# Bundle Mental Health Act Committee 3 January 2019

Agenda attachments

Agenda_Mental_Health_Act_Committee_3_January_2019.docx

1 MHAC19/01 - Apologies

2 MHAC19/02 - Declarations of Interest

3 MHAC19/03 - Minutes of last meeting to be confirmed and review of Summary Action Log

*1) To confirm as a correct record the Minutes of the last meeting held on 21 September 2018*
*2) To deal with any matters arising not dealt with elsewhere on the agenda*
*3) To review the Summary Action log.*

MHAC19.03 - Draft Minutes MHA Committee - 21st September 2018.docx

4 MHAC19/04 - Minutes of the Power of Discharge Sub-Committee

*1) To receive the Minutes of the Power of Discharge Sub-Committee meeting held on 21st September 2018 for information purposes.*
*2) To receive an oral update from the Chair on relevant feedback from the Sub-Committee meeting held 14th December 2018.*

Draft Minutes Power of Discharge Sub Committee 21st September 2018.docx

MHAC Summary Action Plan live version.doc

5 MHAC19/05 - Mental Health Act/Mental Health Measure Monitoring Data - Steve Forsyth / Jill Timmins

MHAC19.05.1 - MHA and MHM powerpoint coversheet.docx

MHAC19.05.2 - MHA_Committee_Report July - Sept 2018.pdf

6 MHAC19/06 - Defining a Health Based Place of Safety for young people under age 18 years – MHA Section 136 - Steve Forsyth

MHAC19.06 - Under 18 136 Data Report.doc

7 MHAC19/07 - Child and Adolescent Mental Health Services (CAMHs) Update - Alison Cowell/Sue Hamilton

MHAC19.07 - MHA Committee Report January 2019.docx

8 MHAC19/08 - Update on the approval functions for Approved Clinicians & Section 12(2) Doctors in Wales - Heulwen Hughes

MHAC19.08 - Approval Functions for Approved Clinicians & Section 12[2] Doctors.docx

9 MHAC19/09 - Independent Mental Health Advocacy Performance Report -

10 MHAC19/10 - Deprivation of Liberty Safeguards - Update Report - Chris Pearson

MHAC19.10 - Deprivation of Liberty Safeguard.docx

11 MHAC19/11 - HIW Monitoring Report (if appropriate) - Steve Forsyth / Jill Timmins

MHAC19.11 - HIW Monitoring Report.doc

12 MHAC19/12 - Mental Health Measure Deep Dive Session - Andy Roach

13 MHAC19/13 - CAMHS Deep Dive Session - Teresa Owen

14 MHAC19/14 - Issues of Significance to inform Chair's Report to Board

15 MHAC19/15 - Date of Next Meeting

*Friday 29th March 2019 - Boardroom, Carlton Court*

# Agenda Mental Health Act Committee

| | |
|---|---|
| **Date** | 03/01/2019 |
| **Time** | 14:00 - 17:00 |
| **Location** | Boardroom, Carlton Court, St Asaph LL17 0JG |
| **Chair** | Mrs Marian Wyn Jones |
| **Description** | |

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|---|---|
| 1 | **MHAC19/01 - Apologies** |
| 2 | **MHAC19/02 - Declarations of Interest** |
| 3 | **MHAC19/03 - Minutes of last meeting to be confirmed and review of Summary Action Log**<br>1) To confirm as a correct record the Minutes of the last meeting held on 21 September 2018<br>2) To deal with any matters arising not dealt with elsewhere on the agenda<br>3) To review the Summary Action log. |
| 4 | **MHAC19/04 - Minutes of the Power of Discharge Sub-Committee**<br>1) To receive the Minutes of the Power of Discharge Sub-Committee meeting held on 21st September 2018 for information purposes.<br>2) To receive an oral update from the Chair on relevant feedback from the Sub-Committee meeting held 14th December 2018. |
| 5 | **MHAC19/05 - Mental Health Act/Mental Health Measure Monitoring Data - Steve Forsyth / Jill Timmins** |
| 6 | **MHAC19/06 - Defining a Health Based Place of Safety for young people under age 18 years - MHA Section 136 - Steve Forsyth** |
| 7 | **MHAC19/07 - Child and Adolescent Mental Health Services (CAMHs) Update - Alison Cowell/Sue Hamilton** |
| 8 | **MHAC19/08 - Update on the approval functions for Approved Clinicians & Section 12(2) Doctors in Wales - Heulwen Hughes** |
| 9 | **MHAC19/09 - Independent Mental Health Advocacy Performance Report -** |
| 10 | **MHAC19/10 - Deprivation of Liberty Safeguards - Update Report - Chris Pearson** |
| 11 | **MHAC19/11 - HIW Monitoring Report (if appropriate) - Steve Forsyth / Jill Timmins** |

12 **MHAC19/12 – Mental Health Measure Deep Dive Session – Andy Roach**

13 **MHAC19/13 – CAMHS Deep Dive Session – Teresa Owen**

14 **MHAC19/14 – Issues of Significance to inform Chair's Report to Board**

15 **MHAC19/15 – Date of Next Meeting**

Friday 29th March 2019 – Boardroom, Carlton Court

**Mental Health Act Committee**

**Draft Minutes of the Mental Health Act Committee held on Friday 21st September 2018**
**Boardroom, Carlton Court**

**Present**

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| Marian Wyn Jones [Chair] | Vice Chair, BCUHB |
| Bethan Russell-Williams | Independent Member |
| Lyn Meadows | Independent Member |

**In Attendance**

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| Alberto Salmoiraghi | Medical Director MH&LD |
| Chris Pearson | Safeguarding Specialist Practitioner/DoLSs & MCA |
| Jill Timmins | Director of Operations & Service Delivery |
| Mark Jones | Wrexham County Borough Council |
| Sandra Ingham | Business Support Manager [BCUHB] |
| Sue Hamilton | CAMHS Consultant |
| Wendy Lappin | MH Act Manager [BCUHB] |
| Chris Robinson | Associate Hospital Manager |

| Agenda Item | Action |
|---|---|
| **MHAC18.32 – Apologies**<br><br>MHAC18.32.1 Apologies for absence were received from Gill Harris, Andy Roach, Peter Gore-Rees, Joan Doyle, Sue Owen, Satya Schofield, Hilary Owen, Cheryl Carlisle<br><br>The Chair introduced herself to the group and asked that members do the same and provide a brief background. | |
| **MHAC18.33 – Declarations of Interest**<br><br>MHAC18.33.1 There were no declarations of interest made at the meeting. | |
| **MHAC18.34 – Membership Update**<br><br>MHA18.34.1 - The Chair welcomed Lyn Meadows to the Committee as the new Independent Member and Chris Robinson, Associate Hospital Manager | |

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| **Resolved:** That the update to membership be noted | |
| **MHAC18.35 – Minutes of last meeting and summary action log**<br><br>MHAC18.35.1 The minutes of the meeting held on 11th May 2018 were confirmed as a correct record. Updates to the summary action log were recorded therein.<br><br>Actions were recorded therein<br><br>MHACS12.2 Discussions were held on the lack of Section 12.2 doctors. Medical Director for Mental Health and Learning Disabilities reported that the Division were only responsible for Section 12.2 doctors in the Division and that most of those in the Community were GPs. It was important to ensure all Psychiatrists are section 12.2 approved. The responsibility lies within the Office of Medical Director portfolio and a letter has been sent to Executive Medical Director. It was agreed there needs to be a combined strategy with Primary Care, Medical Director, Area Directors and Office of the Medical Director n how we can improve availability.<br><br>**Action:** AS to make arrangements for meeting to take place and provide update at the next meeting. | |
| **MHAC18.36 – Minutes of Power of Discharge Sub Committee**<br><br>MHAC18.36.1 Members received the Minutes of the Sub Committee meeting held on 11th May 2018 and the Chair provided feedback following the meeting of the subcommittee earlier in the day.<br><br>MHAC18.36.2 It was noted that items on the morning agenda were replicated in this meeting.<br><br>**Resolved:** That the minutes of the Sub Committee held on 21st September 2018 be received | |
| **MHAC18.37 – Mental Health Act / Mental Health Measure Monitoring Data**<br><br>MHAC18.37.1 The report provided an update in relation to the Mental Health Act and Mental Health Measure Activity within the Division<br><br>MHAC18.37.3 Key areas of concern which were raised in the morning meeting:<br><br>MHAC18.37.4 Section 4 – there was concern around the removal of the Force Medical Office by North Wales Police and the failure to consider the impact on Mental Health Division. However, a meeting | |

had been held with North Wales Police once this was identified as an issue and mitigation actions put in place.

MHAC18.37.5 Medical Director expressed concern highlighting a recent incident where he had been requested to provide a fitness to plead assessment out of hours when no mental illness was present. Director of Operations highlighted that a seconded member of staff is now working with North Wales Police and there is ongoing liaison where issues are raised.

**Action:** The Chair agreed to include this in her Assurance Report to the Health Board.

MHAC18.37.6 Work has been done with NW Police in relation to Police and Crime changes to ensure its units are informed when a patient is being brought in by North Wales Police on a Section 136. JT commented it is important we continue to review which patients are known.

MHAC18.37.7 There has been a reduction in the number of Under 18s detained on a S136, this may be related to the on-going work with NW Police.

MHAC18.37.8 Forensic – recruitment of nursing posts is progressing to open Gwion ward.

MHAC18.37.9 The Chair expressed her concern at the data provided for the meeting which was different to that provided at a recent Board Meeting, JT explained that this is in relation to the dates for validating Mental Health performance prior to submission to Welsh Government.

**Action:** JT to link with Performance Colleagues to ensure updated information is provided for the next meeting.

MHAC18.37.10 It was noted that this will result in the data being invalidated, however it is very rare they change if they do it should only be minor amendments.

MHAC18.37.11 A piece of work is underway with the Delivery Unit in terms of Capacity and Demand. There are dips in performance when there are recruitment difficulties or when people leave or are on long-term sick. A pilot piece of work around primary care being carried out at the moment which has seen specialists in Primary Care Teams working alongside GPs under part 1 of the measure. Relationships with Primary Care have improved and there has been a 20% decrease in the number of referrals to Secondary Care in the areas. Going forward this will form part of the strategy, with radical systematic changes being made around prescribing interventions to reduce the need for reassessments by other specialists. The increase in referrals is an

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| issue and it was hoped the outcome of the work with the Delivery Unit will provide an improvement Quarter 4.<br><br>**RESOLVED:** That the report be noted | |
| **MHAC18.38 – Deprivation of Liberty Safeguards [DoLS] – Update Report**<br><br>MHA18.38.1 Chris Pearson attended the meeting to present the report.<br><br>MHAC18.38.2 It was noted that the Quarter 1 report did not provide much information, more details would be available in Quarter 2. There has been in increase in the number of Best Interest Assessors [BIAs] which an additional 3 being appointed. They are not yet approved and will be attending a course in December and fully qualified by March 2019. The challenge with the new appointments is around the supervisory body, it was suggested they should not be responsible for managing money or staff. Challenge with appointing is major issues around supervisory body, there is currently only one person who can sign off and there are 8 outstanding, with the increased number of BIAs this figure will increase with the number of DoLS assessments being carried out.<br><br>MHAC18.38.3 The Quality & Safety Group have provided a number of options to improve the situation and the outcome will be available at the next meeting.<br><br>MHAC18.38.4 Incomplete applications remain an area of concern. It is important to ensure staff are aware of the Mental Health Capacity Act as this was raised as a concern in the HASCAS and Ockenden reports. An increase in the number of referrals is expected with the addition of more BIAs.<br><br>**Action:** A booklet to be provided for staff who do not have access to e-learning.<br><br>**Action:** A report to be brought back to next meeting in December, providing more detail on the benefits to the service and the quality provided.<br><br>**Action:** Patient story to be provided at the next meeting.<br><br>**Resolved:** That the report be noted. | |
| **MHAC18.39 – HIW Monitoring Report**<br><br>MHA18.39.1 The report provided an update in relation to the inspections conducted by Healthcare Inspectorate Wales, and highlighted findings in relation to the Mental Health Act and Mental Health Measure, the report provided the detail from the past 12 months. | |

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| MHA18.39.2 following the outcome of recent inspections, it was noted that there is a clear indication of the improvements that have been made in the quality of care being provided.<br><br>MHA18.39.3 The report following the recent inspection of Hergest will be available for the next meeting in December. There has been extensive improvements over the past 3-4 years in relation to the Mental Health Act which was down to the scrutiny of this Committee and the support provided by WL and her team and this was recognised by the members of the Committee.<br><br>MHA18.39.4 There remains a number of policies which require updating but work is ongoing and improvements are being made. With the updated governance structure within the Division it was hoped the work will be completed within 6 months.<br><br>**Action:** Update report on the review of policies linked to the Mental Health Act to be provided at the next meeting.<br><br>**Resolved:** That the report be noted. | |
| **MHAC18.40 – Child and Adolescent Mental Health Services [CAMHs] Update Update on the approval functions for Approved Clinicians & Section 12[2] Doctors in Wales**<br><br>MHAC18.40.1 It was noted there had been a meeting in July to look at improving the MH Measure targets. CAPPA does not meet the supply and demand of the service. Assurance was required on how BCU stands against the rest of Wales in relation to the Mental Health Measure and CAMHS.<br><br>**Action:** Bring benchmark back to the next meeting in December.<br><br>MHAC18.40.2 The Medical Director advised that staff are not sufficiently trained to deal with S136 under 18 and work continues to be done on this. Discussions were held around the available bed and the concerns around the staffing of this bed. More worrying cases are those who are brought in and there is no available specialist bed. There were no patients detained under S136 admitted to an Adult environment.<br><br>MHAC18.40.3 It was noted that all concerns were discussed within the Children's services – CAMHS currently sits with Executive Director of Public Health.<br><br>MHAC18.40.4 Previous reports have indicated the CAMHS were on target to meet all the trajectories in relation to Mental Health Measure, but that issues of staff retention were causing problems, a UK wide problem and not just in North Wales. Discussions were held on what | |

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| collaborative work was being done with partner organisations to improve services, joint working with group therapy services went relatively well.<br><br>MHAC18.40.5 The Chair agreed it was a very challenging time for CAMHS but it was hoped the Capacity and Demand piece of work would provide some assistance.<br><br>**Resolved:** That the report be noted | |
| **MHAC18.41– Update on the approval functions for Approved Clinicians & Section 12[2] Doctors in Wales**<br><br>MHAC18.41.1 The report provided an update on the arrangements and service developments for the approval and re-approval of Approved Clinicians and section 12[2] Doctors in Wales.<br><br>MHAC18.41 2 It was noted that due to the implementation of GDPR, the Mental Health Act register for Wales would not be available until next year. The responsibility for driving this lies with the Health Board and once it goes live it will make the process easier. With the new process it will be a requirement that all medics / non-medics not on the specialist register will need to apply and this will generate a delay. Director of Operations and Service Delivery suggested that in terms of revalidation there should be a cross-over where a portfolio will already be in place.<br><br>**Resolved:** That the report be noted. | |
| **MHAC18.42 – IMHA Update Report.**<br><br>MHAC18.42.1 This report was deferred to the next meeting in December | |
| **MHAC18.43 – Sharing of Information with North Wales Police**<br><br>MHAC18.43.1 It was noted that this report had been presented at the Divisional QSEEL meeting and had been approved, it was presented here for information. Report has been through QSEEL<br><br>**Resolved:** The Committee agreed for this information to be shared | |
| **MHAC18.44 – Issues of Significance to inform Chair's report to Board**<br><br>MHAC18.44.1 The Chair agreed to submit her assurance report for the Health Board. | |
| **MHAC18.45 – Any other Business** | |

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| MHAC18.45.1 Discussions were held around the potential merger of the Power of Discharge Sub-Committee and MHA Committee. | |
| **MHAC18.46 - Date of Next Meeting**<br><br>Thursday 3rd January 2019, Boardroom, Carlton Court, St Asaph LL17 0JG | |

**Power of Discharge Sub Committee**

**Draft Minutes of the Power of Discharge Sub Committee held on Friday 21st September 2018**
**Boardroom, Carlton Court**

**Present:**

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| Marian Wyn Jones [Chair] | Vice Chair, BCUHB |
| Ann Owens | Associate Hospital Manager |
| Bethan Russell-Williams | Independent Member |
| Frank Brown | Associate Hospital Manager |
| Delia Fellows | Associate Hospital Manager |
| Christine Robinson | Associate Hospital Manager |
| Lyn Meadows | Independent Member |
| William John Williams | Associate Hospital Manager |

**In Attendance**

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| Sandra Ingham | Business Support Manager [BCUHB] |
| Wendy Lappin | MH Act Manager [BCUHB] |

| Agenda Item | Action |
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| **POD18.25 – Apologies**<br><br>POD 18.25.1 Apologies were received from Gill Harris, Andy Roach, Satya Schofield, Jackie Parry, Hilary Owen and Shirley Cox | |
| **POD18.26 – Declarations of Interest**<br><br>POD 18.26.1 There were no declarations of interest made at the meeting. | |
| **POD18.27– Membership**<br><br>POD18.27.1 – The Chair introduced Lyn Meadows, Independent Member who would be attending future meetings. The Chair also welcomed Delia Fellowes and noted that Delia Fellowes and Diane Arbabi are now POD members.<br><br>The Chair introduced herself to the group and asked each to introduce themselves and provide a brief narrative of their background.<br><br>SI to chase expressions of interest | |

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| **Resolved:** That the update to membership be noted | |
| **POD18.28 – Minutes of last meeting and summary action log**<br><br>POD 18.28.1 The minutes of the meeting held on 11th May 2018 were confirmed as an accurate account.<br><br>The action log was updated therein. | |
| **POD18.29 – Hospital Managers Update**<br><br>POD18.29.1 The report provided an update in relation to the Hospital Managers' Activity within the Division over the last quarter<br><br>POD18.29.2 There were discussions around the terminology used within the report. Hospital Managers did not have the authority to uphold or renew outcomes when they attended hearings, it was important that it was detailed accurately. The responsibility of the Hospital Manager is to ensure compliance with the Mental Health Act.<br><br>**Action:** WL to amend the report to reflect more accurately the responsibility of the Associate Hospital Manager in hearings.<br><br>POD18.29.3 It was noted that whilst there were only 3 discharges, there were a number of reports requested to justify decisions made by clinicians, in many cases this can prompt changes being made to what was previously recorded. There was a situation where a decision was not reached at that time so a further date was required. It was confirmed that this was not an adjournment.<br><br>POD18.29.3 The previously agreed training date in December has been postponed and alternative dates in January will be arranged.<br><br>**Action**: WL to distribute dates for training to new members.<br><br>It was suggested that members of the group who attended the All Wales training will bring something back for sharing at a future meeting.<br><br>POD18.29.4 Recruitment – it was noted that advertisements for Associate Hospital Managers were displayed in many locations and not specifically NHS organisations. This was to encourage appointments from outside the organisation. Discussions were held around the number of Hospital Managers as this can impact on the number of hearings available for them to attend. The Chair asked that she be invited to attend a hearing along with LM the new Independent Member to gain a wider understanding. It was noted the difficulty in anticipating the number of hearings being held within a month so it was important to ensure there were enough Hospital Managers to participate. | |

