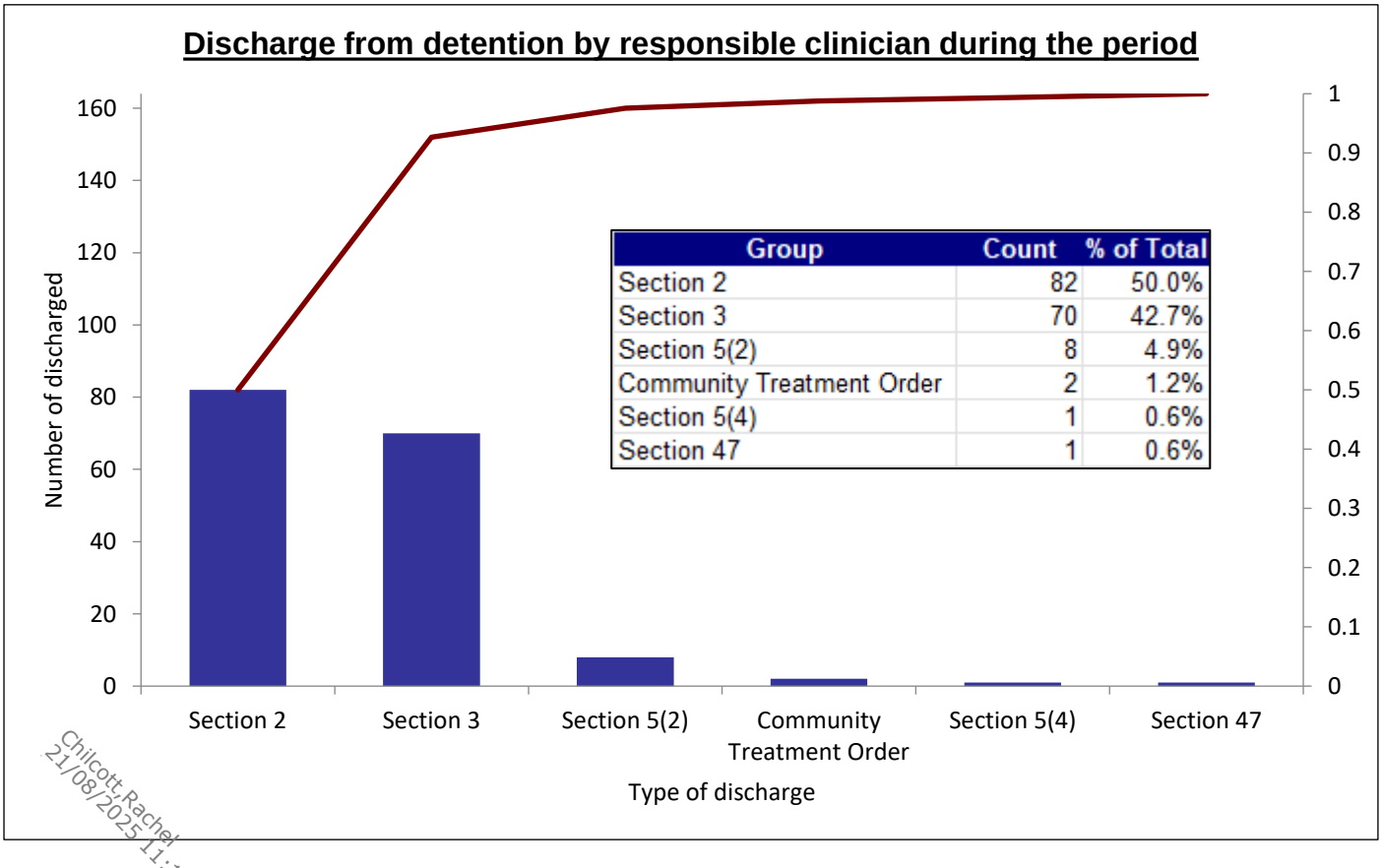


The above chart highlights that Section 64 was used twice during this period for the following reasons:

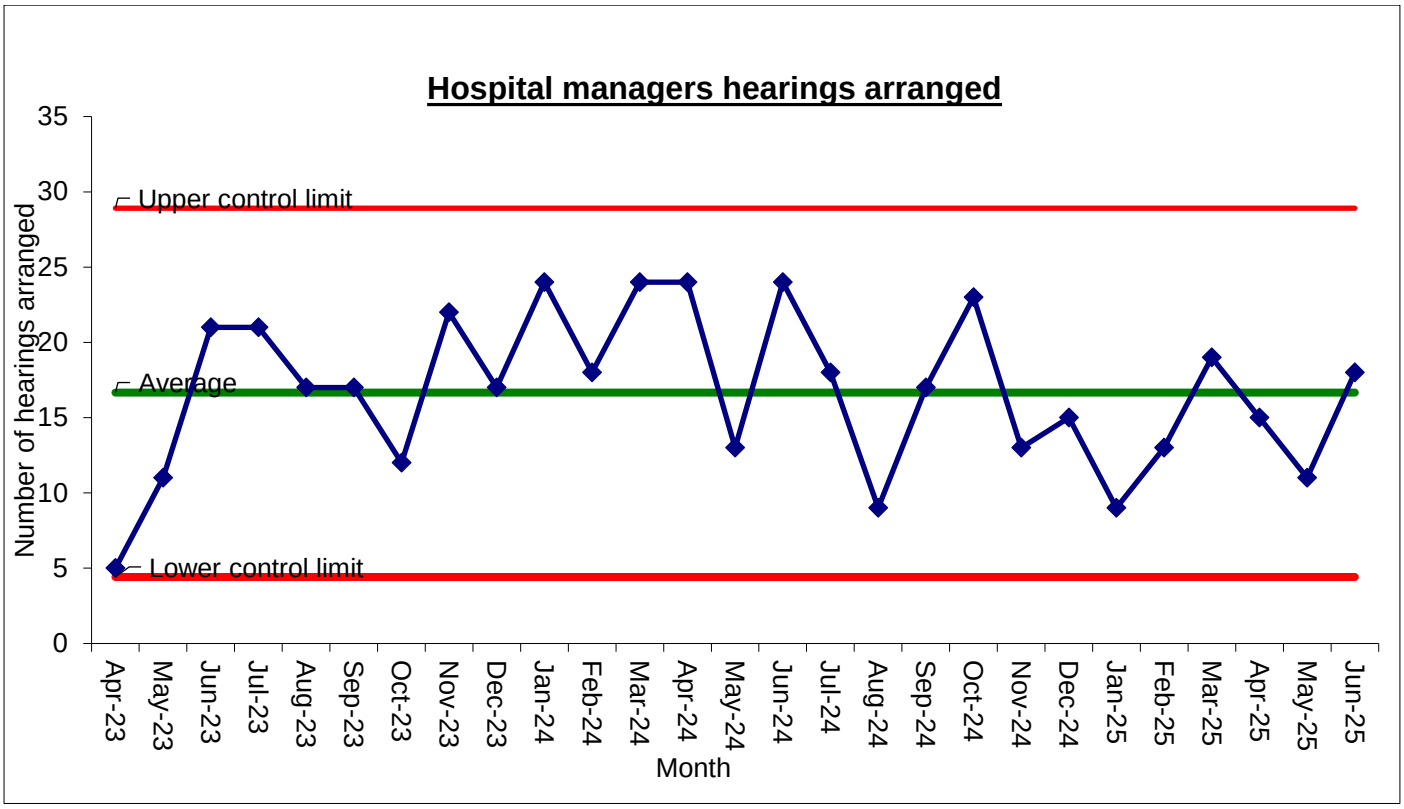
- Change of medication x1
- One-month rule x1

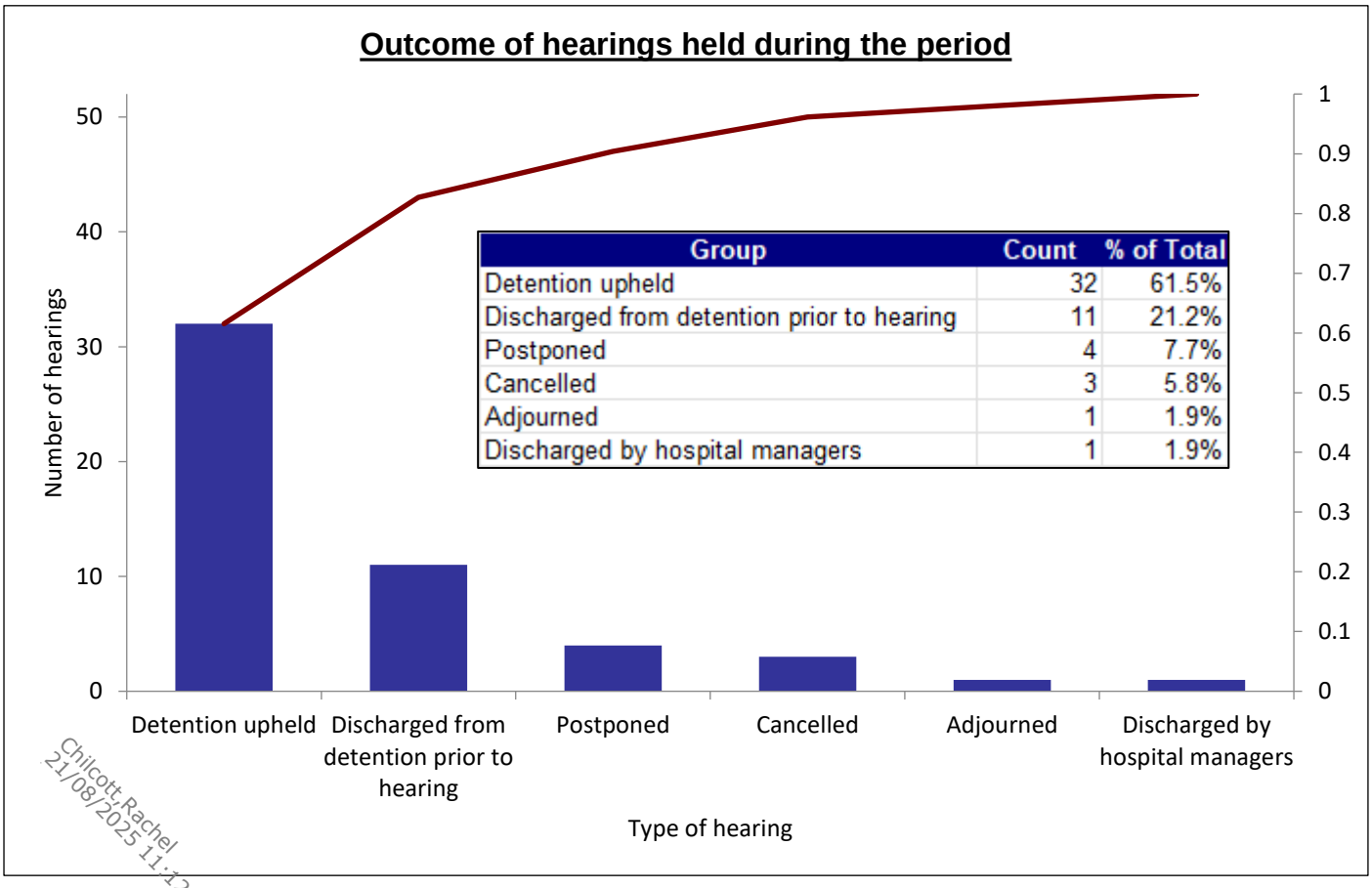
Discharge





Hospital Managers – Power of Discharge





Group	Count	% of Total
Detention upheld	32	61.5%
Discharged from detention prior to hearing	11	21.2%
Postponed	4	7.7%
Cancelled	3	5.8%
Adjourned	1	1.9%
Discharged by hospital managers	1	1.9%

One hearing were adjourned for the following reasons:

- Advocate unavailable x 1

Four hearings were postponed for the following reasons:

- RC unavailable x1
- Patient unwell x 2
- No social circumstances report x 1

Three hearings were cancelled for the following reasons:

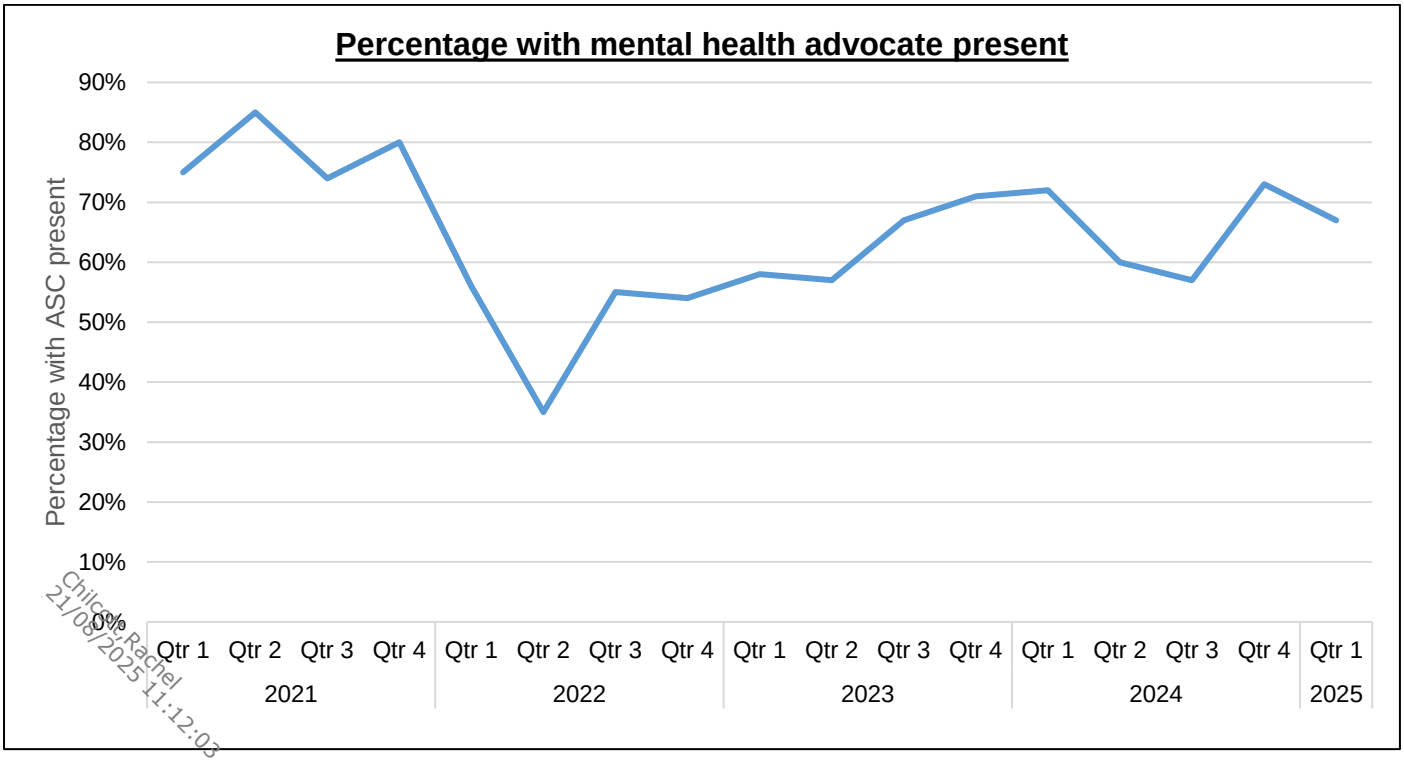
- Patient transferred out x1
- NR no longer wanted patient discharged x1
- Review no longer needed x1

