Mental Health Legislation Committee 27.01.2026

Tue 27 January 2026, 09:00 - 11:00

MS Teams

Agenda

09:00 - 09:05
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 21.10.2025

Ceri Phillips

1.3 - Draft MH Committee Minutes 21.10.2025 (1).pdf (8 pages)

1.4. Actions from the meeting held on 21.10.2025

Ceri Phillips

1.4 - MH Actions 27.01.2026.pdf (1 pages)

1.5. Chair's Action taken since last meeting

Ceri Phillips

No Chair's Actions.

09:05 - 09:20
15 min

2. Mental Capacity Act

2.1. Mental Capacity Act Monitoring Report and DoLS monitoring

15 mins *Chloe Evans*

2.1 - MHLMCA Report Q3 October - December 2025.pdf (10 pages)
2.1b - Committee Slides Q3.pdf (9 pages)

09:20 - 09:50
30 min

3. Mental Health Act

3.1. Mental Health Act Monitoring Exception Report

10 mins *David Seward*

3.1.1 - Exception Report January 2026.pdf (7 pages)
3.1.2 - Monitoring Report for October- December 2025.pdf (37 pages)
3.1.3 - RIGHTS AND RESPONSIBLITIES OF NEAREST RELATIVE UNDER THE MENTAL HEALTH ACT 1983 (1).pdf (10 pages)
3.1.4 - Role of the Nearest Relative leaflet (1).pdf (17 pages)
3.1.5 - NR Discharge Request Questionnaire (1).pdf (2 pages)

3.2. 36 Degrees Summary Report

10 mins *Samuel Barrett*

3.2 - 36 Degrees Summary Update.pdf (9 pages)

3.3. DoLS and MHA Interface - verbal update

10 mins *Chloe Evans*

3.4. Section 12 Challenges

10 mins *Samuel Barrett*

3.4 - Section 12 Challenges v1.pdf (4 pages)

09:50 - 10:05
15 min

4. Mental Health Measure

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

15 mins *Samuel Barrett*

4.1.1 - January 2026 Mental Health Measure Monitoring Reportv1.pdf (8 pages)
4.1.2 - MHLC Jan 2026.pdf (10 pages)

10:05 - 10:20
15 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 January 2026 (1).pdf (4 pages)

5.1.2. Mental Health Legislation and Governance Group Minutes

Julian Willett

5.1.2 - MHLGG minutes January 2026.pdf (6 pages)

5.2. Veterans NHS Wales Annual Report

10 mins *Neil Kitchiner*

5.2 - VNHSW_Annual_Report_2023_24 (1).pdf (32 pages)

5.3. DoLS Internal Audit report

Jason Roberts

20250911163443_cvu252616dolsfinalinternalauditreport.pdf (11 pages)

10:20 - 10:20
0 min

6. Items for Approval / Ratification

Ceri Phillips

6.1. Policies

No policies for approval.

10:20 - 10:20
0 min

7. Any Other Business

Ceri Phillips

10:20 - 10:20
0 min

8. Review of the Meeting

Ceri Phillips

10:20 - 10:20
0 min

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

Ceri Phillips

28th April 2026 via MS Teams

Draft Minutes of the Mental Health Legislation Committee
Held on 21st October 2025 via MS Teams

To view the meeting: https://youtu.be/SZ1OfTGPAIs

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Rachna Upadhya	RU	Committee Vice Chair / Independent Member - General
Clive Curtis	CC	Independent Member - Community
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
In Attendance:		
Chloe Evans	CE	MCA & Consent Lead
Jason Roberts	JR	Executive Director of Nursing
David Seward	DS	Mental Health Act Manager
David Fluck	DF	Executive Medical Director
Matt Phillips	MP	Director of Corporate Governance
Julian Willett	JW	Transformation & Innovation Lead - Mental Health
Tara Robinson	TR	Interim Deputy Director of Nursing – Mental Health
Samuel Barrett	SB	Deputy Director of Operations Children & Women's Clinical Board
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Amanda Morgan	AM	Chair of the Power of Discharge Group
Alex Nute	AN	Vice Chair of the Power of Discharge Group

Item No	Agenda Item	Action
MHL 2025/10/1.1	**Welcome, Introductions and Apologies for Absence** Ceri Phillips (CP), the Committee Chair, welcomed everybody to the meeting in English and in Welsh.	
MHL 2025/10/1.2	**Declarations of Interest** *No declarations of interest were declared*.	
MHL 2025/10/1.3	**Minutes of the Meeting held on 26.08.2025** The Minutes of the Meeting held on 26.08.2025 were received and approved. **The Committee Resolved that:** a) The minutes of the meeting held on 26.08.2025 were agreed as a true and accurate record.	
MHL 2025/10/1.4	**Action Log from the meeting held on 26.08.2025** The Action Log was received and discussed. MHL 2025/08/3.1 - Mental Health Act Monitoring Exception Report – David Seward (DS). the Mental Health Act Manager, explained that the team had produced a questionnaire to	

	send to nearest relatives when they requested discharge. It was agreed that the paper would be circulated with Committee members following the meeting. **The Committee Resolved that:** a) The Action Log was noted.	
MHL 2025/10/1.5	**Committee Chair's Actions** *No Chair's Actions were taken since the last meeting.*	
	Mental Health Act	
MHL 2025/10/2.1	**Mental Capacity Act Monitoring Report and DoLS Monitoring** Chloe Evans (CE), the MCA & Consent Lead, 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: • Mental Capacity Act Monitoring Actions (July - September 2025) • Mental Capacity IMCA Referral type • Awareness Raising / Training Sessions • Mandatory MCA Training • MCA Practitioner Led Training • MCA Team Advice and Support, and Resources for Staff • MCA Audit Action Plans • Deprivation of Liberty Safeguards Monitoring Actions - Quarterly Overview from July – September 2025 • Referrals and Assessments • Internal Audit – DoLS Rachna Upadhya (RU), the Committee Vice Chair, asked whether the team checked why applications had been withdrawn, and whether there was a follow-up process to ensure nothing was missed. CE responded that withdrawn applications were common due to patient discharge, ward transfers, or patients passing away. The MCA team administrator performed weekly checks to confirm patient status. Whilst they relied on ward updates, they also carried out their own checks as notifications could be delayed. CE added that in the past quarter, they identified around 10 withdrawal reasons, but due to strict Welsh Government (WG) criteria, only four were now officially recorded, which reduced the detail in their data. Regarding the Internal Audit – DoLS recommendation to improve DoLS training requirements for staff, RU asked which key staff this applied to. CE responded that this mainly applied to inpatient medicine, specialist services, and older adult mental health wards. Whilst other staff should be aware of DoLS, the legal process differed. They aimed to have trained DoLS staff on every ward to support colleagues. **It was suggested that this report included information on the key staff areas being targeted for DoLS training for completeness – ACTION.**	

	Susan Lloyd-Selby (SLS), the Independent Member – Local Authority, asked what the timescale was for the development of the Standard Operating Procedure (SOP) identified as one of the recommendations in the DoLS – Internal Audit report. CE responded that the aim was for it to be approved by the end of the financial year. SLS asked whether the MCA Practitioner Led Training session had been held in Barry Hospital to improve access for Vale of Glamorgan (VoG) staff, as suggested in a previous Committee meeting. CE responded that they had struggled to find a suitable venue outside Barry Hospital due to parking issues. The Civic Offices in Barry had been suggested, but they were awaiting confirmation. They hoped to run the session in Q4. Clive Curtis (CC), the Independent Member – Community, asked about equitable access to advocacy for younger adults, as a high proportion of referrals were from those aged 65+. CE responded that the INCA service provided advocacy for individuals of any age who lacked capacity for serious medical treatment or long-term care decisions. They promoted advocates' roles through ward visits and training. Whilst most referrals involved older patients, this reflected hospital demographics rather than any bias. Jason Roberts (JR), the Executive Director of Nursing, asked why they had seen an increase in the use of advocates since the last report. CE responded that awareness had improved (34 awareness raising sessions were held this quarter). Additional training was helping people to better understand advocacy and its role. JR noted that there had been a drop in mandatory MCA training across all staff groups, which may reflect current financial pressures. They would monitor this over the coming months. **The Committee resolved that**: a) The contents of the report were noted.	
	Mental Capacity Act	
MHL 2025/10/3.1	**Mental Health Act Monitoring Exception Report** DS 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 DS provided a summary of the following reported during the quarter: • No fundamentally defective applications • Two fundamentally defective reports • Three lapses – two Section 2s, one Section 3 • The use of Section 136s had decreased.	

SLS asked what information they provided to help patients and families understand their rights and consequences if mistakes occur.

DS responded that they provided a leaflet explaining patient's rights, their section, and how long it lasted. It there was an error, they write to inform them, explain the mistake, and advise that they could seek legal advice, speak to an advocate, or contact the team if they wished.

SLS asked what percentage of patients sought legal advice.

DS responded that they had not had anyone come back following legal advice.

RU asked whether they could explore further if the increase in detentions were driven by genuine clinical need, or whether the two independent doctors were less confident to decide whether to keep patients informally.

DS responded that this had been looked in to, and that it could be linked to changes in the DoLS case law and more stringent criteria.

RU clarified whether the key driver seemed to be DoLS, rather than Section 2 or 3.

DS responded that this trend was clear, as DoLS was not recorded in PARIS. They saw a clear marker that people are being detained more, because they could not be put onto DoLS.

Tara Robinson (TR), the Interim Deputy Director of Nursing – Mental Health, explained that there was a wider piece of work already underway to understand the rise in detained patients versus informal ones, so this could be considered as part of this work, and suggested bringing it to a future Committee – ACTION.

JR and CP asked for the outcome of the Section 3 lapse investigation to be shared with himself and the Committee to get assurance about learning – ACTION.

Regarding nearest relative discharge requests, JR noted that concern was raised at the previous MH Committee and explained that they had produced a survey to distribute with a sample of relatives to understand their experience.

CP noted that bare numbers alone did not provide the full picture – they needed to see them in proportion to the overall patient population.

DS added that some relatives did not understand that a nearest relative discharge meant their loved ones would be returning home to them. Once they realised, they often withdrew their request. Feedback received would be included in future reports.

SLS suggested reviewing how they communicated with families. If inappropriate requests were being withdrawn once relatives understood the implications, they may need to be more proactive.

DS explained that they sent families a leaflet explaining informal status, also do local authorities (LAs). However, the UHB often only got involved once a discharge request had been made. DS was working with consultants to ensure that if a relative was considering discharge, the Responsible Clinician and the ward spoke with them first to

	explain the implications. They aimed to be clear so that families understood what the request meant. **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 2025/10/3.2	**Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy – Verbal Update** TR presented the slides to the Committee which provided an overview of the Mental Health and Wellbeing Strategy and the Suicide and Self-Harm Prevention Strategy. It emphasised their person-centred, trauma informed, and preventative approaches, with a focus on early intervention, system-wide transformation, and accessible care. Both strategies required significant service redesign, workforce development, and partnership working. CP asked whether the lived experience team was involved in the service transformation work. TR responded that the lived experience team was a key partner and were involved in all aspects of service design and delivery. They aimed to embed their input throughout. David Fluck (DF), the Executive Medical Director, highlighted that it needed significant transformation, and asked how far they were from this model currently. TR responded that reaching same-day access approach would take significant time and effort. Some parts of their service may be closer, and 36 Degrees was supporting their redesign work. Julian Willett (JW), the Transformation & Innovation Lead - Mental Health, noted this would be a major shift – moving from long referral-based pathways to immediate, same-day access and prompt interventions. It was a big change, but with incremental steps and support from lived experience colleagues, they were confident they could get there. CP emphasised the importance of their relationship with the third sector, and that they had not yet reached their full potential with NHS 111 Press 2. JW explained they had been asked to identify and demonstrate a site for each UHB to get things moving. The focus would be on bolstering NHS 111 Press 2 to make it more effective. TR added that discussions were ongoing with primary care around aligning NHS 111 Press 2 with this work. 36 Degrees had scheduled meetings to support this. **It was suggested that the team bring a summary of the 36 Degrees report to the following Committee meeting to help provide a timeline and understanding of progress towards service redesign – ACTION.** **The Committee resolved that:** a) The verbal update was noted.	.
MHL 2025/10/3.3	**MHA / DoLS Interface - Verbal Update** CE highlighted she had met with a consultant from the Liaison Psychiatry Older People (LPOP) and the MHA office to review a guidance booklet which covered what ward staff	

	should do if someone was ineligible for DoLS and how to arrange an MHA assessment. It also included guidance on the use Section 5(2) and how to arrange an MHA assessment. CE noted that finalisation was due over the following weeks, with a sign-off meeting in November 2025. **It was agreed that the finalised guidance booklet on the DoLS and MHA interface be shared at the following Committee – ACTION.** **The Committee resolved that:** a. The update was noted.	
MHL 2025/10/3.4	**Section 12 Challenges and Futureproofing – Verbal Update** TR highlighted the following to the Committee: • The team were currently scoping the issue and reviewing data to understand what was driving the challenge. • Discussions with the LA were ongoing to identify a possible solution, with further progress expected the following day. • A Wales-wide pilot app was considered, but opportunity to be a part of this trial was limited, as they had questions before joining. The pilot had since closed, so they were looking at alternative options. • TR hoped to update the Committee at the following meeting. Matt Phillips (MP), the Director of Corporate Governance, asked for more context on Section 12 and the challenges around this. TR explained the difficulties in securing Section 12 doctors for assessments, which may be causing delays. To explore options effectively, they needed a clear understanding and data to develop a more comprehensive response. JR provided the following points: • They were working through the Section 12 issue raised by the Regional Safeguarding Board (RSB) and LA colleagues due to delays in assessments. • There were two types of doctors involved – UHB employed psychiatrists, and GPs who opted in independently. • Early indications suggested that delays were more likely with GPs, often due to being out of area and concerns around payment. • JR was coordinating discussions between mental health, the PCIC Clinical Board, and the LA to resolve this. • JR was due to report back to the RSP the following month. TR added that the payment for Section 12 doctors was considerably lower in Cardiff than in other areas. RU provided the following additional comments: • It would be useful to see how many Section 12 MHA doctors were available, and the split between psychiatrists and GPs. It was harder for GPs to get Section 12 approval, so assumed that psychiatrists made up the majority. • They needed to be cautious about potential bias in AMHPs selecting which doctors to call – availability could influence assessments and outcomes.	

	RU offered her help as she was a Section 12 approved psychiatrist. TR explained that the app being considered could help to reduce bias, which made it a promising option. They were currently reviewing the governance aspects around this. **CP suggested that a paper come to the following Committee which outlines the Section 12 challenges, actions to resolve them, and any issues that may need to be addressed. It was requested the paper also include the impact on patients and resource implications across hospital and community settings – ACTION.** **The Committee resolved that:** A) The update was noted.	
	Mental Health Measure	
MHL 2025/10/4.1	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** TR, JW, and Samuel Barrett (SB), the Deputy Director of Operations Children & Women's Clinical Board, presented the Mental Health Measure Report and slides 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 – Self-Referral Assessment Outcomes • Part 4 – Advocacy Access • Key priorities for the next quarter Regarding Part 2 care and treatment planning for children and young people, SLS noted the report highlighted challenges with engagement due to the adult-focused process and paperwork. She asked what impact this had, and what could they do more to support their involvement. SB agreed and noted they were working on engaging with children and young people to understand what was preventing their involvement. The one-size-fits-all approach did not work. **It was suggested that the team bring an update to a future Committee on the progress made to improve engagement of children and young people in Part 2 care and treatment planning, ensuring the process is adapted to their needs – ACTION.** **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 2025/10/5.1	**Sub-Committee Meeting Minutes** The Committee noted the below Sub-Committee Meeting Minutes: • Hospital Managers Power of Discharge (POD) Sub-Committee Minutes – 07.10.2025 • Mental Health Legislation and Governance Group (MHLGG) - 09.10.2025	

	JW provided the following summary of the MHLGG 09.10.2025 minutes: • They were unable to discuss patients detained in A&E due to quorum issues. • Section 12 matters were covered, and Cardiff now had a centralised MHA assessment process, which should streamline things. • The POD Group raised concerns about WARRNs provision for tribunals, which would be taken to the Quality & Safety meeting for clarification. • They were unable to cover the locked doors issue due to quorum. • Feedback from the POD Group highlighted communication gaps, inefficiencies, and increased postponements. DS would meet with consultants to explore solutions. Similar concerns had been raised by advocacy support colleagues around adjournments. • The interface between the MHA and DoLS was discussed. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
	Items for Approval / Ratification	
MHL 2025/10/6.1	*No items.*	
	Any Other Business	
MHL 2025/10/7.1	CC asked how the closure of Cardiff and Vale Action on Mental Health (CAVAMH) had affected the Board's ability to engage with third sector mental health organisations. JW responded that they now worked with the organisation Adferiad for service user and care representation. They also engaged with the Recovery College. MP noted that a few items in the Committee were discussed without papers.	
MHL 2025/10/8.1	**To note the date, time and venue of the next meeting:** 27th January 2026 via MS Teams	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
MENTAL HEALTH	Mental Capacity Act Monitoring Report and DoLS Monitoring	MHL 2025/10/2.1	Standing report to include information on the key staff areas being targeted for DoLS training	Jason Roberts	Chloe Evans	21/10/2025	27/01/2026	COMPLETE	Information included within the report.	
MENTAL HEALTH	Mental Health Act Monitoring Exception Report	MHL 2025/10/3.1	Wider piece of work required to understand the rise in detained patients versus informal ones to be brought to the January meeting	Jason Roberts	David Seward; Tara Robinson	21/10/2025	27/01/2026	COMPLETE	Included within the Exception report.	
MENTAL HEALTH	Mental Health Act Monitoring Exception Report	MHL 2025/10/3.1	Share the outcome and findings of the investigation into the Section 3 lapse with the Executive Nurse Director and Committee.	Jason Roberts	David Seward	21/10/2025	27/01/2026	COMPLETE	Outcome included within the Exception Report.	Sharing to provide assurance regarding learning.
MENTAL HEALTH	Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy	MHL 2025/10/3.2	Present a summary of the 36 Degrees report to the January meeting	Jason Roberts	Tara Robinson	21/10/2025	27/01/2026	ON FORWARD PLAN	On Forward Plan for January's meeting. Paul/Jason lead	Report to help provide a timeline and understanding of progress towards service redesign.
MENTAL HEALTH	MHA / DoLS Interface	MHL 2025/10/3.3	Share the finalised guidance booklet on the DoLS and MHA interface at the following meeting.	Jason Roberts	David Seward; Chloe Evans	21/10/2025	27/01/2026	IN PROGRESS	The guidance booklet is still out for comment at the time of the January 2026 MH Committee. A verbal update will be provided at the Committee.	
MENTAL HEALTH	Section 12 Challenges and Futureproofing	MHL 2025/10/3.4	Share a paper outlining the Section 12 challenges, actions to resolve them, any issues that may need to be addressed, the impact on patients and resource implications across hospital and community settings.	Jason Roberts	Tara Robinson	21/10/2025	27/01/2026	ON FORWARD PLAN	On Forward Plan for January's meeting	
MENTAL HEALTH	Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report	MHL 2025/10/3.4	Update the Committee on the progress made to improve engagement of children and young people in Part 2 care and treatment planning, ensuring the process is adapted to their needs.	Jason Roberts	Samuel Barrett	21/10/2025	28/04/2026	ON FORWARD PLAN	On Forward Plan for April 2026 meeting	

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring**				Agenda Item no.	*2.1*	
Meeting:	**Mental Health Legislation Committee**		Public	X	Meeting Date:	27.01.2026	
			Private				
Status	Assurance	X	Approval		Information		
Lead Executive:	Jason Roberts, Executive Nurse Director						
Report Author:	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 the provision of IMCA services and the 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.

For awareness, the UHB is currently engaging in the tender process for and All Wales Advocacy contract. This will likely be broken down to region by health board and it is expected to include Cardiff and the Vale of Glamorgan Councils. This will provide a smoother transition for advocacy provision when a person moves between hospital and the community and will also enable the UHB to make better use of the funding available for advocacy from Welsh Government. The tender process is working towards an implementation date of 1st January 2027 for the new contracts.

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

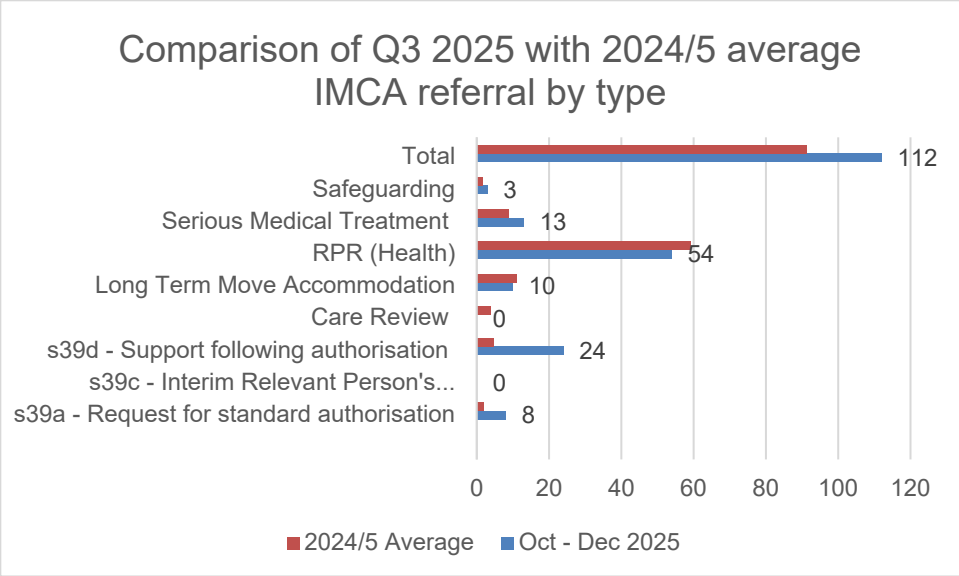
<u>Mental Capacity Act Monitoring Actions (October - December 2025):</u>

Mental Capacity IMCA Referral type

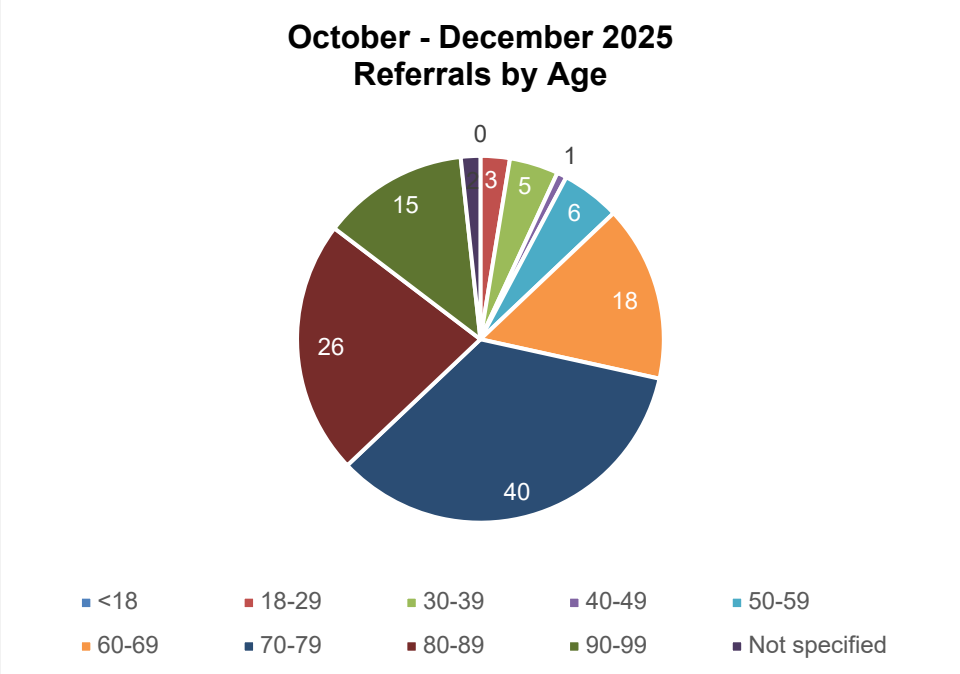
The MCA Indicators outline the breakdown of IMCA referrals for the period from October - December 2025 with a comparison of the 2024/5 mean average.

Overall referral rates are noted to remain higher than last year's average by 19%. RPR referrals have increased from Q2 and remain more in keeping with last year's average. Referrals for advocacy also continue to remain much higher this quarter than last year, which is reportedly due to a shift towards using professional advocacy as opposed to relying on family members; who may not be best placed to navigate the DoLS process and actively raise objection on the person's behalf.

Referrals for Long Term Move of Accommodation had increased to 24 last quarter but this has reduced this quarter back in line with average rates.



The below pie chart provides a breakdown of referrals for the last quarter by age. As the chart outlines. This has now been broken down into further categories rather than simply capturing those aged 65+. The majority of referrals were for people aged 70-79 (34%), with the 80-89 age category much lower the next most common (22%). Those aged 70-99 equated to 70% of all referrals this quarter.



In terms of gender, referrals were almost equally weighted, with males accounting for 51% and females 49%.

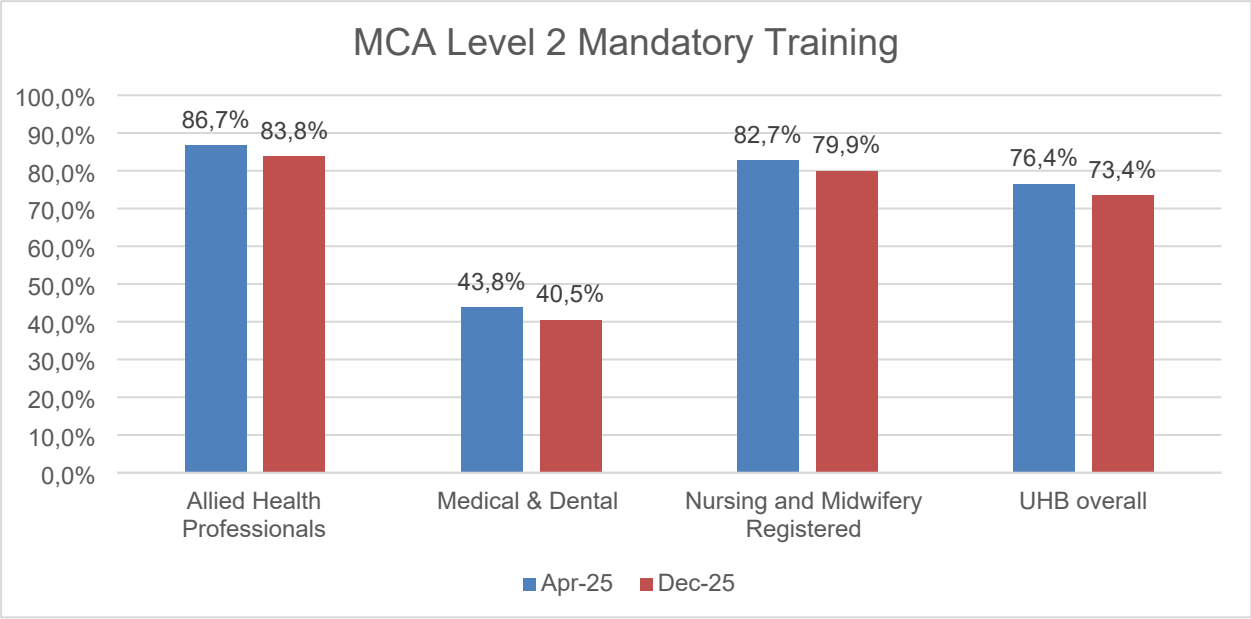
Awareness Raising / Training Sessions

Advocacy Support Cymru continue to offer informal training sessions when visiting patient areas, with 33 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 December 2025. There continues to be a slight downturn in compliance across all professional groups. As previously outlined, this is likely due to competencies expiring at the end of the 3-year renewal period. The team continue to raise awareness of the importance of compliance with mandatory MCA training at every opportunity and staff must be compliant with this to attend Practical Application of the MCA training. Training compliance for each clinical board is shared with the Directors of Nursing on a monthly basis and are also reported at the MCA Focus Group and Safeguarding Steering Group. It is expected that compliance will improve following implementation of clinical board action plans but it is anticipated that it may take until the end of the next quarter to see the impact of this.



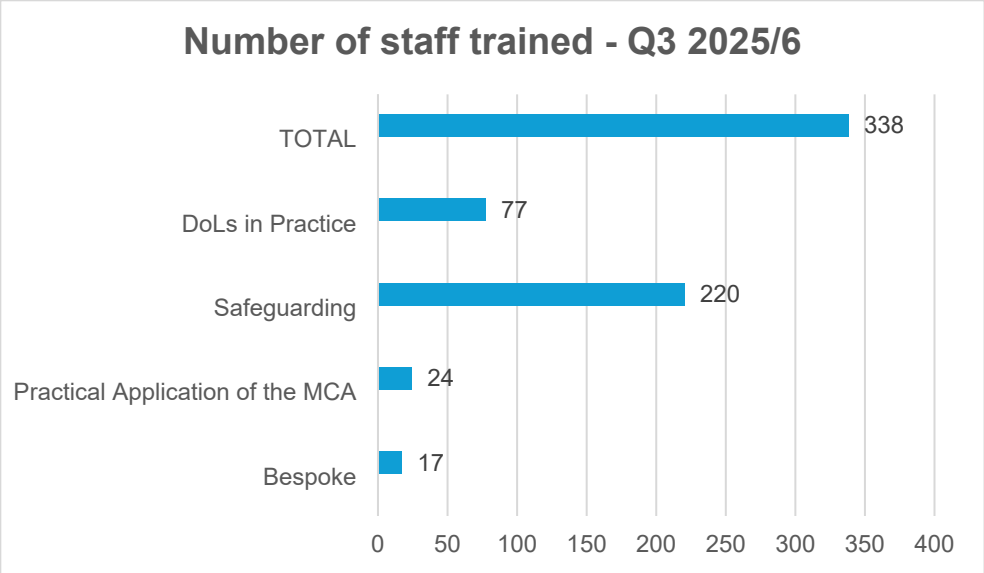
MCA Practitioner led training

DoLS in Practice:
Training attendance is high with all sessions fully booked during this quarter and for Q4.

Practical Application of the MCA:
Attendance remains lower this quarter than in the previous year however, there has been an increase in bookings for Q4 which appears to be as a result of the clincal board action plans in relation to the MCA Audit. A session in the Civic Offices in Barry has now been confirmed for March; which will help to provide greater accessibility for those working and living in the Vale of Glamorgan.

During Q2 the team worked with medical education to pilot a shortened session of the Practical Application of the MCA training. The aim of this was to be able to accommodate more bespoke sessions that are often only able to accommodate a 2.5-3 hour training session instead of the usual 4 hours that the course is delivered in. Following the pilot it was identified that the shortened session meant that the more practical element of the training was lost and it would not be productive to take this forward. Instead, the MCA Team will be looking to present to Resident doctor to highlight the support and resources available form the team and raise awareness of existing training.

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

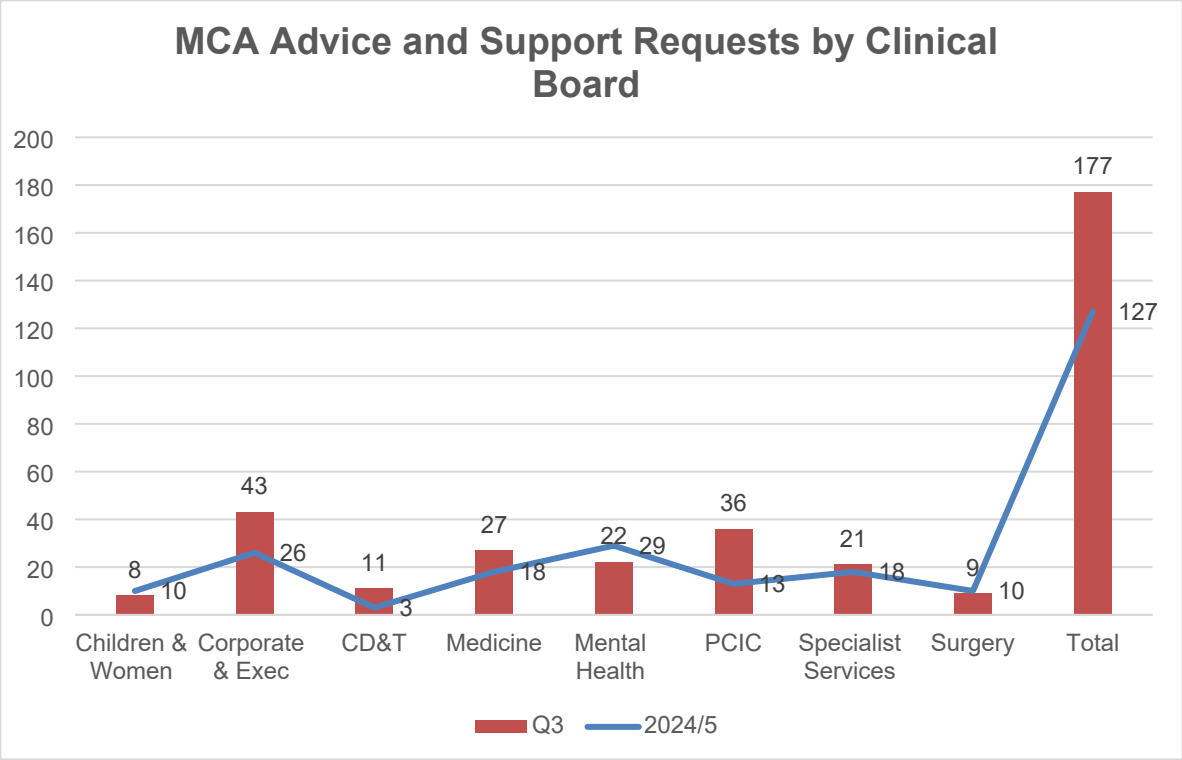


Training feedback is requested following each session of the Practical Application of the MCA, DoLS in Practice and MCA Level 2 face to face training and continues to demonstrate that the training is very well received by those that do attend.

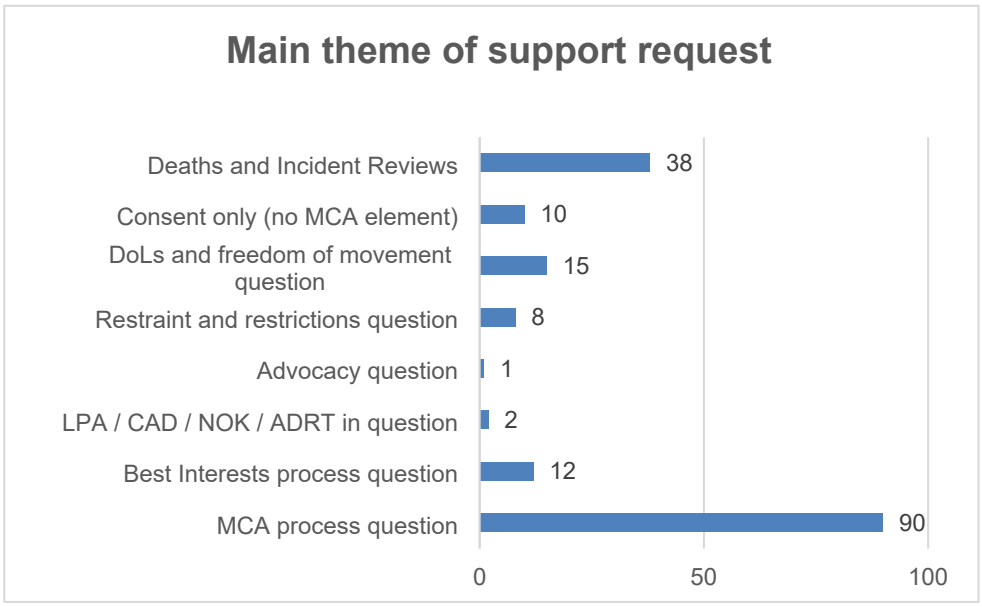
Training Feedback	% Agree or strongly agree	% Neutral, disagree or strongly disagree
My learning outcomes were met	90%	10%
Training was effective and easy to understand	90%	10%
I feel confident about applying principles of MCA to practice	90%	10%
Helped with practical application of MCA as well as theory	95%	5%
I feel confident in knowing how to access MCA support	100%	0%

MCA Team Advice and Support

The below chart outlines the number of referrals received by each Clinical Board during Q3 with a comparison of the mean average for 2024/5. Referral rates are in line with the 2024/5 average however, there has been an increase in referrals from Corporate and Exec, due to the reporting accounting for MCA Team support with Mortality Screening Panel cases, and PCIC clinical boards. Within PCIC there has been a significant amount of work carried out with the district nursing teams to support awareness and identification of patients who may lack capacity to make decisions, following increasing awareness of cases of self-neglect in the community. This appears to be in keeping with the national picture and has noted to be a key theme arising in Safeguarding reviews in recent years.



The main themes for advice and support requests are outlined below, with MCA process queries making up 51% of all referrals. Deaths and incident reviews comprise 22% and best interests (7%) and DoLS related questions (9%) are the next most notable reasons for advice and support. There is little change in the main themes of requests and this is in keeping with previous quarters.



MCA Team Resources

In response to learning from reviews and the recent internal DoLS audit, the MCA Team are in the process of developing new resources in relation to the following:

Patient/carer: Local CAVUHB information leaflet to be provided when urgent authorisation put in place or standard authorisation requested.

Policies and procedures: DoLS Standard Operating Procedure, nearing completion, currently with DolS Team for review before sharing for consultation. DoLS policy in progress.

MCA Audit Action Plans

All Clinical Boards now have identified leads for overseeing these action plans. The main focus is on supporting staff to access available training, raising awareness of the support available and improved governance through the use of the Quality and Safety meeting framework. By having each clinical board develop their own action plan it is hoped this will better tailor the actions required to improve compliance within individual clinical boards. The MCA team are supporting implementation of action plans with involvement in audit, the delivery of service specific training and development of resources for staff.

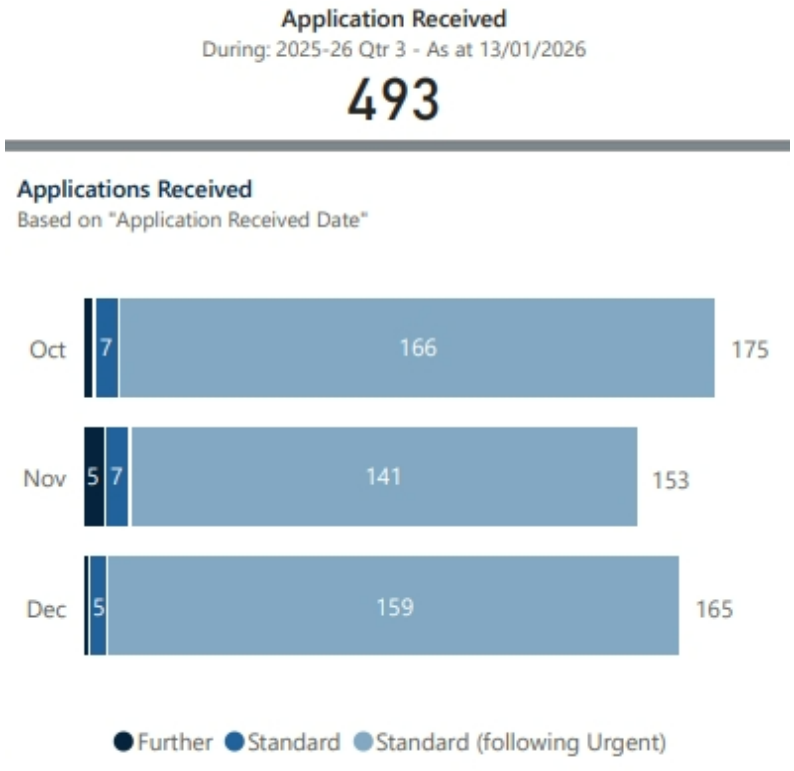
Deprivation of Liberty Safeguards Monitoring Actions:

Quarterly overview from October – December 2025

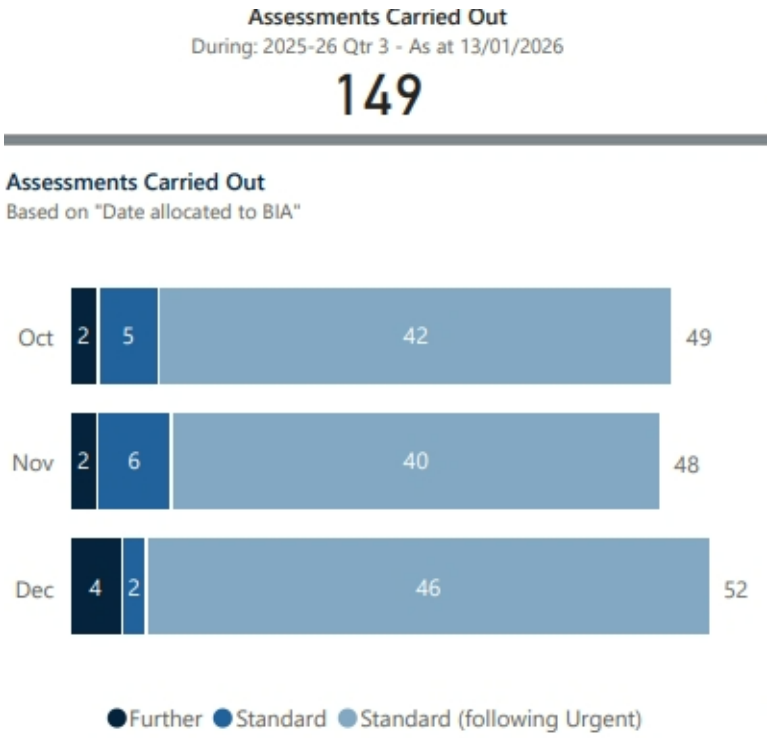
Applications Received	Assessments Carried out	Authorisations Granted	Total Waiting List	Applications Withdrawn
493	149	88	62	341

Referrals and Assessment

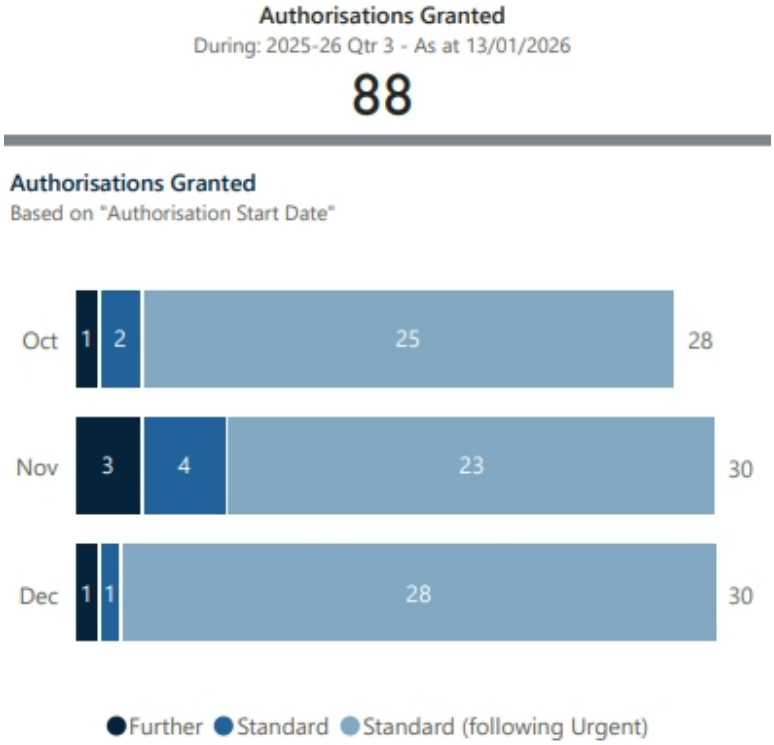
The referral figures for the last quarter are outlined below, with an increase of 48 applications received compared with Q2.



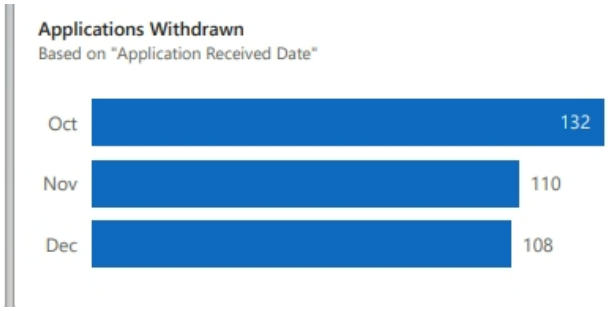
The below chart outlines the number of assessments carried out over the last quarter, by month and type. A total of 149 assessments have been undertaken this quarter, of these 57% (85) have been carried out by internal BIAs and the remaining 43% (64) by external assessors as additional assessments. Additional assessments continued to be commissioned at a rate of 5 per week to try and meet demand.



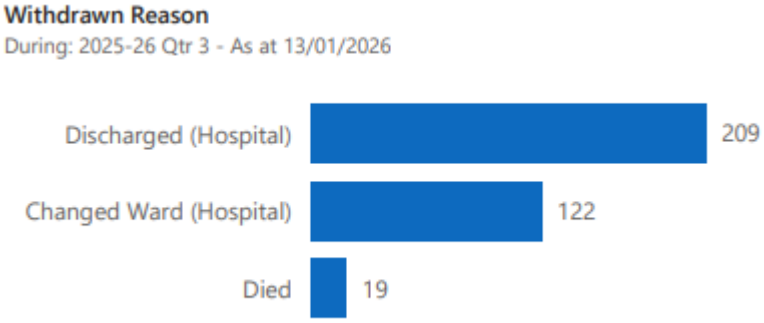
A total of 88 authorisations have been granted this quarter, with an average of 29 authorisations per month; up from an average of 24 per month in Q2. The number of 'authorisations granted' refers to the number of instances where the full authorisation process has been completed. This does not include instances where the application has been withdrawn for any reason prior to sign off by the DoLS signatory. This is in line with Welsh Government reporting processes.



A total of 350 applications were withdrawn this quarter, compared with 257 in Q2.



The reason for withdrawal of DoLS applications for this quarter are outlined below; discharge (60%), changed ward (35%) and death (5%). Due to the reporting requirements for Welsh Government the DoLS team is only able to capture four options for recording.



The waiting list has remained largely stable, with a decrease from 64 to 56 compared with Q2. This is positive in light of the increase in referrals by 48; which has been balanced by a small increase in the number of assessments undertaken compared with last quarter (up 10 assessments, to 149) and the higher rate of withdrawals this quarter (257 in Q2 to 350 in Q3). Average days awaiting BIA allocation remains at 9 days.

Wait Day Groups	Standard (following Urgent)
22-80 Days	1
8-21 Days	28
0-7 Days	27
Total	**56**

Actions from DoLS audit:

Further to the DoLS audit conducted in Q2 the MCA Team has carried out a scoping exercise to consider DoLS training provision within other health boards across Wales. This has identified that the DoLS content contained within the mandatory MCA Level 2 training in CAVUHB is in keeping with that provided within other areas. This mandatory training provides an overview of the law in relation to deprivations of liberty, how to identify when someone is deprived of their liberty and when to make an application. This is designed to ensure that all relevant staff have an awareness of the DoLS process and when the Safeguards will apply. However, this training does not provide the in-depth look into the practicalities of making a DoLS referral, clarification about restraint/restrictive practices and the interface between DoLS and the Mental Health Act, which is covered within the standalone 'DoLS In Practice' training.

The DoLS in Practice training is a 2.5-hour session which provides higher level content and is targeted towards inpatient staff working with those who lack capacity to consent to their admission to hospital. It is acknowledged that there are some areas where this is a more common occurrence than others and there is greater probability of patients in these areas requiring DoLS authorisation. These areas include all general medicine wards, specialist wards (neurosciences, stroke, critical care etc.), trauma and orthopaedics, mental health (particularly MHSOP and neuropsychiatry) and entry points to the hospital such as the emergency department, MEAU and high acuity medical wards.

For Specialist Services arrangements are in place to provide a full day's training combining both 'DoLS in Practice' and 'Practical Application of the MCA', in February. This was requested as part of their MCA action plan and aims to target a high proportion of ward managers, team leaders, deputies and a small number of senior nurses; in order to raise understanding and awareness of the process and staff's responsibilities. However, staff at all levels are encouraged to attend the standalone sessions that are available monthly. If this proves effective, similar sessions will be offered to other clinical boards to try and maximise learning opportunities.

Recommendation:

The Committee is requested to:

a) Note the contents of this paper

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Ways of Working (Sustainable Development Principles) considered

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:

MCA and DoLS Monitoring Report Q3 2025/6

Chloe Evans

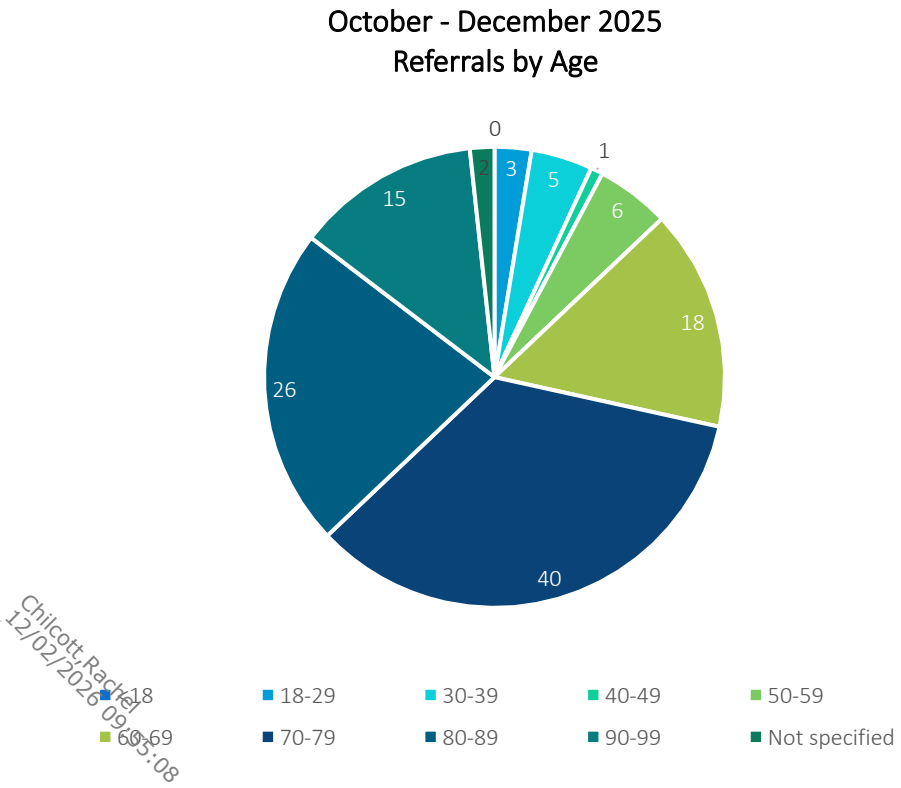
MCA Project Lead

Advocacy:
Referral by type

- IMCA Referrals up 19% this quarter compared with 2024/5 rates.
- Referrals for advocacy continue to remain much higher this quarter than 2024/5, due to a shift towards using professional advocacy as opposed to relying on family members/friends; to ensure rights are properly protected and objections actioned.
- Referrals for Long Term Move of Accommodation had increased to 24 last quarter but this has reduced this quarter back in line with average rates.

Advocacy

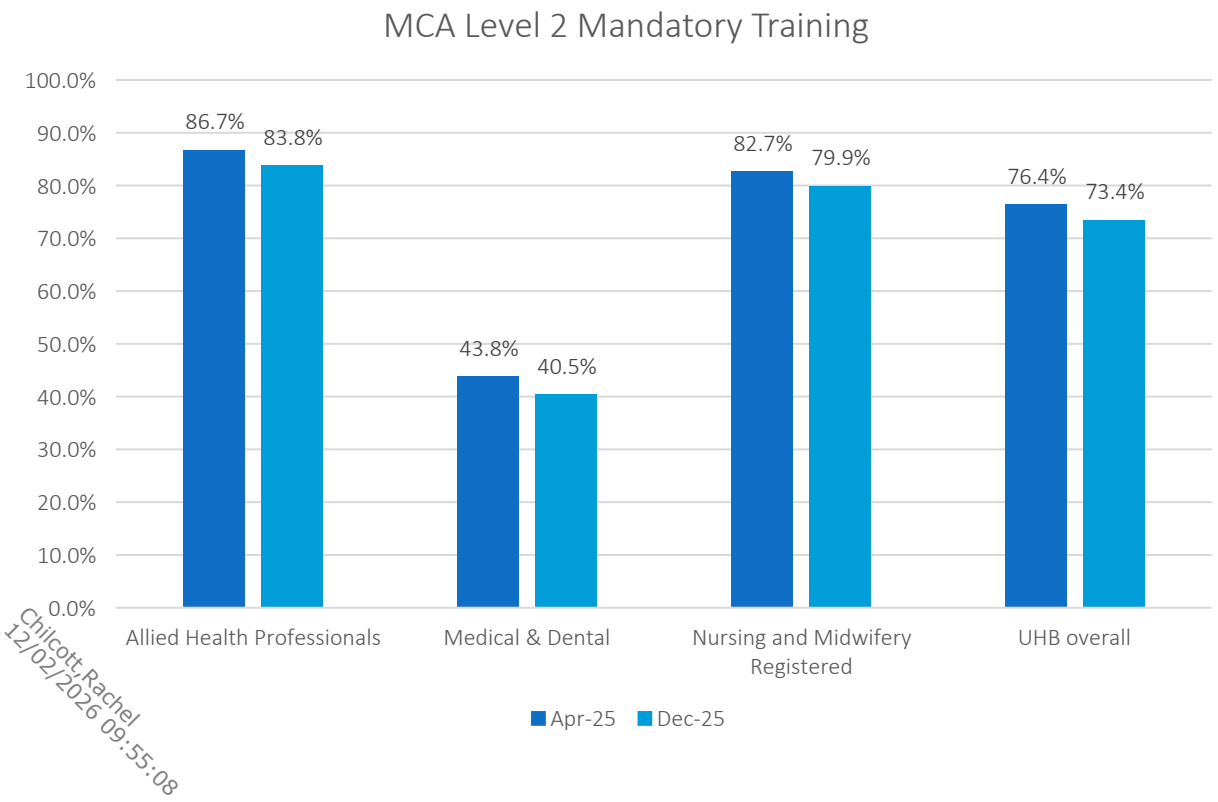
Demographic data



- Age: The majority of referrals were for people aged 70-79 (34%), with the 80-89 age category the next most common (22%). Those aged 70-99 equated to 70% of all referrals this quarter.
- Gender: referrals were almost equally weighted, with males accounting for 51% and females 49%.
- Awareness raising: 33 informal awareness raising sessions undertaken across CAV UHB

Training

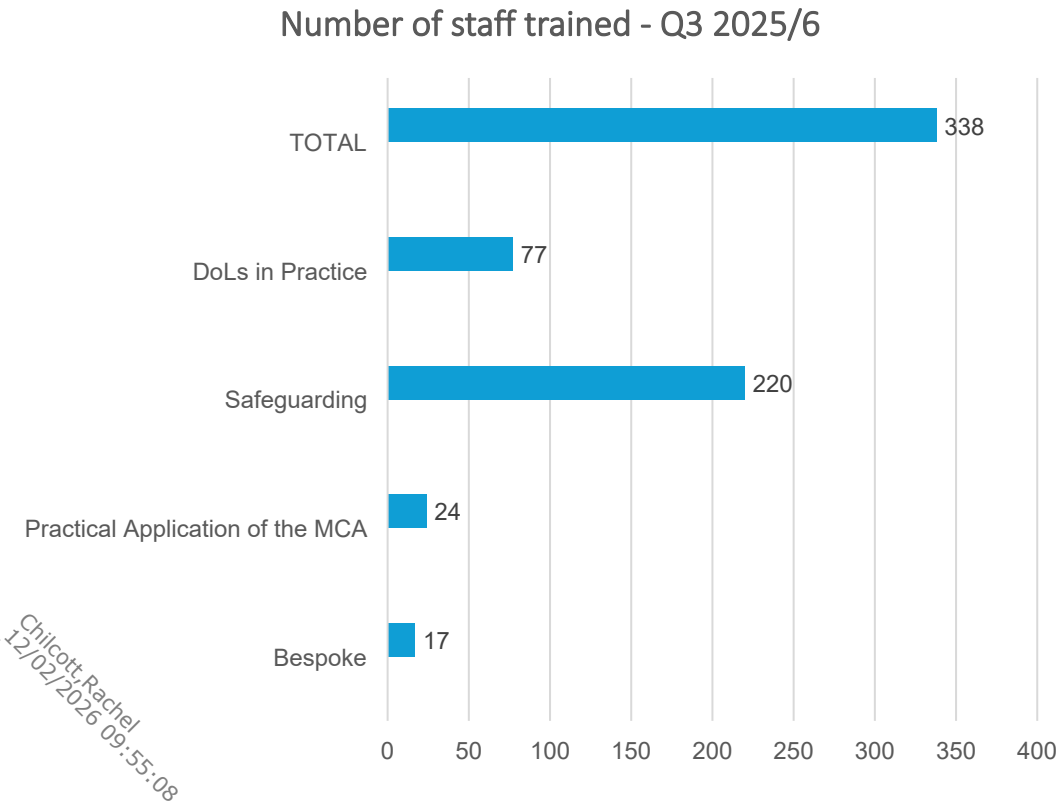
MCA Level 2



- Continues to be a slight downturn in compliance across all professional groups despite frequent awareness raising.
- Training compliance for each clinical board is shared with the Directors of Nursing on a monthly basis, reported at the MCA Focus Group and Safeguarding Steering Group bimonthly.
- It is expected that compliance will improve following implementation of clinical board action plans, though it is anticipated that it may take until the end of the next quarter to see the impact of this.

Training

MCA Practitioner Led

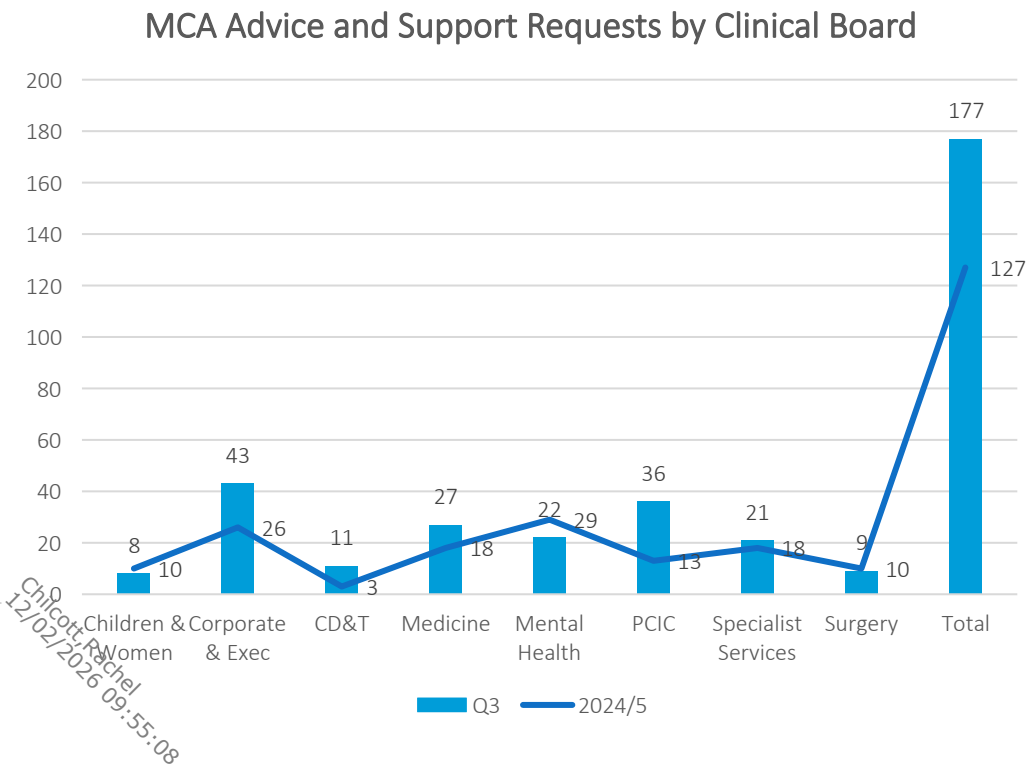


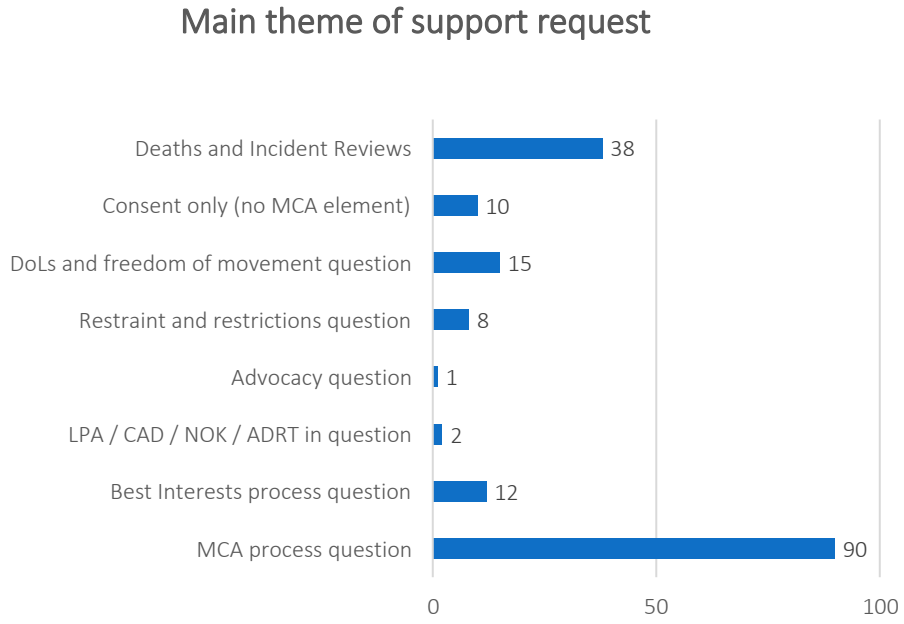
DoLS in Practice: All sessions fully booked

Practical Application of the MCA:
Booking numbers remain low for this quarter though booking noted to have increased for Q4 as a result of CB action plans.
Q4 session arranged for Civic Offices, Barry.
Pilot undertaken with Medicine medics for 3 hour session however, felt that this lost more practical elements of the training.

Safeguarding Level 3:
Specialist theme of Self Neglect - facilitated by MCA Practitioner. This study day received excellent feedback. Including presentations from Safeguarding, Regional Safeguarding Board, Mortality Lead, Consultant Nurse for Vulnerable Adults.

MCA Team: Advice and support requests





DoLS Monitoring

Applications Received	Assessments Carried out	Authorisations Granted	Total Waiting List	Applications Withdrawn
493	149	88	56	350

- **Applications received:** 10% increase in referrals (+48) compared with Q2
- **Assessments carried out:** Total of 149 assessments undertaken. 57% carried out by internal BIAs, remaining 43% carried out by external assessors as additional assessments, which continue to be commissioned at rate of 5 per week.
- **Authorisations granted:** Total of 88 authorisation granted this quarter, mean average of 29 per month (up from 24 in Q2). Refers to instances where full authorisation process completed, excludes those where application withdrawn for any reason prior to sign off by DoLS Signatory, in line with WG reporting.
- **Waiting list:** Decreased from 64 to 56. Positive reduction in light of increased referral rates, balanced with greater assessment capacity. Average waiting time awaiting allocation of BIA remains at 9 days. 29 urgent assessments breached statutory timeframes.
- **Applications withdrawn:** 350 withdrawn this quarter (compared with 257 in Q2). Reasons for withdrawal: discharge (60%), changed ward (35%) and death (5%).

Actions from DoLS audit

Policies and Procedures:

DoLS Standard Operating Procedure – consultation to be arranged from end of January.

Training:

Scoping exercise in relation to mandatory DoLS training to consider provision of mandatory DoLS training across Welsh UHBs.

DoLS contained within mandatory MCA Level 2 training is in keeping with that provided within other areas.

Online ESR module widely used; recently updated by the All Wales MCA/DoLS Network.

Designed to ensure all staff have awareness of the DoLS process and when the Safeguards will apply.

However, this training does not provide the in-depth look into the practicalities of making a DoLS referral, clarification about restraint/restrictive practices or the interface between DoLS and the Mental Health Act; which is covered within the standalone 'DoLS In Practice' training.

DoLS in Practice Training

2.5-hour session which provides higher level content and is targeted towards inpatient staff working with those who lack capacity to consent to their admission to hospital.

Targeted training across all general medicine wards, specialist wards (neurosciences, stroke, critical care etc.), trauma and orthopaedics, mental health (particularly MHSOP and neuropsychiatry) and entry points to the hospital such as the emergency department, MEAU and high acuity medical wards.

For Specialist Services, arrangements are in place for a full day's training in February to provide both 'DoLS in Practice' and 'Practical Application of the MCA'. This was requested as part of the clinical board's MCA action plan and aims to target a high proportion of ward managers, team leaders, deputies and a small number of senior nurses. It is hoped this will raise understanding and awareness of the process and staff's responsibilities.