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| **Resolved:** That the report be noted and the actions outlined be progressed | |
| **POD18.30 – Combined Mental Health Act / Mental Health Measure Report**<br><br>POD18.30.1 The report provided an update in relation to Mental Health Act and Mental Health Measure activity within the Division.<br><br>POD18.30.2 Discussions were held around the appropriate use of 5.4 and 5.2, WL confirmed that having looked at the data in more detail, in many cases 5.2s were not always proceeded by a 5(4), this was because there was a consultant available to see the patient and exercise their rights.<br><br>POD18.30.3 The Chair asked for clarification on how the Health Board measured against the All Wales benchmarking. It was confirmed the Health Board does feed in to the All Wales figures but the information was not available for the period as this is provided at a later date. It was agreed that it will be investigated as to whether this can be provided in future reports as benchmarking. Currently this is highlighted within the errors page of the report for comparisons with the other Health Boards<br><br>POD18.30.4 Previous discussions were held around the number of patients being discharged as the Health Board's figures are relatively high, clarification was required on whether this was a positive or a cause for concern.<br><br>POD 18.30.5 There were discussions around the age appropriate bed in the East and whether this was seen as a positive decision. Further information required on whether this was something that could be rolled out across the Board.<br><br>POD18.30.6 Work was being done to reduce the number of rectifiable errors, guidance has been provided to assist with the completion of paperwork and training awareness is available. With the reduction in the number of locums, nurses are being encouraged to check all paperwork is correct before the clinician leaves the building.<br><br>POD18.30.7 Clarification is required on who should takes responsibility when information around nearest relative is incorrect, who should follow this up, the AMHP or the Care Coordinator.<br><br>**Action:** WL to provide an update at the next meeting.<br><br>POD18.30.8 There has been an increase in the number of S136 in A&E. This will be discussed further at the Committee meeting and a representative from North Wales Police is to be invited to the next meeting. | |

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| **Action:** Request for up to date data going forward regarding reassessment<br><br>**Resolved:** That the report be noted. | |
| **POD18.31 – Health Inspectorate Wales**<br><br>POD18.31.1 The report provided an update in relation to the inspections conducted by Healthcare Inspectorate Wales, and highlighted findings in relation to the Mental Health Act and Mental Health Measure, the report provided the detail from the past 12 months.<br><br>POD18.31.2 It was noted that the Care and Treatment plan must meet the requirements of the MH Measure.<br><br>**Action:** SI to include a copy of the report for Abergele at the next meeting<br><br>A recent unannounced visit to Hergest will be reported at the next meeting.<br><br>**Resolved:** That the report be noted. | |
| **POD18.32 – Item for Information – Under 18s MHA S136 Data Report**<br><br>POD18.32.1 The report provided an update in relation to the activity within the Division for young people under the age of 18 years, ensuring compliance with the Mental Health Act and Mental Health Measure.<br><br>**RESOLVED:** That the reported be noted. | |
| **POD18.33 – Issues of Significance to inform the Chair's Report to the Mental Health Act Committee**<br><br>POD18.33.1 The Chair agreed to raise all issues of concern in her Assurance Report to the Board.<br><br>Assurance that the information provided in reports is up to date to provide consistency | |
| **POD18.34 – Any other Business**<br><br>There were no additional items to be discussed. | |
| **POD18.35 – Date of Next Meeting**<br><br>14th December 2018 | |

| BCUHB MENTAL HEALTH ACT COMMITTEE<br>Summary Action Plan – Live Document – last updated 27/12/2018 10:57 | | | | |
|---|---|---|---|---|
| **Officer** | **Minute Reference and Action Agreed** | **Original Timescal** | **Latest Update Position** | **Revised Timescale** |
| **28th July 2017** | | | | |
| AS | **MHAC18.35** – Arrange meeting with Area Directors and Office of Medical Director and provide update at next meeting | Dec | | |
| JT | **MHAC18.37.9** – Link in with Performance Colleagues to ensure updated information is provided for the next meeting | Dec | | |
| CP | **MHAC18.38.4** – A booklet providing details of DoLs to be provided for staff who do not have access to e-learning | ongoing | | |
| CP | **MHAC18.38.4** – A report to be brought back to the next meeting in December, providing more detail on the benefits to the service and the quality provided | | | |
| CP | **MHAC18.38.4** – Patient story to be provided at the next meeting | | | |
| WL | **MHAC18.39.4** – Verbal update on the review of policies linked to the Mental Health Act to be provided at next meeting | Dec | | |
| | **MHAC18.40** – Benchmarking to be brought back to the next meeting | Dec | | |
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| **Mental Health Act Committee**<br><br>**3rd January 20198** | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board<br>***To improve health and provide excellent care*** |

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| **Report Title:** | *Combined Mental Health Act and Mental Health Measure Report 2017/18 – Quarterly Performance to the end of September 2018* |
| **Report Author:** | *Hilary Owen, Head of Governance*<br>*Wendy Lappin, Mental Health Act Manager* |
| **Responsible Director:** | *Andy Roach, Director of Mental Health and Learning Disabilities* |
| **Public or In Committee** | *Public* |
| **Purpose of Report:** | *To provide an update in relation to the (Mental Health Act and Mental Health Measure) Activity within the Division* |
| **Approval / Scrutiny Route Prior to Presentation:** | *Divisional Q-SEEL Meeting*<br>*Divisional Directors Meeting*<br>*Andy Roach, Director of Mental Health and Learning Disabilities* |
| **Governance issues / risks:** | *None* |
| **Financial Implications:** | *None* |
| **Recommendation:** | *The committee is asked to note the report.* |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
|---|---|---|---|
| 1.To improve physical, emotional and mental health and well-being for all | √ | 1.Balancing short term need with long term planning for the future | √ |
| 2.To target our resources to those with the greatest needs and reduce inequalities | √ | 2.Working together with other partners to deliver objectives | √ |
| 3.To support children to have the best start in life | | 3. Involving those with an interest and seeking their views | |
| 4.To work in partnership to support people – | | 4.Putting resources into preventing | √ |

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| individuals, families, carers, communities - to achieve their own well-being | | problems occurring or getting worse | |
| 5.To improve the safety and quality of all services | √ | 5.Considering impact on all well-being goals together and on other bodies | |
| 6.To respect people and their dignity | √ | | |
| 7.To listen to people and learn from their experiences | | | |

**Special Measures Improvement Framework Theme/Expectation addressed by this paper**

*Governance and Leadership – to ensure compliance with the Mental Health Act and Mental Health (Wales) Measure*

*http://www.wales.nhs.uk/sitesplus/861/page/81806*

**Equality Impact Assessment**

*Retrospective looking report therefore no EQIA*

*http://howis.wales.nhs.uk/sitesplus/861/page/47193 )*

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Combined Mental Health Act and Mental Health Measure Report 2018

## Quarterly Performance to the end of September 2018

Mental Health Act Committee

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# Foreword

## Report to Mental Health Act Committee

This report provides assurance to the Mental Health Act Committee of our compliance against key sections of the legislative requirements of the Mental Health Act 2007 and reflects our performance against key government targets for the Mental Health Measure 2010.

## Seven Domains

We present performance to the committee using the 7 domain framework against which NHS Wales is measured. This report is consistent with the 7 domain performance reporting for our Finance and Performance Committee and Quality, Safety and Experience Committee. The Mental Health Act and Mental Health Measure committee are responsible for scrutinising the performance for Mental Health indicators under Timely Care and Individual Care.


## Advisory Reports & Exception reports

Each report for the Mental Health Act will be presented as an advisory report.

Reports for the Mental Health Measure will be consistent with the Exception report process, exception reports are included where performance is either worse than the required standard or the Board require sight of the actions being taken to maintain or improve performance. After we have achieved an indicator for three consecutive months, it will be stood down from exception reporting.

# Advisory Report Definitions

**Section 5(4) Nurses Holding Power (up to 6 hours):** Criteria: "…the patient is suffering from mental disorder to such a degree that it is necessary for his health and safety or for the protection of others for him to be immediately restrained from leaving the hospital". Secondly the nurse must believe that "…it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2)
**Section 5(2) Doctors Holding Power (up to 72 hours):** Criteria is: that an application for compulsory detention "ought to be made". Patient must be in-patient, can be used in general hospital.

**Section 4: Admission for emergency (up to 72 hours):** Criteria: "it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section "would involve undesirable delay"

**Section 2: Admission for assessment (up to 28 days):**Criteria needs to be met: a) is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and b)ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons

**Section 3: Admission of treatment (up to 6 months, renewable for 6 months, 12 monthly thereafter):** Criteria a)is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital; and b)it is necessary for the health and safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless he is detained under this section; and c)appropriate medical treatment is available for him/her

**Section 17A:** Supervised Community Treatment, also referred to as a CTO – its duration is up to 6 months, renewable for 6 months and 12 months thereafter.
**Section 17E:** Recall – the recall can last for up to 72 hrs. The clinical team must decide to release from Recall, Revoke or Discharge
**Section 17F:** Revocation. Once a patient has been revoked, essentially the Section 3 comes back into force - which can last up to 6 months, renewable for 6 months, then 12 monthly thereafter.

# Advisory Report Definitions

**Section 135 Warrant to search and remove:** *Section 135(1) – warrant to enter and remove*. Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety. *Section 135(2) – warrant to enter and take or retake.* Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

**Section 136 Place of Safety (up to 24 hours):** The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in any place other than a private dwelling or the private garden or buildings associated with that place, to remove or keep a person at, a place of safety under section 136(1) or to take a person to a place of safety under section 136(3)

**Section 35:** Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks.

**Section 36:** Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks.

**Section 37:** Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter
**Section 37/41:Hospital** Order with Restrictions – made with no time limit

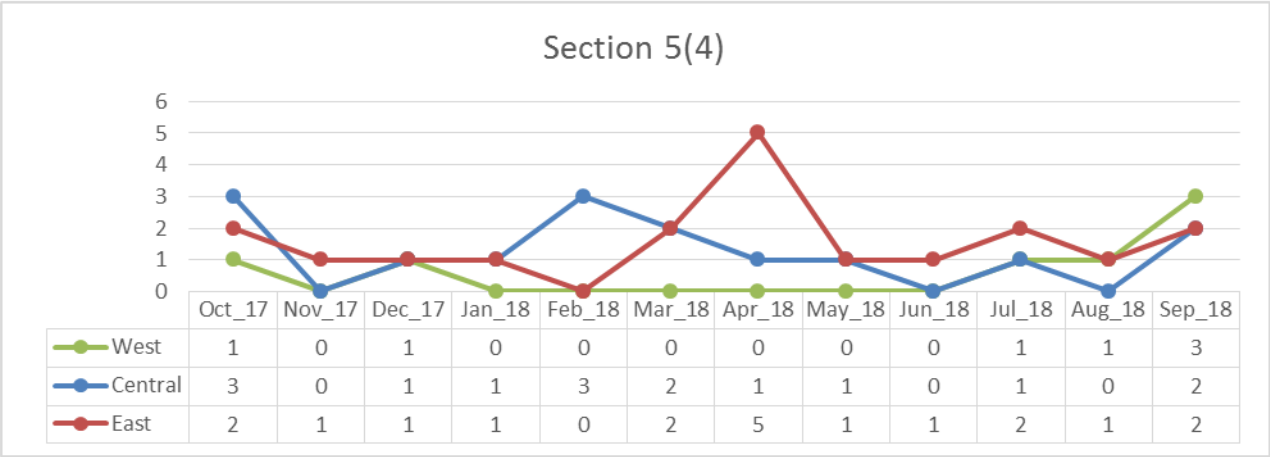
**Section 38:** Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months

**Section 47/49:** Transfer of sentenced prisoners (including with restrictions)

**Section 48/49:** Transfer of other prisoners (including with restrictions) for urgent assessment

**Section 62**: Emergency Treatment of a detained patient regardless of section status.

# Advisory Report: Mental Health Act Section 5




| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 3 |
| Central | 3 | 0 | 1 | 1 | 3 | 2 | 1 | 1 | 0 | 1 | 0 | 2 |
| East | 2 | 1 | 1 | 1 | 0 | 2 | 5 | 1 | 1 | 2 | 1 | 2 |

The trend for 5(4) indicates that the Central area is falling whilst West and East trend following the last three months indicates a rise.

*** Denotes same patient – use of 5(4) five days apart.**

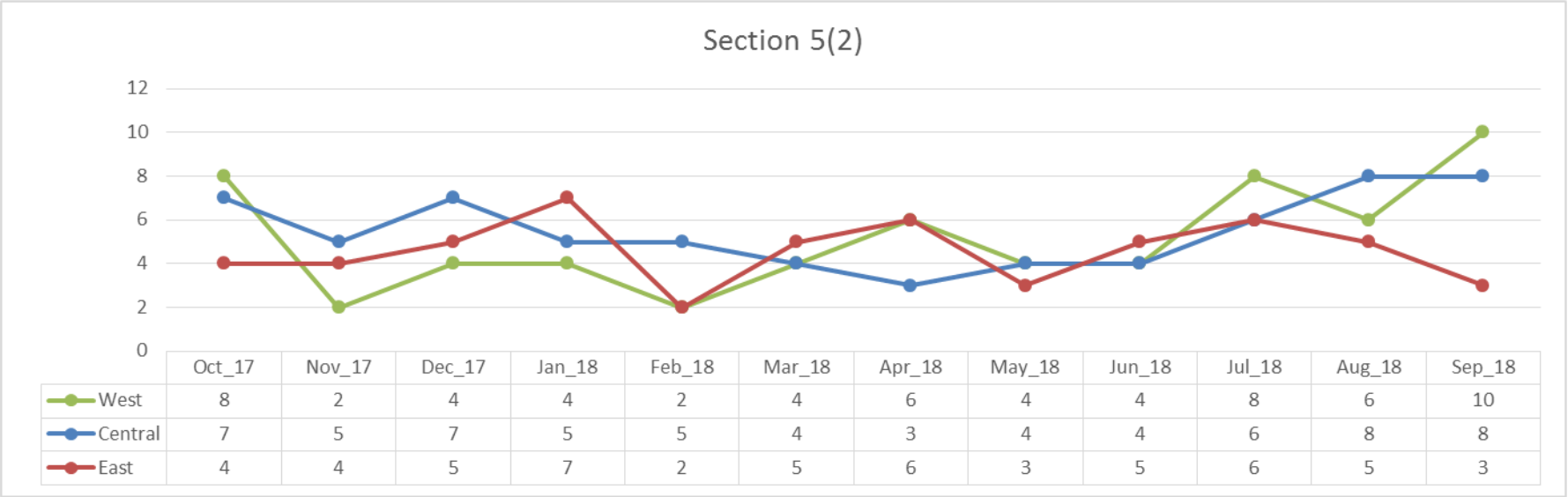
**EXCEPTIONS**
One this quarter – West – Reasons given were not adequate to enact the 5(2) therefore the 5(4) lapsed.

| Month | Duration | Outcome |
|---|---|---|
| **CENTRAL** | | |
| July | 04:45 hrs | 5(2) |
| September | 00:20 hrs | 5(2) |
| September | 01:00 hrs | 5(2) |

| Month | Duration | Outcome |
|---|---|---|
| **EAST** | | |
| July | 00:18 hrs | 5(2) |
| July | 03:14 hrs | 5(2) |
| August | 01:00 hrs | 5(2) |
| September | 00:15 hrs | 5(2) |
| September | 02:00 hrs | 5(2) |

| Month | Duration | Outcome |
|---|---|---|
| **WEST** | | |
| July | 00:13 hrs | 5(2) |
| August | 06:00 hours | Lapsed |
| September | 00:15 hrs | 5(2) |
| September | 02:23 hrs | Informal |
| September | 01:20 hrs | 5(2) |

# Advisory Report: Mental Health Act Section 5




| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 8 | 2 | 4 | 4 | 2 | 4 | 6 | 4 | 4 | 8 | 6 | 10 |
| Central | 7 | 5 | 7 | 5 | 5 | 4 | 3 | 4 | 4 | 6 | 8 | 8 |
| East | 4 | 4 | 5 | 7 | 2 | 5 | 6 | 3 | 5 | 6 | 5 | 3 |

**EXCEPTIONS**

(EAST) 1 x Sections lapsed

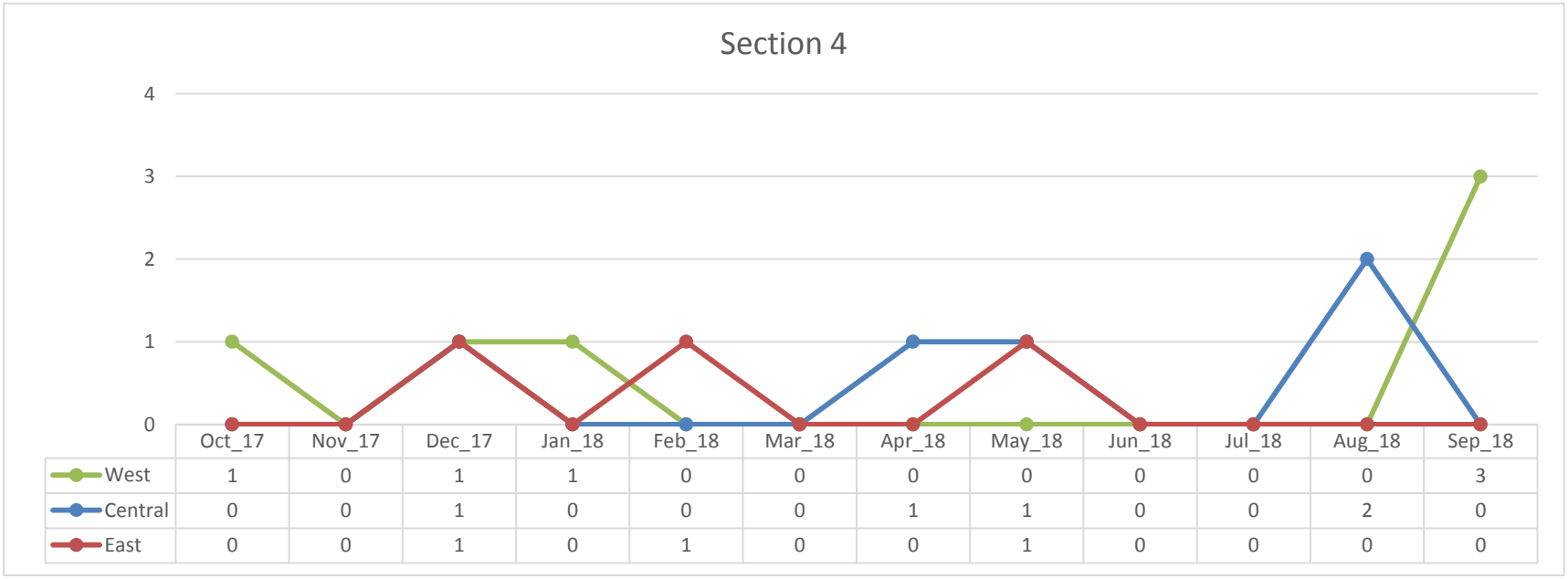
- The HO17 form was completed too late

There were three Invalid section 5(2) completed these are detailed on page 12

This quarter there were two 5(2) sections within the Acute Hospitals.

| Outcomes of S5(2) | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|
| Sec 2 | 9 | 6 | 3 |
| Sec 3 | 2 | 6 | 5 |
| Informal | 4 | 5 | 4 |
| Lapsed | 0 | 1 | 0 |
| Invalid | 0 | 2 | 1 |

# Advisory Report: Mental Health Act Section 4




| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Central | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 0 |
| East | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

The use of Section 4 is a relatively rare event and figures remain low. Section 4 will be used in emergency situations where it is not possible to secure two doctors for a section 2 immediately and it is necessary for a persons protection to detain under a section of the MHA.

