Bundle Power of Discharge Sub-Committee 29 March 2019

1 POD19.01 - Apologies for Absence

2 POD19.02 - Declarations of Interest

3 POD19.03 - Minutes of Last Meeting and review of Summary Action Log

1) To confirm as a correct record the Minutes of the last meeting held on 14th December 2018
2) To deal with any matters arising not dealt with elsewhere on the agenda
3) To review the Summary Action Log

Draft Minutes Power of Discharge Sub Committee 14th December 18.docx

POD Summary Action Plan live version.doc

4 POD19.04 - Hospital Managers' Update - Wendy Lappin

POD19.04 - Hospital Managers Update Report.docx

POD19.04.1 - Final Scrutiny Audit Report.doc

5 POD19.05 - Defining a Health Based Place of Safety for Young People Under 18 Years - MHA Section 136 - Wendy Lapping

POD19.05 - Under 18 years – MHA Section 136 Data Report.doc

6 POD19.06 - Independent Review of Mental Health Act - Steve Forsyth

POD19.06 - Independent Review of the Mental Health Act.doc

POD19.06.1 - MHA Review FINAL.pdf

7 POD19.07 - Consideration of Changes to future POD & MHAC meetings

POD19.07 - Report on consideration for future of MHAC and POD.docx

8 POD19.08 - Issues of Significance to inform the Chair's Report to the Mental Health Act Committee

9 POD19.09 - Date of next meeting

Friday 28th June 2019

Power of Discharge Sub Committee

Draft Minutes of the Power of Discharge Sub Committee held on Friday 14th December 2018
Seminar Room, Llandudno Hospital

Present:

Marian Wyn Jones [Chair]	Vice Chair, BCUHB
Frank Brown	Associate Hospital Manager
Jackie Parry	Associate Hospital Manager
Satya Schofield	Associate Hospital Manager
Shirley Cox	Associate Hospital Manager
Shirley Davies	Associate Hospital Manager

In Attendance

Jill Timmins	Director of Operations & Service Delivery
Sandra Ingham	Business Support Manager [BCUHB]
Steve Forsyth	Director of Nursing
Wendy Lappin	MH Act Manager [BCUHB]

Agenda Item	Action
POD18.25 – Apologies POD 18.25.1 Apologies were received from Gill Harris, Andy Roach, John Williams, Diane Arbabi, Christine Robinson, Jacky Parry, Lyn Meadows, Cheryl Carlisle	
POD18.26 – Declarations of Interest POD 18. There were no declarations of interest made at the meeting.	
POD18.27– Membership POD18.27.1 It was noted that the membership for the Sub Committee is now at full capacity **Resolved:** That the update to membership be noted	
POD18.28 – Minutes of last meeting and summary action log POD 18.28.1 - The minutes of the meeting held on 21st September 2018 were agreed as an accurate record.	

POD18.28.2 – **Matters Arising** POD18.28.2.1 – WL provided clarification on the completion of forms and held responsibility for ensuring they were completed accurately and contained all the relevant information. It was important that staff were clear on the difference between "next of kin" and "nearest relative" **Action:** HIW report for Hergest to be distributed before the next meeting. POD18.28.2.2 - Mixture of ages highlighted in report, 4 key areas, MH Act administration side was seen a huge positive, dormitory style of the ward is very dated, leadership and management very positive, improvements since last visit were noted in the report. The Chair advised that there had been huge improvements in Hergest and clarification was provided on the patient pathway currently in Hergest. The Action log was updated therein.	SI
POD18.29 – Hospital Managers Update POD18.29.1 - Concern was expressed at the number of patients being discharged by a responsible clinician. It was felt this is a process clinicians go through when they are made aware a request for an appeal had been and the decision is often made prior to the hearing when it will be accepted. The role of the Hospital Manager needs to be reinforced, the hearing is an important part of a patient's discharge. SF explained that often when a section 2 is applied, the patient may not be known to the consultant. There would be cause for concern if this happened on a regular basis with patients who are known to the service and are regularly detained. POD18.29.2 - WL explained that paperwork for hearings was produced and distributed at least 2 months prior to the hearing, it is at this time the administrative team will arrange and confirm a date for the hearing. It is the ongoing responsibility of the clinician to have regular updates with patients and if, during one of these sessions, the patient is deemed fit to be discharged, the hearing will inevitably be cancelled. It may be that the administrative process needs to be changed. **Action:** WL to discuss what process is used within other Health Boards across Wales POD18.29.3 - The concerns around the hearings stemmed from the number of locum consultants who were not always aware of the patient's background and there being no continuity for patients. POD18.29.4 - Discussions were held around a recent scrutiny session when during one particular session there was also an unannounced visit from HIW which put staff under considerable pressure. WL	WL

advised that the dates were set well in advance, it was agreed if the AHMs arrived at a unit in these circumstances they should use their judgement as to whether the session should be cancelled. POD18.29.5 - Discussions were held around the recent training for Associate Manager in Cardiff, SS felt it was good and there were a lot of ideas that could be rolled out in BCUHB. **Action**: WL to distribute information from the training POD18.29.6 - WL advised that a feedback session with Associate Hospital Managers had been arranged for 8th February 2019 where the training was to be discussed as part of the agenda. POD18.29.7 - The Chair advised that Senior Managers should be told when important information was not available at hearings. WL explained that a leaflet had been produced which was distributed to the relevant staff members when reports were being requested which is often 2 weeks prior to the hearing, there are occasions when staff have been unable to produce the report due to excessive workload. In such cases discussions are held with their line manager. A request was made for risk assessments to be provided separately from the case file for hearings as this was often missing from the file. There were discussions around reports not being provided for hearings, WL **Action:** WL to ask the Mental Health Act staff to include risk assessments when requesting reports. **Action:** SF to discuss missing information with Heads of Nursing **Action:** JT and SF to discuss the problems around reports with Divisional Directors. POD18.29.8 - The Chair asked for clarification on the Audits and what the objectives were. Assurance required that the recommendations have been taken forward. **Resolved:** That the report be noted and the actions outlined be progressed	WL WL SF JT/SF
POD18.30 – Combined Mental Health Act / Mental Health Measure Report POD18.30.1 – It was reported that the discussion was under target for part 1a and b, due to sickness and annual level. We have been encouraging teams to reach the targets and there has been areas of improvement over the past 3 years. POD18.30.2 - Some areas have struggled historically in meeting the Mental Health Measure targets. There was a request for a paper to be	

prepared and further investment for additional staff to assist in improving targets, an action plan was requested to address the issues and noted that additional investment was required in additional staff to help meet targets. POD18.30.3 – targets are consistently nearly achieving for Part 2 with a validated position of 87.8% and the latest figures indicating 89%. It is important that the quality of Care and Treatment Plans [CTP] continue. JT advised that an All Wales Review has been produced by the Delivery Unit which also includes an action plan, training is being reviewed and discussions are being held in supervision meetings. POD18.30.4 – It was noted that CAMHS were struggling to reach targets. Welsh Government have confirmed they are looking at where the gaps are and have commissioned a piece of work around capacity analysis which should help in improving services. It was noted that this was not specific to Wales and is a UK wide problem. POD18.30.5 – JT advised there had been an increase in the number of 5[2]s. A review will be carried out to ensure forms are being completed appropriately and to look at training requirements. POD18.30.6 - SF suggested clarification was required when the lapse occurred, if it was towards the end of the section this was a cause for concern, it was important that further information was provided. Discussions were held on what was being considered as a lapse, in some cases it may be the responsible clinician was withdrawing permanent detention, in this case it would not be considered a lapse. **Action:** JT to discuss with Divisional Directors the number of S136 who were known to the service and look at how often they were reviewed. POD18.30.7 - The Chair asked for clarification on the under 18 bed available in Abergele and how often this is used. JT advised that there was not a dedicated bed but a place of safety which has been used quite often with some patients being as young as 12. It was noted that CAMHS have done a lot of work and this is reflected in the numbers which have shown a significant decrease, details indicate that a significant number of patients in the East come from various locations across the UK. **Resolved:** That the report be noted	JT
POD18.31 – Item for Information – Under 18s MHA S136 Data Report **RESOLVED:** That the reported be noted.	