However, staff at all levels are encouraged to attend the standalone sessions that are available monthly. If this proves effective, similar sessions will be offered to other clinical boards to try and maximise learning opportunities.

Report Title:	Mental Health Act Monitoring Exception Report				Agenda Item No:	3.1.1	
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	27th January 2026	
			Private				
Status	Assurance	X	Approval		Information/Noting		
Lead Executive	Executive Nurse Director						
Report Author:	Mental Health Act Manager						

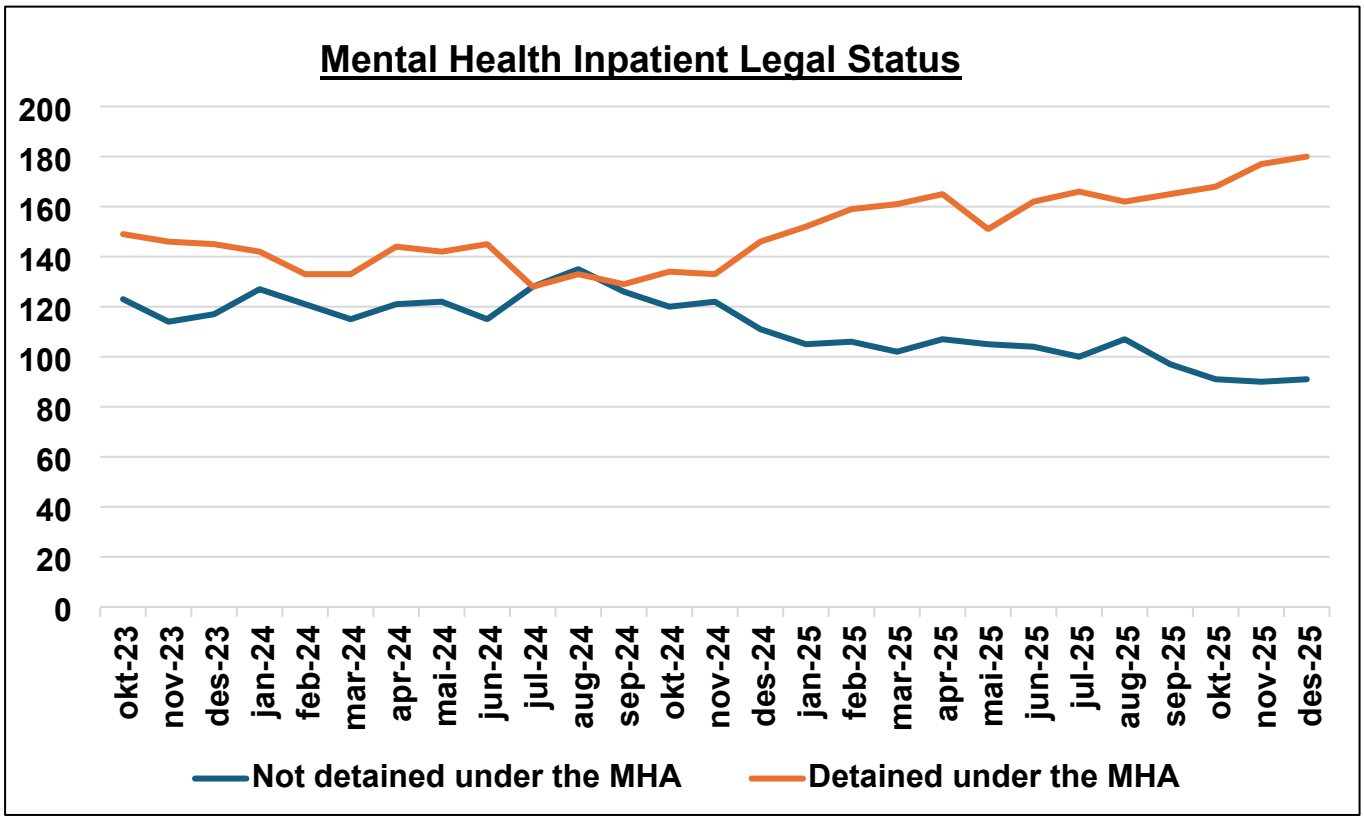
Main Report

Background and Current Situation:

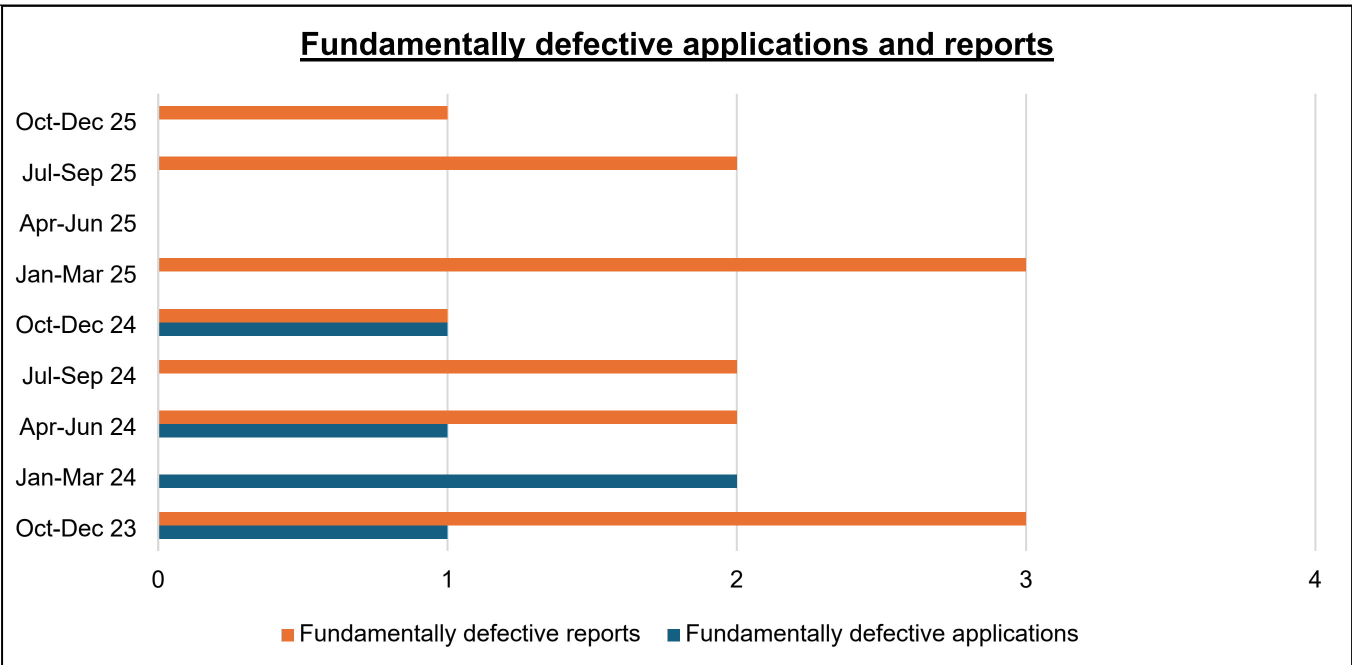
This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring Report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that 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



Fundamentally defective applications and reports



<u>During the quarter there were no fundamentally defective applications</u>

<u>During the quarter there was one fundamentally defective report</u>
P was assessed in UHL and a 5(2) was completed however, the hospital address on the form stated UHW. This was sent and accepted by the shift coordinator without noticing the error and it was picked up by MHA office staff when processing the form that morning. The patient was advised, a new 5(2) was completed and a MHA assessment undertaken. A Datix was raised.

<u>During the quarter there was one lapse</u>
P was assessed in UHW and a 5(2) was completed and sent to the MHA office to process. The ward was contacted and advised who to contact to arrange a MHA assessment. The MHA office sent a chasing email to the psych liaison RC that morning and wasn't aware they were away as there was not an out of office on. The ward had contacted EDT over the weekend, and this was followed up by the duty AMHP, but they couldn't get hold of the ward and the ward hadn't made a referral to psych liaison as per process. P was assessed by psych liaison and went home. P was further detained under s136 and s2 the following day. A Datix was raised.

<u>Previous lapsed section 3</u>
In the previous quarter a section 3 had lapsed by their RC not completing the renewal paperwork. A Datix was raised and investigated on how this occurred. Notifications had been put in place to remind the RC of when the renewal document needed to be completed by as they were waiting for a DoLS to be authorised. The RC didn't put the date in their diary so wasn't notified that the section 3 was expiring. The MHA office get daily reports from PARIS detailing what sections are expiring each day, but this report had been moved into another folder and not checked on the day the section 3 expired.

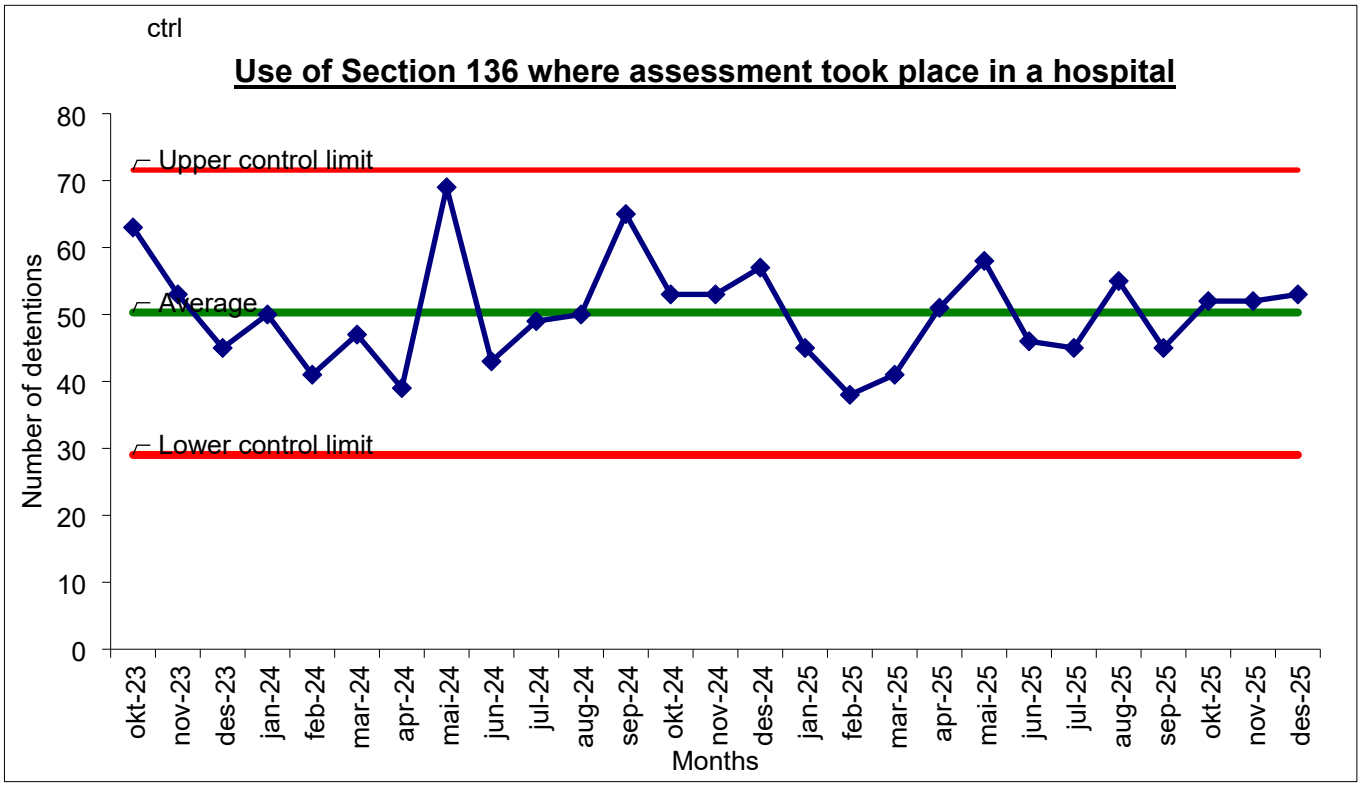
The RC has advised they will put any future expiries in their diary and alert their medical secretary of the importance of these reminders and will share this experience with their colleagues to ensure it doesn't happen again as the team don't often have patients detained under the MHA.
The MHA office have created reminders in their diaries to check the report each day and know to escalate if any are showing as expiring if we haven't had the renewal document for.

<u>Section 136</u>
During the period, the use of section 136 has increased.

It was noted that 77.7% of individuals assessed were not admitted to hospital, with 43.9% being discharged to community services and 33.8% were discharged with no follow up. Overall, during the period 20.4% of patients were admitted to hospital following a 136 assessment which is higher than the previous quarter at 17.3%.

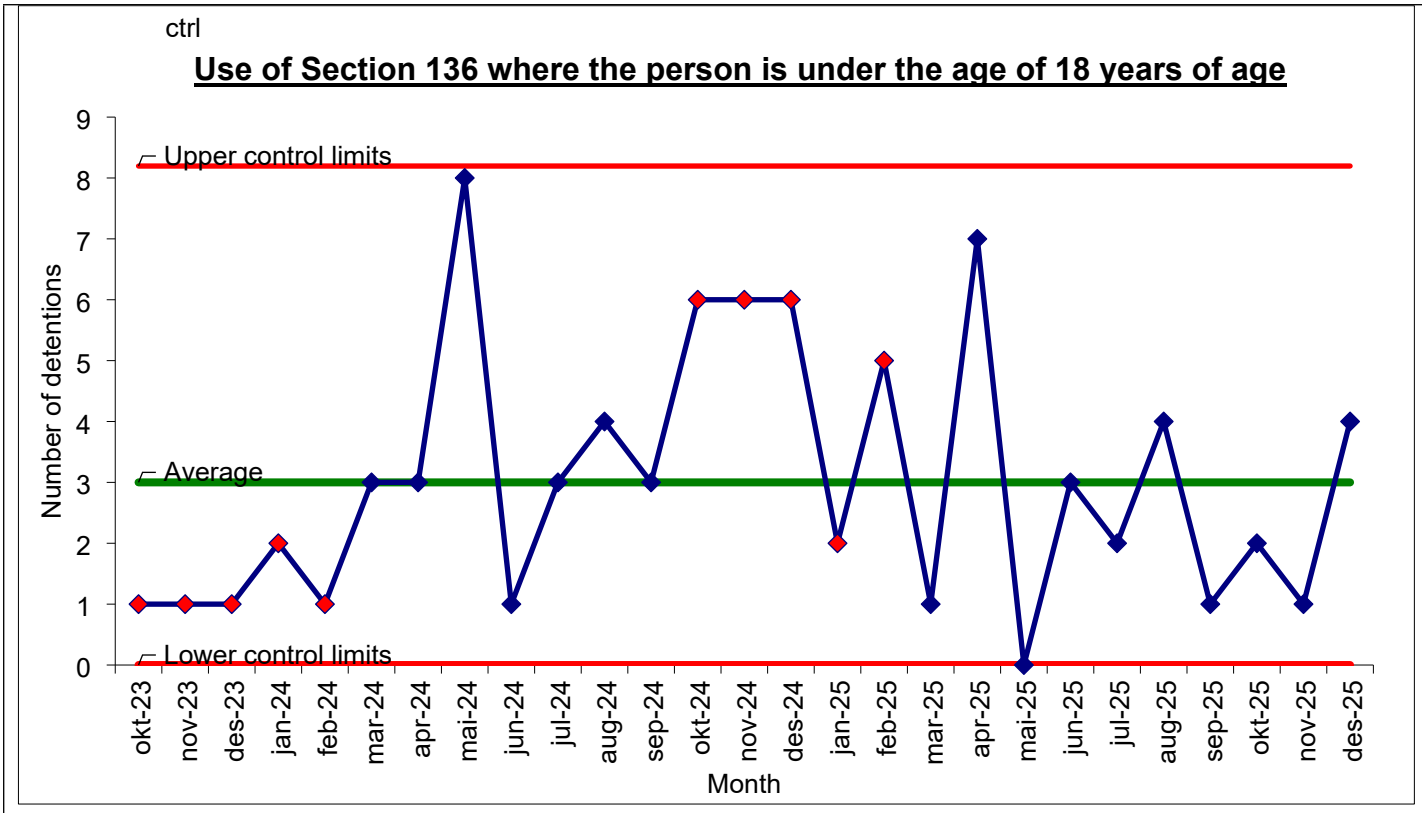
Three 136's lapsed with no assessment taking place due to not being medically fit.

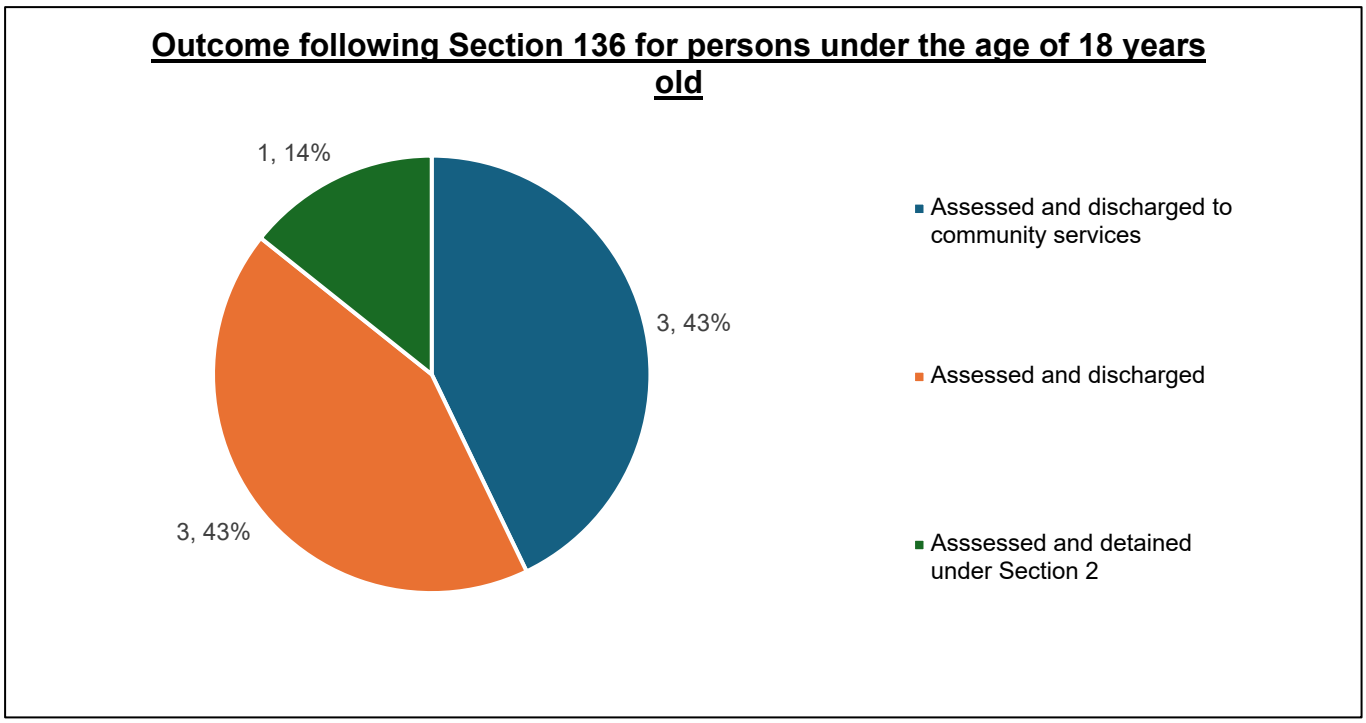
Period	% not admitted to hospital
October – December 2025	77.7%
July – September 2025	82.8%
April – June 2025	77.4%
January – March 2025	77.4%
October – December 2024	78.6%
July – September 2024	72.7%
April – June 2024	79.5%
January – March 2024	83.3%
October – December 2023	80.1%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has decreased from eight in the previous quarter to seven in this quarter. One service user had repeat presentations.





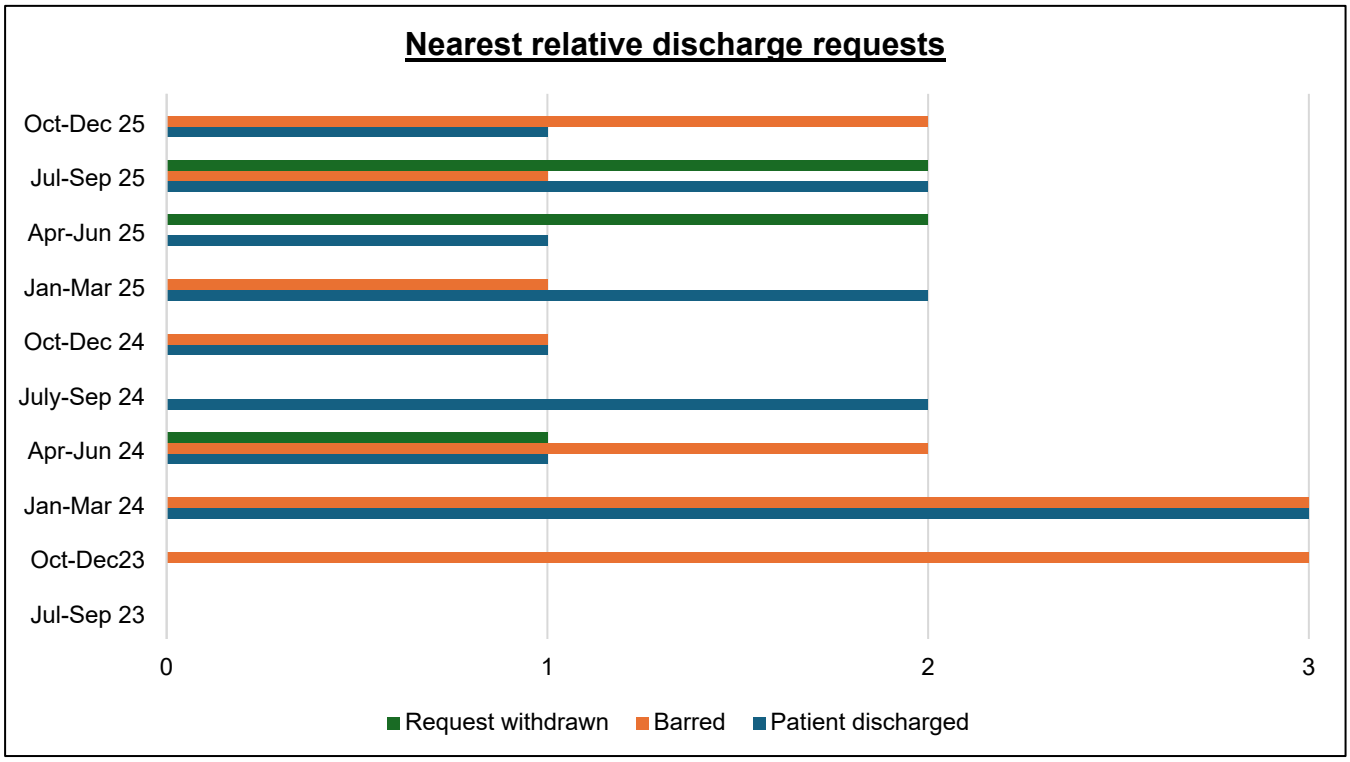
Nearest relatives discharge requests

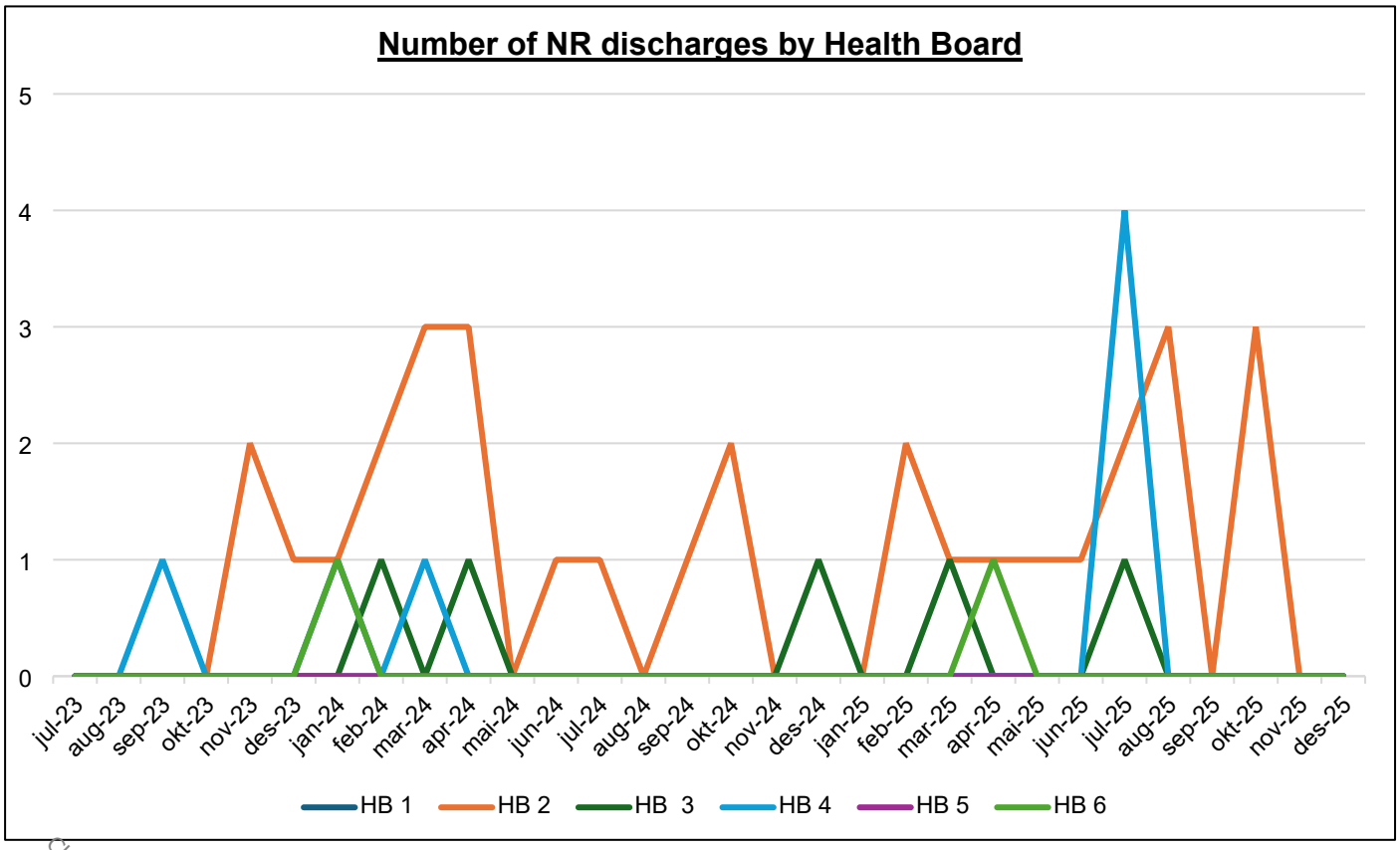
There has been a rise in the number of nearest relative discharge requests with seemingly no reason for this increase. I have investigated to see whether professionals are giving nearest relative's more information regarding their rights, but they are still providing them the same leaflet/information.

Appendix 2 is a leaflet sometimes given out by AMHPs, but the majority will give the relative the verbal information.

Appendix 3 is a leaflet sent out on admission to relatives, if the patient agrees, by the MHA office.

To try and understand the shift in these requests, I created the questionnaire (Appendix 4) to send to relatives to gain a view in their decision to exercise their power – I have not received any questionnaire's back.





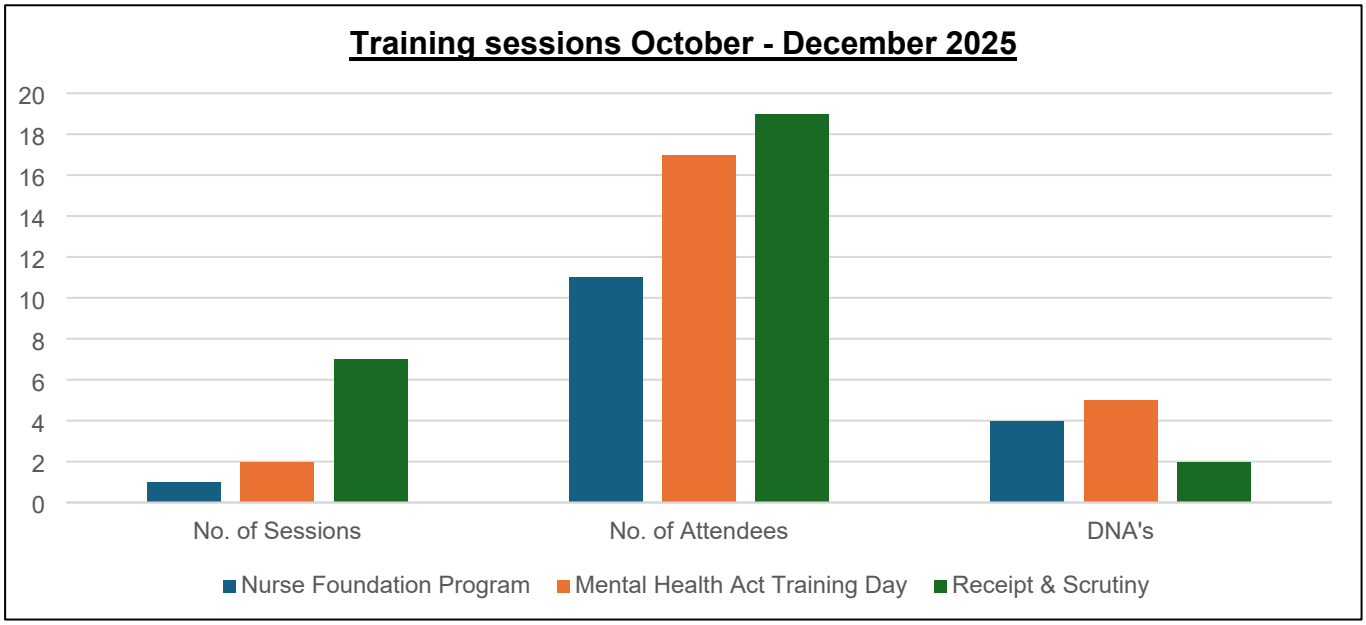
Development Sessions

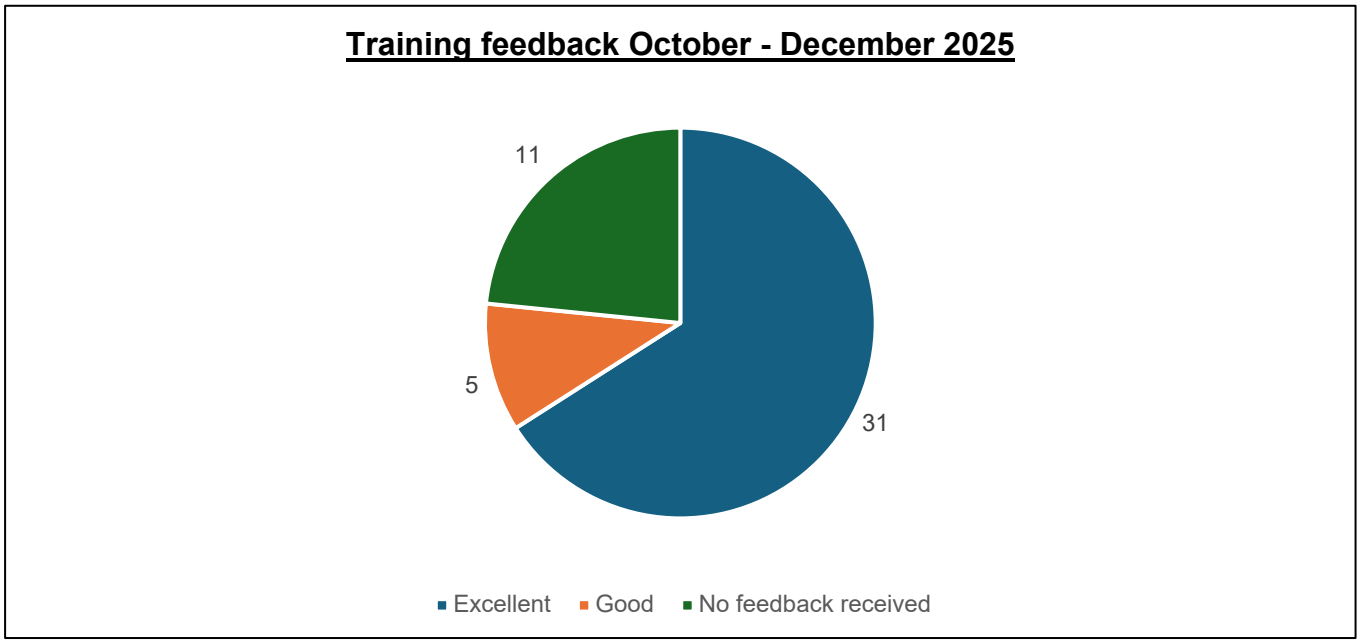
The MHA office continues to run the below awareness sessions available to all staff within the Health Board:

- 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)

- 3.1.2 - Monitoring Report for October- December 2025
- 3.1.3 - RIGHTS AND RESPONSIBLITIES OF NEAREST RELATIVE UNDER THE MENTAL HEALTH ACT 1983
- 3.1.4 - Role of the Nearest Relative leaflet
- 3.1.5 - NR Discharge Request Questionnaire

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

Prevention	X	Long Term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes (please include the complete QIA document)		No (please provide reasoning e.g. not required	X	Not required.

Impact Assessment
Please place an "x" in the below boxes where relevant

Risk: No
Safety: Yes
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	09/10/2025

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

Report to the

Mental Health Legislation Committee

on the use of The Mental Health Act, 1983

October- December 2025

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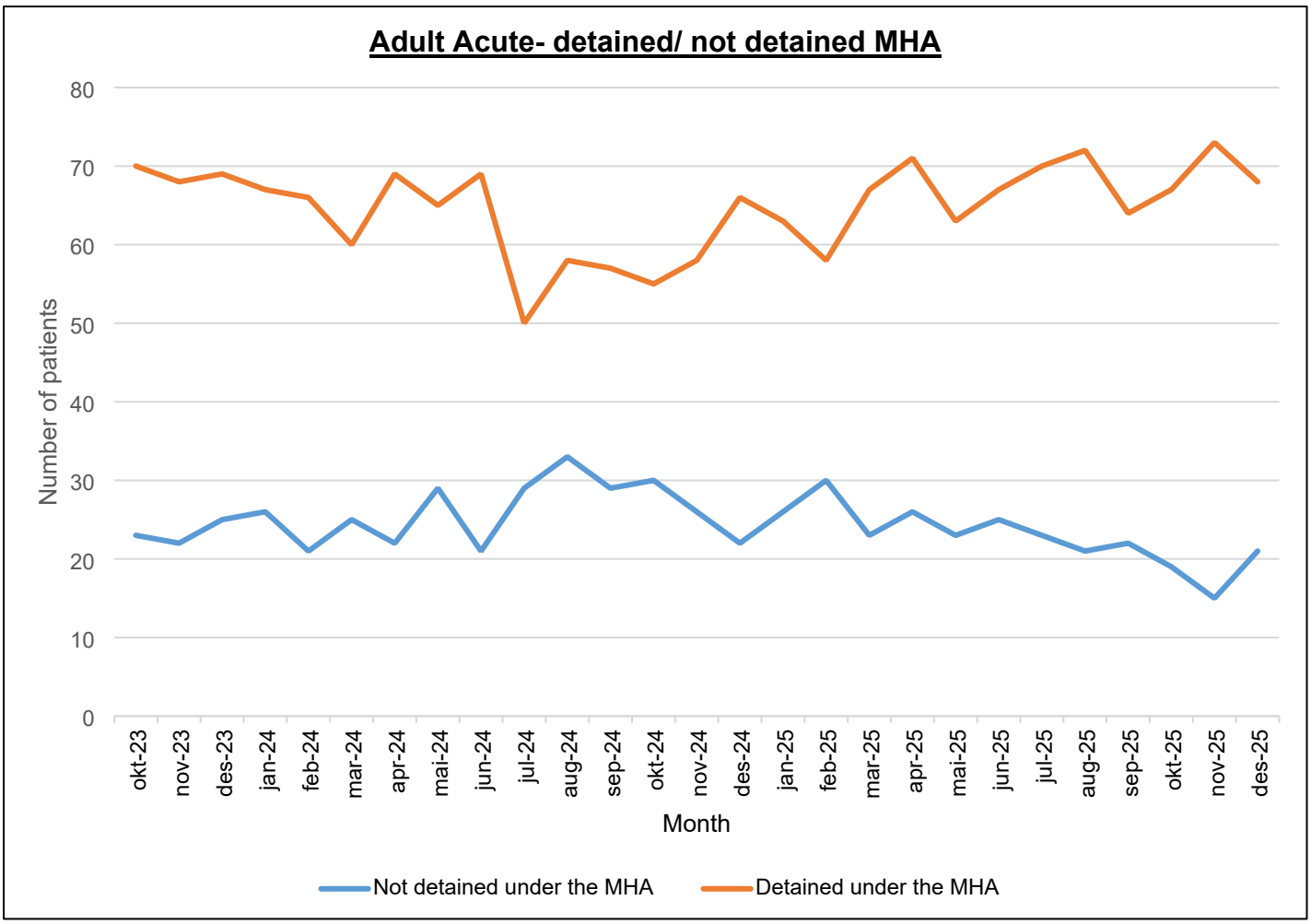
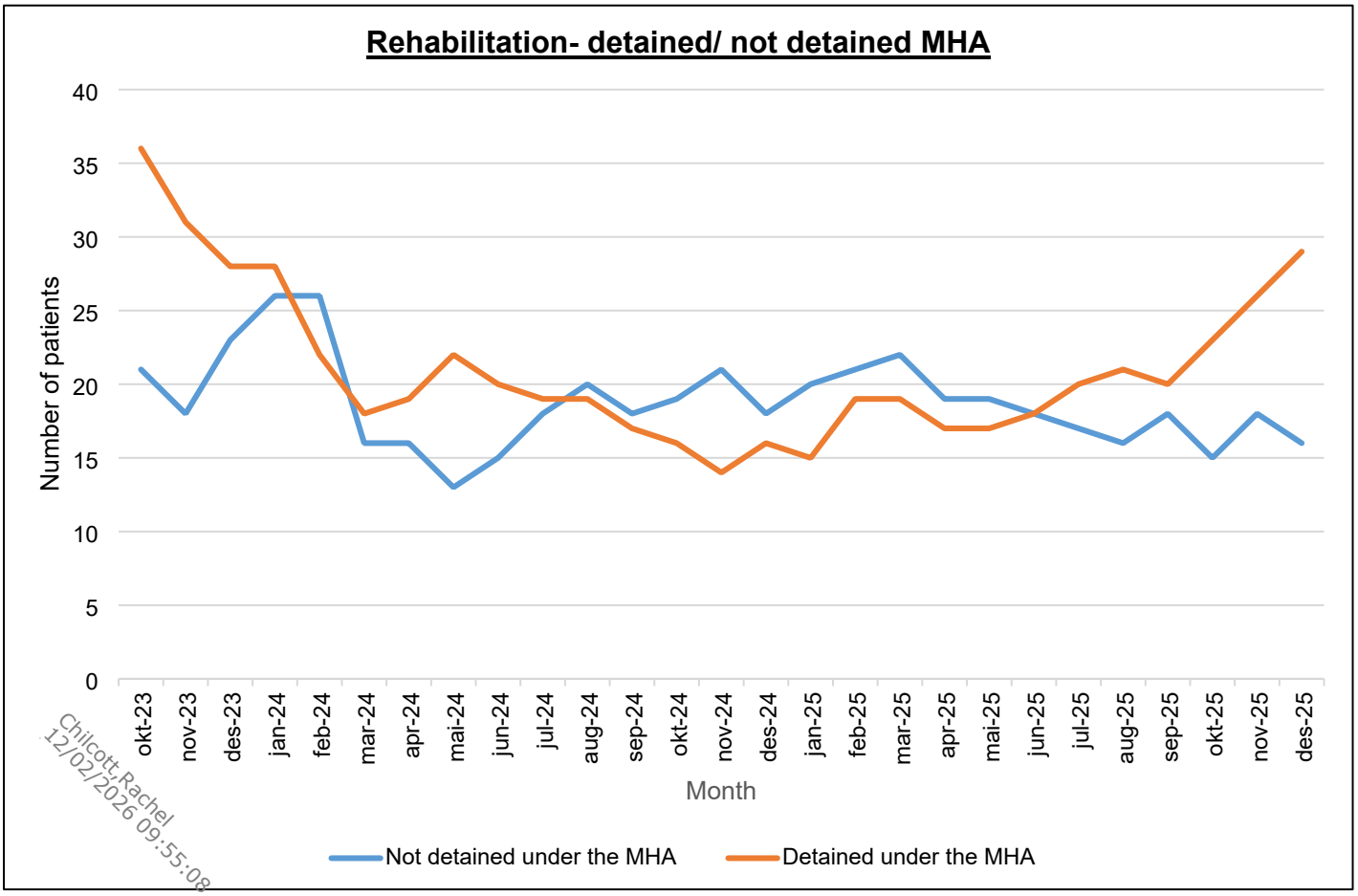
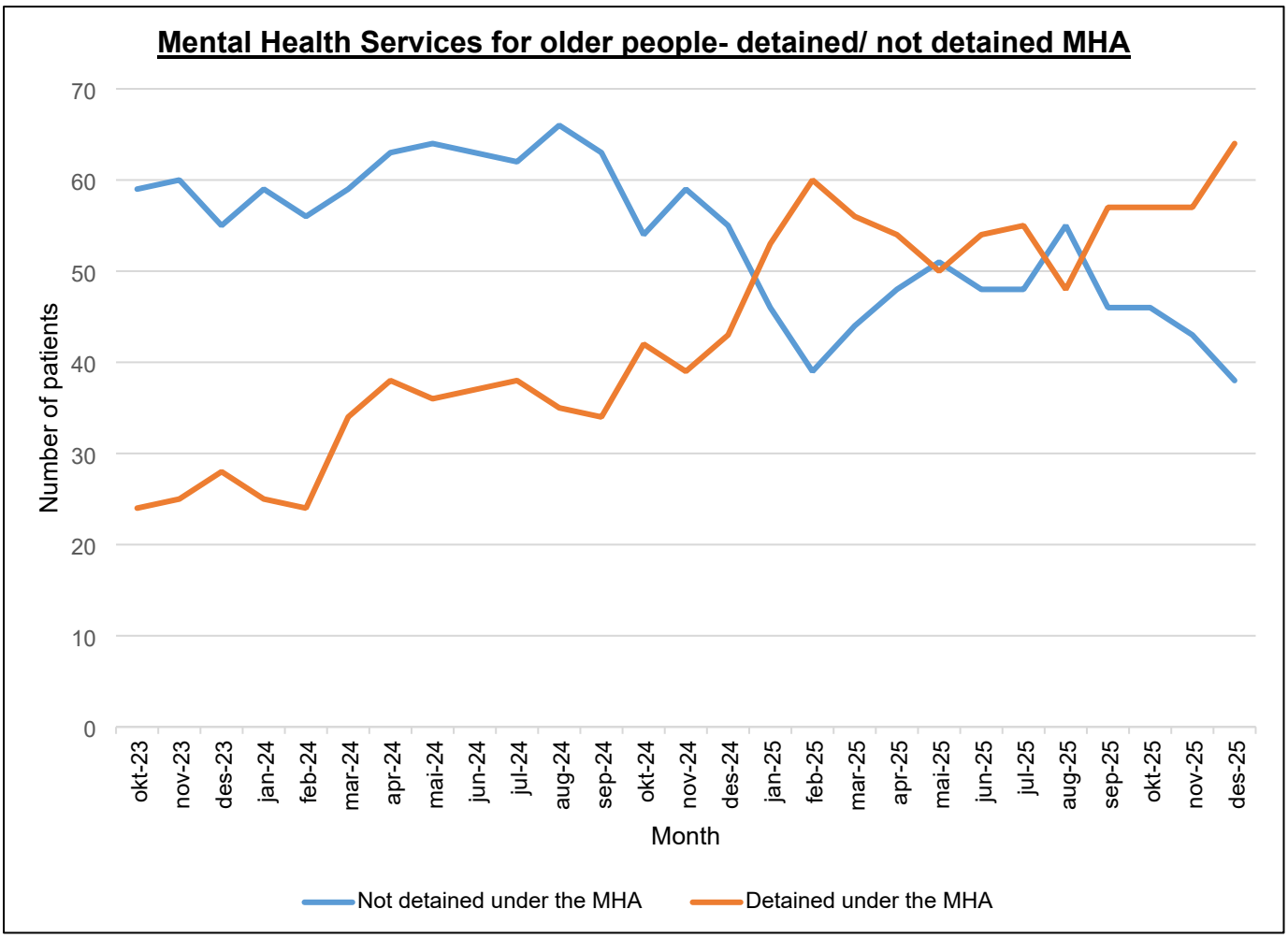
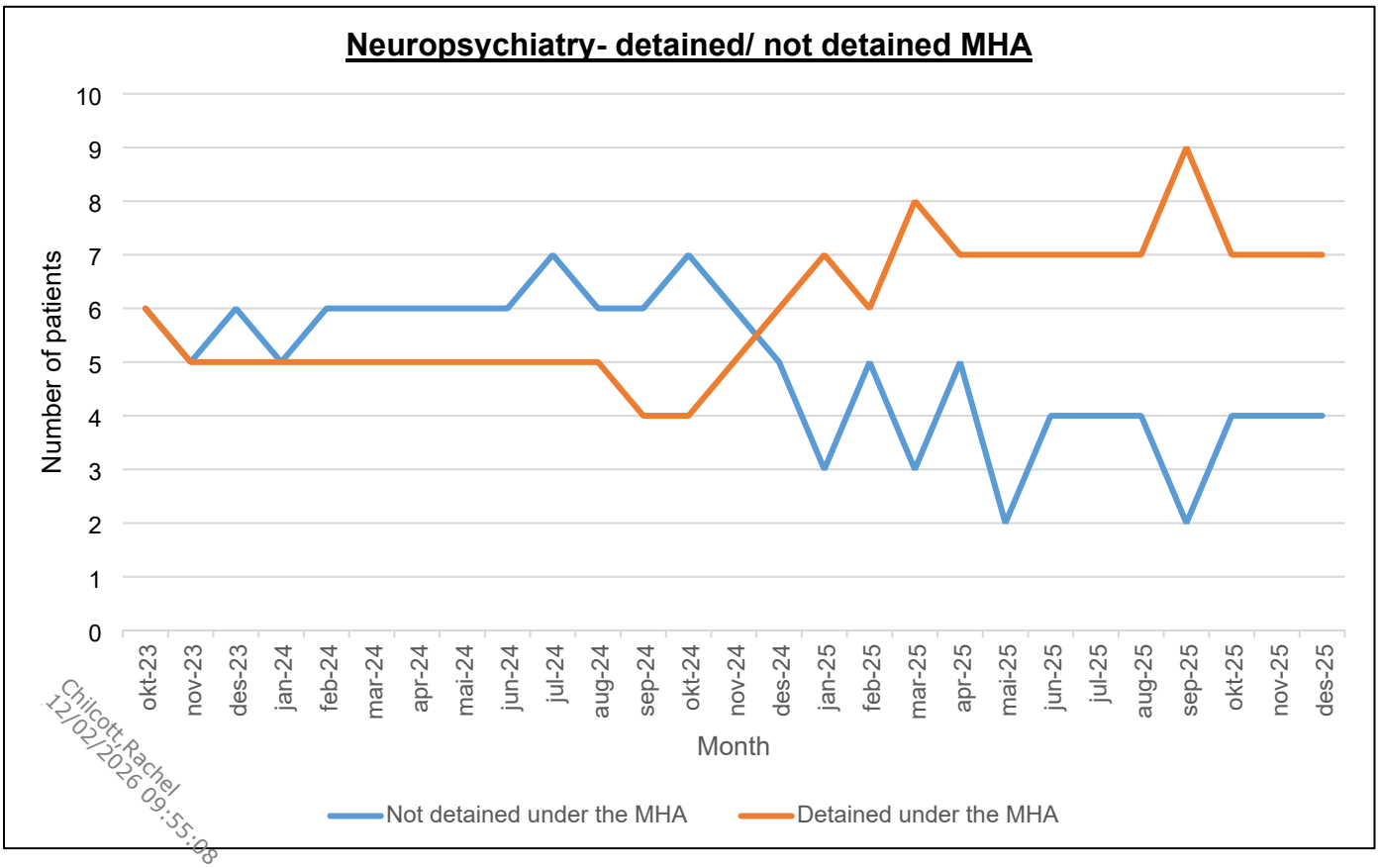
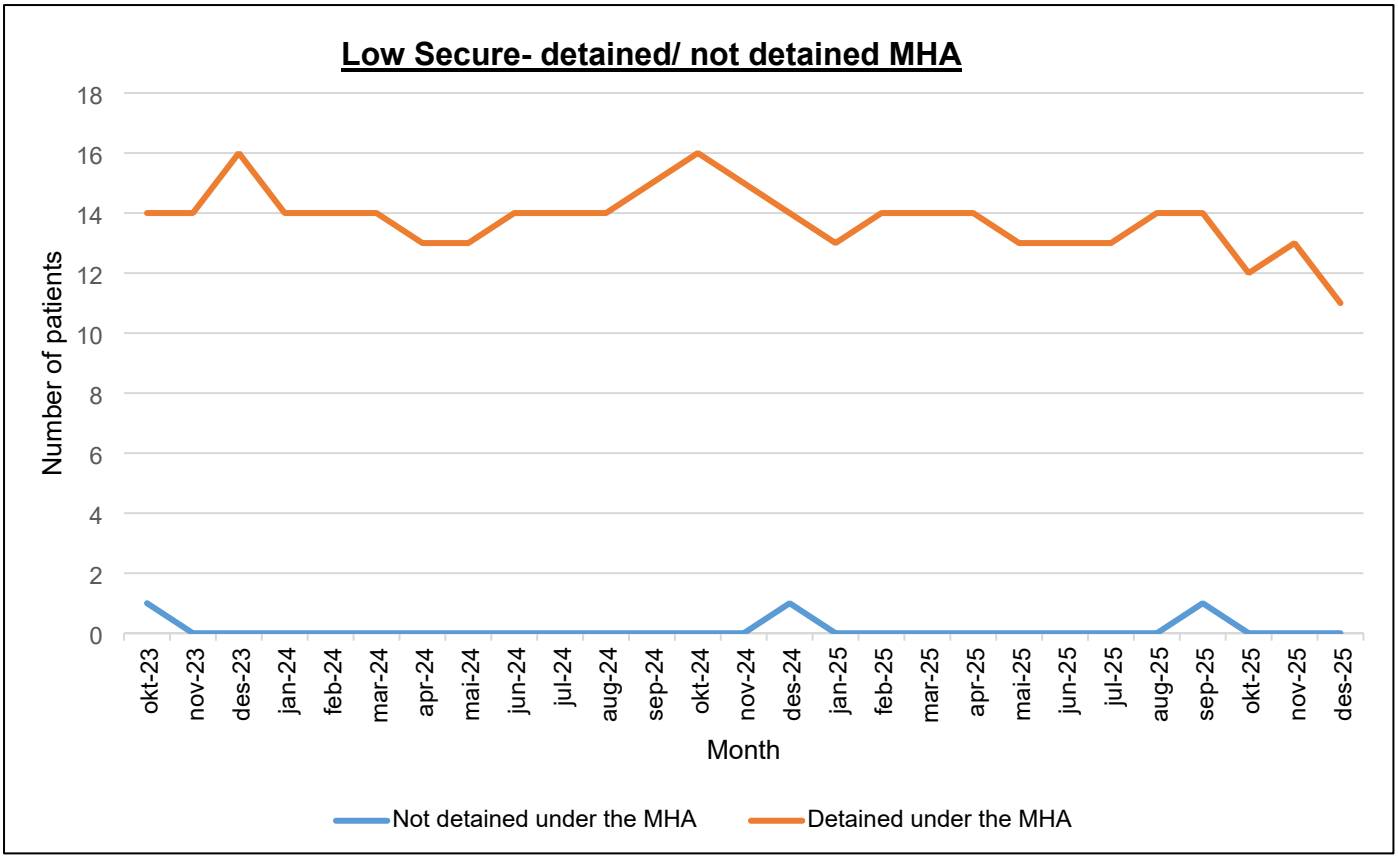
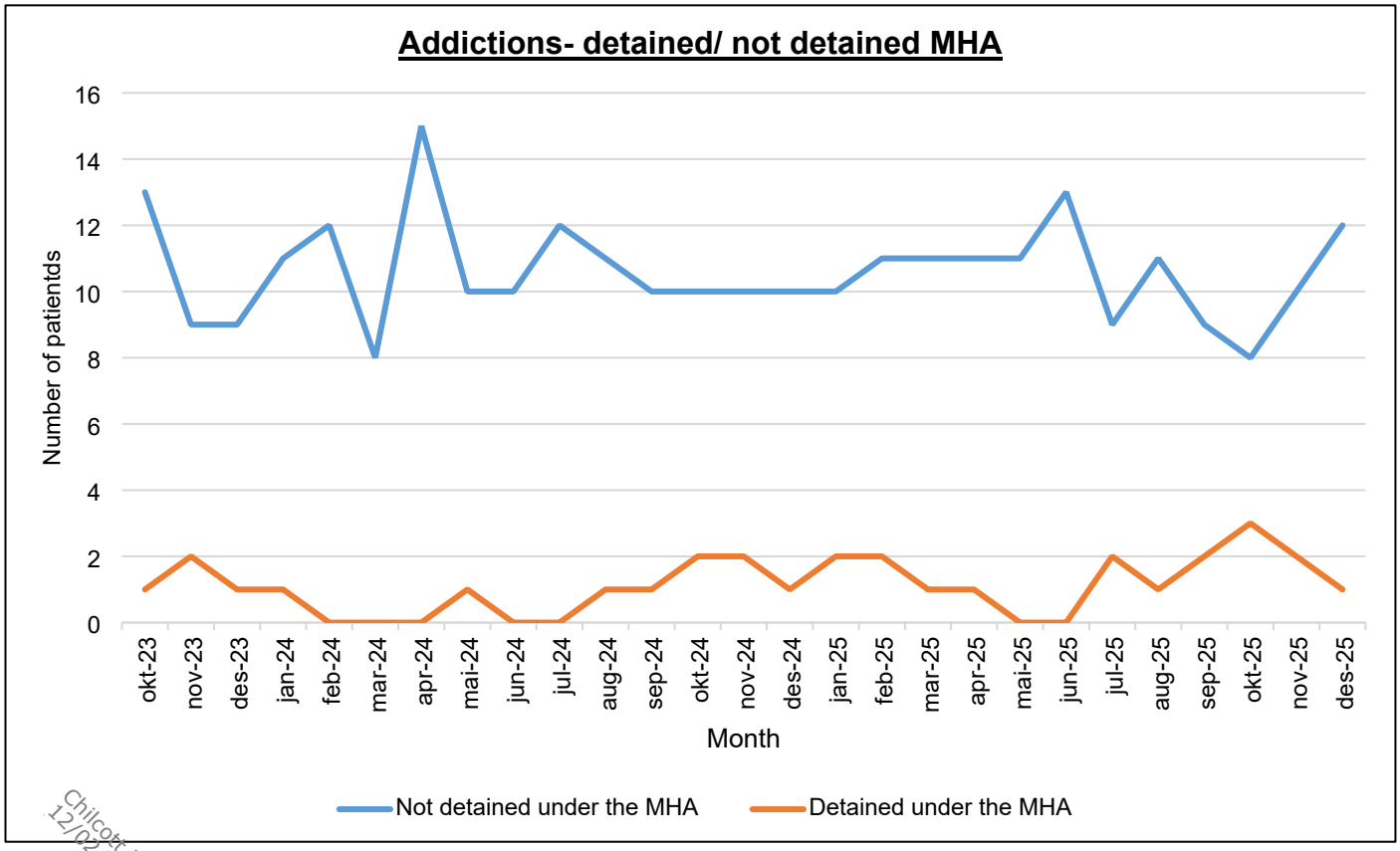












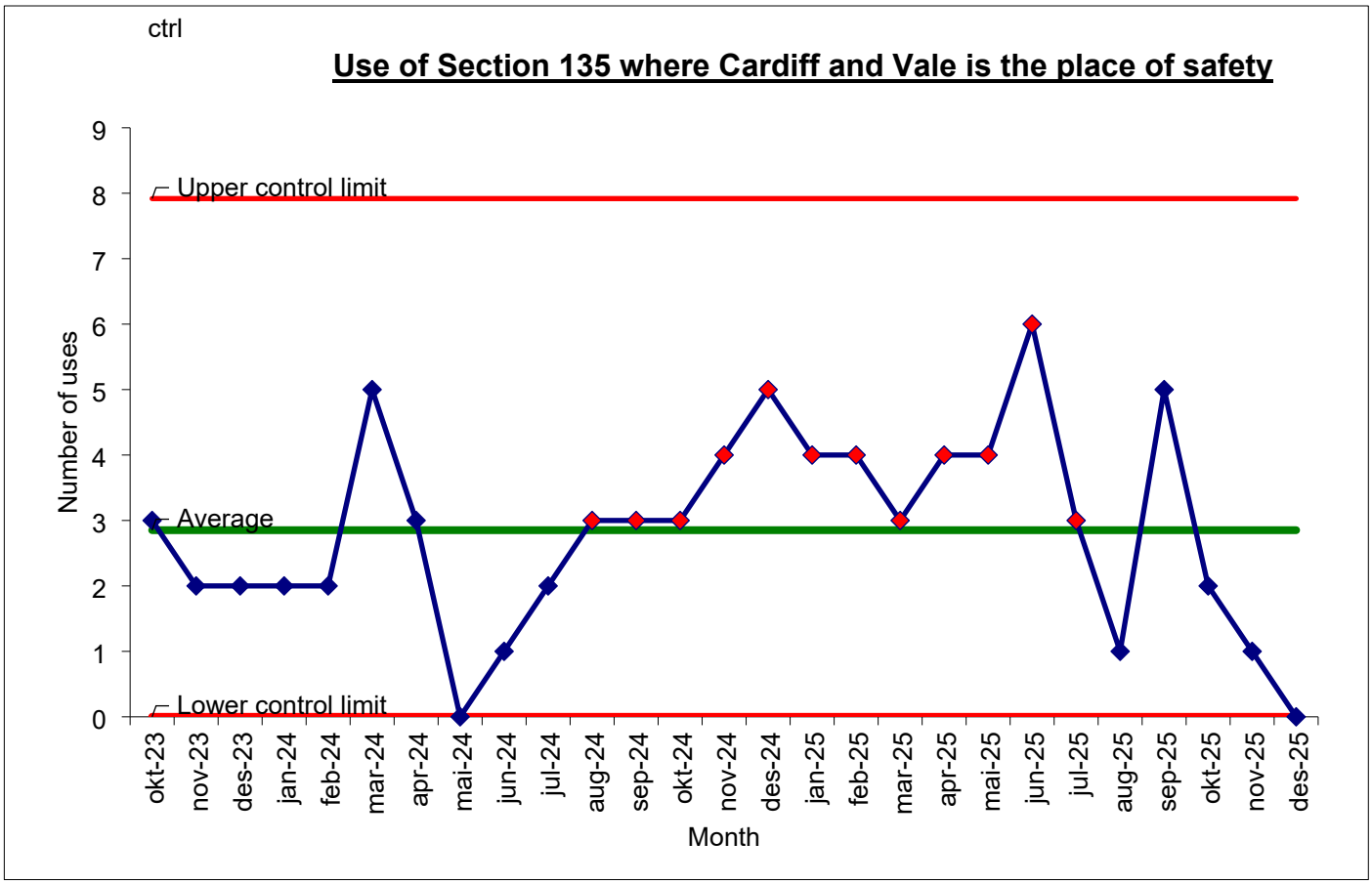
There have been two CAMHS patients detained in Hafan Y Coed during the period.

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 three occasions.

- detained under Section 2 x1
- detained under Section 3 x1
- detained to a hospital under different hospital managers x 1

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;-

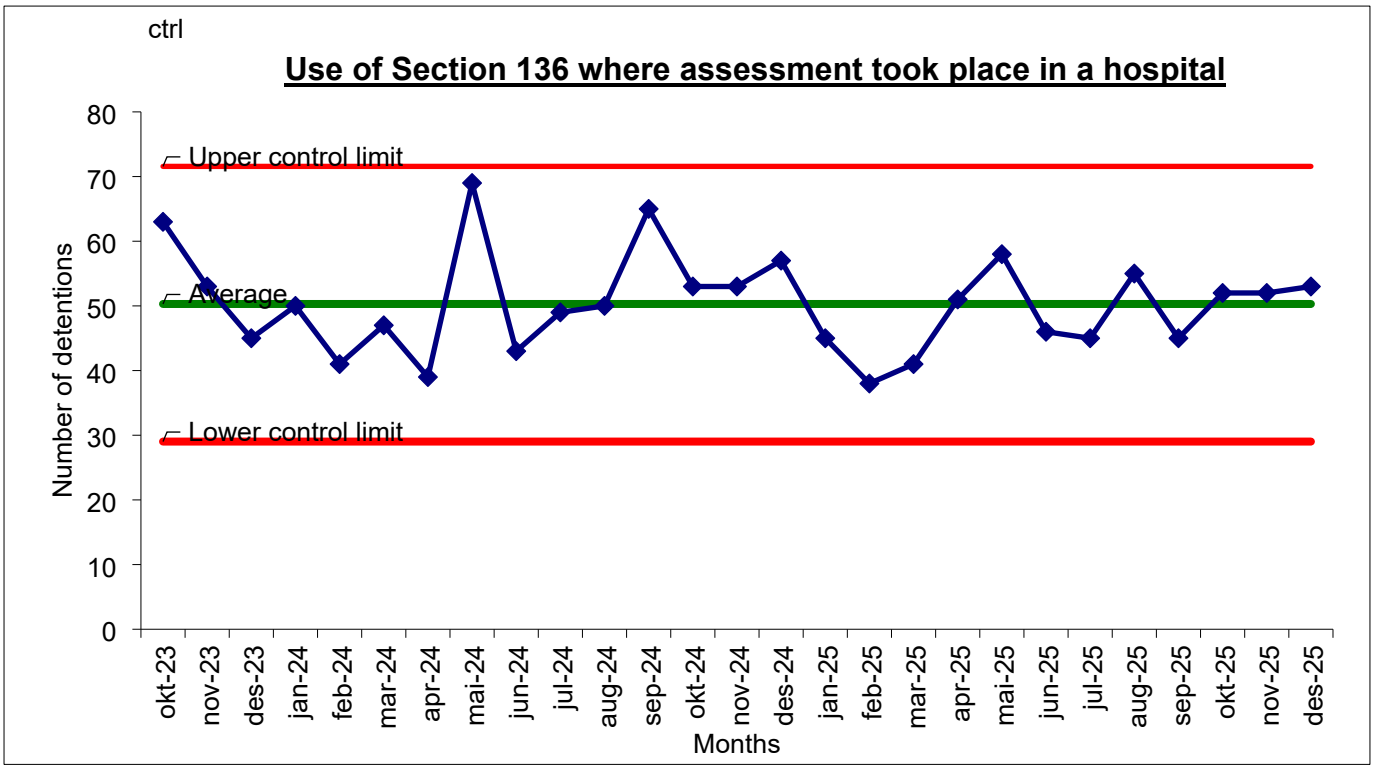
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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.