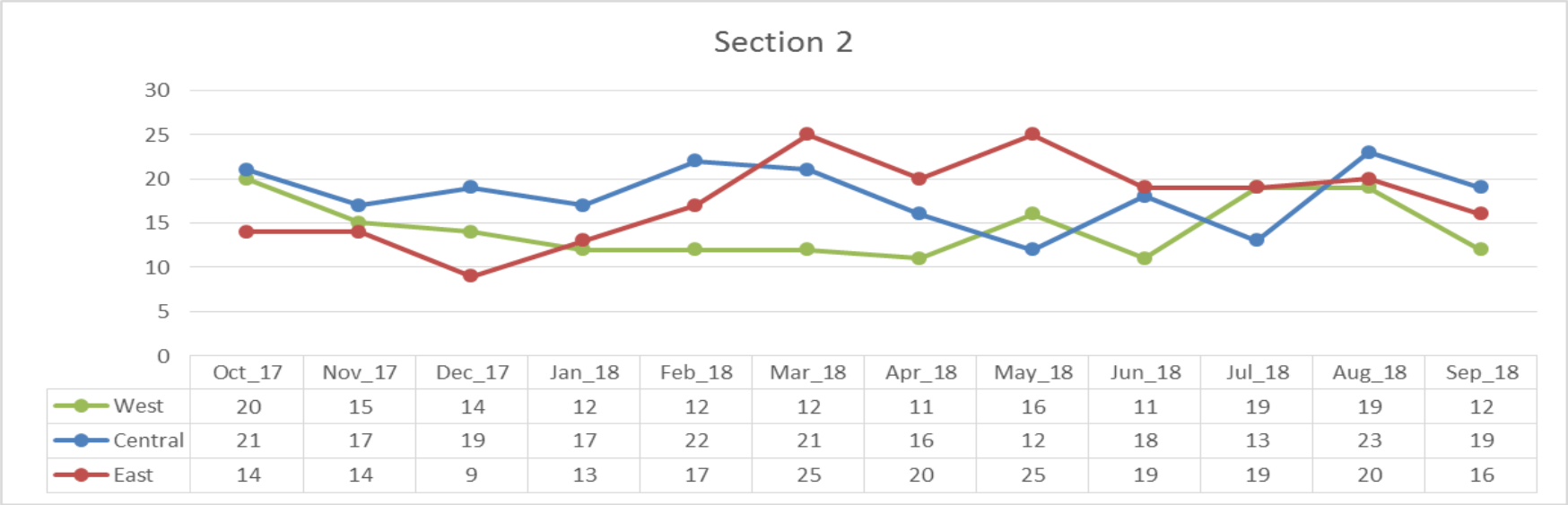
**There are no exceptions to report for S4 this quarter all sections were used appropriately and then converted to another section.**

**West: September –** 3 persons were admitted under **a** S4 two were regraded to a S2, and one was discharged from the section because the Doctor did not agree that the patient should be regraded to a S2.

**Central: August** – 2 persons were admitted under a S4 both were regraded to a S2.

In comparison to the other six Health Boards in Wales BCUHB is not an outlier.

# Advisory Report: Mental Health Act Section 2




| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 20 | 15 | 14 | 12 | 12 | 12 | 11 | 16 | 11 | 19 | 19 | 12 |
| Central | 21 | 17 | 19 | 17 | 22 | 21 | 16 | 12 | 18 | 13 | 23 | 19 |
| East | 14 | 14 | 9 | 13 | 17 | 25 | 20 | 25 | 19 | 19 | 20 | 16 |

| Outcomes - S2 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|
| Sec 3 | 13 | 12 | 8 |
| Informal | 13 | 33 | 17 |
| Lapsed | 0 | 3 | 0 |
| Trans Out | 13 | 10 | 7 |
| Pending | 1 | 4 | 1 |

It is hard to interpret these figures in isolation. However it has to be noted that in the East there are more beds and these figures are on the basis of the applications as opposed to address of residence. The East is currently showing an upward trend whilst West and Central appear stable.

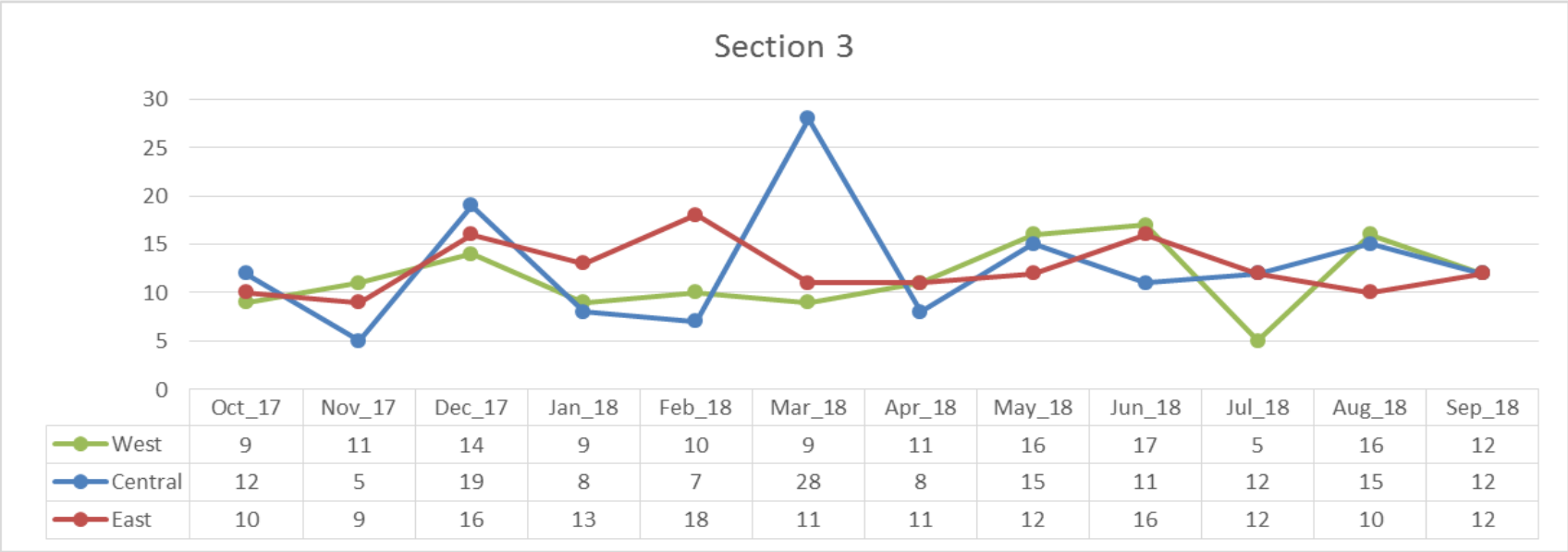
Outcomes of Section 2 are detailed month on month. These figures include any pending from the previous month.

**EXCEPTIONS – Lapses / Use of Section 2 > 18**

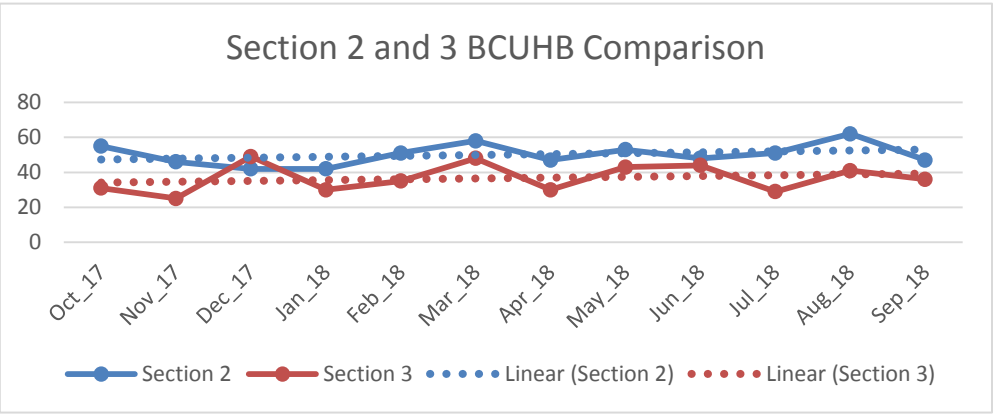
3 x Lapsed - West.- Two assessments for a S3 did not go ahead because the AMHPs did not agree
East - There was confusion between the ward about the section expiry following a transfer.

Under 18 – Six under 18's were placed on a S2 this month between the ages of 14 and 17, four of these were in an age appropriate setting, two were following S136's and were t transferred to appropriate placements under the Section 2

# Advisory Report: Mental Health Act Section 3



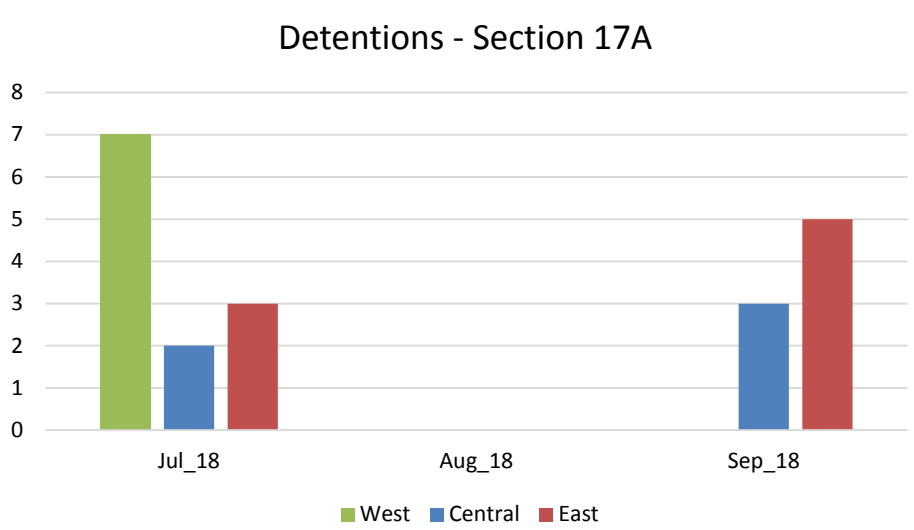

| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 9 | 11 | 14 | 9 | 10 | 9 | 11 | 16 | 17 | 5 | 16 | 12 |
| Central | 12 | 5 | 19 | 8 | 7 | 28 | 8 | 15 | 11 | 12 | 15 | 12 |
| East | 10 | 9 | 16 | 13 | 18 | 11 | 11 | 12 | 16 | 12 | 10 | 12 |

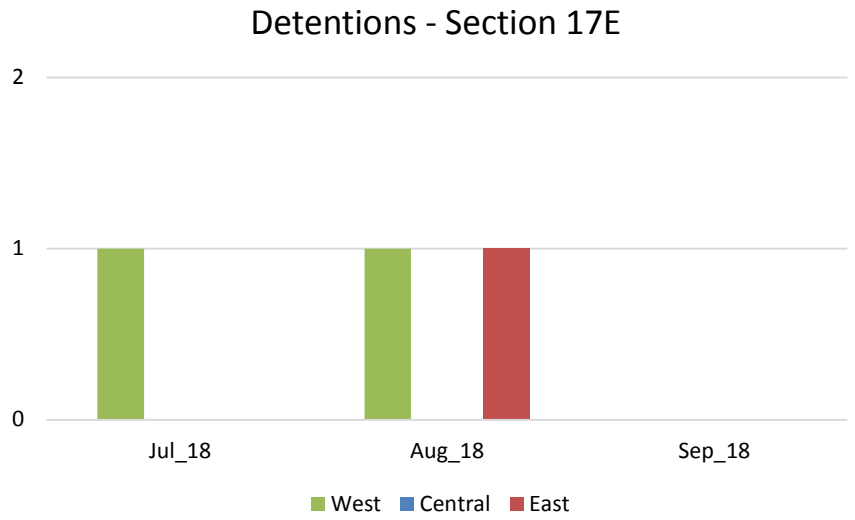


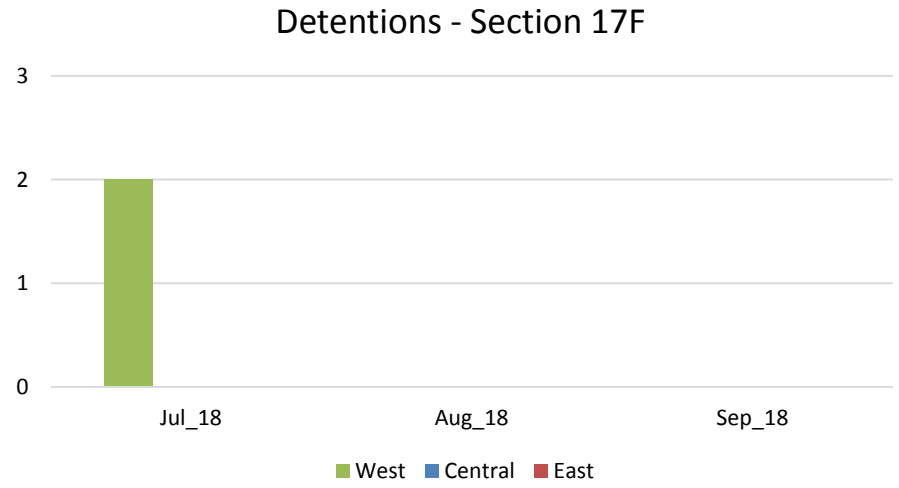

These numbers also include any renewal sections undertaken in the month. As with the data for Section 2, it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

This quarter no under 18 year olds were placed on a Section 3.

# Advisory Report: Mental Health Act Section 17A-F




The quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month.

The number of patients subject to a CTO at the end of September : West: 14, Central: 14 and East: 17.

These numbers are comparative to the last quarters figures.

Three patients were discharged from their CTO all within the West.

**EXCEPTIONS**
One CTO lapsed within the West due to the Consultant not completing the CP3 application to renew on time. This patient has not been subject to any further sections to date.

# Advisory Report: Mental Health Act Errors

## Agreed Invalid Detentions Definition

Health Boards within Wales agreed that the definitions and levels of seriousness were to be simplified into two categories:

**Rectifiable Errors**: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

**Fundamentally Defective Errors** : concerned with errors which cannot be rectified under section 15.

**Lapses of section**: refers to sections that have come to the end of their time period. It is not good practice for sections to lapse and reasons are investigated.

## Where we are and what we are doing:

**Fundamental Errors:- this quarter there were three sections classed as Invalid all under S5(2).**

- Two due to the reasons for the use not being appropriate and the authorised staff who accept the section not being willing to sign off.
- One due to the Doctor not signing, dating or inserting the time the S5(2) was applied.

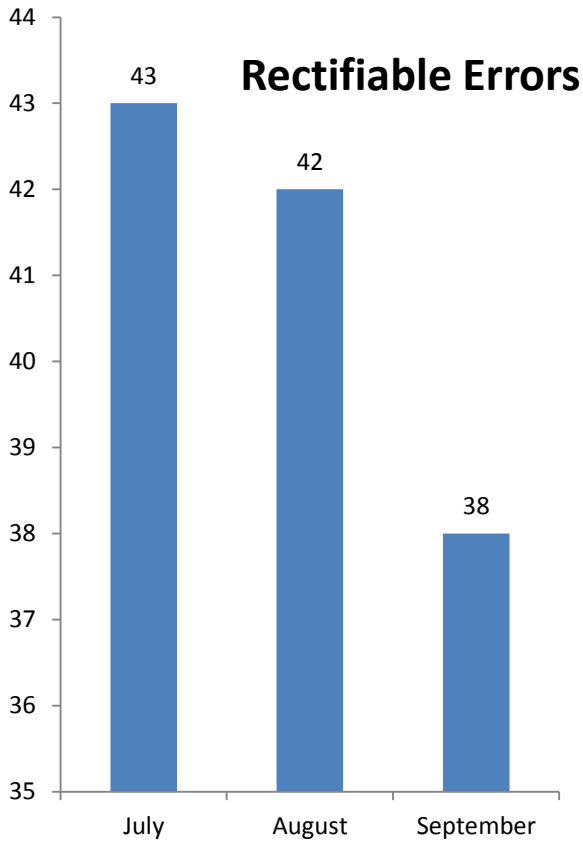
Staff have been reminded that these failings must be put on Datix to ensure an investigation and lessons learnt is undertaken.

In comparison to the other Health Boards in Wales data for this period is not available at the time of writing the report.

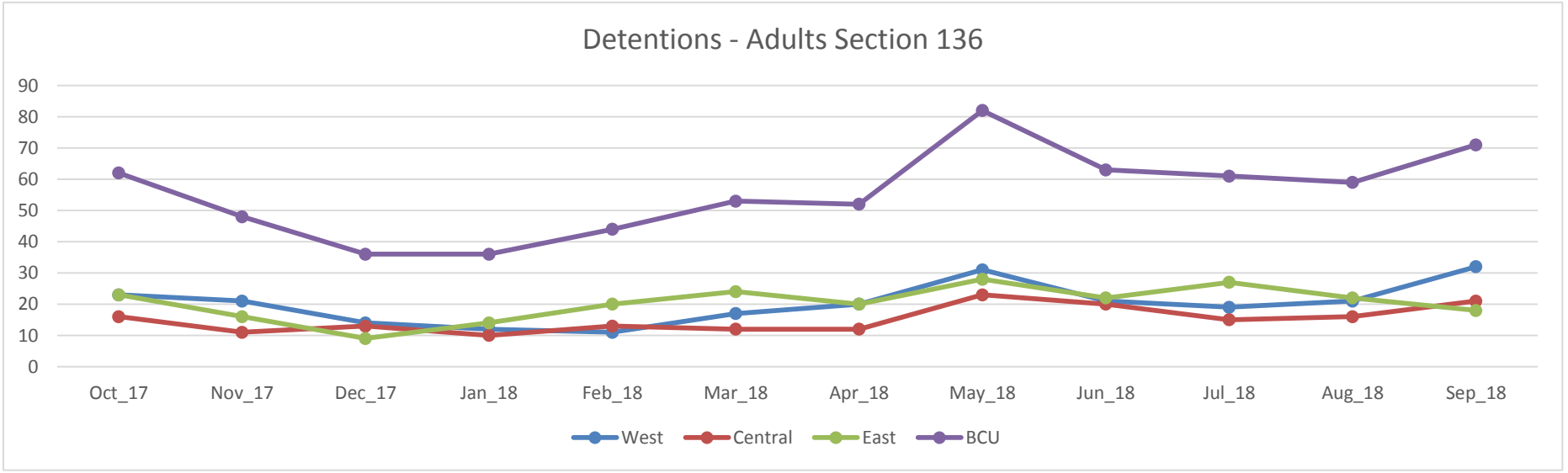
**Rectifiable Errors**: Since recording BCUHB has consistently recorded a high number of rectifiable errors. This quarter recorded 123. This is an increase on the previous quarter 98%. The number of Fundamental Errors would have had an impact on this figure and there is evidence throughout the quarter that these are again decreasing.

In comparison to the other Health Boards in Wales BCUHB accounted for 31% of total rectifiable errors for the previous quarter (April – June), Data for this period is not available at the time of writing the report.

**Section Lapses**: July 1 x s136. August 1 x s5(4), 1 x s5(2) September 1 x CTO reported as exceptions throughout this report.



# Advisory Report: Mental Health Act Section 135-136




| Detentions - Adults Section 136 | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 23 | 21 | 14 | 12 | 11 | 17 | 20 | 31 | 21 | 19 | 21 | 32 |
| Central | 16 | 11 | 13 | 10 | 13 | 12 | 12 | 23 | 20 | 15 | 16 | 21 |
| East | 23 | 16 | 9 | 14 | 20 | 24 | 20 | 28 | 22 | 27 | 22 | 18 |
| BCU | 62 | 48 | 36 | 36 | 44 | 53 | 52 | 82 | 63 | 61 | 59 | 71 |

The data above does not include S135 or under 18's.

The Trend for S136 adults has returned to an upward projection, there continues to be a rise. Total figures for 2016/17 = 669 and 2017/18 = 664, to date the number of S136 detentions is 399 for this financial period. For this quarter compared to last year July and August were similar figures but September 2018 has seen a 37% rise compared to September 2017

There were four 135 detentions for the quarter , three resulting in admission under Section 2 and one informal admission.

Custody detentions – three were reported for the quarter resulting in an informal admission, admission under Section 2 and one discharge.