POD18.32 – Issues of Significance to inform the Chair's Report to the Mental Health Act Committee POD18.32 – The Chair agreed to raise all issues of concern in her Assurance report to the Board	
POD18.33 – Any other Business There were no additional items to be discussed.	
POD18.34 – Date of Next Meeting Friday 29th March 2019 – Boardroom, Carlton Court	

BCUHB POWER OF DISCHARGE SUB COMMITTEE Summary Action Plan – Live Document – last updated 22/03/2019 15:15				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
SI / WL	**POD17.27 and 18.04** - Vacancy	Feb	Full membership – no vacancies	Closed
SI	**POD18.28.2** – HIW Hergest Report to be distributed before next meeting	March		Closed
WL	**POD18.29** – WL to discuss processes used in other HBs across Wales when arranging hearings.	March		Closed
WL	**POD18.29** – Distribute details of training attended by Associate Managers in Cardiff	December		Closed
WL	**POD18.29.7** – advise all MHA Staff that risk assessments should be included in reports when arranging hearings	December		Closed
SF	**POD18.29.7** – Discuss the issues of missing information with Heads of Nursing	March		Closed
JT/SF	**POD18.29.7** – Discuss with Divisional Directors the issues raised around reports	March		

BCUHB POWER OF DISCHARGE SUB COMMITTEE Summary Action Plan – Live Document – last updated 22/03/2019 15:15				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
JT	**POD18.30.6** – Look at the number of S136 referrals who are already known to the service and how often they are reviewed	March		Closed

Power of Discharge Sub Committee

29th March 2019

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Hospital Managers Update 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 (Mental Health Act) Associate Hospital Managers Activity within the Division
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:	The number of Associate Hospital Managers must be kept at a reasonable level to ensure the availability of persons for the future. We have addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level.
Financial Implications:	The closure of local post offices and the need to collect documents from a main depot includes an increase in travel claims.
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)

Hospital Managers Update Report

1. Purpose of report

To provide an update in relation to the (Mental Health Act) Associate Hospital Managers Activity within the Division.

2. Introduction/Context

Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'. In Wales NHS hospitals are managed by local health boards. The local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.

Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)

In practice, most of the decisions of the Hospital Managers are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)

In particular, decisions about discharge from detention and CTOs are taken by Hospital Managers' Discharge Panels, specifically selected for the role. They are directly accountable to the Board in the execution of their delegated functions. (CoPW 37.6).

This report provides assurance that the individuals who form the Hospital Managers' Discharge Panels (namely Mental Health Act Associate Hospital Managers (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards.

The report details the activity of the Mental Health Act Associate Hospital Managers in relation to Hearings and Scrutiny undertaken, concerns raised and improvements to the Division or service to which they have input for the period January 2018 – March 2018.

3. Activity

3.1 Hearings

A total of 31 hearings were held this quarter resulting in 1 discharge. From the hearings held 25 were section renewals, 3 appeals by the patient and 3 discretionary reviews. The discharge was following a patient's appeal.
A breakdown of the hearing activity is detailed below:

October

- ***21 hearings arranged (13 held)***
  11 of the hearings held were section renewals and 2 were patient appeals.
  10 hearings were held in the inpatient units this included 1 CTO renewal (due to room availability in the CMHT, East area), 3 hearings were held within a CMHT or an outpatient hospital.

- ***8 hearings were cancelled***
  1 patient was regraded to informal by the Responsible Clinician
  1 patient was regraded to a restricted section by the Court system
  1 patient withdrew their appeal
  2 patients were discharged by the Responsible Clinician.
  3 hearings were postponed due to the Responsible Clinician being off sick in two instances and an Associate Hospital Manager not arriving all rescheduled hearings resulted in the patient still being detained.

Outcomes of hearings held

12 detentions were upheld
1 patient following their appeal was discharged.

November

- ***14 hearings arranged (8 held)***
  6 of the hearings held were section renewals, 1 appeal from the patient and 1 a discretionary review.
  6 hearings were held in the inpatient units including 2 CTO renewals, 2 hearings were held within a CMHT.

- ***6 hearings were cancelled***
  2 patients were discharged by the Responsible Clinician.
  1 patient was discharged by the MHRT
  1 patient was regraded to informal
  1 hearing was cancelled as the patient went on S17 leave they were subsequently regraded to be subject to a CTO.
  2 hearings were cancelled due to the Responsible Clinician leaving their post and one being off sick. 1 hearing is rescheduled for January 2019 and 1 patient was transferred to another unit.

Outcomes of hearings held

All detentions were upheld

December

- ***18 hearings arranged (10 held)***
  8 of the hearings held were section renewals and 2 were discretionary reviews.
  9 hearings were held in the inpatient units to include 2 CTO renewals, 1 hearing was held in a CMHT.

- ***8 hearings were cancelled***

2 patients were regraded to informal by the Responsible Clinician.
2 patients were recalled from their CTO which was then revoked
1 patient withdrew their appeal
1 hearing was cancelled due to the solicitor being off sick
2 patients were discharged from their section by the Responsible Clinician

Outcomes of hearings held

7 detentions were upheld
1 hearing was adjourned due to reports not containing sufficient information this hearing is still to be arranged.
1 hearing resulted in a split decision a new hearing was held in January and the patient was discharged by the Associate Hospital Managers.
1 hearing was adjourned for further information to enable the panel to come to a decision the hearing is rescheduled for February 2019.

3.2 Scrutiny

Scrutiny for 2018 resulted in a total of 31 sessions taking place with a total of 160 files scrutinised.

An audit of the full year analysis has been produced (Appendix A) which includes a comparison to the initial audit of 2017. The audit shows that six out of the eight questions scrutinised showed an improvement. Scrutiny shall commence again in February 2019.

3.3 Training

Mandatory training is continuing at the time of this report 51% of Managers are fully compliant. Out of the 11 training sessions Associate Hospital Managers are expected to complete a total of 84% of the total training has been completed.

The Associate Hospital Managers Training Day for January unfortunately was cancelled and is to be rearranged as soon as possible.

3.4 Recruitment

The Associate Hospital Manager cohort at the 31st of January 2019 consists of:

28 persons, 22 actively involved in hearings, 1 person currently stepped down, 3 persons shadowing and 2 due to progress to shadowing following completion of training.

This cohort is made up of 13 male and 15 female members of which 9 are Welsh speakers.

3.5 Forums and Meetings

The Chairs Forum and Associate Hospital Managers Forum Meetings are held regularly.

It is felt by the Associate Hospital Managers that these are useful meetings for sharing of information.

4. Assessment of risk and key impacts

The Associate Hospital Managers have requested additional documentation, Risk Assessments, be supplied to them for hearings. It is felt that this information although available within the integrated files is beneficial to see prior to the hearings.

This documentation is not stored within the Mental Health Act Corri Files but will be requested to be forwarded along with the care plans and reports from professionals.

5. Equality Impact Assessment

This is a retrospective report therefore no EQIA required.

6. Conclusions / Next Steps

Scrutiny – To continue for 2019.

Training –Managers to be supported in the completion of training.

Recruitment –Progress to be reported in future reports.

7. Recommendations

It is recommended that the Committee notes this report.

Appendix A - Scrutiny Audit.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Mental Health and Learning Disabilities Division

Mental Health Act
Associate Hospital Managers
Scrutiny Analysis

2018 Full Year Analysis

January 2019

Conducted by:

Wendy Lappin

Mental Health Act Manager

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Appendices

Appendix A – Associate Hospital Managers Scrutiny Section Papers and Casenotes

INTRODUCTION AND AIMS

This Associate Hospital Managers Scrutiny Analysis is an audit of scrutiny sessions conducted throughout a time period. An initial audit was conducted for February – December 2017, an interim audit was produced for the time period February 2018 – July 2018. This audit has been expanded to cover the timer period February 2018 – December 2018. Scrutiny is not conducted in the month of January.

The Mental Health Act Associate Hospital Managers assist the Mental Health and Learning Disabilities Mental Health Act Department. They are independent persons who are appointed to sit on Managers Discharge Panels for the Health Board to decide unanimously whether a patient is still liable for detention and as such confirming that the Health Board is appropriately detaining patients under the least restrictive option. An additional duty the Associate Hospital Managers fulfil is one of scrutiny.

The Mental Health and Learning Disabilities Division holds various forms of scrutiny in relation to the Mental Health Act, (statutory documents and local documents) to monitor and be satisfied that professionals are detaining patients legally and ensuring patients are advised of the rights they are entitled to and are aware of help they can receive.

Scrutiny is conducted in the forms of:

Admin/Pharmacy Scrutiny – Relates to medication forms. The form is checked by the Mental Health Act Office that all areas are completed and signed. Pharmacy check the medication is written up correctly within the correct doses and routes for administering.

Admin/ECT Scrutiny – Relates to ECT forms. The form is checked by the Mental Health Act Office that all areas are completed and signed. ECT check the maximum numbers of ECT, including under S62 (Emergency Treatment Certification) and consider the capacity of the patient.

Medical Scrutiny – A senior Medic will scrutinise section papers and renewal papers to be satisfied that the patient has been admitted under the least restrictive option

and that the use of the Mental Health Act was an appropriate decision due to the patient's presentation and needs.

Approved Mental Health Professional (AMHP) Scrutiny – A Senior AMHP will check the AMHP paperwork and report to ensure that the correct process was followed in relation to identifying the nearest relative and the papers are completed correctly.

Associate Hospital Managers Scrutiny – The Managers conduct scrutiny within the ward areas looking at sections papers and casenotes. This consists of a checklist (Appendix A) which covers documents completed by Medics, AMHPs, nursing staff and the provision of help highlighted to the patients. The general order of the documents is also considered and whether these are contained within the files.

This structure of scrutiny provides the Health Board with assurance that errors are highlighted at the earliest opportunity and informs where improvements are needed.

Following the interim report which showed an improvement in all areas compared to 2017, the aim of this full year report is to show within 2018 the results of the scrutiny sessions which will highlight whether improvement have continued to be made and those areas that may need further guidance.