Advocacy referrals:

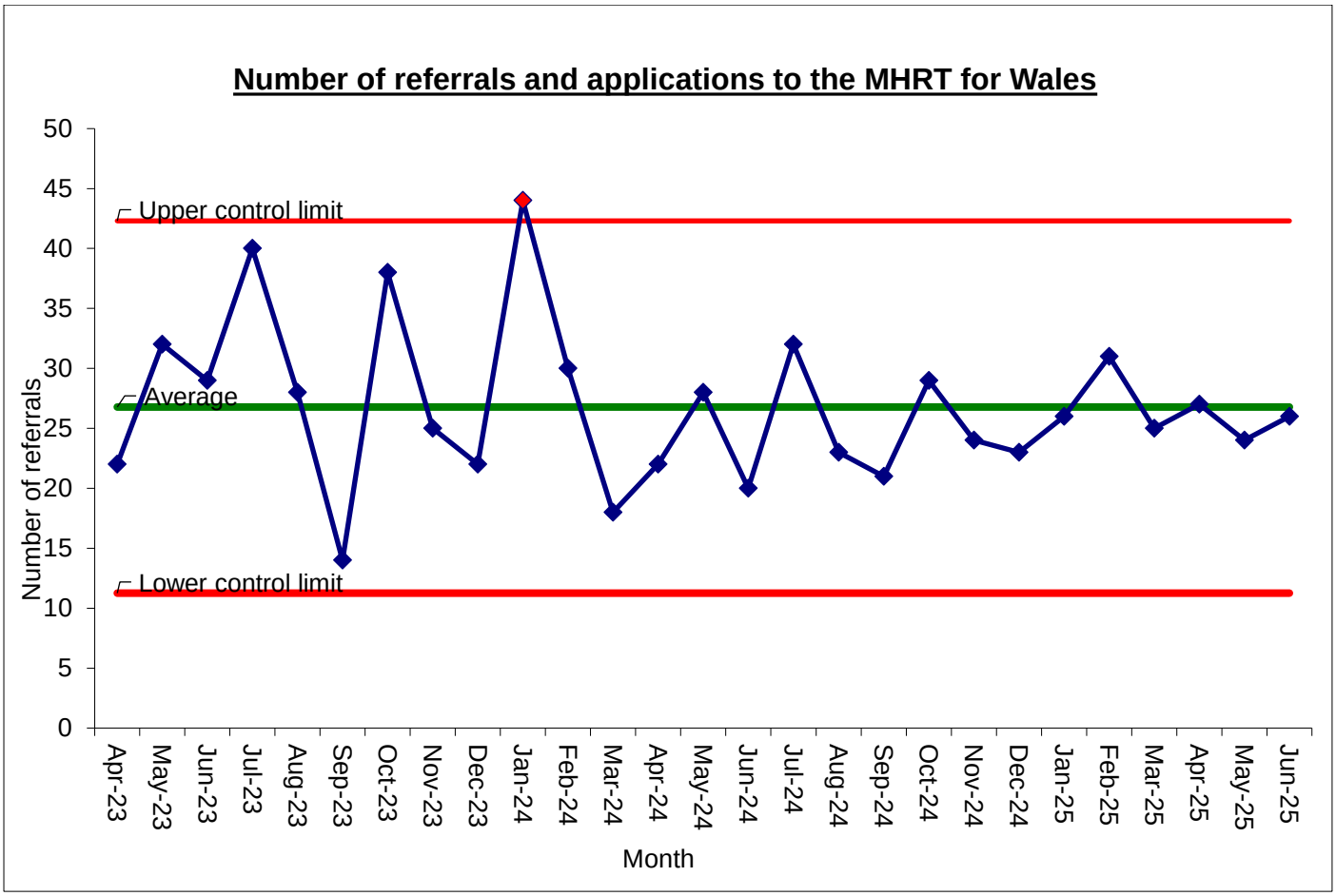
Out of 52 hearings that could have gone ahead during the quarter, 35 of those had been referred for an advocate and advocates attended 20 of those.

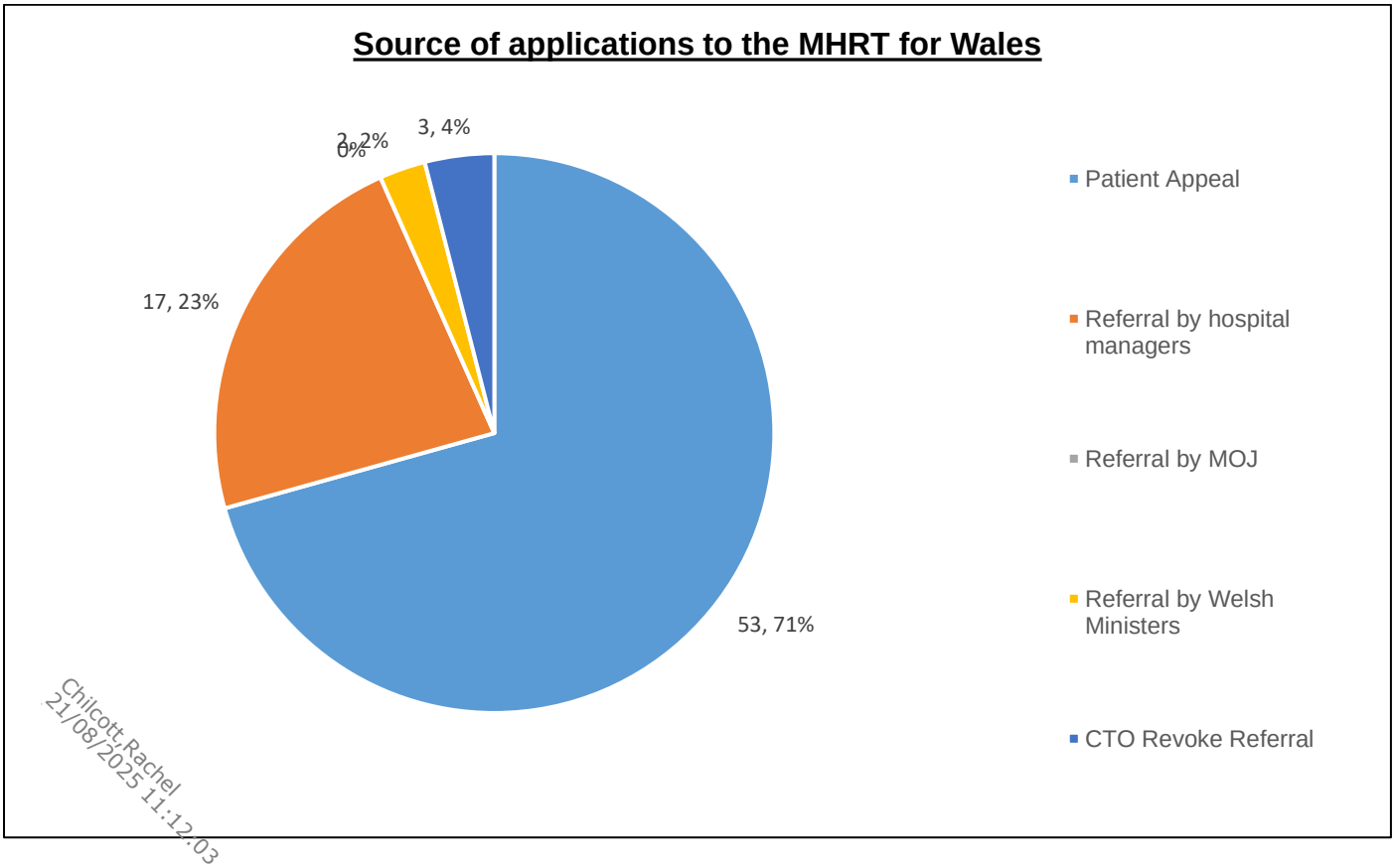
Advocates present:

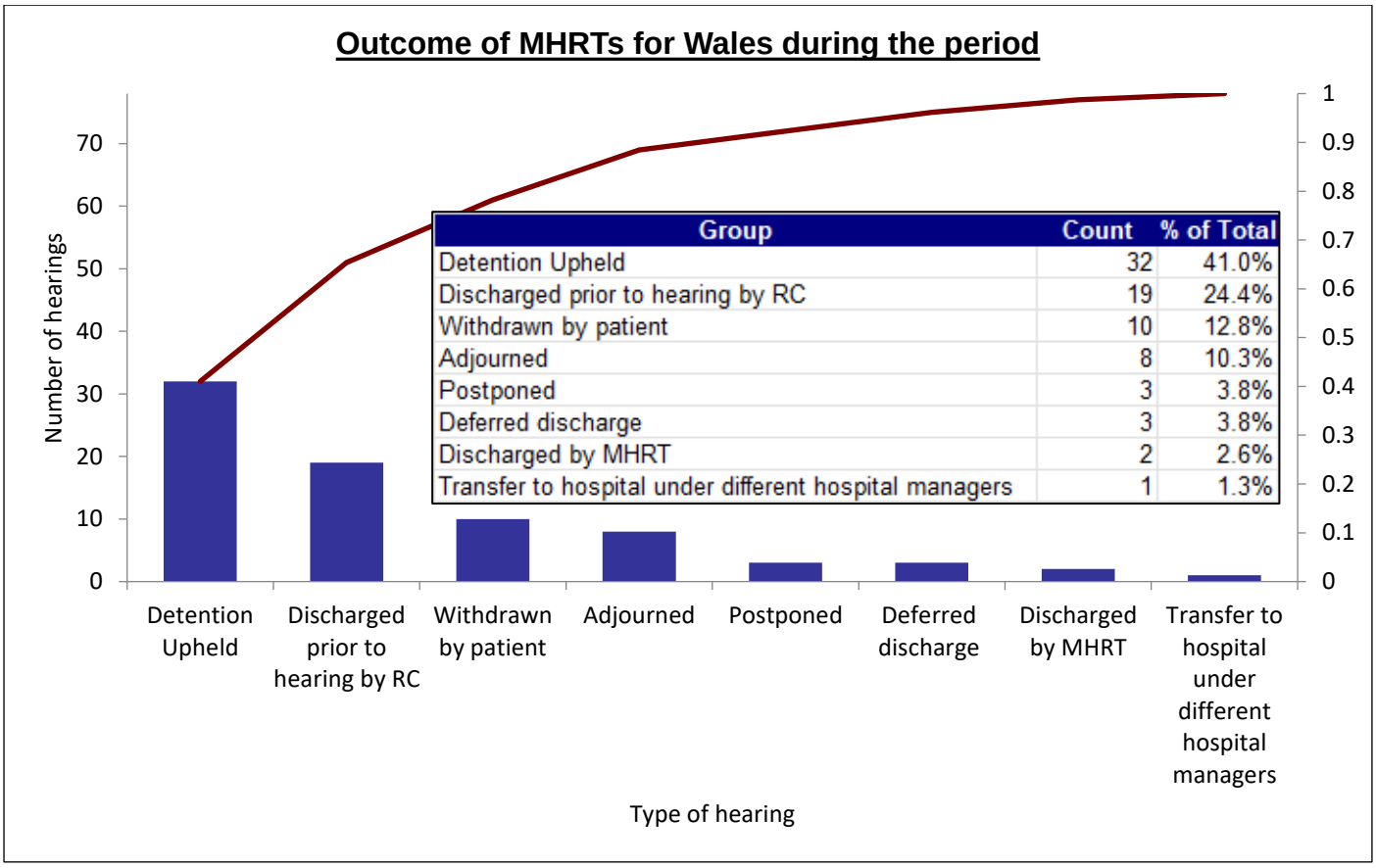
Out of the 52 hearings, only 33 hearings went ahead. Out of that 33, 20 had an advocate present and 13 didn't have an advocate.



Mental Health Review Tribunal (MHRT) for Wales







Group	Count	% of Total
Detention Upheld	32	41.0%
Discharged prior to hearing by RC	19	24.4%
Withdrawn by patient	10	12.8%
Adjourned	8	10.3%
Postponed	3	3.8%
Deferred discharge	3	3.8%
Discharged by MHRT	2	2.6%
Transfer to hospital under different hospital managers	1	1.3%

Eights hearings were adjourned for the following reasons:

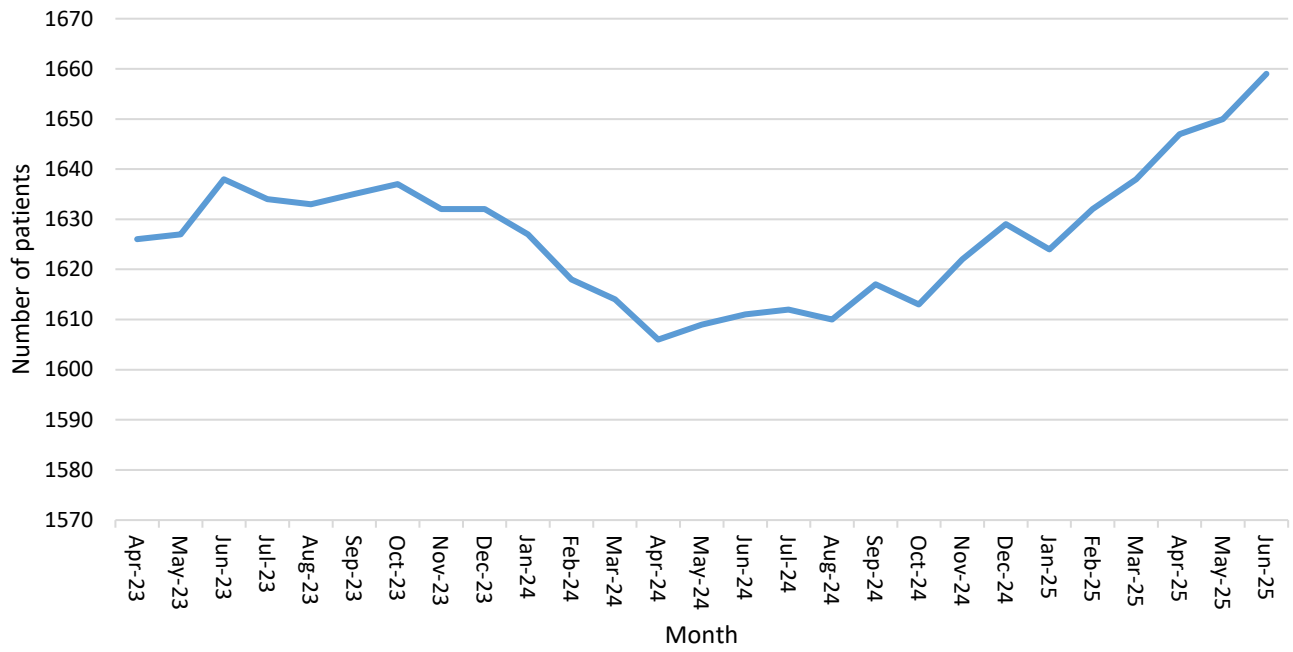
- Needed further reports x4
- No social worker in attendance
- Patient couldn't attend
- Longer time scales needed for hearing to be held fully

Three hearings were postponed for the following reasons:

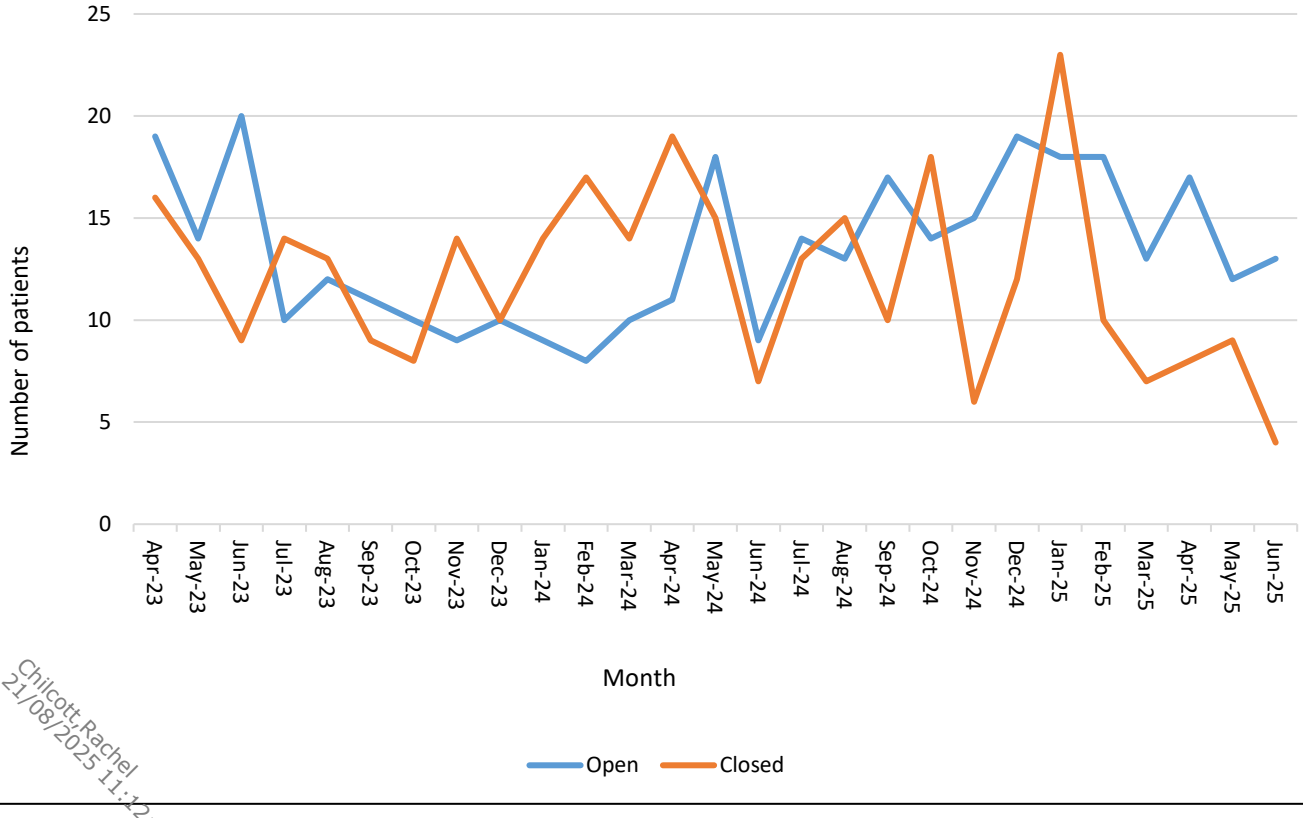
- RC unavailable x1
- Format change-new panel x1
- Detention status changed x 1

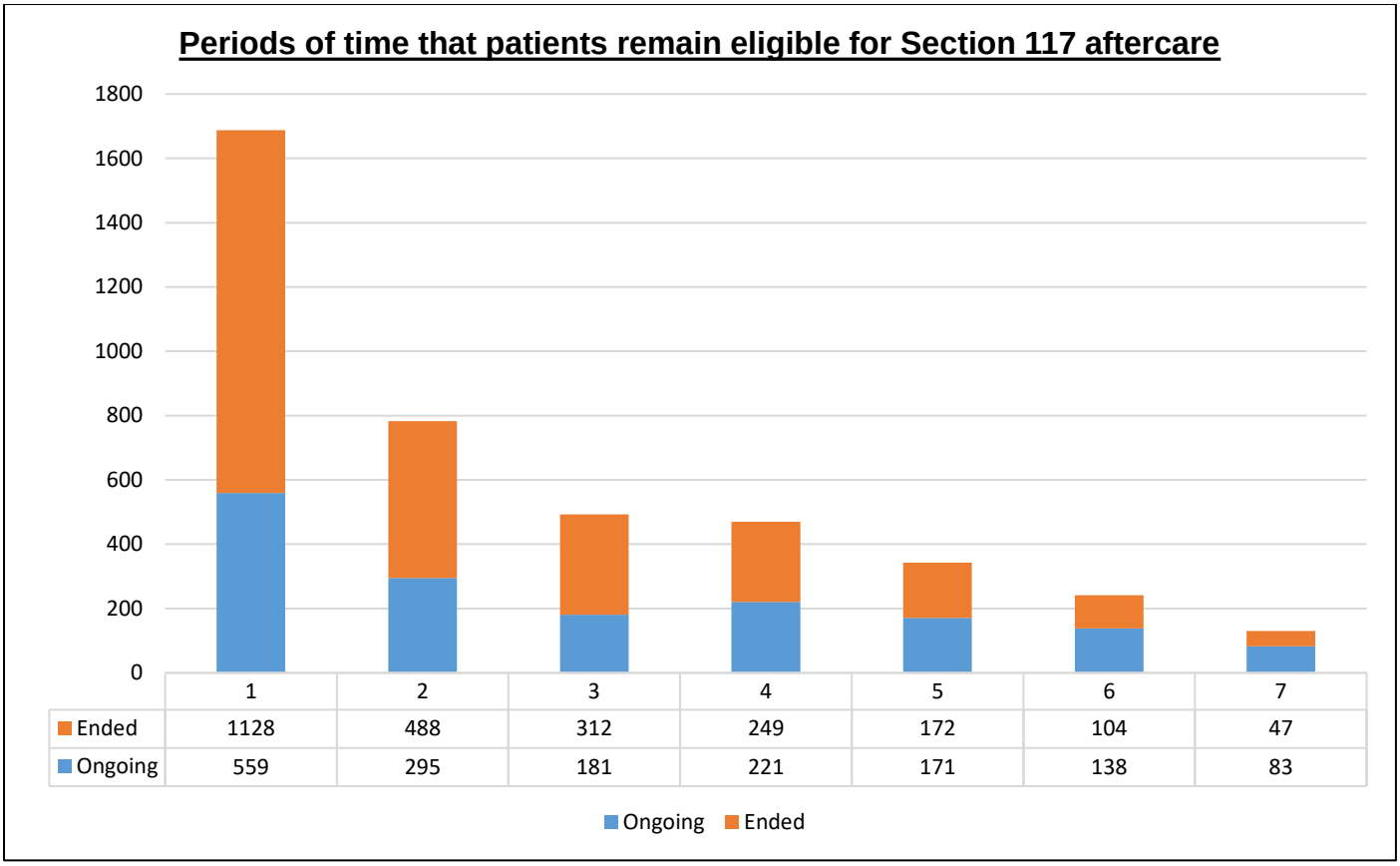
Section 117 Aftercare

Patients eligible for section 117 aftercare



Section 117 Activity

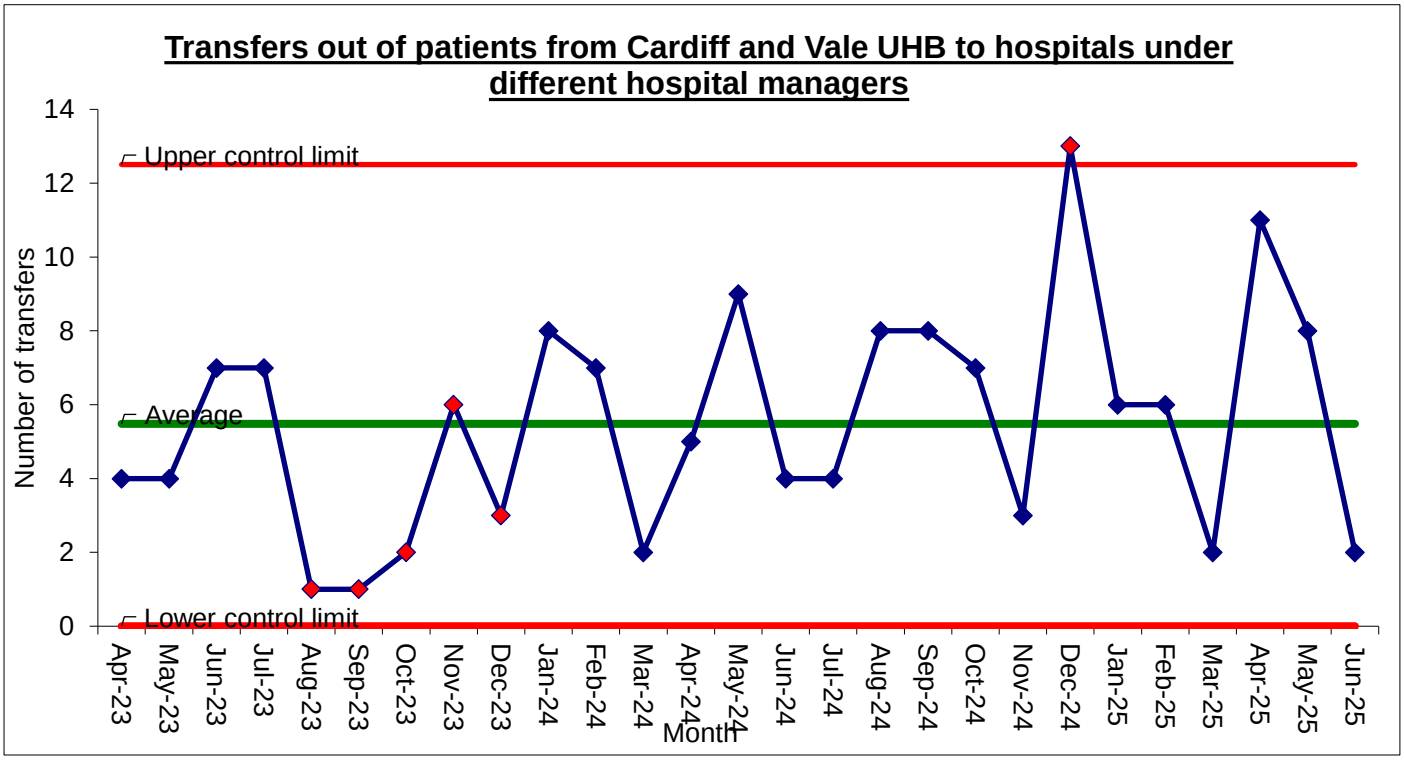




Section 19 transfers to and from Cardiff and Vale UHB

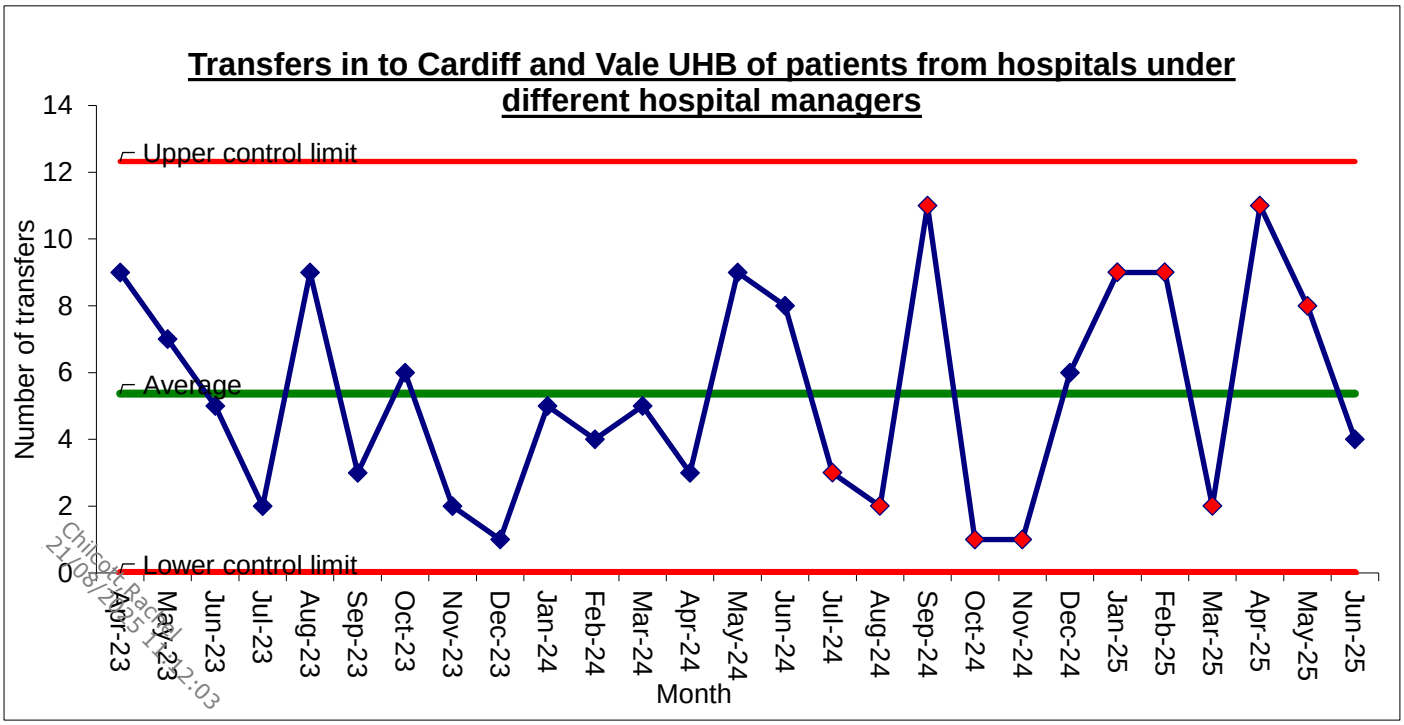
Nineteen patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.

Two patients detained under Part 3 of the Mental Health Act was transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.



Twenty-Two 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.

One patient 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.



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

April - June 2025

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 were three deaths of a detained patient.

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 15:00 ON 22nd JULY 2025 MENTAL HEALTH ACT OFFICE AND VIA TEAMS

Present
Alex Nute (AN) – Vice Chair, PoD
Jeff Champney-Smith (JC-S) - PoD member
Liz Singer (LS) - PoD member
Alan Parker (AP) - PoD member
Margaret Jones (MJ) – PoD member
John Copley (JC) – PoD member via Teams
David Seward (DS) – MHA Manager via Teams
Morgan Bellamy (MB) – Deputy MHA Manager via Teams
Mair Rawle (MR) - PoD member
Carol Thomas (CT) – PoD member via Teams
Peter Kelly (PK) – PoD member via Teams

Apologies for absence
Amanda Morgan (AM) – Chair, PoD
Gerrie Hughes (GH) – PoD member
Ceri Phillips (CP) - Vice Chair, Cardiff and Vale Health Board via Teams
Rashpal Singh (RS) – PoD member

1. Welcome and Introductions
The meeting was held in the MHA office and via Teams and the Vice-Chair welcomed all to the meeting. There were no new members.