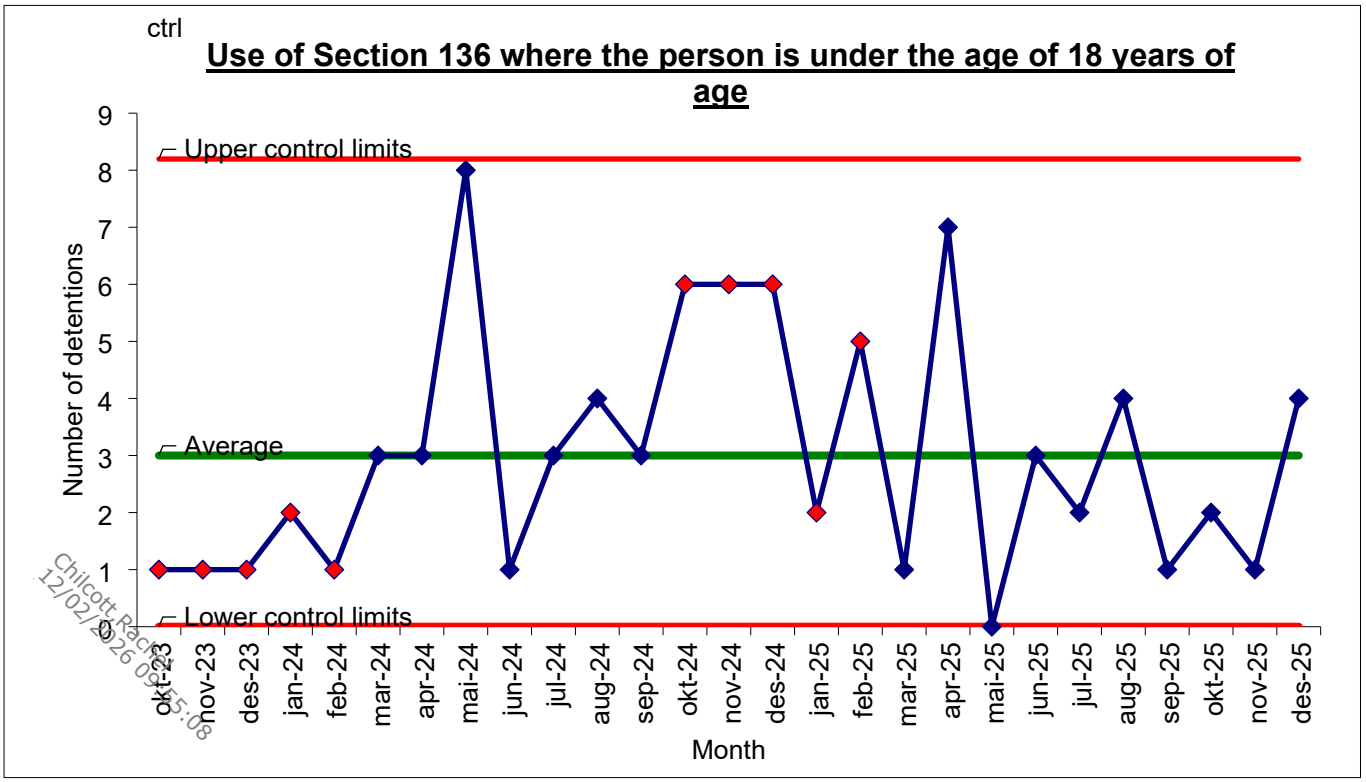
For this period, we have seen eleven Voluntary Assessments. One person was brought into hospital under the Mental Capacity Act.

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

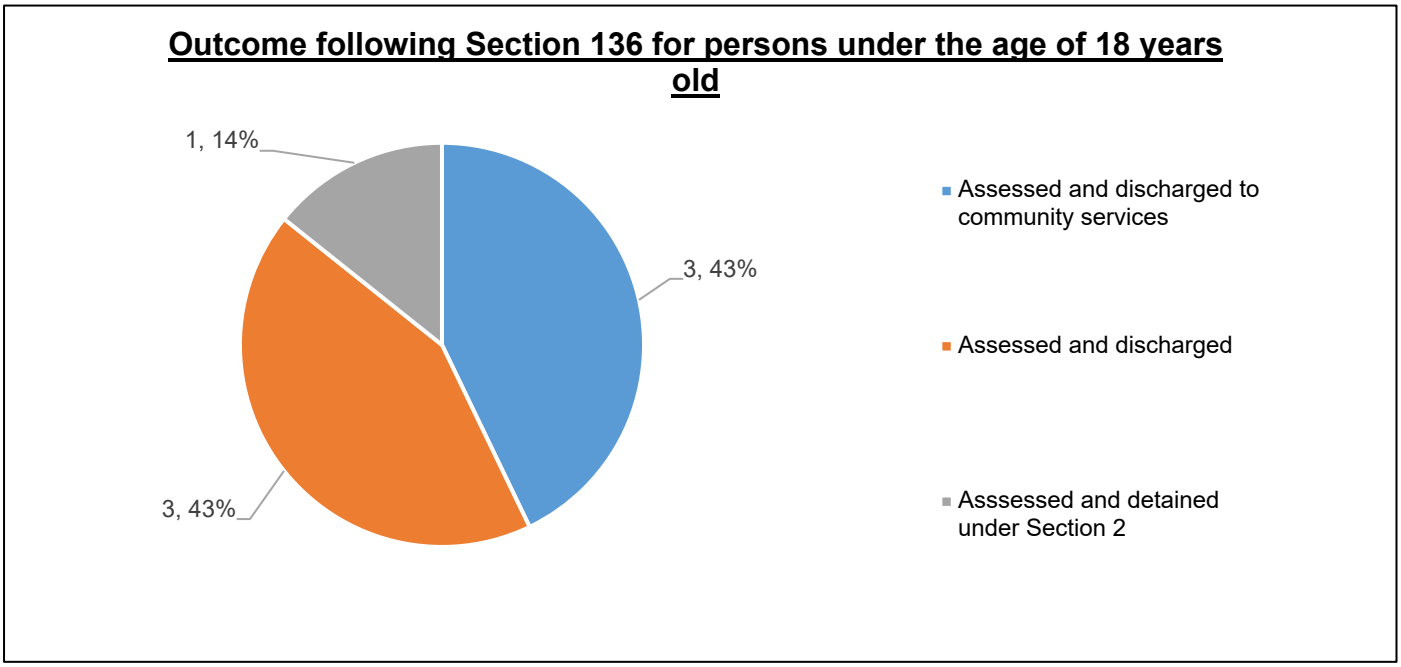
During the period a total of 157 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



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



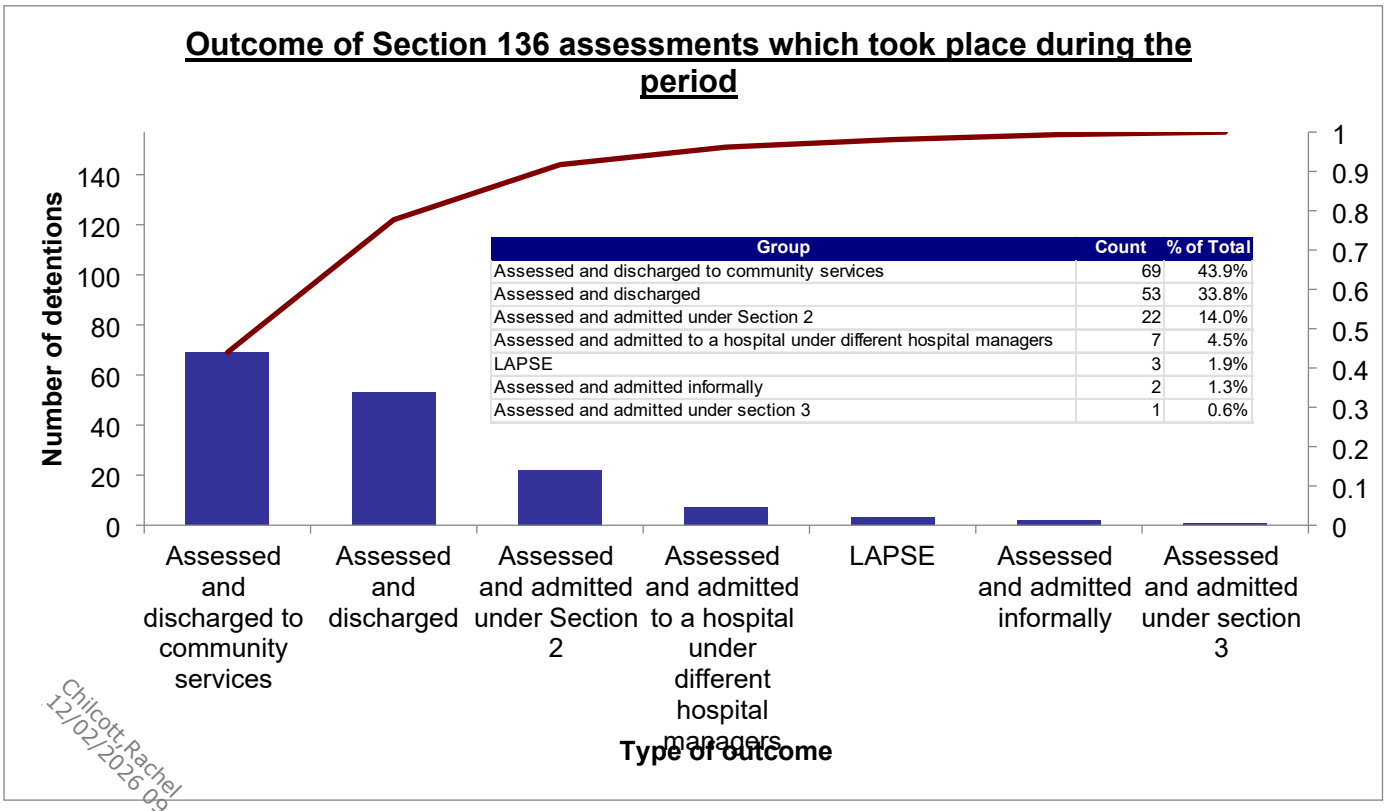
The pareto chart highlights that 79.6% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.



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

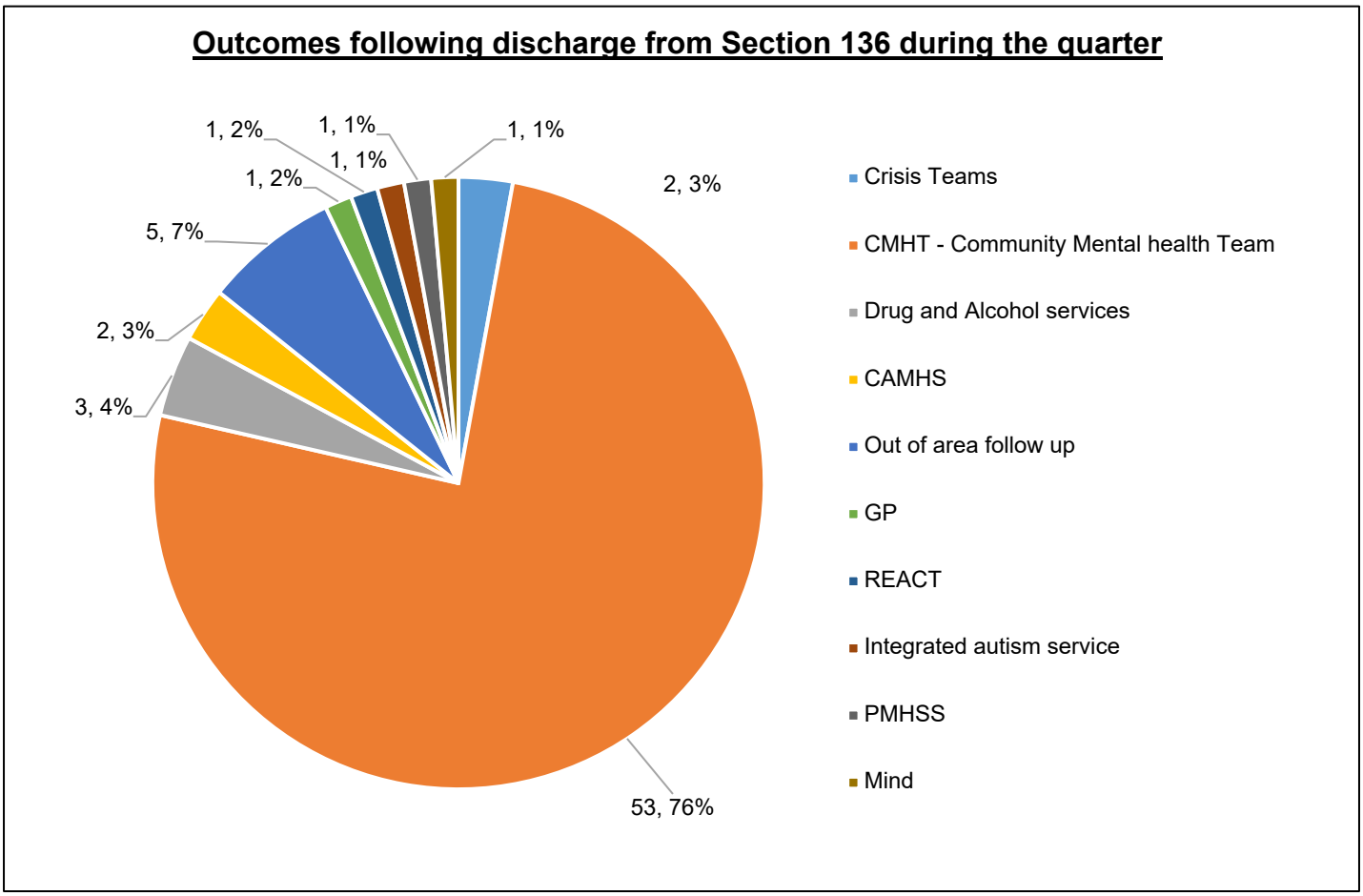
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

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

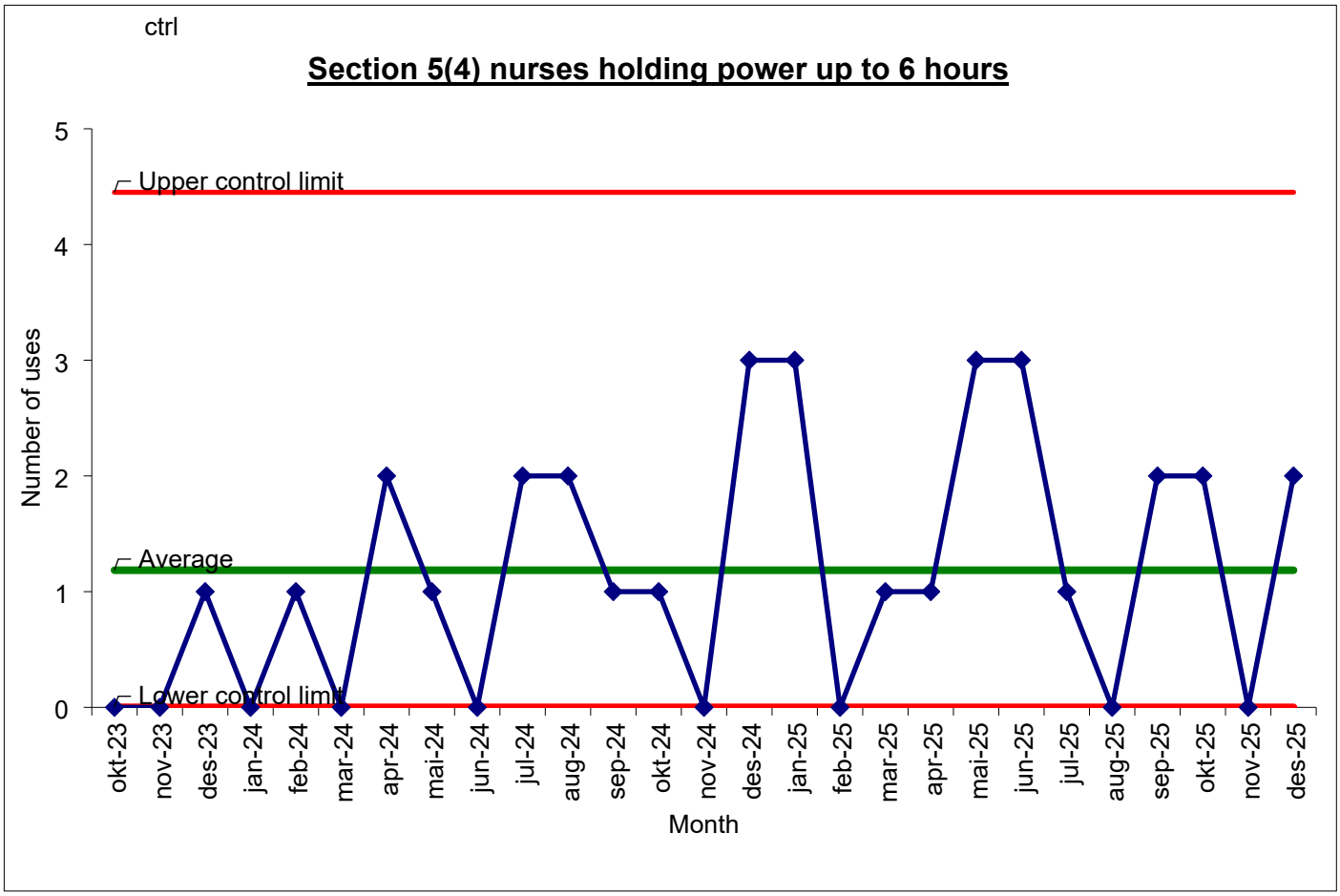


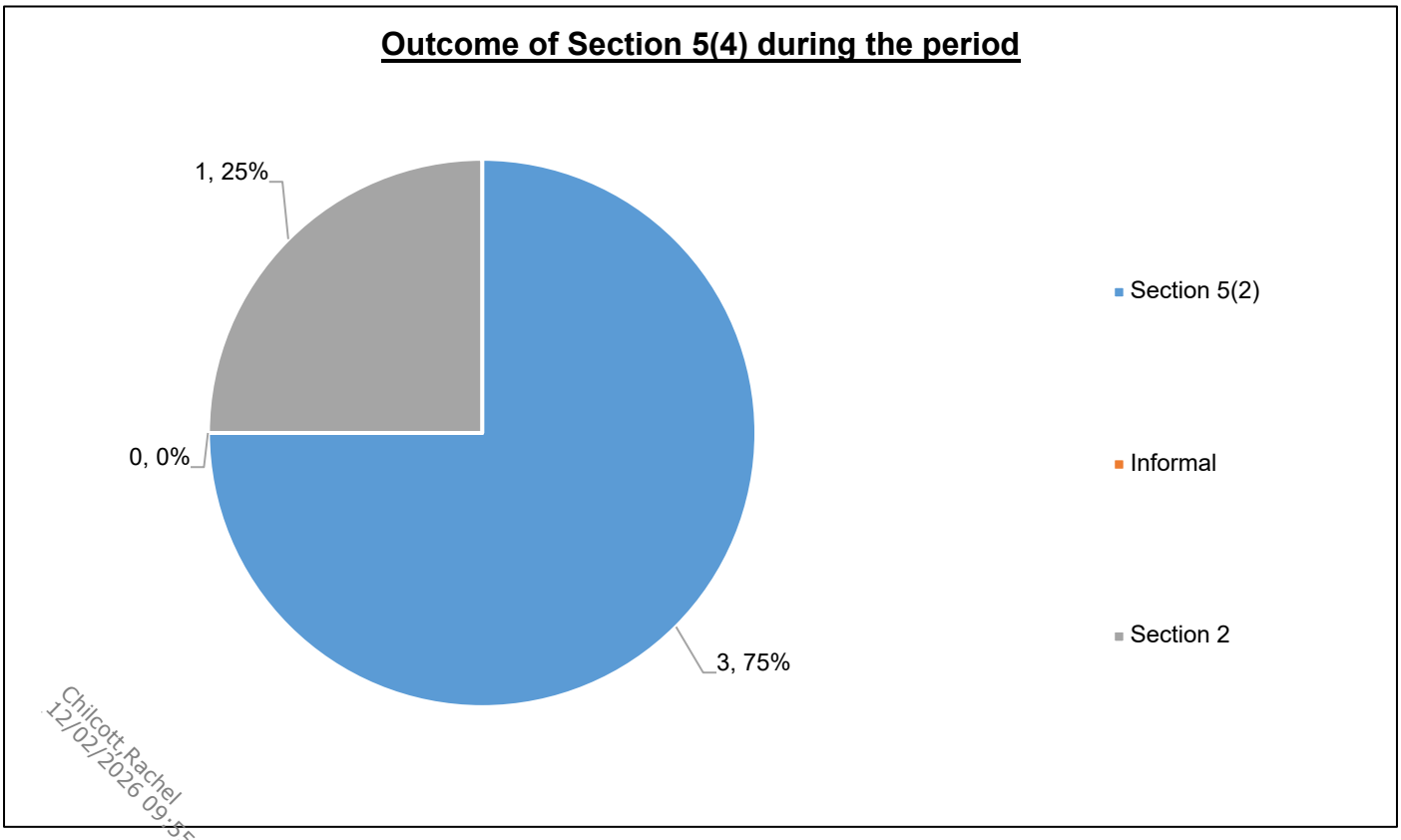
Group	Count	% of Total
Assessed and discharged to community services	69	43.9%
Assessed and discharged	53	33.8%
Assessed and admitted under Section 2	22	14.0%
Assessed and admitted to a hospital under different hospital managers	7	4.5%
LAPSE	3	1.9%
Assessed and admitted informally	2	1.3%
Assessed and admitted under section 3	1	0.6%

Three Section 136 detentions lapsed this quarter. Two were due to the patients not being ft for assessment during the detention period. One was due to the patient having been arrested and not available for assessment during the detention period.

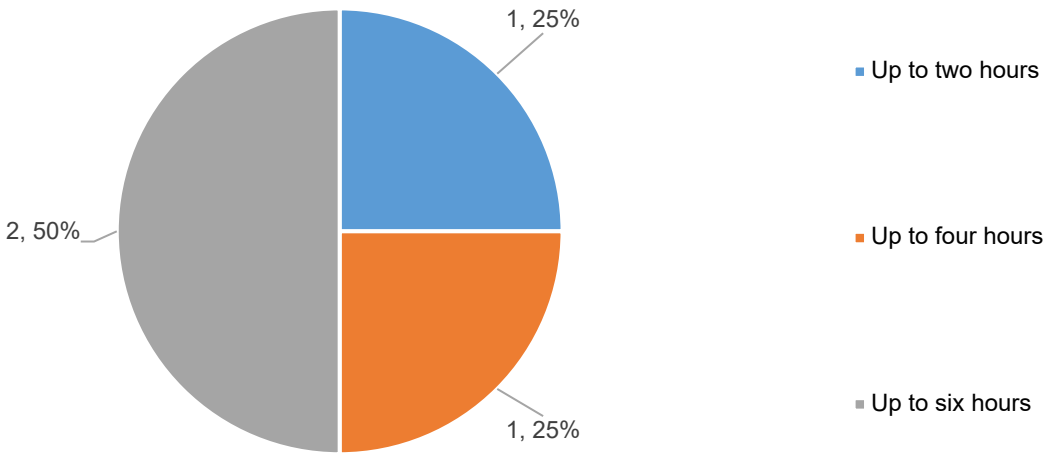


Section 5(4) - Nurses Holding Power

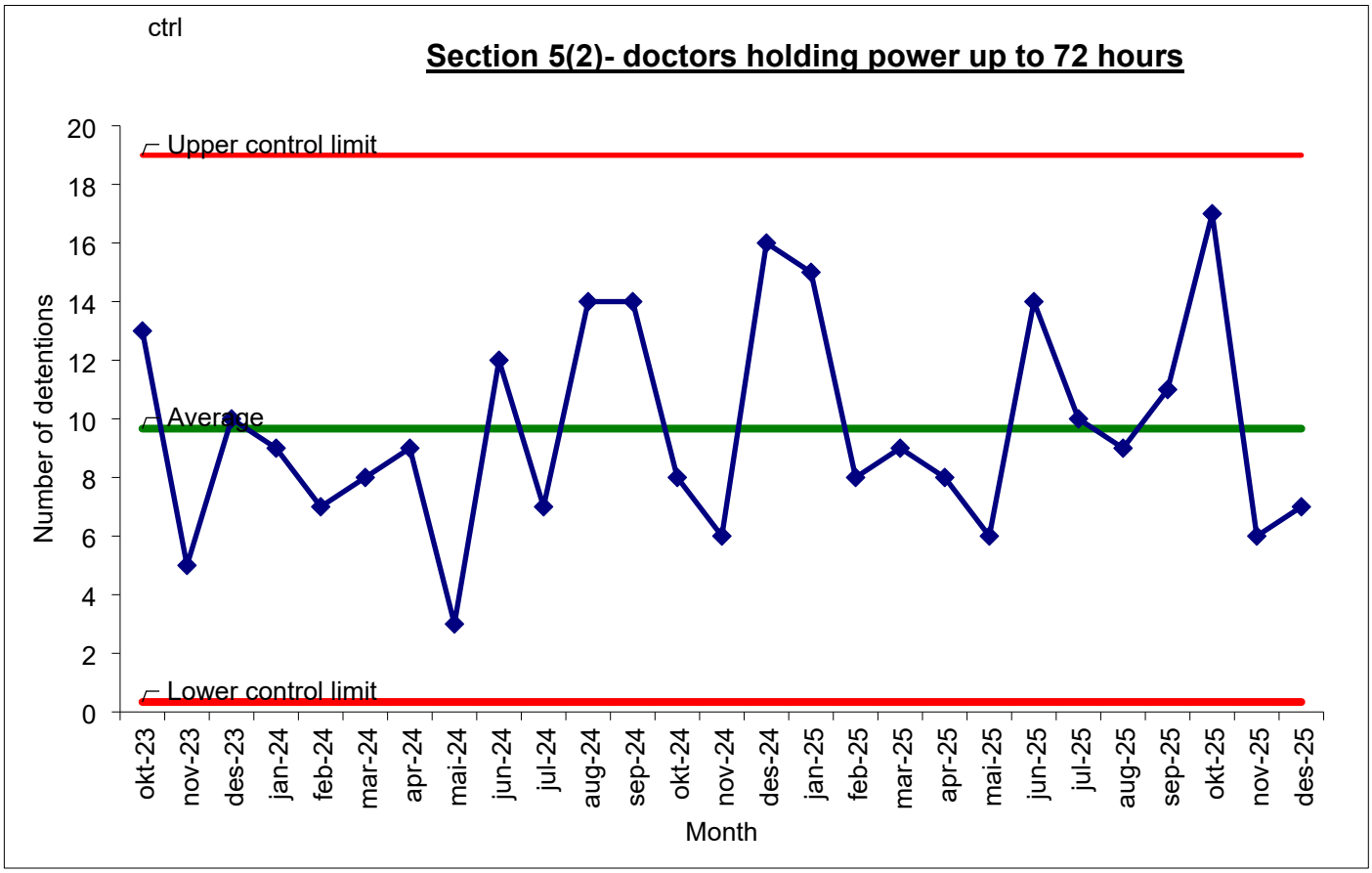


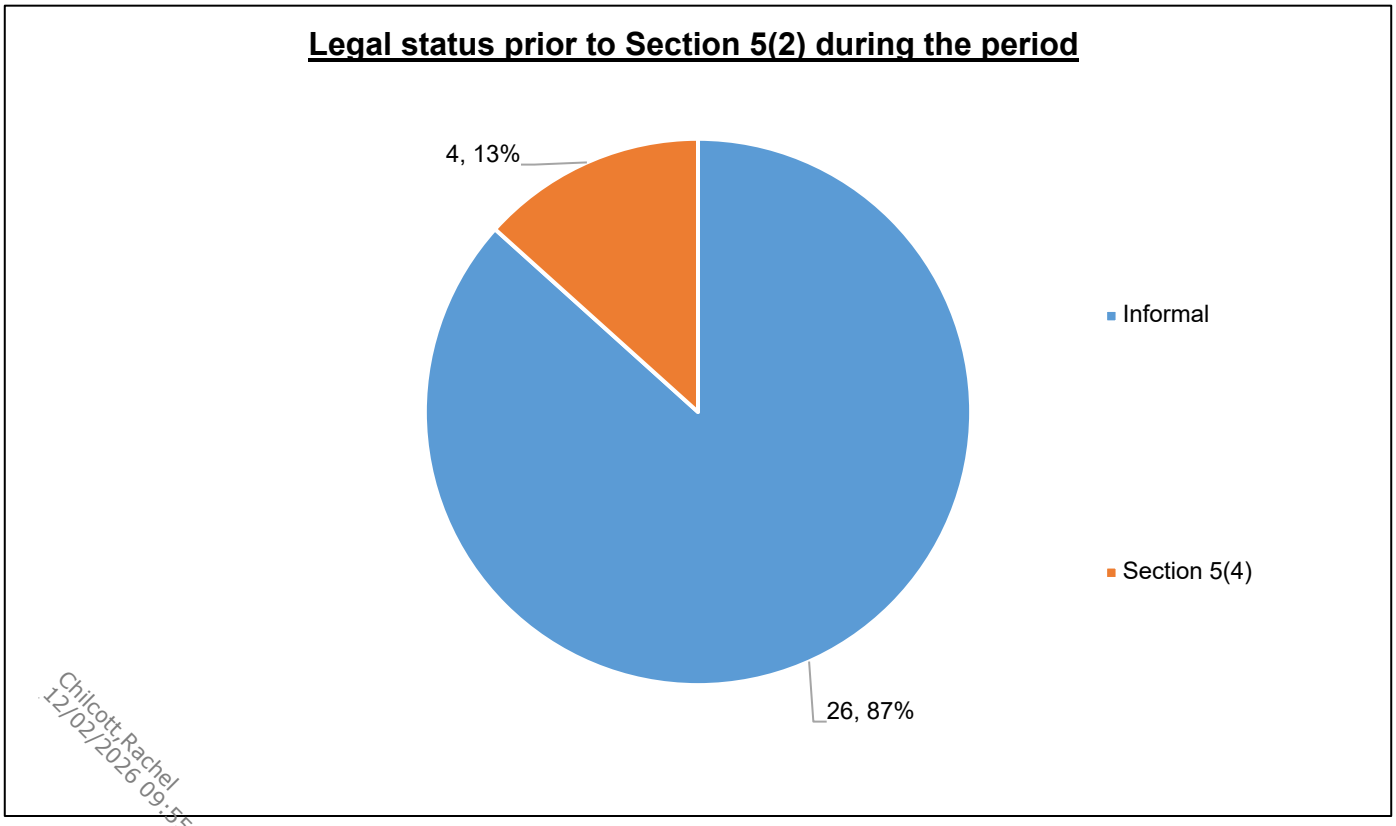


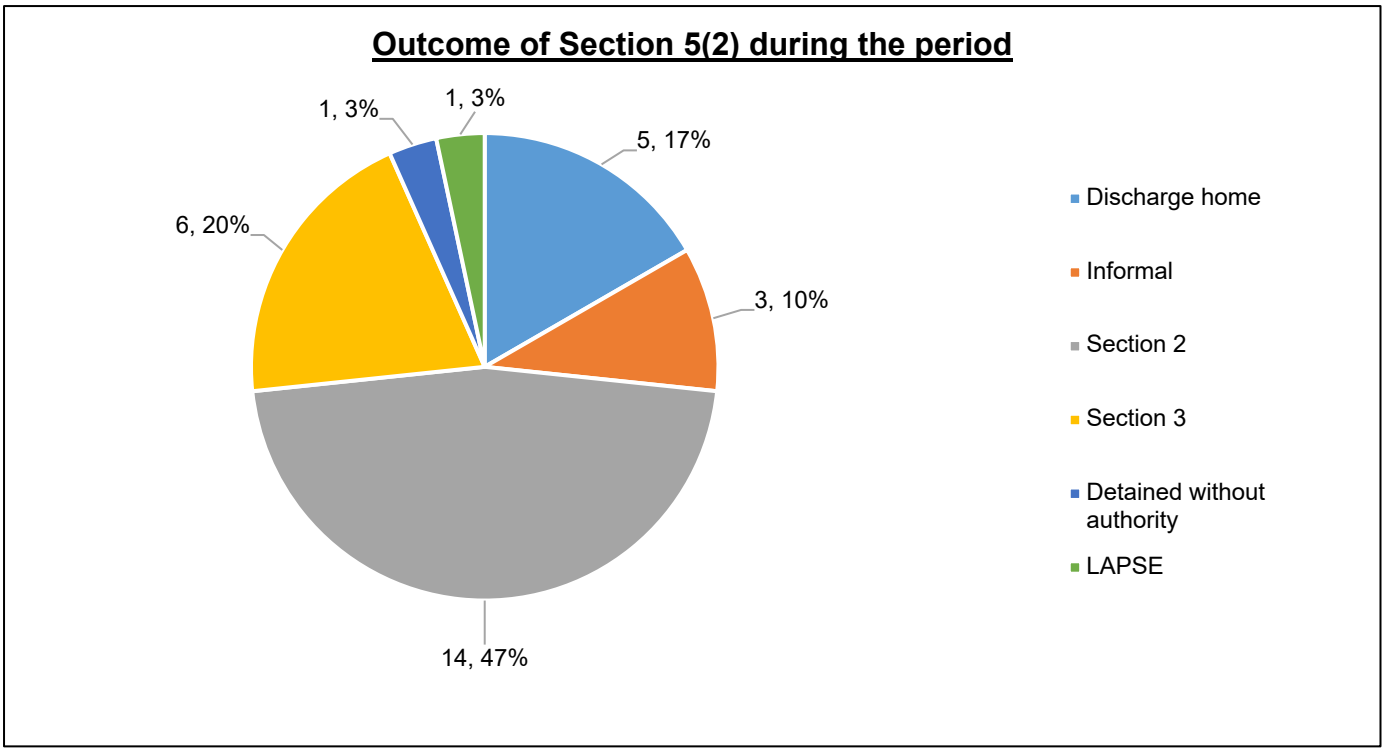
Number of hours patients were detained under Section 5(4) during the period



Section 5(2) - Doctors holding power

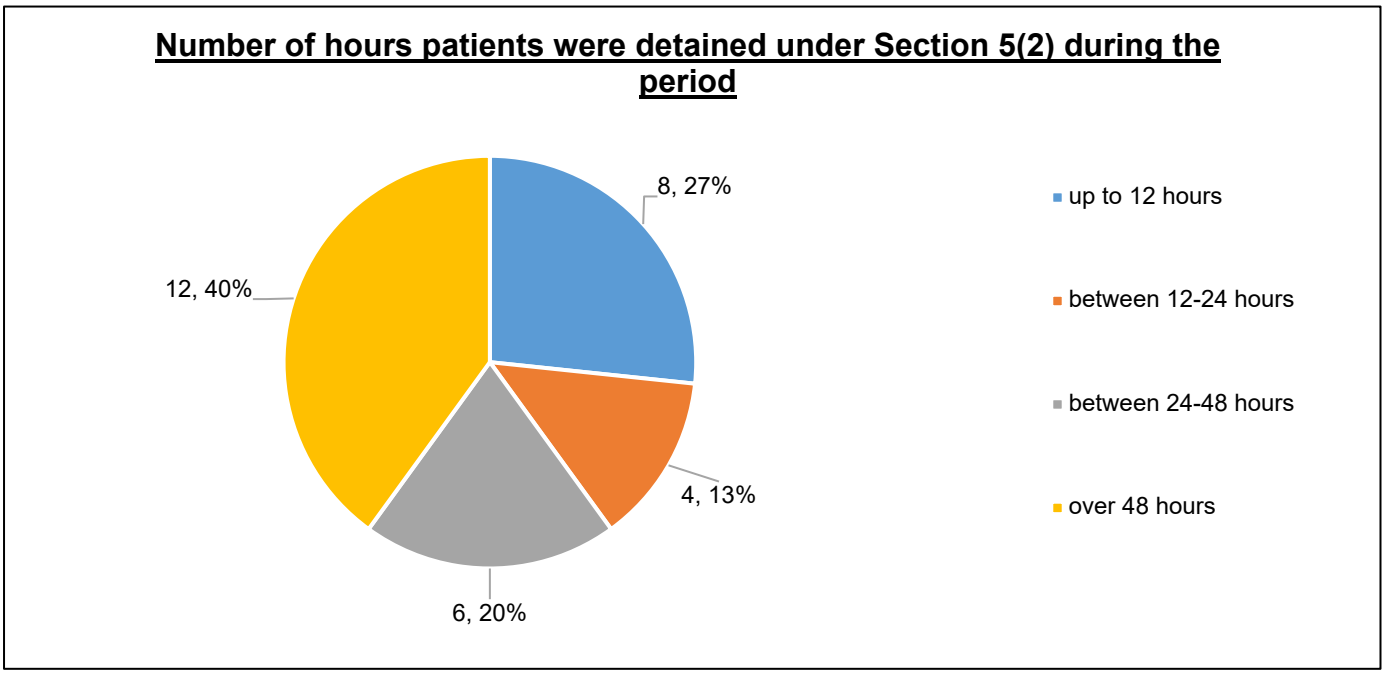






One Section 5(2) was not valid due to the person being detained to a hospital not named on the holding power documentation.

One Section 5(2) lapsed due to the assessment not being able to be arranged due to communication errors.



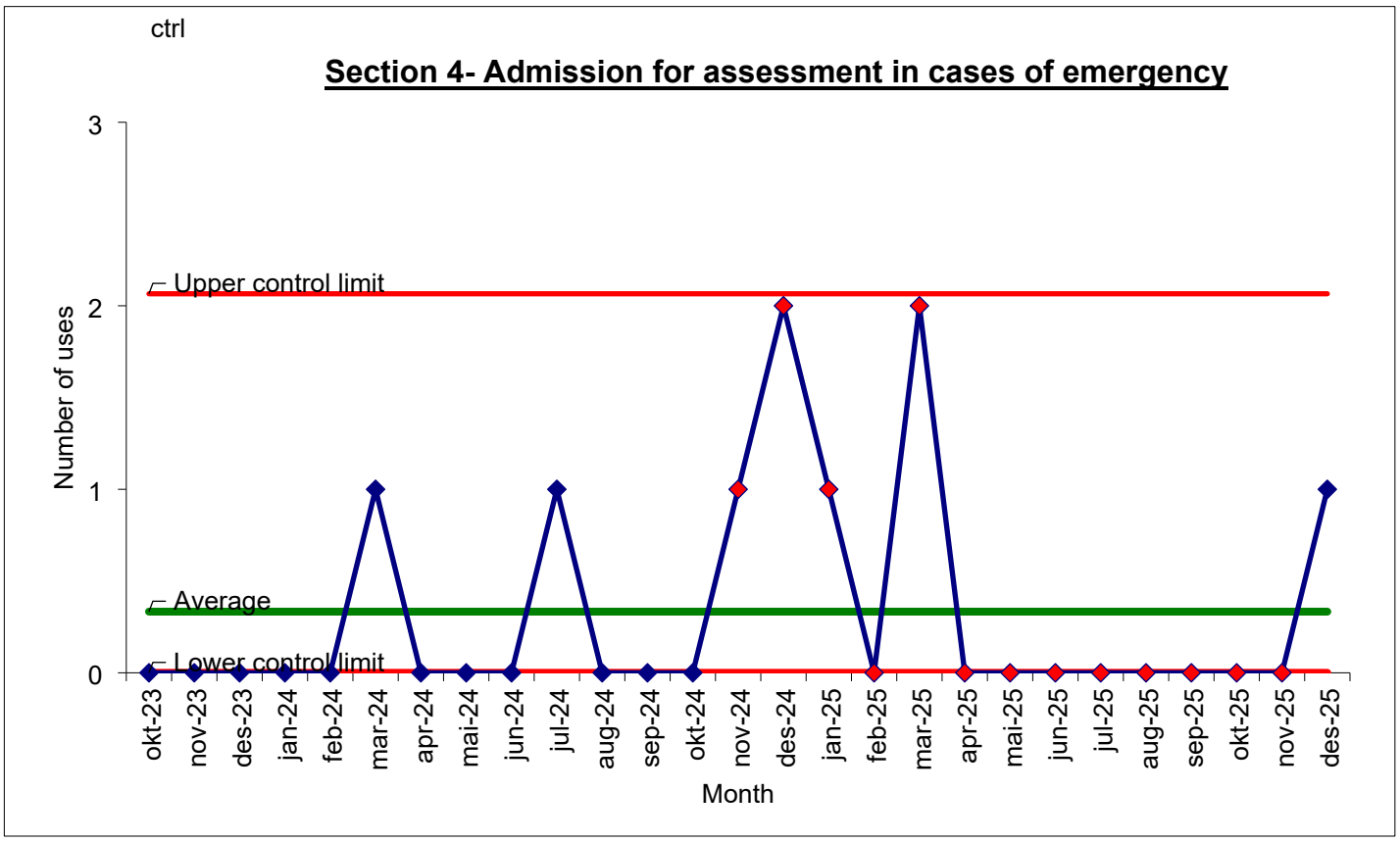
CAMHS Commissioned Inpatient Data

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

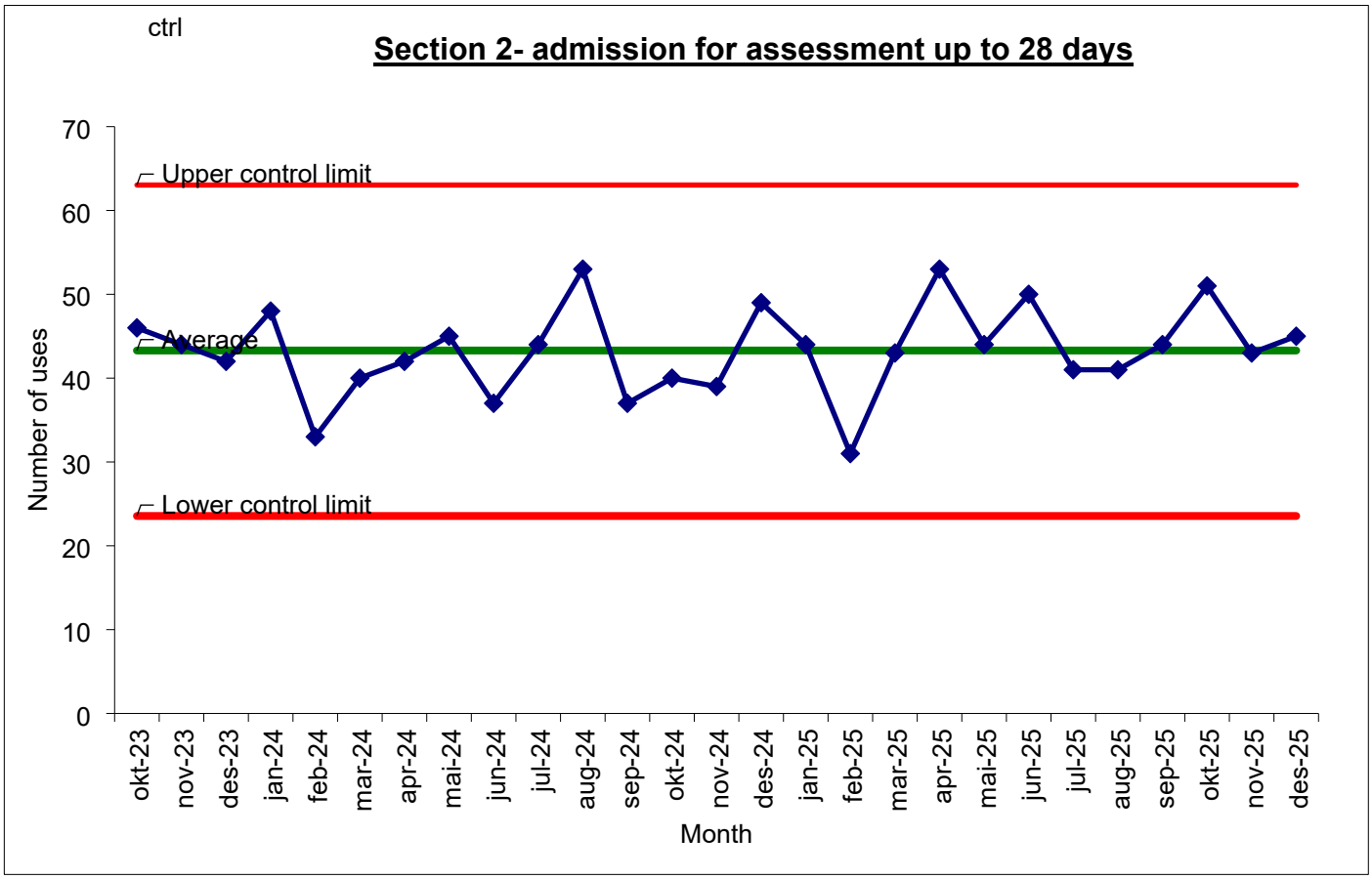
During the period there were no uses of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB.

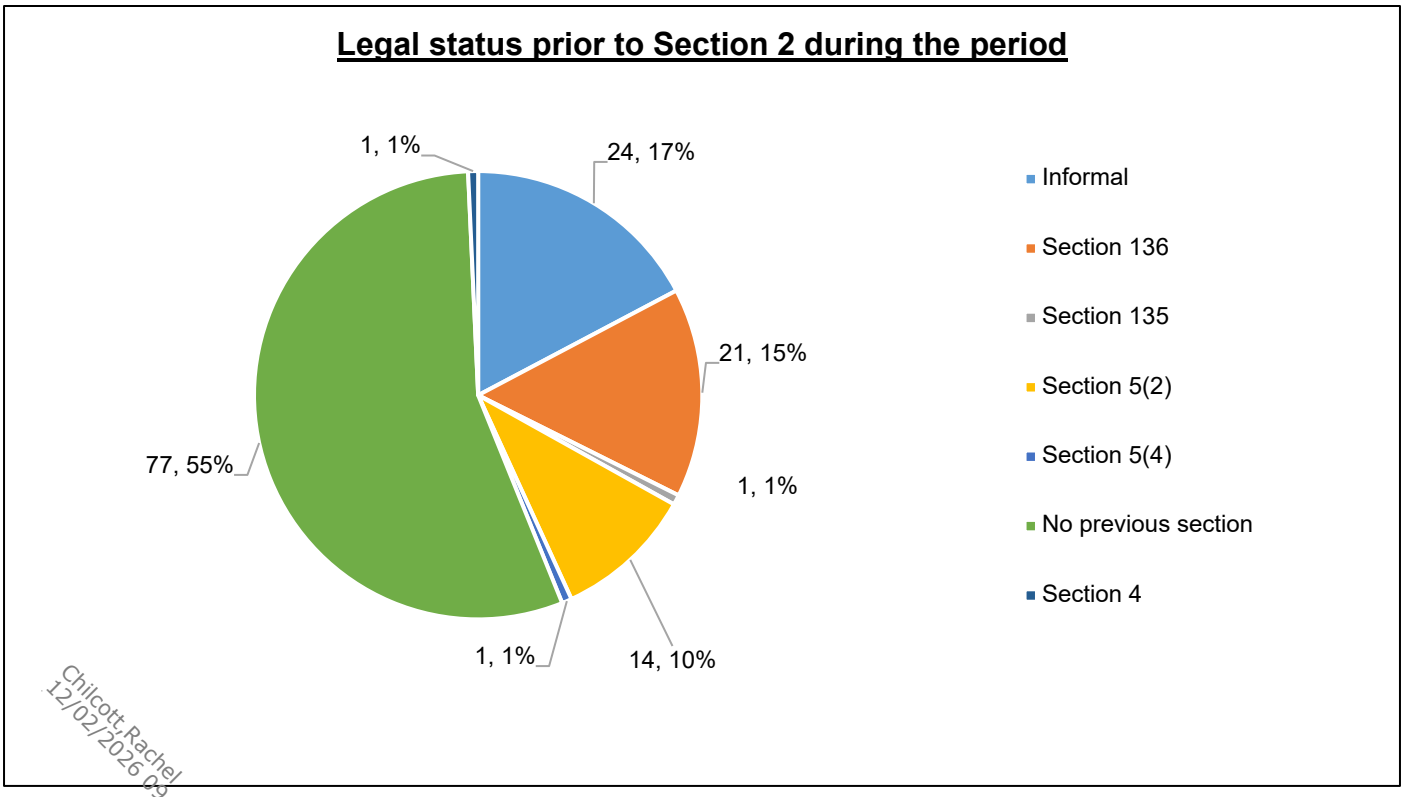
Section 4 - Admission for Assessment in Cases of Emergency

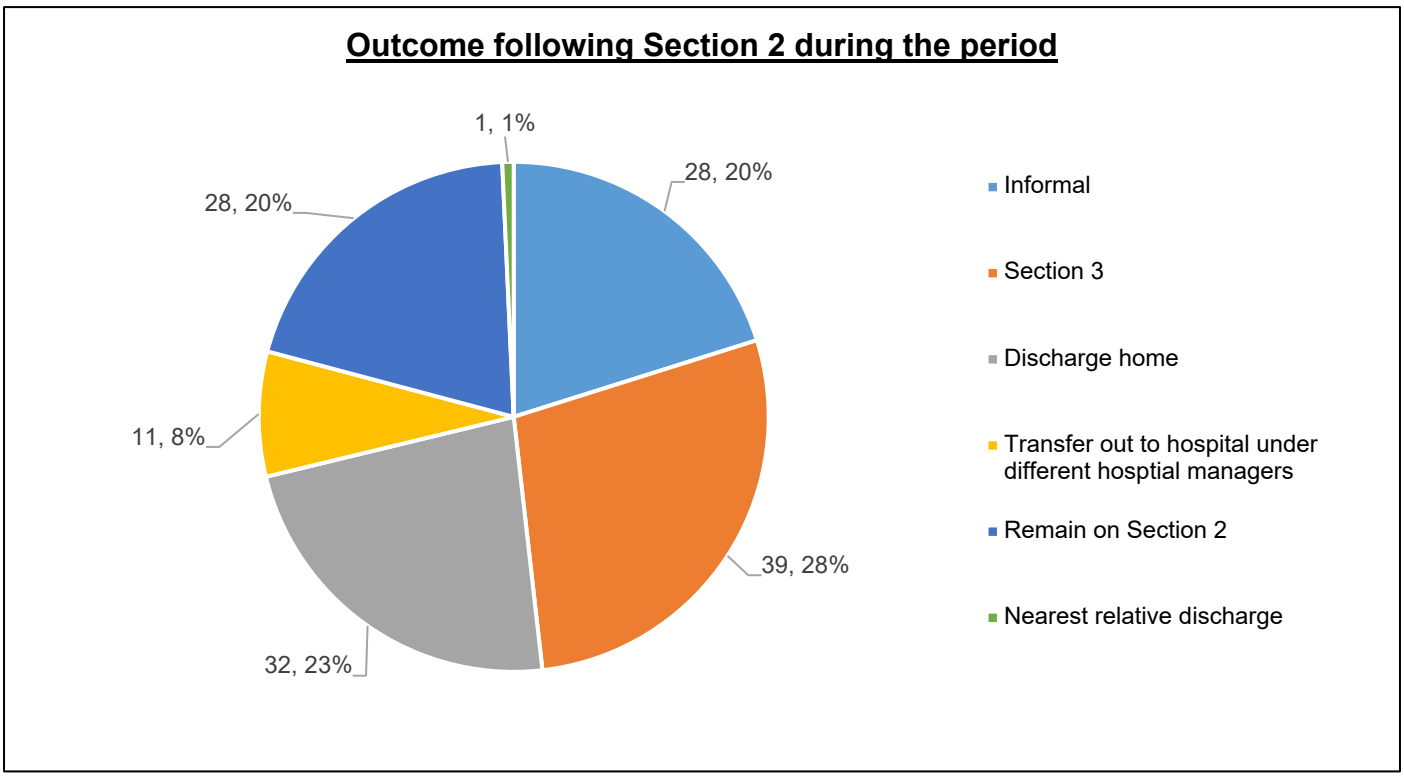
Section 4 used once during the period. The emergency power was then converted into a section 2.



Section 2 – Admission for Assessment



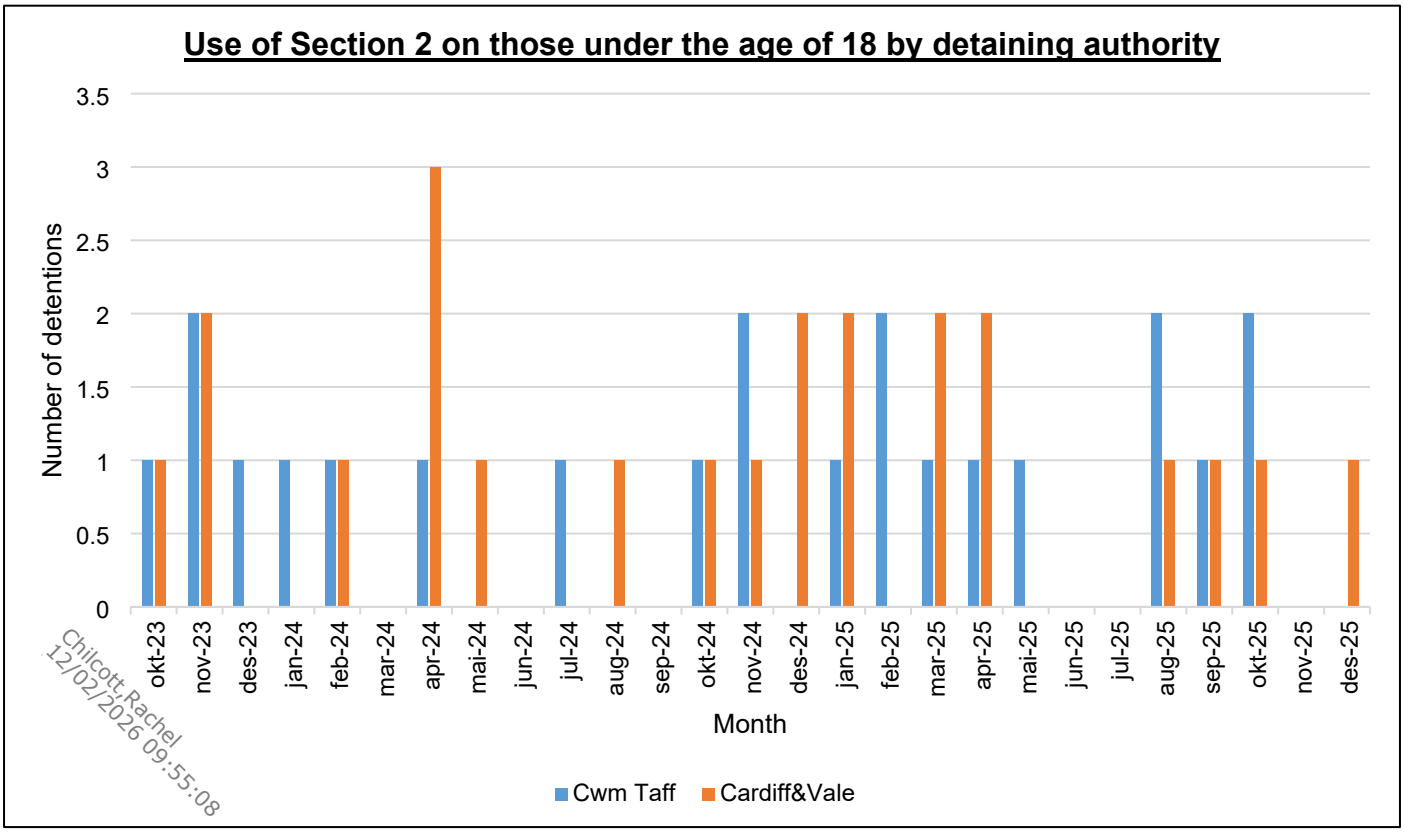


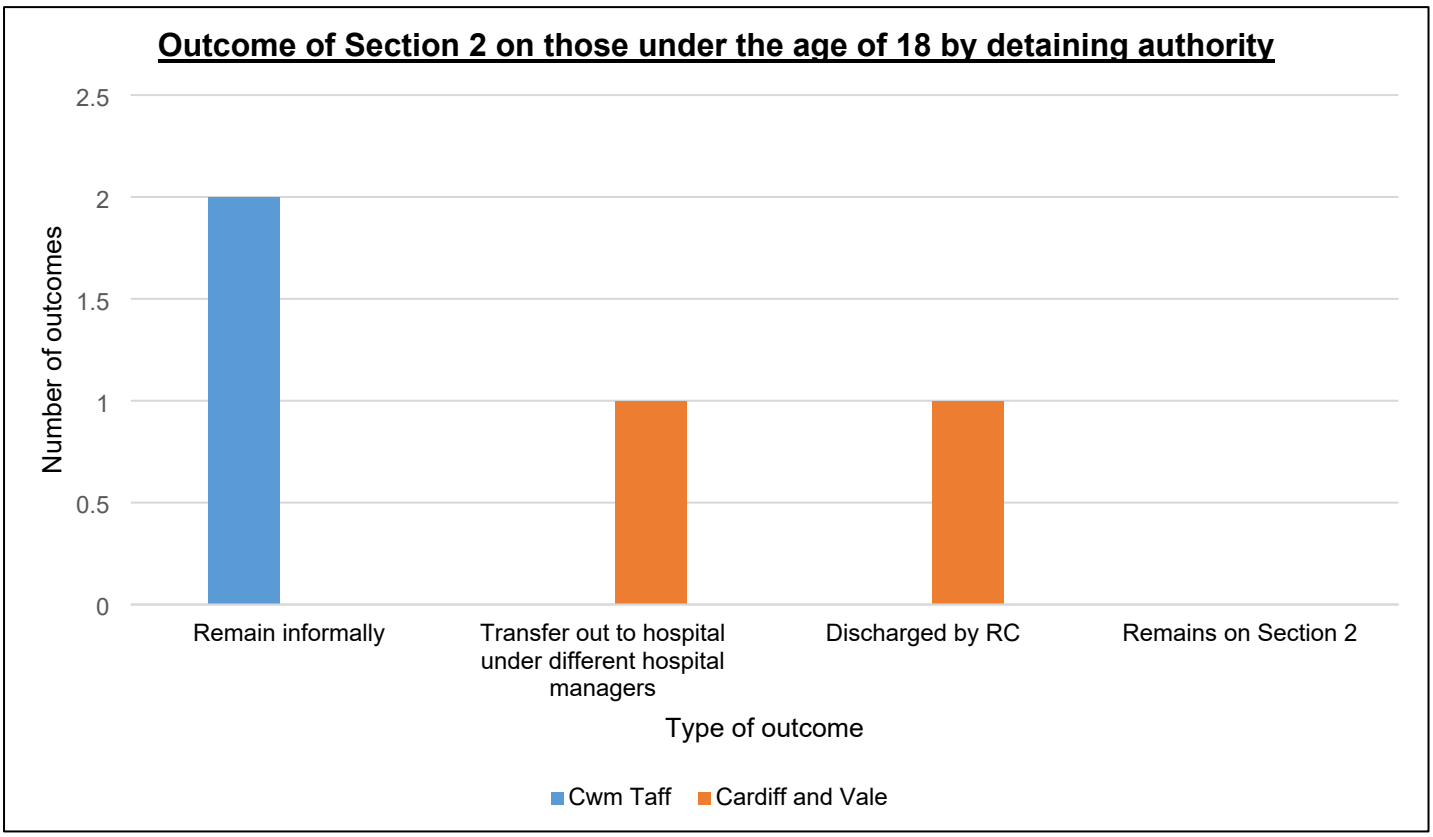


CAMHS Commissioned Inpatient Data

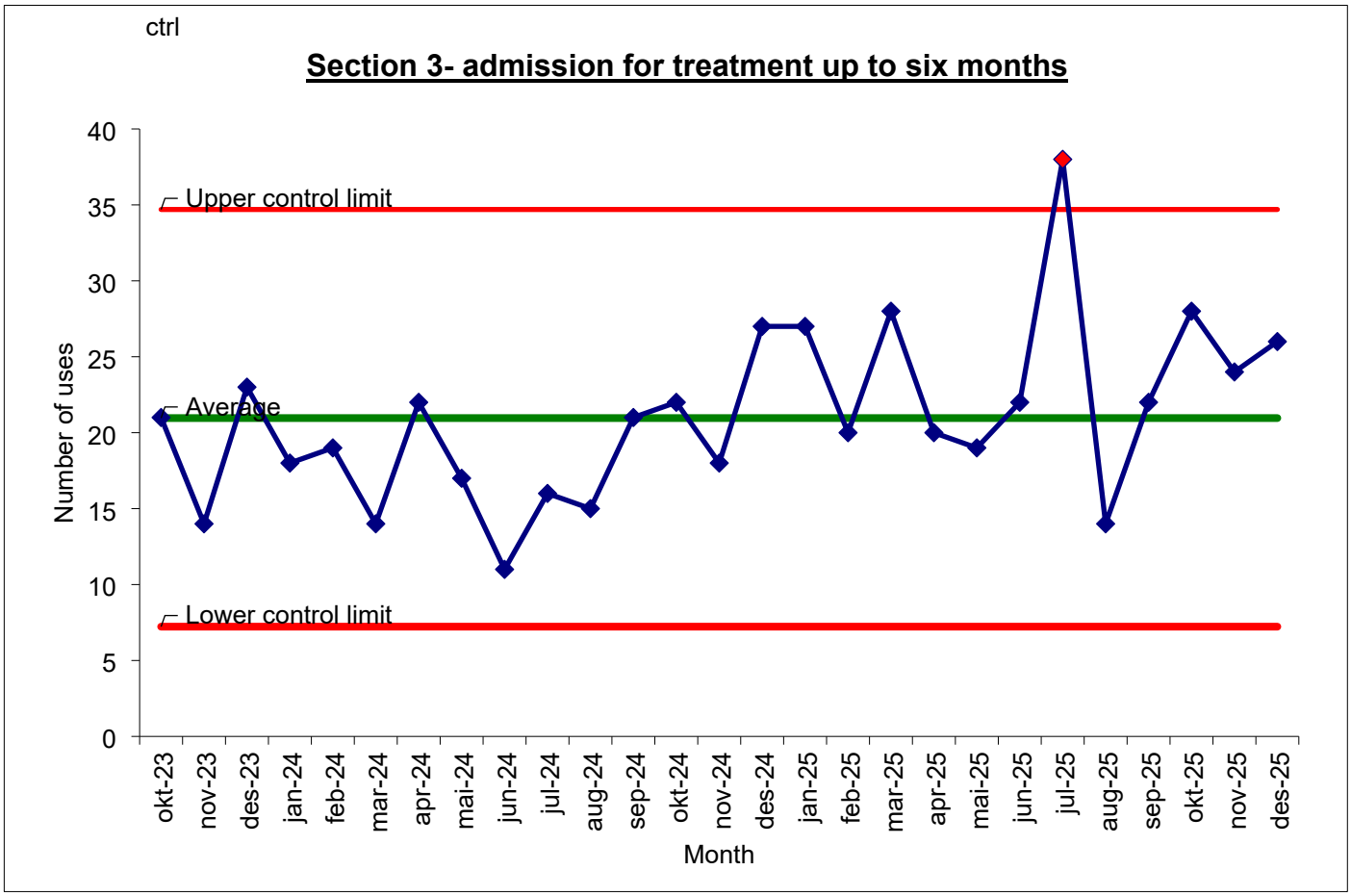
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

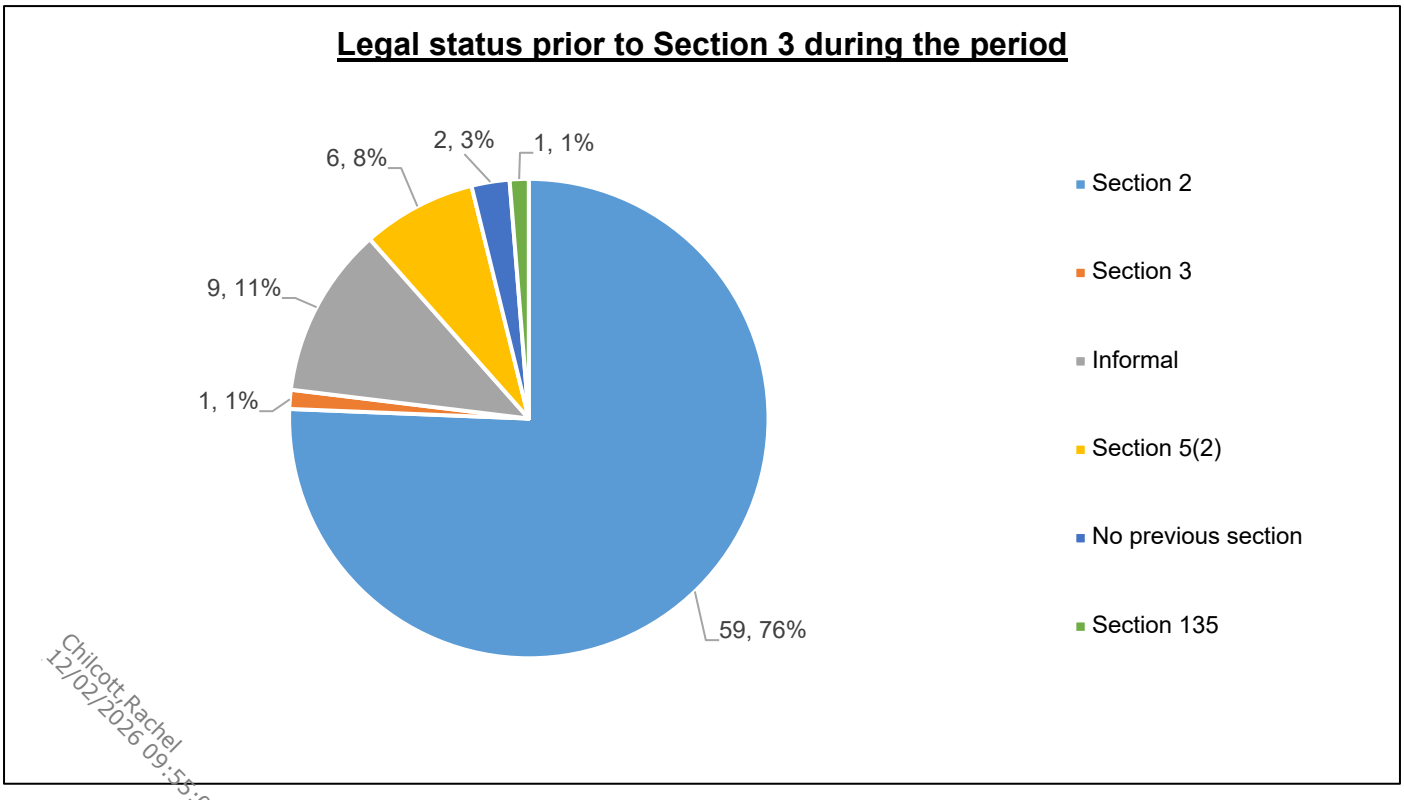
Included in the above data are those under 18 years of age. This is extracted below; -

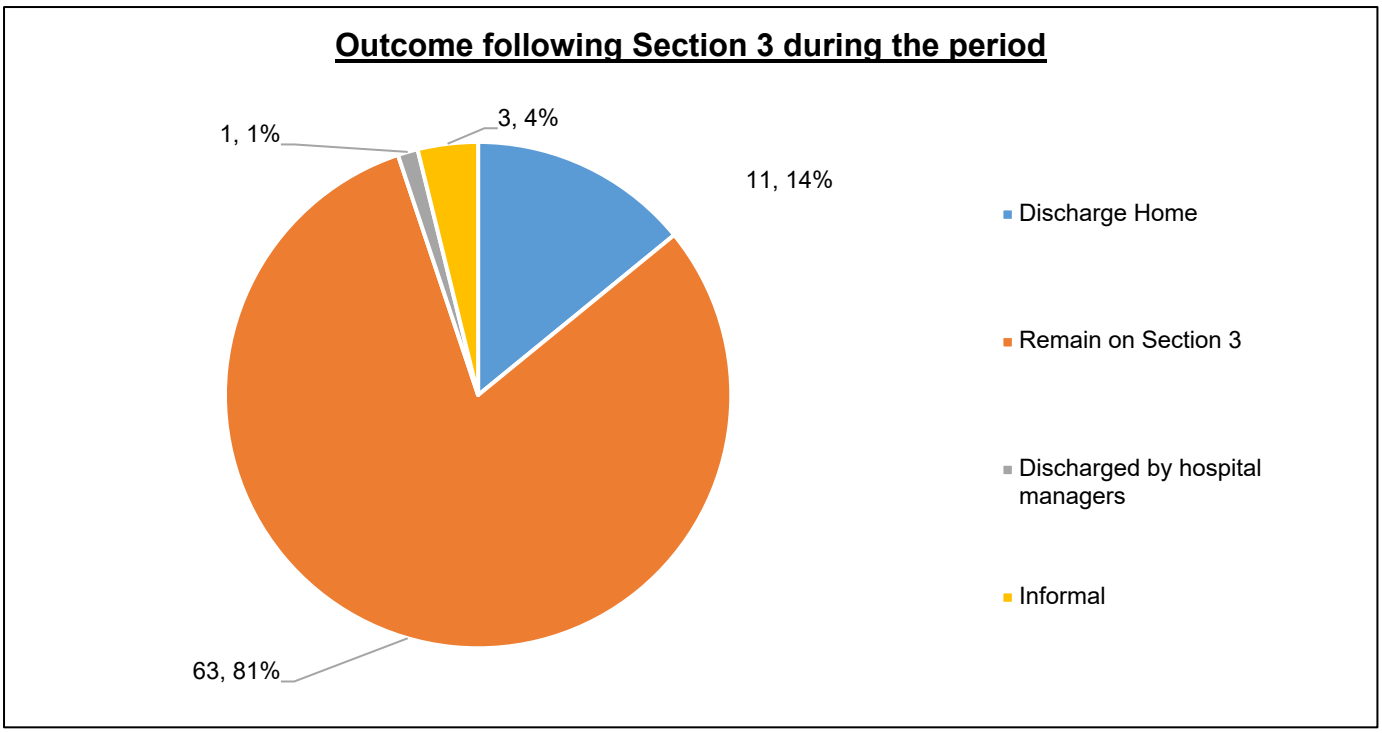




Section 3 – Admission for Treatment



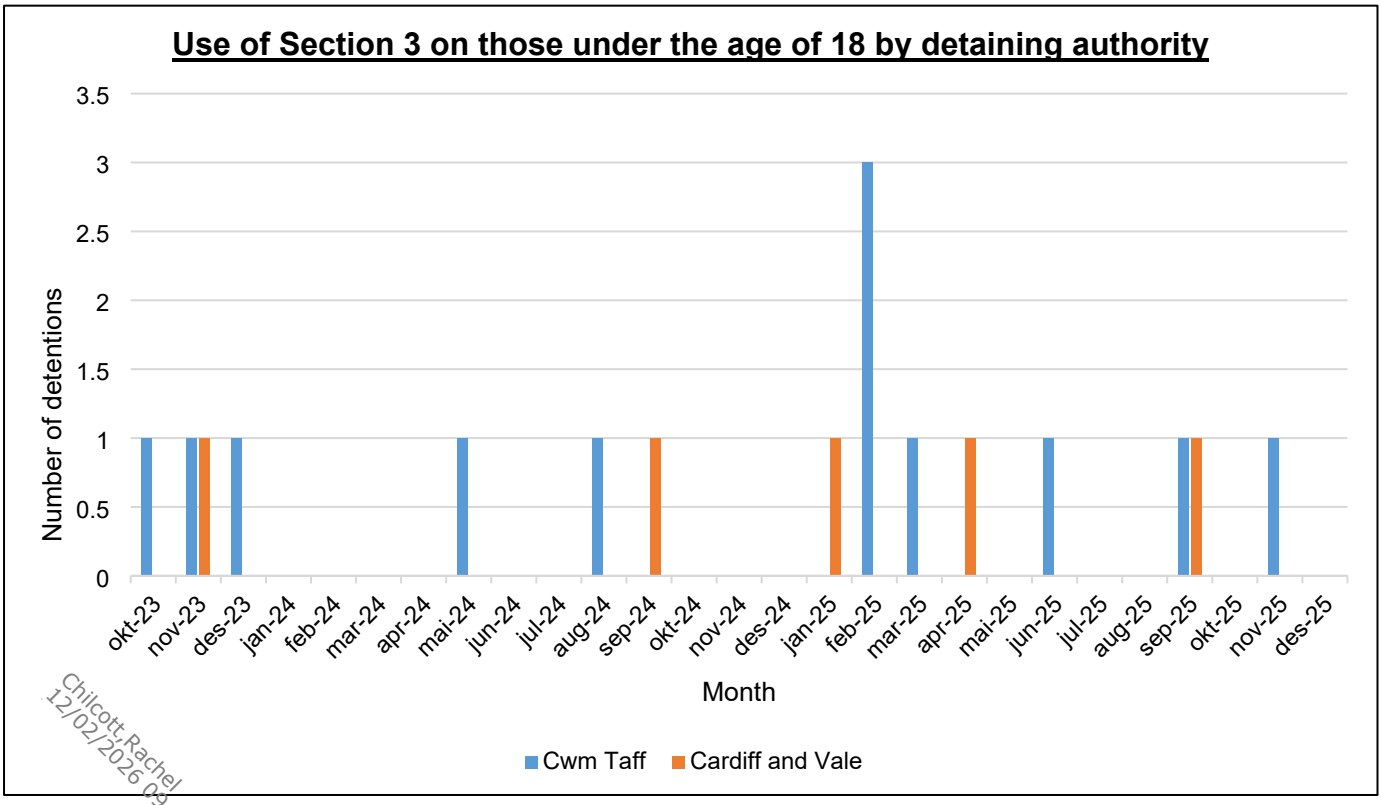




The above data would include those under 18 years of age.