STANDARDS

The standards used for the purpose of this audit are:

1. The Mental Health Act 1983 as amended 2007
2. The Mental Health Act Code of Practice for Wales (revised 2016)

"The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms, those set out in schedule 2 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008. The forms must also be scrutinised to ensure all information contained is accurate and meeting the requirements".

"Hospital Managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers, who may include clinical staff

on wards. Someone with the authority to receive admission document should be available whenever patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents". (CoPW 35.8)

"Hospital managers and local authorities should also ensure arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis". (CoPW 35.20)

METHODOLOGY

Data from the period February 2018 to December 2018 in regards to the Associate Hospital Managers Scrutiny has been collected. The data was collected from the checklists (Appendix A).

Within the period 30 areas were visited for Scrutiny, this included inpatient adult wards of the psychiatric units, older persons units, forensic, learning disabilities rehab and the adolescent service. Some areas were visited on more than one occasion due to the number of persons detained and turnover whilst other areas were visited once.

A total of 162 files were scrutinised consisting of 117 persons on a Section 3, 28 on a Section 2, 3 on Section 37/41, 6 persons whom it was unable to determine the legal status, 3 on Section 37, 1 on Section47, 1 CTO recall and 2 persons who were subject to DOLS, the DOLS files have been discounted from this audit.

RESULTS

Each part of the Scrutiny form has been considered in relation to the answers obtained e.g. Yes (positive) or No (Negative). These have been broken down into the relevant sections on the form to discover the percentage of compliance as a whole but also for the areas scrutinised. As some units did not distinguish between the ward scrutinised the results have been displayed as units rather than being broken down to the wards. Feedback was given to each ward/unit scrutinised following the attendance of the Associate Hospital Managers this is therefore a collective and retrospective report.

1 Medical Recommendations

Each scrutiny form was analysed. The table below shows the number of positive responses in relation to the five relevant questions for the areas scrutinised.

1. Do the doctors appear to be independent of each other?
2. Has the doctor stated why informal admission is not appropriate?
3. Have all forms been completed correctly?
4. Are dates of examination no more than five clear days apart? (not including the dates of the examinations)
5. Are you satisfied with the recommendation(s)?

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	Q3	Q4	Q5
Heddfan (8)	43 (41) Data on 41, two volumes of notes section papers were not included	41	41	40	41	41
Ablett (5)	24 (20) Data on 20, three volume of notes section papers were not included one was not a relevant section	20	20	20	20	20
Hergest (5)	36 (35) Data on 35, one volume in relation to a CTO revocation	35	35	35	35	35
Bryn Hesketh (2)	18	18	18	18	18	18
Cefni Hospital (2)	9	9	9	9	9	9
Coed Celyn (2)	8 (6) Data on 6, two volumes in relation to a 37/41 and 37 so the questions unable to be answered	6	6	6	6	6
Carreg Fawr (0)	0 Not scrutinised this period					
Adolescent Service (1)	1	1	1	1	1	1
Learning Disability Villas (2)	7	7	7	7	7	7
Tan Y Castell (2)	9 (8) Data on 8, one volume of notes section papers not included	8	8	8	8	8
Ty Llywelyn (1)	5	5	5	5	5	5
TOTALS	**150**	**150**	**150**	**149**	**150**	**150**

COMMENTS NOTED

Ablett - Section papers missing from the volumes given for scrutiny.

Tan Y Castell – Joint medical recommendation doctors examined on different days, is the description of detaining valid?

Hergest – HO8 not completed correctly and Doctors handwriting hard to decipher.

Heddfan – some forms have the patients name and reference number recorded differently and section papers missing from the volume given for scrutiny.

Ty Llywelyn – Legal documents not in the correct section of casenotes.

2 Application by the AMHP

Each scrutiny form was analysed. The table below shows the number of positive in relation to the two relevant questions for the areas scrutinised.

1. Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)
2. Has the AMHP given sufficient explanation of his / her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2
Heddfan (8)	43 (41) Data on 41, two volumes of notes section papers were not included	36	34
Ablett (5)	24 (20) Data on 20, three volume of notes section papers were not included one was not a relevant section	20	17
Hergest (5)	36 (35) Data on 35, one volume in relation to a CTO revocation	34	33
Bryn Hesketh (2)	18	18	18
Cefni Hospital (2)	9	8	7
Coed Celyn (2)	8 (6) Data on 6, two volumes in relation to a 37/41 and 37 so the questions unable to be answered	6	6
Carreg Fawr (0)	0 Not scrutinised this period		
Adolescent Service (1)	1	1	1
Learning Disability Villas (2)	7	6	6

Tan Y Castell (2)	9 (8) Data on 8, one volume of notes section papers not included	8	8
Ty Llywelyn (1)	5 (3) Data on 3, two volumes in relation to sections not relevant	2	2
TOTALS	**150**	**139**	**132**

COMMENTS NOTED

Cefni – No AMHP report on file.

Ablett –. AMHP allocation does not have name of applicant on the form. No evidence of a displacement of current nearest relative before appointing another family member.

Heddfan - No AMHP report on file, different people named as nearest relative throughout casenotes.

Hergest – No AMHP report on file, explanation by AMHP regarding Nearest Relative is very brief and does not appear to have been followed up since admission.

3 Casenotes

Each scrutiny form was analysed. The table below shows the number of positive in relation to the two relevant questions for the areas scrutinised. For question 2a and 2b if it has been recorded that the patient did not receive the explanation in their primary language and this was not explained why, 2b has received a minus response followed by the amount.

1. Has Ethnicity been recorded in the casenotes? (Admission Form)
2. Has an Explanation of Rights been given to the patient and recorded in the notes?
   a) Was the Explanation offered in the patient's primary language?
   b) If not have reasons been recorded?
   (MHA Section)
3. Has the patient been referred to the IMHA?
   (MHA Section)
4. Is there an up to date Care and Treatment Plan?

(Care Planning Section)

5. Are the section papers filed in the correct place in the casenotes? (MHA Section)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	2a	2b	Q3	Q4	Q5
Heddfan (8)	43	33	29	24	-10	25	40	40
Ablett (5)	24	22	19	19	1 -1	21	20	17
Hergest (5)	36	34	35	23	-12	29	36	34
Bryn Hesketh (2)	18	15	11	8	-3	13	15	18
Cefni Hospital (2)	9	9	8	7	-1	9	8	9
Coed Celyn (2)	8	6	5	4	-2	4	7	7
Carreg Fawr (0)	0 Not scrutinised this period							
Adolescent Service (1)	1	1	1	1	0	1	1	1
Learning Disability Villas (2)	7	6	5	5	-2	6	6	5
Tan Y Castell (2)	9	9	9	8	-1	9	9	9
Ty Llywelyn (1)	5	4	5	4	-1	4	5	3
TOTALS	**160**	**139**	**127**	**103**	**1 -27**	**121**	**147**	**143**

COMMENTS NOTED:

Cefni – Care and Treatment Plan needs updating.

Adolescent Service – Care and Treatment plan not signed.

Hergest – Wrong name but corrected on Care and Treatment Plan, review date on Care and Treatment Plan missing. Evidence of patients being offered an IMHA but declining. Unsigned Care and Treatment Plans in files. Section papers need to be in

correct section of file. Evidence of old explanation of rights form being used which does not detail primary language question.

Coed Celyn – No explanation of rights form on file, could not identify if a referral had been made to IMHA due to this.

Bryn Hesketh – Ethnicity not routinely recorded, primary language not evident. Care and Treatment Plan needs updating and not signed noted.

Ablett – Care and Treatment Plans out of date. Section papers need to be within the correct file. No record of explanation of rights, referral to IMHA not completed.

Heddfan – Care and Treatment Plan out of date. CTP next review date noted as before actual CTP date. Explanation of rights form not found, Ethnicity not recorded only found in AMHP reports.

Tan y Castell – Care plans needed updating.

LD Villas – patient lacked capacity therefore Q2a and Q2b were not able to be answered. Care plan needed updating.

CONCLUSIONS & DISCUSSION

Medical Recommendations

It would be expected that the Medical Recommendations section should be at 100% for all questions otherwise a patient may potentially be detained illegally.

All areas apart from Heddfan showed 100% compliance to the questions.

A query was raised in relation to a joint medical recommendation and the validity of the reasons, this document had been through various processes of scrutiny and it was confirmed that this was adequate.

It was noted within one area that the HO8 had not been completed correctly on investigation these were adequate and had also progressed through the medical and admin scrutiny.

In comparison to the scrutiny data from 2017 there has been an improvement in the recording of why informal admission is not appropriate on the medical recommendations.

There has been a marked improvement with 2018 only highlighting one file not returning a positive for one question when analysing the reason this was in relation to the spelling of a patient's name. This error is rectifiable and it was confirmed and evidenced that the section papers had been checked and amended as allowed under the Mental Health Act.

The extension of the audit to the end of December has highlighted no additional queries than those previously recorded above.

Application by AMHP

In 2017 it was discovered that the Associate Hospital Managers needed further guidance on Q1 and an additional note of "this cannot be dated before" was added. Some of the scrutiny forms returned in 2018 were of the original version and not the amended ones although this has not appeared to affect the results as it did within 2017.