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

3. Members points for open discussion
Interpreters – MR queried whether the group could have some training on interpreters. There was a presentation/ guidance that was sent out to the group previously and all agreed this can be recirculated. **Action – JC-S to send to group**
DoLs – An RC stayed on after a hearing to discuss DoLs and JC-S fed back to the group that DoLs won't look at any patient if they're in a MH setting and to have that complete withdrawal, it's felt it isn't in the spirit of the MHA. Other members discussed the subject further about professionals' reluctance to use DoLs and PoD might find themselves in a hearing where they don't necessarily meet the criteria for MHA but RC's will argue it as they would need some legal framework as they're not consenting to treatment but DoLs isn't available so MHA would have to be applied but not necessarily the right framework. MB confirmed this has come from new case law so isn't unique to CaV Health Board.
Non-disclosure – LS raised an issue with non-disclosure and whether the panel members decide that the non-disclosure should be upheld or not and how that is communicated in the hearing minutes. MB advised how the Tribunal deal with non-disclosure and it needs to be decided prior to the hearing so then if the panel don't feel it meets the non-disclosure criteria, the author of that report can decide whether to include in the report or not. It was confirmed that the panel need to discuss as a case-by-case basis and MB will investigate to form a process. **Action – MB to investigate**

4. **Minutes of Meeting held on 14 January 2025**
The minutes were confirmed as an accurate record of the meeting.

5. Matters Arising
DoLs training – some of the group attend DoLs training and the slides will be shared with those we couldn't attend. **Action – MB to send to PoD**
Drug testing on wards – the ward manager for Maple confirmed it's a Health Board policy but they will raise it with their senior nurse.
Adolescent without outside leave – it was confirmed in MHLGG that the patient does have outside leave. Patient is also now over 18 so under LD rather than CAMHs.
NR leaflet from AMHPs – DS is chasing for a copy of the leaflet so we can send out to the group for their information. **Action – DS to chased and send**

6. Operational Issues
Split decisions – following on from the previous meeting, advice confirmed the default position was that the patient wasn't discharged if it's a split decision and a new hearing couldn't be set up due to the split decision as the decision is not discharged and it isn't enough to warrant an adjournment. A panel recently had a split decision with one recommending discharge, one recommending renewal and one member on the fence. JC-S wrote a clear way of advising the patient of the decision and their right to appeal which MB will investigate and send out to panel so it can be a standard response. It was agreed more discussion was needed and feed back to the group would be provided. **Action – DS, AM and AN to discuss further**

WARRN – MB raised an issued around one hearing where the social circumstances report had pulled information from a patients WARRN that shouldn't have been shared with the patient as Maple ward patients have two different WARRNS – one that can be shared with the patient and one that can't be. It was discussed that if patients aren't receiving their WARRNS, does this mean the WARRN becomes a non-disclosure document, and should it be treated as such or should we just share the 'diluted version' which the patient will have already seen.
MB checked the MHA/CoP on where our duty lies with sending WARRNS. It isn't a requirement to send them to the Tribunal, but the CoP states Hospital Managers should be advised of the risks. MHAO have decided to no longer send WARRN to the Tribunal, but they will still be sent to the Hospital Managers as a single document, not as part of the full report pack. **Action – MB to investigate further**

7. Lessons Learnt
Nothing to note.

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

- Adjournments and postponements were down for the Hospital managers but higher for Tribunal
- Cancelled hearing reasons were added this quarter
- Hospital Managers discharged one patient this quarter
- There was a continued representation by advocacy at Hearings
- Tribunal discharged 5 patients – 2 absolute and 3 deferred

The graphs that breakdown the outcomes per month will be removed from the report for both Hospital Managers and Tribunal going forward as it is already captured.

9. **Comments/compliments**
Comments/compliments were provided for the period. The responses to the comments were noted.

- There were a few WIP due to DS going off so unable to chase. They will be chased ready for the next quarter
- One comment wasn't clear what the panel wanted or whether the hearing carried on
- CTPs still have a high presence on comments
- It was noted the patients name is present in some comments, which will need to be changed
- Several compliments received for the professionals and one for the panel

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

11. Training
AN is going to discuss training with the Chair and a potential workshop on decision making.

12. Any other business
Performance reviews – JC hasn't had a performance review yet. **Action – DS to discuss with the Chair**

CJSM outcomes – MB has sent an e-mail out regarding the file type in which members save the minutes as. It needs to be saved as a **.x** or **.odt** file type or it will be corrupted on CJSM and the MHAO can't download the minutes to process them.

Date and time of the next meeting - 7th October 2025 3pm Hafan Y Coed/ Teams.

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 31 July 2025 via Microsoft Teams

Present

Julian Willett (JW)	(Chair) Transformation & Innovation Lead MHCB
Morgan Bellamy (MB)	Deputy Mental Health Act Manager
Alex Nute (AN)	Vice-Chair, Power of Discharge Group
Claire Thomas (CT)	South Wales Police Representative
Casey Keegans (CK)	Shift Coordinator Representative
Jayne Jennings (JJ)	Senior Nurse for Crisis & Liaison Services, Adult MH
Kath Lewis (KL)	Consultant Social Worker AMHP/DoLS
Matt Russell (MR)	Operations Manager MH, Cardiff LA
Sunni Webb (SW)	Service Manager, Inpatients & Rehab
Linda Woodley (LW)	Operational Manager MH, Vale of Glamorgan LA
Adele Watkins (AW)	Mental Health CNS, Acute Child Health
Beth Evans (BE)	EDT Service Lead, Cardiff LA
Samantha Kennedy (SK)	Integrated Team Manager MHSOP, Cardiff LA
Chris Frayne (CF)	Lead Nurse, Adult MH
Callista Hettiarachchi (CH)	CAMHs Representative

Apologies

Chloe Evans (CE)	Mental Capacity Act Project Lead
David Seward (DS)	Mental Health Act Manager
Ceri Phillips (CP)	Vice Chair, Cardiff & Vale University Health Board
Amanda Morgan (AM)	Chair, Power of Discharge Group
Demi Barnard (DB)	Advocacy Support Cymru Team Lead
Daniel Crossland (DC)	Director of Operations, MHCB
Clare Davies (CD)	Consultant Representative, A&E
Andrea Sullivan (AS)	Senior Nurse - Education, Quality, Safety and Patient Experience
Marianne Seabright (MS)	Lead Nurse MHSOP and Neuropsychiatry

1 Welcome and Introductions

The Chair welcomed everyone to the meeting.

2 Apologies for absence

Apologies were noted.

3 Minutes of meeting held on 10 April 2025

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

4 MHA Activity

The MHA Monitoring report was gone through by MB who noted most of the activity remained stable this quarter however some parts were highlighted –

Section 135's were mentioned as although they were within the control limits, they were high this quarter with fourteen overall for section 135(1)'s, which resulted in eight being detained on section 2, one admitted informally, three being detained under section 3 and two being discharged home. There were no section 135(2)'s within the quarter.

Section 4's have been increasing recently however, there were none this quarter. Going forward any use will have the details of that use recorded in the report.

Section 3's had been steadily increasing since June 2024 with a noticeable increase since the last quarter which could have been a result of new DoLs case law and more patients being put under MHA than DoLs but section 3's have decreased this quarter.

Section 62's are still high this quarter. There was an increase in the use of section 62's for the 3 month rule and the use is due to the RC's not completing a SOAD request form in good time of the 3 month rule expiring and only completing one the day before or the day of the expiry, meaning a section 62 is issued to cover medication until a SOAD has issued a certificate. The use for ECT is still high but due to the nature of ECT, the high use is unavoidable.

The exception report was gone through by MB who picked out the following that was of note from the monitoring report within the last quarter –

It was noted that the 'detained/ not detained' graph shows that there is a clear separation of more people being detained within our services since the end of last year and KL noted that this could be because of the the new MHA/ DoLs case law that means less people are now eligible for DoLs.

There were no fundamentally defective reports or applications this quarter however, there was a section 5(4) that lapsed. The SHO was in UHW so couldn't complete a section 5(2) hence a 5(4) being used but the SHO couldn't get to HYC before it expired and therefore the 5(4) lapsed. The patient was assessed 20 minutes after the expiry though and was happy to stay informal.

136's have increased significantly from one hundred and twenty-four previously to one hundred and fifty-five this quarter with 77.4% not admitted to hospital and 22.5% admitted to hospital. CAMHs 136's have increased also from seven to ten in this quarter with three patients having repeat presentations.

Nearest relative discharges are still being tracked with three this quarter – two discharge requests were withdrawn, and one patient was discharged as they didn't meet the dangerous criteria.

The MHAO is still offering development/ training sessions and last quarter we did some bespoke training for the international nurse programme, AMHP programme and section 5 training for the major trauma ward in UHW.

5 Matters for Action

Action log - this will be updated and sent separately.

6 Feedback on operational issues and incidents

Locked doors - nothing to note, will roll over to next meeting

7 Feedback from other meetings:

Vale of Glamorgan LA – LW noted that a S12 App has been tried in England with very positive outcomes as they know what assessments are needed and doctors can respond without AMHPs having to ring round all the doctors plus it helps Health Board collect data on assessments and payment is done through it. LW has spoken to the AMHP lead for Social Care Wales about a year free trail but after that year it could be expanded to have more functionality but the only way to have the free rollout is if the Health Board agree and buy into it alongside the Local Authority. IT would need to be involved as well due to some GDPR agreements that need to be signed.
LW raised the importance of something of this nature due to the issues the Local Authority are having with s12's in general and is waiting for DS to issue the s12 survey results, which could inform part of the discussion around this. Another meeting will need to be set up for this discussion.

Action – JW to arrange meeting with attendees provided by LW

DS to share the s12 survey results

LW raised an issue with referrals from the REACT service regarding the quality of the information being received with it not always being an accurate reflection of the situation and MHA assessments being done which aren't appropriate and potentially being distressing for the patient. A meeting between AMHPs and the REACT team to discuss better ways to send the correct information in referrals.

Action – LW to arrange meeting with REACT

Cardiff LA – KL gave an update regarding a change in how MHA assessments will be requested for Cardiff daytime services. From September they will have a centralised AMHP hub with a central phone number which should make it more streamlined for Health to make a request as the feedback that's been received is that it's difficult to know who to call on a certain day so they will be moving to AMHP manager per week rather than per day as it is now.

Action – KL to send information to PB/CH/JJ/TL

South Wales Police – only issue is regarding transport as the ambulance service is required to convey but they don't have the resources therefore, police will contact them

and if they're not able to come in a timely manner it will get escalated, and that information is being used to explore resources.

Advocacy – no-one in attendance.

Power of Discharge - AN raised the following issues that came out of the PoD quarterly meeting –

One was to do with the MCA/DoLs and MHA interface with the number of hearings they will receive and the decision they make for those patients who are on the borderline of MHA/DoLs.

Discussions were had regarding WARRN and that the Tribunal don't require these documents and on Maple they don't routinely give patients access to their WARRN. They discussed that because the WARRNs aren't given to the patient, should they be classed as non-disclosures and follow that process for disclosing them to patients. The MHAO will be sending WARRNs to the panel members only but not to anyone else within the hearing. MB did raise this in the recent Q&S meeting and the group felt that if there is any risk, it should in included in the reports the professional complete. CK and CF noted that due to the risk of certain forensic patients, additional information is included in the WARRN that can't be disclosed to the patient, e.g. exclusion zones where they can't go and by giving that to the patient, you're telling them where the victim lives. The risks that people need to know should be included in the main reports. CF asked what other Health Boards do in order to keep that consistency. MB is due to have a discussion with AN, AM and DS to discuss further.

Action – MB to arrange meeting re: WARRN

8 Power of Discharge Group comments, compliments and feedback

The main trends to come out of the comments and compliments was CTP's still being an issue.

9 External reviews

Nothing to note.

10 Interface MHA/MCA/DOLS

No-one in attendance.

11 Quality indicators and audit activities

Nothing to note.

12 Mental Health Act Reform

MB raised that DS went to an update meeting regarding the changes in the new MH Bill. Currently it is at the report stage with the House of Commons which will need one more reading before being moved onto the final stage. The impact will start from 2027 when it becomes legislation.

13 Any other business

Supreme Court Worcestershire v Swindon Judgment – KL and MR noted that with the new MH Bill it should clarify the issue around section 117 and hoping they will add around ordinary resident and the deeming principle in regard to patients being placed in other areas and re-detained so they new area is then responsible.

Solutions s.12 app – discussed previously, see above.

MHA Pathway bed booking for CAMHs UHW – AW has seen an increase in children under 16 being detained to the children's hospital with five patients since January, which is their normally yearly figure. AW wanted to bring the pathway to the meeting to ensure there is consistency with the MHA paperwork being sent to the MHAO when someone is detained to the children's hospital. AW asked that AMHPs are made aware that nurses in the children's hospital don't know what to do with MHA detention papers so can they send them straight to the MHAO. The pathway will be sent out with the minutes of the meeting. MB reiterated that the process is if AMHPs are detaining in the community to the children's hospital or anywhere else other than HYC so not coming to HYC to give the papers directly to the MHAO, they should be e-mailing the MHAO generic address to inform them of the detention so the MHAO can chase up the papers if they haven't already been e-mailed over as sometimes they are just left in the patients notes on the ward.

Action – AW to send to DS to circulate
KL to send the pathway to AMHPs with guidance for nurses

CAMHs psychiatrists – CH raised an issue regarding the lack of CAMHs psychiatrists on certain days as Wednesday and Thursday are not covered by a consultant psychiatrist so there is no duty. CH had a meeting with the covering Clinical Director for Adult MH that Adult consultants would cover CAMHs on those days if they're able to and if not then it would need to be two s12 doctors. CAMHs are trying to recruit to the roles so is hopefully a short time issue. KL raised an issue with two s12 doctors and have advised AMHPs against doing that as there won't be anyone responsible for sourcing a bed, so KL advised there needs to be additional provision for sourcing a bed. CH confirmed that the CAMHs crisis team will be able to help source a bed in these instances and will e-mail KL with this confirmation.

Action – CH to e-mail KL confirmation of the above

14 Date of future meetings

9th October 2025

15th January 2026

Mental Health Legislation & Governance Group Action Log

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

ACTIONS FROM PREVIOUS MEETINGS

STATUS			
Revised below	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** **RD**
	Locked doors – do informal patients know their rights	Lead Nurse, Adult MH advised information leaflets are being created. Update at next meeting	**CF**
To be removed	~~Specific details for section 4's~~	~~To include specific details on section 4's in the monitoring report going forward~~	~~**DS**~~
Revised below	Completing paperwork for OOA beds	To arrange a meeting with KL/ NM/ BE/ JJ/ TL to discuss a gap with the bed management policy around arranging OOA beds	**SW**
	Split decisions in Hospital Managers hearings	To speak to the live experience team and take to quality and safety	**DS**
	Patients being detained in A&E	SOP with EU had previously been created but need clarity on whether it's been ratified	**JJ**
To be removed	~~OOA patients~~	~~Patient flow manager to send OOA patient list to the local authority~~	~~**TL**~~
	S12 doctors survey	Survey results to be collated and shared with the group	**DS**

ACTIONS FROM THIS MEETING – 31st July 2025

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	SPRs not available for assessments towards the end of day shift	Julian to arrange a meeting with the Clinical Director and daytime/EDT AMHPs for Cardiff/Vale LA	**JW**
	OOA beds for discussion in MHLGG	Dave to add OOA beds as an agenda point going forward in MHLGG	**DS**
	S12 app	A meeting to be arranged to discuss the s12 app	**JW/LW**
	REACT referrals	A meeting to be arranged with REACT to discuss referral information	**LW**
	Cardiff LA new MHA assessment request process	Information on the new MHA assessment request process to be sent out	**KL**
	WARRNs in Hospital Managers hearings	A meeting to be arranged with PoD to discuss WARRNs	**MB/DS/AM/AN**
	CAMHs UHW pathway	New pathway to be sent out	**AW/KL**
	No cover for CAMHs on certain days	E-mail to be sent to KL to confirm the new temporary arrangements	**CH/KL**

Report Title:	**Court of Protection Process and Guidance**		Agenda Item no.	6.1	
Meeting:	Mental Health Legislation Committee	Public Meeting	X	Meeting Date:	26.08.2025
		Private Meeting			
Status:	Assurance		Approval	X	Information
Lead Executive:	Executive Nurse Director				
Report Author:	MCA Project Lead				

Background and current situation:

In recent years, there has been a notable increase in the number of cases concerning CAV UHB patients being referred to the Court of Protection (CoP). This is not isolated to CAV UHB and this pattern appears to be emerging across Wales. The increase in CoP cases appears to be due to improved knowledge and understanding of the statutory responsibilities provided for by the Mental Capacity Act and an increase in delayed discharges where a person under the Deprivation of Liberty Safeguards (DoLS) is objecting to being in hospital and a Section 21a appeal is made on their behalf.