CAMHS Commissioned Inpatient Data

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

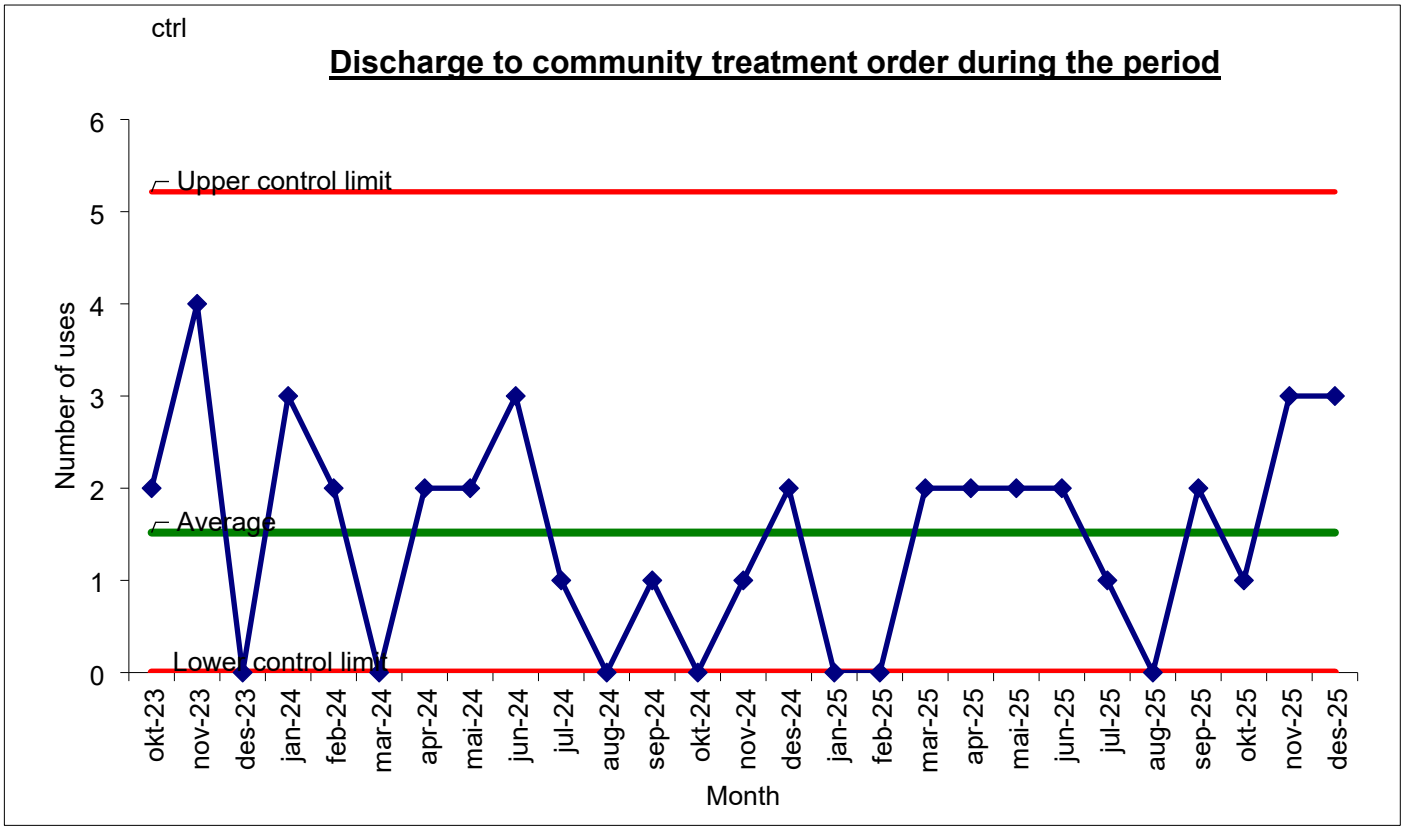


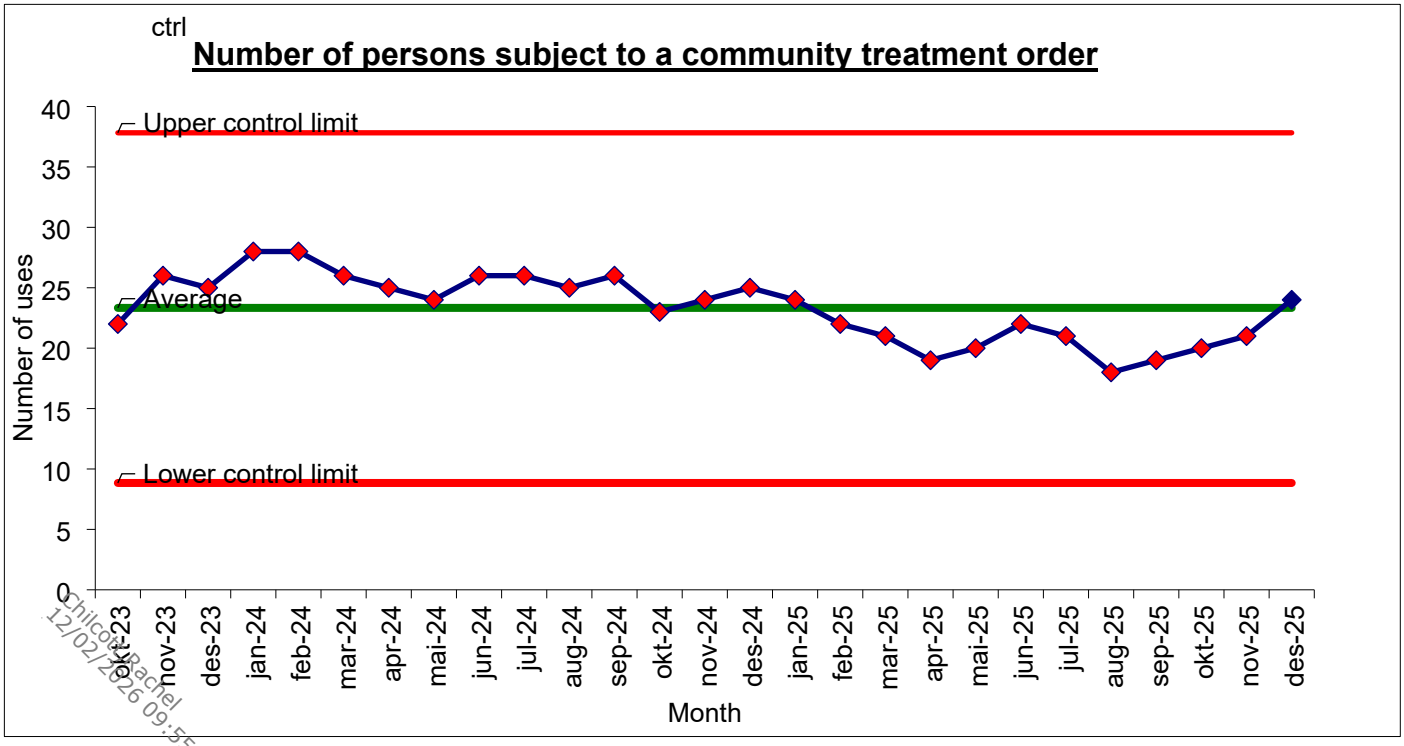
The CAMHS patient detained during the period has stayed in hospital on an informal basis.

Community Treatment Order

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

As of 31st December 2025, twenty-four 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 not used.

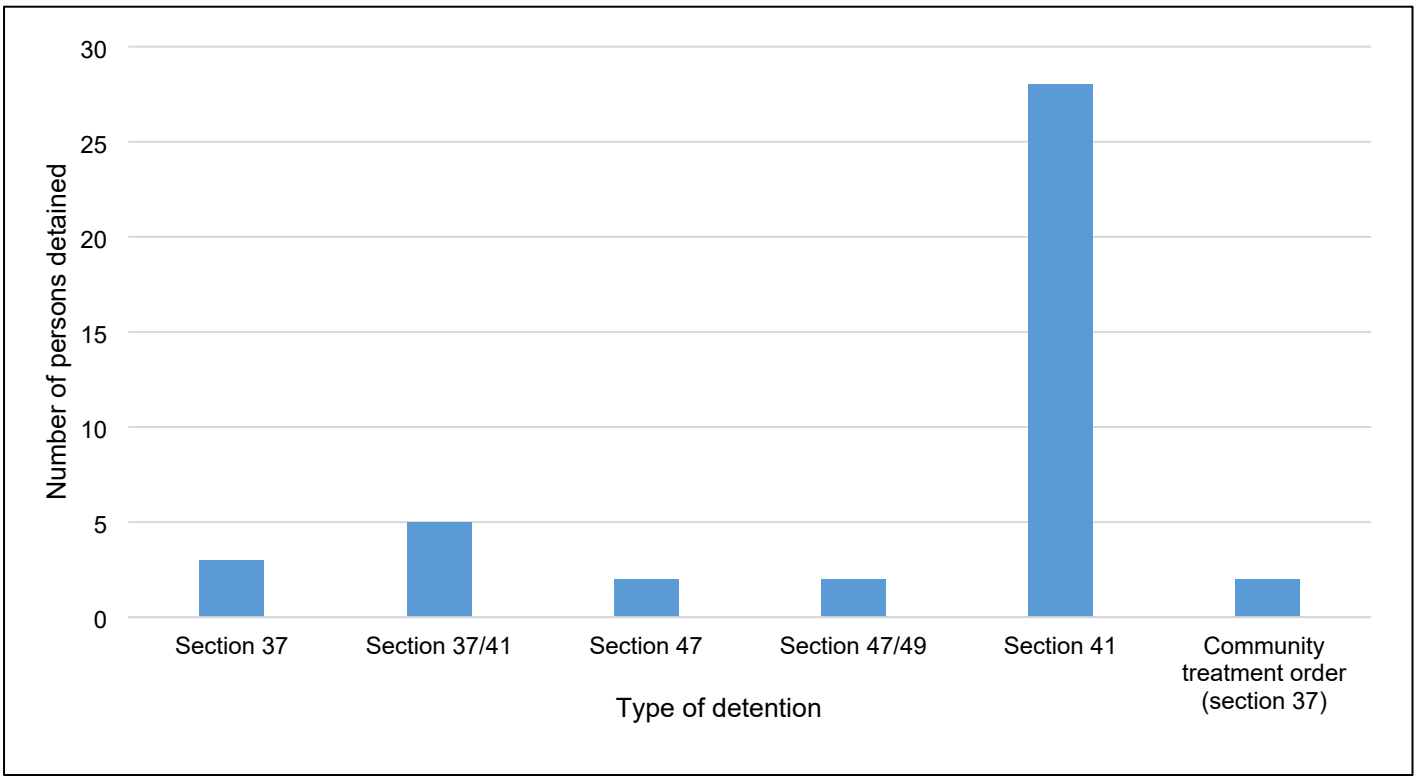
CAMHS Commissioned Inpatient Data

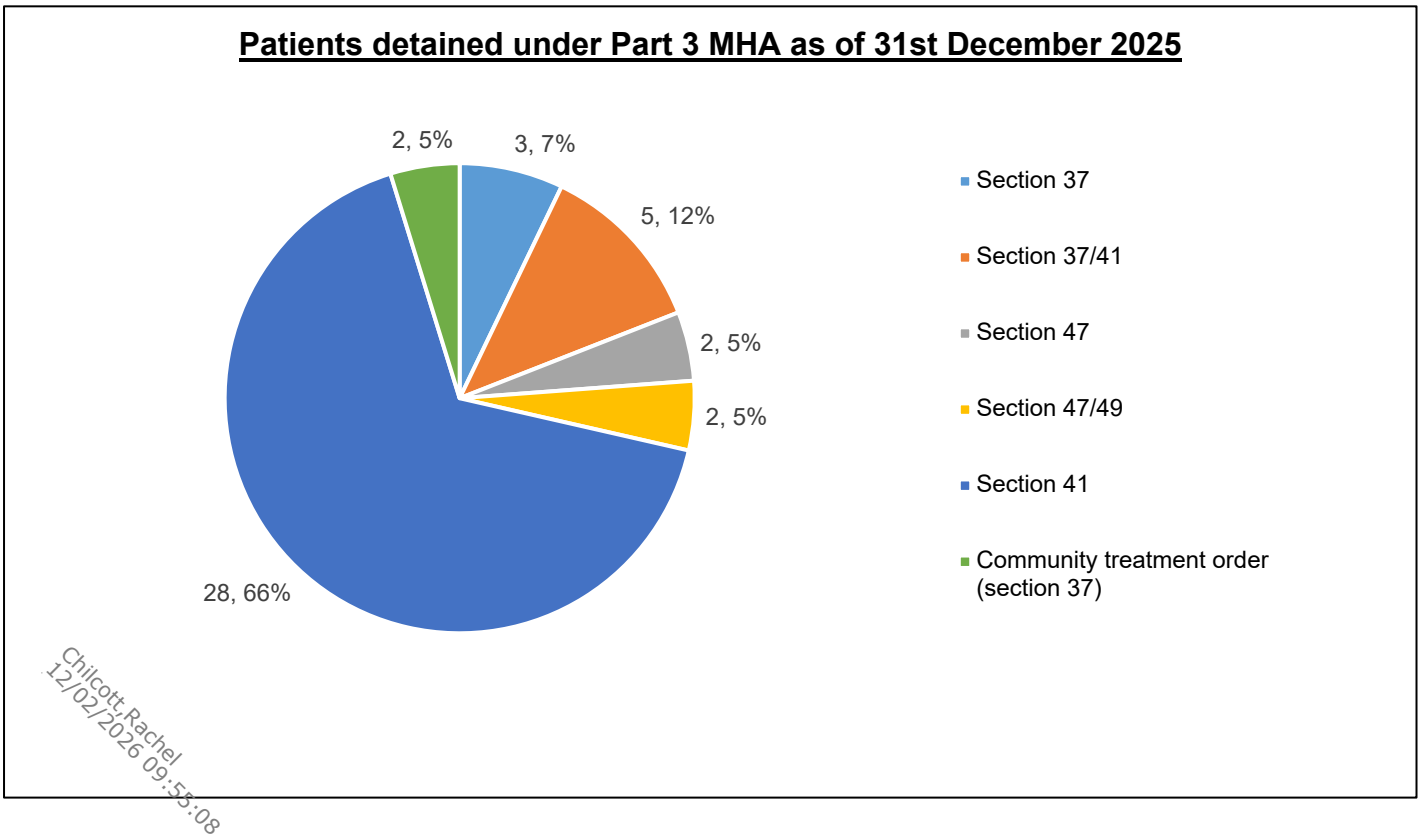
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

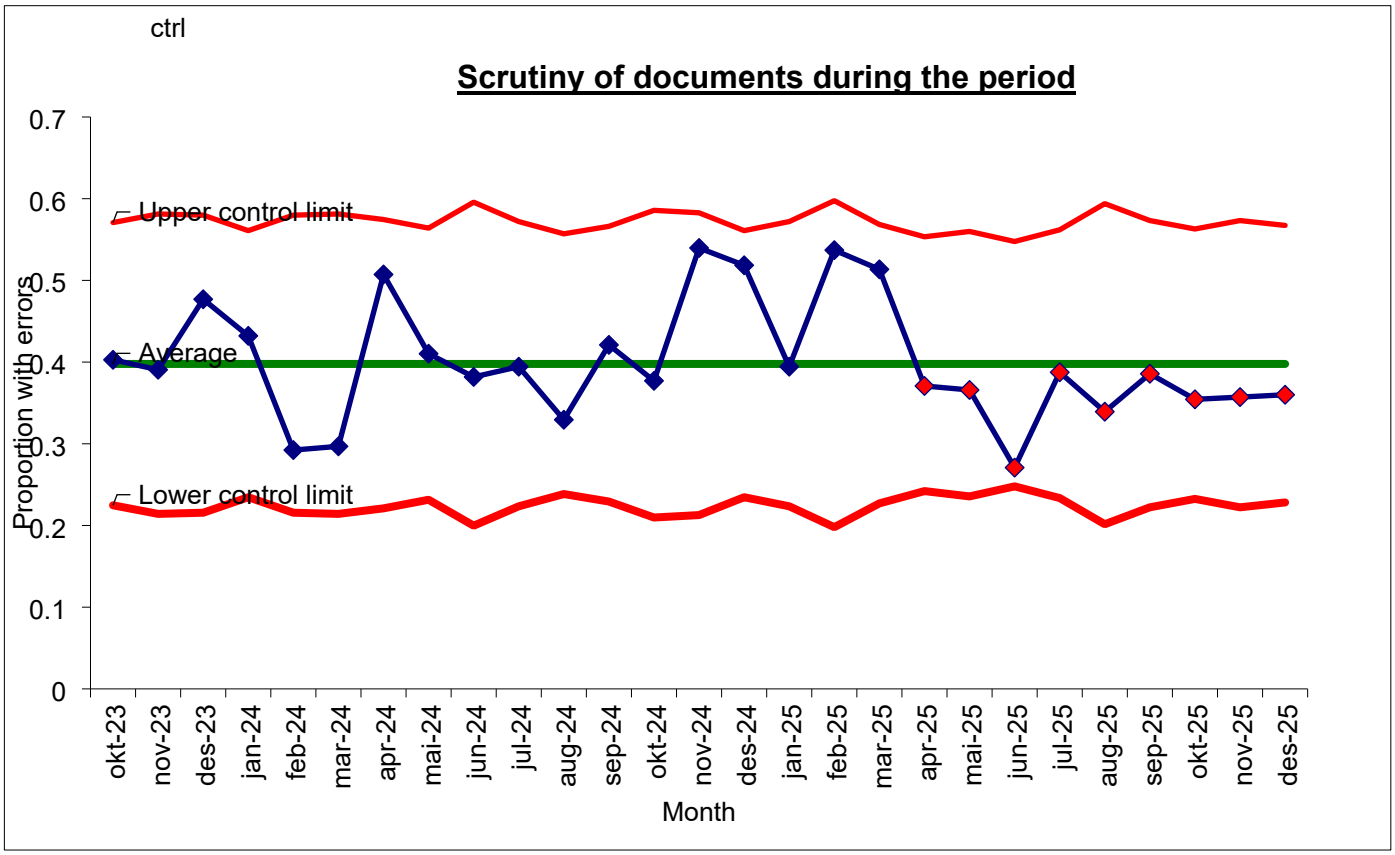
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as of 31st December 2025.

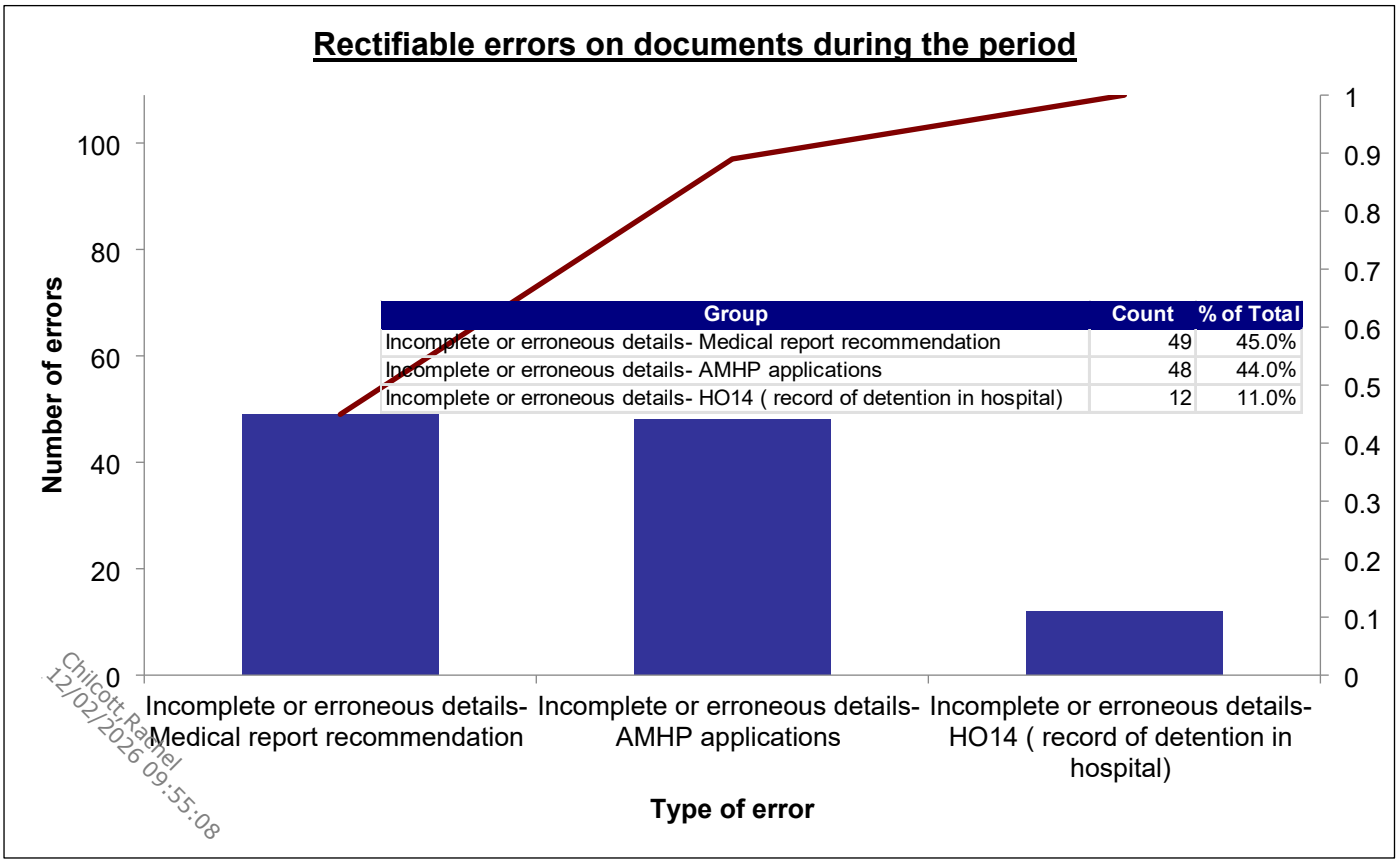




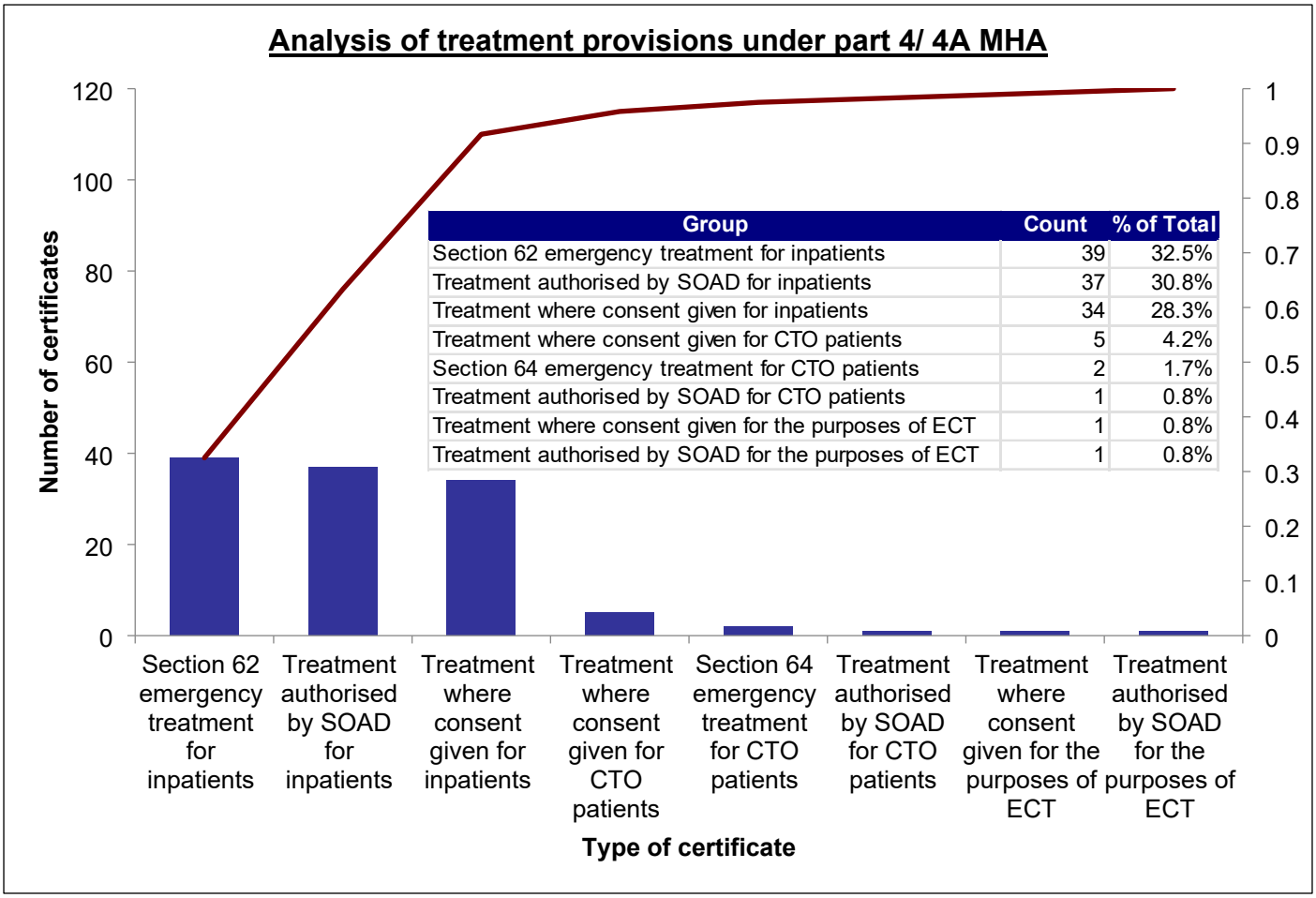
Scrutiny of documents during the period

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	39	32.5%
Treatment authorised by SOAD for inpatients	37	30.8%
Treatment where consent given for inpatients	34	28.3%
Treatment where consent given for CTO patients	5	4.2%
Section 64 emergency treatment for CTO patients	2	1.7%
Treatment authorised by SOAD for CTO patients	1	0.8%
Treatment where consent given for the purposes of ECT	1	0.8%
Treatment authorised by SOAD for the purposes of ECT	1	0.8%

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.

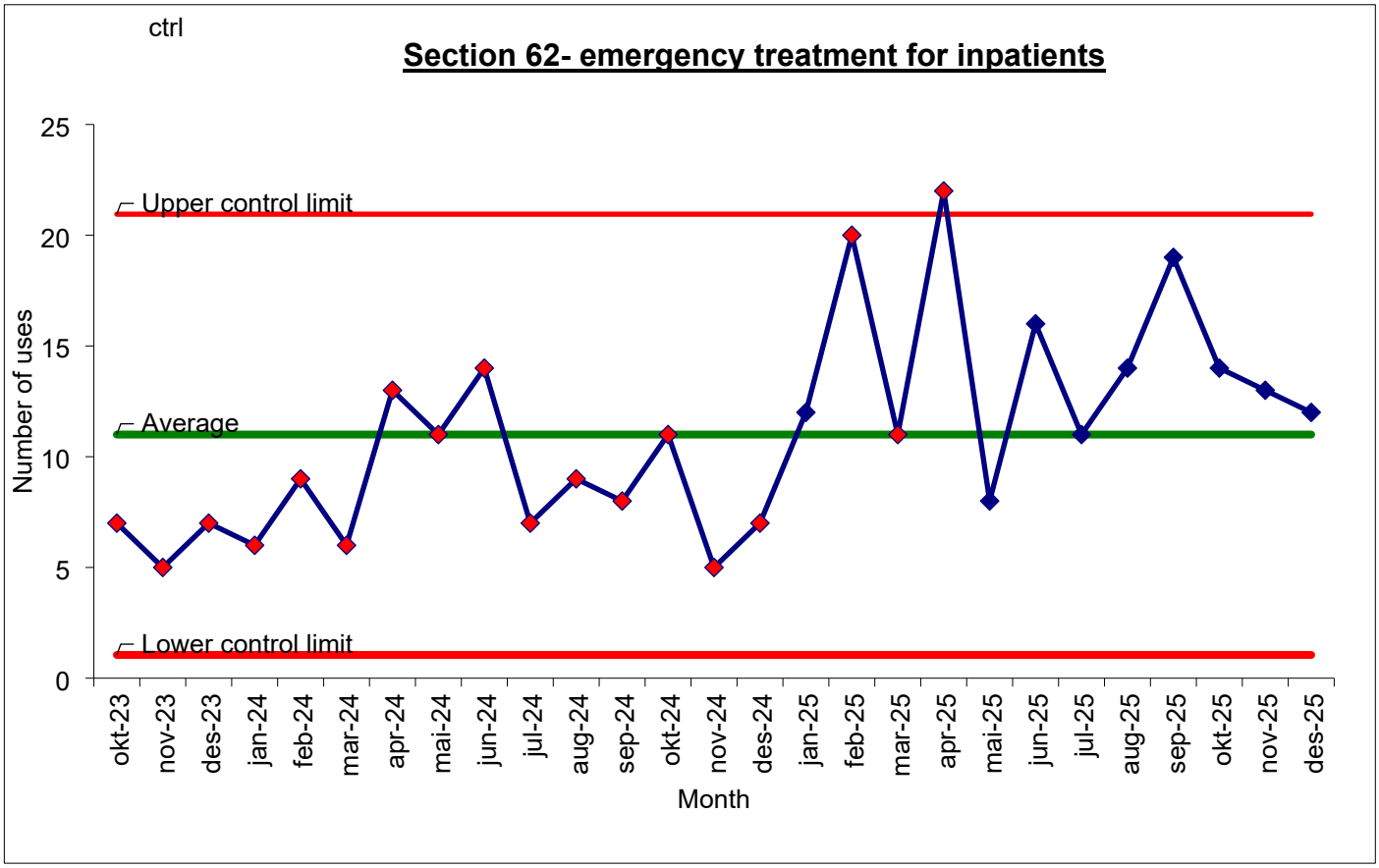
Urgent treatment is defined as treatment that is:

- 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.

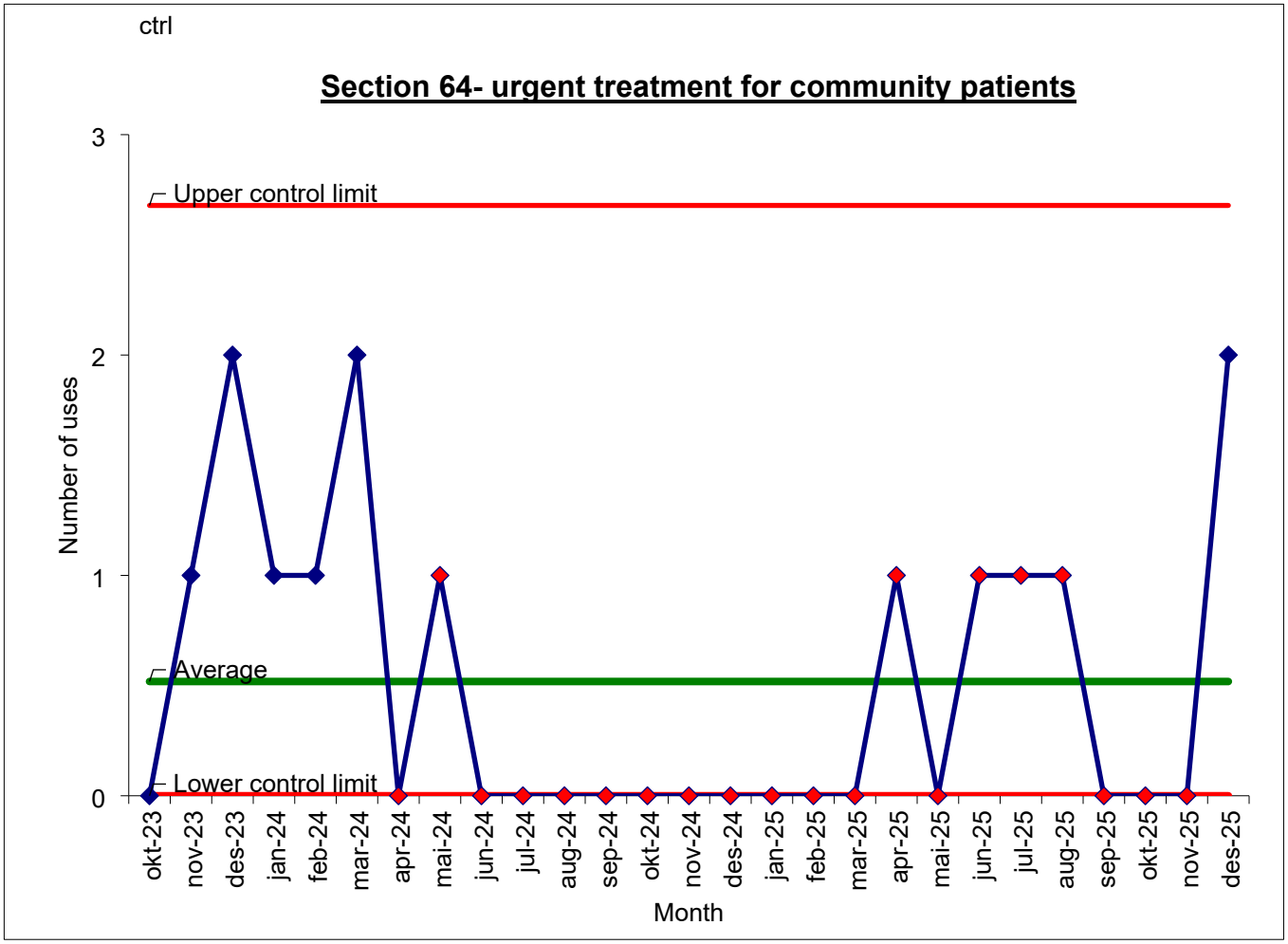
Urgent treatment can be used in any of the following instances:

- 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.



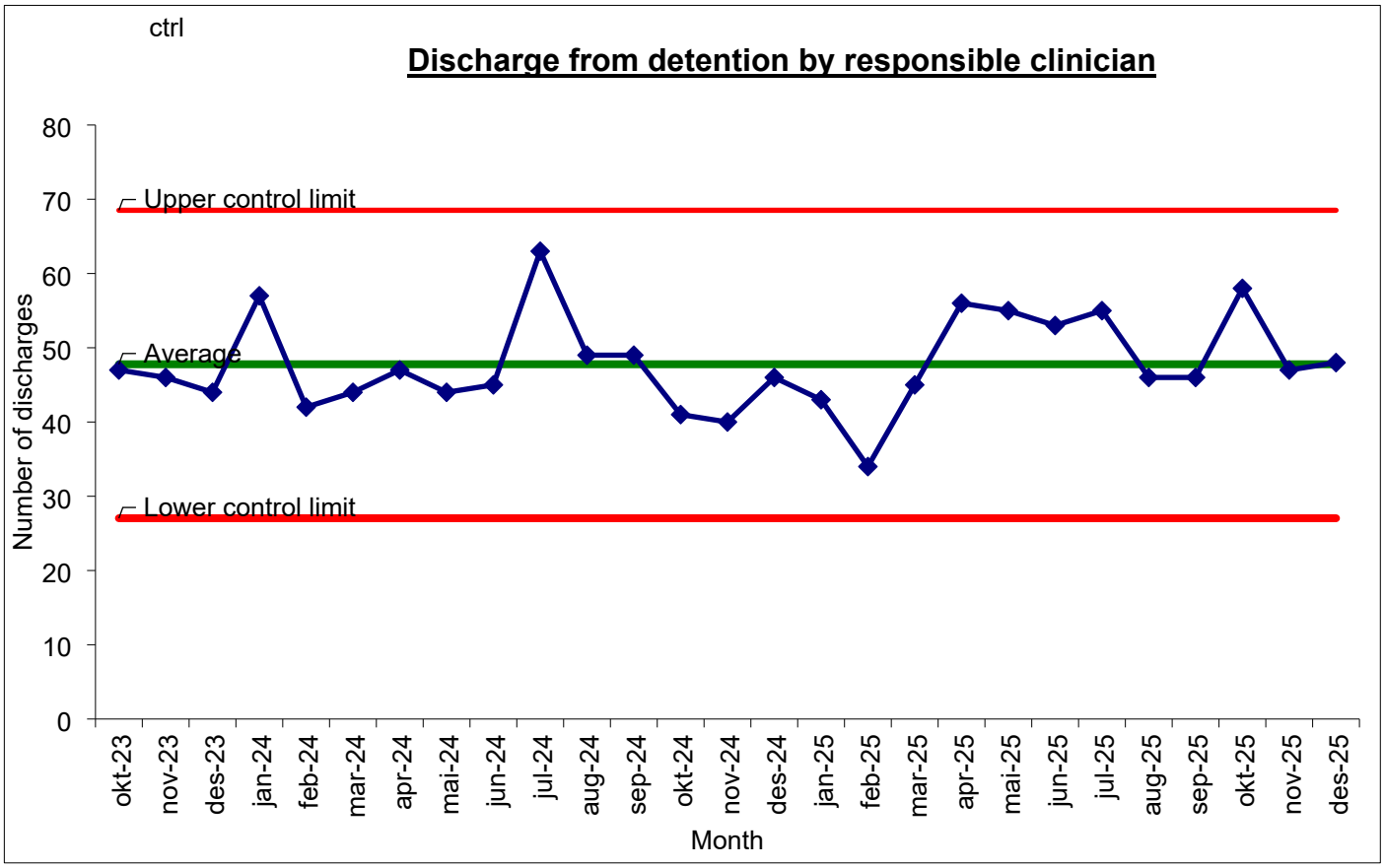
The above chart highlights that Section 62 was used on thirty-nine occasions for the following reasons:

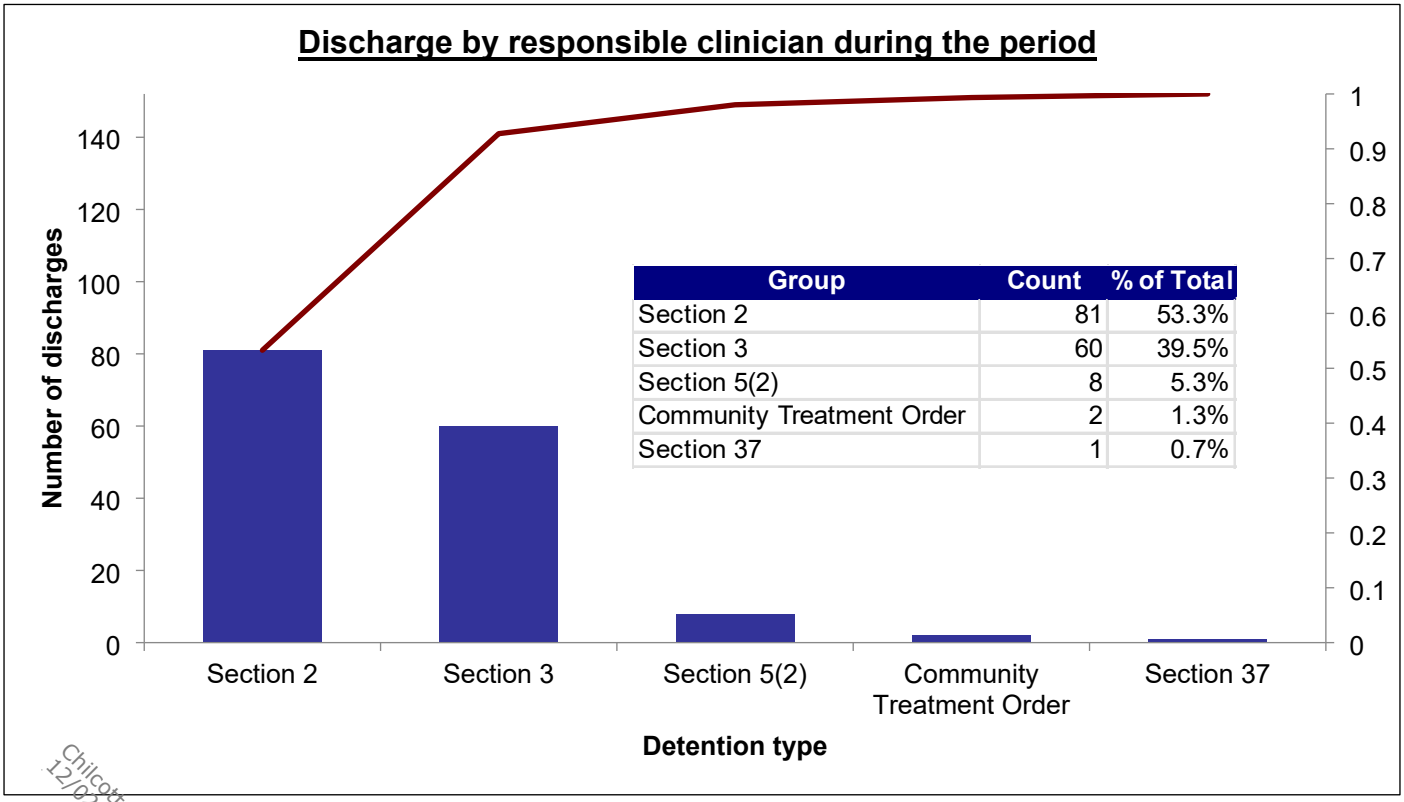
- Change of medication x 3
- Three-month rule x 25
- Emergency ECT x 7
- Time limited certificate- new SOAD needed x 1
- Change of capacity x 3



The above chart highlights that Section 64 was used on two occasions- both in relation to the one-month rule.

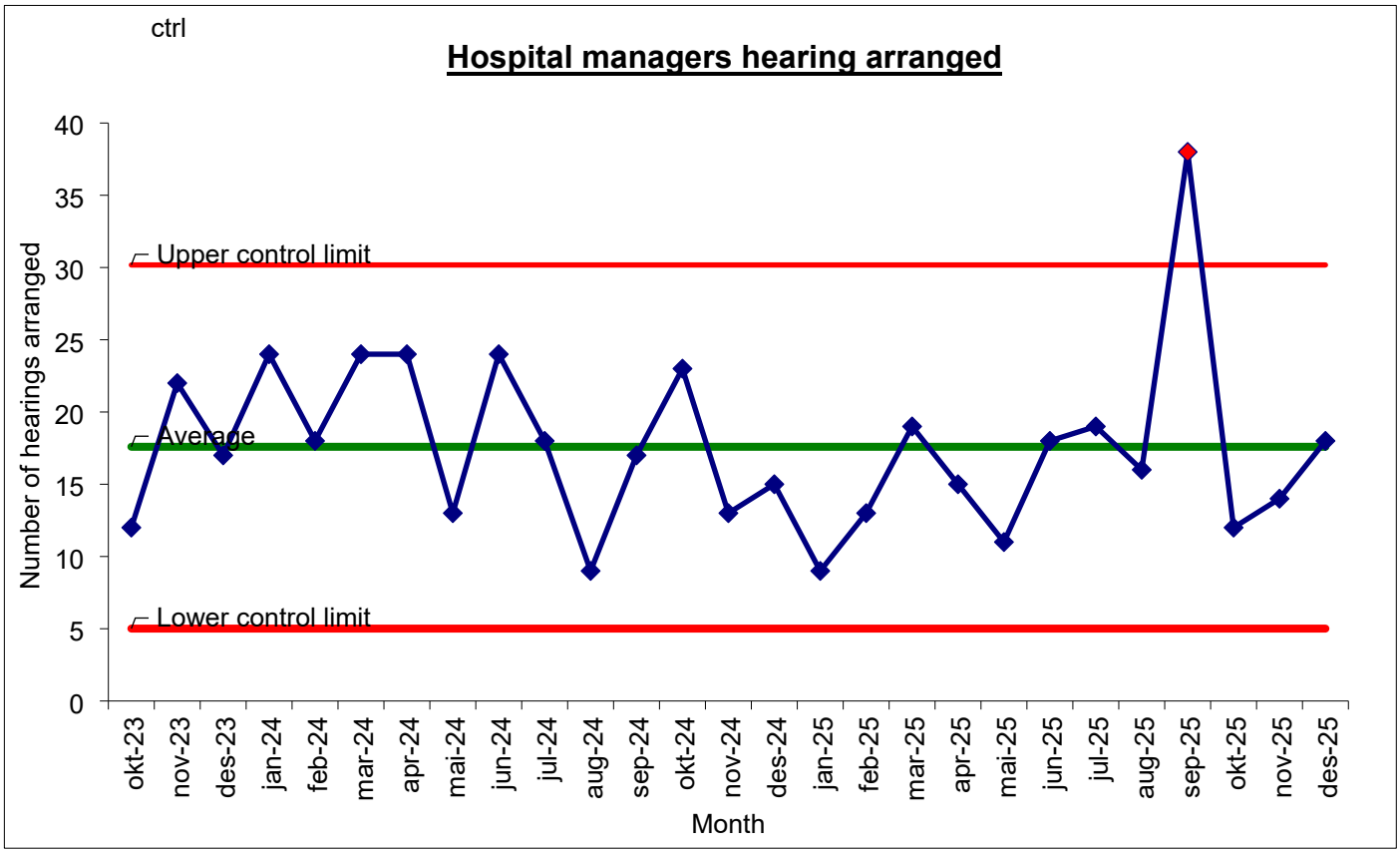
Discharge

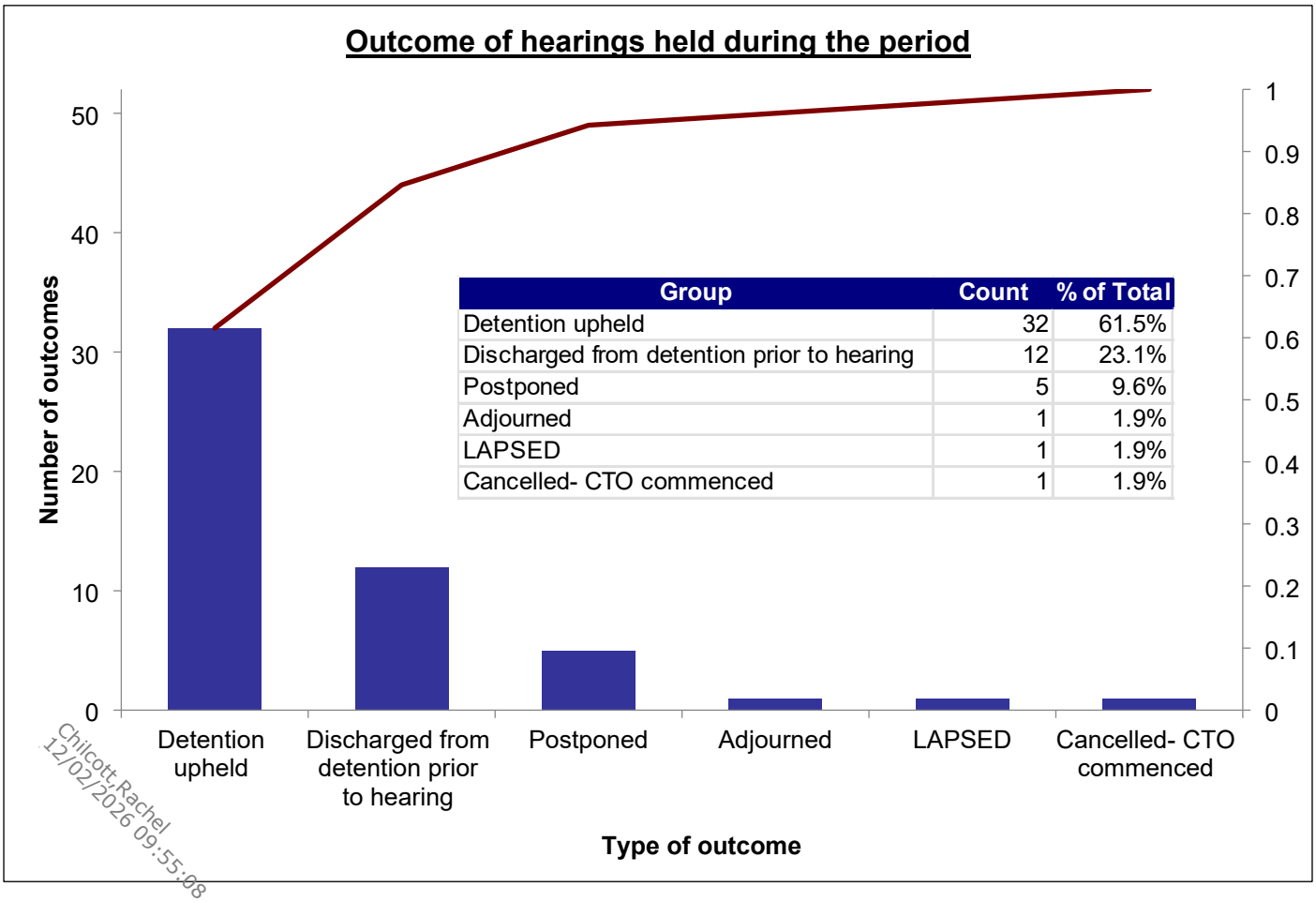




Group	Count	% of Total
Section 2	81	53.3%
Section 3	60	39.5%
Section 5(2)	8	5.3%
Community Treatment Order	2	1.3%
Section 37	1	0.7%

Hospital Managers – Power of Discharge





Group	Count	% of Total
Detention upheld	32	61.5%
Discharged from detention prior to hearing	12	23.1%
Postponed	5	9.6%
Adjourned	1	1.9%
LAPSED	1	1.9%
Cancelled- CTO commenced	1	1.9%

One hearing was adjourned for the following reason:

- To allow for advocacy to attend and the CTP to be completed.

Five hearings were postponed for the following reasons:

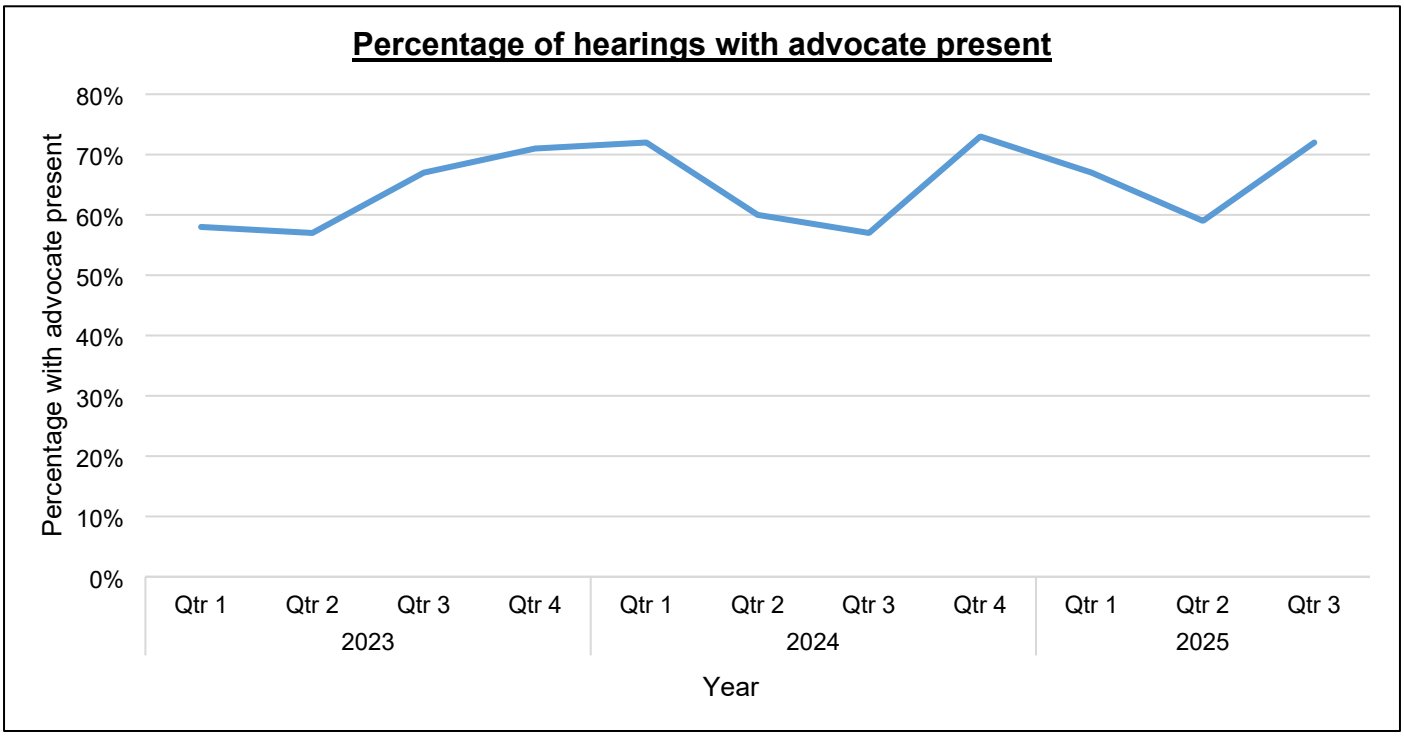
- Responsible Clinician unavailable x1
- Panel member availability x 1
- Late submission of reports 1
- Advocacy availability x 2

Advocacy referrals:

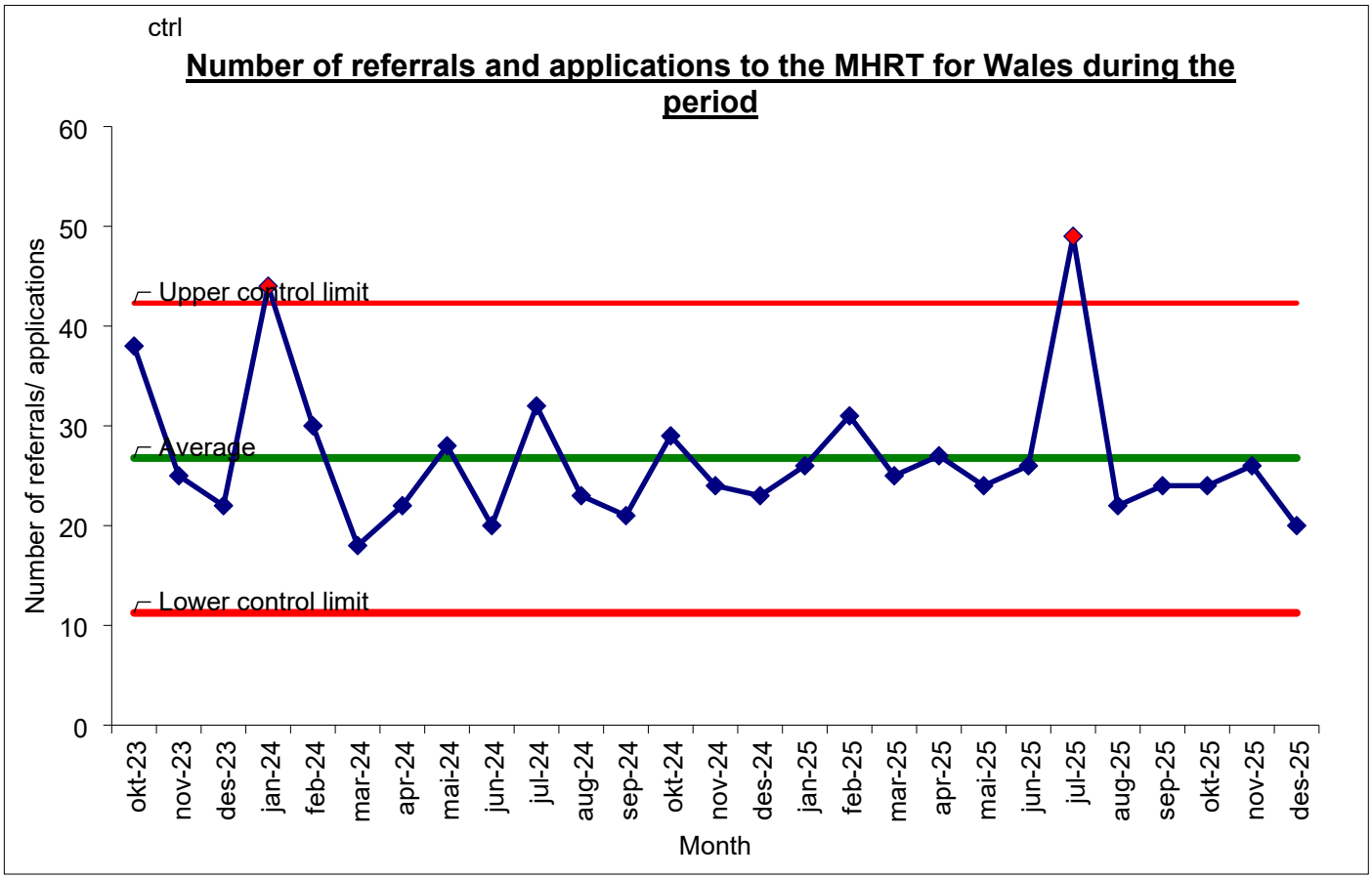
Out of 52 hearings that could have gone ahead during the quarter, 40 of those had been referred for an advocate and advocates attended 24 of those.