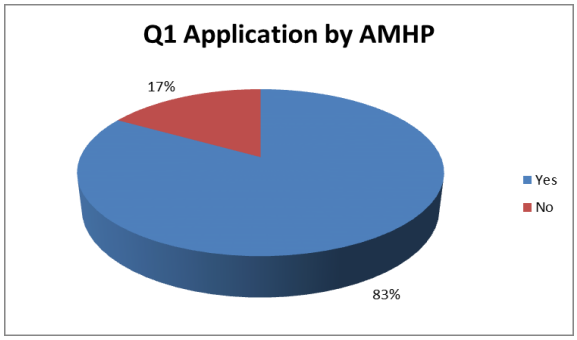
It was highlighted that there was not an AMHP report on some of the files when investigated these were either still to be forwarded by the AMHP or within the filing of the wards. In some instances the nearest relative had not been followed up and confirmed by the ward after admission.

The process and the person named as nearest relative was questioned on several occasions, all documents were scrutinised and checked to ensure accurate.

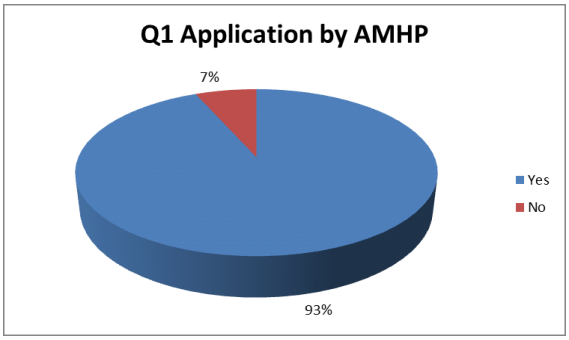
100% for both questions was obtained by Bryn Hesketh, NWAS, Coed Cleyn, Learning Disabilities Villas and Tan Y Castell.

The charts below show the comparisons and percentages of the total files scrutinised for both questions for the years 2017 and 2018.

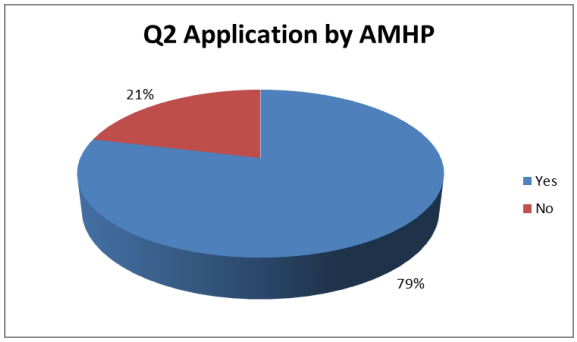
2017

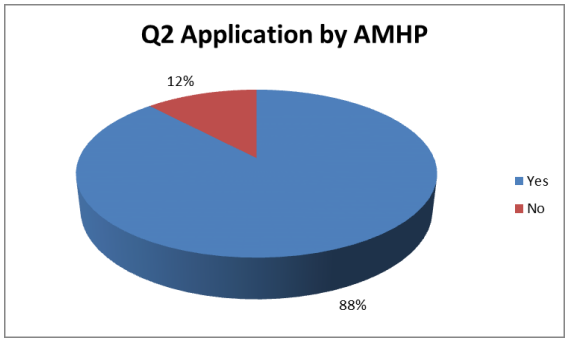


2018



The percentage has not altered following a full audit and has shown an improvement of 10% on the previous audit figures. In essence the section would not be acceptable if the AMHP interview was not on the same day or after the medical recommendation and is showing a negative in relation to this audit due to AMHP reports being absent and the Associate Hospital Managers not being able to ascertain an answer.





The percentage for the full audit has changed from the previous interim report improvement of 11% to an improvement of 9%. It is acknowledged that this is a subjective question and dependant on the knowledge that the Associate Hospital Manager has and the understanding of what is deemed to be a sufficient explanation may affect the response, if a negative is highlighted this is checked for validity and in future if this is due to a lack of understanding by the Associate Hospital Manager will be recorded as a positive. The lack of AMHP reports on file will have affected the recording of this question.

Casenotes

From the 160 files scrutinised one session produced a return of 100% for all questions although only one file was scrutinised in this area. A total of 71 files (44%) produced a return of 100% for all five questions. This was not monitored within the last audit and will be included for future records.

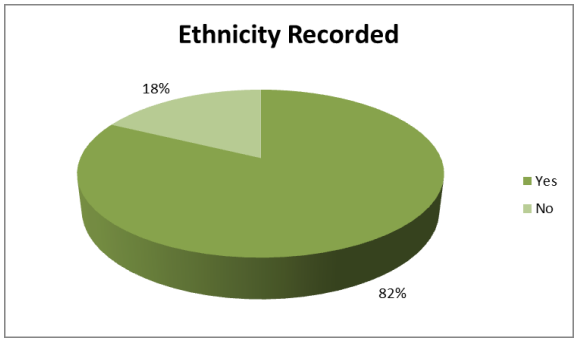
In some instances it was recorded that the explanation of rights form was not within the file therefore the Associate Hospital Managers could not determine an answer for questions 2 and 3 which produces a negative for these questions automatically as there is no evidence to the contrary.

There was evidence of the wrong name left on CTP documents but also evidence that this had been corrected. Several files noted that the Care and Treatment Plans were out of date some of these due to recent re-admissions and a new Care and Treatment Plan not being printed and filed.

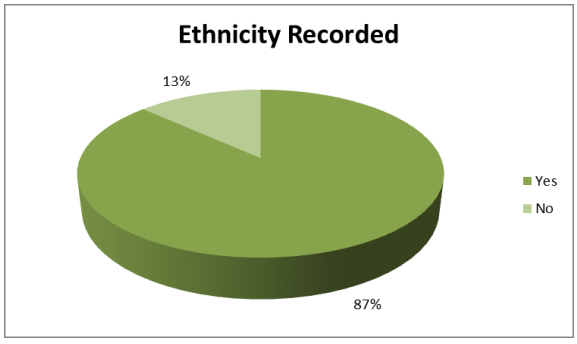
There was clear evidence of patients who lacked capacity that a referral to IMHA had been made. Within one file it was noted that the spouse had been informed of their rights due to the patient lacking capacity and IMHA explained to them.

The charts below show the percentages for each question for all the areas scrutinised in comparison to the results obtained from the 2017 scrutiny sessions.

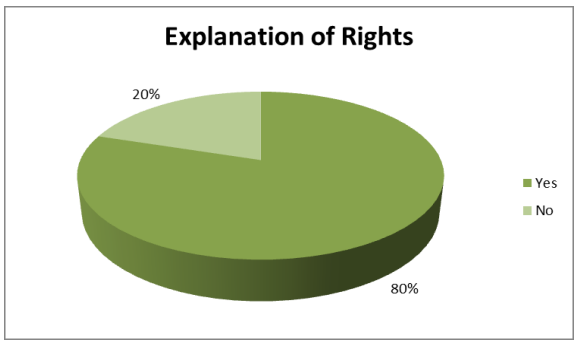
2017

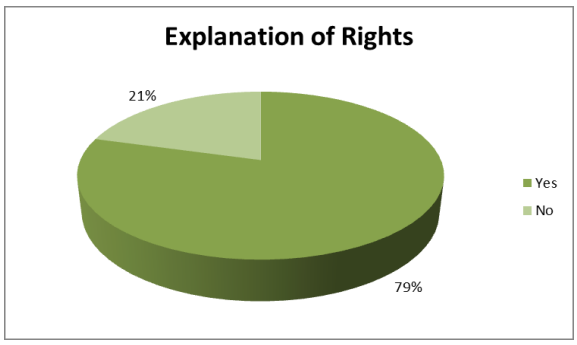


2018

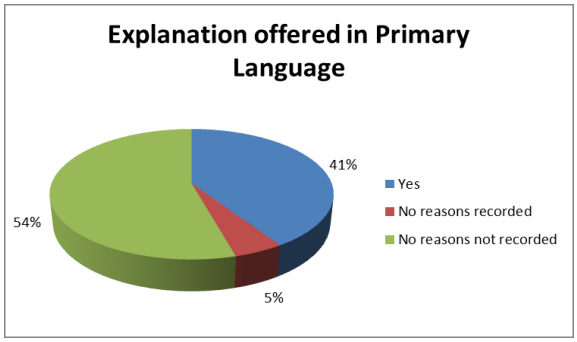


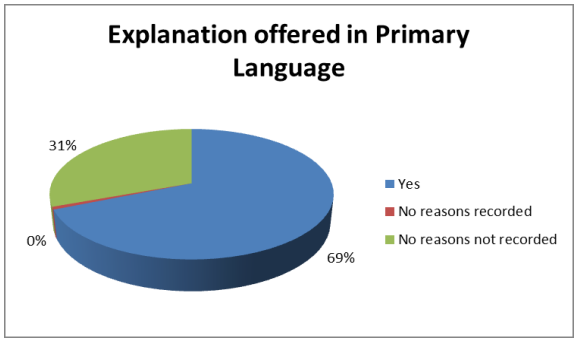
There has been an improvement of 5% in relation to ethnicity being recorded within the files this was in some instances obtained via the AMHP report as well. This is a decrease of 4% on the previous interim audit recording of a 9% improvement.