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

As a result of this increase in CoP cases, the UHB has identified demand for a process and guidance to follow when determining whether an application to the CoP is required and the appropriate process to follow once an application is made, with some examples for guidance.

Appendices *(Please list any appendices that will accompany this report)*

CoP Procedure and Guidance August 2025.docx

Recommendation:

The Committee is requested to:

a) Review the contents of this Process and Guidance document and consider approval for publication

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

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.**	

Chilcott Rachel 21/08/2025 11:12:03

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

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

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: Yes
This process and guidance has been reviewed by legal for accuracy
Reputational: No
Socio Economic: No
Equality and Health: /No
Decarbonisation: No
Welsh Language: No

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

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Court of Protection Procedure and Guidance

Introduction and Aim

This procedure document attempts to clarify the process, where decisions are finely balanced or there is a difference of opinion between interested parties for an individual who lacks capacity to make a specific decision around their care and treatment or discharge arrangements, which may ultimately result in the matter being taken to the Court of Protection for a decision to be made.

It is imperative that patients are supported to make decisions around their care and treatment and/or discharge arrangements so far as is reasonably possible. In order to facilitate decision making patients should be given independent support and advocacy to make decisions, with clear information around all of the **options available**, in a way that takes account of their personal needs.

Differences of opinion will usually lead to delays in treatment or discharge which is rarely in the interests of the health board or individual concerned. Disputes around discharge arrangements can often become particularly protracted and obtaining a decision from the Court can be both timely and costly. Therefore, it is important that attempts are made to resolve issues early on; using mediation where necessary. Matters should only be taken to court where all other avenues to make a decision have been exhausted.

Objectives

This procedure and guidance is designed to support staff within Cardiff and Vale UHB (referred to as the UHB throughout this guidance) where an application to the Court of Protection may be required or in instances where an order has been served on the UHB. Further information on the Mental Capacity Act and the support to be provided for people to make decisions can be found within the UHB's Mental Capacity Act Policy.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts who are caring for patients that may lack capacity to make decisions.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Mental Capacity Act Policy.
Documents to read alongside this Procedure	Mental Capacity Act Policy, 2024 Independent Mental Capacity Advocate Procedure (UHB 186) Lasting Power of Attorney and Court Appointed Deputy Procedure (UHB 113)

	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) Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and Procedure (UHB 044)
Approved by	

Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	MCA Project Lead

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 the Governance Directorate.

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

CONTENTS

1. INTRODUCTION

1. Patient safety issues arise when:

    a. There are delays in admission to hospital due to lack of bed space caused by delayed discharges;
    b. When patients need medical treatment yet disputes about capacity or best interest result in delays;

2. The Health Board may be acting unlawfully if:

    a. A person is deprived of their liberty without proper lawful authorisation;
    b. It does not speedily refer to court when it is known that a person is objecting to their deprivation of liberty

In cases where the patient lacks capacity to make decisions themselves the Health Board needs to ensure it is fully compliant with the Mental Capacity Act 2005 and is protective of patients human rights.

The aim of this Guidance is to help Health Board staff understand:

a) What the Court of Protection is
b) The types of issues that may be referred to the Court of Protection
c) Roles and responsibilities
d) Clarify who can and should make an application to the Court
e) How to access legal advice
f) What staff should do if they are notified that the Health Board needs to respond to a Notice or Order from the Court

2. THE COURT OF PROTECTION

2.1 What is the Court of Protection?

The Court of Protection is a specialist court in England and Wales that was created by the Mental Capacity Act 2005. The Court deals with decisions affecting people aged 16 and over, who may lack capacity to make specific decisions for themselves. The role of the Court is to apply the rules of the MCA (2005) to matters relating to a wide range of different issues and these are normally split into three categories-

1. Health and welfare issues, including:

    - Disputes in relation to issues such as where someone should live or the care and support they should receive
    - Challenges to the Deprivation of Liberty Safeguards (DoLS)
    - Whether or not someone has the mental capacity to make certain decisions and challenges to capacity assessments
    - Safeguarding issues
    - Medical treatment disputes

2. Property and financial affairs:

E.g. if P lacked capacity to make decisions around their finances and needed someone to help them manage their money, the Court might be asked to consider whether someone is appropriate to hold a Lasting Power of Attorney for P or whether a deputy should be appointed

3. Cases involving both health and welfare and property and financial affairs issues

It is within the Court's jurisdiction to:

- Make declarations and decide whether a person has the capacity to make a decision
- Make a decision for the person in their best interests
- Make declarations as to the lawfulness of acts done in relation to the person
- Determine whether a person is being deprived of their liberty
- Decide upon issues relating to the validity and applicability of Lasting Powers of Attorney and Advance Decisions
- Appoint and remove Deputies

The Court cannot:

- make decisions on behalf of a person who has capacity to make their own decisions
- choose something for the person that is not available i.e. demand a treatment option that is not medically appropriate or a placement that is not available or willing to accept the person

Before any case goes to court it is important that all appropriate steps have been taken to try and resolve the situation. For example, through the use of mediation and independent second opinions, where there is dispute about the best course of action and time allows.

In order to make a decision, the Court will require evidence from involved parties. For health and welfare related decisions the Court will usually request evidence including, but not limited to:

- A clear outline of options relating to the person's care and treatment or discharge planning and the perceived benefits and disadvantages of each
- Care plans and risk assessments
- Nursing assessments
- Medical records/patient notes for a specified period
- A clear and thorough assessment of the person's capacity to make the decision
- Records of any best interest meetings or discussions, including meeting minutes, balance sheets etc., statements from involved parties, in particular the decision maker

- Documentation relating to any DoLS authorisations or assessments (these can be obtained from contacting the DoLS Team, if copies are not readily available in the patient's notes)
- Occasionally, the Court may request a specific professional (e.g. psychiatrist, social worker, nurse) visit the patient and report to the Court (s49 report)
- For more complex cases, the Court may request a second opinion regarding the person's capacity to decide or view of what treatment options would be most appropriate

2.2 Applications for Care and Treatment Decisions

Where it is determined that a patient lacks capacity to make a decision regarding an aspect/s of their care and treatment, a decision should be made in their best interests. However, there are times when it may be appropriate to seek legal advice to establish whether the matter needs to be taken to the Court of Protection.

Examples of this are outlined below:

1) **Where the decision is particularly difficult, complex, or finely balanced**

   This may be due to ethical considerations or where there is a fine balance between the benefits and burdens of a particular treatment.

2) **Where there are disagreements amongst or between clinicians, consultees, the person, IMCA, attorney etc.**

   This may include differences in opinion as to whether the person has capacity to make the decision or not, or about what option is in their best interests.

3) **Where more than transient restraint is likely to be required in order to facilitate a treatment or intervention.**
   This may amount to a deprivation of the person's liberty that is not authorised by a Deprivation of Liberty Safeguards (DoLS) Authorisation.

4) **Excluded decisions**

   There are some decisions that cannot be made on behalf of a person. These are called 'excluded decisions' and are outlined in Sections 27, 28, 29 and 62 of the Act. Examples include:

   - Consenting to marriage or a civil partnership
   - Consenting to sexual relations
   - Consenting to divorce
   - Consent to treatment under the Human Fertilisation and Embryology Act 1990 or the Human Fertilisation and Embryology Act 2008
   - Consent for a child of an incapacitated parent to be placed for adoption by an adoption agency
   - Consent to the making of an adoption order
   - The discharging of parental responsibility for a child's welfare
   - Decisions about voting in a public election or referendum

If there are concerns about a person's ability to make any of these decisions their capacity should be assessed and action should be taken as appropriate to safeguard the person from any risk of harm or abuse. Legal advice should be sought as required to determine the appropriate course of action and establish whether the case should be taken to the Court for a judge to decide what is in the person's best interests.

2.3 Roles and Responsibilities

There is often no one person within the UHB who is the decision maker for all of a person's care and treatment decisions. There are usually a number of decisions to be made within the multi-disciplinary team and therefore it can be helpful to prepare a list of all the key contacts who will be potential witnesses in any court proceedings.

This will often include:

- Care co-ordinator (Mental Health)
- Ward Manager, Senior or Lead Nurse
- Consultant
- Therapists e.g.: Occupational Therapy, Speech and Language, Psychologist, Physiotherapy.
- Social Worker.

The Court of Protection has the ability to call any health care professional to provide evidence to the Court. Failure to comply with the Directions of the Court can result in the Chief Executive Officer being called to give evidence on the UHB's failure to comply. The court can also make costs orders against the Health Board.

2.4 Who can make an application to the Court?

Applications can be made to the Court of Protection by:

5) Representatives of P e.g. an advocate or RPR;
6) Family members;
7) Local Authority or
8) The Health Board .

There is often an advantage to the Health Board making the application rather than responding to one brought by another party.

Where an application is being made by the UHB please follow the process outlined in Section 3.

2.5 Accessing Legal Advice

Where it is identified that an application to the Court may be required, legal advice should be sought at the earliest opportunity in order for the legal team to be involved in any relevant discussions, such as best interest meetings etc.

Details on how to access legal advice can be found on the UHB's Corporate Governance Sharepoint page.

Further information relating to when an application may be required in relation to disputed discharge arrangements is contained in Section 4 of this guidance.

2.6 Recording of Court of Protection Matters

In most cases, Legal & Risk Services will need to be instructed to support the UHB with Court of Protection matters.

To instruct Legal & Risk services, the person requesting legal advice must complete the Complex Patient Electronic Instruction Form on the Corporate Governance Sharepoint page here.

On completion, the electronic instruction form will automatically be sent to the Complex Patient Team in Legal & Risk Services for review and will then be allocated to the most appropriate Solicitor. Corporate Governance will maintain a repository of all complex patient instructions and monitor the numbers and types of Court of Protection matters across the UHB.

2.7 Responding to Notices or Orders from the Court

Notices and Orders from the Court are usually received by Corporate Governance who will look to identify the relevant clinical team to respond as soon as possible. If any requests are sent directly to a person's care team, it is essential that Corporate Governance are made aware of the request as soon as it is received.

It is important to establish early on if the requested information is:

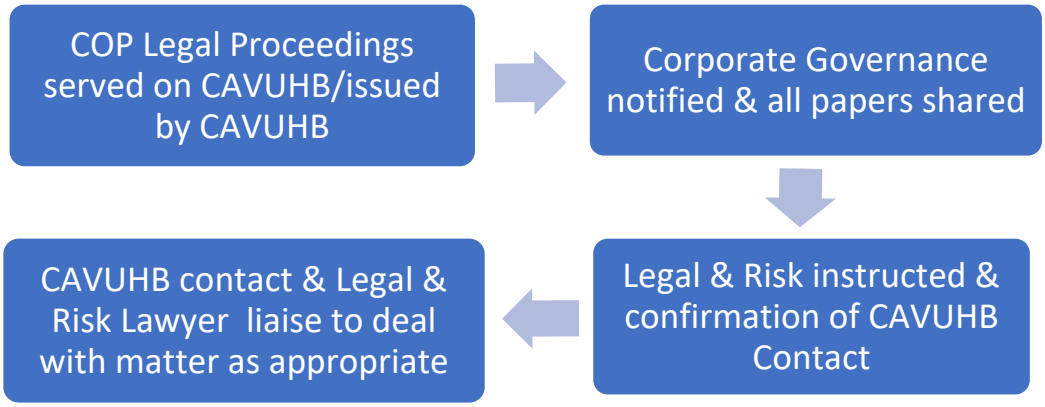
a) A realistic and appropriate request
b) Achievable in the timeframe set

If not, then a request can be made to vary the Court Order however, this must be done within the timeframe given in the order (usually 7 calendar days of the order being made)).

Any delays in identification of the correct team to respond can have a negative impact on the UHB's ability to vary a Court Order within this timeframe; this can impact on the ability of the UHB to comply with what has been requested and the timeframe it is expected by. It is imperative that any requests from Corporate Governance are responded to in a timely manner so that the correct team can be established and legal representation can be sought.

Once the referral for legal representation is received, a co-ordination meeting can be arranged with the allocated solicitor from Legal & Risk Services, to discuss next steps and requirements.

The below flowchart provides a brief overview of the process for responding to orders and notices:



2.8 Case Examples and Process Flowchart

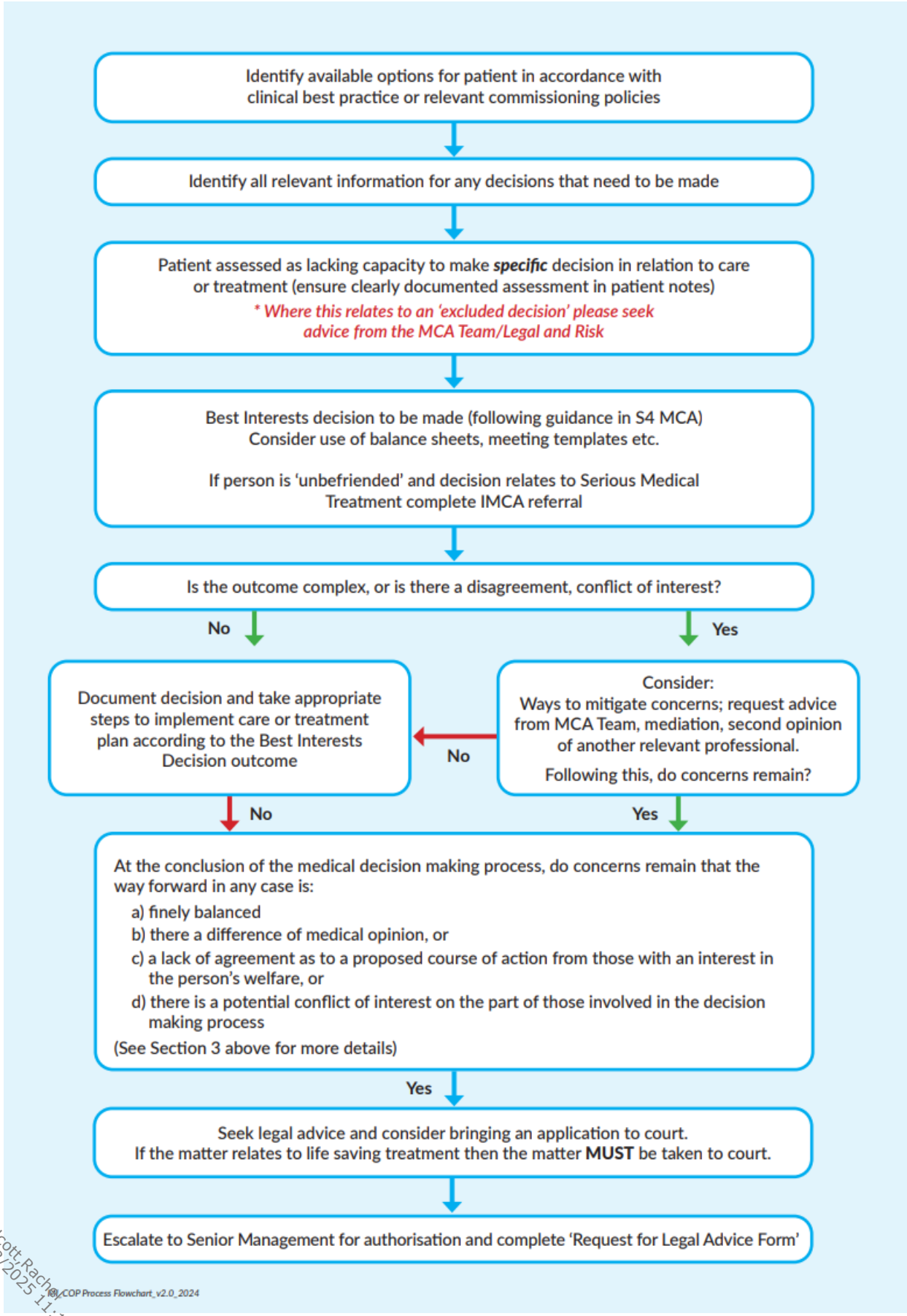
The below table includes some (non-exhaustive) examples of cases which would require Court of Protection proceedings.