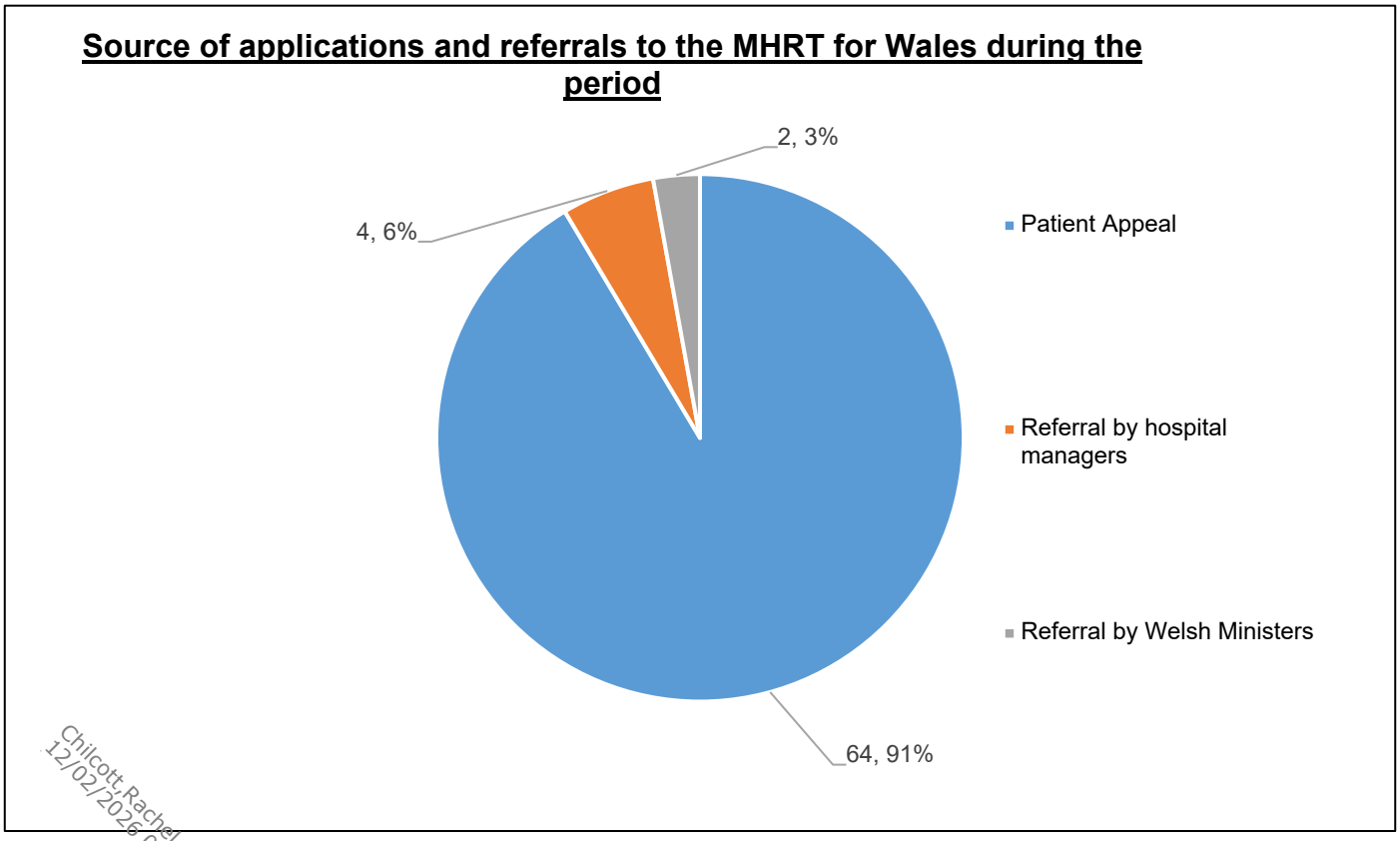
Advocates present:

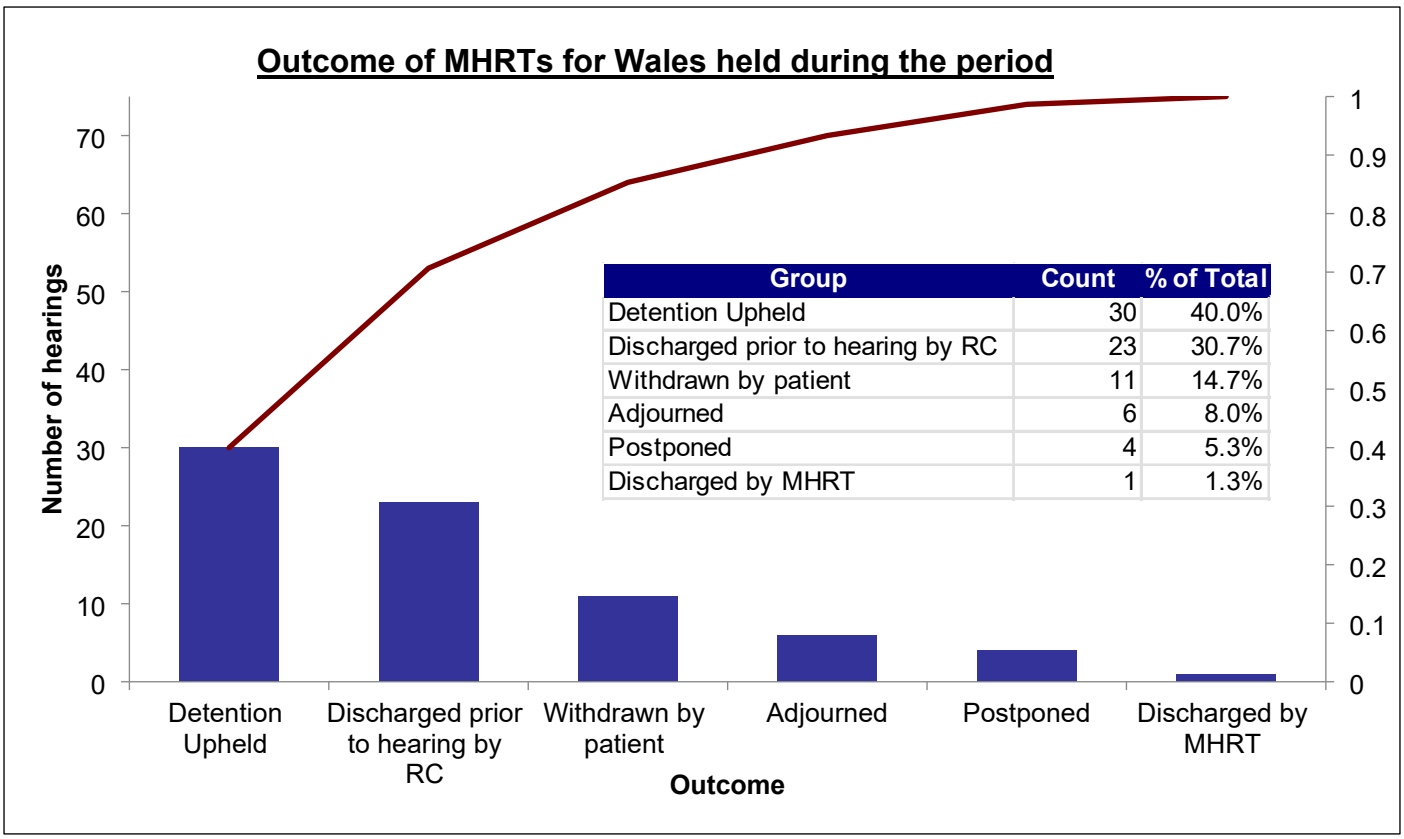
Out of the 52 hearings, only 33 hearings went ahead. Out of that 33, 24 had an advocate present and 9 didn't have an advocate.



Mental Health Review Tribunal (MHRT) for Wales







Group	Count	% of Total
Detention Upheld	30	40.0%
Discharged prior to hearing by RC	23	30.7%
Withdrawn by patient	11	14.7%
Adjourned	6	8.0%
Postponed	4	5.3%
Discharged by MHRT	1	1.3%

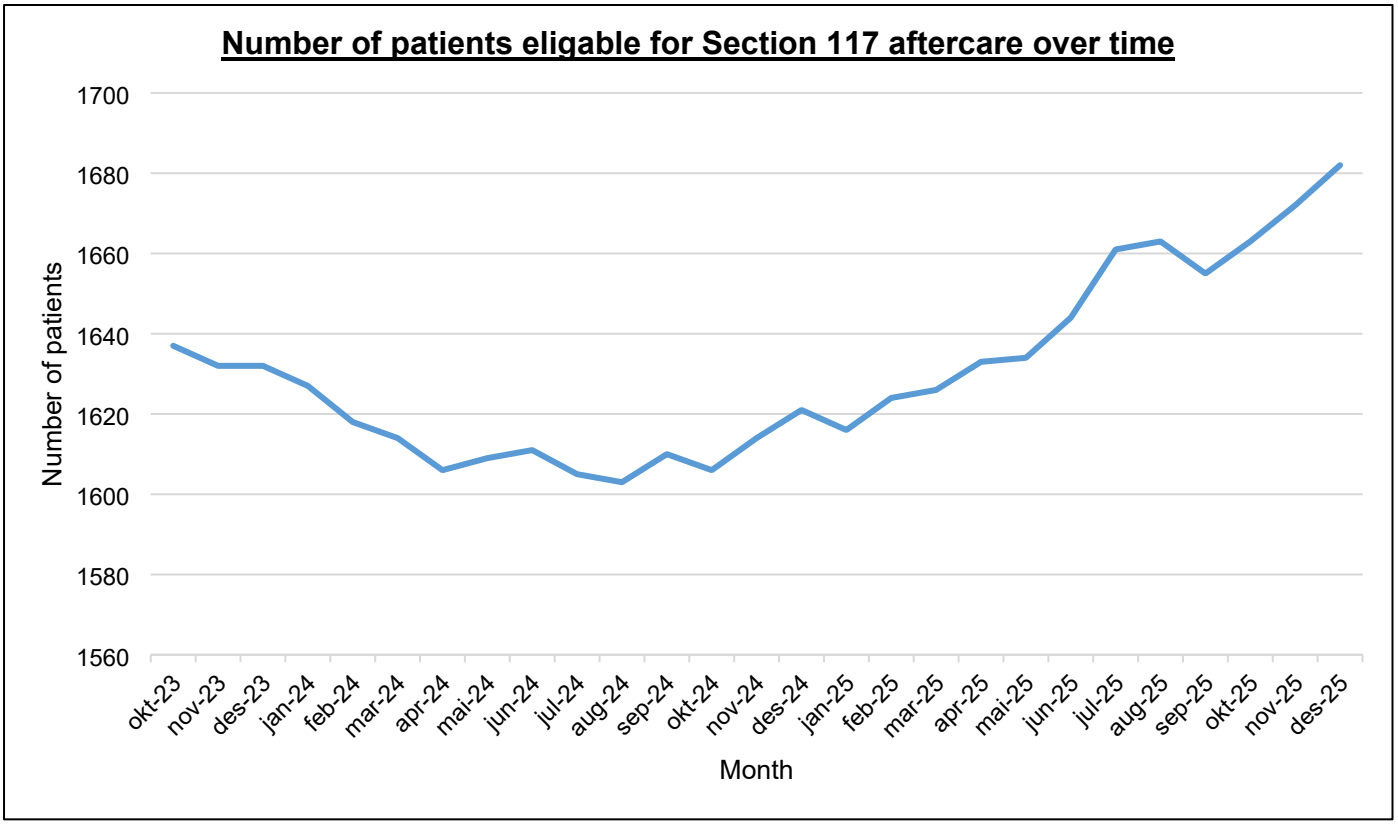
Six hearings were adjourned for the following reasons:

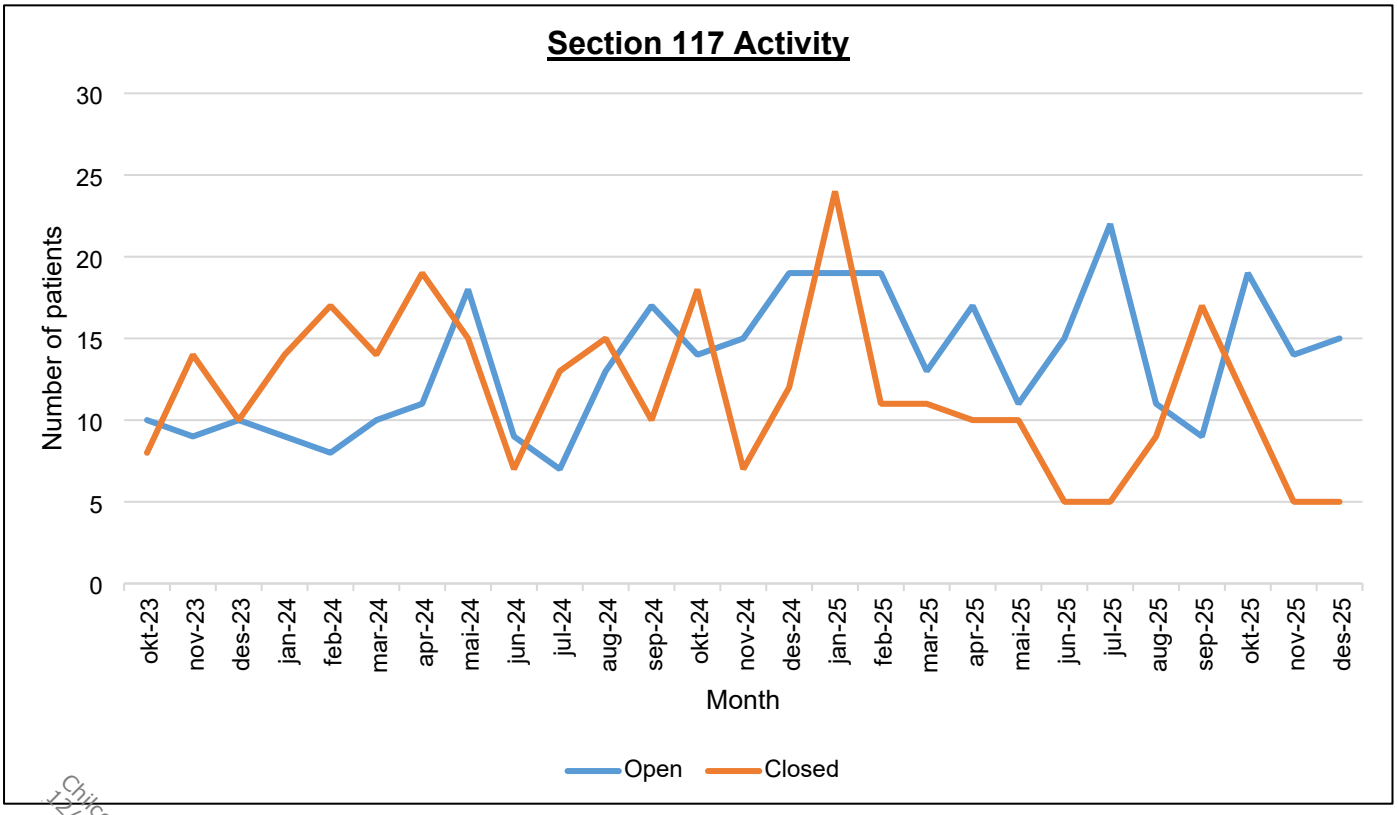
- To allow for discharge planning x 3
- No social worker attended x 1
- No RC attended x 2

Four hearings were postponed for the following reasons:

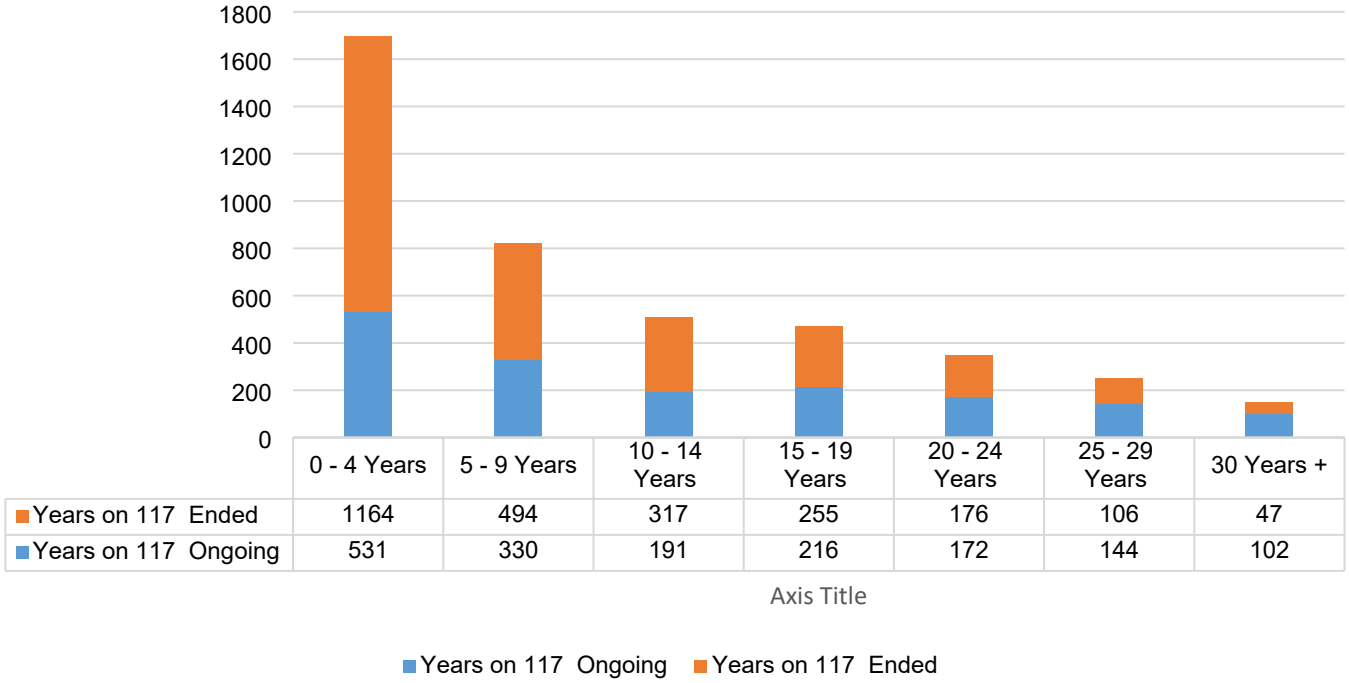
- No solicitor available x 2
- For patient to read reports in good time x 1
- For an afternoon hearing to be arranged x 1

Section 117 Aftercare





Periods of time that patients remain eligible for Section 117 aftercare

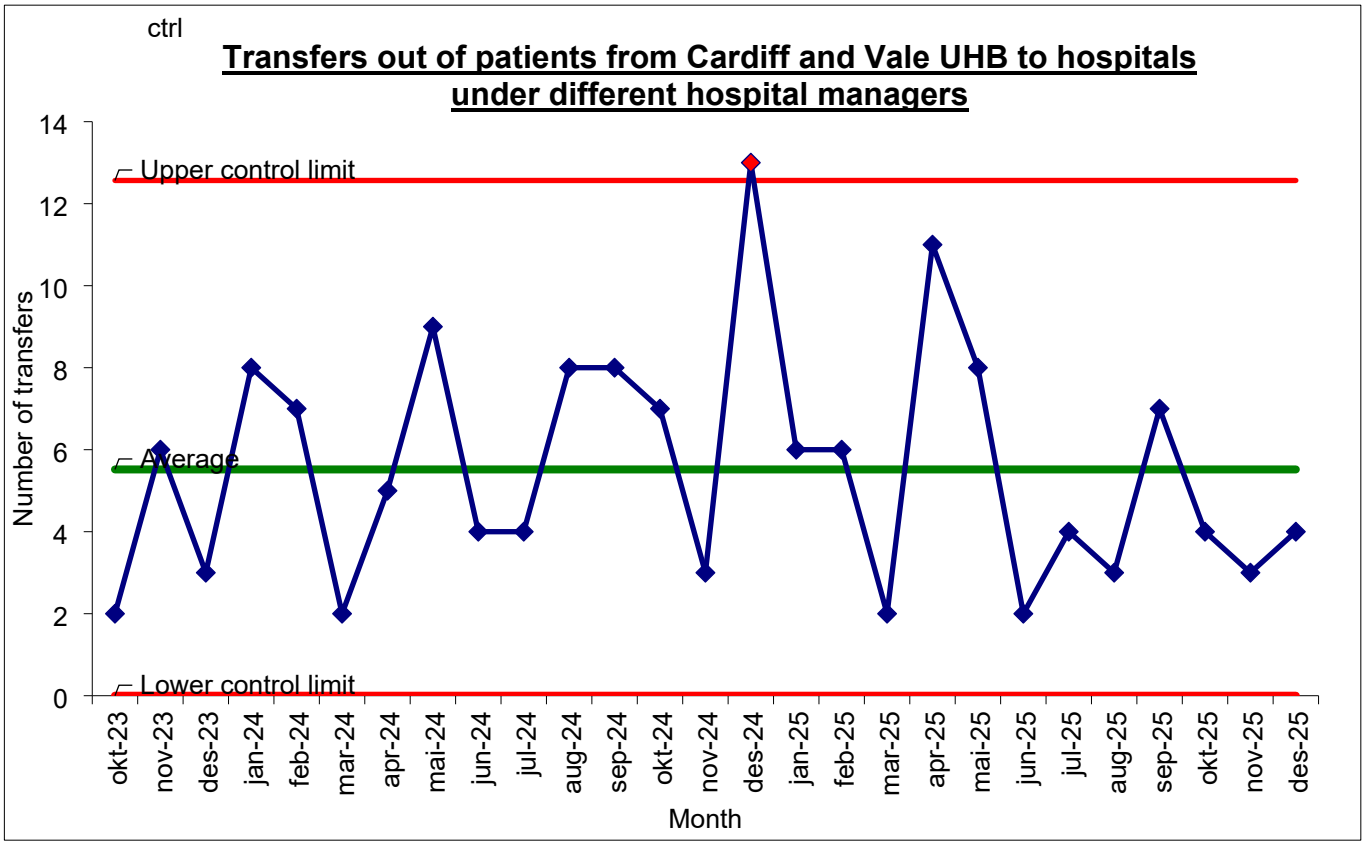


	0 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	20 - 24 Years	25 - 29 Years	30 Years +
Years on 117 Ended	1164	494	317	255	176	106	47
Years on 117 Ongoing	531	330	191	216	172	144	102

Section 19 transfers to and from Cardiff and Vale UHB

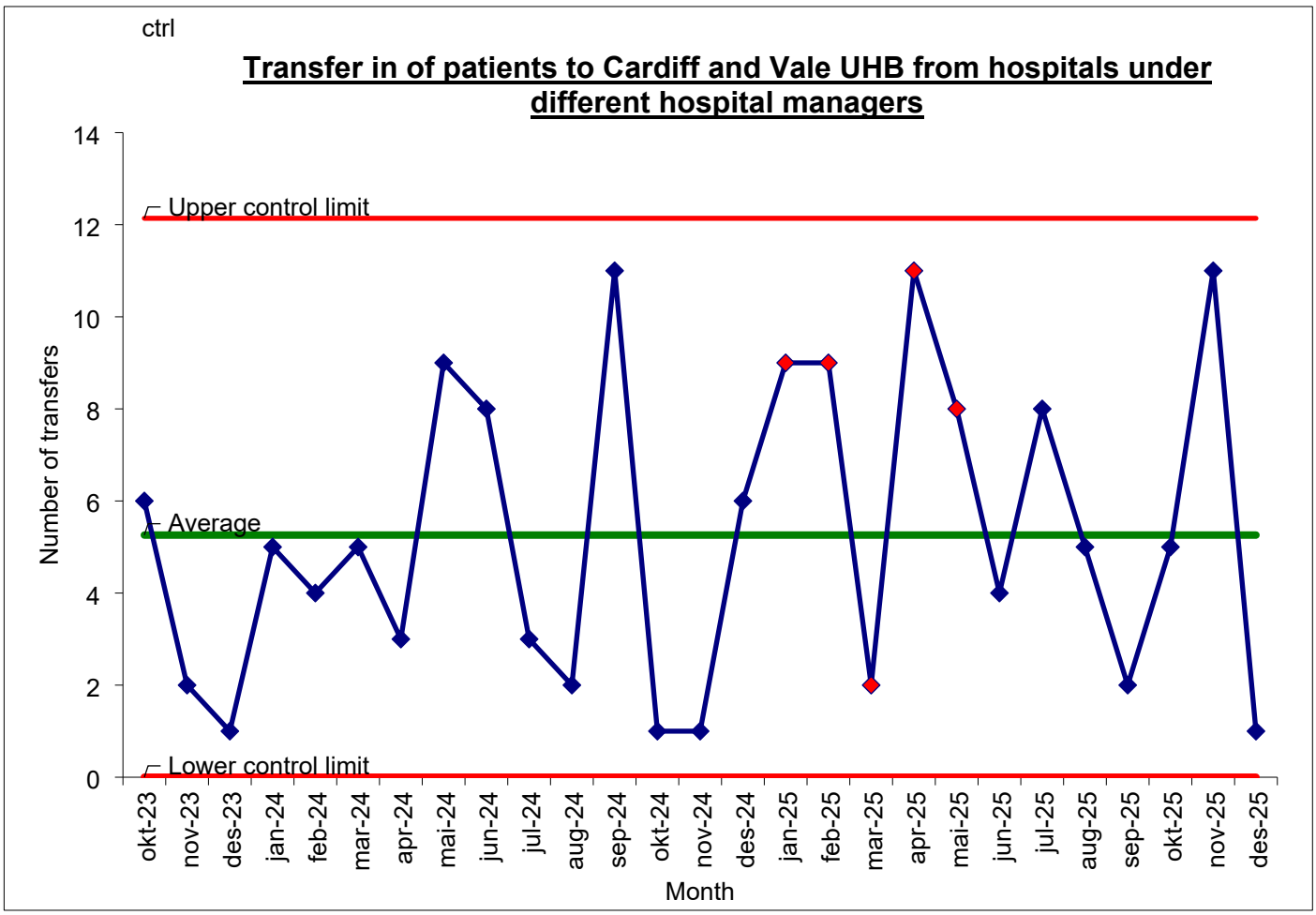
Eleven patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.

No patients detained under Part 3 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.



Sixteen 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

October- December 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 no deaths of a detained patient.

YOUR NEAREST RELATIVE UNDER THE MENTAL HEALTH ACT 1983

(Sections 26-30 of the Mental Health Act 1983)

INTRODUCTION

What is this leaflet about?

This leaflet is about your “nearest relative” under the Mental Health Act.

It is in three parts:

- Part 1 explains the rules about who your nearest relative is;
- Part 2 explains the things that your nearest relative can do under the Mental Health Act (their rights);
- Part 3 explains how the county court can change your nearest relative, or make someone your nearest relative if you don’t have one already.

PART 1 –YOUR NEAREST RELATIVE

What does the Mental Health Act mean by my relatives ?

In the Mental Health Act, the following people are treated as your “relatives”:

- your husband, wife or civil partner;
- a partner who has been living with you as if they were your husband, wife or civil partner for more than six months
- your son or daughter;
- your mother or father;
- your brother or sister;
- your grandmother or grandfather;
- your grandson or granddaughter;
- your aunt or uncle;
- your nephew or niece;
- anyone else you have been living with for at least five years.

If your mother and father were not married when you were born, your father (and his relatives) are only included in this list if he gained parental responsibility for you under the Children Act 1989.

Adoptive relatives are included in the list (for example, your adopted parents or a child you adopted). Step-relatives (for example, your step-parent or step-child) are not included.

Who is my nearest relative ?

Your “nearest relative” is normally the person who comes highest in this list of relatives. For example, if you are married and have a child, your husband or wife is the highest person in the list and your child comes second. But if your only relatives are your mother and a niece, your mother comes highest in the list and your niece comes second.

If there is more than one person in the same position in the list, relatives of the “whole blood” come before those of the “half-blood”. For example, if your nearest relative could be either your full brother or your half-sister, it will normally be your full brother.

Otherwise, if more than one person comes in the same position, the oldest one comes first. For example, if your nearest relative is one of your children, it will normally be your oldest child.

But if you usually live with, or are cared for by, someone in the list of relatives, that person goes to the top of list and will normally be your nearest relative. If you are in hospital, this includes people you lived with, or were cared for by, before you went into hospital. If there is more than one person, the one who was already highest in the list will normally be your nearest relative. For example, if your only relatives are your father and your two sisters, and you live with your two sisters, they go to the top of the list above your father, and the older of your two sisters will normally be your nearest relative.

There are several exceptions to these rules:

- someone who is in the list of relatives only because they have been living with you cannot be your nearest relative if you have a husband, wife or civil partner who could be your nearest relative instead;
- your husband, wife or civil partner cannot be your nearest relative if you are permanently separated, if they have deserted you, or you have deserted them;

- someone who is under 18 cannot be your nearest relative, unless they are your husband, wife or civil partner;

- someone who lives abroad cannot be your nearest relative, unless you also normally live abroad. “Abroad” means outside the United Kingdom, the Isle of Man or the Channel Islands.

In these cases, the next person in line will normally be your nearest relative.

Are there different rules if I am under 18 ?

For most people under 18, the rules are the same. But there are a few exceptions.

If a court has made a care order putting you in the care of a local authority, the local authority will be your nearest relative (unless you have a husband, wife or civil partner could be your nearest relative instead).

If someone is your legal guardian, that person (or all of those people, if there is more than one) will normally be your nearest relative. This does not include a guardian you have because you are on guardianship under the Mental Health Act itself.

If a court has made a residence order saying who you should live with, that person (or all of those people, if there is more than one) will normally be your nearest relative.

Can my nearest relative change?

The rules about who your nearest relative is mean that sometimes your nearest relative might change without you or anyone else doing anything. For example, if you got married, your husband or wife would normally become your nearest relative.

The county court can also change your nearest relative, or make someone your nearest relative if you don’t have one already. This is explained in Part 3 of this leaflet.

PART 2 - YOUR NEAREST RELATIVE’S RIGHTS

The Mental Health Act says that your nearest relative can do various things in connection with your care and treatment. It also says that other people sometimes have to tell your nearest relative things about your care and treatment. These things are called your nearest relative’s “rights”.

The right to ask for you to be detained or put on guardianship

If you have a mental disorder, your nearest relative can ask for you to be detained (kept) in hospital if they think you need to be in hospital, but you do not agree. This is called making an application for you to be detained.

To make an application, your nearest relative must fill out an official form and give it to the hospital. Two doctors must agree that you should be detained (one doctor if it is an emergency).

Your nearest relative can also make an application for you to be put on guardianship, if two doctors agree that you need a guardian to help you. If this happens, you will be told more about what guardianship means.

The right to ask for an approved mental health professional to see you

Normally, it is an approved mental health professional (AMHP) who makes an application for someone to be detained or be put on guardianship. An AMHP is someone who has been specially trained to decide whether people need to be detained or put on guardianship.

Your nearest relative can ask your local social services authority to get an AMHP to think about whether you need to be detained or on guardianship. If the AMHP decides you don't need to be detained or on guardianship, they must tell your nearest relative why in writing.

The right to be told about your detention or guardianship

If an AMHP makes an application for you to be detained for assessment, they must normally do all they can to tell your nearest relative about the application and about your nearest relative's rights. "Assessment" means finding out what is wrong with you and starting to give you any treatment you need for up to 28 days. Your nearest relative cannot stop an AMHP making this kind of application.

If an AMHP is thinking about making an application for you to be detained for treatment (for up to six months at first), they must normally do all they can to ask your nearest relative about it first. An AMHP must also do this if they are thinking about making an application for you to be put on guardianship.

If your nearest relative does not want you to be detained for treatment or put on guardianship, they can stop the AMHP making the application, by telling either the AMHP or the social services authority the AMHP is working for.

But if the AMHP thinks your nearest relative's decision is unreasonable, they can ask the county court to make someone else your nearest relative instead. This is explained in "Can other people change my nearest relative ?" in Part 3 of this leaflet. If you have already been detained for assessment, and the staff think you need to stay in hospital, you may be kept there until the court decides what to do.

The right to be given information

If you are detained, the hospital must explain to you why and what your rights are. The hospital must normally give your nearest relative a copy of what they tell you, unless you ask the hospital not to.

The same applies if you go onto supervised community treatment after you have been detained in hospital. Being on supervised community treatment means that your care team will do their best to help you to stay well after you leave hospital, but you can be told to come back to hospital for the treatment you need, if necessary.

If you are put on guardianship, the social services authority must tell you about your rights. The social services authority must normally give your nearest relative a copy of what they tell you, unless you ask them not to.

If you are detained for treatment for more than six months, your detention will have to be renewed from time to time, if the person in charge of your treatment (your responsible clinician) thinks you need to stay in hospital for longer. The hospital must normally tell your nearest relative if this happens, unless you ask the hospital not to. The same applies if your responsible clinician extends your supervised community treatment, so that you have to stay on supervised community treatment for longer.

If your guardianship is renewed, your social services authority must normally tell your nearest relative, unless you ask them not to.

The right to be told if you are to be discharged

If you have been detained, but are now going to be discharged, the hospital must normally tell your nearest relative, unless you ask the hospital not to. "Discharged" means being allowed to leave hospital. The same applies if you stop being on supervised community treatment. If your nearest relative does not want to be told, they can ask the managers of the hospital not to tell them.

The right to discharge you

If you have been detained because of an application made by your nearest relative or an AMHP, your nearest relative can write to the hospital managers to say that they want you to be discharged.

If your nearest relative does this, the hospital managers must let you leave within 72 hours unless your responsible clinician tells them you might be a danger to yourself or other people if you are discharged.

Your nearest relative may also be able to end your supervised community treatment in the same way.

You will be told more about what your nearest relative can do if you are detained or put on supervised community treatment.

If you are on guardianship, your nearest relative can end your guardianship by writing to your social services authority.

The right to apply to the Tribunal for you to be discharged

Most people who are detained can also ask an independent panel – called a Tribunal - to say they should be discharged. People can also ask the Tribunal to end their supervised community treatment or guardianship.

Normally, your nearest relative will be told if you apply to the Tribunal.

Sometimes, your nearest relative may also be able ask the Tribunal to discharge you. You will be told more about what your nearest relative can do if you are detained or put on supervised community treatment or guardianship.

The right to ask for an independent advocate to see you

Your nearest relative has the right to ask for an independent mental health advocate to see you. However, you do not have to see this advocate if you do not want to.

Can my nearest relative give their rights to someone else?

Your nearest relative can delegate their rights. This means they can say that someone else should do the things which they would normally do as your nearest relative.

If your nearest relative wants to delegate their rights to someone else, they must write to that person saying so. Later on, if your nearest relative wants to take their rights back, they can do that by writing again to the other person.

Your nearest relative must tell you if they have delegated their rights, or taken them back. If you are detained in hospital or on supervised community treatment, they must also write to the managers of your hospital. If you are on guardianship, they must write to your local social services authority (and if your guardian is not a social services authority, they must also write to your guardian).

Your nearest relative can delegate all the rights explained in this leaflet, except for one. If you have been detained in hospital by the courts – or moved from prison to hospital – your nearest relative cannot delegate their right to ask the Tribunal to discharge you.

PART 3 – GETTING A NEW NEAREST RELATIVE

What if I don't have a nearest relative ?

If you do not have a nearest relative – or no-one can work out who your nearest relative is – you can ask the county court to make someone your nearest relative.

Some other people can also ask the court to do this. The other people who can do this are:

- an AMHP;
- anyone in the list of relatives in Part 1 of this leaflet; and
- anyone else who lives with you (or if you are in hospital, lived with you before you went into hospital).

The court can make an order saying who should be your nearest relative. This could be anyone the court thinks is suitable and who agrees to be your nearest relative. It does not have to be someone in the list of relatives in Part 1 of this leaflet.

If you ask the court to make someone your nearest relative, you can tell the court who you think that should be. If someone else asks the court to do it, they can say who they think your nearest relative should be. If that person agrees to be your nearest relative, and the court thinks they are suitable, it will make an order saying they should be your nearest relative. Otherwise,

the court will choose someone else it thinks is suitable and who agrees to be your nearest relative.

Can I change my nearest relative ?

If you don't think your nearest relative is suitable to be your nearest relative, you can ask the county court to change your nearest relative.

You can also ask the court to change your nearest relative if your nearest relative is too ill to do the things the Mental Health Act says a nearest relative can do.

Your nearest relative will probably get a chance to tell the court if they think that they should stay as your nearest relative.

If the court agrees that your nearest relative is not suitable, or is too ill, it will make an order saying that someone else should be your nearest relative.

You can tell the court who you think your new nearest relative should be. If that person agrees to be your nearest relative, and the court thinks they are suitable, it will make an order saying they should be your nearest relative. Otherwise, the court will choose someone else it thinks is suitable and who agrees to be your nearest relative.

The new person could be anyone who the court thinks is suitable and who agrees to be your nearest relative. It does not have to be someone in the list of relatives in Part 1 of the leaflet.

Can other people change my nearest relative ?

Some other people can also ask the county court to change your nearest relative. The other people who can do this are:

- an AMHP;
- anyone in the list of relatives in Part 1 of this leaflet; and
- anyone else who lives with you (or if you are in hospital, lived with you before you went into hospital).

Like you, they can ask the court to do this if they think your nearest relative is not suitable or is too ill to be your nearest relative.

They can also ask the court to change your nearest relative if:

- your nearest relative refuses to allow you to be detained or be put on guardianship and they think your nearest relative is being unreasonable; or
- they think your nearest relative has used their right to discharge you – or is likely to use it – without properly thinking about the effect on you or other people.

(You can also do this yourself, but normally an AMHP or someone else would do it.)

How do I ask the county court to make someone my nearest relative?

If you want the county court to say who your nearest relative should be, you have to fill in a form called an “application”. You may also have to pay a fee. It is probably best to ask a solicitor to help you with this. The solicitor will be able to tell you if you can get help free of charge under the Legal Aid scheme.

What happens if the court makes someone my nearest relative?

If the court makes an order changing your nearest relative because it thinks your nearest relative:

- has objected unreasonably to you being detained or going onto guardianship; or
- has used their right to discharged you – or is likely to use it – without properly thinking about the effect on you or other people

the new person will only be your nearest relative for as long as you are detained in hospital, or are on supervised community treatment or guardianship. If you have not been detained in hospital or put on supervised community treatment or guardianship, the new person will only be your nearest relative for three months. After that, the rules in Part 1 of this leaflet about who your nearest relative is will apply again. Normally that means your old nearest relative will become your nearest relative again.

In other cases, if the court makes an order saying who your nearest relative should be, it might decide to say how long they should stay your nearest relative. Once that time is up, the rules in Part 1 of this leaflet will apply again.

Otherwise, once the court has made an order saying who your nearest relative should be, only the court will be able to change your nearest relative

(even if your new nearest relative dies or does not want to be your nearest relative anymore).

Can my nearest relative be changed again?

The court can vary (change) its order, to say that someone else should be your new nearest relative instead.

You can ask the court to do this. So can:

- an AMHP;
- the person the court said should be your nearest relative; and
- (if that person has died) anyone in the list at the start of this leaflet.

The court can also discharge (end) its order. You can ask the court to do this. So can:

- the person who used to be your nearest relative;
- anyone else who would now be your nearest relative if the rules in Part 1 of this leaflet applied;
- the person the court said should be your nearest relative; and
- (if that person has died) anyone in the list at the start of this leaflet.

If the court ends the order, the rules in Part 1 of this leaflet about who your nearest relative is will apply again.

To ask the county court to change or end its order, you will have to make an application and you may need to pay a fee. It is probably best to ask a solicitor to help you with this. The solicitor will be able to tell you if you can get help free of charge under the Legal Aid scheme.

Further help and information

Please ask the person who gave you this leaflet or another member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Please ask if you would like another copy of this leaflet for someone else.

mind cymru
for better mental health
o blaid gwell iechyd meddwl

Llywodraeth Cymru
Welsh Government

Role of the Nearest Relative

October 2016

 WG 29874 Digital ISBN 978-1-4734-7660-8

Introduction

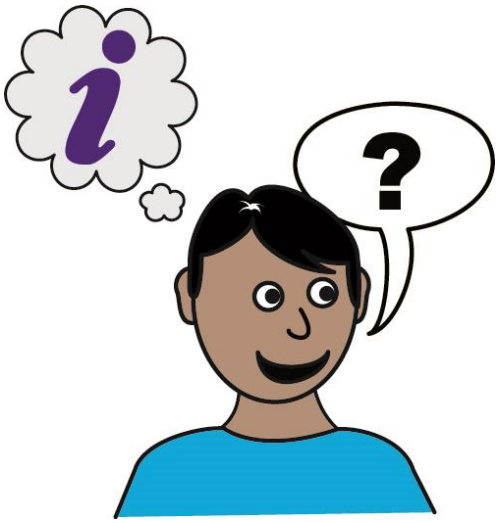
This guide gives information on what it means to be a patient's nearest relative. When someone is detained in hospital under certain sections of the Mental Health Act, one member of their family – their 'nearest relative' – has special rights and responsibilities.

This is an important safeguard for people who are affected by the Mental Health Act.

What are my rights as nearest relative?

You have a really important role to play in making sure your relative's voice is heard, and their rights are protected, if they are detained in hospital under the Mental Health Act. You have a number of powers and rights that nobody else has.

Right to information



You have the right to be told certain information about your relative, including:

- why your relative has been detained in hospital
- your relative's rights while in hospital
- if your relative's section is renewed or changed
- if your relative is going to be discharged.

You must also be given copies of any written information that is given to your relative. However, your relative has the right to request that information about their care and treatment is not shared with you. They can also object to you being given copies of any written information they receive.

Right to discharge

You have the right to discharge your relative from hospital. To do this, you first need to inform the hospital managers in writing. You then need to wait 72 hours before discharging your relative, as the **responsible clinician** has the right to stop you if they think your relative could be a danger to themselves or others.

You may have the right to apply to the Mental Health Review Tribunal for Wales if your application to discharge your relative is refused by the hospital managers.

Hospital managers

This is an independent team of people in a hospital who make sure that the requirements of the Mental Health Act are properly applied. They have certain important responsibilities and can make decisions about your relative's detention – for example, they hear applications for discharge and decide whether or not to approve discharge of your relative.

Responsible clinician

This is the approved clinician in charge of your relative's care and treatment while in hospital. They do not have to be a doctor, but will be the most appropriate person to help your relative.

Right to ask an IMHA to contact your relative

You have the right to ask for an independent mental health advocate (IMHA) to see your relative, but it will be up to your relative whether they accept support from them (see Who can help my relative speak up when I am not there?).

Right to delegate

If you do not want to be the nearest relative, you can give your powers to someone else, as long as that person agrees. You also need to write to the hospital managers to let them know.

How will hospital help my relative?

Being in hospital should help your relative get the support and treatment they need to recover and feel well enough to go home.

Assessment

The professionals working with your relative will assess what type of mental health problem they are experiencing and what treatment they may need to help them.

This can involve answering some questions and talking to staff about the way your relative has been feeling and what has been happening in their life. Sometimes this can seem strange and confusing, but they will be asking your relative questions to try and find the best way to help them. They might also be offered treatment while they are being assessed.

Treatment

Different people need different treatments, even when they seem to experience similar mental health problems.

Your relative can only be treated for their mental disorder under the Mental Health Act if appropriate medical treatment is available. This means it must be suitable for them as an individual and it must also be actually available at the time. It should also be the best, evidenced based, option available. Your relative may be offered a choice between treatments.

Treatment might include nursing care, medication, talking to doctors or psychologists, taking part in activities that can help your relative feel better or learning new skills.

It can also involve treating their physical health if it is part of, or supports, treatment for their mental health problem, such as for self-harm injuries.

Consent

Your relative must always be asked whether they agree (consent) to proposed treatment while in hospital.

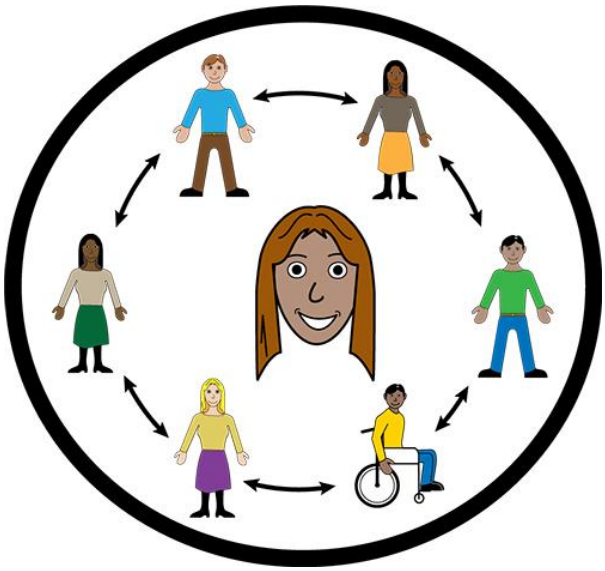
In order to consent, your relative must have been given enough information about:

- the proposed treatment
- what it will achieve
- possible side effects
- what will happen if they are not given the treatment and
- any alternatives.

However, it is important to be aware that the Mental Health Act allows a person to be treated without consent if they are detained. This can only happen if the treatment is for their mental health problem **and** it is prescribed by the approved clinician in charge of the treatment. This will usually be the responsible clinician.

There are special rules in relation to medication, electroconvulsive therapy (ECT) and neurosurgery, and special rules that apply when a person lacks capacity to consent to treatment. Your relative can ask an IMHA or their care team for more information about these.

How will my relative be involved in decisions about their care and treatment?



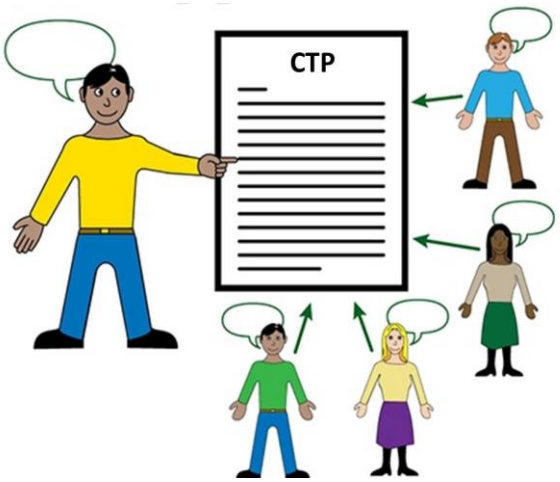
Your relative is at the centre of their care and treatment and should be given all the relevant information to make informed decisions about their treatment options. There are a number of people who are responsible for making different decisions about your relative's care and treatment.

Care co-ordinator

A care co-ordinator must be appointed as soon as possible following your relative's admission to hospital. If your relative was receiving support from secondary mental health services before they were admitted, they will already have a care co-ordinator.

A care co-ordinator may be a:

- social worker
- nurse
- occupational therapist
- psychologist
- doctor
- dietician
- physiotherapist
- speech and language therapist



While your relative is in hospital their care co-ordinator will work with them (and, if they wish, their family and friends) to draw up a care and treatment plan (CTP). This will be designed to meet their individual needs and the outcomes they would like to achieve.

A CTP will cover one or more of the following:

- finance and money
- accommodation
- personal care and physical wellbeing
- education and training
- work and occupation
- parenting, or caring relationships
- medical and other forms of treatment
- social, cultural or spiritual needs

A CTP should record the services to be provided and the action needed to achieve each of the outcomes your relative has agreed. This will include when treatment or services will be provided and by whom.

Their care co-ordinator will be responsible for overseeing the co-ordination of your relative's care and treatment and for reviewing the plan. If your relative already has a CTP, it should be reviewed within 72 hours of their admission and updated as needed.

A step-by-step guide to care and treatment planning can be found here:
http://www.hafal.org/pdf/Care_and_Treatment_Planning_1.pdf

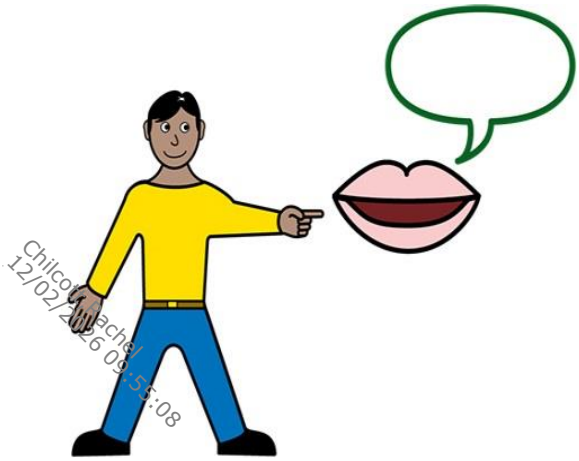
How will I be involved in decisions about my relative's care and treatment?

You should be involved in discussions about your relative's care and treatment and the drawing up of their care and treatment plan, unless your relative objects.

Who can help your relative speak up about what they want?

While in hospital, your relative is entitled to help and support from an independent mental health advocate (IMHA).

They must be told about the support an IMHA can provide when first admitted to hospital. A member of the ward staff, your relative's responsible clinician or an approved mental health professional (AMHP) can give your relative information about getting an IMHA.



An IMHA is there to support your relative and no one else. They can help your relative express their views about their care and treatment, and make sure your relative's voice is heard.

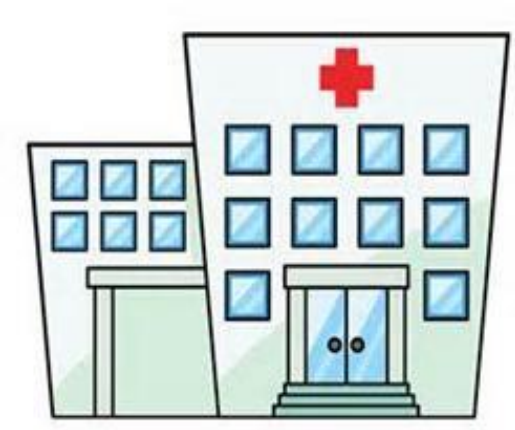
Their role is to help your relative understand any medical treatment they are given or might be given, as well as the reasons and legal basis for it.

Your relative should have access to a phone which they can use to contact and talk to an IMHA in private.

IMHAs are there to help your relative understand:

- their rights under the Mental Health Act
- the rights other people (such as you) have
- the parts of the Mental Health Act which apply to them
- any conditions or restrictions during their stay (for example, about leave of absence from hospital)
- any medical treatment they are receiving or might be given, including:
  - the reasons for that treatment or proposed treatment
  - the legal basis for providing that treatment
  - the safeguards and other requirements of the Mental Health Act which apply to that treatment.

How long will my relative have to stay in hospital?



The length of time your relative can be kept in hospital depends on which section of the Mental Health Act they are detained under. Your relative will be given written information about how long they can be detained when they are admitted to hospital.

How does my relative get discharged from hospital?

There are several ways of getting discharged once a person has been detained under the Mental Health Act.

Your relative can ask the hospital managers to consider discharging them.

Your relative can request a meeting with them and ask to be discharged.

Your relative can ask their responsible clinician to discharge them.

Their responsible clinician must do this if the legal reasons for detaining your relative no longer apply. This could be because their mental health has improved so that they no longer need to be kept in hospital for assessment or treatment.

Your relative can apply to the Mental Health Review Tribunal for Wales to be discharged

The Tribunal cannot look at the reasons why your relative was detained in the first place – it will only look at how they are now and whether they should still be under section or discharged.

Your relative will be able to get free advice and representation from a solicitor to help them with their application and during the hearing.

It does not matter what money they have coming in, what savings they have or whether they own their home.

> They can apply to the Tribunal each time they are put on a section or their section is renewed.

You should be told 7 days before your relative is due to be discharged from hospital, unless your relative does not want you to be told.

What are my rights if my relative is discharged from hospital onto a community treatment order or guardianship order?

If your relative is discharged to receive care and treatment in the community under a community treatment order (CTO) or a guardianship order, you continue to have a role to play as their nearest relative.

You have similar rights to information and to discharge your relative as you do when your relative is detained in hospital.

Community treatment order

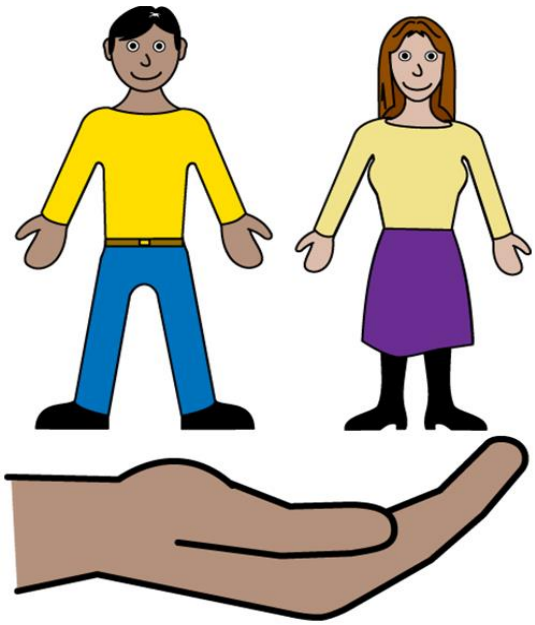
This is where someone is treated in the community for their mental health problem instead of staying in hospital, but they must follow certain conditions and their responsible clinician can return them to hospital and give them immediate treatment if necessary.

Guardianship

This is where someone called a 'guardian' is appointed to help someone live as independently as possible in the community, instead of being detained in hospital. Someone would be placed under guardianship if their mental health problem meant that it would be difficult for them to avoid danger or people taking advantage of them. The guardian has the power to make certain decisions about the person subject to the guardianship order and to make conditions that they will be asked to keep to.

How will the hospital keep my relative safe?

Feeling safe is really important in helping your relative to get well, so the hospital should have anti-bullying and safeguarding policies to protect your relative from any potential physical or verbal abuse.



When your relative is admitted to hospital, staff should carry out a risk assessment. This is done to help keep your relative and others as safe as possible.

Your relative should be asked about any risks they feel they may pose to their own safety or the safety of others, and agree with staff how best to manage these risks. This information should be included in your relative's care and treatment plan.

If your relative behaves in a way that puts their or others' safety at risk, the hospital may use a range of measures to keep them safe. In limited situations, these may include observation, rapid tranquilisation, seclusion or restraint.

Observation

Increased levels of observation may be used if your relative is at risk of self-harm or suicide, such as:

- staff checking on your relative, sitting with and talking to them at regular intervals
- your relative being kept within sight of a staff member at all times
- in the most extreme circumstances, your relative remaining within arm's length of a staff member.

If observation is used, your relative should be told why, its purpose, how long it is likely to last, and what needs to happen for it to be stopped. It should only be used after other less intrusive options have not worked.

Rapid tranquilisation

This refers to the use of medication to calm or lightly sedate a person to reduce the risk of them harming themselves or others. It may include oral medication or injections. Medication should only be used in this way when other therapeutic interventions have not worked to contain your relative's behaviour, and not as a substitute for adequate staffing.

Seclusion

This involves being taken to a room away from other patients. The room may or may not be locked. If your relative is in a hospital or unit that uses seclusion, there should be a designated seclusion room that:

- is private from other patients, but allows staff to observe and communicate with your relative at all times
- is safe and secure, and does not contain anything that could cause harm to your relative
- is quiet, but not soundproofed
- is well insulated and ventilated
- has access to toilet and washing facilities.

Seclusion should only be used as a last resort and for the shortest time possible.

Restraint

This involves health professionals preventing a person from hurting themselves or another person and could include holding them.

It should not cause pain, and must only be used in an emergency and as a last resort.

The hospital should have policies on the use of observation, seclusion, rapid tranquilisation and restraint. They must never be used as a form of punishment for not following the rules.

Will I be told when restrictions have been used?

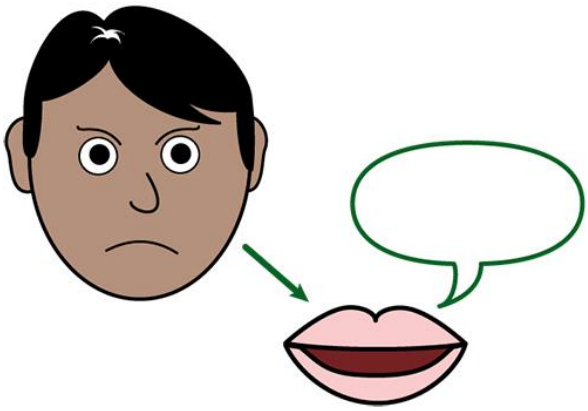
Normally yes, unless your relative has asked that you are not told.

What can I do if I feel my relative is not safe?

You should talk to hospital staff if you are worried about your relative's safety. You can also ask an IMHA to talk to your relative.

Giving feedback

Complaint



There are a number of things you can do if you are not satisfied with how your relative has been treated in hospital. The best course of action for you will depend on what exactly has happened.

Often a problem can be sorted out by speaking informally with the person involved.

If the problem cannot be resolved informally, you can raise a concern with the health board, which must have a written policy that explains how they deal with concerns
.
Your relative's IMHA can also help them raise a concern or, if they no longer have an IMHA, they can ask their local Community Health Council to help. For more information see www.wales.nhs.uk/ourservices/directory/communityhealthcouncils/

A concern should be reported within 12 months of the incident, though it may still be investigated if it is raised after 12 months, if there was a good reason for the delay.

If you're not happy with the health board's response, you can make a complaint to the Public Service Ombudsman for Wales. See www.ombudsman-wales.org.uk/

If your complaint is about the way your relative was treated by a particular nurse, doctor or other professional, you can make a complaint to their regulatory body.

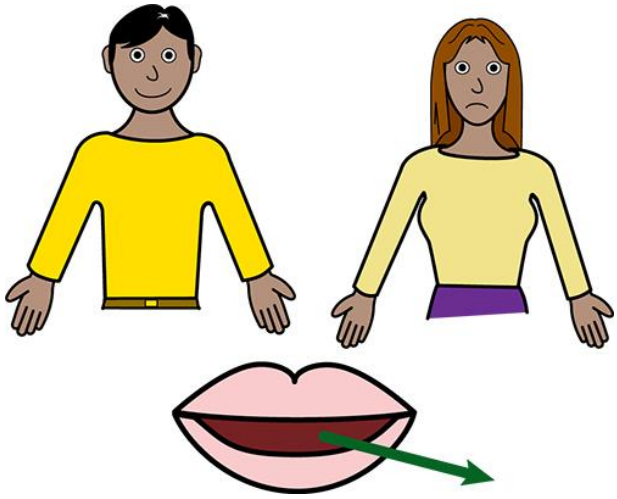
Doctors, including psychiatrists: the General Medical Council www.gmc-uk.org/

Nurses: the Nursing and Midwifery Council www.nmc.org.uk/

Occupational or speech and language therapists, psychologists, dieticians and physiotherapists: the Health and Care Professions Council www.hcpc-uk.co.uk/

Social workers: the Care Council for Wales www.ccwales.org.uk/

Comment

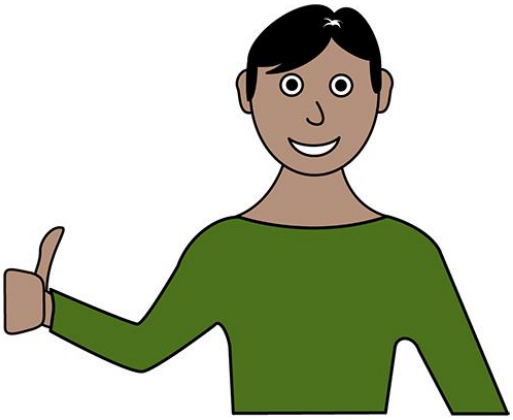


If you do not want to formally raise a concern or complaint, but you want someone official to know your relative had a bad experience in hospital, you can tell Healthcare Inspectorate Wales (HIW). HIW monitors and inspects all health services in Wales.

Although they do not investigate individual complaints, HIW want to hear about experiences of poor care, as this helps them make informed decisions about when, where and what services they inspect.

If you think the Mental Health Act has not been used properly, you can contact the Mental Health Review Service. This service is run by HIW and is responsible for checking people are lawfully detained and well cared for under the Act. Go to hiw.org.uk for more information.

Compliment



You can also give positive feedback about your relative's care and treatment to their care team, IMHA, Community Health Council or HIW at any time.

Complaints and compliments are both helpful for services.

With special thanks to Simon Meadowcroft from Betsi Cadwaladr University Health Board and other members of the Accessible Information Advisory group.

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

Mental Health Act Department
Cardiff and Vale University Local Health Board
Hafan Y Coed
University Hospital Llandough
Penlan Road
Penarth
CF64 2XX

Dear

WE VALUE YOUR FEEDBACK……

Further to your recent request to discharge your relative from detention under the Mental Health Act, it would be helpful if you could complete the below questionnaire and return it to the Mental Health Act Manager by one of the following methods: We really appreciate you taking the time to complete this form.

- Hand to a member of staff
- Post to us at the address above
- Email: Mentalhealthact.Team.CAV@wales.nhs.uk

Patient name:

1. How did you know you could apply for you relative's discharge?

2. Before you made this decision, did you discuss this with your relative's doctor or a member of the care team in advance?

"This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg"

3. What was the reason for your decision?

4. Is there anything you think may be helpful to share with us?

Your feedback will be used to contribute to continuous improvement within the service provided by the Mental Health Clinical Board on behalf of Cardiff and Vale University Local Health Board.

"This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg"

Shaping Our Future
Wellbeing

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Cardiff and Vale University Health Board

Thirty Six Degrees Update

Mental Health Clinical Board

What we heard - summary

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

Siloed Working: persistent silos within teams and services	**Need:** demand and expectations growing faster than resources	**Positive change:** strong commitment and innovation across	**Commissioning:** not matching demand areas, changing need
There are examples of limited collaboration, bottlenecks in the flow of information and teams feeling like they are not part of the wider clinical board. Role clarity is important at every level including within the MDT – with examples observed of staff meeting each other in person for the first time during this engagement.	A strong case for further investment in and innovation within mental health services, with a view that investment has not kept up with inflation and increased demand and expectations of services. A comprehensive population health model is needed to inform investment decisions including for crisis and community alternatives.	We experienced an almost universal commitment to staff participating in and driving positive change – however, people feel over-burdened, lacking the tools, data and permission to make change happen on the ground. A clear direction of travel with distributed leadership is likely to make a difference.	The current commissioning architecture requires review to explore how the wider system can be streamlined for wider public benefit, with opportunities to create consistent service offerings which at the same time reduce inefficiencies, enhance quality and promote partnerships.
➜ *Clarity of service boundaries but person and outcomes focused*	➜ *Status quo & burn-out is not an option, innovation required*	➜ *Will, ideas and delivery to drive positive change*	➜*ADHD, medium secure*

What we heard - summary

Communication: inconsistent and complex; limits proactive planning	**Autonomy:** skilled staff feel unable to own and influence decisions	**Shape of services:** fragmentation and inconsistency	**Partnership:** appetite for joint working, but structures don't enable it
An urgent area for the clinical board to address – as an enabler for greater cohesion as well as supporting day-to-day service delivery. Effective communication has the potential to result in a more engaged, inclusive and motivated culture.	Instances of staff feeling disempowered and not using their skills and expertise to their full potential. Impact on staff health and wellbeing and patient outcomes. Examples of hidden talent – which can be unlocked to support innovation and improvement.	Services are experienced as fragmented and inconsistent across sites, creating gaps, duplication and avoidable delays. Staff want clearer, more coherent models of care that enable smoother pathways and more reliable delivery.	Significant support from system partners who have a wealth of experience and ideas to work in a more integrated way without need of additional investment. Opportunities to strengthen joint working in the UHB and all partners will enable delivery of the Welsh strategy and need to be codeveloped and owned by
➜ *More direct, open, respectful and action-focused*	➜ *Governance focused on impact and accountability*	➜ *Clear articulation of models of care to meet population need*	➜ *Re-focus to system, community and neighbourhood*

Cross cutting workstreams

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

1. Safety

Creating consistently safe, therapeutic and rights-based environments across inpatient, community and crisis services, supported by reliable staffing, clear clinical standards and timely estates responses.

2. Governance

Building a governance system that enables timely, transparent and consistent decision-making, with clear accountability and a collective sense of ownership.

3. Culture

Creating a compassionate, trauma-informed and psychologically safe culture where staff feel heard, respected and supported to raise concerns and contribute to improvement.

4. Data

Developing a modern, integrated data infrastructure that supports safety, flow, quality, workforce planning and strategic decision-making.

5. Leadership

Ensuring clinical teams have clear roles, autonomy and authority to lead service delivery and improvement within a consistent organisational framework.

6. Clinical Operating Model

Designing a unified, consistent and locally grounded model of care that clarifies pathways, interfaces, standards and expectations across the system.

Operations workstreams

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

7. Acute Flow & OOA

Acute inpatient care, bed flow, demand and capacity management, alternatives to admission, and reduction of out-of-area (OOA) placements.

8. Primary MH Services

Access, assessment, triage and therapeutic support for people with mild to moderate mental health needs.

9. Discharge & Social Care Interface

Discharge planning, social care coordination, section 117 processes, and transitions from hospitals to community settings.

10. Strengthening CMHTs

The operational structure, caseload management, triage, coordination, and clinical functions of CMHTs.

11. Specialist Pathways Stablisation

Specialist clinical services such as eating disorders, perinatal mental health, liaison psychiatry, veterans' mental health and therapies

12. ADHD / ASD Demand & Waits

Neurodevelopmental services including ADHD and ASD assessment, diagnosis, treatment, and support.

Model of Care

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Cardiff and Vale University Health Board

1. Goals and values

- Health gains for patients through practice values
  - Legal and human rights
  - Safe therapeutic environments
  - Prioritise treatment
  - Evaluate health gains.

2. Pathways and Practices

- Accessibility solutions and triage
  - Life cycle pathways
  - Tier / stepped care
- Practice based models, continuity of care
- Active management of case load and length of stay

3. Processes / grip

- Single point of access
- Trage criteria
- Active management of case load
- Stepdown processes

4. Treatments

- Physical health
- Mental health
- Psychological and behavioural
- Self care and ADL
- Education, occupation, creativity
- Family and relationships
- Cultural
- Co-production

5. Evaluation

- Four recoveries – symptomatic, functional, civil and personal
- Logic model
- KPIs at service and population level – service strain?.