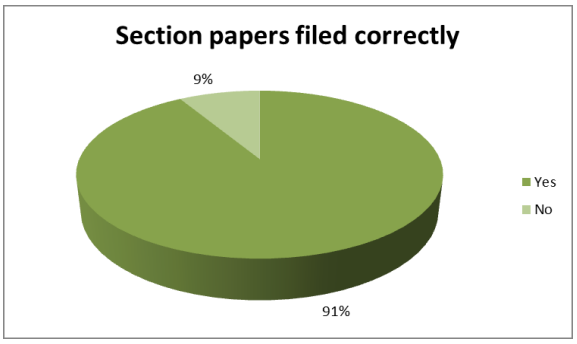


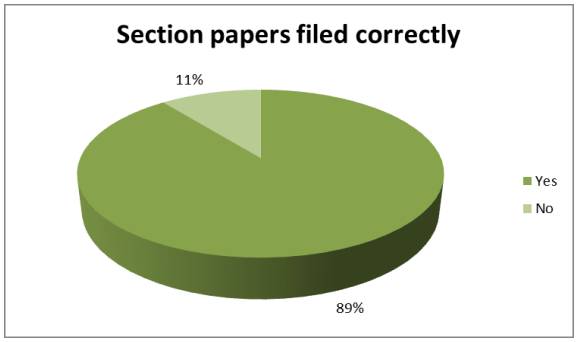
There has been no improvement in relation to the explanation of rights and the figures have shown a negative of 1%. This is surprising as the interim report had shown an improvement of 11%. During the latter part of 2018 many of the files scrutinised recorded that the explanation of rights forms could not be found.



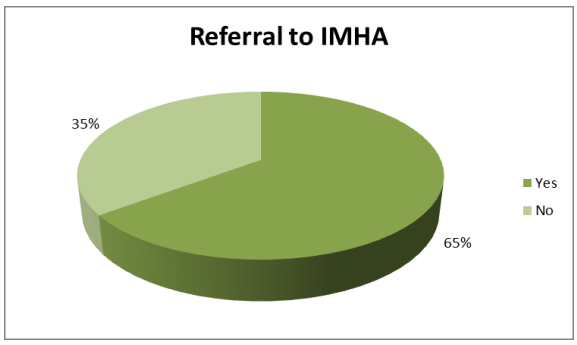


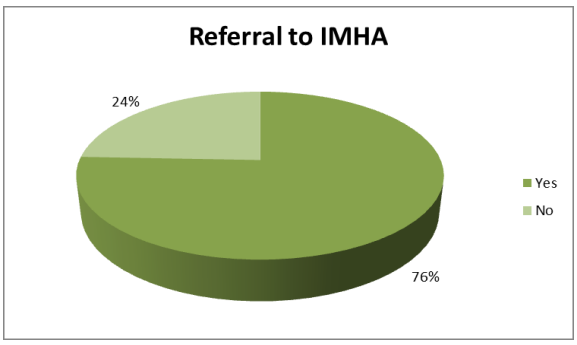
There has been an improvement of 28% in evidence of the explanation of rights being offered in the primary language of the patient. This is an increase on the interim audit figures.



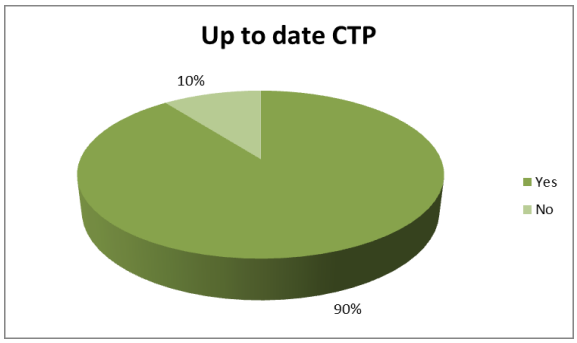


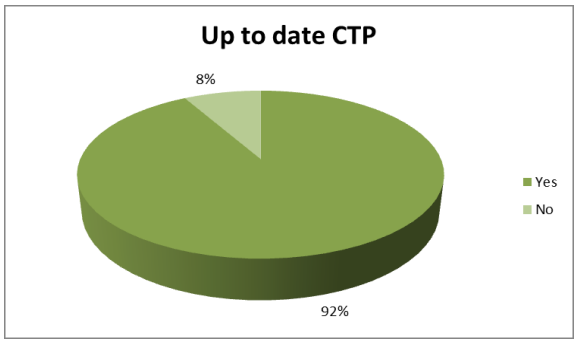
For the full year audit this has not produced an improvement and has resulted in a negative of 2%.





There has been an improvement of 21% in evidence of referrals to IMHA being made in 2018 compared to 2017.





There has been an improvement of 2% in up to date CTP's being within the files.

In comparison to the scrutiny data from 2017 for the interim report no question or area showed a decrease with all questions and areas showing improvements of record keeping and documentation being completed correctly. Following the full analysis no improvement has been made in relation to the section papers being filed correctly and the recording of the patient receiving an explanation of their rights. It must be noted that although the recording of the explanation of rights has returned a negative of 1% when recorded there has been a 28% increase that the explanation has been conducted in the patients primary language.

General Comments

General comments were received that the Associate Hospital Managers were well received and looked after by the Adolescent Service.

Within Hergest it was noted that the files were well presented and that the yellow sheet detailing the Section details and Consent to Treatment status were very useful,

evidence of file notes explaining admission and recall process were highlighted as very helpful.

Within Bryn Hesketh scrutiny it was highlighted that there was “well filed documentation” and “nicely organised files”.

It was noted that it is evident when the Mental Health Act Administrators have asked for section papers to be amended therefore providing evidence that the Mental Health Act Office is undertaking appropriate scrutiny.

Coed Celyn scrutiny recorded easy to read files although there was a loose envelope in a file containing a referral letter it was not clear if this was the original or a copy. An ID label was reported to be faded and difficult to read.

Within the Learning Disability Villas it was highlighted “a well organised set of case notes” and that a volume was basic and up to date but the old notes were not available.

ACTIONS TAKEN

Following each scrutiny session the areas have been informed of their results and areas of concern highlighted.

All issues raised by the Associate Hospital Managers have been looked into, assurance provided that everything is in order or amendments and corrects have been made immediately.

RECOMMENDATIONS

Scrutiny to be conducted for 2019, following a query in relation to continuation if it appears wards are busy it has been confirmed that areas are informed prior of the attendance of the Associate Hospital Managers and given the opportunity to select a timeframe. It is therefore recommended that unless a serious incident occurs or HIW attend for an unannounced visit the scrutiny should proceed as planned.

The report will be shared with the Mental Health Act Committee, Associate Hospital Managers, the Heads of Nursing and Head of Operations for each area, Clinical Directors and Divisional Directors.

It is recommended that Heads of Nursing disseminate the information contained within the report to Modern Matrons and Ward Managers.

The Information to Patients Policy to be highlighted to staff by the Heads of Nursing in relation to Explanation of Rights and the process, work still needs to be undertaken to ensure that the forms are fully completed. This policy with the form can be accessed via the link and is available on the intranet. MHLD 0030 Policy for information to patients (s132/3 MHA).

http://howis.wales.nhs.uk/sitesplus/861/opendoc/454531

Mental Health Act Administrators must ensure that the correct scrutiny form is in use as per the policy to assist Associate Hospital Managers in accurately recording findings.

Nearest Relatives need to be identified under the Mental Health Act. If the AMHP is unable to ascertain for a Section 2 this must be followed up by the Care Coordinator and the inpatient services to ensure the Nearest Relative is aware of and able to exercise their rights under the Mental Health Act as they see fit.

A yearly audit to be conducted.

Appendix A
(Appendix 13 of Admission receipt and Scrutiny of Statutory Documentation Policy)

(Name of Unit - Hergest, Heddfan, Ablett Unit)

Associate Hospital Managers Scrutiny
Section Papers and Casenotes

Venue:
Names of Managers undertaking Scrutiny:
Number of files scrutinised:
Date:
Any issues of concern which need raising:

Please note a separate page 2 and 3 of Appendix 13 should be used for each file scrutinised.

Appendix 13 p.2

Associate Hospital Managers Scrutiny
Section Papers and Casenotes

Patient's Name:

Ref No: Section: Section Date:

PLEASE NOTE:

- All forms must be for the same section detailing the patients name and address identically on each form.
- Forms should be signed and dated.
- If the section papers need to be amended you will be required to check them again.