**Please note: whilst cases relating to children are not heard in the Court of Protection and different requirements apply, the process for accessing legal advice from the Complex Patient Team remains the same.*

Case Type	Definition	Examples
Deprivation of Liberty Appeal	Health Board have been notified that a DOLS appeal has been filed or is imminent.	Patient in hospital, subject to a DOL and who is objecting to remaining in hospital Patient in hospital, subject to a DOL and who is objecting to going into a care home in accordance with discharge plan
Medical Treatment - Adult	Where the issue of medical treatment is the key issue even if other categories may apply	An adult refusing treatment Doctors recommending withholding/discontinuing treatment and patient or family object

***Medical Treatment - Child**	Where the issue of medical treatment is the key issue even if other categories may apply	A child refusing treatment or family refusing treatment on a child's behalf Doctors recommending withholding/discontinuing treatment and child or family object
Community Deprivation of Liberty	Where P is deprived of their liberty in supported living or their own home and the DOLS Safeguards do not apply	Someone under continuous supervision and control where they are living such as with a 24 hour care package Someone not free to leave where they are living (even if they are also physically incapable of leaving) - would they be stopped from leaving if they were able to try?
Court of Protection - Personal Welfare Application	Including disputes about discharge from hospital, contact with others. Also requests for s49 reports where the Health Board is not a party to the court proceedings	Can include disputes about care, contact, contraception, hospital discharge, hoarding, education, marriage, residence, social media, sex, sharing healthcare information or termination of pregnancy
***Deprivation of Liberty for a Child**	In hospital or in care home. Often includes disputes with Local Authorities.	Child with challenging behaviour requiring restrictions but not eligible under the Mental Health Act.

The below flowchart outlines the process to be followed when determining whether an application to the Court of Protection is required:



4. DISPUTED DISCHARGE ARRANGEMENTS

If resolution cannot be achieved at ward level within a reasonable period, the following process should be followed:

Phase 1

The patient will have been identified as D2RA pathway 3 due to the complexities of discharge planning. The Integrated Discharge Service (IDS) should be aware of pathway 3 patients but the ward team should contact IDS to confirm.

A Discharge Support Referral form to be completed as an early discussion may be required. This can be done before the patient is clinically optimised as long as this is made clear on the DSR.

Once the individual is clinically optimised, if there is reason to doubt their capacity in relation to decisions around their discharge arrangements, a mental capacity assessment should be completed.

If the person is found to lack capacity to make a decision about their discharge arrangements, a Best Interest Meeting (BIM) will be required. This should be attended by health staff, a local authority representative and family members/advocate/Relevant Persons Representative (if under a DOLs).

At this point it needs to be clearly documented if there is any objection from the patient regarding the outcome of the BIM.

It is important to note that if the Patient/Patient Representative is wishing to choose a particular care home and the care home has stated they cannot meet the care needs of the individual concerned, that particular care home should not be included as an option in the decision-making process.

Clarify if there are any areas of dispute. No case should proceed to the Court of Protection if related to funding issues.

Ensure all options explored e.g. interim arrangements based on D2A model.

Phase 2

1. Arrange a complex case review within 7 days of BIM to include:
    a. Senior ward team member
    b. Local authority colleagues
    c. Representative from the IDS team

2. Agenda for the meeting should include:
    a. Whether an application to the Court of Protection is required
    b. Who will be responsible for making the application (see further guidance below).

Phase 3

If it has been agreed that the UHB will make the application, IDS will apply for legal support as per the UHB's Request for Legal Advice process and arrangements will be agreed for an initial fact finding meeting within an agreed time frame.

An IDS representative will be responsible for co-ordinating the initial fact finding meeting (with potential to discuss multiple cases).

This meeting should be attended by: Legal and Risk Representative, Head of Discharge Team and Clinical Board Senior Nurse.

The outcome of the initial fact finding meeting will result in agreement of the following items:

a. Is a COP application needed before discharge?

If agreed to proceed, the Director of Nursing for the relevant Clinical Board to be made aware to ensure support is provided to ward teams in order to compile robust statements and documentation to prevent avoidable delays.

b. Who should bring the application?

This will be determined at the initial fact finding meeting and will usually be the UHB, although it may be from the Local Authority, an advocate, RPR or LPA.

c. What evidence is required?

A comprehensive list of the documentation required and any statements to be written by ward-based team and any other professional involved in the case to date will be developed. This evidence should always include the risks of remaining in hospital.

For further guidance on relevant documentation please refer to Section 2 above.

d. Identification of Coordinator

The responsible clinical team will identify an individual whose responsibility it will be to: engage with Legal & Risk for the duration of the proceedings, collate all relevant documentation, monitor progress of the application and chase any outstanding actions to prevent any avoidable delays.

This should be a member of staff from at least Senior Nurse level.

This individual will also be required to write a statement and may be called upon to give evidence in court. Please note: support will be provided both by the UHB and Legal & Risk as required.

5. EQUALITY INCLUDING WELSH LANGUAGE

An Equality Impact Assessment has not been carried out as this procedure has been developed in support of the UHB's Mental Capacity Act Policy. The MCA Policy is designed to support vulnerable individual's and there is no evidence that the policy adversely affects any of the equalities groups and it is neither directly nor indirectly discriminatory under the equalities legislation.

When assessing a person's capacity and making decisions in their best interests staff will need to consider the needs of different groups of people. These groups will include people whose first language is not English or Welsh and people with sight or communication difficulties. The Mental Capacity Act 2005 requires clinicians to optimise every patient's ability to make decisions.

The UHB is committed to providing information to patients in a range of formats i.e. other languages, easy read and other formats (including audio).

6. TRAINING

Mental Capacity Act Training is mandated for all staff working within CAV UHB at a level appropriate to their role and level of responsibility. This is available as an online ESR course for Level 1 and 2. Level 2 training is also available as a classroom based session and can be booked through ESR or by contacting the MCA Team.

Additional specialised training is also available from the MCA Team and details of courses available can be found on the MCA Team's Training page on SharePoint.

7. DISTRIBUTION

This procedure will be made available on the UHB's SharePoint site.

8. REVIEW OF THIS GUIDANCE

This procedure will be reviewed every three years or sooner if appropriate.

9.COURT OF PROTECTION CONTACTS IN CARDIFF & VALE UNIVERSITY HEALTH BOARD (AS OF JUNE 2025)

Type of Request	Contact	Email
Continuing Health Care (CHC) Mental Health	Senior Nurse CHC Project Lead	Julia.West@wales.nhs.uk

Integrated Discharge Team (IDS)	Head of Integrated Discharge Senior Nurse IDS	Diane.Walker@wales.nhs.uk Frances.Woodyatt@wales.nhs.uk
Corporate Contact	Head of Corporate Governance	Francesca.thomas3@wales.nhs.uk
Deprivation of Liberty (DOLS)	DoLS Team Manager	MCA-DOLS@valeofglamorgan.gov.uk
Legal & Risk Contacts	COP Team CAV Lead COP Solicitor COP Team Lead	LegalandRiskCOPTeam@wales.nhs.uk Hannah.Watkins-Pyne@wales.nhs.uk Gavin.Knox@wales.nhs.uk
Medical Records (Disclosure)	Medical Records Team	CAV.AccessToRecords@wales.nhs.uk Sion.OKeefe@wales.nhs.uk
Mental Capacity Team	Mental Capacity Specialist Practitioners MCA and Consent Lead	Mca-lps.cav@wales.nhs.uk Chloe.Evans@wales.nhs.uk

Report Title:	**MHA/DoLS Interface Guidance -**		Agenda Item no.	6.1	
Meeting:	Mental Health Legislation Committee	Public Meeting	X	Meeting Date:	26.08.2025
		Private Meeting			
Status:	Assurance		Approval	X	Information
Lead Executive:	Executive Nurse Director				
Report Author:	MCA Project Lead				

Background and current situation:

Further to the recent report provided to the Committee in April, the MHA/DoLS Interface Guidance has been produced to support staff in identifying the correct regime to apply where a person is detained in hospital for care and treatment.

This document has been developed in conjunction with Cardiff and Vale Local Authorities, as both Mental Health Act and Deprivation of Liberty Safeguards assessments require input from both health and local authority.

Training has recently been provided for health and local authority colleagues from an external trainer with specialist knowledge and expertise in this area. This was well received and appears to have supported clinicians understanding of the process and when issues or conflict between the two regimes may arise. It is hoped that this guidance will further support this training and provide greater clarity to all those involved in making these decisions.

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

As previously outlined, following these changes to the guidance from case law there are potential implications for:

- Patient flow
- Increase in requests for a transfer to MHSOP inpatient wards from medical wards.
- Increase in costs re: S117.
- Impact on community services, in respect of allocations for social worker and CMHNs

Appendices *(Please list any appendices that will accompany this report)*

CAV - MoU MHA-DoLS - Aug 25.doc

Recommendation:

The Committee is requested to:

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

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

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
Delivering in the Right Places 3. **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:									
Prevention	X	Long term		Integration		Collaboration		Involvement	

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

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: Yes
This process and guidance has been reviewed by legal for accuracy
Reputational: No
Socio Economic: No
Equality and Health: /No
Decarbonisation: No
Welsh Language: No

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

Memorandum of Understanding:

MHA/DoLS Interface Guidance

Cardiff and Vale

This document has been developed by Cardiff and Vale UHB, in collaboration with Cardiff and Vale Local Authorities.

Contents

Deprivation of Liberty (DoL) in Hospital: Agreed Principles

Deprivation of Liberty ("DOL") in hospital: agreed principles

1. INTRODUCTION

This document has been agreed by the following partner organisations as accurately reflecting the law in September 2024:

a. Vale of Glamorgan Local Authority
b. Cardiff Local Authority;
c. Cardiff & Vale University Health Board.

The principles set out in this document reflect shared understanding of the interface between the Mental Capacity Act 2005 ("MCA") and Mental Health Act 1983 ("MHA"). They are set out in order to support legal compliance, foster consistency of practice and reduce disagreement. The intended outcome is to ensure that individuals receive support in the least restrictive way and that unavoidable deprivation of liberty (DOL) is lawfully authorised in accordance with the appropriate legal regime. Practitioners must plan proactively to avoid gaps or lapses in authorisation.

This document addresses the law in relation to the deprivation of liberty of individuals (aged 18 or over) in hospital for the purposes of care and/or treatment, referred to as 'P'. It does not address the position with regard to children and young people (aged under 18).

Practitioners are expected to follow these principles in practice. Disagreements should be escalated in accordance with the procedure described with Section 7.

2. DEFINITIONS

"mental health patient" means a person accommodated in a hospital for the purpose of being given medical treatment for mental disorder;

"mental health treatment" means the medical treatment for mental disorder

"medical treatment for mental disorder" refers to medical treatment with the purpose to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

3. GENERAL POINTS

A deprivation of liberty in hospital, for the purpose of providing care or treatment, is unlawful unless authorised by an established legal process.

The legal processes are:

a) Consent of a patient who has capacity to make the decision themselves;
b) Urgent Authorisation under the Deprivation of Liberty Safeguards
c) Standard Authorisation under the Deprivation of Liberty Safeguards
d) Part 4 of the Mental Health Act which is inclusive of:
    a. Section 2
    b. Section 3
e) An order of the Court of Protection;

In a care/treatment setting, objective DOL is identified by applying the "acid test" set down by the Supreme Court in *Cheshire West* [2014].

Assessments of mental capacity are of supreme importance and must be undertaken with care, applying the test set out in the MCA and the guidance in the MCA Code of Practice. The question will be:

> *Does P have capacity to consent to being in hospital for the purpose of receiving care and/or treatment?*

An urgent authorisation under the DOLS will only be lawful in exceptional circumstances where the need for the deprivation of liberty is so urgent that it is in P's best interests for it to begin before a standard authorisation has been issued.

All relevant assessments and decisions must be clearly recorded, setting out reasons.

Professionals must take a fact sensitive approach, having regard to all relevant circumstances in a particular case.

4. DECISION MAKERS

This guidance is aimed at the following people who may have to consider what the most appropriate legal process is to ensure a deprivation of liberty is lawfully authorised:

a. A DOLS Eligibility Assessor: as part of the assessment process for considering whether a person meets the requirements of a Standard Authorisation under the Deprivation of Liberty Safeguards;
b. An AMHP: when considering whether an application under the MHA ought to be made;
c. Hospital Managers: when considering whether continued use of the MHA is appropriate;
d. A Responsible Clinician (RC): when considering whether P ought to be discharged from MHA detention;
e. Mental Health Review Tribunal for Wales: when considering whether P ought to be discharged from MHA detention.

5. MHA OR MCA/DOLS?

P will be ineligible to be deprived of their liberty under the Deprivation of Liberty Safeguards or by an order of the Court of Protection if:

a) P is within the scope of the Mental Health Act;
b) They are already subject to detention under Part 4 of the Mental Health Act;
c) The Standard Authorisation or Court order would be for the purpose of authorising P to be a mental health patient;
d) P objects:
    a. To being a mental health patient; or
    b. To being given some or all of the treatment for their mental health.

*Treatment for mental health under the MHA is broad in its scope, please see further guidance outlined below in section 6.

In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—

(a) P's behaviour;
(b) P's wishes and feelings;
(c) P's views, beliefs and values.