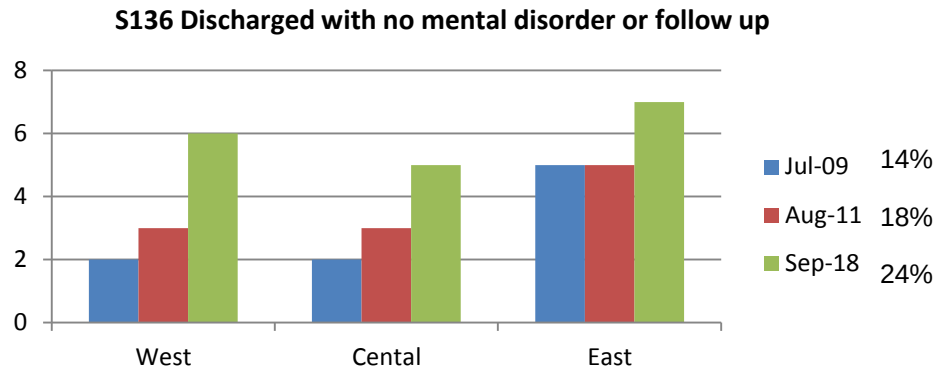
**EXCEPTIONS** – One 136 lapsed in the East due to the patient not being fit for assessment.

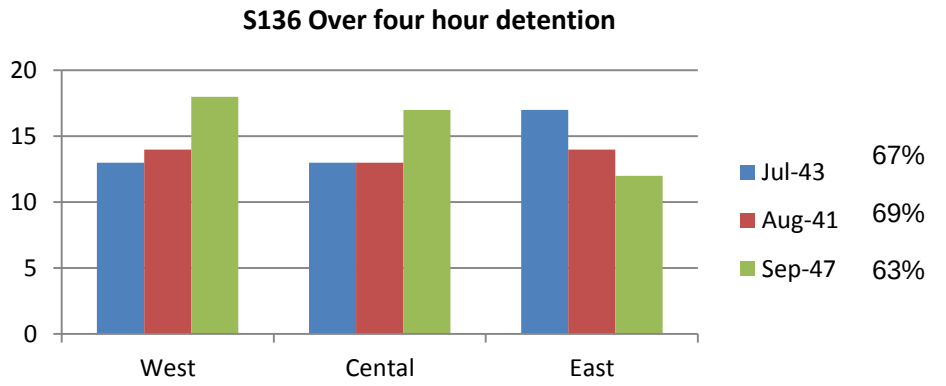
# Advisory Report: Mental Health Act Section 135-136

## Outcomes for 136 detentions July 18 – September 18

| Section 136 Outcomes | | | |
|---|---|---|---|
| Period 1 | Jul_18 | Aug_18 | Sep_18 |
| Discharged | 36 | 34 | 52 |
| % of outcomes | 59.02% | 55.74% | 72.22% |
| Informal Admission | 14 | 13 | 10 |
| % of outcomes | 22.95% | 21.31% | 13.89% |
| Sec 2 | 11 | 13 | 10 |
| % of outcomes | 18.03% | 21.31% | 13.89% |
| Sec 3 | 0 | 1 | 0 |
| % of outcomes | 0.00% | 1.64% | 0.00% |
| Other | 0 | 0 | 0 |
| % of outcomes | 0.00% | 0.00% | 0.00% |

| S136 - Known to service | | | |
|---|---|---|---|
| Period 1 | Jul_18 | Aug_18 | Sep_18 |
| Yes | 29 | 23 | 28 |
| % | 46.77% | 44.23% | 41.18% |
| No | 33 | 29 | 40 |
| % | 53.23% | 55.77% | 58.82% |

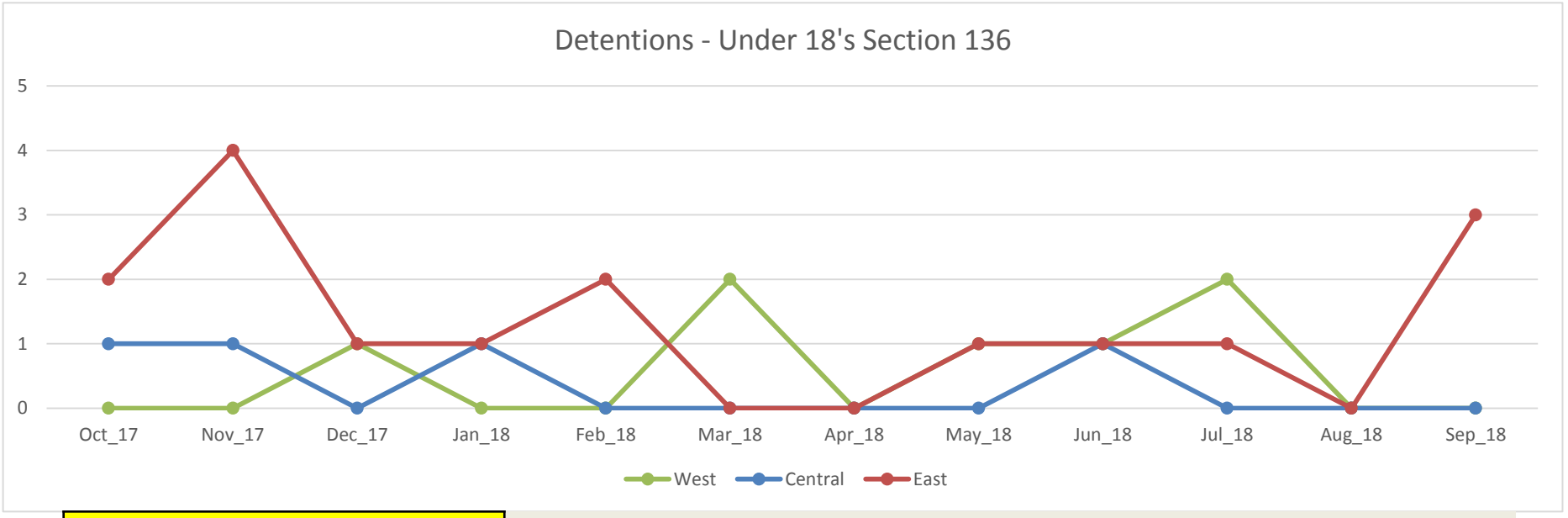



The data shows figures from outcomes recorded and whether a patient is known to service.
Whilst a large proportion of 136's are discharged those with no mental disorder alone is relatively low.
A large number of assessments result in delays over four hours. There have been four instances where a person has not been fit for assessment and an extension of 12 hours was been requested on three occasions. Maximum time recorded for s136 assessment to conclude is 36:00 hours.

**EXCEPTIONS**: East 36:00 hours the patient was subsequently discharged as per the legislation, was not fit for assessment and remained in A&E.

# Advisory Report: Mental Health Act Section 136 - <18




| Detentions - Under 18's Section 136 | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | 1 | 2 | 0 | 0 |
| Central | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| East | 2 | 4 | 1 | 1 | 2 | 0 | 0 | 1 | 1 | 1 | 0 | 3 |
| BCU | 3 | 5 | 2 | 2 | 2 | 2 | 0 | 2 | 3 | 3 | 0 | 3 |

A total of 6 under 18's were assessed this quarter between the ages of 14 and 17 years old.

Four assessments resulted in discharge, one in an admission under S2 to an age appropriate bed and one in admission under S2 to the adult unit whilst awaiting transfer, the child remained in the s136 suite.

Quarterly figures have shown a steady decrease of under 18 detentions during the past 12 months.

**EXCEPTIONS** None recorded this quarter

# Advisory Report: Mental Health Act – <18 Admissions

**Under 18's assessed for Section 136 between 01.07.18 – 30.09.18**

| Date of Admission | Place of Assessment | Outcome | Assessing Clinician | Total Hours | Age |
|---|---|---|---|---|---|
| | | | | | |
| July | Hergest | Admission | CAMHS | 17:25 hrs | 14 |
| | Hergest | Discharged | CAMHS | 07:19 hrs | 17 |
| | Heddfan | Discharged | Adult Consultant | 21:51 hrs | 17 |
| | | | | | |
| September | Heddfan | Discharged | Adult Consultant | 04:35 hrs | 17 |
| | Heddfan | Discharged | Adult Consultant | 02:49 hrs | 17 |
| | Heddfan | Admission | CAMHS | 12:25 hrs | 15 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Under 18's assessed**

Out of the 6 persons assessed
4 Originated from their own homes, 1 was from a foster care placement and 1 from a care home.

5 out of the 6 detentions were initiated out of hours.

The Assistant Area Directors of the CAMHS service are notified straight away of a young persons, 15 and under who is detained under S136, within hours the MHA office notify. Out of hours this responsibility lies with the duty staff.

Average PoS hours: 07:54 hrs this is a decrease on the previous quarter figures. (11:45 hrs)

**Under 18's admitted to Adult Psychiatric Wards**

There was one admission to the Adult Psychiatric Unit this quarter whilst an appropriate bed was being found. The young person remained within the S136 suite as this was deemed the most suitable place to meet their needs at the time.

# Advisory Report: Mental Health Act - Forensic

| Section | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | April 18 | May 18 | June 18 | July 18 | Aug 18 | Sept 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sec 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sec 37 | 2 | 3 | 3 | 3 | 2 | 2 | 3 | 3 | 3 | 4 | 4 | 3 |
| Sec 37/41 | 5 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 7 | 8 |
| Sec 38 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sec 47 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sec 47/49 | 4 | 4 | 5 | 6 | 6 | 6 | 5 | 6 | 6 | 5 | 5 | 5 |
| Sec 48 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sec 48/49 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Sec 3 | 2 | 3 | 3 | 3 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Informal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 13 | 15 | 17 | 18 | 18 | 18 | 18 | 19 | 19 | 19 | 20 | 20 |

Ty Llywelyn Medium Secure Unit, Llanfairfechan is a 25 bedded all male facility. The nature of the forensic sections does not always generate rapid activity.

There are times when Section 3 patients will be detained to this Unit.

The unit had been running on lower bed numbers since February 2016. The unit is now fully functional and can house 25 patients.

# Advisory Report: Mental Health Act - Transfers

**Total Transfers April 2018 – September 2018**

| | | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|
| Internal Transfers | | 13 | 14 | 12 |
| External Transfers (Total) | | 18 | 11 | 4 |
| External Transfers (In) | | 8 | 7 | 3 |
| External Transfers (Out) | | 10 | 4 | 1 |

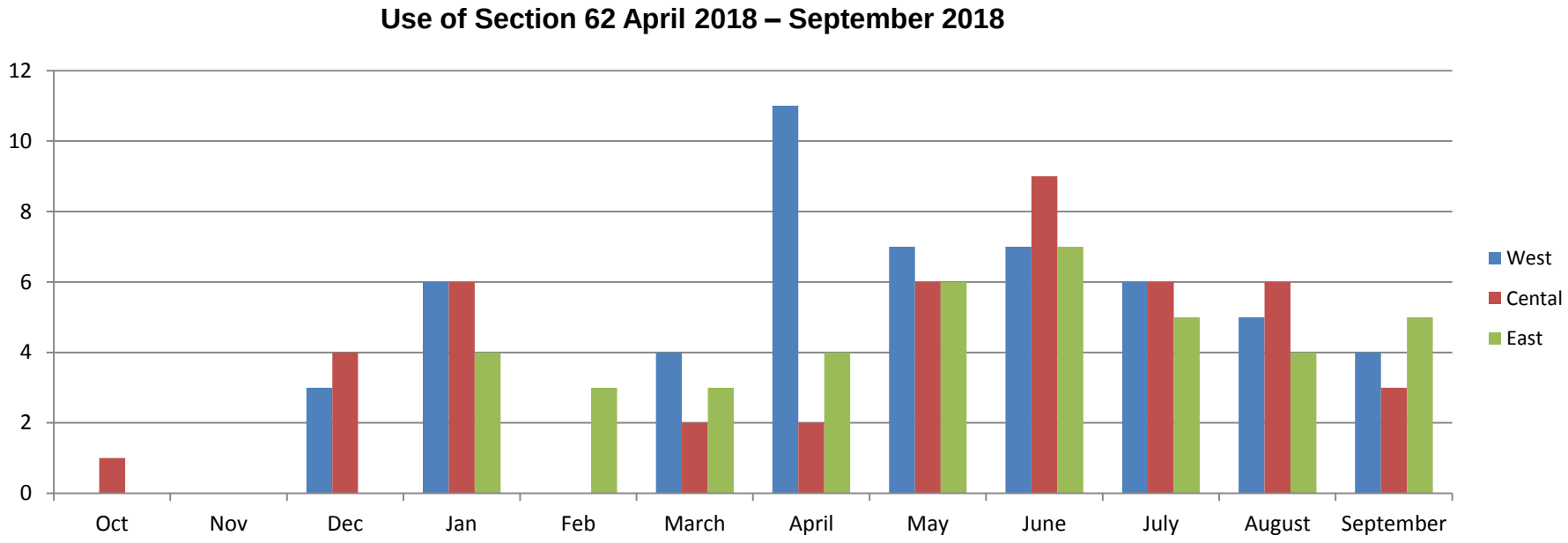
**Internal transfers**
This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway.

**External transfers**
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised care.

The table details IN where the patient has come from and their home origin and OUT where the patient has gone to.

| Month | In | Out |
|---|---|---|
| July | Ashworth Hospital (Cardiff) | Ty Grosvenor (Gwynedd) |
| | Phoenix House (Powys) | Dudley (Repatriated) |
| | Redwoods (Conwy) | Cygnet Hospital (Denbighshire) |
| | Redwoods (Denbighshire) | Carmarthen (Repatriated) |
| | Arbury Court (OOA) | St Michael Warwick (Flintshire) |
| | Arbury Court (OOA) | Redwoods (Conwy) |
| | Phoenix House (Wrexham) | Norfolk (Flintshire) |
| | Bradgate, Leicester (Flintshire) | Cygnet Hospital (Wrexham) |
| | | Redwoods (Powys) |
| | | St Georges (Repatriated) |
| | | |
| August | Kneesworth (Denbighshire) | Milton Keynes (Gwynedd) |
| | Hopewood Park (Gwynedd) | Stockport (Ynys Mon) |
| | Redwoods (Gwynedd) | Redwoods (Denbighshire) |
| | Redwoods (OOA) | Chadwick Lodge (Wrexham) |
| | Redwoods (Conwy) | |
| | Prestley Dewsbury (Denbighshire) | |
| | Whiston (Flintshire) | |
| | | |
| September | Redwoods (Conwy) | New Hall (Denbighshire) |
| | New Hall (Wrexham) | |
| | Hywel Dda (Conwy) | |

# Advisory Report: Section 62




Monitoring of Section 62 is a requirement of the Code of Practice (25.38).

Reasons for S62 use:
Medication changes
Patient no longer able to give consent to treatment or refusing to consent
ECT
Awaiting a Second Opinion Appointed Doctor to arrive and three month consent to treatment expired.

The recording of s62 has been reviewed to ensure accuracy due to the lack of available data for Oct – Dec.

Within February no S62's were completed for the West and Central, all SOAD requests were actioned prior to the expiry of the three month consent to treatment.
.

# Mental Health



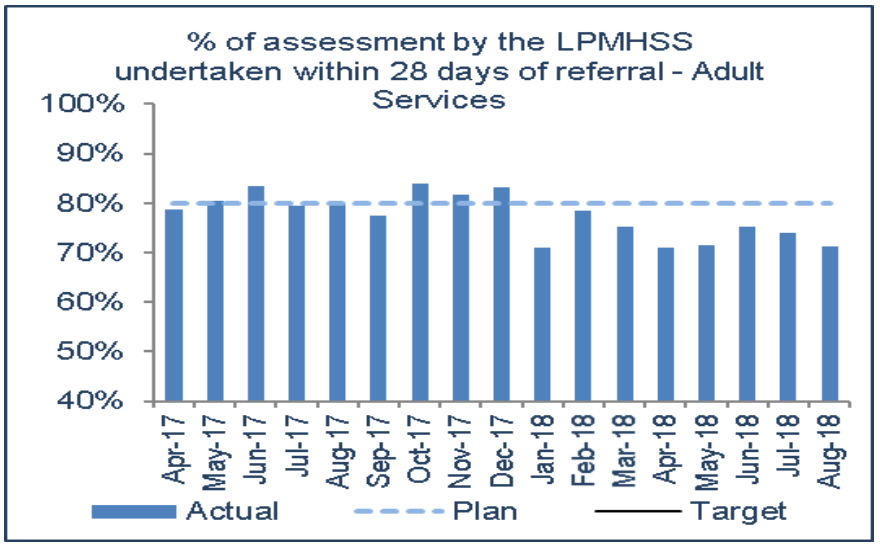

| Measure | Status | (Target) |
|---|---|---|
| MHM1a - Assessments within 28 Days | 72.70% | >= 80% |
| MHM1b - Therapy within 28 Days | 55.40% | >= 80% |
| MHM2 - Care Treatment Plans (CTP) | 87.80% | >= 95% |
| MHM3 - Copy of Agreed plan within 10 Days | 100% | 100% |
| Delayed Transfers of Care (DToC) Rate | 3.49 | <= 2.70 |
| Delayed Transfers of Care (DToC) Days | 2,311 | >= 2,089 |

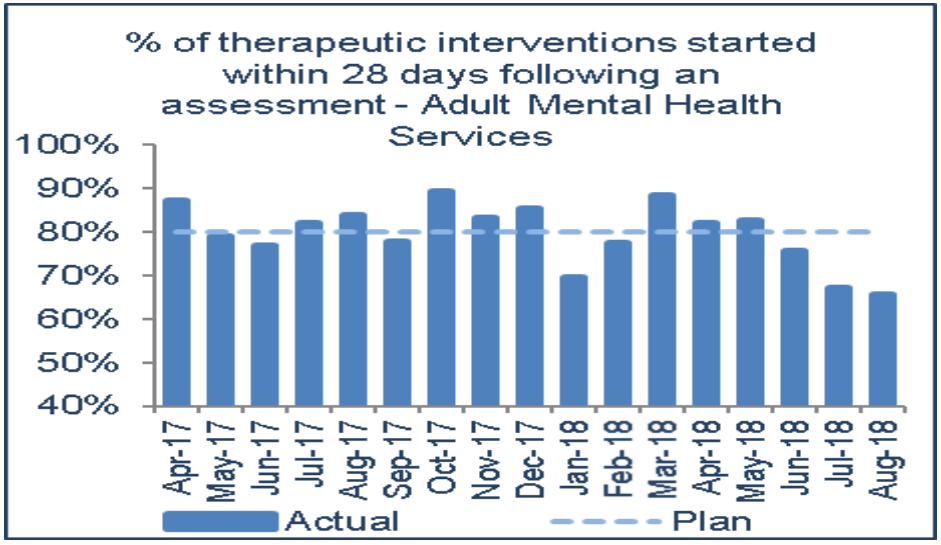
# Chapter 5 – Mental Health

## MH Measures - Adult



| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LM 074A | % of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult | Target >= 80% | Plan | Aug-18 | 71.20% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | | Months in Exception | 6+ | Escalation Level | |
| LM 075A | % of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult | Target >= 80% | Plan | Aug-18 | 65.67% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | | Months in Exception | 6+ | Escalation Level | |




**Actions**
- Staffing reconfigured to meet changes in demand
- Monitoring of patients approaching the 28 day breach limit
- Education and support to GP's on appropriate referrals

**Outcomes**
- Improved capacity
- Reduced number of patients breaching the 28 day limit.
- Reduced number of inappropriate referrals

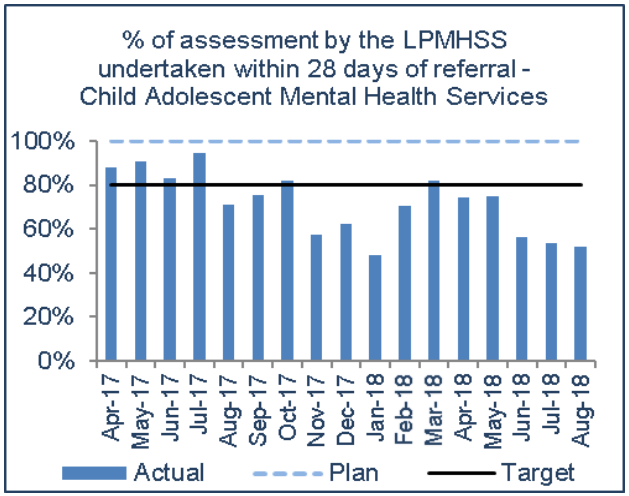
**Timelines**
Sustained achievement of the target rate for this measure is expected from December 2018 onwards