6. Practice Excellence

- Diffused clinical leadership – informal authority, formal responsibility.
- Professional values – courtesy, boundaries,
- Sustainability – teaching, training, recruit, retain
- Inter-professional boundaries and courtesies

Cross cutting theme delivery

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Cardiff and Vale University Health Board

1. Safety

- Ensure patient safety across all care settings, minimising risks and incidents.
- Reduce the frequency and severity of safety incidents in both inpatient wards and community services.
- Create and maintain therapeutic environments that support patient recovery and well-being.

2. Governance

- Establish a robust governance system that is clear, accountable, and responsive.
- Accelerate decision-making processes and reduce delays in risk escalation.
- Goal is to improve oversight and progress tracking for all improvement programmes.

3. Culture

- Foster a culture where psychological safety, respect, and continuous learning are core values.
- Reduce instances of bullying and incivility and ensure concerns are addressed promptly.
- Encourage open communication where staff feel safe to speak up and contribute to improvement

4. Data

- Provide timely, reliable, and accessible data that supports operational decision-making and governance.
- Reduce reliance on manual reporting enhance data-driven improvement.
- Build data literacy across clinical teams for continuous improvement.
- Align financial and clinical data to maximise value, use of resources and reduce unwarranted variation.

5. Leadership

- Empower multidisciplinary teams by clarifying decision rights and enhancing leadership visibility.
- Embed clinicians fully in operational planning, flow management, and governance.
- Strengthen team identity and ensure professional skills are optimally utilised.

6. Clinical Operating Model

- Create a unified and co-produced clinical operating model that standardizes care pathways and improves coordination.
- Reduce duplication and improve the consistency of service delivery across all sites.
- Clarify referral thresholds, escalation routes and care coordination responsibilities.

Operational improvement delivery

7. Acute Flow & OOA

- Restore safe and predictable patient flow across acute services.
- Reduce the need for OOA placements through improved capacity, discharge planning and alternatives to admission.
- Improve MDT decision-making, reduce variation and ensure consistent processes across all wards and crisis services.

8. Primary MH Services

- Improve access, responsiveness, and clarity within primary mental health services.
- Reduce waiting times for assessment and therapeutic interventions.
- Streamline triage and referral pathways to reduce duplication and improve service user experience

9. Discharge & Social Care Interface

- Reduce delayed transfers of care and improve the coordination between health and social care.
- Create predictable, efficient discharge processes that support safe transition

10. Strengthening CMHTs

- Standardise the operating model for Community Mental Health Teams and improve their responsiveness.
- Manage caseloads effectively and clarify referral criteria to ensure safe and effective care.
- Enhance the MDT skill mix and expand community-based interventions.

11. Specialist Pathways Stablisation

- Stabilize specialist mental health pathways facing demand pressures and workforce constraints.
- Improve access, safety and integration of specialist services with wider care pathways.
- Enhance the capability and confidence of specialist MDTs.

12. ADHD / ASD Demand & Waits

- Reduce waiting times and improve the quality of neurodevelopmental services for ADHD and ASD.
- Manage increasing demand effectively and streamline pathways.
- Improve coordination between neurodevelopmental services, CMHTs, and primary mental health services

Operational improvement priorities

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Cardiff and Vale University Health Board

7. Acute Flow & OOA

Primary drivers

- **Reliable and Safe Acute Flow:** A consistent, predictable approach to admission, assessment, leave, discharge and escalation, supported by real-time operational visibility.
- **Reduced Reliance on Out-of-Area Placements:** Increased local capacity, improved discharge planning, strengthened community pathways and proactive repatriation.
- **Effective MDT Decision-Making:** Clear roles, consistent processes and accessible data enabling timely assessment, flow and risk management.
- **Stronger Interface with Crisis, Community and Social Care:** Coordinated handovers, shared planning, and aligned capacity across the whole pathway to reduce avoidable delays.

Prioritised interventions

- Introduce estimated discharge dates (EDD) for all patients within 72 hours of admission.
- Introduce daily multidisciplinary flow huddles supported by real-time dashboards, identify patients who are clinically ready for discharge and needs best met in the community.
- Implement criteria-led discharge.
- Strengthen crisis and home treatment teams to increase alternatives to admission.

10. Strengthening CMHTs

Primary drivers

- **Consistent Operating Model:** Consistent CMHT operating model will be developed and implemented across localities with localisation.
- **Daily Triage and Urgent Response:** Daily triage and guaranteed urgent response within agreed set time period.
- **Caseload Management:** Weekly allocation and waiting-list huddles introduced alongside caseload reviews.
- **Interface Clarity:** The interface between CMHTs, primary mental health, and specialist pathways clarified.
- **Strengthened MDT Roles:** Across all disciplines.
- **Standardised Care Planning:** Care and Treatment Planning (CTP) processes will be standardised and reviewed regularly.
- **Expanded Community Interventions:** Community-based group and brief interventions will be expanded to increase capacity – link to open access requirements

Prioritised interventions

- Develop a consistent CMHT operating model across all localities and with localisation where appropriate
- Introduce daily triage with RAG rating and urgent response within 24-48 hours.
- Implement fully weekly allocation and waiting list huddles together with caseload reviews
- Set caseload caps with regular structured caseload review.

Report Title:	Section 12 Challenges				Agenda Item No:	3.4
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	27.01.2026
			Private			
Status	Assurance	X	Approval		Information/Noting	
Lead Executive:	Executive Nurse Director					
Report Author:	Julian Willet					

Main Report
Background and Current Situation:

Situation

This is a situation of concern that began some years ago but there are increasing reports, predominantly from Approved Mental Health Professional (AMHPs), regarding difficulty accessing Section 12 Doctors, across all hours of service but principally during out of hours, for the purposes of carrying out Mental Health Act (MHA) assessments. This is ultimately causing unacceptable delays in the process of assessing vulnerable young people and adults. It can also create inefficiencies for day services when out-of-hours work seeps into in-hours work.

Background

MHA assessments can be carried out pretty much anywhere but in the main they occur in Mental Health units, such as Hafan y Coed's Emergency Assessment Clinic (EAC), Emergency Departments, Police cells, and in the community, including somebody's home, so potentially a cross section of people are involved in and affected by a MHA assessment.

When a MHA assessment is applied for it is the Duty AMHP who effectively sets up the assessment, part of which is arranging for the S.12 Doctor to attend and assess. In C&V the AMHP selects from a list of some fifty Doctors who are in our 'pool' of S.12 Doctors. Sometimes it is clear when a S.12 Doctor is available but sometimes it isn't so there is an amount of cold-calling the AMHP must do in order to secure a S.12 Doctor to undertake the assessment. This, as is being made clear to us, can be a quite protracted process, particularly out of hours, sometimes spanning an entire night shift and seeping into the following day shift.

It is the responsibility of the respective University Health Board to maintain this pool of S.12 Doctors. Payment for work done is calculated on a flat rate, i.e., there is no difference between undertaking a MHA assessment during the day on a weekday than there is undertaking the assessment in the very early hours of a Saturday morning, for instance. Similarly, there is no difference in hourly rate between undertaking a MHA assessment than there is in undertaking a Deprivation of Liberty Safeguards (DoLS) assessment, the latter of which is rarely so urgent it needs undertaking in the early hours of a Saturday, for instance. It is the respective University Health Board that sets this pay tariff.

Assessment

A recent survey of our pool of S.12 Doctors (N=17) produced the following information:

- The biggest proportion (41%) are aged between 40 and 49 with the next biggest (29%) being aged between 50 and 59. 18% are aged over 60.
- More than half (59%) have been S.12 Doctors for over ten years. A quarter (24%) have been S.12 Doctors for three years or less.
- The vast majority (82%) intended continuing as S.12 Doctors for four years or more.
- The two most common reasons for becoming a S.12 Doctor were for professional interest and career development respectively.
- Nearly two thirds (65%) undertake both MHA and DoLS assessments. In a Wordle directed at those who do undertake both MHA and DoLS assessments, most prioritized

MHA assessments over DoLS but there were those who prioritized DoLS as they "can be planned".
- The vast majority (88%) said they would encourage colleagues to become S.12 Doctors. Of those who said they wouldn't, none explained why they wouldn't when asked.

Data for 2024/25 shows out of 1,200 MHA assessments undertaken there were 41 documented examples of delays. For 2025/26, we don't have this level of granularity as regards the data but anecdotally there appear to be between 1 to 4 incidents involving delays per month. Although this may seem quite a low figure – some 4% - the actual effects of these delays can be quite marked as illustrated below:
"A referral came in at 5.15am from A&E UHW and EDT were unable to complete assessment as no S.12 Doctor. This was subsequently handed over to daytime AMHP service and assessment arranged for 11am and it looks like the patient arrived on Cedar ward HYC just after 2pm. In the grand scheme of things this was quite a quick turnaround as there was a bed available and transport although it meant that this individual was in UHW A&E for about 8 hours from when the referral was made when really it should have been a much shorter period (if a S.12 doctor had been available when the referral came in overnight)".

There have been reports shared by S.12 Doctors of problems getting paid for assessment work when the work has been undertaken in other UHBs.

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

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

Nil

Recommendations:

- Increase the pool of S.12 Doctors particularly those who are agreeable to covering out of hours assessments.
- Change the pay structure to reflect the nature of the work being undertaken and when:
  - Payment for MHA assessments is at a higher hourly rate than that for DoLS.
  - Payment reflects work undertaken within unsocial hours.
- Consider the use of 'retainers' for night and weekend periods.
- The use of an app – like that which is being trialled in neighbouring UHBs – which can undertake a lot of the administrative tasks that AMHPs currently have to do manually

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	X	2. Providing Outstanding Quality	X
3. Delivering in the Right Places	X	4. Acting for the Future	

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

Prevention	X	Long Term	X	Integration		Collaboration		Involvement	

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

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
Delays in accessing Section 12 doctors create a clear operational and clinical risk. The SBAR highlights repeated reports from AMHPs of difficulty securing a doctor, particularly out of hours, leading to prolonged Mental Health Act (MHA) assessment times and cases where assessments spill from night into day services. Documented delays (41 incidents in 2024/25 and 1–4 per month in 2025/26) increase the risk of service failure and extended detention in A&E or police settings. These present foreseeable risks that require mitigation.
Safety: Yes
Long waits in Emergency Departments, police cells or other assessment locations expose vulnerable people to unnecessary safety risks. The SBAR's case example shows an individual remaining in A&E for eight hours purely due to lack of an available S.12 doctor. Such delays increase the risk of deterioration, self-harm, behavioural escalation and use of restrictive practices. Improving access to S.12 doctors is directly linked to improving safety and reducing avoidable harm
Financial: Yes
The current flat-rate payment model for MHA and DoLS assessments does not reflect urgency, complexity or unsocial hours. This contributes to poor engagement from doctors during out-of-hours periods and drives inefficiencies—AMHP time, prolonged ED stays, and assessments rolling into daytime hours. There are also reports of cross-UHB payment issues. The SBAR recommendations (enhanced MHA rate, unsocial hours uplift, and retainers) have financial implications but are intended to reduce waste and improve system efficiency.
Workforce: Yes
AMHPs are spending extended periods "cold-calling" up to 50 S.12 doctors, which can take an entire night shift. This is inefficient, increases workload pressures, and erodes morale. The workforce challenges are compounded by the demographic profile of the S.12 doctor pool — ageing, long-standing, and limited out-of-hours availability. Addressing rota reliability, payment structure, and introducing the app-based solution would reduce burden on AMHPs and support workforce sustainability.
Legal: Yes
The Health Board has statutory duties under the Mental Health Act 1983 to ensure assessments occur promptly and lawfully. Documented delays risk prolonged de facto detention and potential breaches of the Act, particularly when individuals are held in A&E or police custody longer than clinically required. Inadequate S.12 availability increases risk of legal challenge, especially where delays are systemic or predictable.
Reputational: Yes
Delayed MHA assessments can damage the reputation of the Health Board with patients, families and partner agencies such as police, local authorities and ED teams. The SBAR notes ongoing concerns raised by AMHPs and specific negative incidents. Without improvements, the organisation risks being perceived as unable to deliver timely crisis care.
Socio Economic: Yes/No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*

People requiring MHA assessments often face social disadvantage and instability. Delays in assessment prolong distress and limit access to timely treatment, disproportionately affecting those who are already vulnerable. Improving S.12 availability supports better, more equitable outcomes and aligns with the Socio-Economic Duty by reducing avoidable barriers to care.
Equality & Health: Yes/No
Prolonged delays in assessment can disproportionately affect individuals with severe mental illness, neurodiversity, communication difficulties or cognitive impairment, worsening their experience and outcomes. Ensuring timely access to S.12 doctors aligns with the need for equitable crisis response under the Mental Health Act. Given the scale of service change proposed (pay, rota model, digital tools), an EHIA is likely required.
Decarbonisation: Yes/No
Delays result in avoidable repeat journeys by AMHPs and S.12 doctors, extended use of high-energy acute environments (such as A&E), and inefficient deployment of staff. Improving the responsiveness of the S.12 rota and introducing an app-based system may reduce unnecessary travel, paper processes and duplicated attendance.
Welsh Language: Yes/No
Delays increase the likelihood that Welsh-speaking patients cannot be matched with a Welsh-speaking S.12 doctor, particularly out of hours. Expanding the pool of doctors and improving rota coordination provides an opportunity to strengthen the Active Offer and ensure assessments can be delivered bilingually where needed.

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Report Title:	Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report			Agenda Item no.		4.1	
Meeting:	Mental Health Legislation Committee		Public	X	Meeting Date:	27.01.2026	
			Private				
Status:	Assurance	X	Approval		Information		X
Lead Executive:	Chief Operating Officer						
Report Author:	Interim Director of Operations Mental Health Clinical Board						

Background and current situation, with summary:

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government monthly, with reports back to the UHB Performance Monitoring Committee. For the information of the Committee, the Delivery Unit has restarted its 90-day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets.

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

Summary

- **Part 1 (PMHSS):** Adult and CYP services exceed the 28-day referral-to-assessment and assessment-to-intervention targets, despite a significant rise in referrals.
- **Part 2 (Care and Treatment Planning):** Adult compliance remains below the 90% standard, but a five-month improvement plan is underway, aiming for compliance by March 2025. CYP compliance has been above 90% for a year, though engagement challenges persist.
- **Part 3 (Self-Referral Assessments):** Over 90% of outcome letters are sent within 10 working days for the sixth consecutive month.
- **Part 4 (Advocacy):** 100% compliance with timely access to advocacy.

Key Issues: Rising demand, ongoing performance management, and targeted improvement plans are in place, especially for adult care and treatment planning. Advocacy and self-referral standards are being met consistently.

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

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information are collated and submitted to WG via standard reporting templates.

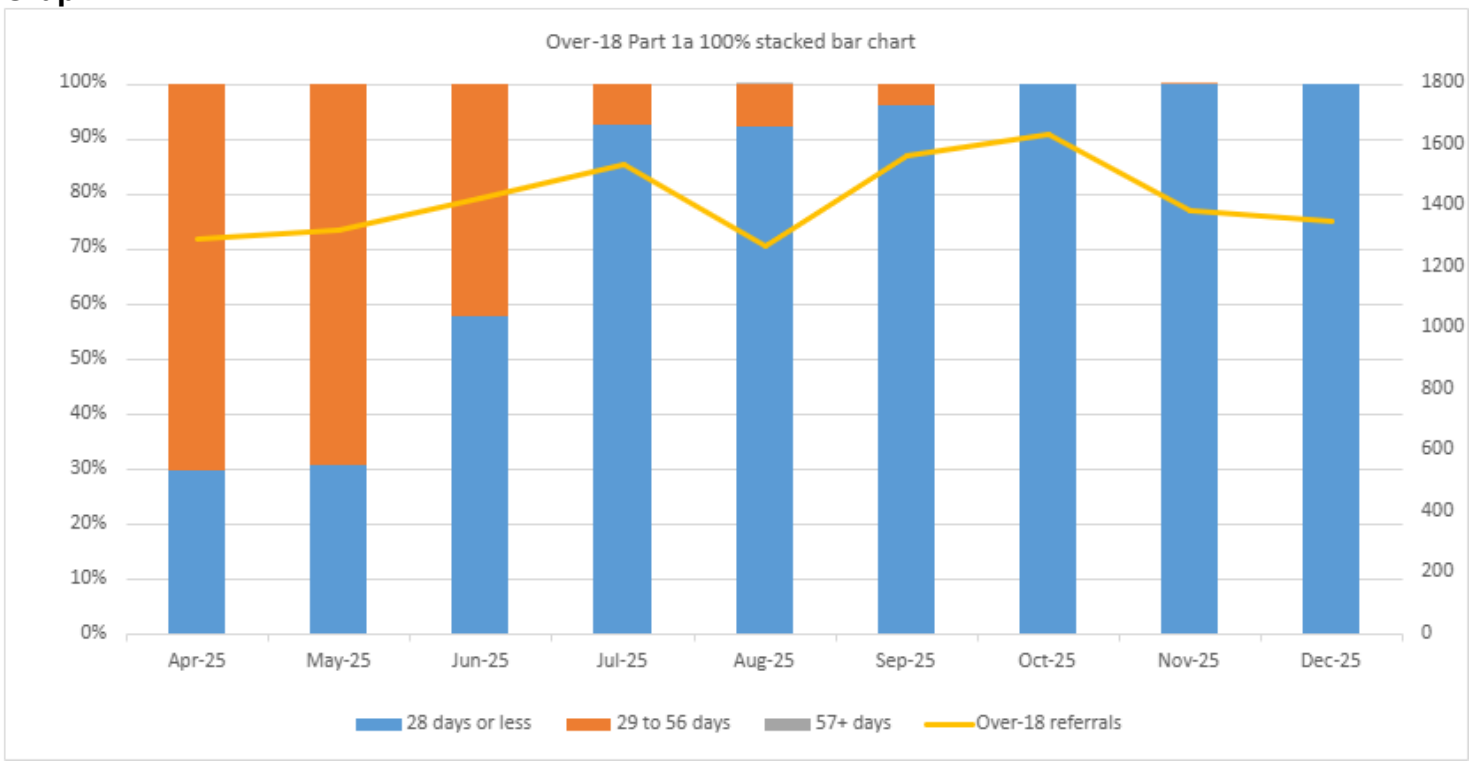
Part 1: PMHSS

Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)

- Part 1a was 100% compliant for the month of December 2025.
- This is the third consecutive month of 100% compliance, the average wait for assessment is currently 22 days.
- The waiting list for assessment is currently 167
- Current average waiting time for assessment is 14 days
- December saw over 1,620 referrals (all age) in December

Actions to maintain compliance:
The data continues to show an overall increase in referrals, resulting in heightened pressure on service capacity and demand. To address this growth and ensure compliance with the Tier 1 target, additional bank assessments will be required to meet increased service demand.

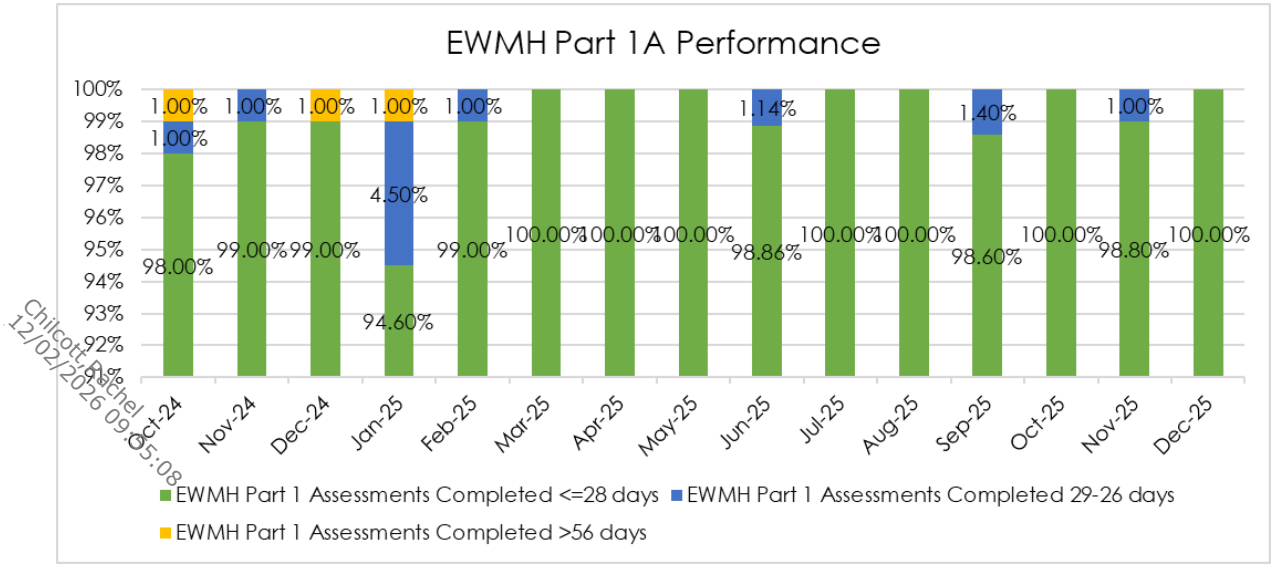
Graph 1:



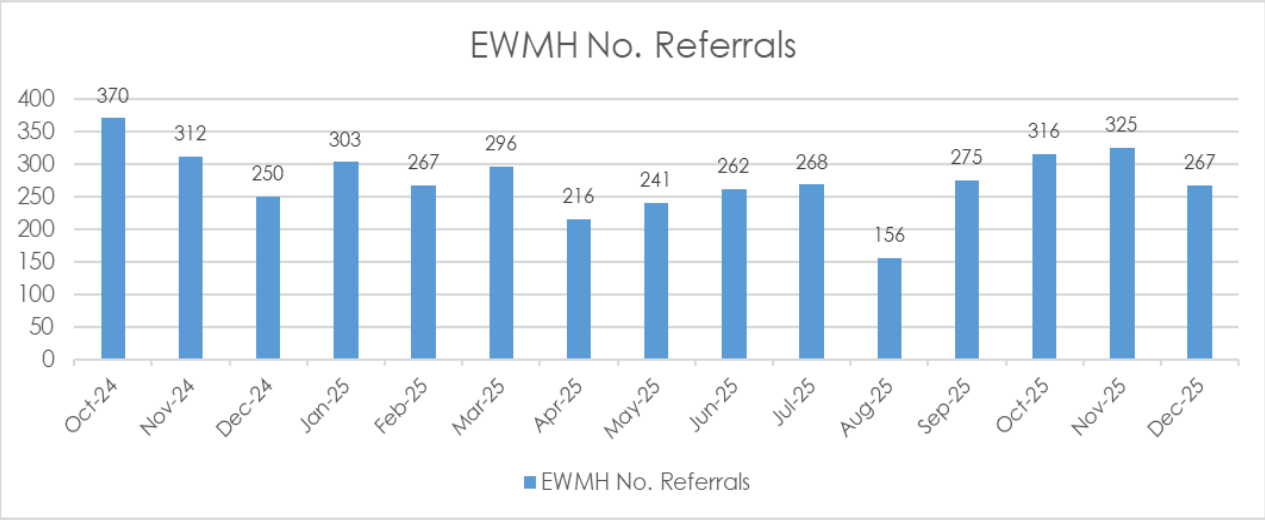
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

Compliance has been maintained. The establishment of the Assessment Team continues to support the service in providing sufficient capacity to meet incoming demand and the average wait for assessment is currently 20 days.

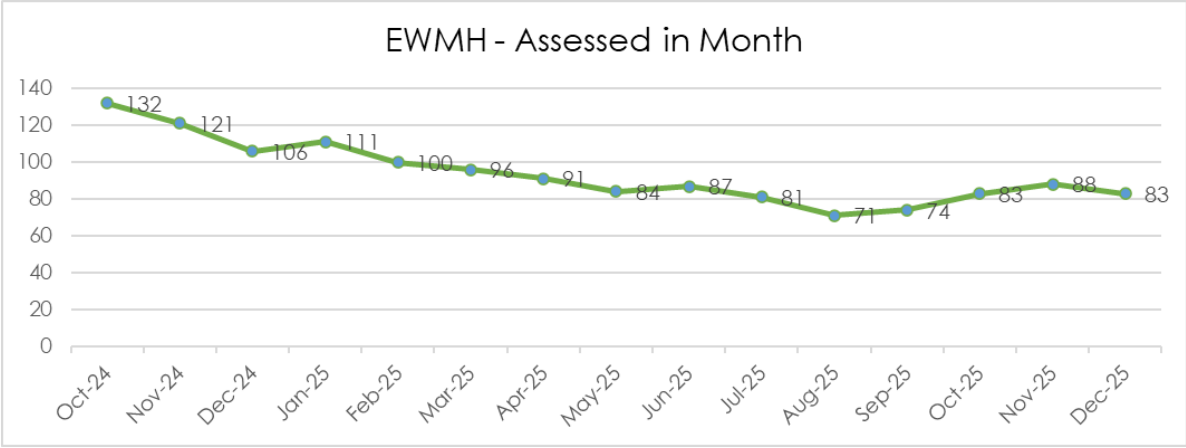
Graph 2:



Graph 3:

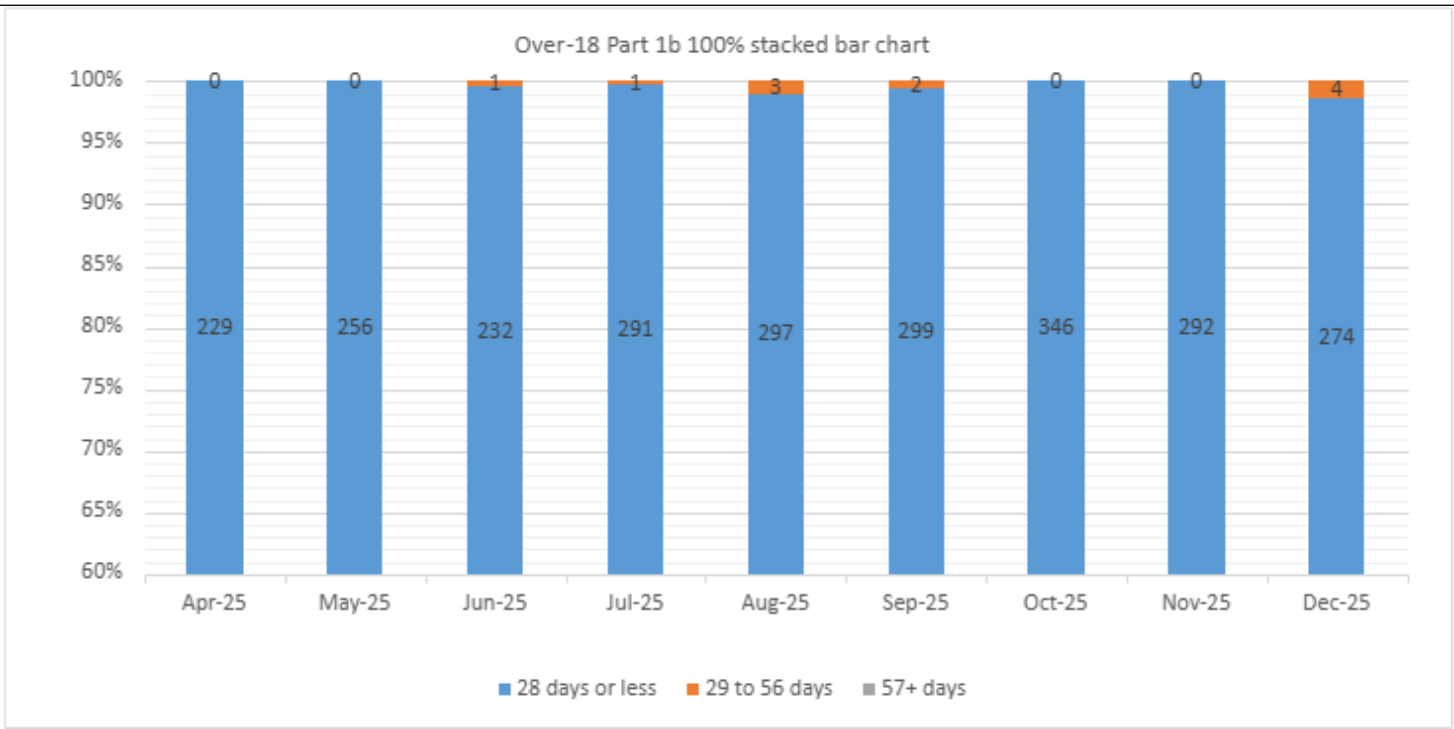


Graph 4:



Part 1b – 28-day assessment to intervention compliance target of 80% (Adult)
Part 1b remains compliant (Graph 5).

Graph 5:

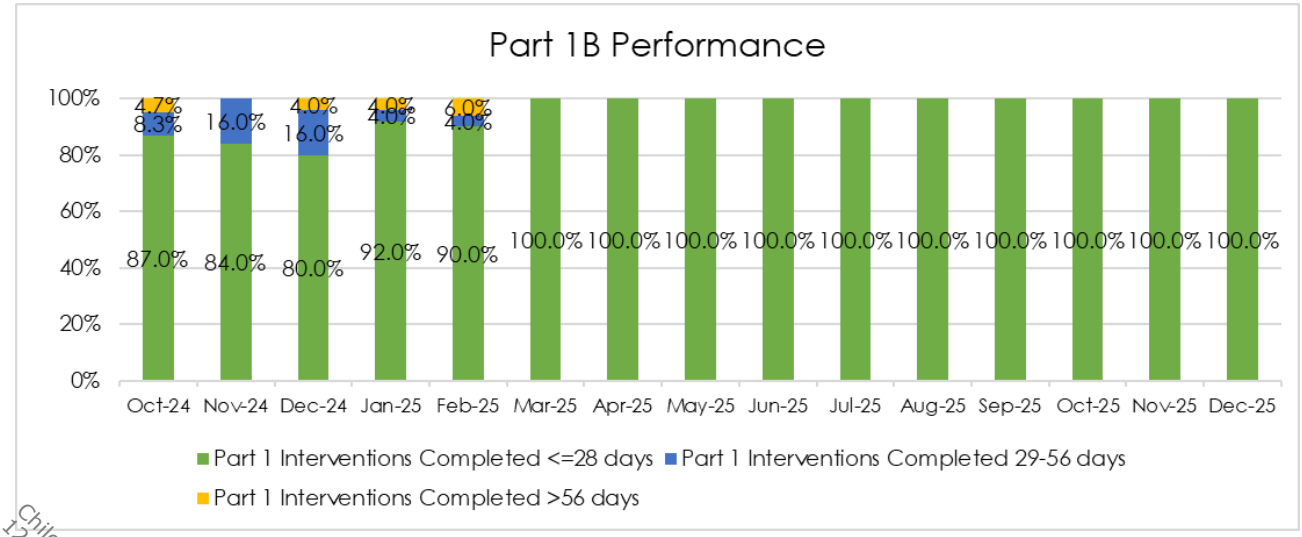


The PMHSS team continue to deliver Matrics Cymru compliant group interventions for:

- Living Life to the Full
- Behavioral Activation
- ACT for Wellbeing
- Open access to Stress Control.

Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)
100% compliance sustained for the 7th consecutive month.

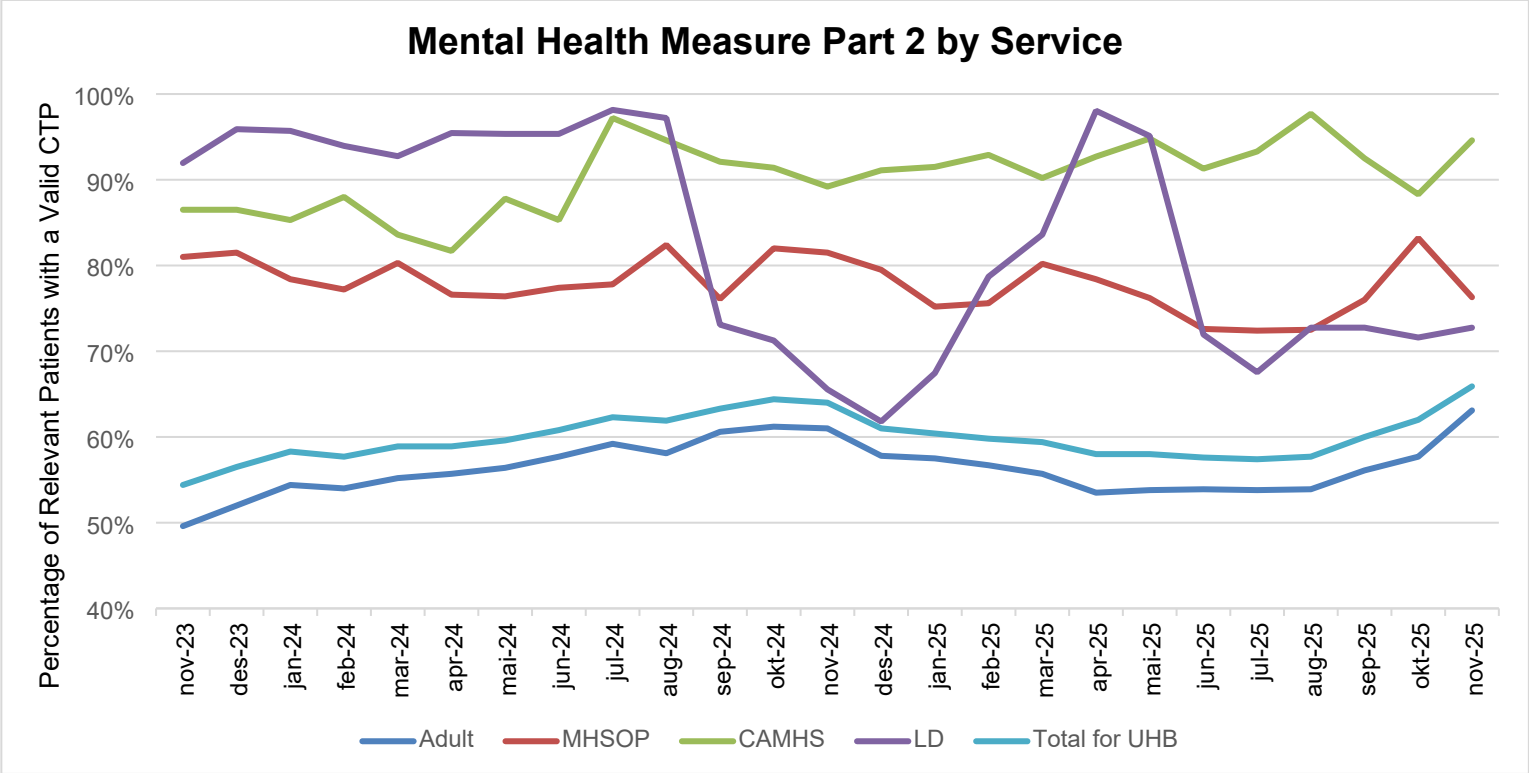
Graph 6



Part 2 – Care and Treatment Planning (over 18)

All relevant secondary care users should have an outcomes-based, holistic, co-produced care Plan.

Graph 7:



The CTP compliance for the Health Board continues to be an area which requires improvement. The Standard is that 90% of relevant patients should have a valid CTP. NHS performance and improvement has requested an improvement trajectory of the standard with relevant actions detailed to deliver.

Actions taken:

1. All CMHT's, who hold most of the responsibility for CTP compliance, have been met with to achieve:
    a. An agreed team level trajectory
    b. Detailing the nuances of delivery for each team to develop improvement plans

2. Agreed an improvement trajectory over a 5-month period for the Health Board.
This approach has been shared with NHS P+I in the monthly monitoring meeting and agreed as an acceptable approach.

Recovery plan:

1. Improvement plan over 5 months is based on working with individual professions sequentially
2. Where appropriate there will be a shift of care co-ordination from Psychiatrists to other appropriate professions
3. There has been some modest improvement in compliance, but this is an area that still requires urgent focus

Timeline:

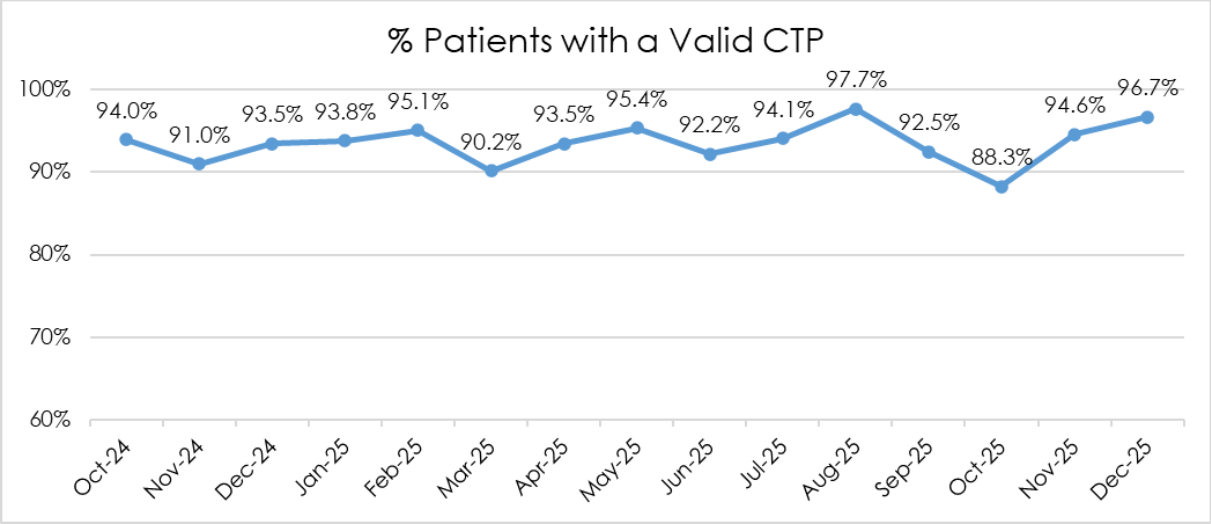
· Monitoring of improvement from November 2025 through Directorate performance reviews
· Further improvement plan opportunities to be developed in December to support sustainability
· Aim to meet standard by March 2025

<u>Part 2 – Care and Treatment Planning (Children & Young People)</u>

Compliance took a small dip under target in October and this was due to delays in completing the CTPs for young people who had been admitted to Ty Llydiard. Compliance has been reestablished in November and December.

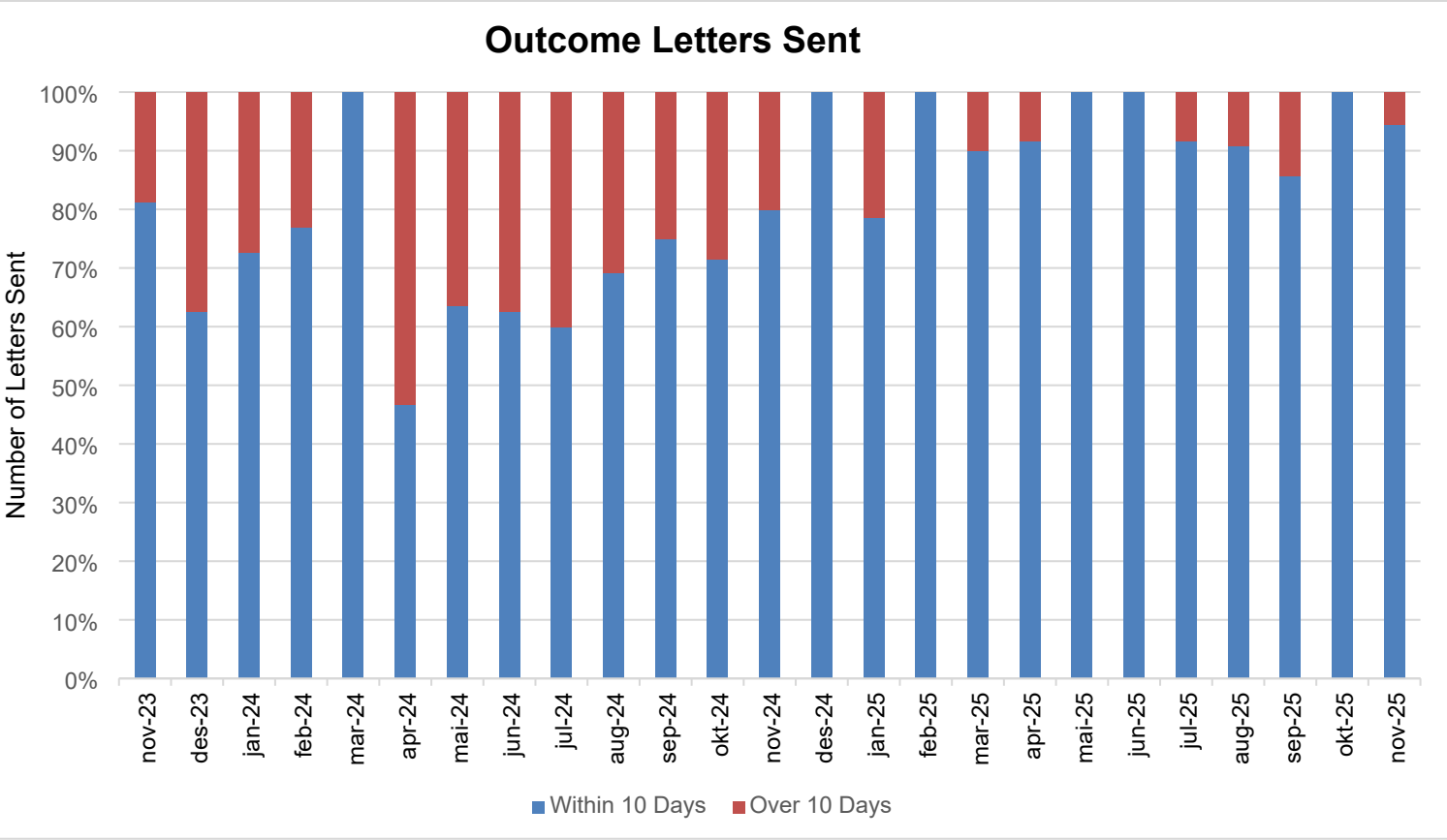
However, challenges remain with engagement from CYP due to the adult focus of the process and paperwork and this is being addressed nationally through the CAMHS Stakeholder Reference Group.

Graph 8:



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

Graph 9:
Compliance in ensuring that service users who have self-referred receive an outcome letter of their assessment within 10 working days has remained above 90% for the last 6 consecutive months



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

100% compliance.

Conclusion

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:

- **Part 1**: The number of individuals requesting assessments continues to rise, and the current funded establishment does not adequately meet the existing level of need.
- **Part 2:** Ongoing performance management, and the development of a recovery plan to improve compliance
- **Part 3:** Monthly performance management and implementation of process mapping.
- **Part 4:** Continues to be 100% compliant

The Committee is requested to:

a) **NOTE** the contents of the report.

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

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

						Click the objective above to view more detail.			

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

Quality Impact Assessment Completed?					
Yes -		No –		X	n/a

Impact Assessment:
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

January 2026 Mental Health Measure Monitoring Report

Summary of Key Findings

Strong Compliance in Parts 1, 3, and 4

Parts 1, 3, and 4 consistently meet or exceed compliance targets, showing strong performance in referrals, self-assessments, and advocacy.

Challenges in Adult Care Plans

Part 2 compliance for adult Care and Treatment Plans remains below 90%, indicating a need for targeted improvements.

CAMHS Engagement Issues

While CAMHS compliance is strong, engagement is challenged by adult-oriented processes needing adaptation.

Need for Targeted Interventions

Focused actions are required to address capacity pressures and improve adult CTP compliance while maintaining strengths.

Part 1 – Primary Mental Health Support Services

Adult Service Compliance

Adult mental health services achieved 100% compliance with the 28-day referral-to-assessment target for three months.

Increased Referral Demand

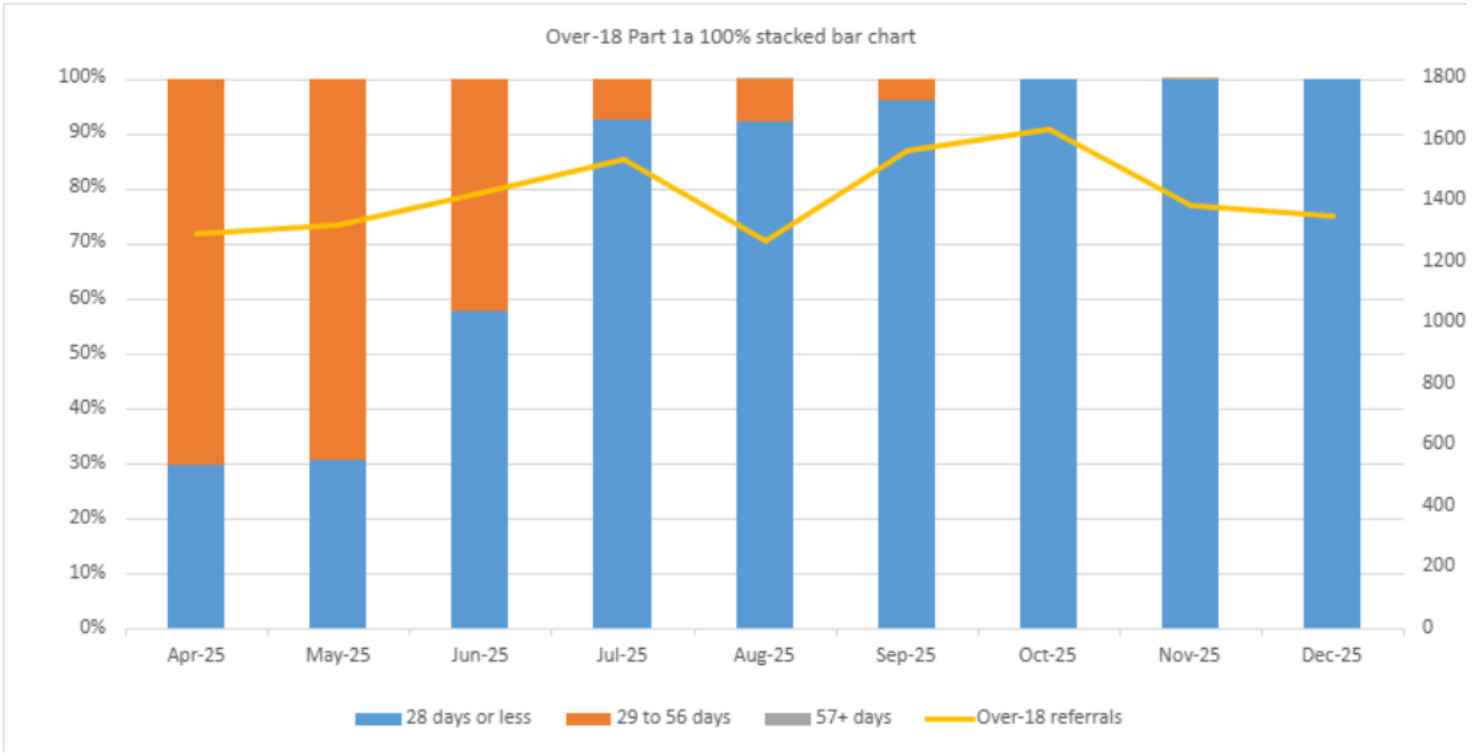
December recorded over 1,620 referrals, indicating rising demand managed by planned additional bank assessments.

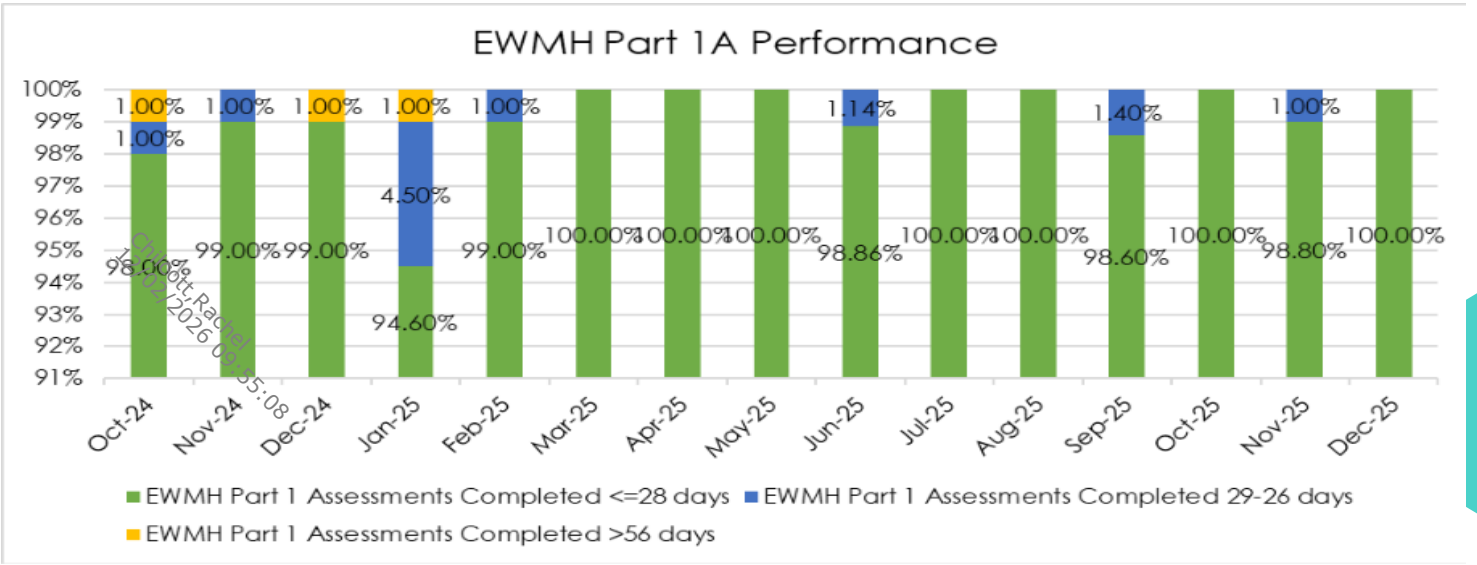
Children's Assessment Team

A dedicated team supports sustained compliance for children with an average assessment wait of 20 days.

Strong Intervention Performance

Part 1b shows adults and children maintain high compliance from assessment to intervention delivery.





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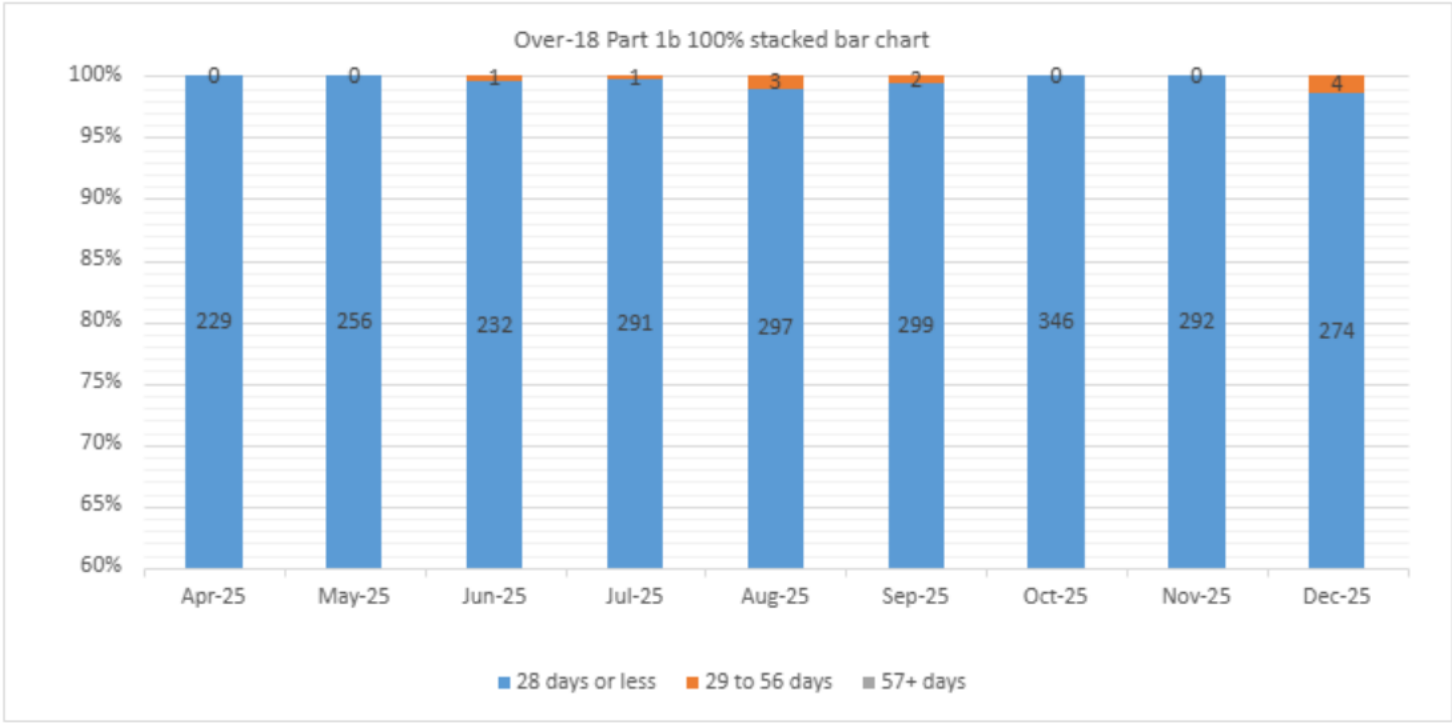
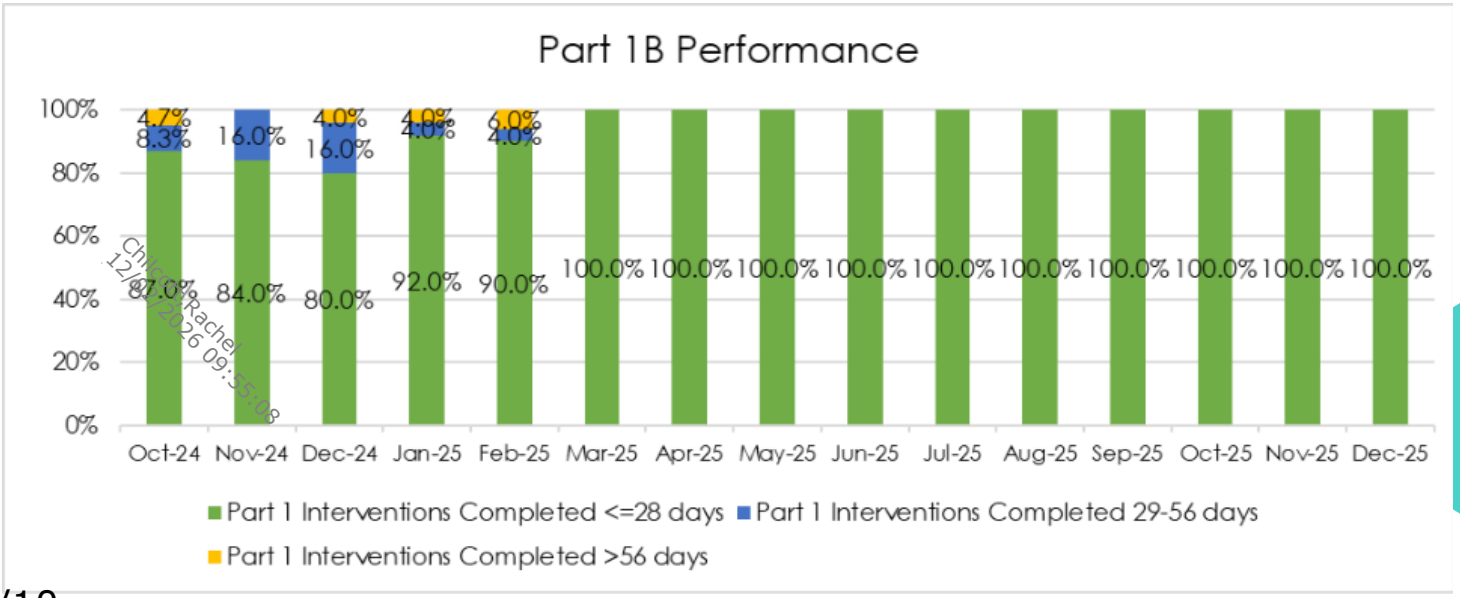
Cardiff and Vale University Health Board


Over-18 Part 1b 100% stacked bar chart
100%
95%
90%
85%
80%
75%
70%
65%
60%
0
0
1
1
3
2
0
0
4
229
256
232
291
297
299
346
292
274
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
28 days or less
29 to 56 days
57+ days


Part 1B Performance
100%
80%
60%
40%
20%
0%
4.7%
8.3%
16.0%
4.0%
16.0%
4.0%
4.0%
6.0%
4.0%
92.0%
90.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Part 1 Interventions Completed <=28 days
Part 1 Interventions Completed 29-56 days
Part 1 Interventions Completed >56 days

Part 2 – Care and Treatment Planning

Adult Care Plan Compliance

Compliance remains below 90%, prompting a focused five-month improvement plan to meet standards by March 2025.

Improvement Actions

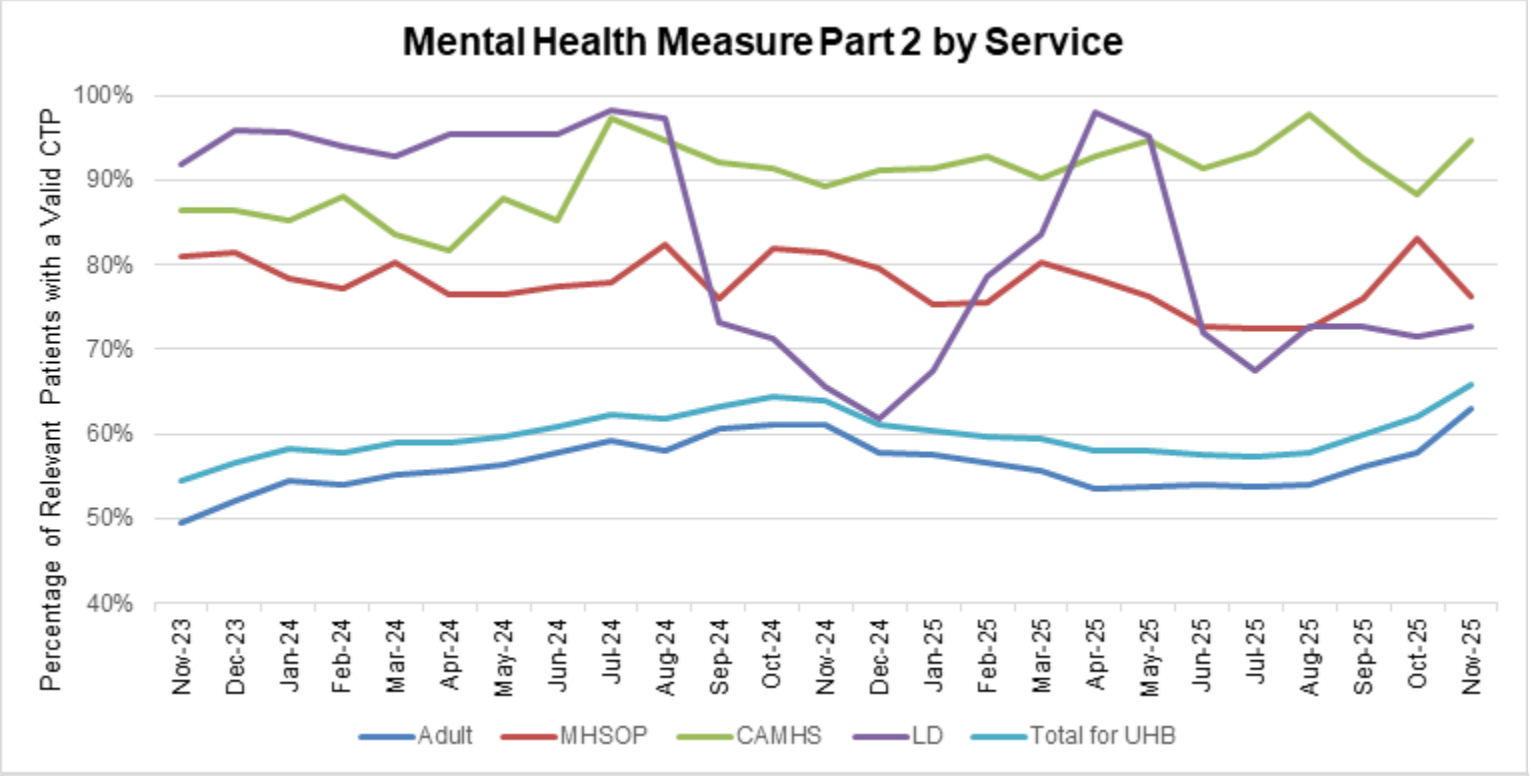
Actions include team-level trajectories, tailored plans, and shifting care coordination from psychiatrists to other professionals.

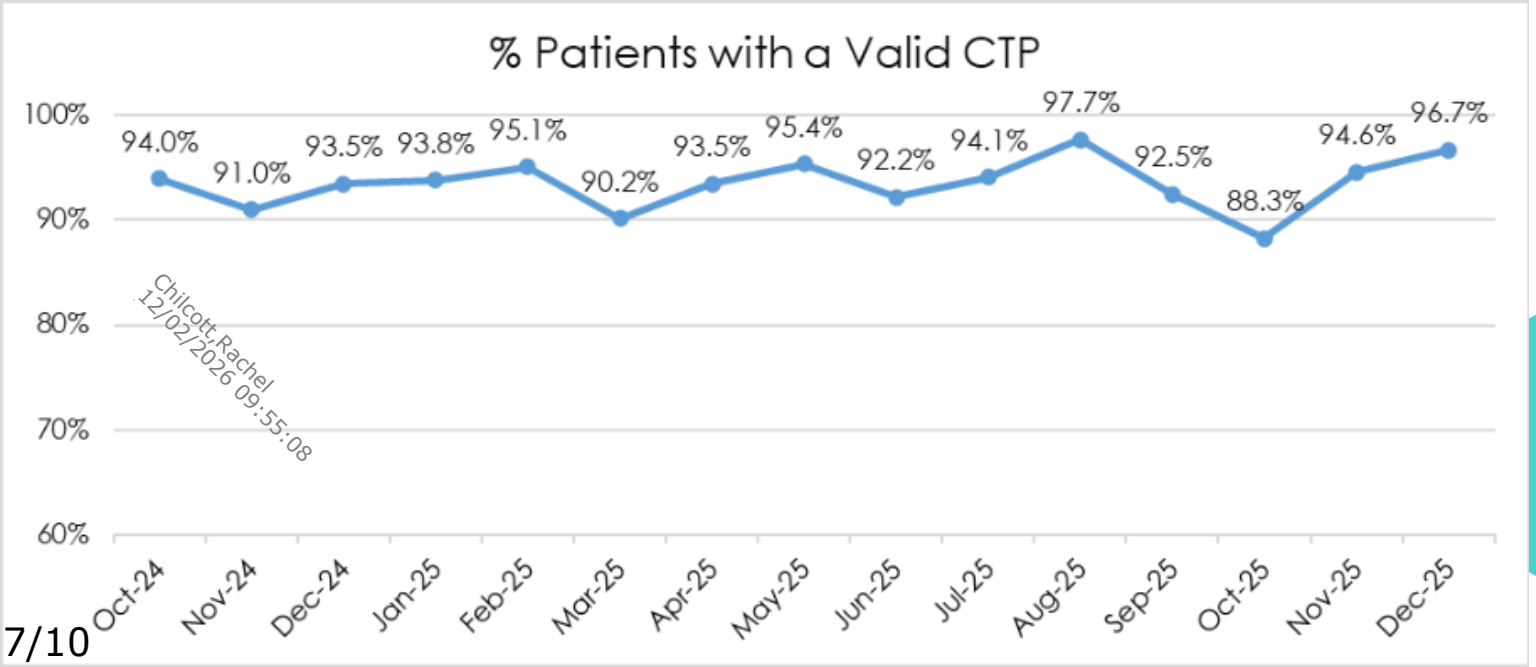
Children and Young People Compliance

Compliance dipped due to delays but recovered; challenges remain due to adult-focused processes and paperwork.

Stakeholder Engagement

National efforts via CAMHS Stakeholder Reference Group aim to improve engagement and care plan relevance for youth.