Please check the medical recommendation(s) for the following:

		Yes	No
1	Do the doctors appear to be independent of each other?	☐	☐
2	Has the doctor stated why informal admission is not appropriate?	☐	☐
3	Have all forms been completed correctly?	☐	☐
4	Are dates of examination no more than five clear days apart? (not including the dates of the examinations)	☐	☐
5	Are you satisfied with the recommendation(s)? If not please details reasons below:	☐	☐

_____

_____

_____

Please check the Application by the AMHP for the following:

		Yes	No
1	Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)	☐	☐
2	Has the AMHP given sufficient explanation of his/her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)	☐	☐

Appendix 13 p.3

Please check the casenotes for the following:

		Yes	No
1	Has Ethnicity been recorded in the casenotes? (Admission Form)	☐	☐
2	Has an Explanation of Rights been given to the patient and recorded in the notes?	☐	☐
	Was the Explanation offered in the patient's primary language?	☐	☐
	If not have reasons been recorded? (MHA Section)	☐	☐
3	Has the patient been referred to the IMHA? (MHA Section)	☐	☐
4	Is there an up to date Care and Treatment Plan? (Care Planning Section)	☐	☐
5	Are the section papers filed in the correct place in the casenotes? (MHA Section)	☐	☐

Any further Comments:

_____

_____

_____

_____

_____

Signature(s): .....

Print Name(s): .....

Date undertaken: .....

Power of Discharge Sub Committee

29th March 2019

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, Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide an updated 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 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:	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 December 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 – December 2018	22 admissions age range 13 - 17	9.57 hours

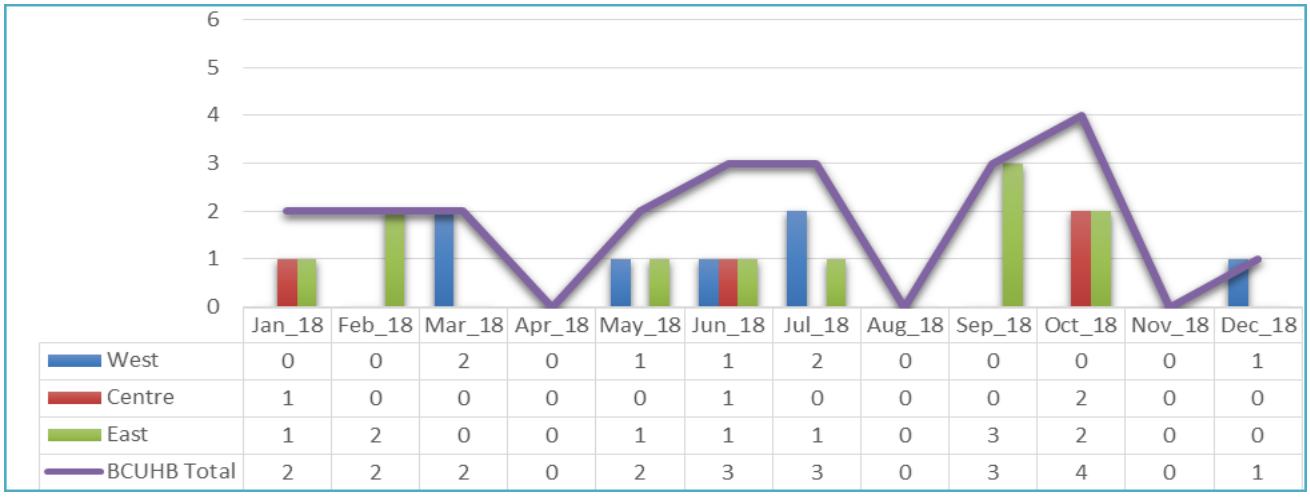
January 2018 – December 2018	**No Assessed**	**AGE OF CHILD**
17 admissions age range 13-17	0	12
Average time PoS – 9:06 hours	2	13
	3	14
	2	15
	4	16
	10	17
OUTCOME following assessment	**No**	
Returned Home	12	
Returned to Care Facility	4	
Admission Children's Ward	0	
Admission Adult Mental Health Ward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

COUNTIES ORIGINATED FROM AND WHERE ASSESSED.

County	POS East	POS Central	POS West
Wrexham	8	1	
Flintshire			
Denbighshire	2	2	1
Conwy		1	2
Gwynedd			2
Ynys Mon			2
Other	1 x Shropshire		

Seventeen 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 Dec 18



	Jan_18	Feb_18	Mar_18	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18
West	0	0	2	0	1	1	2	0	0	0	0	1
Centre	1	0	0	0	0	1	0	0	0	2	0	0
East	1	2	0	0	1	1	1	0	3	2	0	0
BCUHB Total	2	2	2	0	2	3	3	0	3	4	0	1

Power of Discharge Sub Committee

29th March 2019

To improve health and provide excellent care

Report Title:	Independent Review of the Mental Health Act
Report Author:	Wendy Lappin, Mental Health Act Manager
Responsible Director:	Andy Roach, Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide an update in relation to the Independent Review of the Mental Health Act and the recommendations published in December 2018.
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 - 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)

Independent Review of the Mental Health Act

The Independent Review of the Mental Health Act was commissioned by Government in October 2017 and began with the Terms of Reference being published on the 4th of October which detailed the background, purpose of the review, expected outputs, leadership, co-production, governance and devolution.

The Independent Review was conducted throughout 2018 which involved engagement with Service Users, Carers and Professionals facilitated through surveys, meetings and conferences, commissioning of academic literature allowed the latest evidence on themes under the Mental Health Act to be gathered.

An interim report was published in May 2018 with the final report and recommendations published on the 6th of December 2018. This report is accessible via the link below:

https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The final report sets out recommendations covering 4 principles that the review believes should underpin the reformed Act:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- people as individuals – ensuring patients are viewed and treated as rounded individuals

The review looked at:

- rising rates of detention under the Act
- the disproportionate number of people from black and minority ethnic groups detained under the Act
- processes that are out of step with a modern mental health care system (https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review)

The Mental Health Network NHS Confederation provided a briefing paper in December 2018 Issue 310 as attached.

MHN Briefing 310
MHA review FINAL.pc

RECOMMENDATIONS

The review has made the following recommendations to the government to enable to Mental Health Act to be modernised and fulfil the criteria that the panel feel is essential.

The recommendations include proposed changes to current parts of the Mental Health Act and introductions of new ideas. Recommendations provided below are not in full but snapshot aspects that initially will affect the Health Board. The full recommendations are detailed within the report.

Proposed changes to current practices

1 **A purpose and new set of principles should be included in the Act**. These four principles covering the areas Choice and Autonomy, Least Restrictive, Therapeutic Benefit and People as Individuals should be included within the Statutory documentation to enable professionals to record how these have been taken into consideration. It is suggested that CQC take this into consideration in their monitoring and review role.

2 **Nearest Relative (NR)**. To be replaced by a Nominated Person (NP) which the patient will be able to choose under section 26 MHA. Displacement should be done via a Mental Health Review Tribunal rather than the County Court. For those who do not have capacity the AMHP will have the power to nominate an interim NP. Patients under Part III who currently do not have the rights to a NR will have limited eligibility to a NP in relation to care planning. NP will be consulted with in relation to treatment and care planning rather than informed about changes.

3 **IMHA's** The IMHA service will be opt out. It will be a statutory requirement that each patient whether informal or formal is allocated an IMHA. The IMHA will assist the patients with the Advanced Choice Document.

4 **Section 132 Information to patients and rights** Information is to be clearer and improved in relation to the complaints procedure which needs to be made known to the patient and their Nominated Person. Staff dealing with the complaints should have an understanding of the MHA.

5 **Detention and timeframes.** If a person has been subject to a Section 3 within the last 12 months unless a material change has happened then any re-detention should be under section 3 and not section 2.

Section 2. A second clinical opinion to be conducted at 14 days. The time period for right of appeal to be extended past the current 14 days.

Section 3. Timeframes to be changed to initially 3 months, followed by a further 3 months and then 6 months rather than the current 6,6 and then yearly. An RC and AMHP will be required to confirm 10 days prior to a Tribunal that the patient still meets the criteria for detention.

Bed availability. A time limit to be introduced to find a bed.

6 **Tribunals**. A patient should have an automatic referral to a Tribunal at 4 months since their detention, followed by 12 months and then annually thereafter currently this is 6 months then every 3 years thereafter. For Part III patients it is recommended every 12 months, currently this is 3 yearly. The tribunal will be given additional powers such as granting leave and transfer between hospitals. Section 67 to be expanded so that SOADs and CQC could refer patients to a tribunal. Specific training to be provided to the Tribunal panel members so that they are aware of the patients needs.

7 **CTO's**. Proposal for a CTO to require two doctors (inpatient and community consultant) and an AMHP. CTO timeframe to be 6-6-12 with each renewal involving an AMHP and two doctors unless a review has been held by the Tribunal. CTO's should end after 24 months, If longer than the two years it must be authorised again by an AMHP and two doctors. Automatic referrals will need to be made within each period if the patient does not exercise their right to a Tribunal. It is recommended that if the changes are put in place a review will be held in five years with the view to abolish if outcomes are not improved.

8 **Hospital Managers**. The managers of the hospital (the MHA office) will continue to have the duty to scrutinise documents and renewal documents. The power of Associate Hospital managers to order discharge from hospital will be removed. The Government and CQC to consider a new 'Hospital Visitors' role to be developed to look at day to day life and ensure the patient is being treated with dignity and respect.