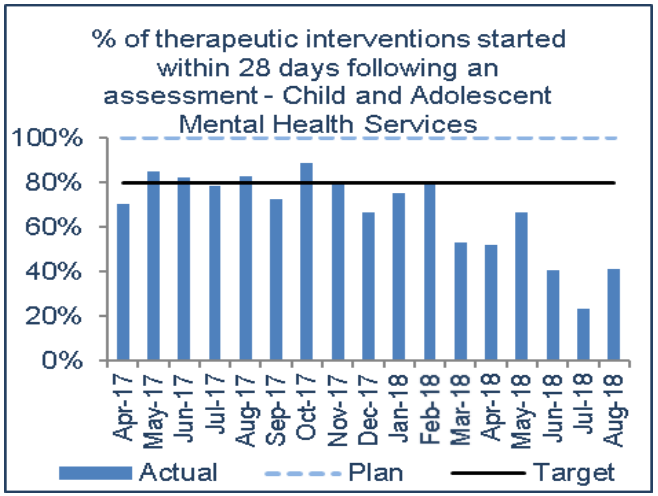
# Chapter 5 – Mental Health

## MH Measures - CAMHS



| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LM 074B | % of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS | Target >= 80% | Plan | Aug-18 | 51.85% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | ↓ | Months in Exception | 6+ | Escalation Level | |
| LM 075B | % of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS | Target >= 80% | Plan | Aug-18 | 40.98% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | ↑ | Months in Exception | 6+ | Escalation Level | |




| CAMHS | Assessment (within 28 days) | Therapy (within 28 days) |
|---|---|---|
| West | 71% | 60% |
| Conwy | 33% | 36% |
| Denbighshire | 46% | 100% |
| Flintshire | 60% | 0% |
| Wrexham | 91% | 0% |

**Actions**

- Action Plan and Trajectories being produced
- Set up task and Finish Group to review backlog
- Provide additional hours from current budgets
- Bids for additional funding submitted to WG
- Contributed to Local Authority Crisis Bid

**Outcomes**

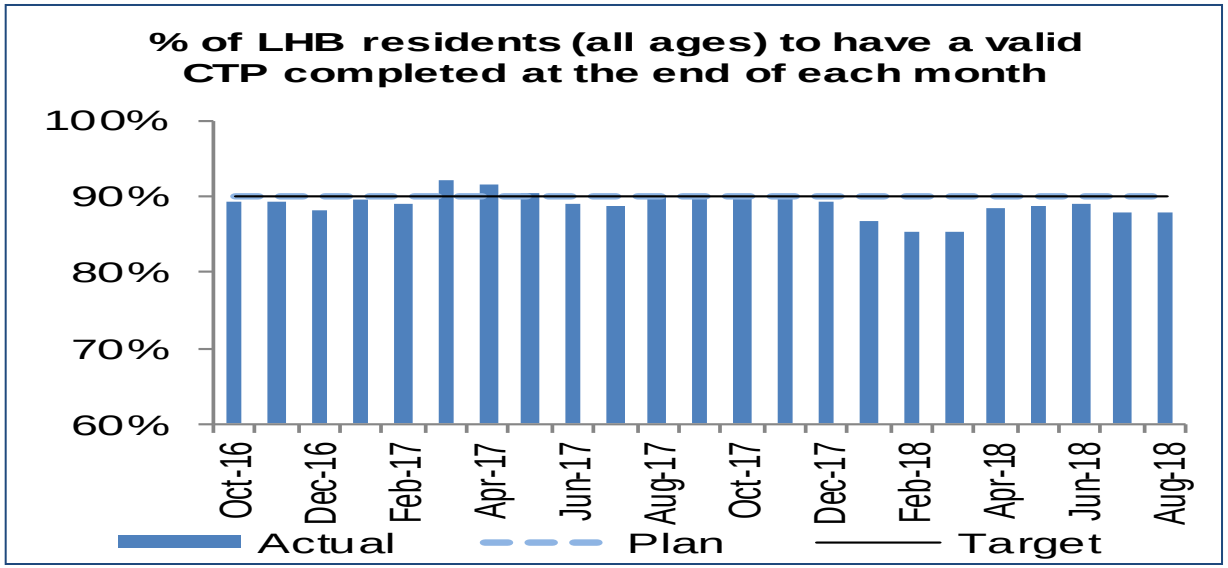
- Reduction in the number of patients breaching the 28 day target threshold.

**Timelines** It is expected to consistently achieve the assessment measure from October 2018 onwards (except Central) and performance against the therapy measure is expected to improve by March 2019. This is however dependent upon receipt of investment and no significant changes in demand or capacity.

# Chapter 5 – Mental Health Care Treatment Plan



| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DFM 085 | % of LHB residents (all ages) to have a valid CTP completed at the end of each month | Target | Plan | Aug-18 | 87.80% | Wales Benchmark | 3rd | Executive Lead | Andy Roach | Status | ↓ | Months in Exception | 6+ | Escalation Level | |
| DFM 086 | Service users assessed under part 3 to be sent a copy of the assessment in 10 working days | Target 100% | Plan | Aug-18 | 100% | Wales Benchmark | 1st | Executive Lead | Andy Roach | Status | ↑ | Months in Exception | | Escalation Level | |




**Actions**
- Review of invalid CTPs

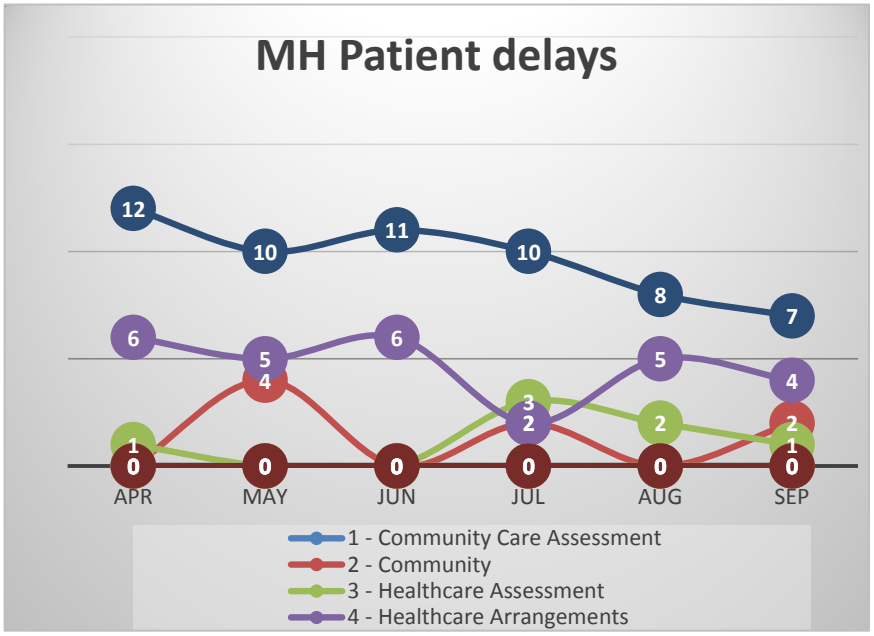
**Outcomes**
- None stated

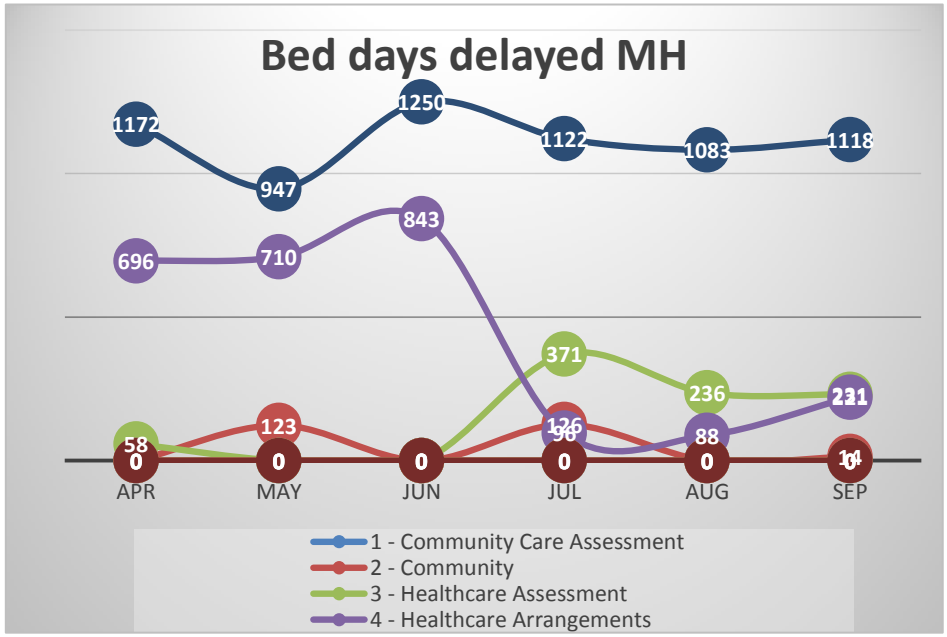
**Timelines**
It is expected to be back on track by December 2018

# Delayed Transfers of Care (DToC)



| DFM | | Target | Plan | | | Wales Benchmark | | Executive Lead | | Status | Months in Exception | | Escalation Level | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 030 | Delayed Transfers of Care(DToC): Rolling 12 months - Number of Mental Health | <= 194 | | Jul-18 | 248 | | 6th | | Andy Roach | ↓ | | 6+ | | |




**Actions**

- Strengthen adherence to DToC procedures
- Increased scrutiny of DToC patients
- Closer engagement with CHC and Local Authorities to address DToC

**Outcomes**

- Reduced number of patients being delayed for discharge

**Timelines**

**Mental Health Act Committee**

3rd January 2019

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

***To improve health and provide excellent care***

| | |
|---|---|
| **Report Title:** | *Under 18 years – MHA Section Data report* |
| **Report Author:** | *Wendy Lappin, Mental Health Act Manager* |
| **Responsible Director:** | *Andy Roach, Director of MH&LD* |
| **Public or In Committee** | *Public* |
| **Purpose of Report:** | *To provide an update in relation to the activity within the division for young people under the age of 18 years – Section 136.* |
| **Approval / Scrutiny Route Prior to Presentation:** | *This paper prior to presentation at the Mental Health Act Committee Meeting will be presented to the MH&LD Q-SEEL meeting for the Senior Management Team and then to the Divisional Directors Meeting and Andy Roach.* |
| **Governance issues / risks:** | *All areas should have agreed a protocol and have a designated place of safety provision for young people within their area.* |
| **Financial Implications:** | *None* |
| **Recommendation:** | *The committee is asked to note the report* |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
|---|---|---|---|
| 1.To improve physical, emotional and mental health and well-being for all | √ | 1.Balancing short term need with long term planning for the future | √ |
| 2.To target our resources to those with the greatest needs and reduce inequalities | √ | 2.Working together with other partners to deliver objectives | √ |
| 3.To support children to have the best start in life | √ | 3. Involving those with an interest and seeking their views | √ |
| 4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being | √ | 4.Putting resources into preventing problems occurring or getting worse | √ |

| | | | |
|---|---|---|---|
| 5.To improve the safety and quality of all services | √ | 5.Considering impact on all well-being goals together and on other bodies | √ |
| 6.To respect people and their dignity | √ | | |
| 7.To listen to people and learn from their experiences | √ | | |

**Special Measures Improvement Framework Theme/Expectation addressed by this paper**

**Governance and Leadership – to ensure compliance with the Mental Health Act and Mental Health (Wales) Measure.**

*http://www.wales.nhs.uk/sitesplus/861/page/81806*

**Equality Impact Assessment**

**Retrospective looking report therefore no EqIA required.**

*(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193 )*





**Under age 18 years – MHA Sec 136 Data**

**Data Report up to September 2018**

| YEAR | No of Admissions for assessment | Average time spent in PoS |
|---|---|---|
| **January 2014 – December 2014** | 18 admissions age range 13-17 | Unavailable |
| **January 2015 – December 2015** | 15 admissions age range 13-17 | 11 hours |
| **January 2016 – December 2016** | 38 admissions age range 12-17 | 11.8 hours |
| **January 2017 – December 2017** | 52 admissions age range 12 – 17 | 13.25 hours |
| **January 2018 – September 2018** | 17 admissions age range 13 - 17 | 9.06 hours |

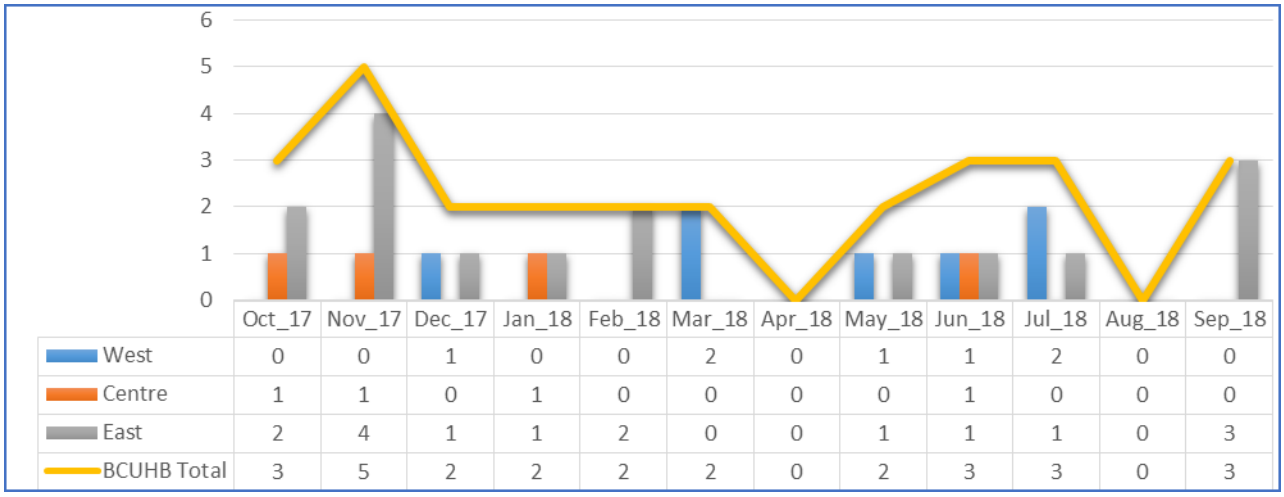
| **January 2018 – September 2018** | **No Assessed** | **AGE OF CHILD** |
|---|---|---|
| 17 admissions age range 13-17 | 0 | 12 |
| Average time PoS – 9:06 hours | 2 | 13 |
| | 2 | 14 |
| | 1 | 15 |
| | 3 | 16 |
| | 9 | 17 |
| | | |
| **OUTCOME following assessment** | **No** | |
| Returned Home | 10 | |
| Returned to Care Facility | 4 | |
| Admission Children's Ward | 0 | |
| Admission Adult Mental Health Ward | 1 | |
| Admission NWAS / CAMHS service | 1 | |
| Admission out of area placement | 0 | |
| Other (friends, Hotel, B&B, family) | 1 | Stayed within the 136 Suite |

**COUNTIES ORIGINATED FROM AND WHERE ASSESSED.**

| County | POS East | POS Central | POS West |
|---|---|---|---|
| Wrexham | 7 | | |
| Flintshire | | | |
| Denbighshire | 1 | 1 | 1 |
| Conwy | | 1 | 2 |
| Gwynedd | | | 1 |
| Ynys Mon | | | 2 |
| Other | 1 x Shropshire | | |

Twelve of the children originated from their own homes and five from care homes. All children from the care homes are Welsh residents.

**Section 136 twelve month trend up to and including Sep_18**




| | Oct_17 | Nov_17 | Dec_17 | Jan_18 | Feb_18 | Mar_18 | Apr_18 | May_18 | Jun_18 | Jul_18 | Aug_18 | Sep_18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| West | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | 1 | 2 | 0 | 0 |
| Centre | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| East | 2 | 4 | 1 | 1 | 2 | 0 | 0 | 1 | 1 | 1 | 0 | 3 |
| BCUHB Total | 3 | 5 | 2 | 2 | 2 | 2 | 0 | 2 | 3 | 3 | 0 | 3 |

| | |
|---|---|
| **Health Board / Mental Health Act Committee**<br><br>3rd January 2019 | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board<br>***To improve health and provide excellent care*** |

| | |
|---|---|
| **Report Title:** | **CAMHs Service Update** |
| **Report Author:** | **Fiona Wright, Operations Manager Children's Services** |
| **Responsible Director:** | **Peter Gore-Rees – Clinical Director** |
| **Public or In Committee** | Public |
| **Purpose of Report:** | To update the Committee on CAMHs Services within the Health Board including Mental Health Act and Mental Health Measure compliance |
| **Approval / Scrutiny Route Prior to Presentation:** | Teresa Owen, Executive Lead for Children's Services |
| **Governance issues / risks:** | Sustained delivery of Mental Health Measure targets across the teams |
| **Financial Implications:** | Non-recurrent funding received to address above |
| **Recommendation:** | The Committee is asked to note the above |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
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| 5.To improve the safety and quality of all services | √ | 5.Considering impact on all well-being goals together and on other bodies | √ |
| 6.To respect people and their dignity | √ | | |
| 7.To listen to people and learn from their experiences | √ | | |
| **Special Measures Improvement Framework Theme/Expectation addressed by this paper** | | | |

This paper addresses 'Strategic and Service Planning' providing an update on various service developments in both Tier 3 and Tier 4 CAMHs services and measures undertaken to deliver performance targets and provides update on working in partnership with other services.