Mental Health Measure Part 2 by Service
Percentage of Relevant Patients with a Valid CTP
100%
90%
80%
70%
60%
50%
40%
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Adult
MHSOP
CAMHS
LD
Total for UHB


% Patients with a Valid CTP
100%
90%
80%
70%
60%
94.0%
91.0%
93.5%
93.8%
95.1%
90.2%
93.5%
95.4%
92.2%
94.1%
97.7%
92.5%
88.3%
94.6%
96.7%
Chilcott,Rachel
12/02/2026 09:55:08
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25

Parts 3 and 4 – Self-Referral and Advocacy

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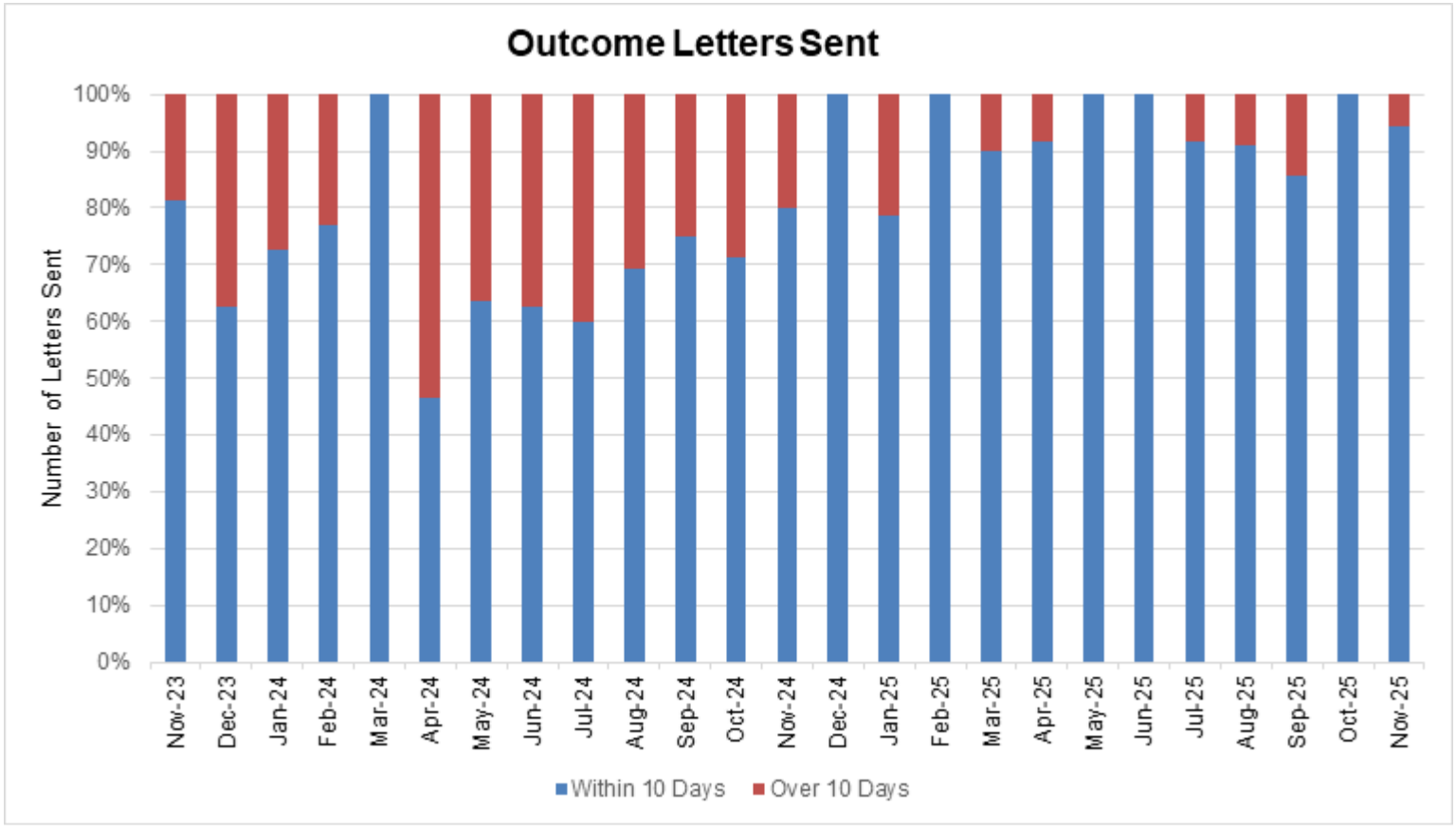
Timely Outcome Communication
Individuals who self-refer receive outcome letters within 10 working days, ensuring prompt feedback and transparency.

Independent Advocacy Access
Access to Independent Mental Health Advocates is guaranteed within five working days, supporting patient rights effectively.

Compliance and Service Excellence
Consistent high compliance rates demonstrate robust processes and commitment to equitable mental health support services.



Key Risks and Capacity Pressures

Rising Demand Impact

Increasing mental health service demand strains current capacity, risking delays in patient assessment and intervention.

Capacity Insufficiency

Current funded resources are insufficient to meet adult mental health needs, impacting statutory compliance and outcomes.

Engagement Challenges in CAMHS

Challenges engaging younger service users highlight the need for process redesign to improve mental health services for youth.

Operational Constraints

Financial, workforce, and operational constraints compound risks, requiring strategic planning and resource allocation.

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 15:00 ON 13th JANUARY 2026 VIA TEAMS

Present
Amanda Morgan (AM) – Chair, PoD
Alex Nute (AN) – Vice Chair, PoD
Liz Singer (LS) - PoD member
Alan Parker (AP) - PoD member
Margaret Jones (MJ) – PoD member
John Copley (JC) – PoD member
David Seward (DS) – MHA Manager
Morgan Bellamy (MB) – Deputy MHA Manager
Bianca Lepore (BL) – Deputy MHA Manager
Mair Rawle (MR) - PoD member
Peter Kelly (PK) – PoD member
Mike Lewis (ML) - PoD member
Jeff Champney Smith - PoD member
Carol Thomas - PoD member

Apologies for absence
Ceri Phillips - Vice Chair, Cardiff and Vale Health Board
Gerrie Hughes (GH) – PoD member
Rashpal Singh (RS) – PoD member
Sharon Dixon (SD) – PoD member

FOR INFORMATION

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

2. Apologies
Apologies were received and noted.

3. Previous minutes and reporting
Minutes of the previous meeting were accepted as accurate. The Mental Health Legislation and Governance Group minutes were accepted.
It was briefly discussed that there were no statistics that were out of the ordinary in terms of use of the Act this quarter.
It was noted that clinicians have been reminded of the importance of hearings and that the utmost effort should be made to not postpone or cancel hearings. The volume of discretionary reviews seems to have decreased. This was discussed as possibly a positive sign that professionals are providing better information to enable panels to make decisions.
PK felt the number of postponements in one month during the last quarter was of concern. It was however recognised that the numbers involved were relatively low compared to historical patterns.

FOR DISCUSSION

4. Comments/ Compliments from Power of Discharge Group October- December

It was noted that we need to improve the process for getting outstanding comments from previous quarters over to the PoD members. There seems to have been a change in stance of what the members require.

Action- BL to look into including previous WIP comments

A couple of specific cases were discussed, and it was agreed that there should be a resolution to these very imminently. The stance taken by the crisis team in relation to forensic discharges was discussed and did give rise to concern. It was noted that despite this being an uneasy situation for the managers, that it was outside of their remit to pursue further.

The most prevalent concern this quarter was that of nurses that do not know patients well being sent to hearings. AN felt that most of the time the nurse sent to a hearing will have only had a brief look at the submitted report and that on occasion the nurses sent to represent the report did not know the patient in any where near as much detail as required. The overarching feeling from PoD is that their part in a person's detention is being undervalued over time and that this takes away from the patient's experience. It was agreed that this will be escalated to the MHLGG meeting again and that BL will investigate the process of who attends hearings. The group were reassured that the training provided does encourage the importance being placed on hospital managers hearings. It was agreed that it would be reasonable to ask ward staff who should be attending about 2 days prior to a hearing. It was discussed that the MHAO staff do ring wards a few days prior to a hearing to confirm that the patient has had access to and read their reports therefore it seemed reasonable to ask MHAO staff to prompt staff during this phone call. AN felt that the issue is largely with nursing staff and that permission is often sought from social workers or RC's if the regular staff cannot attend. Some members of the group felt that if needed hearings should either be adjourned or hearings delayed by an hour or so if nurses aren't knowledgeable enough to give them time to read the report in full.

Action- BL will investigate nursing staff representation at hearings

Action- AN will raise with the Nursing Board and AM will raise at MHLGG

It was noted that CTPs are being corrected and improved upon more quickly than has historically been realistic. Some PoD members do still feel that the quality of CTPs can be improved upon. It was agreed that standards need to be maintained and improved upon in many areas.

5. Matters Arising

None

6. Operational Issues

The group were informed that WARRNs will now be sent to panels again. This was a contentious issue at the last meeting and most members felt strongly that WARRNs should be sent. The rationale for the change in decision was discussed, and the group were told the further training on the completion of WARRNS would be afforded to staff so that they

are used appropriately going forward. The group were informed that the stance on sending these documents is consistent for both Tribunals and hospital managers hearings. The over all feeling from the group is that this decision is the correct one in terms of robust and confident decision making.

Paper reviews will not be rolled out any further for now. The group were informed that the Code of Practice is clear that their use shouldn't be widespread and that the challenges from the MHA Office perspective were not realistic to achieve at present for us. Given the groups concern at the lack of importance placed on hearings it was also felt that paper reviews could perpetuate this problem. Some members of the group were aware of the upcoming changes in legislation but for those that weren't aware a brief overview was provided, and it was suggested that once these changes have been implemented, the likely increase in volume of hearings we may have no other choice than paper reviews. One member felt strongly that in certain circumstances a paper review would be an efficient use of time for professionals, staff and PoD members, and whilst this is recognised in many veins it was decided now is not the right time for this change.

The group were informed that recruitment of new members is imminent and that AM, AN and the management team would be progressing this at speed. It is hoped that the new members may be appointed by April.

DS has recently held in depth conversations about the use of personal devices for PoD work and how best to overcome the GDPR and logistical challenges of not being able to provide UHB laptops to members anymore. It has been agreed that members have a personal responsibility to dispose of devices securely themselves or alternatively they can give devices back to the UHB and we can destroy them in line with legislation. ML asked for this to be put into writing as they had previously been informed that they cannot use their own devices to access information. This guidance has changed in line with the extra financial constraints that the UHB is now under. It was noted that the requirement of the role is now such that people need to have their own devices and JC confirmed that other organisations had not provided any technology.

Action- DS to provide a written statement in relation to the disposal of personal devices.

Some members of the group are having problems with Microsoft and access to the outlook calendar, and it has been agreed that if needed the members should bring in their devices to the next F2F meeting in April for us to investigate further.

7. Training

It was agreed that training on the MCA is pertinent and useful to all. Extra training can be seen as new training for some and refresher training for longer standing members.
Best practice as far as decision writing is also felt to be a good use of time during the next PoD training day so this will also be tabled.

Dependant on time scales it may also be worth discussing the upcoming changes to the MHA. Some members did voice concerns about the upcoming changes, but it has been agreed that the changes are unavoidable and may have unintended consequences.

8. Themes for discussion

LS and AP discussed a recent hearing in which the patient's family member had asked to record the hearing. This was discussed amongst the group, and it was explained that the

decision had already been made that the hearing must not be recorded. It was recognised that the use of virtual hearings poses difficulty in ensuring this abided by.

A discussion was held in relation to panels being provided extra written information at short notice and whether this situation may give rise to an adjournment. It was eventually agreed that a bespoke approach should be taken.

9. **Sharing experiences and best practices**
To table for F2F meeting

10. Any other business
AM will check the social fund and confirm the with group if more is needed.

The changes to the day of the week of these meetings were explained. These changes aren't convenient for some members, but it is acknowledged that there is unlikely to be a time that suits everyone.

11. Date of Future meetings
The next meeting is scheduled for 15th April- face to face all day in Hafan Y Coed.

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 15th January via Microsoft Teams

Present

Julian Willett (JW)	(Chair) Transformation & Innovation Lead MHCB
David Seward (DS)	Mental Health Act Manager
Morgan Bellamy (MB)	Deputy Mental Health Act Manager
Bianca Lepore (BL)	Deputy Mental Health Act Manager
Amanda Morgan (AM)	Chair, Power of Discharge Group
Claire Thomas (CT)	South Wales Police Representative
Kath Lewis (KL)	Consultant Social Worker AMHP/DoLS
Matt Russell (MR)	Operations Manager MH, Cardiff LA
Linda Woodley (LW)	Operational Manager MH, Vale of Glamorgan LA
Adele Watkins (AW)	Mental Health CNS, Acute Child Health
Samantha Kennedy (SK)	Integrated Team Manager MHSOP, Cardiff LA
Pippa Johnson (PJ)	Mental Capacity Act Project Lead
Gemma Lewis (GL)	Service Manager MH, Cardiff LA
Noel Martinez Walsh (NMW)	Lead Social Worker- Vale of Glamorgan LA
Alex Allegretto (AA)	Advocacy Representative
Ryan George-McDowell (RGM)	DoLS Representative
Andrea Sullivan	Senior Nurse Education, Quality, Safety & Patient Experience

Apologies

Bethan Evans	EDT Lead
Ceri Phillips	Vice Chair, Cardiff & Vale University Health Board
Ceri Lovell	CAMHS Representative
Callista Hettiarachichi	CAMHS Consultant
Rachel Dix	Interim Deputy Director of Nursing MHCB
Chris Frayne	Interim Lead nurse
Gwilym Griffiths	Interim Directorate Manager Adult MH
Tara Robinson	Director of Nursing MHCB
Rhiain Lewis	Senior Nurse – Education Quality, Safety and Patient Experience

1 Welcome and Introductions

The Chair welcomed everyone to the meeting.

2 Apologies for absence

Apologies were noted.

3 Minutes of meeting held on 09th October 2025

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

4 MHA Activity

It was noted that the activity report doesn't necessitate a thorough discussion as there is nothing out of the ordinary this quarter. All activity was within the normal parameters.

The exception report was gone through in more detail, and it was explained to those present that there has been a change in the proportion of our patients that are now detained rather than here on an informal basis. This is seen across the directorates and rationale was given so far as changes to guidance on use of the MCA in place of the MHA and vice versa. More work is being done by DS and JW in relation to how to report on this. This is at the behest of the Mental Health Legislation Committee, and it is yet to be decided how this will come to fruition. KL felt the increase in proportion may have at least partially be accounted for by the same individuals being detained and discharged several times due to switching between MHA and DoLS. KL asked whether we could pull these figures out relatively easily which DS and BL confirmed we can, and these figures will help the future work to see the true reflection of whether there are more people being detained vs informal.

Action- DS to include figures in next quarter exception report

There were no fundamentally defectives applications but there was one defective use of a holder power. The reasons behind this were explained to the group and advised the group that a Datix was raised. DS did reiterate that our training is robust and that our SharePoint page is up to date and very user friendly. One holding power lapsed during the quarter due to communication failures amongst several teams. This has been investigated and thoroughly Datixed and noted that this type of lapse is very unusual.

The lapse of the section 3 during the previous quarter was explained in further detail at the request of the Mental Health Legislation Committee. DS explained that the situation came with many anomalies and that two pieces of legislation were being considered and that the team looking after the patient rarely use the MHA. The situation has been mitigated against by passing on learning from both an MHA Office and wider professional perspective.

The use of section 136 has increased this quarter but is still within the normal control limits. There were three lapses of section 136 due to the patients not being fit for assessment during the detention period.

The volume of nearest relative discharge requests was raised by DS. It was agreed that this can be seen in a positive light in that people appear to know their rights more.

It is, however, a particular change within Cardiff and Vale UHB and it has been queried by the Mental Health Legislation Committee why this change has arisen. The change doesn't parallel with the increase in detentions as the number of requests has risen beyond the expectation. DS has attempted to communicate with nearest relatives that have used their power of discharge and has devised a questionnaire. Unfortunately, no feedback has been provided thus far by the nearest relatives, but it is hoped that this will change in future. GL asked whether there may have been a correlation between the use of out of area beds and the increase in discharge requests, but DS stated that there doesn't appear to be evidence of this. It was agreed that we will continue to try and identify qualitative data around this and may approach the lived experience team in future if needed.

Training sessions continue to be offered across the UHB with uptake and feedback being good. Audits across the wards and CMHT's throughout the previous year have been less frequent due to staffing within the MHA Office. Staffing is now back to its regular amount, and it is expected that the frequency of audits will increase again. it is hoped that we will soon have enough data around these to bring to results to this meeting.

5 Matters for Action

The action log was discussed

Locked doors- the lead on this was not present at the meeting and therefore this is being left on the log.

The section 12 doctors survey has been created and disseminated. This action can come off.

The suggested section 12 app is not being considered within Cardiff or the Vale as the deadline to sign up has passed but WhatsApp groups are being used as a work around. It was broadly agreed that the outcomes of the section 12 SBAR will be shared at the next Mental Health Legislation Committee and that issues sourcing section 12 independent doctors have been prolonged and don't show any signs of improvement without a clear pathway forward being devised. It was noted that there is a particular issue with nighttime assessments. The group also noted that the amount paid to section 12 doctors has not changed in around two decades which is also likely to be a factor in the difficulties that we all experience. It will be kept on the agenda.

The group were informed that neither of the two locum CAMHS doctors currently employed are AC approved and therefore cannot act as Responsible Clinicians. The doctor regularly named as RC for young people has returned to work but only on a part time basis. The issue is still live and will remain on the log.

WARRNs have been reinstated to be sent for Hospital Managers hearings as part of their report packs having received final clarification of our position from the MHCB. To be removed.

A pathway is still needed but the CAMHS representative is not present so this will remain live on the log.

The Power of Discharge Group highlighted the lateness in submission of many reports and the challenges this poses so far as patients, relative and advocates accessing reports within good time. It has been suggested that an arbitrary time scale for postponing hearings may be prudent so this will be discussed within the MHA Office and taken to the MAC group by DS if it needs to be moved forward.

The group were reminded of the change in time of future meetings from 10:00 to 14:00 and DS agreed to send out future meeting dates in the next few weeks.

6 Feedback on operational issues and incidents

The group weren't sure who was now taking over the locked door policy but the person who it was felt most appropriate wasn't at the meeting. JW will bring this to his attention.

7 Feedback from other meetings:

The issues that regularly crop up for AMHPs were discussed again but particular attention was given to the quality of medical recommendations during the Vale forum. It was questioned whether AMHPs have a legal duty to check recommendations. The group were informed that Vale AMHPs will be making a positive push towards asking if patients want to see assessors on their own. The forum was focused on qualitative issues which is felt to be a good use of these platforms in the context of the use of the Act.

KL reported that Cardiff's AMHP service has been running a pilot of the use of a hub for requesting MHA assessments. This has proved to be an efficient way of working and it is likely that the pilot will be rolled out on a more permanent basis. Conveyance of patients to hospital has been problematic in the last quarter. One incident involving a private provider was discussed and the group were informed that meetings to resolve this problem are due to be held within the next couple of weeks. The most contentious issue that arose from the Cardiff AMHP forum was that of the use of DoLS and the MHA. There are still many occasions whereby an individual is discharged from the MHA and is deemed not eligible for DoLS. Individuals lacking capacity are then left in hospital without any legal framework which gives rise to concern to all those present. The issue is not just one of people's rights but is one of inefficient use of resource too. AMHPs are assessing the same patients several times and are also having to needlessly explain the situation to families/carers. The MCA representative did explain that training had been provided earlier in the year, but this doesn't seem to have filtered down to decision makers. Training was offered widely across the UHB. Several cases have gone to the UHB's legal team as the issues seems to be pervasive and across the board. The guidance booklet is still in draft format. It was confirmed that unfortunately local authority colleagues can't access Datix in its full format, so this isn't a viable option for reporting and tracking.

Action- DS to discuss the issue of lack of legal frameworks with both Adult acute and MHSOP Clinical Directors.

KL informed those who were not aware that the reform to the MHA has now gained Royal Assent. The group were informed by DS that implementation of the new MHA is likely to go ahead in stages and that clauses are likely to be turned on one or two at

a time. The anticipated time scales are for the whole process to take up to a decade. DS confirmed that he is part of an implementation board with Welsh Government and that as and when changes are coming in, the relevant staff will be notified. It has been agreed that once changes start to be operational then this agenda item will be moved up the agenda of this group.

Nothing was raised in relation to policing and use of the Act.

AA did voice concerns that Hafan Y Coed often seems to be understaffed. One consequence of this is service users being denied access to leave as there aren't enough staff to escort them. AA did inform the group of an attack on an advocate during the last quarter and measures have been taken to mitigate against this happening again, but the advocacy service did want to assure the group that their service is still available on the ward the attack happened on.

Action- JW to share the under-staffing concerns with relevant senior nurses.

DS informed the group of some recent guidance issued by the Mental Health Review Tribunal in which hearings will now be held remotely unless it is expressly requested by the patient that the hearing be held F2F. The method of booking dates for hearings is also going to change in the next month. Whilst this change will largely affect Responsible Clinicians, it was explained to the group that the change may well have teething problems. DS will raise these at the next MAC meeting for their thoughts.

8 Power of Discharge Group comments, compliments and feedback

There remain ongoing concerns about the quality of care and treatment plans, and it seems the discrepancy between what is being provided and what is being evidenced persists. Of particular concern to the Power of Discharge Group this quarter is the apparent lack of importance placed on sending appropriate nursing staff to hearings. Panels have on occasions felt that the nurse sent to represent the report doesn't know the patient well, or some time not at all. This means they're unable to provide robust evidence and makes decisions made by the panels more difficult. The overall feeling by the Power of Discharge Group is that their role in being undervalued at present. The MHA Office have agreed to provide an extra prompt to nurses around two days prior to hearings to help ensure a knowledgeable nurse attend. The Vice Chair of the Power of Discharge Group has contacts within Cardiff University and has said he will raise the concerns in this context. BL will reach out to ward managers to decipher whether there is a process being used by wards to decide who attends.

Action- BL to speak to ward managers re: nursing attendance at managers hearings.

9 External reviews

Nothing to note.

10 Interface MHA/MCA/DOLS

The necessary amendments are being made to the guidance, and it is hoped that this can be issued soon.

11 Mental Health Act Reform

This was discussed earlier in the meeting.

12 Any other business

JW queried whether an item relating to the Mental Health Measure could be added to the agenda and terms of reference to this meeting. At present there isn't a forum to discuss the use of the Measure and whether it is working as intended. It has been proposed that to avoid another separate meeting be set up, that an item be added to this meeting going forward. This will be discussed with the Vice Chair of the UHB and a decision will be made. KL reference that a lot of people in this meeting don't have anything to do with the Measure so queried if it was a relevant forum for it or not.

NMW noted that their seems to a high number of Cardiff and Vale UHB residents in out of area beds on an informal basis. He is concerned about the capacity of people making a decision to be admitted to a hospital far away from home. It was recognised that this fact can be looked at in two lights and that from one perspective it is preferable to have these people out of area without being detained. The use of out of area beds is also causing confusion amongst some shift coordinators and this being filtered through to AMHP services.

The HB is aware of the high numbers of out of area beds being sourced and is trying to make measures to reduce this.

13 Date of future meetings

16th April 14:00

VETERANS NHS WALES

Annual Report

April 2023 – March 2024

GIG CYMRU NHS WALES

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

MINISTRY OF DEFENCE

Contents

Service Aim - to improve the provision of mental health care to veterans living in Wales

Veterans' NHS Wales - is the first point of contact for ex-service personnel residing in Wales, with a 'service related' mental health problem

Welcome

Dear Reader,
Veterans' NHS Wales (VNHSW) is outpatient psychological therapies service for British military veterans living in Wales. The service started in Cardiff in 2008 as a MoD and Welsh Government funded pilot for two years led by Prof. Jonathan Bisson and Neil Kitchiner. Following a successful pilot the Welsh Government funded the all-Wales veterans' mental health and well being service in 2010. Since then, the service has grown and had a name change to Veterans' NHS Wales (VNHSW). VNHSW provides military mental health clinical expertise to treat veterans across Wales through our skilled clinical, administrative and peer mentor staff.

At time of writing this, we have just celebrated 15 years of the service in Cardiff Bay. At our celebration event on 30th April 2025 our peer mentors, based in three of the seven health boards, talked about their work as part of the multi-disciplinary team at VNHSW. As military veterans themselves (see their biographies on page 5-6), their work with our services users is invaluable, providing additional support to veterans and their families with a range of psychosocial issues, alongside their out-patient psychological therapy with our highly experienced psychological therapists.

For example, peer mentors help our veterans reengage with activities they used to enjoy, provide advice for social or economic stressors and importantly, lend an understanding ear using their own lived experience.

Given the value of their work, my colleagues and I continue to work hard to gain additional peer support provision in all seven NHS Wales health boards. I hope in future versions of this report I can update that we have been successful with this mission.

I would like to acknowledge that a wide range of organisations that support and promote our service. These colleagues make sure our service is accessible and meets our veterans' needs. I would also like to thank all the staff at Veterans' NHS Wales who have worked extremely hard over 2023-2024 and continue to do so today.

This report will describe service data from 1st April 2023 - 31st March 2024. Data was recorded by team administrators and analysed by Helen Dare, Assistant Psychologist. The report has been written and compiled by Helen Dare, Dr Gwen O'Connor and myself. Acronyms are used in this report, if needed see Appendix 1 for full breakdown. If you wish to discuss this report further, please contact us via admin.vnhswcandv@wales.nhs.uk.

Finally, you can find more information about Veterans' NHS Wales by visiting our website (www.veteranswales.co.uk) or by scanning the QR code. If you know a veteran who may need support, you can also make a referral via our website.

Neil J Kitchiner

Dr Neil J Kitchiner

Director & Consultant Clinical Lead, Cardiff and Vale University Health Board and Honorary Research Fellow, Cardiff University

Executive Summary

Referral

- Six-hundred and twenty-eight referrals were received by Veterans' NHS Wales (VNHSW) from 1st April 2023-31st March 2024. This is slightly less referrals than the previous year (n=14).
- Most commonly, referrals were self-referrals (n=262, 42%) followed by Primary Care referrals (n=195, 31%).
- The service had a higher number of re-referrals than previous years (47%, +8%).
- Eighty-one percent of referrals (n=507) were appropriate referrals, 19% of referrals were inappropriate (n=121).
- The mean age of veterans referred to VNHSW was 47 years.
- Most referrals were male (91%, n=574), but the service continues to see a growth in the percentage of female veterans accessing the service (9%, n=54 in 2023-2024, 6% in 2022-2023, 5% in 2021-2022).

Opt-in

- Of the 507 appropriate referrals, 374 opted in (74%).
- Annually, referral to opt-in has consistently been the stage that the service sees the largest drop-off in number of veterans. The service continues to explore ways to maximise engagement at this stage.

Assessment

- All 374 veterans who opted-in were offered an assessment.
- Eighty percent (n=299) attended their assessment.
- Seventy-three percent (n=219) of those veterans were offered treatment and placed on treatment waiting lists.

Presentations at assessment

For the first time, this report presents a detailed analysis of common presentations at assessment using clinical measure data.

- Where data was available, we found that 50% of veterans reported childhood abuse as a non-military trauma.
- Thirty-eight percent (n=84) of veterans who were assessed had experienced 4 or more Adverse Childhood Experiences (ACEs). This figure is significant when compared to the wider population 14% of Welsh people have four or more ACEs (Public Health Wales, 2015).
- We also looked at the presence of probable Anxiety (89%, n=234), Depression (89%, n=235), PTSD (84%, n=212), and Insomnia (69%, n=174) at assessment. It is worth noting that high rates of anxiety are not surprising given there is a cross over of symptoms between Generalised Anxiety Disorder (GAD) and PTSD.
- Forty percent of veterans (n=101) has an increasing or high risk of alcohol misuse.

Treatment offer and start

- Some veterans who attended assessment disengaged whilst on the waiting list (n=18), but 201 veterans were offered a first treatment date.
- The service aims to offer a first treatment session within 26 weeks of assessment and 85% (n=159) of veterans were offered their first treatment session in this timeframe.

Treatment outcomes

- When analysing data for this report 41 veterans who were referred in 2023-2024 were still in treatment and not included in treatment outcome figures.
- Of the remaining 160 veterans who were offered a first treatment session: 90 veterans (56%) completed treatment.

Clinical Outcomes

- Overall, an improvement after treatment was found in a range of mental health symptoms.
- Before treatment, the mean score on clinical measures for PTSD, Depression, Anxiety and Insomnia were above case-ness thresholds, which indicates a probable diagnosis for these disorders.
- After treatment, all mean scores were below case-ness for these disorders.
- Reliable improvement data, spanning the past five years (2019-2024) showed that improvement rates for Depression, Anxiety and Insomnia have gradually decreased in the last two years whereas rates for PTSD improvement have increased and remained steady.

Service Overview

Service Aims

- To improve the mental health and wellbeing of veterans with a service-related mental health problem
- Develop sustainable, accessible and effective services that meet the needs of veterans with mental health and wellbeing difficulties who live in Wales

Service Eligibility

Any veteran living in Wales who has served at least one day with the British Armed Forces, as either a regular service member or as a reservist, who has a 'service-related psychological injury' is eligible to self-refer/be referred and be assessed by a VNHSW clinician.

Veterans with a 'service-related' mental health injury are eligible to receive outpatient treatment (psychological and/or medication). Those with a 'non-service related' mental health injury are signposted to appropriate services for ongoing treatment. See Appendix 2 for the full care pathway.

Key Features of the Service

- An All-Wales NHS outpatient service for veterans with service-related mental health problems
- A multi-disciplinary team comprised of staff with personal experience working in and for the military and/or extensive experience of working with the mental health needs of veterans
- Veterans receive a comprehensive assessment that accurately assesses their psychological and social needs
- Veterans are signposted or referred to appropriate services for any physical needs that are identified
- Following assessment, veterans, and others involved in their care (e.g. family) members, are collaboratively involved in the development of an individualised management plan to address health and psychosocial needs
- The service promotes a recovery model so that veterans can maximise their physical, mental and social wellbeing in line with Welsh Governments Prudent Healthcare policy (Welsh Government, 2019)
- The service provides psychological interventions (approximately 16-20 outpatient therapy sessions) in addition to Consultant Psychiatrist outpatient clinics for diagnostic assessment, second opinion and medical reviews
- The service shares expertise and raises awareness of the needs of veterans and military culture to ensure improved treatment and support across services
- The service is committed to ongoing evaluation and research on the needs of veterans in the community to inform future policy making and commissioning of services

Our Teams

VNHSW operates via a 'Hub and Spoke' model. Cardiff and Vale (CAVUHB) host the national 'hub' for VNHSW and the service 'spokes' are in Aneurin Bevan (ABUHB), Betsi Cadwaladr (BCUHB), Cwm Taf Morgannwg (CTMUHB), Hywel Dda (HDUHB) and Swansea Bay (SBUHB). Veterans residing in the Powys Teaching Board area are referred to their neighbouring health boards in ABUHB, BCUHB, SBUHB (see Appendix 3).

All teams work within the guidelines of the VNHSW Pan-Wales Operational Policy. Each team is broadly made up by a Clinical Lead, Veterans' Therapist(s) and Administrator. The Hub team also includes the Director who is also the Consultant Clinical Lead, Highly Specialist Clinical Psychologist and Assistant Psychologist. All health boards have access to a Consultant Psychiatrist who offers two sessions per month (total = 7.5 hrs). Details of each team and its members can be seen in the map below.

Several clinicians have personal experience of military life. Dr Neil Kitchiner, Director and Consultant Clinical Lead (CAVUHB), served as a Captain with 203 (Welsh) Field Hospital based in Cardiff, HQ. Neil deployed to Afghanistan during Herrick 19a (Oct 2013 – Jan 2014) as part of the two-person field mental health team. Neil retired from the army in 2016.

Julie Graham, Lead Therapist (HDUHB) has worked as a civilian community psychiatric nurse with SSAFA, the Armed Forces Charity, based in Germany for several years, delivering mental health care to serving personnel from various MoD mental health facilities.

Our peer mentors have a wide range of experience and expertise to bring to their role in supporting veterans. Damon Rees, Peer Mentor (ABUHB) served for 28 years in the army retiring as a Platoon Sergeant in 2016. Damon completed two tours of Northern Ireland, the Gulf War 1990-1991 and the Iraq War 2003.

Ian Moore MBE, Peer Mentor (CTMUHB) served 44 years and retired in April 2024. Ian served in 1st The Queens Dragoons Guards (The Welsh Cavalry) for 24 years and 3rd Battalion and the Royal Welsh for 20 years. Ian achieved the rank of Captain in the role of Operational Support Officer and was deployed to Northern Ireland three times, UN Cyprus, Bosnia Op RESOLUTE, the Gulf War 1990-91 Op GRANBY and the Gulf War 2003 – Op TELIC.

Jordan Lloyd, Peer Mentor (BCUHB) joined the army in 2010 serving with the 1st Battalion Welsh Guards and was medically discharged in 2016. During his time in service Jordan deployed to Afghanistan OP HERRICK and took part in multiple ceremonial duties in London as well as being part of the regional army recruitment team.

Kevin Hackett, Peer Mentor (BCUHB) joined the Royal Navy in 1978 as a Weapons Engineering Mechanic (Ordnance). Kevin was deployed to the Falklands in 1982 following the Argentine invasion, as part of the second task force. Kevin was discharged in 1991 as a Leading Weapons Engineering Mechanic (Ordnance) and spent his later career working for North Wales Police. He joined VNHSW as part of Change Step peer mentoring programme in 2017 and has been a peer mentor for the service ever since.

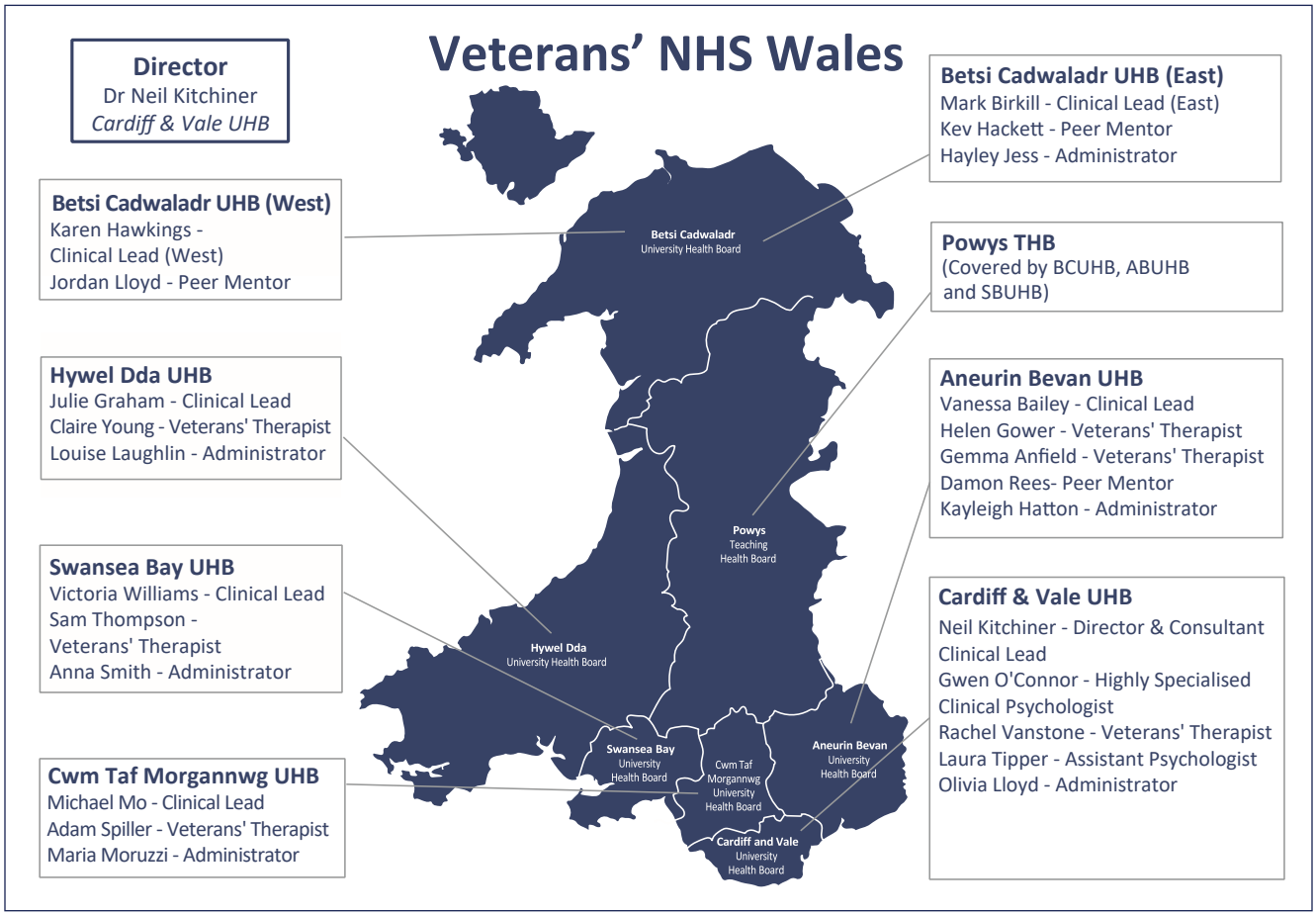


Figure 1: Map of Wales

Evidence-based Psychological Therapies and Interventions

Our clinical staff are trained in a range of psychological therapies and interventions, these include:

- Acceptance and Commitment Therapy (ACT)
- Cognitive Analytic Therapy (CAT)
- Cognitive Behavioural Therapy (CBT) Trauma-Focussed CBT
- Compassion Focussed Therapy (CFT)
- Cognitive Processing Therapy (CPT)
- Emotional regulation training (STAIR/DBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Interpersonal psychotherapy (IPT)
- Integrated Psychotherapy (IP)
- Prolonged exposure (PE)
- SPRING and Military-SPRING – online guided self-help interventions
- Schema Therapy
- The REWIND Technique

Stakeholder Involvement

VNHSW continues to host six-monthly national steering groups, in addition to attending key stakeholder meetings and contributing to armed forces forums in most health boards. The service engages in the following stakeholder groups:

- Armed Forces Community Covenant meetings
- Armed Forces Local Health Board Forums
- UK National Veterans Mental Health Network meetings
- Welsh Government Cross Party Group for Armed Forces and Cadets
- Welsh Government Armed Forces Expert Group
- Armed Forces and Veterans Champions meetings
- Welsh Prison Veterans' meetings

Projects and Research Involvement

The service continues to run quality improvement projects, service evaluations and is involved in research trials to contribute to the advancement of evidence-based treatments for veterans. In 2023-2024, VNHSW teams engaged in the following activity:

Operational Policies and Service Developments:

- Pan-Wales Prison Pathway
- Pan-Wales Operational Policy
- Swansea Bay GP referrals audit to streamline the referral process

Research Projects and Publications by VNHSW staff:

- Thompson, S. (2024). Recognising mental health challenges and barriers to treatment among veterans in the UK. British Journal of Mental Health Nursing, 13(4), 1-3.
- Bisson, JI., Ariti, C., Cullen, K., Kitchiner, NJ., Lewis, C., Roberts, NP., et al. (2023) Pragmatic randomised controlled trial of guided self-help versus individual cognitive behavioural therapy with a trauma focus for post-traumatic stress disorder (RAPID). Health Technol Assess 27(26). https://doi.org/10.3310/YTQW8336.
- Whiteford, S., Quigley, M., Dighton, G., Wood, K., Kitchiner, NJ., Armour, C., & Dymond, S. (2024). Anxiety, distress tolerance, and the relationship between complex posttraumatic stress disorder symptoms and alcohol use in veterans. Journal of Clinical Psychology, 80, 158–169. https://doi.org/10.1002/jclp.23604.
- Astill Wright, L., Barawi, K., Kitchiner, NJ., Kitney, D., Lewis, C., Roberts, A., Roberts, NP., Simon, N., Ariti, C., Nussey, I., Muss, D., Bisson, JI. (2023) Rewind for Posttraumatic Stress Disorder: A Randomised Controlled Trial. Depression and Anxiety, 6279649, https://doi.org/10.1155/2023/6279649
- Simon, N., Lewis, C., Smallman, K., Brookes-Howell, L., Roberts, NP., Kitchiner, NJ., Ariti, C., Nollett, C., McNamara, R., & Bisson, JI. (2023). The acceptability of a guided internet-based trauma-focused self-help programme (Spring) for post-traumatic stress disorder (PTSD). European Journal of Psychotraumatology, 14(2) https://doi.org/10.1080/20008066.2023.2212554
- Lewis, C., Bailey, L., Ariti, C., Kitchiner, NJ., Roberts, NP., Simon, N., & Bisson, JI. (2023). Social support as a predictor of outcomes of cognitive behavioral therapy with a trauma focus delivered face-to-face and via guided internet-based self-help. Journal of Traumatic Stress, 36, 511–523. https://doi.org/10.1002/jts.22947
- Hannigan, B., van Deursen, R., Barawi, K., Kitchiner, NJ., & Bisson JI (2023) Factors associated with the outcomes of a novel virtual reality therapy for military veterans with PTSD: Theory development using a mixed methods analysis. PLOS ONE 18(5): e0285763. https://doi.org/10.1371/journal.pone.0285763.

Accreditation Processes:

- Royal College of Psychiatrists Veterans' Mental Health Accreditation, mid-point self-review and audit (CAVUHB)
- Pride in Veterans Standard Accreditation (CAVUHB)

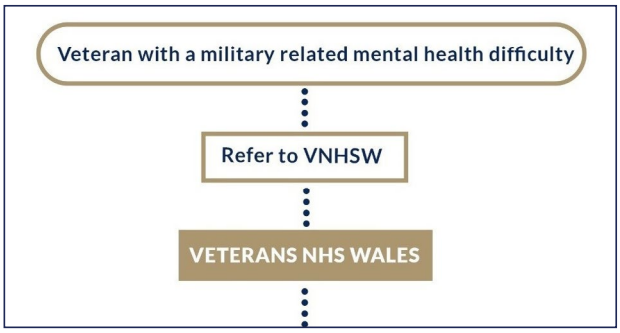
Conferences and Training:

- Panel discussion at Kings College London veterans' mental health conference on integrating health systems (Dr Gwen O'Connor, CAVUHB)
- Military Mental Health training for student mental health nurse cohorts (Mark Birkill and Kevin Hackett, BCUHB)
- Workshop at BABCP Annual Conference, Cardiff University. The development of Spring for treating PTSD (Dr Neil Kitchiner, C&VUHB)
- Skills based workshop at BABCP Annual Conference, Manchester University. The development of Spring and Military Spring (Dr Neil Kitchiner, C&VUHB)
- Keynote at 12 Annual Vilnius Trauma Conference, Vilnius University (Dr Neil Kitchiner, C&VUHB)

Service Demand and Performance

VNHSW conducts the same operational process across all Wales UHBs. Once a referral is received, the veteran is required to opt-in (consent to accessing VNHSW and the service accessing their MoD records), before the assessment is booked. After assessment, treatment decisions are made following a discussion in the weekly multi-disciplinary team meeting and if deemed appropriate for the service offered various courses of treatment (psychological and/or medication).

Appendix 2 presents this process in more detail. Data presented in the coming sections breaks down VNHSW performance and demand across 1st April 2023–31st March 2024 through these broad stages (Referral, Opt-in, Assessment, Treatment, and Discharge).

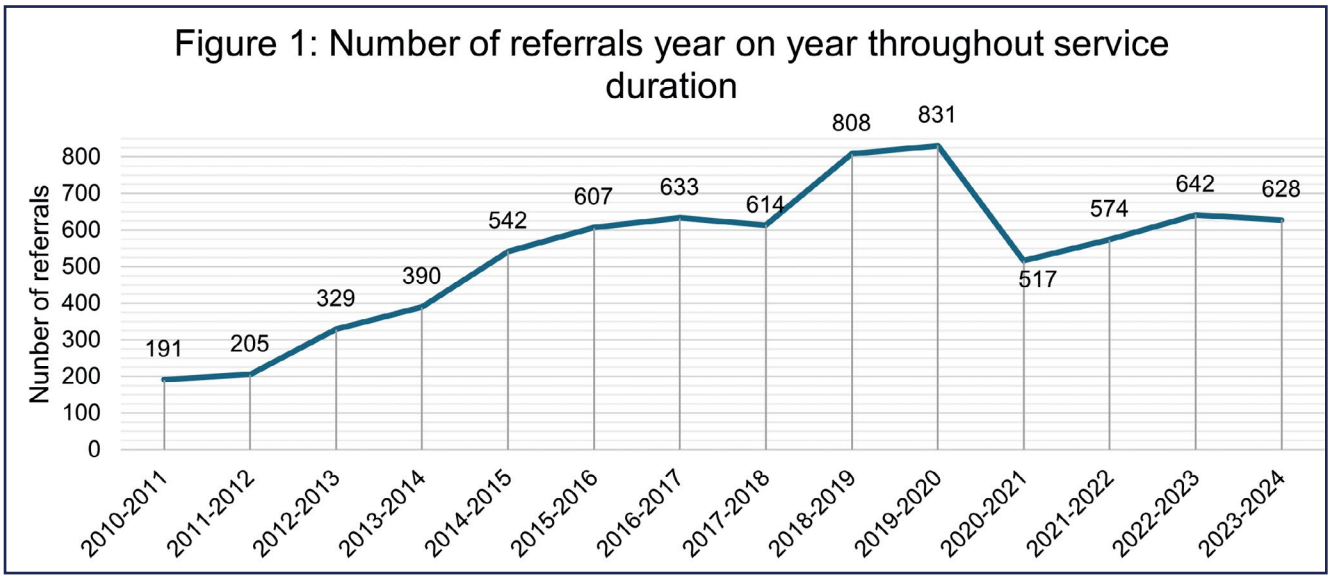


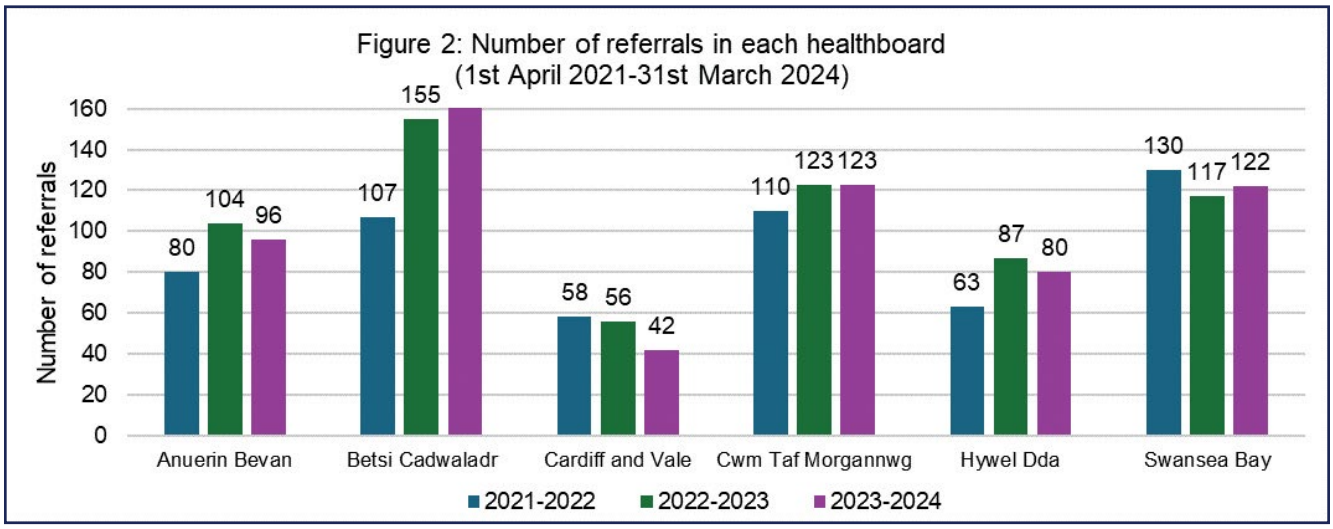
Referral stage

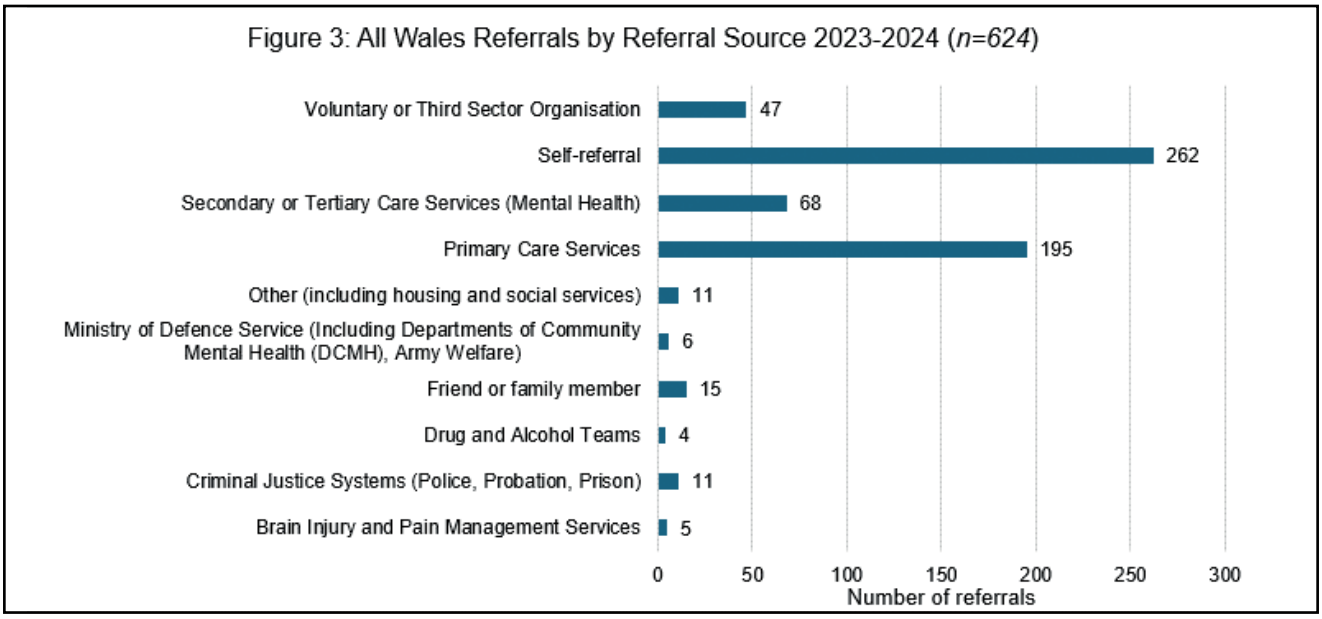
In 2023-2024, the service received 628 referrals. This is a slight decrease (n=-14) from 2022-2023. The number of referrals from 2010 (service start) 2024 can be seen in Figure 1.

BCUHB had the most referrals (n=160) in 2023-2024, followed by CTMUHB (n=123) and SBUHB (n=122). The fewest referrals were received in CAVUHB (n=42). This trend has been seen in the previous two years, for full health board referral numbers see Figure 2.

Fifty-two percent (n=329) of referrals were received online via the VNHSW website. This is higher than the previous year (42%). Most referrals (n=262, 42%) were self-referrals, primary care services (e.g. GPs) were the second most common referral source (n=195, 31%) consistent with previous years. This trend was mirrored when looking at individual LHBs. Figure 3 shows full, all-Wales referral source details.







In recent years, the service has begun tracking re-referral rates. In 2023-2024, 47% (n=293) of referrals were re-referrals which is the highest percentage in the past three years (see Figure 4). Re-referral rates in 2023-2024 for each health board are reported in Table 1.

Previous reports have outlined multiple reasons why a veteran may be re-referred to the service. In addition to possibly needing further treatment, a veteran's previous referral may not have been appropriate, the veteran may not have opted-in or disengaged at assessment or treatment. However, a veteran may now be in a better position to engage with the service.

The service currently has no further data on the reason veterans are re-referred to the service. This data will be collected and reported in the future.

Figure 4: Percentage of re-referral 2021-2024 *(n=623)*
1st April 2021-31st March 2024

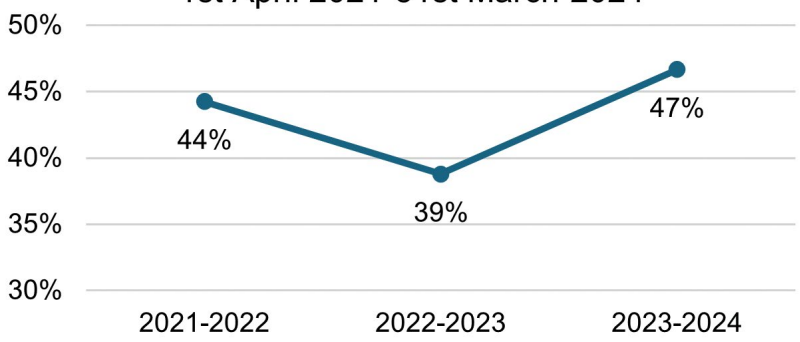


Table 1: Percentage of re-referral per LHB in 2023-2024 *(n=623)*	
Local health board	**Percentage of re-referral**
Aneurin Bevan	91
Betsi Cadwaladr	111
Cardiff and Vale	73
Cwm Taf Morgannwg	33
Hywel Dda	15
Swansea Bay	26

Across all-Wales referrals, 81% (n=507) of referrals were appropriate referrals, 19% (n=121) were inappropriate referrals. Inappropriate referrals are defined as those where the individual referred does not meet VNHSW inclusion criteria, for example, where the individual's mental health difficulty is not related to military service. Table 2 outlines the percentage of inappropriate referrals in each health board.

Table 2: Inappropriate referrals in 2023-2024 *(n=623)*							
	Health Board						
	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Swansea Bay	All Wales Total (Mean)
Percentage of inappropriate referrals	16%	20%	8%	28%	34%	5%	19%

Opt-in stage

Of the 507 appropriate referrals, 374 opted into the service (74%). One hundred and thirty three veterans did not return opt-ins and were therefore discharged from the service at this stage. The service was quick to triage and respond to referrals with opt-in packs. Eighty six percent of opt-ins packs were sent to veterans within a week of referral receipt, and 40% of opt-in packs were sent on the same day.

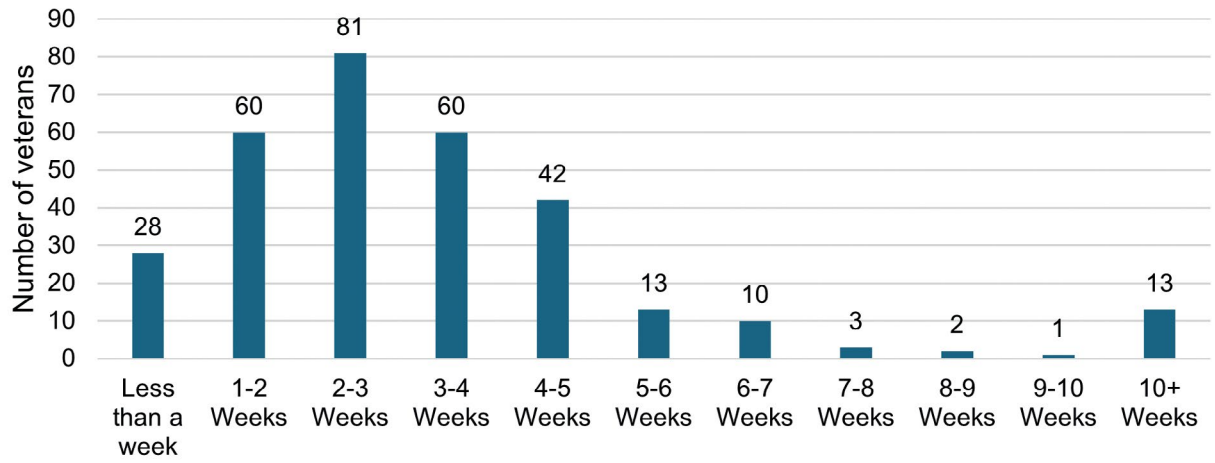
Where data was available, analysis showed that there is a disparity between opt-in returns and veterans' sex. Thirty five percent (n=19) of female veterans did not return their opt-ins whereas 20% (n=114) of male veterans did not return theirs. VNHSW may need to consider additional support to encourage initial female veteran engagement with the service. For example, the service could contact female veterans to further discuss their referral on receipt, provide information about the service and encourage engagement. If the service had female peer mentors these could also be a first point of contact.

Assessment stage

Assessment appointments were offered to each of the 374 veterans who opted in. VNHSW attempts to see veterans for assessment within four weeks of opt-in paperwork being received. This 4-week target is set by Welsh Government. Primary Care services are expected to meet this target for a minimum of 80% of cases.

Data is available for 313 veterans (61 data points missing) when reviewing opt-in to assessment wait times. Of the available data 73% of veterans were seen in 4 weeks or less for assessment. This is under the 80% target expected of Primary Care services. However, most referrals were responded to in 5 weeks or less (87%). Full opt-in to assessment wait-time data can be seen in Figure 5. Eighty percent of veterans attended their assessment appointment (n=299).

Figure 5: Wait time from opt-in to assessment during 2023-2024 *(n=313)*



Assessment to treatment offer

In 2023-2024, 73% (n=219) of those who attended their assessment appointment were offered treatment. The percentage of veterans offered treatment ranged from 63-83% across health boards. SBUHB had the highest percentage of veterans who were offered treatment after assessment. Table 3 outlines assessment to treatment offer data.

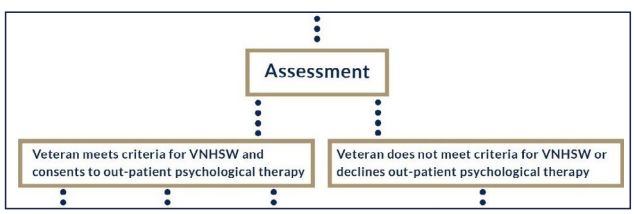
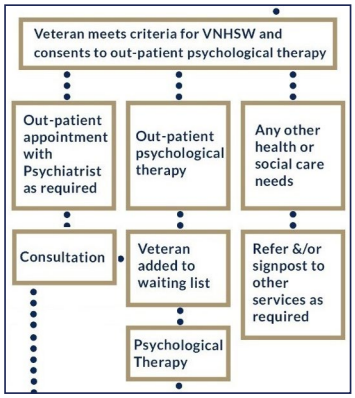


Table 3: Assessment attendance to treatment offered in 2023-2024							
	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Swansea Bay	All Wales Total (Mean)
Attended assessment	50	80	25	61	24	59	299
Offered treatment	37	50	20	49	14	49	219
Percentage offered treatment	74%	63%	80%	80%	58%	83%	73%

Treatment stage

Once offered treatment, veterans are placed on a waitlist until there is a Veterans' Therapist available to treat them. In 2023-2024, 201 (92%) veterans were offered a first treatment date. Veterans' NHS Wales aims to start treatment 26 weeks, or less, after the assessment appointment. This target is set by Welsh Government. In 2023-2024, 85% (n=159) of veterans were offered a first treatment session within 26 weeks after assessment (See Figure 6, 22 data set unavailable).



At the end of the reporting period, 41 veterans were still in treatment and are not included in the following treatment outcome figures.

Of the 160 veterans who were offered a first treatment date, 90 veterans (56%) completed treatment. A further 31 veterans (19%) dropped out of treatment early. Seventeen veterans (11%) suspended or postponed treatment and 12 veterans (8%) did not attend their first treatment session. A small percentage (4%, n=6) of veterans never booked their first treatment date when contacted. Table 4 summarises these results.

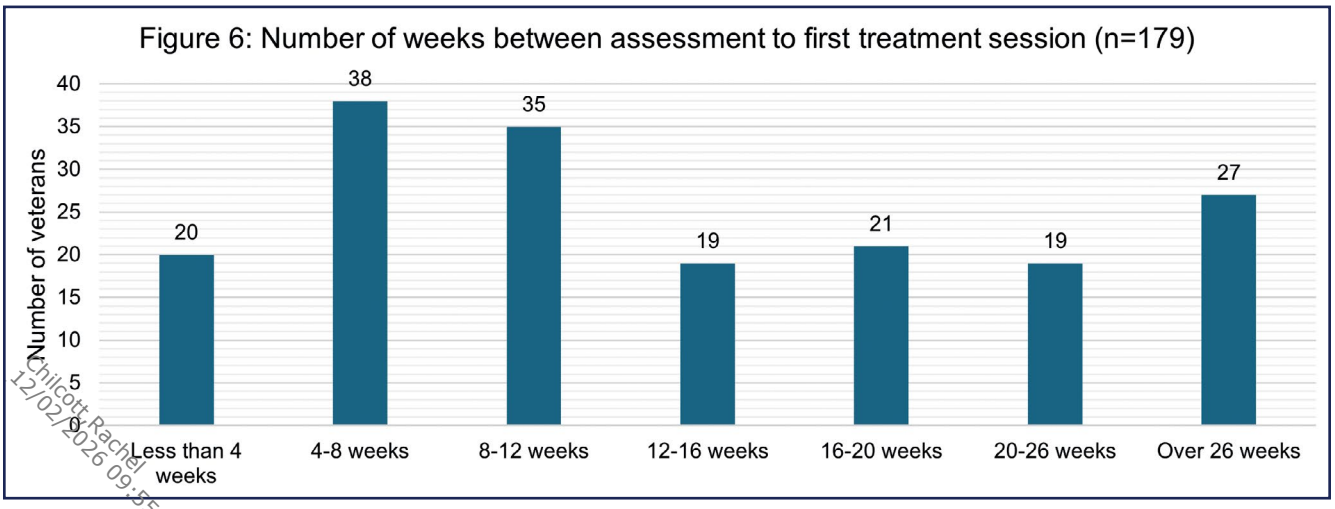


Table 4: Discharge outcomes for veterans offered first treatment session in 2023-2024 *(n=160)*		
Discharge outcomes	Number of veterans	Percentage of veterans
Completed treatment	90	56%
First treatment session not booked (no contact)	6	4%
Did not attend first treatment session	12	8%
Dropped out of treatment early (Did not attend and/or no contact)	31	19%
Treatment suspended/postponed	17	11%
Discharge data unavailable	4	3%

Demographics

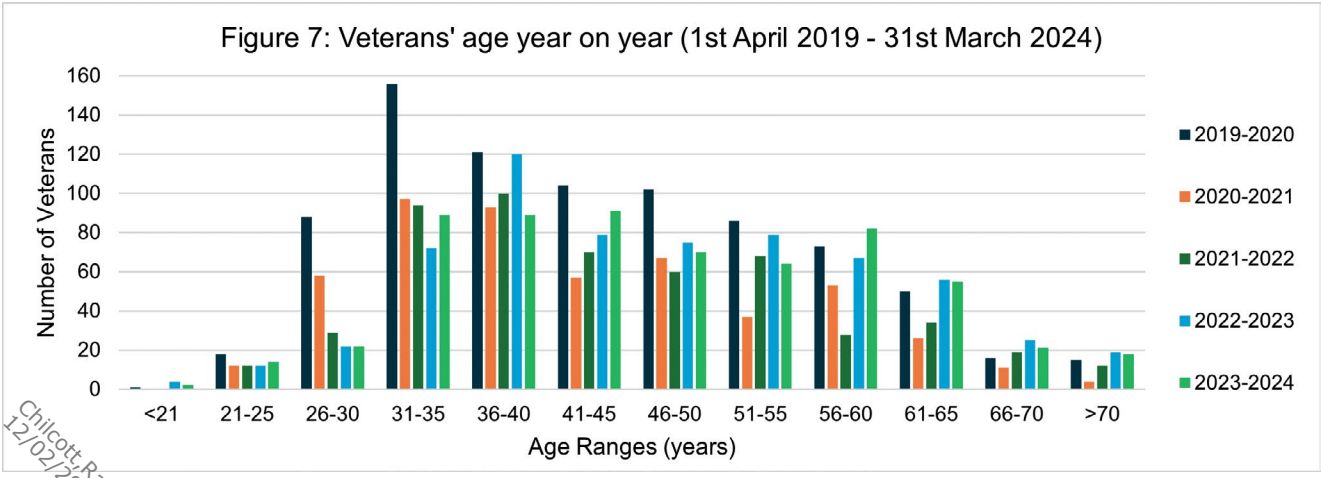
The following section outlines veterans' demographic data from 2023-2024. Age and sex data is collected at referral. Remaining data is taken at assessment stage.

Age

In 2023-2024, the mean veteran age was 47 years. Just under 80% of veterans fell between ages 31 and 60. The youngest veteran seen in 2023-2024 was 18 and oldest 98.

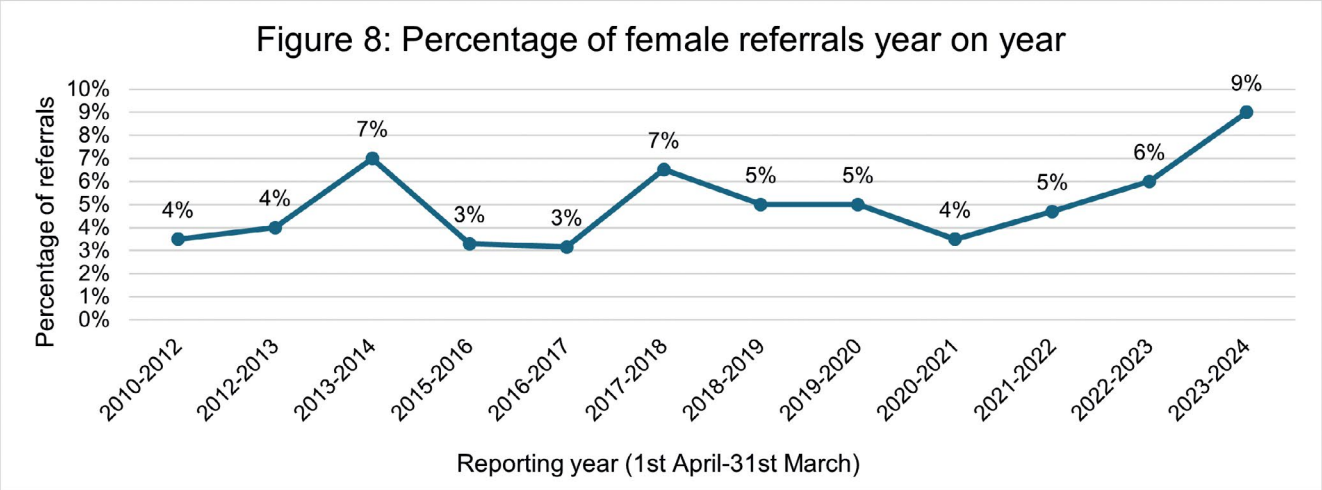
The service is seeing a gradual trend toward its population getting slightly older over time. The average age bracket was 26-30 years from 2015-2019, increasing to 41-45 service years in the current year. Despite this, most veterans continue to fall between 31-60 years. See Figure 7 for veterans age statistics year on year (2019-2024).