The MHA Code of Practice outlines that the bar for what amounts to an objection is low. Examples of situations that would suggest there is objection from P include:

- The use of chemical restraint or covert medication for mental health
- Refusal of medication
- Distress upon personal care due to symptoms of mental health disorder
- Attempting to leave the ward
- The need for restraint of P to protect others is a strong indicator that the MHA is the appropriate legal framework
- Any form of physical restraint
- Enhanced levels of supervision or staffing for any interventions

Where P is ineligible to be deprived of their liberty under the MCA/DoLS then consideration should be given to authorising the deprivation of liberty under the Mental Health Act.

P is within the scope of the Mental Health Act if—

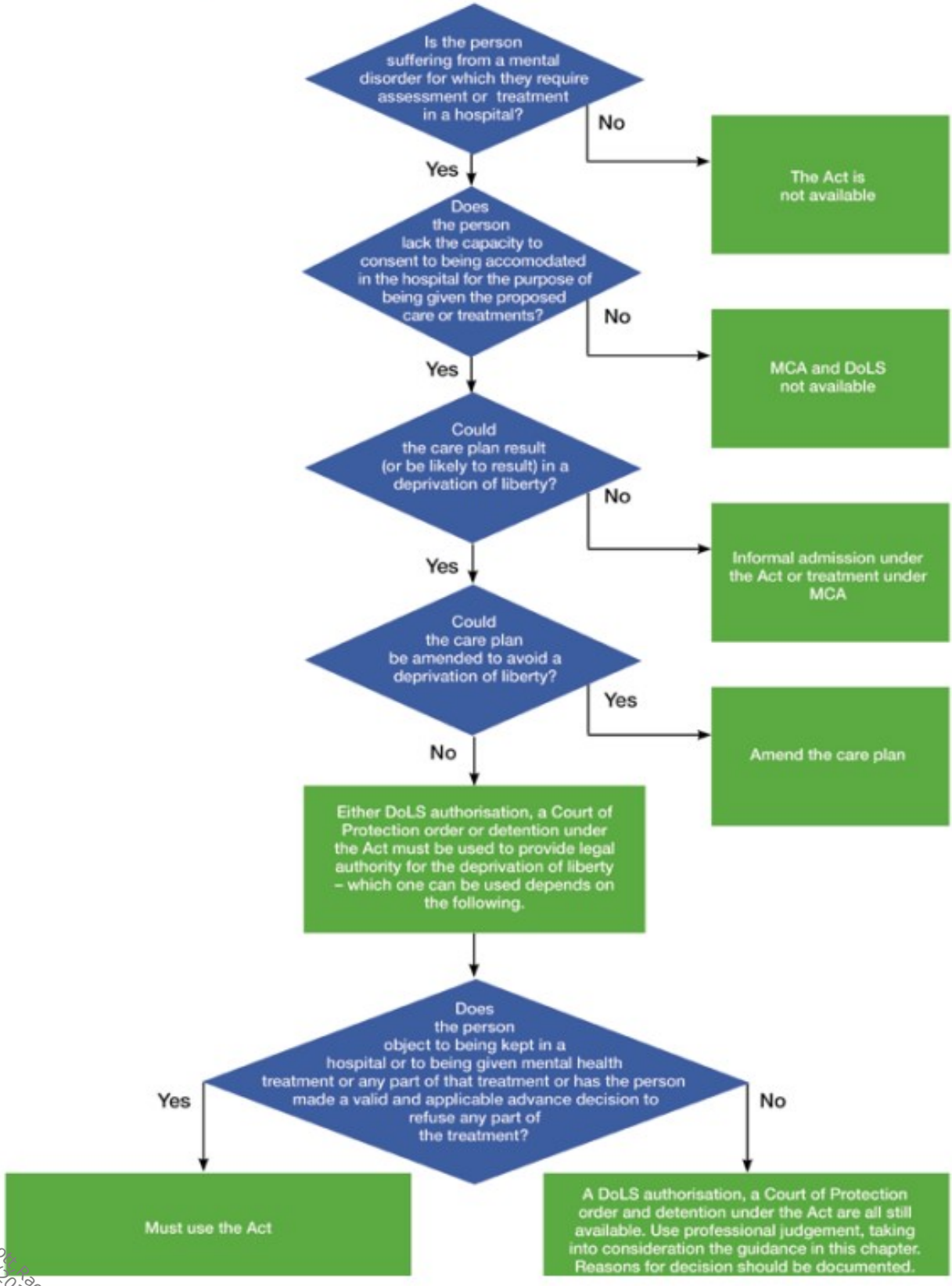
(a) an application in respect of P could be made under section 2 or 3 of the Mental Health Act, and
(b) P could be detained in a hospital in pursuance of such an application, were one made.

Summary of the availability of the Act and of DoLS for the treatment of mental disorder		
	Individual **has the capacity to consent** to being accommodated in a hospital for care and/or treatment	Individual **lacks the capacity to consent** to being accommodated in a hospital for care and/or treatment
Individual objects to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	**Only the Act** is available	**Only the Act** is available
Individual **does not object** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder.	**The Act is available**. Informal admission will usually be the appropriate course of action. **Neither** DoLS authorisation **nor** Court of Protection order available	**The Act is available.** **DoLS authorisation is available, or potentially a Court of Protection order**

(Taken from Chapter 13.38, Mental Health Act Code of Practice for Wales Review, 2016)

The flowchart below, taken from the MHA Code of Practice, describes the key decision-making steps when determining whether the Act and/or the MCA including the DoLS will be available to be used. The flowchart does not replace careful consideration by decision-makers of all relevant circumstances in individual cases. Decision-makers should use their professional judgment within the framework of the legislation.

Figure 6: Deciding whether the Act and/or MCA will be available to be used



(Taken from Chapter 13.49, Mental Health Act Code of Practice for Wales Review, 2016)

6. MEDICAL TREATMENT UNDER THE MENTAL HEATH ACT

Below are some cases that illustrate what may amount to medical treatment for a mental disorder under Section 63 MHA.

JK v A Local Health Board [2019] EWHC 67 (Fam)

This case concerned JK, who was on remand for an alleged murder and transferred to prison under s.48 MHA. He had Autism Spectrum Disorder, was refusing food and had made 2x advance decisions to refuse medical treatment. He had capacity to refuse food and refuse medical treatment. The issue was whether force-feeding would be treatment for his mental disorder which could fall within the auspices of s.63 MHA (and therefore be given without his consent).

It was held that:

- The treatment of JK's medical disorder by medical treatment **to include feeding by way of nasogastric tube is treatment within the scope of section 63 MHA 1983 because JK's refusal to eat is a manifestation or symptom of his autistic spectrum disorder.**
- Notwithstanding that JK has capacity regarding his medical treatment, pursuant to section 63 MHA 1983, JK's consent is not required for the medical treatment of his mental disorder, including by force feeding.

A Healthcare, B NHS Trust v CC [2020] EWHC 574 (Fam)

This case concerned a 34-year-old man with psychotic depression, mixed personality disorder who was deaf, had diabetes and was detained under s.3 of the MHA. The main issue for the Court was whether haemodialysis was medical treatment for his personality disorder for the purposes of MHA s.63.

It was held that the dialysis treatment, use of light physical restraint and chemical restraint (if required), was authorised by s.63:

> *"In my view this is a clear case of the treatment proposed, the dialysis, treating a manifestation of the mental disorder, namely personality disorder. The need for dialysis stems from CC's self-neglect, including in regard to diet, which has led in whole or in part to his kidney failure. The reason his diabetes has resulted in kidney failure is to a large extent because of that self-neglect, which is itself a consequence of his mental disorder….[I]t seems to me clear that the physical condition CC is now in, by which dialysis is critical to keep him alive, is properly described as a manifestation of his mental disorder. There is a very real prospect that if he was not mentally ill he would self care in a way that would have not led to the need for dialysis. Further, that CC is refusing dialysis is very obviously a manifestation of his mental disorder. When he is mentally well he agrees to dialysis. His situation is therefore highly analogous with that of the force feeding cases."(Lieven J)*

Lieven J rejected the argument that in order for s. 63 MHA to apply, the 'primary purpose' of the treatment must be to treat the mental disorder, and outlined that in cases of uncertainty it is appropriate to apply to the Court.

7. DISCHARGE FROM MHA DETENTION ONTO DOLS IN HOSPITAL

If it is anticipated that P will no longer meet the criteria for detention under the MHA then consideration needs to be given as to whether, when discharged from the MHA, they will need to be further deprived of their liberty.

Guidance can be found at Chapter 13 of the Mental Health Act Code of Practice.

Any ongoing deprivation of liberty will need to be authorised by one of the lawful processes set out above.

If a Standard Authorisation is applied for then P should not be discharged from MHA detention until a DOLS standard authorisation has been granted.

This is because there is the potential for the Eligibility Assessor to consider that P is still within the scope of the Mental Health Act making P ineligible to be subject to a Standard Authorisation.

A DOLS urgent authorisation cannot be used lawfully in these circumstances because the situation is not urgent.

Recent case law clearly highlights that where an individual is awaiting placement or a package of care in the community and they lack capacity to consent to their admission, the MHA remains applicable.

Manchester University Hospital NHS Foundation Trust v JS and Manchester City Council [2023] EWCOP (summary of the judgement available here)

This case concerned a 17 year old (JS) with autism, ADHD, learning disability and attachment disorder. She had a history of self-harm and absconding and was detained under Section 2 MHA on an acute adult medical ward. When this lapsed, the hospital incorrectly claimed she did not meet the threshold for detention under Section 3 of the Mental Health Act despite being held in hospital under significant levels of restriction including physical and chemical restraint. She was objecting so did not meet the 'eligibility' test. The judge criticised the hospital for not using the Mental Health Act and attempting to (unlawfully) detain her under the 'common law' after the Section 2 expired.

The judge said: '*I have concluded for the reasons I have given that she could have been detained and treated under the MHA. I would go further and say that she should have been so detained and treated*.'

'There seems to be a belief... that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken.' And: '...where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances...then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.'

Following the case, JS was detained under Section 3.

In his summary of the case the Judge outlined a clear view that:

"If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the Mental Capacity Act but rather under the Mental Health Act."

Consequently, where an individual remains in hospital awaiting placement for their mental health needs, they should not be discharged from the MHA and then placed on to the DoLS.

8. ESCALATION

Where disputes arise, the 'practical suggestions' put forward by the Secretary of State for Health and Social Care to address 'stalemate' situations (as endorsed by J Theis in *Manchester v JS [2023] EWCOP 33)*, should be applied:

(1) MHA and MCA/DoLS decision-makers should arrange for discussions between the relevant professionals, undertaken in 'the spirit of cooperation and appropriate urgency'. This will ensure the relevant professionals have reviewed and considered relevant evidence and if required further inquiries can be made.

(2) If these discussions do not result in a detention being authorised under the MCA the hospital has a number of choices:

(i) It can seek the person's admission under the MHA 1983 to authorise the deprivation of liberty, including on a short term basis while it seeks to advance the person's discharge;

(ii) It can seek the person to be detained in an alternative setting, such as a care home, in which Case E has no application with consideration being given to what can be put in place to support the person in the community under s 117 MHA 1983 and/or Social Services and Wellbeing (Wales) Act 2014 duties.

(iii) It can stop depriving the person of their liberty if it considers the person should not be detained under MHA 1983, even with the knowledge that the person will not be detained under the MCA 2005.

(3) If the hospital does not consider that an application for assessment or treatment under MHA 1983 is warranted but does consider it is in the person's best interests to be detained in hospital for treatment of a mental disorder, it should consider carefully its reasons for drawing this distinction. The hospital could apply to the Court of Protection for a determination of whether the person is eligible for detention under the MCA 2005.

APPENDIX 1

Case Studies to support application of this Guidance

1. William

William is a 78-year-old former labourer. He's known to suffer from schizoaffective disorder which can manifest in significant changes in behaviour. These changes can be cyclical.

He is under the care of CMHT and there have been concerns regarding a recent decline in his mental state with reports that he is experiencing hallucinations and is erratic in his behaviour.

On review he is deemed to lack capacity to consent to admission to hospital for treatment, but it is decided admission is necessary. He is admitted to a functional MHSOP ward on the Friday and an urgent DOLS authorisation is issued on the following Monday. William remains there under the DOLS.

Consider:

1. What is the primary purpose of William's admission to hospital?
    a. Is it for treatment of his mental disorder?
    b. Or for treatment of some other form of ill health?

2. If the former, could William potentially be detained under the MHA?

3. Is William objecting to some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment?
    a. If yes, where does that leave us?
    b. If no, where does that leave us?

4. What authorisation is there for his conveyance to hospital on Friday?
    a. How could this be addressed?

5. What authorisation is there for his admission between Friday and Monday?
    a. How could this be addressed?

William appears to physically deteriorate and is subsequently admitted to the MEAU for investigation for shortness of breath. He is diagnosed with COPD and discharged back to MHSOP services

6. What form of authorisation could be used for the admission to the acute unit?

Proposed answer

We suggest that the MHA should be used for William.

The primary purpose of the admission is for medical treatment for his mental disorder. He lacks capacity and therefore cannot consent to informal admission. It is not clear where William is or whether he is objecting to admission but note that the MCA does not confer any powers of entry and may not be sufficient to authorise the conveyance. If he meets the MHA detention criteria and is objecting he will be ineligible for the DOLS. Once detained under the MHA he can go to MEAU under section 17 leave: the medical ward will need to consider whether any additional form of authorisation may be needed to cover the care and treatment he receives there.

2. Mina

Mina is an 81-year-old lady who is admitted to the MH ward under Section 2 MHA. She is discharged from Section 2 and is discharged from her Section before the end of the 28-day maximum detention period. She then remains on the MH ward for some weeks before being discharged to a care home provider. Whilst on the ward PRN Lorazepam is administered along with antipsychotics. Mina is not always the instigator of the request for PRN medication.

Records shows Mina lacks capacity to consent to her treatment and accommodation. On occasions Mina has pushed other patients aside and needs 2 (and sometimes 3) members of staff to ensure her personal hygiene needs are met.

Consider:

1. How could Mina's discharge from Section 2 be justified?

2. Where does her discharge from section leave her in legal terms? What authority is there for her continued admission to hospital?

3. Is Mina no longer deprived of her liberty when her Section 2 is discharged? Or is she still deprived of her liberty in hospital?
    a. Explain your answer.

4. What is the legal authority for the treatment she receives in hospital?

Proposed answer

It is not clear why Mina has been discharged from her Section 2. It appears that she is still deprived of her liberty in hospital after the discharge of her Section 2. It appears she lacks capacity to consent to her admission. If so, she is unlawfully detained.

Mina is in hospital (MH ward) for medical treatment for an unspecified mental disorder (treated with antipsychotics). The use of Lorazepam, her behaviour towards other patients and the high staffing ratio strongly suggest she is objecting to being in hospital or to at least some of the treatment for her mental disorder. If so she will be ineligible for the DOLS.

The legal authority for her treatment (without consent) is unclear.

We suggest that Mina should have remained under the MHA (Section 2, then assessed for Section 3 after no more than 28 days) until her discharge from hospital to the care home provider. There must be a clear and lawful justification for keeping her in hospital and providing her with treatment in the interim. Otherwise, she must be allowed to leave.

3. Janice

Janice is a 40-year-old lady, admitted under Section 2 MHA on 7th Feb from an acute medical ward to an acute MH ward.

Janice is assessed as lacking capacity to consent to her care, treatment and accommodation in hospital. She presents as largely settled on the ward and poses no management problem.

The Section 2 ends after 28 days. On 13th March the MH ward issues an urgent DOLS authorisation and applies for a standard authorisation. Janice is discharged on 28th March back to her home where she is cared for by her husband.