9 **Children**. Admissions to an adult unit CQC should be informed within 24 hours. Section 17 of the Childrens Act 1989 to be amended so that an admitted child is considered a child in need and therefore will have access to services from the local authority. Young people aged 16/17 should not be admitted or treated on the basis of parental consent. The MCA tests should be used in the process for determining the young persons ability to make decisions, the presumption of capacity not to be used for those under 16.

Introduction of new ideas

1 **Care and Treatment Plans**. CTP's should be developed through shared decision making between the patient and the clinicians. These must be

formulated within 7 days of admission and reviewed and signed off by 14 days. Patients will have the right to objection via a Tribunal if they did not agree with the treatment plans and the ability to request a SOAD following the 14 day sign off. A new statutory document advanced choice document (ACD) to be developed to enable patients to make a range of choices and statements in relation to their inpatient care and treatment.

2 **Deaths in Detention**. A family liaison role to be developed to support families, families should receive none means tested legal aid and patients who are under DOLS/LPS should be considered as a death in state detention so that it triggers an investigation by a coroner and an inquest with a jury.

3 **Tackling the rise in detentions**. There should be more accessible and responsive mental health crisis services and community based mental health services to respond to people's needs and keep them well.

4 **Admissions**. Section 131 (voluntary admission) to be moved above section 2 and 3 within the Act to give it more prominence. Capacity to consent to admission to always be recorded on the application forms. Detention criteria to be strengthened.

5 **MCA (DOLS/LPS).** Only the MCA framework (DOLS to be LPS) to be used where a person lacks capacity to consent to their admission or treatment for mental disorder but it is clear that they are not objecting. The ability to hold the patient in hospital for 72 hours under MCA/LPS whilst it is determined if they are objecting.

6 **CQC**. To develop stricter criteria in relation to NICE guidelines, ward maintenance and structures and provisions.

7 **Cultural requirements**. Cultural appropriate advocacy should be available to all ethnic backgrounds and communities. Safeguards should be created so that people are able to continue spiritual practices or religion whilst in hospital. More research and funding should be available.

8 **Policing**. Ambulance services should establish formal standards to S136 conveyances. 2023/24 should see the removal of police cells as a place of safety. NHS England should take over the commissioning of health services in police custody.

9 **Criminal Justice System**. Magistrates courts to have powers amended to bring them in line with Crown Courts.

Recommendations have also been made in relation to data collection and cross referencing, the publishing timescales of data, Quality Improvement programmes, the availability and use of s12(2) doctors and linking staff morale with patient experience.

It is noted that there is a difference between the Tribunal workings in Wales compared to England and it is hoped that the recommendations will ensure that patients who are subject to the MHA in Wales or England will be treated the same and have the same rights and opportunities.

The review considered the use of the MHA and MCA and whether these should be fused together at the current time this is not a recommendation that is being made only that each Act is updated and kept separate.

The recommendations have been submitted to the Government.

Implications to the Health Board

The above recommendations will have implications to the Health Board and are bullet pointed below:

- Strengthened assurance that patients are detained appropriately
- Strengthened assurance that patients have access to an IMHA
- Additional administrative tasks for the Mental Health Act Office
- Additional reports required and assessments by Professionals
- Additional monitoring and checks
- Increased use of S12(2) doctors and financial implications
- Increased data assurance and availability enabling comparisons and benchmarking.

Acknowledgments

The independent review of the Mental Health Act was conducted by Professor Sir Simon Wessely, Steven Gilbert, Sir Mark Hedley and Rabbi Baroness Julia Neuberger.

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Mental Health Network
NHS CONFEDERATION

Modernising the Mental Health Act

A summary of the final report of the Independent Review of the Mental Health Act

Key points

- In October 2017, the government announced an independent review of the Mental Health Act would take place.
- An interim report from the review team was published in May 2018.
- It highlighted a range of issues relating to before and during detention, as well as issues relating to specific groups of people including BAME communities.
- The final report was published in December 2018.
- This briefing summarises key points from the final report for Mental Health Network members.

Introduction

In October 2017, the Prime Minister, The Rt Hon Theresa May MP, announced an independent review of the 1983 Mental Health Act (MHA). Chaired by Professor Sir Simon Wessely, the review was tasked with making recommendations for improvements "in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system".[1] The review team were asked to look at both legislation and practice.

On 1 May 2018 the review team published an interim report, which summarised their work to date and outlined emerging priority areas. The second stage of the review probed further into 18 separate topic areas which were highlighted in the interim report.

The review's final report was published on 6 December 2018 and makes a total of 154 recommendations.[2] This briefing sets out an overview of the final report for Mental Health Network members, with a particular focus on those recommendations relevant to service providers.

Review activity

Supporting Professor Sir Wessely as vice chairs to the review were Steven Gilbert (a service user and lived experience consultant), Sir Mark Hedley (a retired high court judge), and Rabbi Baroness Julia Neuberger (former chief executive of The King's Fund and chair of the Liverpool Care Pathway Review). In turn, the review was supported by four governance groups (a working group, a service user and carer group, an African and Caribbean group, plus an advisory panel). Eighteen topics groups were also established to explore the priority areas identified in the review's interim report.

The Mental Health Network's chief executive, Sean Duggan, chaired the review's topic group on reducing detention rates. Over the course of the review, the Mental Health Network hosted two private roundtables for members to meet with Professor Sir Wessely and members of the review team.

The review team undertook extensive engagement. This included holding over 50 focus groups and examining over 1,500 survey responses from service users and carers. The review also held seven public workshops with over 550 attendees, as well as a series of bespoke roundtables on priority areas. This included a roundtable at 10 Downing Street to discuss priorities for African and Caribbean communities.

Lastly, a short note on scope. The MHA applies to England and Wales. However, the health policy aspect of the act is the responsibility of the Welsh Government, while the justice side of the act is the responsibility of the UK Government. Therefore, the recommendations in the review cover England for health, but both Wales and England for justice.

The case for change

The review sets out a clear case for change. Rates of detentions in psychiatric hospitals have more than doubled since 1983, with the steepest rises seen over the last decade and during the late 80s and early 90s. From 2005/06 to 2015/16, the reported number of uses of the MHA to detain people in hospital increased by 40 per cent. The review states that emerging data from the last three years suggest that this trend may be changing. A considered analysis of the data relating to these trends is set out in the report, including consideration of which societal and legal factors, as well as issues relating to patterns of service provision, could be contributing to rising rates of detentions.

The review also provides a thoughtful consideration of the experience of service users. Overall, the review finds, they "have been disturbed and saddened by what we have heard from patients". Too many people are described as being cared for in wards which are below standard, and the experience of care is too often found wanting. The review "heard repeatedly of the distressing and unacceptable experiences from people from ethnic minority communities and in particular black African Caribbean men. Fear of what may happen if you are detained, how long you may be in hospital and even if you will get out are all widespread in ethnic minority communities".

The review found that "there is unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism are at a particular disadvantage". There is a need, says the review, to achieve a greater focus on rights-based approaches.

New Mental Health Act principles

The review recommends that a statement of fundamental purpose and principles should be articulated in the MHA's opening section. They would provide the basis for all actions taken under the act, setting the standards against which decisions can be held to account and providing service users with clear expectations for their care and treatment.

The review proposes this should enshrine the concepts of:

- **Choice and autonomy**: Ensuring service users' views and choices are respected.
- **Least restriction**: Ensuring the act's powers are used in the least restrictive way.
- **Therapeutic benefit**: Ensuring patients are supported to get better, so they can be discharged from the act.
- **The person as an individual**: Ensuring patients are viewed and treated as rounded individuals.

These four principles form the basis for the 154 recommendations set out by the review. The following section summarises those proposed actions. Later in this briefing, the government's initial response to those recommendations is outlined as well as a consideration of next steps.

"If there is one theme that runs through this review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past."

PRINCIPLE ONE: CHOICE AND AUTONOMY

Making decisions about care and treatment

The review makes approximately 30 recommendations relating to strengthening the principle of choice and autonomy. As the review states:

"If there is one theme that runs through this review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past. It is our intention that even when deprived of their liberty, patients will have a greater say in decisions, including decisions about how they are treated. We also want to make it harder to have those decisions overruled."

In relation to making decisions about care and treatment, the review seeks to increase service user involvement by ensuring shared decision-making is the basis, as far as possible, for care planning and treatment decisions made under the act. It also seeks to establish a new basis for making treatment decisions which respects both the service user's expertise and knowledge and that of the clinician. Further, it recommends making it harder for clinicians to administer treatment which a service user has refused and strengthening challenges to treatment. The review also recommends providing in statute the right for people to express their choices in advance, and better recording of service users views.

Recommendations of particular interest here include proposing the introduction of statutory advance choices documents (ACDs) that enable adults to make a range of choices and statements about their care and treatment. Service users should also be able to request a second opinion appointed doctor (SOAD) review from once their care and treatment plan has been finalised or 14 days after their admission, whichever is the sooner; and again, following any significant changes to treatment. Service users should be able to appeal treatment decisions at the Mental Health Tribunal following a SOAD review. The review also recommends that mental healthcare providers should be required to demonstrate that they are co-

producing mental health services, including those used by service users under the MHA.