Figure 7: Veterans' age year on year (1st April 2019 - 31st March 2024)



Sex

Consistent with previous reporting years, most referrals were male (91%, n=574). The service has seen an increase in female veterans referred. In 2023-2024, 9% (n=54) of veterans were female compared to 6% in 2022-2023. The percentage of female referrals from 2010-2024 can be seen in Figure 8.

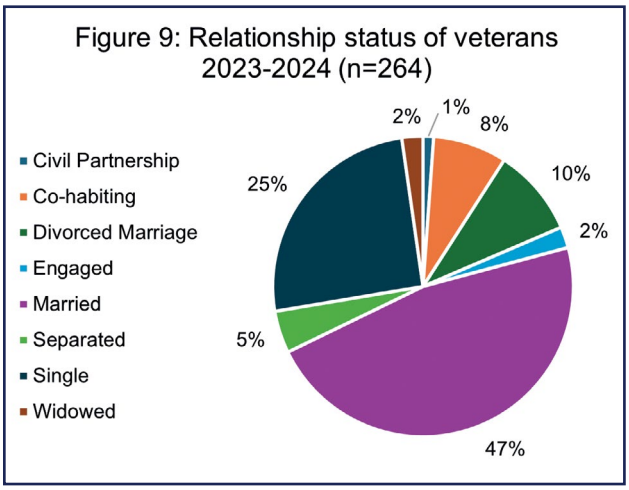


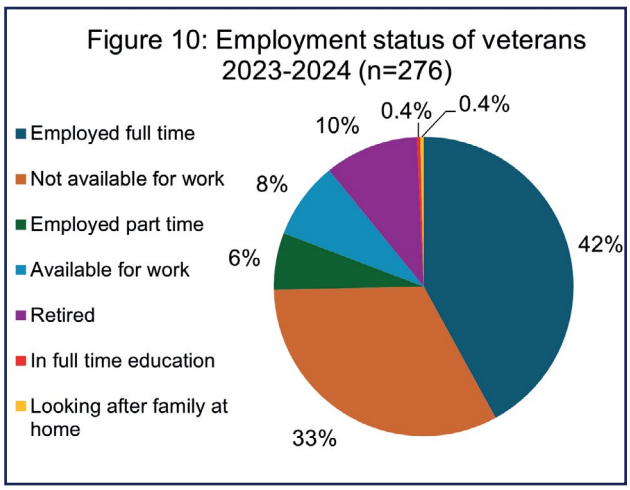
Identity, cultural and social demographics

Two thirds of veterans identified as British (66%, n=186) and 28% (n=79) identified as Welsh. Most veterans were white British, or from another white background (97%, n=238). Over half of veterans (61%, n=168) reported a disability. Table 5 outlines national identity, ethnicity and disability data.

Figures 9-10 present relationship and employment status of veterans. Almost half of veterans were 'Married' (47%, n=124), and a further 25% (n=67) were 'Single'. Most commonly, veterans were 'Employed Full-Time' (42%, n=116) or 'Not Available for work' (33%, n=90).

Table 5. Identity, ethnicity and disability demographics	
Demographic item	Veterans, n (%)
National Identity (n=281)	
British	186 (66%)
English	9 (3%)
New Zealand	1 (0.4%)
Scottish	4 (1%)
Welsh	79 (28%)
Prefer not to say	2 (1%)
Ethnicity (n=246)	
Black, Black British Caribbean, African or any other Black background	1 (0.4%)
Mixed White & Black Caribbean, White & Black African, White & Asian or any other mixed background	7 (2.8%)
White British or any other white background	238 (96.8%)
National Identity (n=281)	
British	186 (66%)
English	9 (3%)
New Zealand	1 (0.4%)



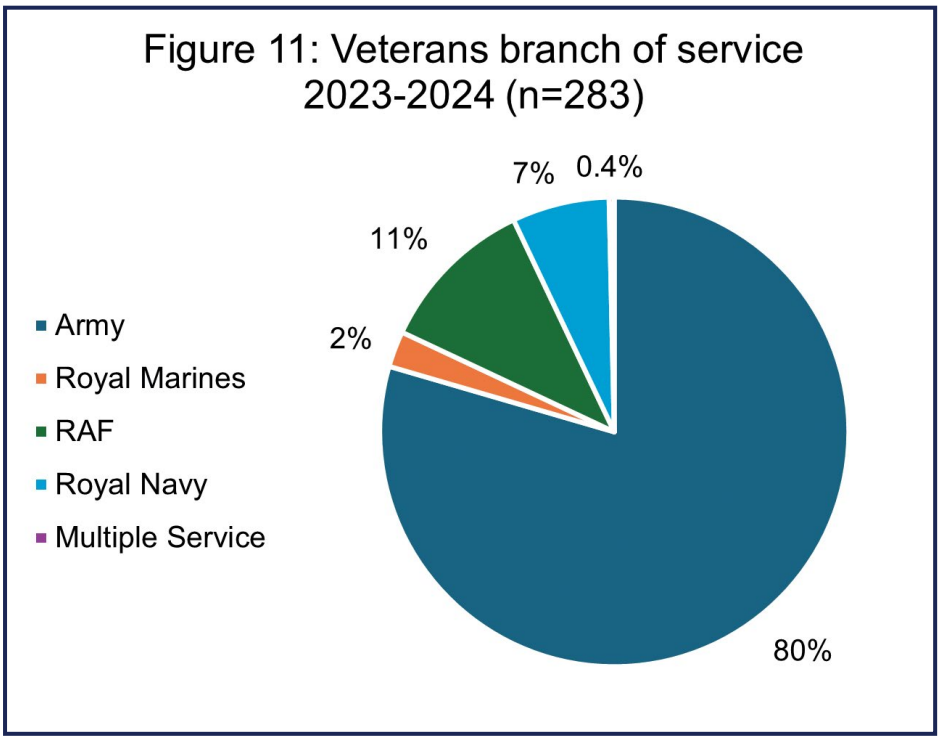


Military demographics

As shown in Figure 11, most veterans assessed by the service served in the Army (80%, n=225), followed by the Royal Air Force (11%, n=31) and the Royal Navy (7%, n=19). One veteran (0.4%) had served in multiple armed forces.

Veterans' time in service ranged from under one year to 50 years. The mean length of service was 12 years.

Only 12% (n=33) of veterans had never been deployed. Most veterans had been deployed either once (26%, n=68) or twice (24%, n=64). The most common deployment location was Afghanistan, followed by Northern Ireland.

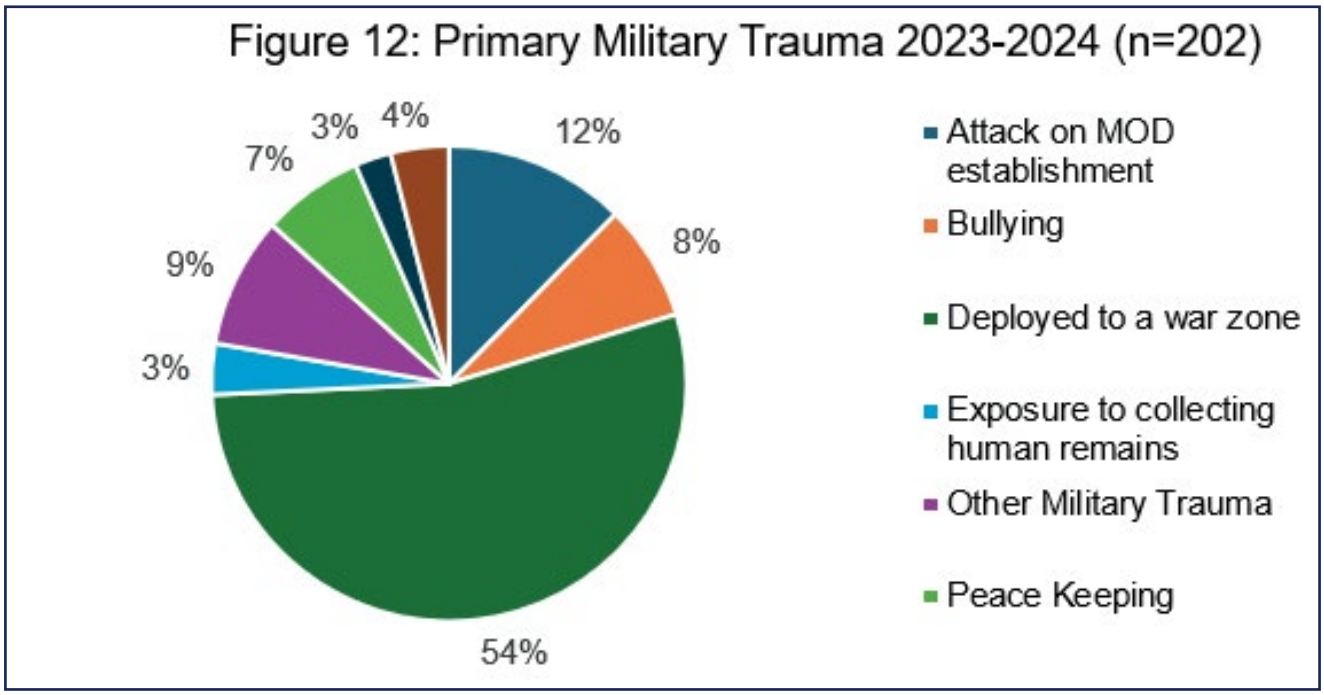


Trauma Experiences

Detail on traumatic events experienced are also taken at assessment. Where data is available, the next section reports primary military trauma, primary non-military trauma and Adverse Childhood Experiences. Exposure to traumatic events increases the likelihood of common mental health problems (Public Health Wales, 2016).

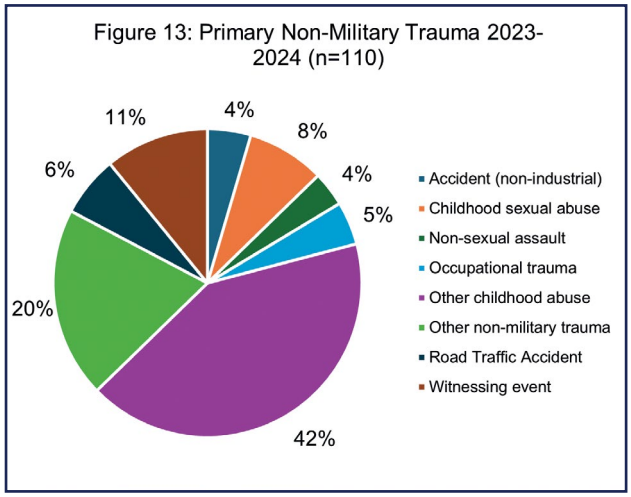
Primary Military Trauma

The most common primary military trauma reported was 'Deployment to a war zone' (54%, n=109), followed by 'Attack on a MOD establishment' (12%, n=25), 'Bullying' (8%, n=16), and 'Peace Keeping' (7%, n=14). 'Other military trauma' equates to 9% of trauma-types reported and includes Training exercises, Vicarious Trauma, Sexual Assault or Rape and Witnessing Suicide. Individually, each 'other military trauma' made up 2% or less (n≤4). Figure 12 shows full details.



Primary Non-Military Trauma

The first, and third, most common primary non-military trauma reported were linked to childhood abuse ('Other childhood abuse (non-sexual)' 42%, n=46, and 'Childhood sexual abuse' 8%, n=9). The second most common non-military trauma reported was 'Witnessing event' (11%, n=12). This may include Witnessing suicide, or Violent events. 'Other non-military trauma' equates to 20% of the overall data. However, each individual item made up 3% or less (n≤3). Items include Miscarriage, Imprisonment, Natural disaster and Industrial Accident. These items are combined within 'Other non-military trauma' and presented in Figure 13.

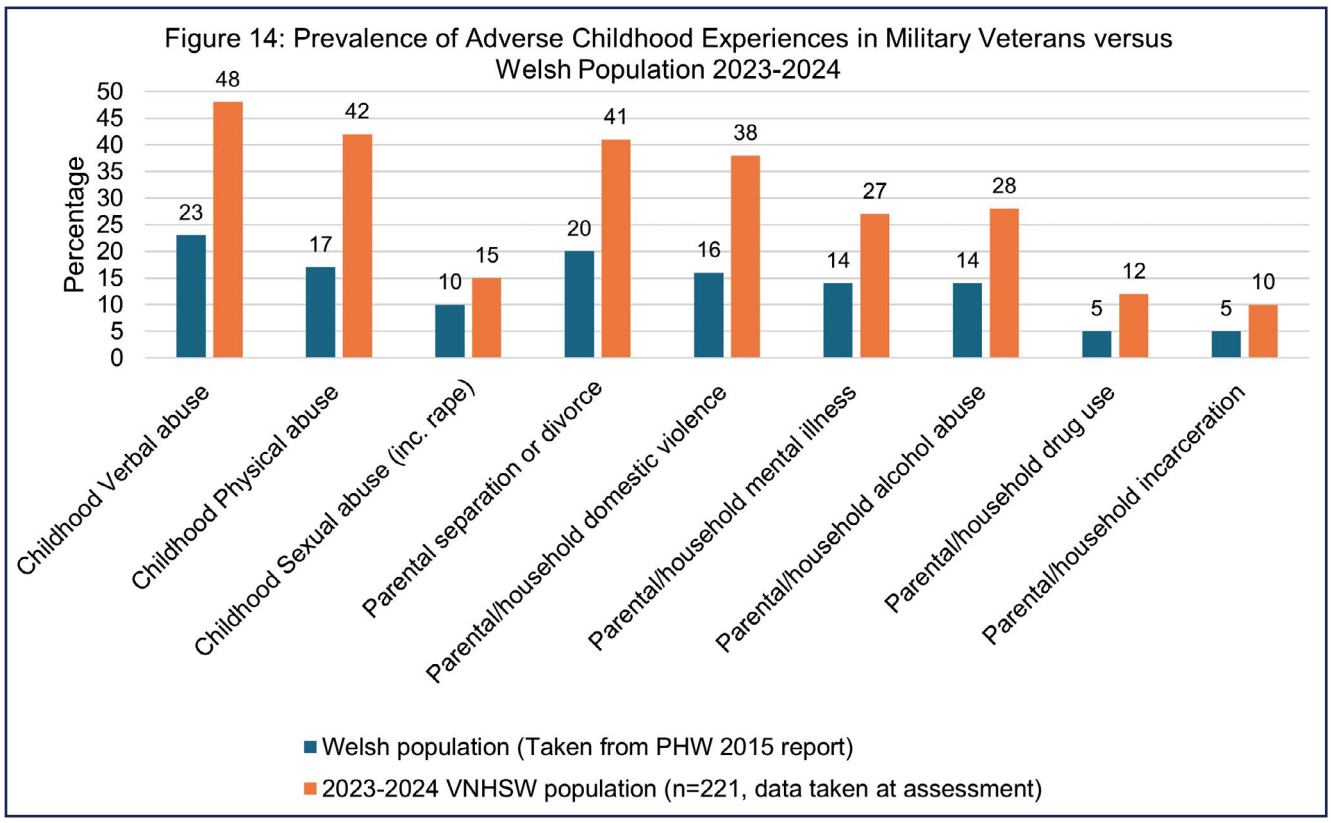


Adverse Childhood experiences (ACEs)

Fifty-percent of primary non-military traumas reported were linked to childhood abuse. VNHSW administers the Public Health Wales's ACE questionnaire at assessment to identify childhood (pre-18) experiences of adversity or trauma.

Fourteen percent of people living in Wales have four, or more, Adverse Childhood Experiences (ACEs) (Public Health Wales, 2015). In 2023-2024, 38% (n=84) of veterans who were assessed had experienced 4 or more ACEs.

Figure 14 highlights the prevalence for individual ACEs in 2023-2024 for veterans at assessment (n=221), versus the wider Welsh population (Public Health Wales, 2015). Veterans presented with higher percentage of ACEs on all items, compared to the Welsh population. This data may be biased as it is taken at assessment from treatment seeking veterans with mental health problems. ACEs significantly increase the risk of mental health difficulties in adult life, therefore VNHSW population could be skewed towards a higher prevalence of ACEs. Regardless, the data in Figure 14 highlights high percentage of ACEs in VNHSW population which suggests potential complexity in trauma presentations and psychological treatment.



Mental Health Presentations

This section will discuss the prevalence of common mental health difficulties, comorbid presentations and treatment outcomes in the 2023-2024 VNHSW population.

Veterans' complete self-report psychometric measures for Post Traumatic Stress Disorder (PTSD), Depression, Anxiety, Insomnia, Alcohol and Substance Misuse at assessment, start of their treatment and completion of treatment. A veterans' probable diagnosis is indicated by psychometric measures and clinician judgment following the veteran's biopsychosocial assessment.

The psychometric measure data is presented in this section. These screening measures provide a picture of each veteran's probable diagnosis and presenting symptoms but are self-report measures and should be interpreted with caution. However, these measures provide the best data we have of the mental health presentations veterans attending VNHSW present with.

Psychometric measures used are:

1. PTSD (PCL-5)
2. Depression (PHQ-9)
3. Anxiety (GAD-7)
4. Insomnia (ISI)
5. Alcohol and substance use (ASSIST LITE)

A higher score on each of these measures indicates a higher severity of symptoms.

Single probable diagnosis at assessment

The data below shows the percentage of veterans screening for a common mental health difficulty or substance misuse issue at assessment.

Three-hundred and seventy-four veterans were offered an assessment and sent our clinical measures to complete before they were assessed. Not all veterans engaged with assessment or completed online measure questionnaires, data is included where available. The prevalence rate detailed below for probable PTSD, Depression, Generalised Anxiety Disorder and Insomnia are presented in Figure 15.

PTSD

- Eighty four percent (n=212) of veterans met the threshold for PTSD indicated by their PCL-5 (score ≥33)
- Presentation rates ranged from 82% (HDUHB, SBUHB) - 89% (CTMUHB) across each health board

Depression

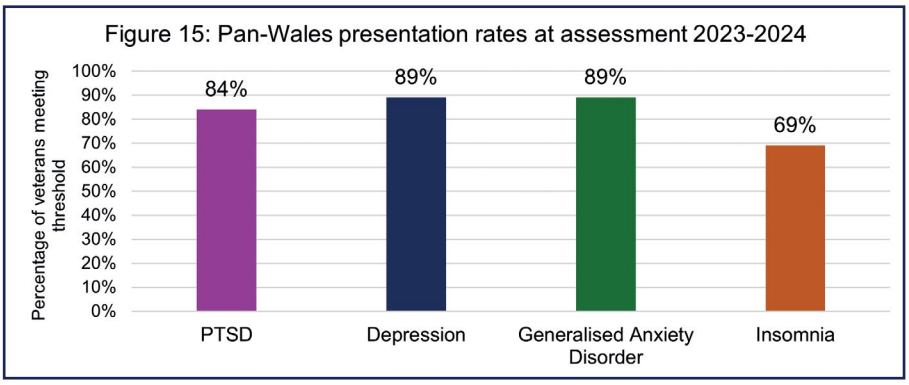
- Eighty-nine percent (n=235) of veterans met the threshold for Depression indicated by the PHQ-9 (score ≥10)
- Presentation rates ranged from 75% (CAVUHB) – 96% (HDUHB) across each health board

Generalised Anxiety Disorder

- Eighty-nine percent (n=234) of veterans met the threshold for Generalised Anxiety Disorder indicated by the GAD-7 (score≥8).
- Presentation rates ranged from 75% (CAVUHB) - 95% (ABUHB) across each health board

Insomnia

- Sixty nine percent (n=174) of the veterans met the threshold for Clinical Insomnia indicated by the ISI (score ≥15)
- Presentation rates ranged from 57% (CAVUHB) – 84% (CTMUHB) across each health board



Alcohol and Substance use

- Forty percent (n=101) of veterans had either "increasing risk" (score=5-7), "higher risk" (score=8-10) or "high-risk" (score=11-12) alcohol misuse indicated by the ASSIST-Lite self-report clinical measure
- "Increasing risk", "higher risk" or "high-risk" substance use was prevalent for 9% of Veterans: for Cannabis, 7%, for Sedatives, 7% for Stimulants, 2% for Opioids and 2% for any other substance

Common Comorbidities

The above data looks at each mental health presentation individually, but the service sees many veterans with multiple difficulties. In fact, the number of veterans presenting with only one probable diagnosis at assessment are small to non-existent. For example, only four (1.5%) veterans met probable PTSD threshold at assessment but did not meet thresholds for anxiety or depression. Three of these four veterans still met clinical insomnia threshold. The high rate of comorbidity seen across the self-report screening measures is not surprising given the cross over of symptoms within these diagnostic categories.

The following section highlights some of the most common comorbidities in our veteran population according to assessment self-report clinical measures. Outcomes for comorbid groups are also presented. Outcomes are defined by service discharge outcome (e.g. 'dropped out of treatment', 'completed treatment').

PTSD and Depression Comorbidity

- Eighty one percent (n=202) of veterans had a probable comorbid PTSD and Depression
- Thirty three percent (n=66) of veterans with probable comorbid PTSD and Depression completed treatment, compared to 63% (n=5) with PTSD and no Depression, and 25% with Depression and no PTSD (n=5)

Alcohol Use Comorbidity (Depression)

- Thirty six percent (n=91) had probable comorbid Depression and increasing Alcohol use risk
- Thirty percent (n=27) of veterans with comorbid Depression and increasing Alcohol use risk completed treatment

Alcohol Use Comorbidity (with PTSD)

- Thirty two percent (n=76) of veterans had probable comorbid PTSD and increasing Alcohol use risk
- Thirty three percent (n=25) of veterans with probable comorbid PTSD and increasing Alcohol use risk completed treatment

Across comorbid presentations, the dropout rate of therapy was between 10-11%. This is lower than the therapy dropout rate for overall 2023-2024 population (16%). This indicates that no combination of presentations assessed increases the likelihood of therapy dropout.

Clinical Outcomes of Treatment

Veterans' complete self-report clinical measures to screen for probable diagnosis at assessment as listed in the previous section. These measures also indicate symptomatic change and are repeated at the start (pre) and end (post) of treatment. The following section compares pre- and post-treatment data for the ninety veterans who completed treatment in 2023-2024.

Analysis has been conducted using complete data sets only, whereby veterans have completed start of treatment self-report clinical measures, finished treatment, and completed end of treatment measures. Number of data points (N=x) are reported in each section as some data points are missing.

Table 6 summaries the clinical outcome data reported in this section for each clinical measure.

Table 6: Description of Clinical Outcomes of Treatment

Outcome Measure	Outcome Description
Mean pre and post treatment scores	Mean pre and post treatment scores are reported for each clinical measure. This is the mean score of all veterans who completed treatment in 2023-2024
Clinical measure threshold, pre and post treatment	Of those who completed treatment, the number of veterans who were above the case-ness threshold pre-treatment, compared to post-treatment.
Reliable Recovery	Reliable recovery is found when a veteran meets case-ness at the start of treatment, but not at the end. Reliable recovery is only reported for veterans who met case-ness at the start of treatment.
Reliable Improvement	Reliable improvement is found if a veterans' score reduces by a specified value, or more, after treatment compared to before treatment. Each clinical measure has a different value for improvement change score, these are defined in the relevant sections below. Reliable improvement is reported for all veterans who completed treatment and pre- and post- treatment measures.
Clinically Significant Improvement	Clinically significant improvement is found where both reliable recovery and improvement are met.
NB: Case-ness is defined when an individual is regarded as a clinical case on the clinical measure. Individual clinical measures have case-ness cut-point thresholds.	

PCL-5 for symptoms of PTSD (n=85)

Figure 16 presents a mean pre and post-treatment PCL-5 score for 85 veterans. A total score of 33 or higher indicates case-ness for probable PTSD. Pre-treatment, the mean PCL-5 score was 49 and above case-ness. Post-treatment mean was 24 and no longer met case-ness.

At the start of treatment 67 veterans met case-ness threshold for PTSD. After treatment, only 22 veterans met this threshold. These results indicate an improvement in PTSD symptoms after treatment with VNHSW. These results are summarised in Table 7.

Additionally, Table 7 presents Reliable Recovery, Improvement and Clinically Significant Improvement rates. Eighty-five percent of veterans showed reliable improvement and 69% of veterans reliably recovered from PTSD. Overall, 69% showed clinically significant improvement in the PTSD symptoms.

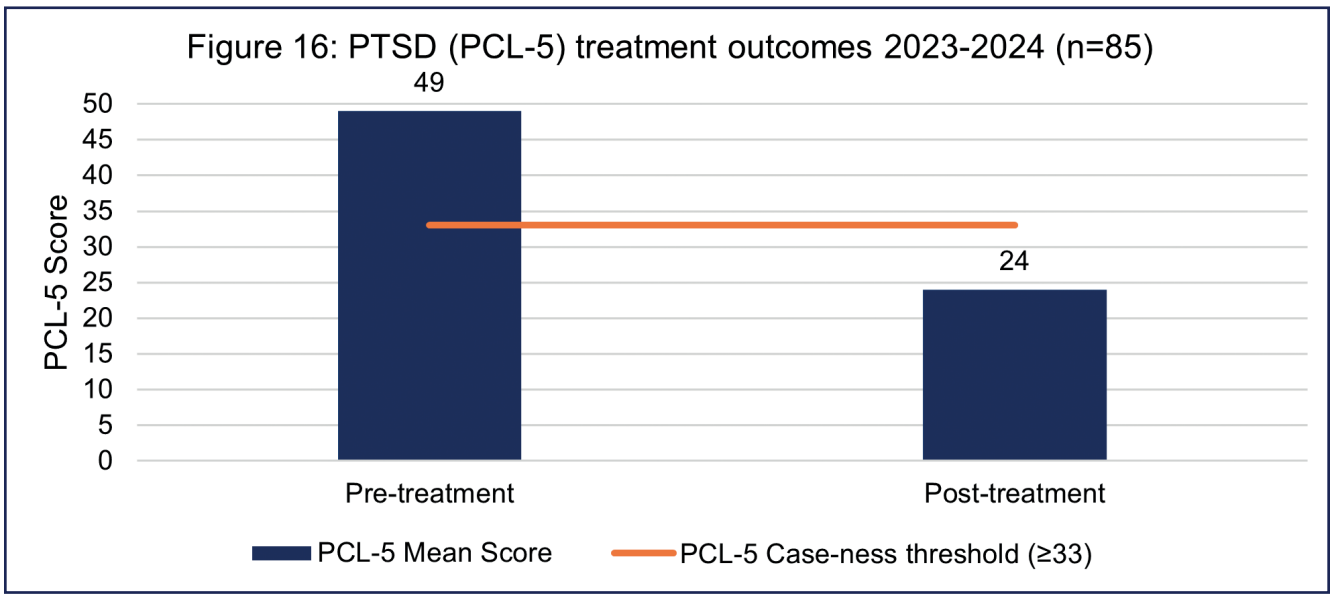


Table 7: Outcome measures for PTSD using PCL-5 pre and post treatment scores (n=85)		
Mean PCL-5 scores (n=85) (See Figure 16)	Pre-treatment = 49	Post-treatment = 24
Veterans above clinical measure threshold (≥33) (n=85)	Number of veterans	
	Pre-treatment = 67 (79%)	Post-treatment = 22 (26%)
Reliable Improvement (≥5 point reduction in PCL-5 score post-treatment) (n=85)	85% (n=72)	
Reliably Recovered (≥33 pre-treatment and ≤33 post-treatment) (n=67)	69% (n=46)	
Clinically Significant Improvement (n=67)	69% (n=46)	

PHQ-9 for symptoms of Depression (n=85)

PHQ-9 clinical ranges are 0-4 = normal range, 5-9 = mild depression, 10-14 = moderate depression, 15-19 = moderately severe depression and 20-27 = severe depression.

Figure 17 presents mean pre- and post-treatment PHQ-9 score for 85 veterans. At start of treatment, the mean PHQ-9 score was 17, which indicates moderately severe depression. After treatment, the mean score had reduced to 9, indicating mild depression. This shows a reduction in mean score by two clinical ranges and the post-treatment mean score dropping below the case-ness threshold of ≥10. Overall, these figures suggest a reduction in self-reported depression symptoms for veterans completing treatment.

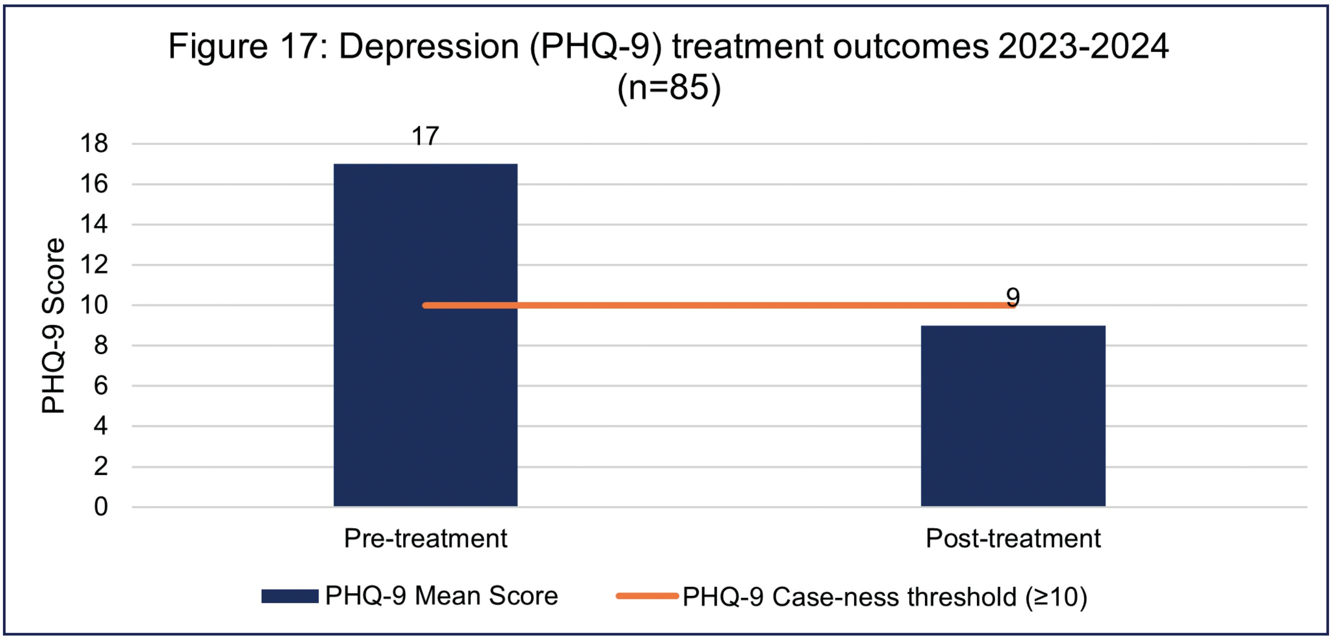


Figure 17: Depression (PHQ-9) treatment outcomes 2023-2024 (n=85)

Table 8 presents these results alongside depression Reliable Recovery, Improvement and Clinically Significant Improvement results. Of 85 veterans, 58% (n=49) veterans met reliable improvement threshold. Of 71 veterans, 58% (n=41) showed reliable recovery and 51% (n=36) met the threshold for clinically significant improvement.

Table 8: Outcome measures for Depression using PHQ-9 pre and post treatment scores (n=85)

Mean PHQ-9 scores (n=85)	Mean PHQ-9 Score	
	Pre-treatment = 49	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 71 (84%)	Post-treatment = 34 (40%)
Reliable Improvement (≥6 point reduction in PHQ-9 score at post-treatment) (n=85)	58% (n=49)	
Reliably Recovered (≥10 pre-treatment and ≤10 post treatment) (n=71)	58% (n=41)	
Clinically Significant Improvement (n=71)	51% (n=36)	

GAD-7 for symptoms of Generalised Anxiety Disorder (n=85)

The GAD-7 clinical ranges are: 0-4 = normal range, 5-9 = mild anxiety, 10-14 = moderate anxiety and 15-21 = severe anxiety.

Figure 18 presents a mean pre- and post-treatment GAD-7 score for 85 veterans. At start of treatment, the mean GAD-7 score was 14 which indicates moderate anxiety. After treatment, the mean score was 7, indicating mild anxiety. These results demonstrate a reduction in average anxiety score by one clinical range and that the mean post-treatment score drops below the GAD-7 case-ness threshold of ≥8. These figures suggest a reduction in self-reported anxiety symptoms.

Figure 18: Generalised Anxiety Disorder (GAD-7) treatment outcomes 2023-2024 (n=85)

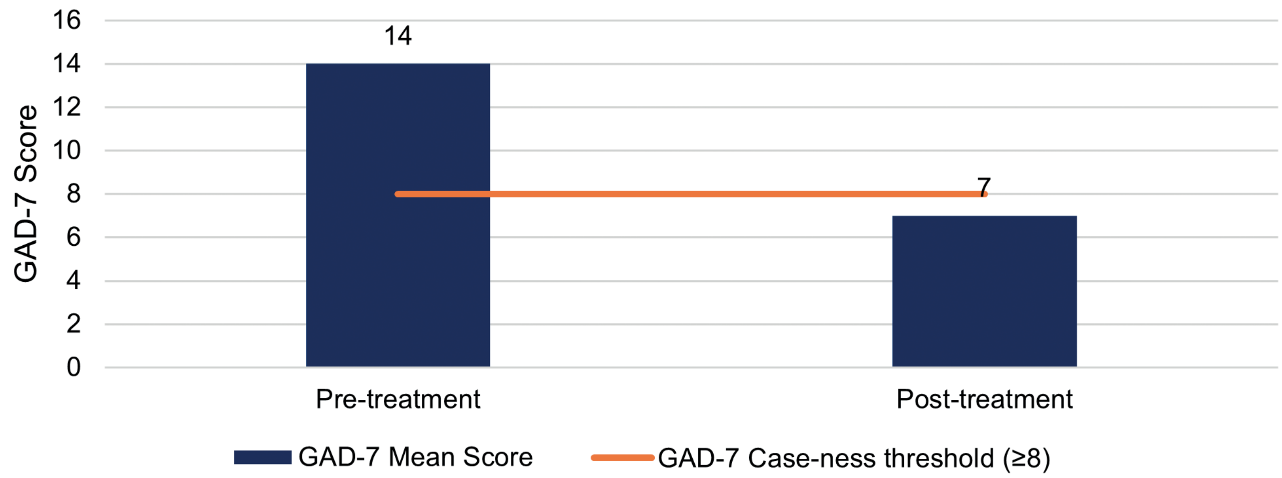


Table 9 presents these results alongside Reliable Recovery, Improvement and Clinically Significant Improvement results for anxiety. Of 85 veterans, 66% of veterans met the reliable improvement threshold for anxiety symptoms. Seventy-one veterans met the GAD-7 case-ness threshold for clinically significant anxiety pre-treatment. Of these 71 veterans, 37% met reliable recovery and 37% also met both improvement and recovery measures for anxiety symptoms.

Table 9: Outcome measures for Generalised Anxiety Disorder using GAD-7 pre and post treatment scores (n=85)		
Mean GAD-7 scores (n=85) (See Figure 18)	Mean GAD-7 Score	
	Pre-treatment = 14	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 71 (84%)	Post-treatment = 34 (40%)
Reliable Improvement (≥4 point reduction in GAD-7 score at post-treatment) (n=85)	66% (n=56)	
Reliably Recovered (≥8 pre-treatment and ≤8 post treatment) (n=71)	37% (n=26)	
Clinically Significant Improvement (n=71)	37% (n=26)	

ISI for symptoms of Insomnia (n=59)

The ISI clinical ranges are: 0-7 = no clinically significant insomnia, 8-14 = subthreshold insomnia,15-21 = clinical insomnia (moderate severity) and 22-28 = clinical insomnia (severe).

Figure 19 presents a mean pre and post-treatment ISI score for 59 veterans. At start of treatment, the mean ISI score=17, which indicates moderate severity clinical insomnia. After treatment, the mean ISI score=12 which is categorised as subthreshold insomnia. This shows a reduction in mean score by one clinical range. The post-treatment mean score also drop below the ISI has a "case-ness" threshold of ≥15.

Figure 19: Insomnia (ISI) treatment outcomes 2023-2024 (n=59)

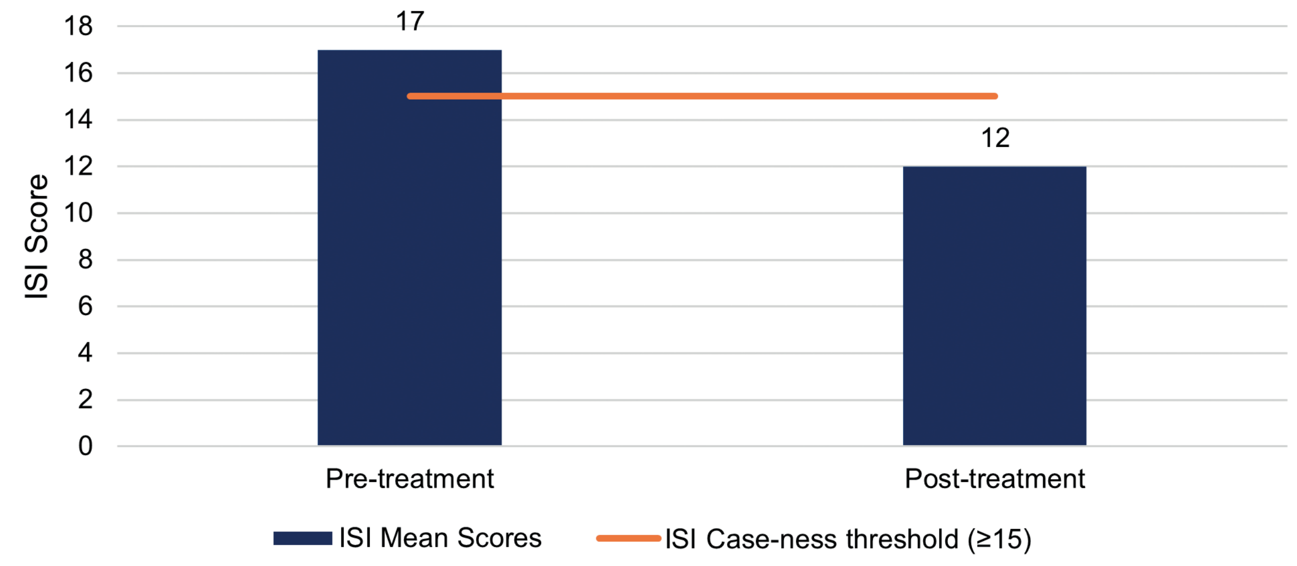
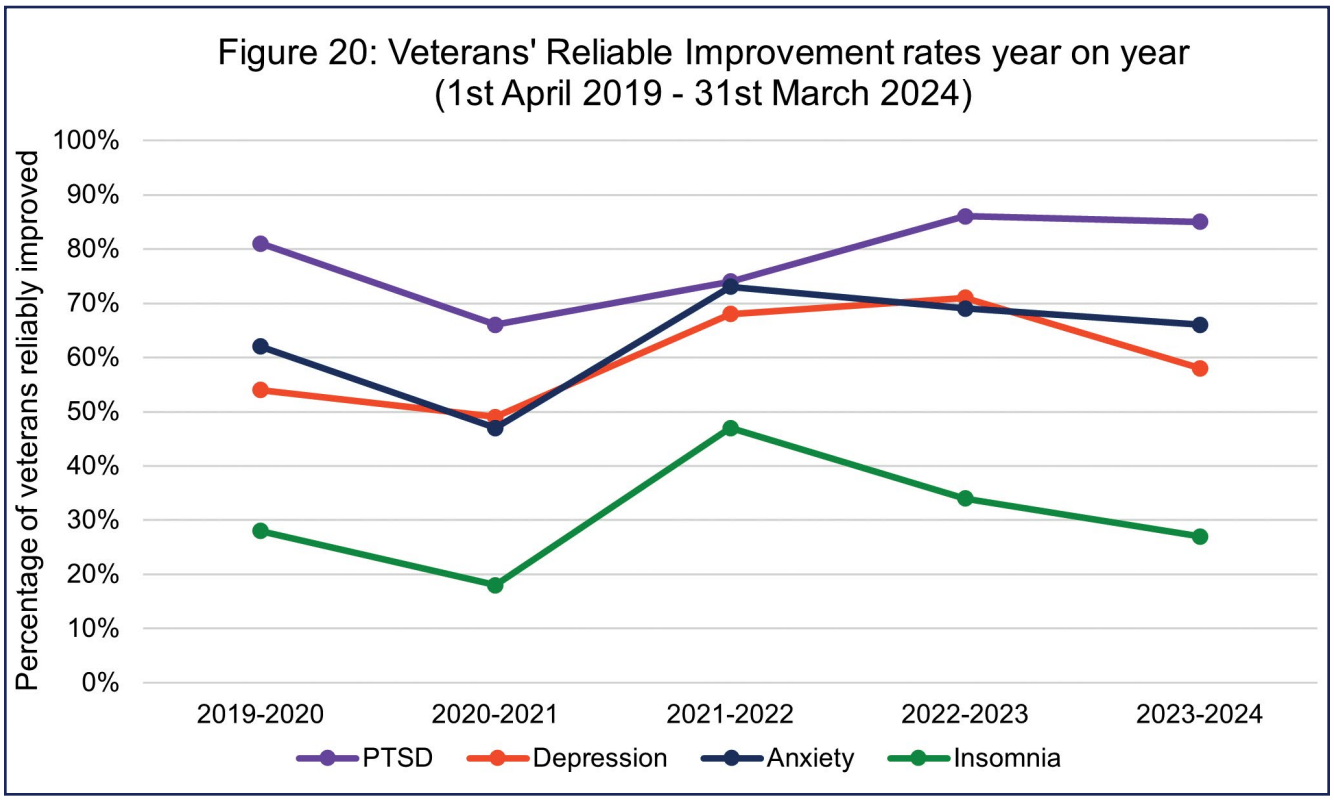


Table 10 presents recovery and improvement rates for insomnia, in addition to the figures above. Only 27% of veterans showed reliable improvement (8-point reduction in their ISI score). It is worth noting that an 8-point reduction is the highest value reduction of all four clinical measures reported. Fifty-one percent (n=20) showed reliably recovery and 36% (n=14) of veterans met the threshold for clinically significant improvement.

Table 10: Outcome measures for Insomnia using ISI pre and post treatment scores (n=59)		
Mean ISI scores (n=59) (See Figure 19)	Mean ISI Score	
	Pre-treatment = 17	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 39 (66%)	Post-treatment = 22 (37%)
Reliable Improvement (≥8 point reduction in ISI score at post-treatment) (n=59)	27% (n=16)	
Reliably Recovered (≥15 pre-treatment and ≤15 post-treatment (n=39)	51% (n=20)	
Clinically Significant Improvement (n=39)	36% (n=14)	

Reliable improvement over time

Figure 20 presents reliable improvement rates for PCL-5, PHQ-9, GAD-7 and ISI over the last five years. Improvement rates for Depression, Anxiety and Insomnia have gradually reduced in the last two years whereas rates for PTSD symptom improvement have increased and remained steady.

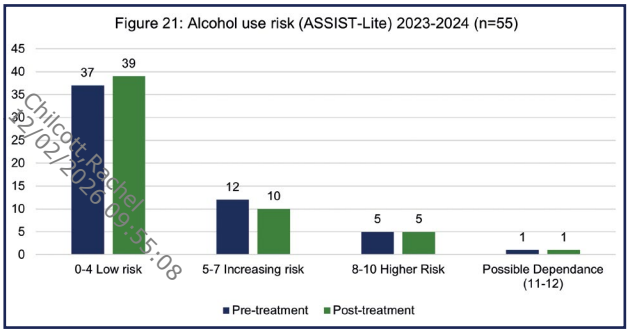


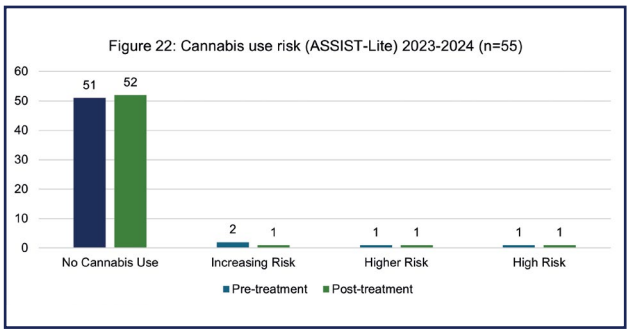
ASSIST-Lite for alcohol and substance use

The ASSIST-Lite is scored over several subsections, rather than as an overall measure. However, the maximum score is = 28 when all subsections are combined. In 2023-2024, the mean ASSIST-Lite scores reduced after treatment. Before treatment, the mean, combined ASSIST-Lite score = 4, and after treatment, the mean combined score reduced to = 2. This indicates a trend in symptom improvement for alcohol and substance misuse difficulties.

A more representative picture of veterans' alcohol misuse pre and post-treatment in 2023-2024 is presented in Figure 21. This graph shows the number of veterans in each of the alcohol risk categories pre and post-treatment. Post-treatment, only two veterans reduced in risk. Moving from "increasing risk" to "low risk".

Figure 22 presents the same data for veterans' cannabis misuse and highlights that one veteran dropped in risk category in 2023-2024. Data sets for other substances are too small to present, but figures presented here for alcohol and cannabis use show limited symptom improvement post-treatment.





Service User Feedback

In 2023-2024, 24 veterans (27%) completed service experience questions (SEQ) after completing treatment. Overall, all feedback was positive with all 24 veterans responding as 'strongly agree' when asked if they would recommend the service to other veterans.

Below, are quotes from our feedback forms. Veterans were asked to tell us about their experience of the service.

Excellent service and would recommend to others (ABUHB)

From my initial call at the start, I have been treated with empathy and kindness. The therapists have been extremely supportive, and I cannot thank them enough for all the help, support and encouragement they have given to me since starting therapy. I can honestly say they brought me back and out of a very dark episode that I was struggling with (CAVUHB)

From the initial contact by a Peer Mentor, through to therapy from my Veteran's Therapist, I have received very professional care process (BCUHB)

I can't thank you enough. I have now changed into the man I used to be, still a long way to go but I'm on the up, thanks to you all (HDUHB)

I had quite a few issues which were taken and dealt with very quick... I felt valued (CTMUHB)

It was extremely helpful and gave me ways to deal with my problems, being able to talk through all my issues and be listened too, with care and understanding (ABUHB).

My relationship with my therapist was excellent, they were someone I could trust. They talked me through every step of the treatment plan and explained in depth of how each treatment worked (CAVUHB)

When I first started, I felt like I was a broken man and had nowhere to go in life but after months being with my therapist, I am totally changed person. I feel 100% better than I was and my whole experience has been fantastic. I cannot thank my therapist enough for what he has helped me achieve within the last 9 months and I feel I am back to the person I used to be (BCUHB)

This Service is outstanding for Veterans it's a real game changer. I didn't know about this service until my GP informed me (BCUHB)

Walk and Talk experience was excellent being outside I felt relaxed to open up. Appointment times were flexible. Therapist was easy going and approachable. I felt listened to for the first time ever (HDUHB)

Excellent rapport and understanding from the therapist and selection of the therapy. Explanation of the process confirmed my understanding (CAVUHB)

Very Professional, Supportive and insightful (HDUHB)

The high degree of professionalism and ability to make me feel comfortable when we spoke (SBUHB)

References

Public Health Wales. (2016). Adverse Childhood Experiences and Adult Mental Well-Being in Wales. Accessed July 2025: https://phwwhocc.co.uk/wp-content/uploads/2020/08/FINAL-ACE-Mental-Well-being-Infograph-E.pdf

Public Health Wales. (2015). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Accessed April 2024: https://phw.nhs.wales/files/aces/infographic-aces-and-their-impact-on-health-harming-behaviours-in-the-welsh-adult-population/

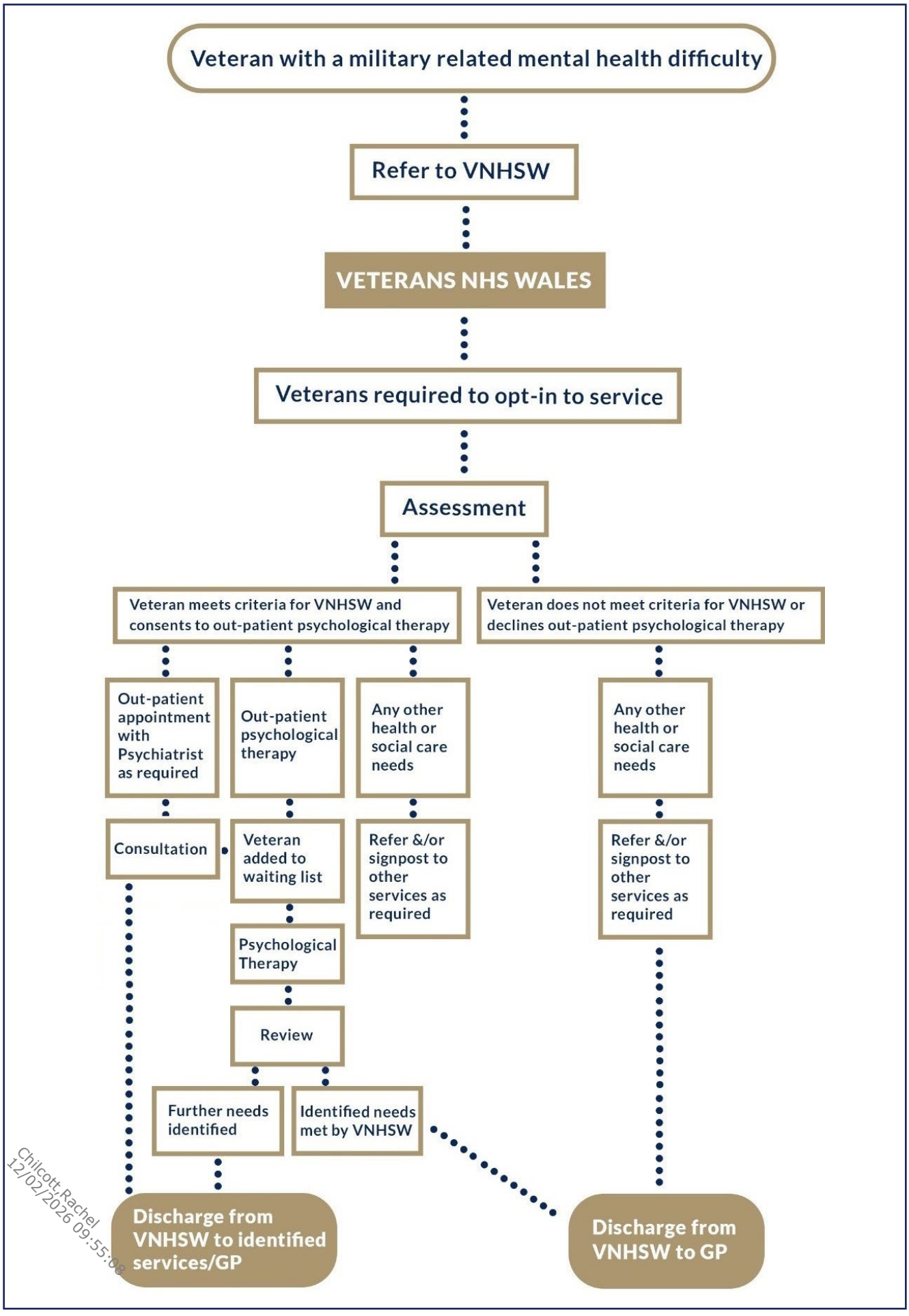
Welsh Government (2019) Prudent Healthcare Securing Health and Well-being for Future Generations: securing-health-and-well-being-for-future-generations.pdf

Appendices

Appendix 1: Acronyms Table

Acronym	Full Name
ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
CAVUHB	Cardiff and Vale University Health Board
CTMUHB	Cwm Taf Morgannwg University Health Board
HDUHB	Hywel Dda University Health Board
PTSD	Post Traumatic Stress Disorder
SBUHB	Swansea Bay University Health Board
SEQ	Service Evaluation Questionnaire
VNHSW	Veterans' NHS Wales

Appendix 2: Veterans' NHS Wales Care Pathway



Appendix 3: Powys Teaching Health Board VNHSW Out-Patient Clinics

VETERANS NHS WALES

Website: **www.veteranswales.co.uk**
(For useful information on the Veterans' NHS Wales and links to other helpful websites)

Deprivation of Liberties Safeguards (DoLS)

Final Internal Audit Report

2025/26

Cardiff & Vale University Health Board

Reasonable Assurance

Contents

Review Reference	CVU-2526-16
Fieldwork	July - August 2025
Executive Sign Off	September 2025
Audit Committee	November 2025
Executive Lead	Jason Roberts, Executive Director of Nursing
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Rachel 26/11/2025 09:55:08

Executive Summary

Purpose

The overall objective was to review the arrangements for ensuring compliance with DoLS requirements.

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.

In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing DoLS policies, rules and regulations are still extant.

Our review was to look at current processes for DoLS applications and ensure they are managed in accordance with DoLS Code of Practice, Welsh Government guidance and Health Board procedures.

Overview

We have concluded reasonable assurance on this area. The significant matters requiring management attention include:

- There is currently no DoLS policy in place within the Health Board.
- There is no documented Standard Operating Procedure in place.
- Training on DoLS is not mandated for staff including those who are responsible for identifying DoLS cases and completing applications.
- The number of DoLS assessments required to be completed in an average week is consistently higher than the number of assessments that are being paid for to be undertaken by the Local Authority.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- There are numerous documents relating to DoLS on Sharepoint; however, not all of these are structured within the DoLS specific Sharepoint page and it is not clear which of these are still current and relevant. This has also been identified within the DoLS Work Plan Tracker 2025/26 which includes a 'review of Sharepoint and resources'.
- Reports to and discussions within the Mental Health Legislation Committee could be strengthened with greater focus on the applications that have not been undertaken in the timeframes including trend analysis and data on the number of staff that have been DoLS trained by Clinical Board.

Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.	1, 2	**Limited**
2	Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.	3	**Reasonable**
3	An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary.	4	**Reasonable**
4	The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework.		**Substantial**

Management Actions

1 High priority

3 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.	**Limited**

Overview / Summary of Observations

The Health Board does not currently have a documented policy or procedure covering DoLS. The Health Board's Sharepoint site holds several documents including various guides and training materials that provide an overview of the DoLS processes employed. However, this gives a fractured view without illustrating the full end-to-end process. Furthermore, the available resources do not sufficiently detail the roles and responsibilities of all involved with an application or clearly detail the timeline targets for the processing of DoLS applications.

Whilst there are numerous documents on DoLS available on Sharepoint, they are not all consolidated on the DoLS specific intranet page, and it is not clear which of these remain current and relevant and which may be out of date or have been replaced.

	Key Findings	Risk & Impact	Agreed Management Action
1	**The Health Board does not have a DoLS policy** The Health Board does not have a specific policy on DoLS in line with the Welsh Government guidance. Whilst the Welsh Government guidance provides the benchmark, this should be translated into standardised guidance in the form of a policy that as a minimum: • Explains the Health Board's objectives regarding DoLS; • Provides clarity over roles and responsibilities with regards to DoLS within the Health Board; and • Ensures alignment between the Health Board's operating procedures and mandated legislation. Previous audits undertaken within two other Health Boards identified that they have specific DoLS policies in place.	Absence of an up-to-date policy may risk non-compliance with legislation and/or best practice guidance	**Suggested Action:** A DoLS policy will be written, reviewed, approved and implemented. The policy will align to Welsh Government and best practice standards. **Expected Evidence of Implementation:** An approved DoLS policy will be available on the Health Board Sharepoint site.
	Theme: Policies & Procedures	**High Priority** Control Design	**Officer: Chloe Evans, MCA Project Lead** **Target Implementation Date: March 2026**

2	**The Health Board does not have a Standard Operating Procedure on DoLS** The Health Board has several documents describing the DoLS process including guides and training materials. Whilst useful, these documents do not describe the full end-to-end procedure and associated target timelines. However, it was recognised in the Mental Capacity Act (MCA) Team's formal DoLS Work Plan Tracker 2025/26 that a formal procedure document is to be produced, and this will commence in August 2025. The aforementioned previous audits also identified that the two Health Boards have documented DoLS procedures in place.	Absence of up-to-date procedures may risk non-compliance with legislation and/or best practice guidance	**Suggested Action:** A DoLS procedure document will be produced to illustrate and explain the full end-to-end procedure for DoLS to provide staff with a clear overall view.
			Expected Evidence of Implementation: An approved DoLS procedure will be available on the Health Board Sharepoint site.
		Medium Priority	**Officer: Chloe Evans, MCA Project Lead** **Target Implementation Date: March 2026**
	Theme: Policies & Procedures	Control Design	

Objective 2: Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.	**Reasonable**

Overview / Summary of Observations

Training on DoLS is not mandated for Health Board staff. Instead, attendance is left to the discretion of individual staff and ward managers. This has resulted in historically, a low uptake of training. Feedback from the Mental Capacity Act (MCA) team suggests two potential issues as a result:

1) Low confidence that DoLS scenarios are being correctly identified on wards, potentially resulting in patients being unlawfully deprived of liberty; and
2) Application form quality is inconsistent, and errors can result in administrative delays.

To address these points, a new face-to-face training programme was launched in April 2025 and attendance at these sessions has steadily increased following an MCA team drive to promote this training. Records show that whilst 37 staff attended training in Quarter 1, this has increased to 103 staff booked to attend sessions in Quarter 2.

During the audit review, DoLS training was added as a non-mandatory requirement to ESR. This change will provide greater transparency over training statistics, enabling analysis of the number of staff trained across different clinical areas and wards, which in turn will assist with the ability to report numbers of DoLS trained staff. Training records from April to July 2025 need to be uploaded to ESR now that the module is available and the MCA Team have confirmed they are targeting completion of this by end of August 2025.

We visited three wards during the audit, and the following was noted:

1) At least one team member was trained on DoLS (however in one ward, there was only one staff member that had been trained);
2) Materials promoting DoLS awareness and training sessions were available on the wards visited;
3) Staff stated that there had been a noticeable improvement in DoLS resources and support available to them; and
4) Staff were generally able to explain the DoLS process however, there remained some challenges in recognising DoLS scenarios and in completing application forms. This is consistent with the feedback received from the MCA Team as noted above.

We acknowledge that the MCA team have made significant advances in training and awareness through the calendar year, and this can be demonstrated with the team's "DoLS workplan tracker". This ten-point action plan was compiled in response to an annual self-assessment audit conducted by the MCA team most recently in Quarter 3 of 2024-25 with the focus primarily on awareness and training improvements. The plan is actively managed showing completion of six of the ten actions and evidence of the impact of these actions was noted through our audit.

Key Findings		Risk & Impact	Agreed Management Action
3	**DoLS training is not mandatory** DoLS training is not mandatory for staff in the Health Board. Instead, training is optional, and completion is left to the discretion of individual staff members and their ward managers. This has resulted in a low number of staff being trained on DoLS and this was substantiated by our ward visits whereby one ward had only one trained staff member. Ward Managers highlighted that DoLS training can be challenging to manage as it is not recorded on ESR. In two of the three wards visited, ward managers could not confirm the number of staff trained. We reviewed DoLS training in two other Health Boards and found that DoLS training was mandatory for ward staff in both.	Non-compliance with policy or legislative standards causing patient distress and potential for Board complaints and compensation liabilities.	**Suggested Action:** A training strategy will be developed that considers how DoLS training should be implemented across the UHB within available resource. This will consider different approaches such as: the use of a staged approach to target key staff i.e. ward managers and deputy ward managers (with dissemination of learning through clinical teams), hybrid training, support from ECOD. A scoping exercise will be undertaken to identify what has worked well in other organisations. **Expected Evidence of Implementation:** Improvement in the number of staff trained in DoLS. This will be monitored on a monthly basis and fed back to clinical boards along with MCA Training compliance figures.
		Medium Priority	**Officer: Chloe Evans, MCA Project Lead** **Target Implementation Date: March 2026**
	Theme: Training & Development	Control Design	

Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary.	**Reasonable**

Overview / Summary of Observations

The Health Board contract DoLS assessments from the Local Authority by way of a tripartite agreement. Through this agreement, the Health Board pay for six assessments per week from the Local Authority. However, this capacity was temporarily extended by an additional five assessments per week, to 11 in total on 7 July 2025, which is ongoing but is not currently funded. The increase was due to the number of assessments that were breaching timelines.

In Quarter 1 2025-26, the Health Board submitted 439 applications. Of these, 311 were withdrawn with the remainder (128) requiring assessment. Based on these figures and averaging across the 13 weeks in a quarter; increasing the number of paid for assessments to 11 per week is appropriate.

A database of DoLS applications is maintained by the MCA Team via a spreadsheet. This is updated daily with logs made for new applications and progress updates recorded for existing ones. We reviewed this database and noted the following:

- Updates are recorded daily so that the database is constantly up-to-date and accurate;
- Every application had a record of the patient, assessor and signatory providing traceability of all individuals involved with the process;
- File notes were recorded making it possible to identify exactly where in the process every application was at a given point in time; and
- The database contained automated calculations to display how long the various stages of the process had taken.

We reviewed a random sample of 27 completed assessments selected from Quarter 1 2025-26 (60% of total). Of these, only six had been completed within the mandated timescales. We noted the following observations during our review:

- 22 of the 27 assessments were for "Urgent" referrals. Of these, only three had been completed within the mandated 7-day timeframe.
- Five of the 27 assessments were for "Standard" or "Further" referrals. Of these, three had been completed within the mandated 21-day timeframe.
- The average amount of time taken to allocate a Mental Health Assessor for all 27 assessments was 27 days.

For those assessments that breached timescales, delays were noted at all stages of the process but, analysis as detailed above shows that the critical delay resulting in breach was that of allocating a Mental Health Assessor (MHA).

For all assessments reviewed, the files contained all required paperwork. Furthermore, all paperwork had been completed to a high standard, supporting the ultimate approval decision. All DoLS applications had been approved by the approved signatories for DoLS.

Key Findings		Risk & Impact	Agreed Management Action
4	**Assessment time breaches** Whilst the database managed by the MCA Team is accurately maintained, it consistently shows assessments to be breaching the mandated timescales for completion. The Health Board participate in a tripartite agreement through which, six assessments per week are paid for. This was temporarily extended on 7 July to 11 assessments per week with the additional capacity provided by an agency. With an average of ten assessments required per week through Quarter 1 of 2025-26, the baseline of six is insufficient for volumes required. This is demonstrated by the following breakdown of assessments required in the months of Quarter 1: • April – 48. • May – 36. • June – 44. We acknowledge that the MCA Team have submitted business cases requesting additional funding and that to date, these have not been approved.	DoLS applications are not submitted/logged/actioned according to mandated standard resulting in possible unlawful deprivation of patient liberty.	**Suggested Action:** Management will revise and re-submit their business case requesting additional funding to be made permanent, based on comparison of assessment data between Quarter 2 and Quarter 1. **Expected Evidence of Implementation:** A revised business case will be produced requesting the additional funding.
	Theme: Resourcing	**Medium Priority** Control Design	**Officer: Jason Roberts, Executive Director of Nursing and Chloe Evans, MCA Project Lead** **Target Implementation Date: January 2026**

Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework.	**Substantial**

Overview / Summary of Observations

The MCA Team maintain an accurate database of all applications and their status. As well as providing a robust overview of operational activity at any given point in time, the data provides the basis for monthly performance meetings between the Health Board MCA Team and Local Authority (LA) DoLS Team. In addition, the Local Authority also submit a weekly breakdown of assessments conducted via an agency. This supplementary report provides transparency over the additionally commissioned assessments the Health Board is currently contracting.

The monthly performance review meetings allow opportunity to discuss and challenge activity recorded on the live database and the supplementary report provide assurance that the commissioning arrangement with the LA is being actively managed and constantly assessed to ensure value for money.

Quarterly activity reports are produced by the Local Authority and submitted to the MCA Team. These reports detail all applications submitted during the quarter and an up-to-date status for each, effectively summarising the data maintained on the MCA Teams database. This report is submitted to both the Safeguarding Steering Group and the Mental Health Legislation Committee and is presented by the MCA Lead/Director of Nursing at Committee meetings. The report includes a breakdown of all activity KPIs including measures covering applications and assessments.

We reviewed the minutes and video recordings of the Mental Health Legislation Committee meeting from 29 April 2025. To improve transparency for Committee members on DoLS operational performance, we have suggested some minor improvements in the Executive Summary section of this MCA DoLS report.

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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