**Equality Impact Assessment**

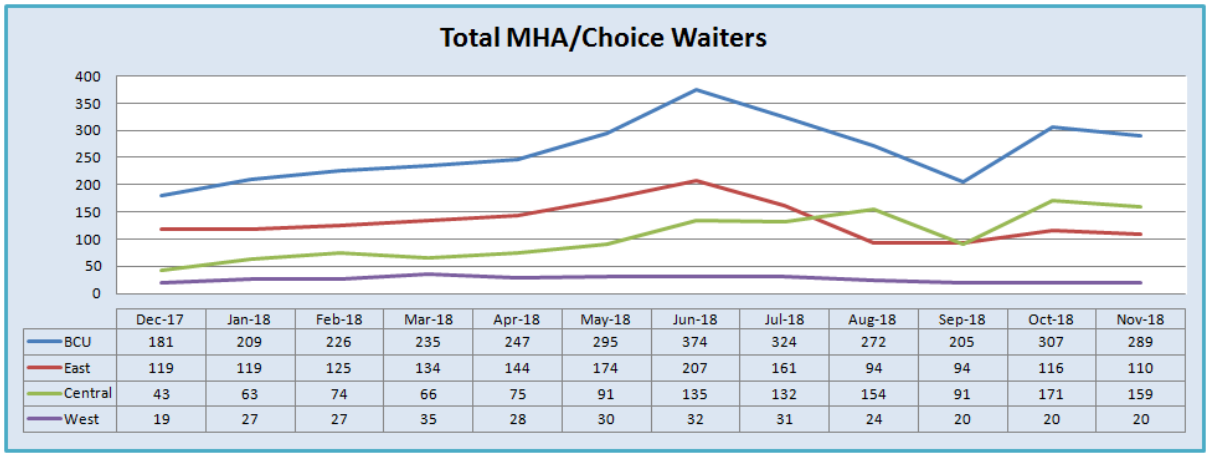
*Quarterly update report on CAMHs services - no EqIA required.*

*Disclosure:*
*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

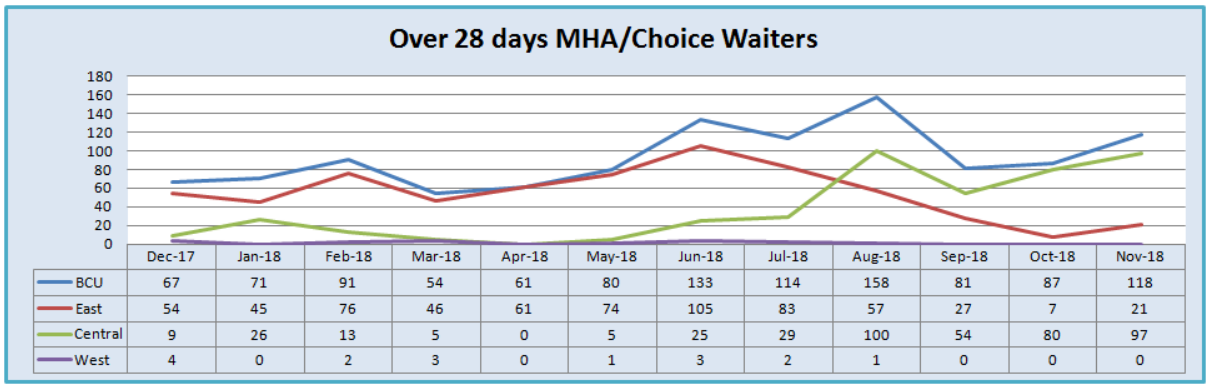
# CAMHs Services update – MHA Committee January 2019

## Performance

There were 289 children and young people waiting for a Mental Health Assessment as at the end of November 2018, of which 118 had been waiting more than 28 days. The longest wait stood at 14 weeks.




| | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BCU | 181 | 209 | 226 | 235 | 247 | 295 | 374 | 324 | 272 | 205 | 307 | 289 |
| East | 119 | 119 | 125 | 134 | 144 | 174 | 207 | 161 | 94 | 94 | 116 | 110 |
| Central | 43 | 63 | 74 | 66 | 75 | 91 | 135 | 132 | 154 | 91 | 171 | 159 |
| West | 19 | 27 | 27 | 35 | 28 | 30 | 32 | 31 | 24 | 20 | 20 | 20 |




| | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BCU | 67 | 71 | 91 | 54 | 61 | 80 | 133 | 114 | 158 | 81 | 87 | 118 |
| East | 54 | 45 | 76 | 46 | 61 | 74 | 105 | 83 | 57 | 27 | 7 | 21 |
| Central | 9 | 26 | 13 | 5 | 0 | 5 | 25 | 29 | 100 | 54 | 80 | 97 |
| West | 4 | 0 | 2 | 3 | 0 | 1 | 3 | 2 | 1 | 0 | 0 | 0 |

## MHM Part 1 targets

Delivery against the 80% targets regionally in November was as follows:

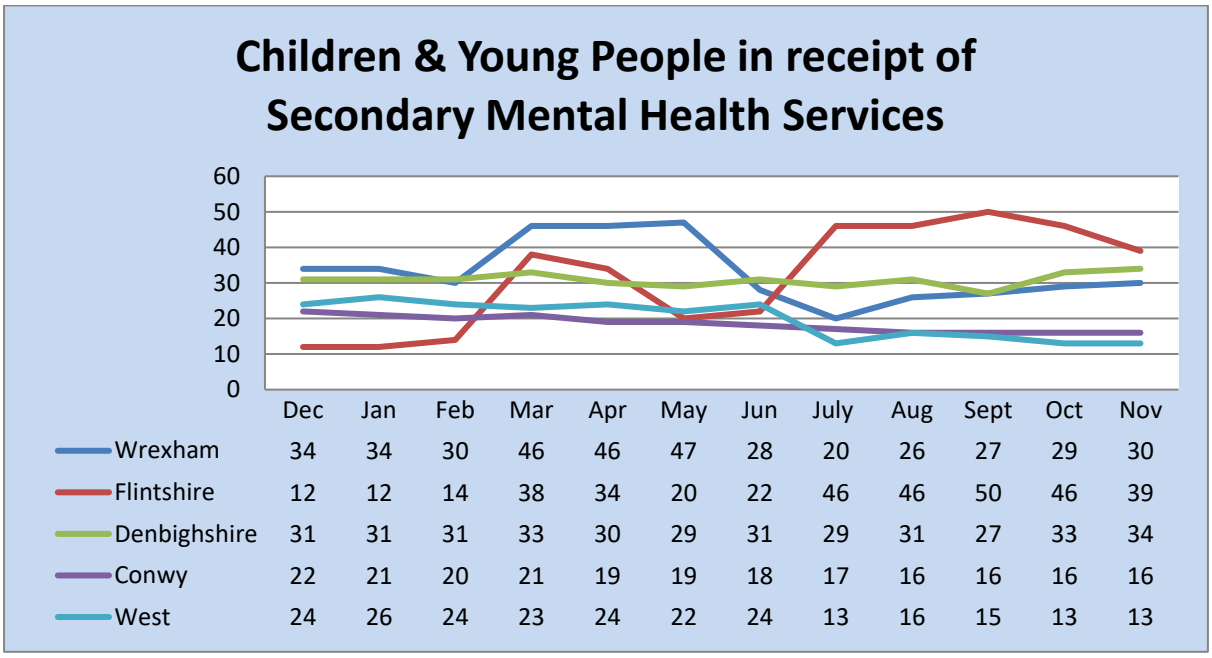
Assessments – 72%

Therapeutic interventions – 39%

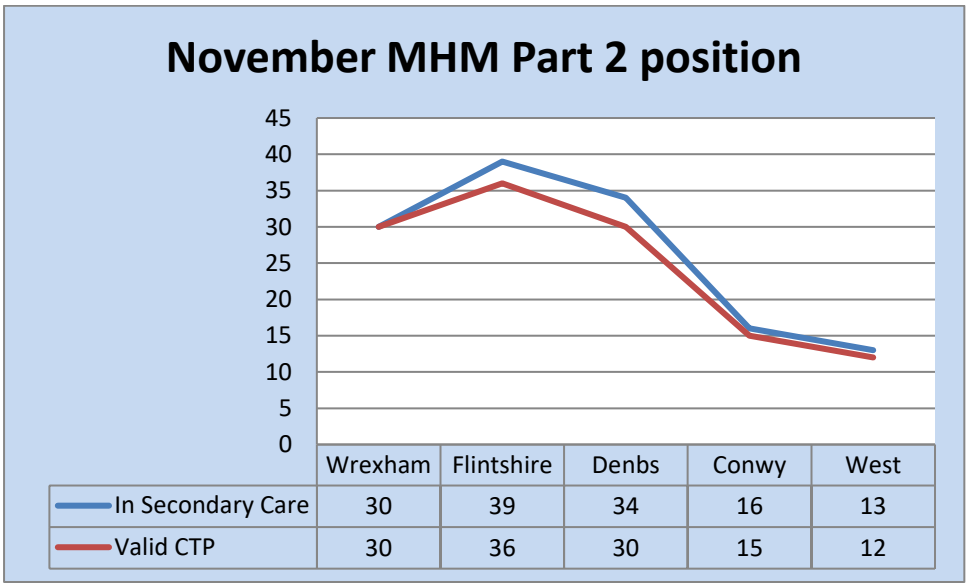
## MHM Part 2

The table below details the number of patients receiving secondary care in each of the teams and of those how many have a valid CTP. The overall position in November is that 93.18% have a valid CTP against a 90% target with some teams achieving 100%.

Processes are now in place to ensure that CTPs are reviewed regularly, it is anticipated that the target will be met and maintained in the coming months.




| | Dec | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sept | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wrexham | 34 | 34 | 30 | 46 | 46 | 47 | 28 | 20 | 26 | 27 | 29 | 30 |
| Flintshire | 12 | 12 | 14 | 38 | 34 | 20 | 22 | 46 | 46 | 50 | 46 | 39 |
| Denbighshire | 31 | 31 | 31 | 33 | 30 | 29 | 31 | 29 | 31 | 27 | 33 | 34 |
| Conwy | 22 | 21 | 20 | 21 | 19 | 19 | 18 | 17 | 16 | 16 | 16 | 16 |
| West | 24 | 26 | 24 | 23 | 24 | 22 | 24 | 13 | 16 | 15 | 13 | 13 |




| | Wrexham | Flintshire | Denbs | Conwy | West |
|---|---|---|---|---|---|
| In Secondary Care | 30 | 39 | 34 | 16 | 13 |
| Valid CTP | 30 | 36 | 30 | 15 | 12 |

## Section 136 and Children placed on an adult ward

The table below details Section 136 Assessments undertaken and admissions to adult wards. As at the end of November 2018 there have been 15 S136 assessments undertaken of which 6 were for children of 15 years of age and younger.

There has been one young person admitted to an adult ward during 2018/19.

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S136 Assessments Undertaken | | | | | | | | | | | | | |
| 2014-15 | 1 | 1 | 2 | 1 | 1 | 4 | 4 | 3 | 3 | 0 | 1 | 2 | 23 |
| 2015-16 | 2 | 0 | 7 | 1 | 0 | 0 | 2 | 1 | 2 | 1 | 0 | 3 | 19 |
| 2016-17 | 4 | 7 | 1 | 2 | 4 | 4 | 6 | 3 | 3 | 1 | 3 | 4 | 42 |
| 2017-18 | 12 | 6 | 3 | 7 | 2 | 3 | 3 | 5 | 2 | 2 | 2 | 2 | 49 |
| 2018-19 | 0 | 2 | 3 | 3 | 0 | 3 | 4 | 0 | | | | | 15 |
| Admissions to Adult Ward | | | | | | | | | | | | | |
| 2014-15 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 4 |
| 2015-16 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 5 | 9 |
| 2016-17 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 3 |
| 2017-18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| 2018-19 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 1 |

## Summary

The MHM targets for assessment and therapy have not been met regionally in recent months primarily due to decreased capacity within the teams with a significant increase in demand across all teams in October. Additional non-recurrent funding of £182k has been secured from WG to address the waiting times for both assessment and therapy. Actions being undertaken across the teams include establishment of both assessment and therapy Task and Finish groups to focus wholly on the backlog. Weekly demand and capacity meetings are taking place across the teams to review demand and allocate capacity as appropriate; capacity is being increased through use of additional hours, agency and private providers.

The WG have allocated recurrent full year funding of £284k from the Psychological Therapies fund, this funding will be utilised to expand the provision of Family Therapy and provide supervision for the delivery of both EMDR and IPT. The funding also allows for some regional clinical leadership for Psychological Therapy. The bid for additional funding for Crisis Services remains under consideration with WG.

The Health Board have agreed to undertake a ‘deep dive’ to review service models for both CAMHs and Neurodevelopmental Services and gain an understanding of the

difficulties in both meeting and maintaining the targets for both services. It is acknowledged that the services have separate and distinct pressures on them hence the ‘deep dive’ will take place over two days focussing on CAMHs Services on the first day and Neurodevelopmental Services on the second day. The CAMHS day will take place on January 10th 2019 with the Neurodevelopmental day on January 17th 2019. Clinical colleagues from the services along with Operational Management, Finance, Information Department, Performance Department and Workforce will be in attendance. The programme for the days will include process mapping of the services, empirical data review to identify demand, capacity, budgets and workforce, appreciative enquiry to gain an understanding of how staff see the services and their challenges along with a ‘deep dive’ of cases from each Area using the ‘5 Whys’ approach.

The Service have commissioned Miller Research to undertake a Service User project which is due to complete shortly with the final report due by the end of March 2019. The project has included various forms of engagement with staff, Service Users and their families to gain their input and views including workshops and one on one interviews. The Service look forward to receiving the final report to take this forward.

| **Mental Health Act Committee**<br><br>*3rd January 2019* | GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board<br>***To improve health and provide excellent care*** |
|---|---|

| | |
|---|---|
| **Report Title:** | *Update on the approval functions of Approved Clinicians & section 12(2) Doctors in Wales* |
| **Report Author:** | *Heulwen Hughes, All Wales Approvals Manager for Approved Clinicians and section 12(2) Doctors* |
| **Responsible Director:** | *Dr Evan Moore, Executive Medical Director* |
| **Public or In Committee** | *Public* |
| **Purpose of Report:** | To provide an update on the arrangements and service developments for the approval and re-approval of Approved Clinicians and section 12(2) Doctors in Wales.<br><br>Additions and removals to the all Wales registers of Approved Clinicians and section 12(2) Doctors (due to the timing of the Committee meeting, the report will contain information from the previous month). |
| **Approval / Scrutiny Route Prior to Presentation:** | The report has been scrutinised by the Medical Director prior to submitting to the Committee. |
| **Governance issues / risks:** | *Ensuring the All Wales process is being implemented.* |
| **Financial Implications:** | |
| **Recommendation:** | To note the arrangements for approval and re-approval of Approved Clinicians and section 12(2) Doctors in Wales. |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
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| | | | |
|---|---|---|---|
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**Special Measures Improvement Framework Theme/Expectation addressed by this paper**

*http://www.wales.nhs.uk/sitesplus/861/page/81806*

**Equality Impact Assessment**

*(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193 )*

# Update on the Approval Functions of Approved Clinicians and Section 12(2) Doctors in Wales 29th August – 14th November 2018

## Situation

Betsi Cadwaladr University Health Board is responsible for initial approval, re-approval, suspension and termination of Approved Clinicians and section 12(2) Doctors in Wales.

## Background

The change introduced to the Mental Health Act 1983 was the abolishing of Responsible Medical Officers (RMOs) and Community Responsible Medical Officers (CRMOs) and the introduction of Approved/Responsible Clinicians (ACs and RCs) in their place.

The Minister for Health and Social Services agreed that as of the 3rd November 2008 Wrexham Local Health Board (LHB) would act as the Approval Body for Approved Clinicians and section 12(2) Doctors on behalf of the LHBs in Wales. The transfer of function from Wrexham Local Health Board to Betsi Cadwaladr University Health Board took place on the 1st October 2009.

## Service Developments

### New web-based MHA Register for Wales

The feedback at the Department of Health National Reference Group (NRG), in respect of how the database is working in England, was discussed at the last panel meeting. The NRG had reported the use was minimal and was not adding the value they had hoped and were disappointed in the developments received from LAB Lateral. The All Wales Approval Panel were adamant that local records were completely up to date, and supported the local service provision.

In terms of assuring complete accuracy of information, a review of the absolute value of progressing a National Database in Wales is being undertaken

Once the Approval Team receive feedback, we will provide a report, which will inform how we progress in the future.

### Review of Arrangements for Approval and Re-approval of Approved Clinicians with Welsh Government

The new AC Approval Process came into place on 20th July 2018. The process appears to be working well with no major problems.

The Panel have yet to receive a portfolio application but the Approvals Team are aware of three professionals who are preparing to submit portfolios.

The new process had highlighted an issue with locums who are being taken on without AC approval in England and who are not on the GMC Specialist Register.

The doctor would, therefore, be required to attend induction training and submit a portfolio of evidence which could take some months. This means that the doctor is unable to carry out the functions of an AC which they have been employed to do. To date, there have only been two doctors across Wales who this has affected since the inception of the new approval process.

Heulwen has met with BCUHB Medical Staffing to discuss the problem. The new process has been clarified and the department are now aware of the necessity to hire locum psychiatrists who are either AC approved in England or who are on the GMC Specialist Register. Heulwen will also raise at the All Wales Mental Health Act Administrators Forum when they meet during the Spring of 2019.

**Approved Clinician/section 12(2) Induction and Refresher Training**

The next induction/refresher training will took place from 20th – 22nd November in Newport, South Wales. Training dates for 2019 have been secured and venues booked.

## Additions and Removals to the all Wales registers of Approved Clinicians and section 12(2) Doctors 29th August – 14th November 2018

### Approved Clinicians (ACs)

| | |
|---|---|
| **New Applications Received** | **7** |
| Number of applications from professions other than Psychiatrists | |
| Mental Health/Learning Disability Nurse | 0 |
| Social Worker | 0 |
| Occupational Therapist | 0 |
| Psychologist | 0 |
| Number of applications approved | 7 |
| Number of ACs already approved in England | 5 |
| Number of applications with panel | 0 |
| Number of applications not approved | 0 |
| **Re-approval Applications Received (5 Yearly)** | **6** |
| Number of applications re-approved | 4 |
| Number of applications with panel | 2 |
| Number of applications pending awaiting further evidence | 0 |
| Number of applications not approved | 0 |
| **Number of ACs reinstated following suspension** | **1** |
| **Number of re-approvals which have come to an end** | **4** |
| Expired | 0 |
| Retirement | 1 |
| No longer working in Wales | 2 |
| No longer registered with professional body | 0 |
| AC requested | 0 |
| Registered without a licence to practise | 1 |
| **Total Number of Approved Clinicians on Register** (Includes re-approvals) | **400** |

## Section 12(2) Doctors

| | |
|---|---|
| **Number of Applications Received:** | **11** |
| **New Applications Received** | **4** |
| Applications from GPs | 0 |
| Applications from Psychiatrists | 4 |
| Application from Forensic Medical Examiner | 0 |
| **Re-approval Applications (5 years)** | **7** |
| Applications from GPs | 2 |
| Applications from Psychiatrists | 5 |
| Applications from Forensic Medical Examiners | 0 |
| **Number of Applications with Panel** | **3** |
| **Transferred from AC register** | **0** |
| **Number of Approvals which have come to an end:** | **12** |
| Expired | 3 |
| Become an Approved Clinician | 3 |
| No longer working in Wales | 3 |
| No longer registered | 2 |
| Registered without a licence to practice | 1 |
| Retired | 0 |
| Under Police Investigation | 0 |
| RIP | 0 |
| Suspended from Medical Practitioners List | 0 |
| **Total Number of S12(2) Doctors currently approved** (Includes re-approvals) | **143** |

| **Mental Health Act Committee**<br><br>*3rd January 2019* | GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board<br>***To improve health and provide excellent care*** |
|---|---|

| | |
|---|---|
| **Report Title:** | ***Deprivation of Liberty Safeguards (DoLS) Update Report*** |
| **Report Author:** | Chris Pearson, Safeguarding Specialist Practitioner /DoLS Manager |
| **Responsible Director:** | Gill Harris, Executive Director of Nursing and Midwifery |
| **Public or In Committee** | *Public√: Any case scenarios are confidential and though anonymised are based on actual cases* |
| **Purpose of Report:** | The DoLS Supervisory Body are accountable to report all data relating to deprivation because patients are detained in hospital under statutory legislation. The report also provides a wider perspective on the recruitment and training of Best Interest Assessors (BIA); Supervisory Body functions and responsibilities; the provision of training, advice and support delivered to BCUHB staff. |
| **Approval / Scrutiny Route Prior to Presentation:** | This is a standing item for the MHA Committee that requires an oversight of DoLS and its activity and relationship to the use of the Mental Health Act 1983 (as amended 2007) and training and development for staff in mental health settings. |
| **Governance issues / risks:** | DoLS activity and issue of risks and mitigating factors are addressed within the governance framework of Quality and Safety Group and are shared through this report to the Mental Health Act Committee given there is an interrelationship and interface with DoLS and the Mental Health Act 1983. |
| **Financial Implications:** | Not applicable |
| **Recommendation:** | The Committee is asked to note the content of the report |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
|---|---|---|---|
| 1.To improve physical, emotional and mental health and well-being for all | √ | 1.Balancing short term need with long term planning for the future | √ |
| 2.To target our resources to those with the greatest needs and reduce inequalities | √ | 2.Working together with other partners to deliver objectives | √ |

| | | | |
|---|---|---|---|
| 3.To support children to have the best start in life | | 3. Involving those with an interest and seeking their views | |
| 4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being | √ | 4.Putting resources into preventing problems occurring or getting worse | √ |
| 5.To improve the safety and quality of all services | √ | 5.Considering impact on all well-being goals together and on other bodies | √ |
| 6.To respect people and their dignity | √ | | |
| 7.To listen to people and learn from their experiences | √ | | |

**Special Measures Improvement Framework Theme/Expectation addressed by this paper**

*http://www.wales.nhs.uk/sitesplus/861/page/81806*

**Equality Impact Assessment**

*(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193 )*

**Deprivation of Liberty Safeguards (DoLS) Update Report**

## 1. Purpose of Report

1.1 The report provides Quarter 2 update on the DoLS data. The report also identifies current challenges of capacity and demand of DoLS applications and any mitigating actions; the recruitment and training of Best Interest Assessors (BIA); and challenges to the role and functions of the Supervisory Body. It highlights the provision of training to health board staff and the interface between mental capacity, DoLS and the Mental Health Act 1983.