Consider:

1. Is it right simply to allow Janice's Section 2 to expire?
    a. How else could this have been approached?

2. Where does the expiry of Janice's Section 2 leave her in legal terms?
    a. Is she still deprived of her liberty in hospital? Explain your reasoning.
    b. What authority is there for her continued admission to hospital?

3. In what circumstances can an urgent authorisation legitimately be used?
    a. Is this a legitimate use of an urgent authorisation?
    b. If not, where does this leave Janice in legal terms from 13 March?

Proposed answer

There appears to be no proper authorisation for the continued deprivation of Janice's liberty once her Section 2 has expired.

It is not clear why Janice's Section 2 has been allowed to expire. Before expiry, consideration must be given by the RC to the authority for her continued admission to hospital. She is not able to give her own consent. We presume she will continue to be deprived of her liberty in hospital, given the later attempt to use the DOLS to authorise this. In that case her continuing deprivation of liberty this will need to be authorised either under the MHA (by using Section 3) or under the MCA (DOLS authorisation). There must be no gap in authorisation, otherwise the deprivation of her liberty will be unlawful during the period of the gap.

Janice's eligibility for the DOLS will need to be considered.

If she would be ineligible for the DOLS, the continuing deprivation of her liberty can only be authorised using the MHA (Section 2 followed by Section 3).

If she would be eligible for DOLS, she should remain under the MHA (using Section 3 if necessary) until a standard authorisation is granted by the supervisory body, otherwise there will be a period of unlawful deprivation of liberty in the interim.

An urgent authorisation cannot lawfully be used in these circumstances because the circumstances are foreseeable and not urgent.

4. Melanie

Melanie is a 70 year old lady living in a care home. She has dementia. She is admitted to hospital due to aggressive behaviour on 1st October and detained under Section 2 MHA. On 26th Oct the Section 2 is discharged and Melanie is re-graded as informal. It is recorded that she "could be managed on DOLS".

An urgent DOLS authorisation is put in place and a standard authorisation requested on the 26th October.

Melanie is discharged to a care home provider on 27th November. In the period of time following the discharge of her Section 2, Melanie continues to receive antipsychotic medication. Notes detail that her behaviour is deteriorating as well as assaults on a service user and member of staff. Notes continue to say Melanie remains hostile.

Consider:

1. Could it have been right to discharge Melanie from Section 2 MHA on 26 October?
    a. Please explain your answer.

2. Can Melanie legitimately be considered an informal inpatient from 26 October?
    a. Please explain your answer.

3. Would Melanie be eligible for a DOLS authorisation from 26 October onwards?
    a. Please explain your answer.

4. In what circumstances can an urgent authorisation legitimately be used? Is this a legitimate use of an urgent authorisation?
    a. Please explain your answer.

5. In light of your answers above, where does this leave Melanie in legal terms from 26 October?

6. What could have been done instead in order to ensure that all periods of deprivation of liberty are properly authorised?

Proposed answer

We suggest that Melanie should not have simply been discharged from her Section 2 and instead an application should have been made for her continued detention under Section 3 MHA.

It is not clear why Melanie was discharged from the MHA on 26 October. Given that a DOLS application has been made the same day, she has presumably been assessed as lacking capacity in relevant contexts and is still considered to be deprived of her liberty upon discharge of the Section 2. She continues to receive medical treatment for her mental disorder, without her consent. In that case it is highly likely she will meet the criteria for continued detention under Section 2 followed by Section 3 MHA.

Her behaviour strongly suggests she is objecting to being in hospital or to at least some of the treatment for her mental disorder. If so she will be ineligible for the DOLS and the MHA must continue to be used to authorise her ongoing detention in hospital.

It is contradictory to deem Melanie informal but also issue an urgent authorisation. The urgent authorisation will not be lawful because: 1) the circumstances are foreseeable and not urgent; 2) Melanie will almost certainly be ineligible for the DOLS.

Melanie's deprivation of liberty from 26 October appears to be unlawful. She should have remained under the MHA until her discharge from hospital.

5. Alan (Part 1)

Alan, aged 73, has been admitted to a MH ward for treatment for his dementia. He is assessed as lacking capacity to consent to the care regime, which is assessed as amounting to continuous supervision and control. Alan would not be allowed to leave hospital. He is described as wholly compliant with his

care regime, well settled and appears to be content. He has never tried to leave nor indicated he wants to. His family are happy with his care plan.

Because of the concern that Alan is deprived of his liberty he has been made subject to s3 MHA. It is now argued he should be discharged from section.

1. Do you agree that Alan is deprived of his liberty in hospital?
    a. Please explain your answer.

2. What are the options for authorisation of Alan's deprivation of liberty in hospital?
    a. Please set out each, explaining why they are available.

3. Is Alan eligible for an authorisation under the DOLS?
    a. Please explain your answer.

Proposed answer

It appears that Alan is deprived of his liberty in hospital because he lacks mental capacity in relevant contexts, his situation satisfies the "acid test" set down in *Cheshire West*, and the arrangements for his residence and care are attributable to the state.

The MHA has already been used to authorise his admission and this may well be justifiable and lawful. We know that he is receiving treatment for a mental disorder in hospital. We would need to know more about the facts of his case to be sure that the Section 3 MHA criteria have been applied correctly but they may well have been.

If Alan truly is wholly compliant and well settled, he may be eligible for a DOLS authorisation as an alternative to remaining under the MHA. Under Schedule 1A MCA (Case E) he would be ineligible if he met the criteria for detention under ether Section 2 or Section 3 MHA and was objecting to receiving some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment. If he is truly wholly compliant (which will need to be assessed carefully), it will follow that he is not objecting, in which case a DOLS authorisation may be available if he also meets the other qualifying requirements.

The decision maker will need to consider which regime (MHA or MCA/DOLS) would be most appropriate for Alan. Having regard to the guidance in Chapter 13 of the MHA Code of Practice and recent case law, which outlines that where a person has required detention for their mental disorder and there is no alternative outside of the hospital setting, the MHA would continue to be the most appropriate framework.

Alan (Part 2)

You now learn that Alan is being covertly medicated.

Consider:

4. Does this change any of your answers to question 1-3 above?
    a. Please explain your reasoning.

Proposed answer

The use of covert medication may be justifiable but it will almost certainly indicate that Alan is objecting to some or all of the treatment for his mental disorder. If Alan is not objecting it is difficult to see how covert medication could be justified.

If Alan is objecting to some or all of the treatment for his mental disorder, he will not be eligible for the DOLS and if he will continue to be deprived of his liberty in hospital, this will need to be authorised under the MHA (i.e. he should not be discharged from Section 3).

6. Charlie

Charlie is admitted to a MH ward under Section 2 MHA for treatment of his dementia. He is assessed as lacking capacity with regard to his admission and treatment. He is subject to continuous supervision and control on the ward and he would not be allowed to leave if he wished to. Charlie is described as 'wholly compliant' on the ward. However, nursing staff also say that he becomes upset when he has visitors and tries to leave with them (but is prevented from doing so).

At a Hospital Manager's hearing his solicitor argues he should be discharged from section and remain in hospital informally.

1. Do you agree that Charlie is deprived of his liberty in hospital?
    a. Please explain your answer.

2. What are the options for authorisation of Charlie's deprivation of liberty in hospital?
    a. Please set out each, explaining why they are available.

3. Is Charlie eligible for an authorisation under the DOLS?
    a. Please explain your answer.

4. Is the solicitor right that Charlie should be discharged from the MHA and remain in hospital informally?

Proposed answer

It appears that Charlie is deprived of his liberty in hospital because he lacks mental capacity in relevant contexts, his situation satisfies the "acid test" set down in

Cheshire West, and the arrangements for his residence and care are attributable to the state.

The MHA has already been used to authorise his admission and this may well be justifiable and lawful. We know that he is receiving treatment for a mental disorder in hospital. We would need to know more about the facts of his case to be sure that the Section 2 MHA criteria have been applied correctly but they may well have been.

Because Charlie lacks capacity and is deprived of his liberty in hospital, he cannot be discharged from the MHA and remain as an informal patient. The deprivation of his liberty must be authorised under either the MHA or the MCA/DOLS, otherwise he will be unlawfully detained. He cannot consent to remaining in hospital. It is clear that he will not be allowed to leave as things stand.

The fact that Charlie becomes upset and tries to leave hospital with his visitors strongly indicates that he is objecting to receiving some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment (as per Schedule 1A MCA, Case E). If so, and assuming he still meets the criteria for detention under Section 2 MHA, he will be ineligible for an authorisation under the DOLS and so this will not be an option.

In that case the only option, if Charlie is to remain deprived of his liberty in hospital, is for him to remain under Section 2 MHA.

APPENDIX 2

Relevant case law

What is a deprivation of liberty?	P v Cheshire West & Chester Council, P & Q v Surrey CC [2014] UKSC 19 Supreme Court: ' ...the acid test is whether a person is under the complete supervision and control of those caring for her and is not free to leave the place where she lives…'
Mental Health Act or DoLs	Manchester University Hospital NHS Foundation Trust v JS and Manchester City Council [2023] EWCOP 12 The judge said: 'There seems to be a belief... that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken.' And: '...where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances...then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.' Manchester University Hospitals NHS Foundation Trust v JS & Anor [2023] EWCOP 33 The judgment above was appealed by the NHS Trust. A senior High Court judge, Mrs Justice Theis dismissed the appeal and confirmed the first ruling was legally correct. The woman concerned was detained under Section 3 after the first ruling from Judge Burrows confirming that the MHA could have been used. AM v SLaM & Sec State for Health [2013] UKUT 0365 The procedure for admitting a person to a mental health ward and the decision about whether to use MHA 1983 or DoLS.
Relevant information for person to consent to a placement that amounts to a DoL	A PCT v LDV [2013] EWHC 272 This case provides guidance on the relevant information a person needs to understand, retain and use or weigh in order to have the mental capacity to: '...to consent to a placement which amounts to a deprivation of liberty.' The judge stated: 'I consider that on the facts of this case, the clinicians and the court should ask whether L has the capacity to understand, retain, use and weigh the following information: 1) That she is in hospital to receive care and treatment for a mental disorder; 2) That the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood; 3) That staff at the hospital will be entitled to carry out property and personal searches; 4) That she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision; 5) That if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.'

	Note: this case was very person specific in relation to the information to be understood. In relation to admission for care/treatment the benchmark was laid out by the Justice Theis in LBX v K, L, M [2013]**.**
Capacity to decide on care	LBX v K, L, M [2013] EWHC 3230 (Fam) The court highlighted the need for evidencing a clear rationale; guarding against imposing too high a test of capacity; the importance of using tangible resources, like drawings and pictures, to assess and improve the person's level of understanding; and clearly articulating the information relevant to the decision. Justice Theis outlined what should be considered relevant and not relevant when determining someone's capacity to decide on care: Relevant: 1) What areas he needs support with; 2) What sort of support he needs; 3) Who will be providing him with support; 4) What would happen if he did not have any support or he refused it; 5) That carers might not always treat him properly and that he can complain if he is not happy about his care. Not relevant: 1) How his care will be funded 2) How the overarching arrangements for monitoring and appointing care staff work.
Applying the '*acid test'*	NHS Trust & Ors v FG [2014] EWCOP 30 While this specifically refers to childbirth, we can make parallels to other physical treatment. In his judgement, Keehan J gave the first judicial confirmation that the 'acid test' set down by Lady Hale in *P v Cheshire West and others [2014] UKSC 19* applies in the acute setting. It appears that by 'acute' here, Keehan J intended not just to mean the acute psychiatric setting because his observations were expressly directed to circumstances outside such a setting. Applying the acid test, Keehan J observed at that: "It will commonly be the case that when at the acute hospital P: i) will have obstetric and midwifery staff constantly present throughout her labour and delivery; ii) will be under the continuous control of obstetric and midwifery staff who, because she lacks capacity to make decisions about her medical case, will take decisions on her behalf in her best interests; iii) will often not be permitted to leave the delivery suite." Those factors may, when applying the acid test, lead to a conclusion that P is or will suffer a deprivation of her liberty when at the acute hospital. If the Trusts are to deprive P of her liberty, they have a duty not to do so unlawfully: s6 HRA 1998. Justice Keehan also highlighted where there is a foreseeable deprivation of liberty and a standard authorisation is not sought, the use of an urgent authorisation under DoLS may be unlawful. Paragraphs 6.2 and 6.3 of Deprivation of Liberty Safeguards Code of Practice provide that urgent authorisations should normally only

	be used in response to sudden unforeseen events and they should not be used where there is no expectation that a standard authorisation will be required. He also laid out the following observations in relation to what care would amount to a deprivation of liberty: i) a mental health patient enjoys all of the fundamental rights and freedoms guaranteed under the ECHR save to the extent that their liberty is restricted pursuant to the MHA; ii) restraint or measures to facilitate P's care which amount to a deprivation of liberty would interfere with their rights under Articles 3, 5 and 8 of the ECHR unless authorised in accordance with the law; iii) total restraint for very short periods may amount to a deprivation of liberty; *ZH v Commissioner of the Police for the Metropolis [2013] 1 WLR 3021*; and iv) P's lack of objection to care or any restraint used to facilitate it is irrelevant in determining whether the actions amount to a deprivation of liberty: *P v Cheshire West and others [2014] UKSC 19* v)
MCA treatment for MHA patient	Norfolk and Suffolk NHS Foundation Trust v HJ [2023] EWFC 92 HJ was detained under MHA 1983 s3 but treatment under restraint for her constipation could not be provided under MHA 1983 s63. The trust asked the Court to authorise deprivation of liberty; the judge in email correspondence expressed doubts; subsequently the Trust and Official Solicitor changed their minds and agreed that the treatment did not involve deprivation of liberty. The judgement outlined: (1) The following principles apply: (a) only in exceptional cases will something amount to a further deprivation of liberty of someone already lawfully deprived of liberty; (b) this is because the usual position is that Article 5(1)(e) is not in principle concerned with suitable treatment or conditions; (c) the test is whether there is an unacceptable element of arbitrariness in the actions taken by a state body. (2) Applying that approach, proper and lawful exercise of clinical judgment will, save in exceptional circumstances, lack arbitrariness and will not amount to deprivation of residual liberty; partly that is because the trust owe a common law duty of care to the patient to provide appropriate treatment (the patient cannot be deprived of liberty by actions that the trust are required to take). (3) The MCA 2005 s4 best interests process, MCA 2005 s6 restraint limitations, MHA framework and Mental Health Units (Use of Force) Act 2018 requirements are a sufficient procedural framework for Article 8 purposes and do not need to be supplemented by a court order.
Ancillary medical treatment	B v Croydon Health Authority [1994] EWCA B v Croydon Health Authority - Case Law - VLEX 792564969 Use of NG Tube when considering ancillary medical treatment.

Consent to informal admission to a Mental Health Inpatient Unit	The below two cases highlight what a person must be able to understand in order to be able to consent to informal admission: AM v SLAM [2013] UKUT 0365 (AAC) (para. 40) • Capacity to agree to the relevant admission to hospital for the relevant purpose, • to stay in hospital whilst its purpose is carried out and • to the circumstances relating to a possible deprivation of liberty that will prevail during that admission. A PCT v LDV et al (2013) EWHC 272 (Fam) • she is in hospital to receive care and treatment for a mental disorder; • the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood; • staff at the hospital will be entitled to carry out property and personal searches; • she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision; • if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.