## 2. Introduction/Context

2.1 The Deprivation of Liberty Safeguards was introduced in April 2009. The safeguards as set out in Schedule A1 are an amendment to the Mental Capacity Act 2005 introduced by the Mental Health Act 2007. DoLS is supported by a supplement to the Mental Capacity Act Code of Practice. The safeguards were introduced to ensure that any deprivation of liberty of a person who may lack capacity complies with the Convention on Human Rights (ECHR). A DoLS authorisation provides a legal framework and protection when a deprivation of liberty is considered unavoidable and in the person's best interests when in a hospital setting.

**2.2** Following the Supreme Court judgment (Cheshire West) in March 2014, the total number of DoLS applications within BCUHB has significantly increased creating pressure within the Supervisory Body to manage capacity and demand.

**Figure 1**

| **Total Numbers of BCUHB DoLS Applications** | |
|---|---|
| Year | Total Number |
| 2013/14 | 27 |
| 2014/15 | 414 |
| 2015/16 | 787 |
| 2016/17 | 964 |
| 2017/18 | 854 |
| **2018 (Q1 -Q2)** | **355** |

## 3. Deprivation of Liberty Safeguards

3.1 Within BCUHB, the DoLS activity is reported annually to Healthcare Inspectorate Wales (HIW) by the DoLS team. HIW produce a retrospective All Wales Monitoring report on DoLS activity within Health Boards and Local Authorities. It is evident that all those Supervisory Bodies responsible for DoLS in Wales are struggling to meet demand. The same picture is also evident in England. So the issue of capacity and demand is not an anomaly within BCUHB, it is recognised as a concern nationally.

3.2 In May 2018, the end of year report on DoLS identified that actions are in place to mitigate the risks of capacity and demand by arranging recruitment to four (4) additional Best Interest Assessor (BIA) Posts. Safe recruitment has taken place and 3 by November 2018 and recruitment for the vacant BIA post will commence in January 2019. Each BIA is appointed to a safeguarding area team and the current complement of BIAs are located as follows:

West – 1 BIA in post (1 Vacancy)
Central – 2 BIAs in post
East - 2 BIAs in post

3.3. The three newly appointed BIAs have undertaken their training for the Best Interest Assessor award at Manchester University and are due to submit their assignments in January 2019 and should be qualified to practice in England and Wales by March 2019.

3.4 In order to continue to meet capacity demands the DoLS team will retain the services of a Sessional BIA to undertake assessments until the full integration of qualified BIA staff is complete.

## 4. Supervisory Body:

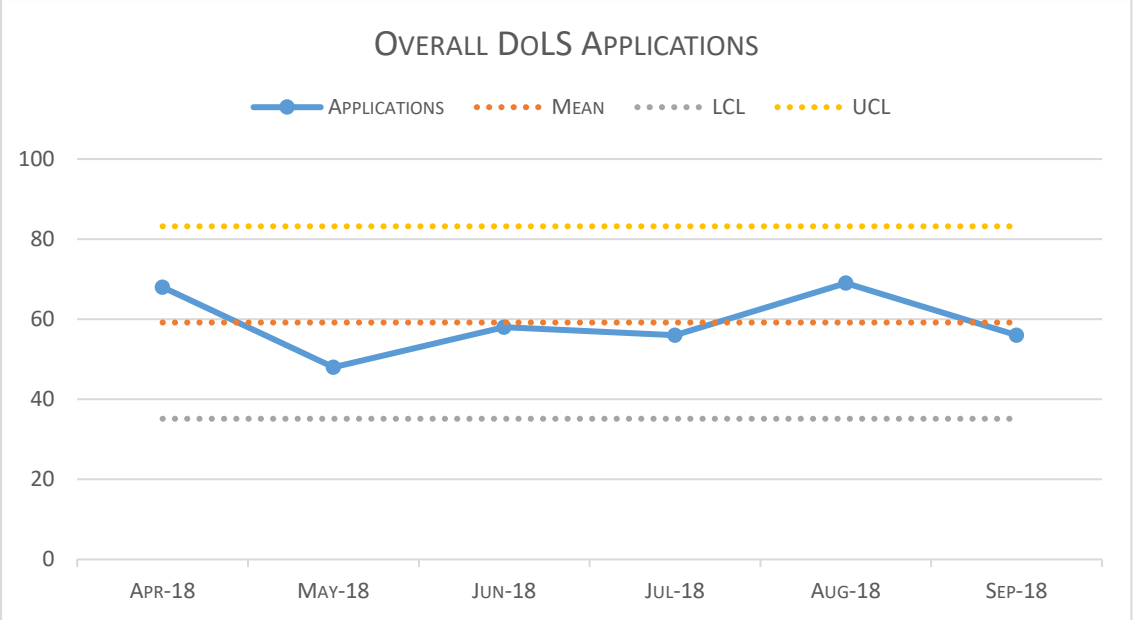
4.1 There is a challenge that additional appointments of BIAs will inevitably increase the number of completed DoLS authorisations required to be signed off by those with responsibility within the Office of the Medical Directorate. The DoLS Team Manager has anticipated this challenge and undertook a review in May 2018 of the existing arrangements approved by Betsi Cadwaladr University Health Board's Executive Board in 2015. A report has been presented to the Quality and Safety Group (QSG) on 12 September 2018 on the significant and critical challenges in gaining signatories for applications and an options appraisal put forward to address the risks. QSG approved Option 2 (see report, Appendix 1).

4.2 The DoLS Manager has put together a governance framework to support signatories which will include the provision of bespoke training in undertaking the role, functions and responsibilities of a Signatory; access to information around current guidance and relevant case law; peer support and reflective practice; an external annual training event for all signatories which will include current case law and guidance of the role of the Supervisory Body (See Appendix 2). Further on-going discussions are taking place to decide whom may be included as named signatories but it will be Band 8C and above. Once the DoLS Manager has named signatories, he will arrange to meet individually with each person to go through the DoLS process.

## 5. DoLS Activity

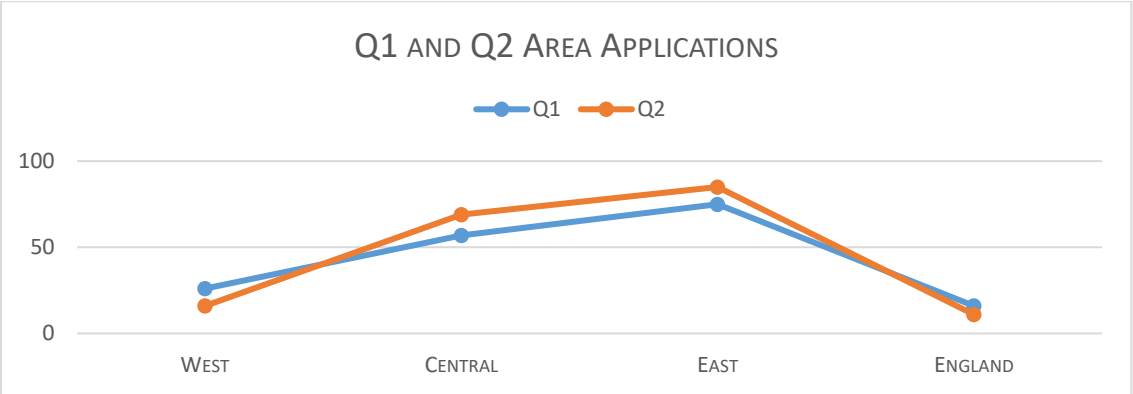
5.1 The range of applications for a request for a DoLS are outlined in Figure 2 below.

**Figure 2: Overall Applications:**




| | |
|---|---|
| **Apr-18** | 68 |
| **May-18** | 48 |
| **Jun-18** | 58 |
| **Jul-18** | 56 |
| **Aug-18** | 69 |
| **Sep-18** | 56 |

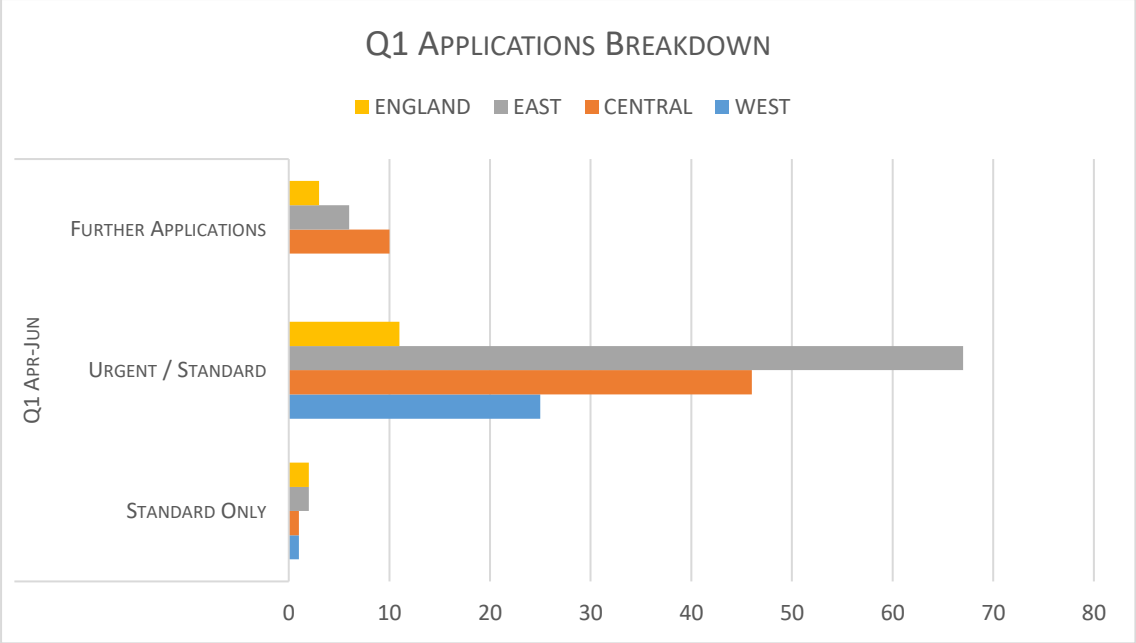
**Figure 3: Applications by Divisional Area:**

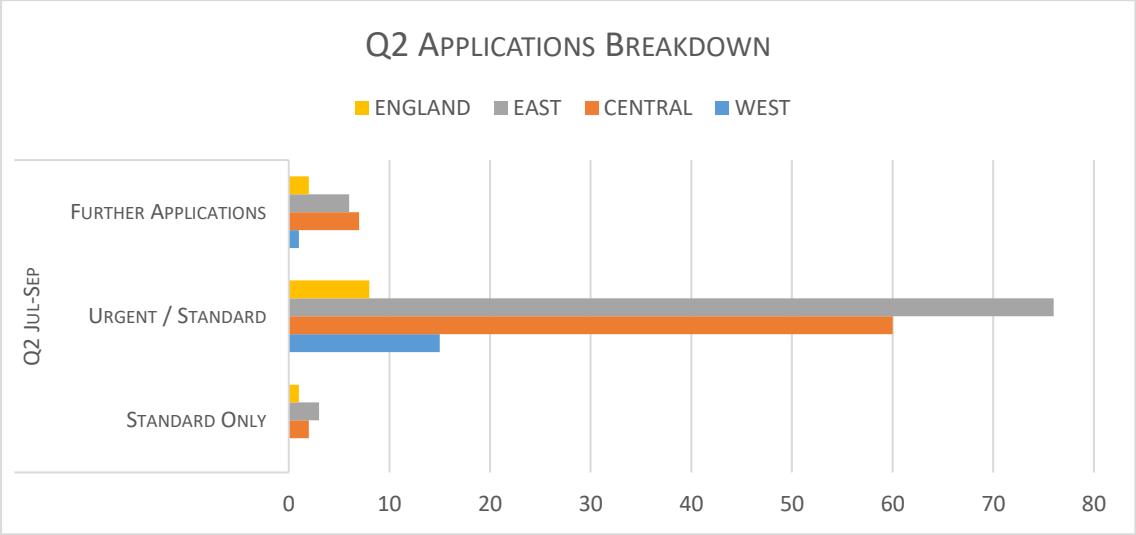



| | Q1 | Q2 |
|---|---|---|
| **West** | 26 | 16 |
| **Central** | 57 | 69 |
| **East** | 75 | 85 |
| **England**** | 16 | 11 |

** includes out of area placements in hospital

**Figure 4: Applications by Type:**



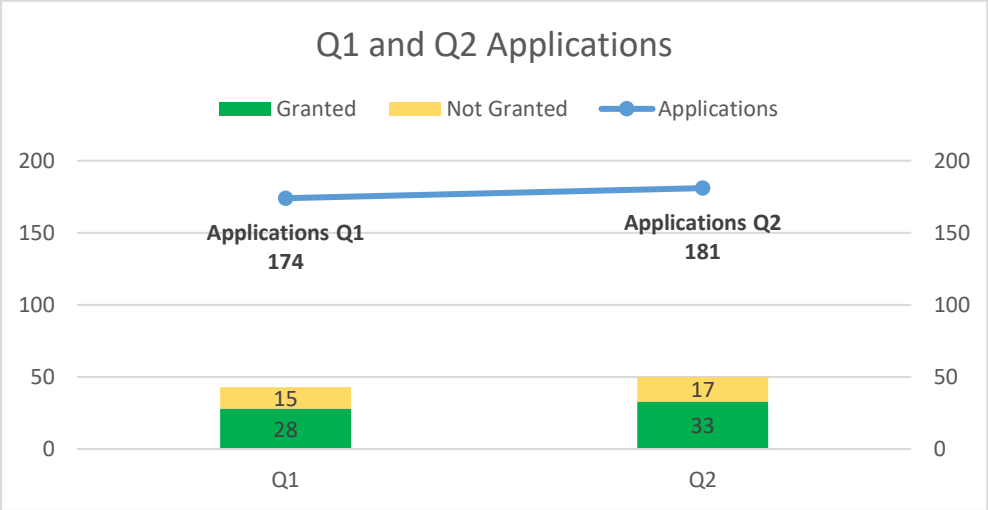

| | Q1 Apr-Jun | | | Q2 Jul-Sep | | |
|---|---|---|---|---|---|---|
| | Standard Only | Urgent / Standard | Further Applications | Standard Only | Urgent / Standard | Further Applications |
| **WEST** | 1 | 25 | 0 | 0 | 15 | 1 |
| **CENTRAL** | 1 | 46 | 10 | 2 | 60 | 7 |
| **EAST** | 2 | 67 | 6 | 3 | 76 | 6 |
| **ENGLAND**** | 2 | 11 | 3 | 1 | 8 | 2 |

** includes out of area placements in hospital

5.2. There are a range of issues identified within the applications at the point of receipt by the DoLS Team. These includes not identifying individuals lack capacity to be accommodated in hospital; not specifying what levels of care and treatment individuals receive; whether individuals are objecting to being in hospital; not

putting on the form relevant signatures, times or dates that correspond to legal requirements. There are also emerging issues relating to the use of DoLS within Mental Health Units when it is evident that the Mental Health Act should be considered as set out in the Mental Health Act Code of Practice (revised 2016). This will be reported with evidence in the Q3 report in March 2019.

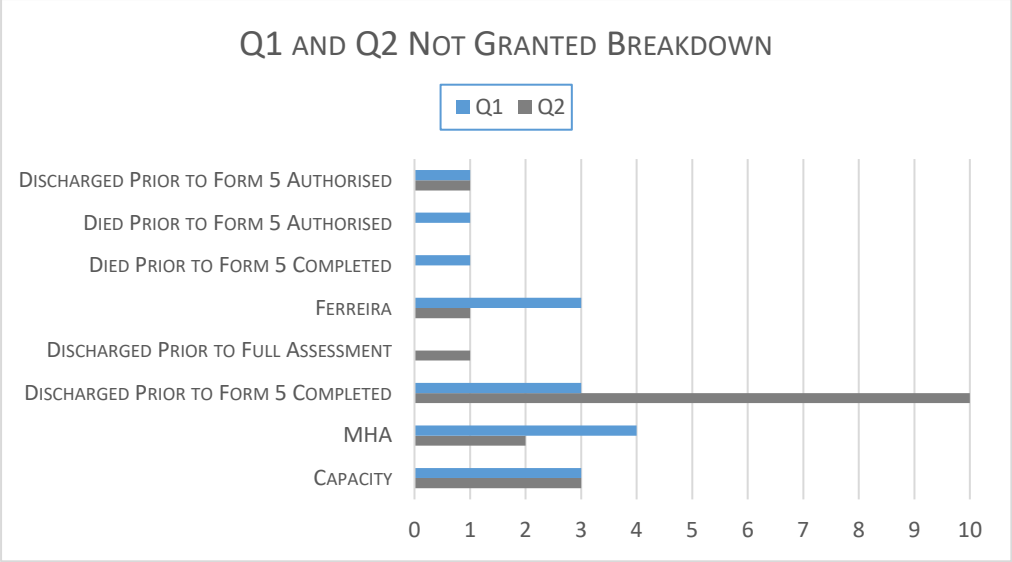
**Figure 5: Application Outcomes from the Supervised Body:**




| | Q1 | Q2 |
|---|---|---|
| Applications | 174 | 181 |
| Applications Allocated to BIA | 46 | 55 |
| Assessed by BIA | 43 | 54 |
| Granted | 28 | 33 |
| Not Granted | 15 | 17 |

**Figure6: Outcomes of Not Granted Applications:**

**5.3** This graph shows that the range of application not granted is because the BIA has identified that the individual has capacity. Whilst these numbers are comparatively small (18%) are deemed to have been assessed to have capacity. This aspect is supported by research evidence from a national survey in 2016 by Edge Training which brought to the fore that BIAs make a difference by challenging that individuals have capacity to make a decision to be accommodated for their care and treatment. The use of the Ferreira case law and challenge about the more appropriate use of the Mental Health Act is also significant (18%).




| NOT GRANTED | Q1 | Q2 |
|---|---|---|
| Not Granted | 15 | 17 |
| Capacity | 3 | 3 |
| MHA | 4 | 2 |
| Discharged Prior to Form 5 Completed | 3 | 10 |
| Discharged Prior to Full Assessment | 0 | 1 |
| Ferreira | 3 | 1 |
| Died Prior to Form 5 Completed | 1 | 0 |
| Died Prior to Form 5 Authorised | 1 | 0 |
| Discharged Prior to Form 5 Authorised | 1 | 1 |

## 6. Training

6.1 Currently the DoLS Team (DoLS Manager and a BIA) provide training across BCUHB at Level 2 and Level 3. This training is mandatory for mental health and learning disability division. There is an emerging picture of non-attendance at this 3 hr training course which is provided across the 3 Divisions. The vast majority of staff attend this training within their divisional area which is offered on a three monthly cycle rotation at locations in East, West and Central. It is possible that staff can attend any of the sessions in any area but that will be a decision taken by the manager of any attendee.

6.2 Since September 2018 there has been a marked drop in attendance when previously, attendance at sessions have been full and have waiting lists. The range of attendance and no-attendance is identified below.

| Date/Month | Available Places & Venue | Total Places Available | No Booked to Attend compared to & of total | Actual Attendees | % of Attendees | % Non-Attendees |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | places available | | | |
| 4 Sept 18 | Y. Gwyned d – 40 | 40 | 12 (30%) | 6 | 50% | 50% |
| 17 Sept 18 | Glan Clwyd – 31 | 31 | 15 (48%) | 10 | 66.7% | 33.3% |

6.3 The DoLS Manager has taken action to get improvement in attendance. Prior to September 2018, sessions previously have been quite full. The first point to state about bookings and take up of places is that I have agreed with Training and Development co-ordinator that we oversubscribe booking by 20%. Secondly, managers need to remind staff that if they are booked on the course they need to give reasons for their non-attendance and also inform training and development who co-ordinate attendance on this mandatory course. There are currently two experienced BIA doing this training that put a significant amount of commitment to preparation, travel and delivery and they want to use their time productively. This training is mandatory for staff at Band 5 and above within Mental Health and learning Disability so attendance should be much better than indicated above.

6.4 An important recommendation from the HASCAS and Ockenden reports require staff to take account of the legislative framework that should be used for individuals who lack capacity to agree to be accommodated in hospital for their care and treatment, all the more reason therefore that staff demonstrate they have attended training which raises their understanding of the interface between the MCA 2005 and the option of either a DoLS or MHAct being used as appropriate. The DoLS Manager has reviewed the current training content for the MCA and DoLS and outcomes are more focussed upon case studies/scenarios and reduced the course time from 3 hours to 2 ½ hours.

6.5 The DoLS team are committed to deliver training but need that same commitment for those who book attendance. For instance, two1 hr sessions were set aside to deliver training to Medical Consultants and F2 Doctors in the East Division. 25 attendees signed up to attend the first session in April 2018, 11 attended. The next same training event was cancelled with 5 days notice because of poor expected attendance.

6.6. The DoLS Manager has been discussing an option of producing a handbook booklet for those unable to access on-line level 1 or level 2 training, which will include estates, porters, domestic staff and community staff without access to a computer. The DoLS Team are exploring the commissioning of a handbook for such staff to meet required competency training on mental capacity. This training handbook will be signed off by the relevant staff manager. This will not be at additional cost to BCUHB but will be supported through the mental capacity grant to the DoLS team provided by Welsh Government. This will allow people access to the same mental capacity modules on line and needs to be processed through ESR by their managers. This will significantly improve the delivery and compliance of mandatory training.

6.5 Despite the pressures in the Team in managing DoLS applications and the issues that arise from them, the Team have managed to deliver training during Q1 and Q2 as follows.

**Figure 6: Mandatory and Bespoke Training**

| Training | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Mandatory | 109 | 37 | | |
| Bespoke | 30 | 23 | | |
| Total overall | 139 | 60* | | |

*** No training provided in Aug 2018**

## 7. Advice and Support

7.1 The DoLS Team continuously provide day to day support and advice to staff about mental capacity issues and its application, as well as advice on completing applications under DoLS. The DoLS Team have in place a governance scrutiny around receiving applications from hospitals and, if necessary, will elicit further information that is required as part of the DoLS process. Ward Managers can inform the DoLS team if they are aware of any their ward staff who wish us to deliver training on the application of MCA 2005 or DoLS. Contact in the first instance is through BCU.admin@dols.nhs.uk

## Recommendation

8.1 That Committee note the content of the report.

# APPENDICES

## APPENDIX 1:

| **Quality and Safety Group: 12.09.18** | GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board |
|---|---|

| **Subject:** | **Deprivation of Liberty Safeguards Signatories** |
|---|---|

| **Summary** or **Issues of Significance** | **Situation**<br><br>The Supervisory Body, Betsi Cadwaladr University Health Board, has responsibility for considering requests for authorisation of Deprivation of Liberty Safeguards (DoLS) having obtained the relevant assessments, which are age, mental capacity, mental health, capacity, best interest and no refusals.<br><br>A panel of authorised signatories, approved by Betsi Cadwaladr University Health Board's Executive Board in 2015, has been established and these responsibilities are undertaken by named officers within the Office of the Medical Directorate to authorise the Deprivation of Liberty.<br><br>Since 2017, the availability of officers approved to act as signatories has diminished from eight to four staff. This became more critical in July 2018 with two of those officers leaving their posts and a further officer due to cease his current signatory function in the near future.<br><br>Failure to put in place sufficient signatory arrangements would leave the Board operating outside the provisions of the Mental Capacity Act 2005 and the Mental Capacity Act 2005, Deprivation of Liberty Safeguards Code of Practice and Mental Capacity Act 2005 Code of Practice.<br><br>**Background**<br><br>The Health Board is responsible for ensuring that systems and processes are in place for the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS) in order to discharge their functions as both the Supervisory Body (SB) and a Managing Authority (MA).<br><br>The Guidance for MA and SB working within the Mental Capacity Act Deprivation of Liberty Safeguards (Welsh Assembly Government February 2009), recommend that there is a clear separation of the different functions within management structures |
|---|---|

| | |
|---|---|
| | where an organisation acts as both a MA and a SB. It is important that staff responsible for carrying out the supervisory function should operate entirely independently of staff responsible for managing the services and they should not be accountable to the same senior manager or operate from the same budget. The Guidance also defines a MA as follows:<br><br>*"In the case of an NHS hospital, the managing authority is the NHS body (e.g. Local Health Board or NHS Trust) responsible for running the hospital in which the relevant person is (or is to be) resident"*.<br><br>Wards and departments within each division in the Health Board are all considered to be a MA in its own right.<br><br>**<u>Assessment</u>** |
| Items for escalation | In a report to the Board on the role and responsibilities of the Supervisory Body (23 October 2014) it stated that "The Medical Director has responsibility for providing support and advice for Clinical Ethics, Mental Capacity, DoLS and Human Rights, which are corporate functions. A panel of signatories is required to authorise any deprivations of liberty granted. This currently consists of the Medical Director, Assistant and Associate Medical Directors. These arrangements allow for a clear separation between the supervisory functions and the operational delivery of services."<br><br>A review of the Supervisory Body panel of authorised signatures for the Deprivation of Liberty Safeguards has been undertaken. There are now significant and critical challenges in gaining signatories for applications which are: |
| Key risks for escalation and local mitigation in place | • The DoLS Team is due to increase its BIA provision from 2 to six staff. This will increase the number of completed assessments which will require them to be signed off within a legal timeframe;<br>• The existing level of availability of signatories is not on a daily basis but anecdotally it takes sometimes 5 days to arrange for a DoLS application to be signed off which adds to the period of time that a patient is unlawfully deprived of their liberty;<br>• The potential reduction in signatories will mean an even greater threat to breaching the legal framework for Deprivation of Liberty Safeguards;<br>• Since the restructure of the DoLS Team moving from the Office of the Medical Director to become realigned within Corporate Safeguarding, there needs to be a decision as to who should be approved as signatories for the DoLS Team. This will have implications upon resources; |

| | |
|---|---|
| | • There is a lack of a governance framework for Supervisory Body signatories which includes the need for training and awareness to implement best practice, access to relevant guidance and case law in order to ensure and promote the rights of patients under article 5 and 8 and avoiding the risk of legal challenge as far as possible.<br><br>**<u>Option Appraisal:</u>**<br><br>**<u>With consideration given to;</u>**<br><br>1) What is not in doubt is the responsibility to have a clear separation of the different functions of a Managing Authority (i.e. *the managing authority is the NHS body (e.g. Local Health Board or NHS Trust) responsible for running the hospital in which the relevant person is (or is to be) resident.* (MCA Deprivation of Liberty Safeguards (Welsh Assembly Government Guidance 2009);<br><br>2) The Supervisory Body has to be independent of those staff responsible for managing services;<br><br>3) Wards and departments within each division in the Health Board are all considered to be a MA in its own right;<br><br>4) It is clear that the current situation of sufficient signatories is critical therefore maintaining the current arrangement of even less signatories is not a viable option. An increase in the number of signatories, no less than at Band 8 and above is a 'must do' option;<br><br>5) Comparison shows that four Health Boards in Wales give the responsibility for signatories at a Band 8 level;<br><br>6) A rota of availability needs to be agreed and in place to enable a standard authorisation application to be granted within a timely and co-ordinated way;<br><br>7) For assurance; in addition to the six assessments, there are governance arrangements in place through the DoLS Co-ordinator or Team Manager. This involves scrutinising all the assessments for each application to ensure compliance and completes a summary form of the case issues and recommendations regarding an IMCA and Conditions.<br><br>The options put forward for consideration are: |

| | |
|---|---|
| | **Option 1:**<br><br>The Office of the Medical Directorate increases the number of signatories to a level which demonstrates availability and sufficient resource management to ensure the legal framework for DoLS is compliant with demand.<br><br>To support signatories, the DoLS Team Manager and DoLS Co-Ordinator will provide bespoke training in undertaking the role, functions and responsibilities. The DoLS Team will provide access to information around current guidance and relevant case law, peer support and reflective practice. The DoLS Team will arrange external annual training for all signatories which will include current case law and guidance of the role of the Supervisory Body.<br><br>**Option 2:**<br><br>Area/Secondary Care Nursing Directors and other staff (minimum at Band 8) would be eligible to become signatories as long as they do not approve a standard authorisation in their own area of responsibility. So for example, it would be possible for an Area Director in the East to sign off any application in Central, West, or out of area. The same provision around support and training identified in Option 1 will apply.<br><br>**Option 3:**<br><br>Signatories include both Option 1 and Option 2<br><br>**Option 4:**<br><br>Less favourable but considered.<br><br>Corporate Safeguarding, which will involve the DoLS Manager together with other area safeguarding team managers become signatories. The caveat to this arrangement is that no manager in safeguarding would authorise any Standard Authorisation if there is any active involvement with a case as this could result in a conflict of interest. In addition, it is envisaged Safeguarding Clinical Specialists will become BIA trained and actively engage in BIA assessments, which will further increase the possibility of conflict. The arrangements for the provision of training and support to safeguarding managers will be the same as recommended in the above. |

| | |
|---|---|
| **Recommendations:** | The proposed option is Option 2 |

| | |
|---|---|
| **Author(s)** | Chris Pearson, Specialist Practitioner/DoLS & MCA |

| | |
|---|---|
| **Presented by** | Chris Pearson |

| | |
|---|---|
| **Date of report** | 15.08.18 |

| | |
|---|---|
| **Date of meeting** | 12.09.18 |

**APPENDIX 2:**

## TRAINING FOR SUPERVISORY BODY SIGNATORIES:

### Introduction & Background:

The core duties and responsibilities in the role and functions of the Supervisory Body comprise two key aspects:

- **The DoLS Team** whose responsibilities include receiving and responding to requests for urgent and standard authorisations and the extension of an urgent authorisation; commissioning the relevant IMCA service; commissioning the six DoLS assessments from a Best Interest Assessor (BIA) and s12(2) approved Doctor; scrutinising applications and applying conditions to any application to be granted, the appointment of a relevant person's representative (RPR). Respond to requests to any legal challenge within the Court of Protection where a standard authorisation has been granted by the Health Board.
- **The Designated Signatories of the Supervisory Body** holds corporate responsibility to act on behalf of the health board to grant a standard authorisation of deprivation of liberty to a person in a hospital (includes NHS, independent hospitals and Hospices in Wales or commissioned in England) if all the assessments are positive, or not grant if one or more assessment is not met. Respond to a standard authorisation granted by the Health Board if challenged in the Court of Protection.

The supervisory functions require that those holding responsibility at an operational level (DoLS Manager, DoLS Co-ordinator, Best Interest Assessors) or corporate level (Designated Signatories) are supported and cognisant of the Safeguards, including relevant case law, compliance of regulations and that assessors are trained and supervised and commissioned according to requirements. Those undertaking assessments (BIAs' and Mental Health Assessors) already have access to updated case law, training and supervision to support them in their role. What has not been put in place to a governance standard are the levels of support necessary to those appointed designated signatories for the Supervisory Body. This paper sets out how that will be put in place.

### Designated Signatories:

There is a positive obligation put on the Supervisory Body to ensure that there is an active promotion of the human rights of citizens. DoLS is about ensuring human right compliance that a person cannot be deprived without the authority to do so. The role of Signatories is to ensure that the process in each case is compliant with the DoLS process, the Code of Practice and that where case law does apply it is incorporated into assessments where relevant.

In order to support designated signatories, the DoLS Team Manager and DoLS Co-Ordinator will provide bespoke training in undertaking the role, functions and responsibilities of the Supervisory Body. 'Training' in this context is not a one off event

but a package of information that help support and update the individual in their role as signatories.
This package will include:

**Introduction as a S.B Signatory:**

Upon appointment of the signatory, the DoLS Manager and DoLS Co-ordinator will set up a meeting to go through a pack of information relevant to their role. This can be set up for a group of signatories or for an individual person. This pack of information will include;

- The role of the Supervisory Body (SCIE guidance)
- The role of the Managing Authority
- The DoLS Forms completed by the Managing Authority (Hospital) requesting an authorisation and the role of the DoLS team in scrutinising documents
- Defining a Deprivation of Liberty including a flow chart determining "when is a patient deprived. The DoLS process for assessment and scrutiny.
- Setting out in written form current key case law information that is relevant and pertinent to current DoLS.
- The DoLS Forms that are used in the 6 assessments, their rational and the Form 5 used to summarise that the DoLS team has scrutinised the assessments.
- Case law relating to the Supreme Court ruling – Cheshire West
- Links to mental capacity newsletter produced by 39 Essex Street which explores current case law, updates and reflection on recent Court of Protection cases. The link will allow an email to be received monthly to download the newsletter.

**Commitments**: The DoLS Team will devise a rota so that availability and commitments are known in advance and this will be managed at source by the DoLS team.

**Governance Feedback and Learning from Supervisory Body:** The DoLS Team will always respond to concerns raised about any aspects to do with the DoLS process or queries on assessments. In addition the DoLS Team will devise a quarterly questionnaire aimed to get feedback on the process involved in the functions of the designated signatory. Any key issues will be raised and share any actions to improve the process of scrutiny.

**Feedback and Learning for Managing Authorities:** Learning should be fed back to the relevant wards in hospitals in order to improve the care provided when a deprivation is in place or there are less restrictive alternatives that could and should be considered. This will include comments from supervisory body delegated signatories so that we can demonstrate shared learning and use it within our DoLS and MCA training for staff.

**Annual Events:** The DoLS Supervisory Body within BCUHB currently lead on supporting a regional network for BIAs across the 6 Local Authorities and also includes IMCA. The objectives are to share and discuss good practice and the impact of

updated case law. One meeting quarterly is set aside as an annual event for all BIAs, IMCAs and S12(2) Doctors. This event is already open to Local Authority Supervisory Body staff. This can now be opened to designated supervisory body signatories within the health board in North Wales.

It is recognised that the designated signatories may specifically want to consider updated case law relating to their specific role and functions. The DoLS Manager will explore engaging with a legal expert trainer who can provide training specific to the Supervisory Body and current case law. This will be an annual event.

Chris Pearson
DoLS Manager

**Mental Health Act Committee**

**3rd January 2019**

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

***To improve health and provide excellent care***

| | |
|---|---|
| **Report Title:** | *Healthcare Inspectorate Wales (HIW) Monitoring Report* |
| **Report Author:** | *Wendy Lappin, Mental Health Act Manager* |
| **Responsible Director:** | *Andy Roach, Director of Mental Health and Learning Disabilities* |
| **Public or In Committee** | *Public* |
| **Purpose of Report:** | *To provide an updated in relation to the inspections conducted by Healthcare Inspectorate Wales, to highlight findings in relation to the Mental Health Act and the Mental Health Wales Measure.* |
| **Approval / Scrutiny Route Prior to Presentation:** | *This paper prior to presentation at the Power of Discharge Committee Meeting will be presented to the MH&LD Q-SEEL meeting for the Senior Management Team and then to the Divisional Directors Meeting and Andy Roach.* |
| **Governance issues / risks:** | *None* |
| **Financial Implications:** | *None* |
| **Recommendation:** | *The committee is asked to note the report* |

| **Health Board's Well-being Objectives** *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)* | √ | **WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)* | √ |
|---|---|---|---|
| 1.To improve physical, emotional and mental health and well-being for all | √ | 1.Balancing short term need with long term planning for the future | √ |
| 2.To target our resources to those with the greatest needs and reduce inequalities | √ | 2.Working together with other partners to deliver objectives | √ |
| 3.To support children to have the best start in life | | 3. Involving those with an interest and seeking their views | √ |
| 4.To work in partnership to support people – individuals, families, carers, communities - | √ | 4.Putting resources into preventing problems occurring or getting worse | √ |

| | | | |
|---|---|---|---|
| to achieve their own well-being | | | |
| 5.To improve the safety and quality of all services | √ | 5.Considering impact on all well-being goals together and on other bodies | √ |
| 6.To respect people and their dignity | √ | | |
| 7.To listen to people and learn from their experiences | √ | | |

**Special Measures Improvement Framework Theme/Expectation addressed by this paper**

**Governance and Leadership – to ensure compliance with the Mental Health Act and Mental Health (Wales) Measure.**

*http://www.wales.nhs.uk/sitesplus/861/page/81806*

**Equality Impact Assessment**

**Retrospective looking report therefore no EqIA required.**

*(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193 )*

# Healthcare Inspectorate Wales (HIW) Monitoring Report

## 1. Purpose of report

To provide an update in relation to the Inspections conducted by Healthcare Inspectorate Wales (HIW) within a period of twelve months. To highlight findings in relation to the Mental Health Act and Mental Health Wales Measure.

## 2. Introduction/Context

HIW is the independent inspectorate and regulator of all health care in Wales.

HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board. Their primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizen's experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely. useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all

This report provides assurance that following inspections and recommendations that these actions are followed up.

## 3. Inspections (within the last 12 months)

### 3.1 Nant Y Glyn CMHT NEW

Inspection date: 6 – 7 of November 2018 joint review with CIW
Publication of report due: To be confirmed

Any information contained within the report once published in relation to the Mental Health Act or Mental Health Measure will be cited once the report has been received.

### 3.2 Hergest Unit NEW

Inspection date: 4 - 5 of September 2018
Publication of report due 6 December 2018

Initial verbal feedback received from the inspection was positive.

Any information contained within the report once published in relation to the Mental Health Act or Mental Health Measure will be cited once the report has been received.

### 3.3 Abergele CAMHS UPDATE

Inspection date: 25 – 27 June 2018
Publication of report: 28 September 2018

The visit focused on the Kestrel Ward CAMHS.

The summary of the report found that all employees interacted and engaged with patients respectfully, established evidence of governance for safe and clinically effective care and multi-disciplinary working with coordinated engagement of community and paediatric teams. Improvements were highlighted around the upkeep of outside areas, information displayed and systems for maintaining the safety of patients and staff this was in relation to personal alarms and nurse call buttons within the reach of the bed.

In relation to the Mental Health Act and the Mental Health Wales Measure the improvement plan highlighted the actions below.

| Improvement Needed | Service Action | Timescale |
|---|---|---|
| The Health Board must ensure that the ward displays relevant patient information in a suitable format. | Source and display age appropriate Mental Health Act Information posters. | September 2018 |
| The Health Board should consider including body maps in all patient records | Discuss the pros and cons of using body map recording with adolescents in the next safety sub committee | September 2018 |

### 3.4 Glan Clwyd Hospital Ablett Unit

Inspection date: 20 – 21 November 2017
Publication of report: 22 February 2018

The HIW visit focused on two wards within the Ablett Unit, Cynnydd and Dinas.

The summary of the report was in relation to the building structure of the unit and safe observation of patients. Whilst there was a lack of patient engagement with care and treatment plans there was evidence of new patient care documentation being trialled working well.

The improvement plan did not stipulate improvements to standards in relation to the Mental Health Act and Mental Health Measure and were focused around the standard of record keeping in relation to care and treatment plans.

## 4. Assessment of risk and key impacts

Policies –Policies are an ongoing project that requires updating and change as statute and documents change.

Policies which have been highlighted as urgent and should be progressed asap are:

Bed Escalation Procedure
Staffing Escalation Procedure
Restricted Items Policy

## 5. Equality Impact Assessment

This is a retrospective report therefore no EQIA required.

## 6. Conclusions / Next Steps

**Policies** – On going.

**HIW Inspections** – Inspections will be reported on and information updated on a three monthly basis.

## 7. Recommendations

It is recommended that the Committee notes this report.