Family and carer involvement

The review recommends that service users should be able to choose a new nominated person to replace the current nearest relative role under section 26 of the MHA. A new interim nominated person selection mechanism should be created for those who have not nominated anyone and do not have capacity to do so. Nominated persons should have the right to be consulted on care plans, and to challenge treatment decisions before the Mental Health Tribunal where the service user does not have the capacity to do it themselves.

Advocacy

The review recommends enhancing and extending advocacy provision. Specifically, it recommends that the statutory right to an independent mental health advocate (IMHA) should be extended so that it includes all mental health inpatients, including informal patients. In addition, it should also include patients awaiting transfer from a prison or an immigration detention centre, as well as people preparing their advance choice documents that refer to detention under the MHA. IMHA services should be 'opt out' for all who have a statutory right to it, and the Care Quality Commission (CQC) should monitor access. Commissioning by local authorities should also be strengthened so that the requirement for IMHAs to be available to meet the needs of different groups, particularly ethnic minority communities, is made clear, in light of the public sector equality duty.

Complaints

The review makes a number of recommendations relating to complaints. Among them, it recommends that section 132 of the MHA should be amended to require managers of hospitals to provide clearer information on making complaints to patients and their nominated person. Information going to hospital boards should be separated between complaints made by patients detained under the MHA and complaints made by informal patients.

Deaths in detention

Lastly in this section, the review makes a number of important recommendations relating to responding to deaths in detention. It recommends that a formalised family liaison role should be developed to offer support to families of individuals who die unexpectedly in detention. Further, it recommends that guidance should make clear that a death under deprivation of liberty safeguards (DoLS) or liberty protection safeguards (LPS) in a psychiatric setting should be considered to be a death in state detention, as this would trigger the duty for an investigation by a coroner. An inquest with a jury should also be held.

PRINCIPLE TWO: LEAST RESTRICTION

Tackling rising rates of detention

In relation to tackling the rising rates of detention, the review states that there is "no clear single driver for the rising rates of detention" and that "similarly there is no simple solution to addressing them". Bringing rates of detention down will require government and other agencies to work together to develop a long-term approach, supported by better partnership working on the ground. The review calls for the government and national bodies to fund and undertake a major programme of research into service models, as well as clinical and social interventions, and their relationships to rates of detention.

The review heard of many examples of services providing alternatives to detention, as well as interventions to prevent a crisis or the escalation of crisis. These included a case study of a mental health crisis house run by Look Ahead Care and Support that was visited by Professor Sir Wessely. The service provides a non-clinical alternative to an acute hospital admission. The review recommends that there should be more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well. The government should resource policy development looking into alternatives to detention, and prevention of crisis.

Criteria for detention

Considering criteria for detention, the review states that there is "great value in patients being able to be treated as an inpatient voluntarily with their own

consent wherever possible, in line with the principles of least restriction and patient choice". It recommends that people should be treated as an inpatient with consent wherever possible. A service user's capacity to consent to their admission must always be assessed and recorded, including on the application form. In order to be detained under the MHA, the review states that a service user must be objecting to admission or treatment. Otherwise they should be admitted informally or be made subject to an authorisation under the framework provided under the Mental Capacity Act (MCA). Detention criteria concerning treatment and risk should also be strengthened.

A statutory care and treatment plan

The review recommends that a statutory care and treatment plan (CTP) is developed soon after the point of detention, which should evolve at each state of the process. This should be the responsibility of the responsible clinician (RC). The CTP should be in place within seven days and reviewed at 14 days. During the assessment period, the plan should be developed, so that by the time of a long-term order being imposed under section 3, there is a clear account of why detention is needed and what it seeks to achieve. The plan "will continue to develop during detention and should be updated before renewals of detention periods, and appeals to the tribunal. Increasingly it will focus on how to support the ending of detention and the aftercare that should be in place on discharge". The review sets out a number of components that should be covered within the plan. The new CTP is described as "a cornerstone" of the review, which will enable the delivery of all four key principles.

Length of detention

A further area of consideration for the review was how periods of detention could be shortened. The review recommends a number of changes to the code of practice. That includes amending the guidance so that, where a person has been subject to detention under section 3 within the last 12 months, an application for detention under section 2 can only be made where there has been a material change in the person's circumstances.

Further, the review states that the detention stages and timelines should be reformed so that they are less restrictive through a number of changes. This includes introducing a requirement for a second clinical opinion at 14 days of a section 2 admission for assessment, as well as extending the right of appeal for section 2 beyond the first 14 days. In addition, the review recommends introducing a new time limit by which a bed must be found following an order for detention, as well as requiring the RC and the approved mental health professional (AMHP) to certify ten days in advance of a tribunal hearing for section 3 that the person continues to meet the criteria for detention.

Challenging detention

During the review, the team heard from service users and carers that they would appreciate having greater access to the tribunal, and for the tribunal to have greater powers afforded to it. Careful consideration is paid to these questions in the review and a number of recommendations made. In doing so, the review makes clear that they have worked closely with the judiciary to develop their recommendations and are mindful of the need to undertake a full impact analysis for any future consultation.

The review recommends that the tribunal should have the power, during an application for discharge, to grant leave from hospital and direct transfer to a different hospital, as well as a limited power to direct the provision of services in the community. Among a range of other recommendations, it states that where the tribunal believes that the conditions of a patient's detention breaches the Human Rights Act 1998, they should bring this to the attention of the CQC. A statutory power should be introduced for IMHAs and nominated persons to apply for discharge to the tribunal on behalf of the service user. There should be an automatic referral to the tribunal four months after the detention started, then after 12 months and then annually after that. For part III patients, automatic referrals should take place once every 12 months.

The Mental Health Act or the Mental Capacity Act?

As the review points out, both the MHA and the MCA provide different legal frameworks to treat someone without consent, and to deprive them of their liberty by detaining, or confining, them in hospital. The MCA can only be used where the person lacks capacity

to consent to their confinement. Where the MCA is enacted, professionals must use the DoLS process to authorise detention and protect the patient's rights. The review states that "we have been particularly concerned to hear that the MHA has been used, at least in some cases, because it is easier to use than DoLS". Further it states that "we want to take use of the MHA back to the position that it can only be used for people who are obviously objecting to treatment".

The review makes a number of relevant recommendations here, including that only the MCA framework (DoLS, in future the LPS) should be used "where a person lacks capacity to consent to their admission or treatment for mental disorder but it is clear that they are not objecting". They further suggest that "a patient could be held in hospital for a statutory period of up to 72 hours under MCA LPS amendments whilst it is determined whether the person is objecting".

Community treatment orders

Introduced in 2007, community treatment orders (CTOs) are a form of supervised community treatment for people who had previously been detained in hospital under section 3. The review finds that, overall, "the academic literature currently does not give much support to the theory that CTOs reduce re-admission". Further, the review raises some concerns relating to the fact that a 'Black or Black British' person is over eight times more likely to be given a CTO than a white person.[3] On the other hand, the review states, they heard from service users, carers and professionals that there are a small number of people for whom CTOs represent the least restrictive option.

A large number of recommendations are made that are relevant to this issue, a number of which are highlighted below.

The review recommends that the criteria for CTOs should be revised in line with detention criteria. It further recommends that the onus should be on the RC to demonstrate that a CTO is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the service user and others. The evidence threshold should be raised for demonstrating that contact with services has previously reduced, and that this led to significant decline in mental health. Applications for a CTO should be made by the inpatient RC, with the community supervising clinician who will be responsible following discharge, and an AMHP. The nominated person/interim nominated person will have the power to object to both applications and renewals of CTOs.

CTOs should have an initial period of six months, renewed at the end of the first period, and then at 12 months. Each renewal must involve two approved clinicians and an AMHP, unless the tribunal has recently reviewed the order. CTOs should end after 24 months, though provision should be made for the RC to make a new application.

Coercion and restrictive practices

The review recommends that wards should not use coercive behavioural systems and restrictions to achieve compliance from patients, but should develop, implement and monitor alternatives. Further, providers should take urgent action to end unjustified use of 'blanket' restrictions applied to all service users.

PRINCIPLE THREE: THERAPEUTIC BENEFIT

The third principle underpinning the review is to achieve better and more therapeutic experiences for those who are detained under the MHA, as well as preventing crisis and the requirement for detention.

Care planning and aftercare

The review acknowledges significant issues with the complexity of the system and different sets of entitlements service users may have. The team heard of a number of issues relating to the provision of section 117, and say that they would have liked to have recommended the extension of aftercare to more categories of service users who may benefit from it. Within the current financial envelope they have concluded this is not possible in the short or medium term without the risk of creating further inequalities.

In the short to medium term they make a number of recommendations including the creation of a new high-quality care plan with a statutory footing. There should be a statutory care plan (SCP) for people in contact with community health teams, inpatient care and/or social care services. The SCP will encompass existing rights under the Care Act, NHS continuing healthcare and personalised budgets (and section 117 entitlements if someone has been detained on an eligible section). The new SCP should follow service users through the system, and incorporate the new statutory care and treatment plan when someone is detained, as well as discharge planning and aftercare provision.

The review recognises the value of better discharge planning. The period after discharge carries with it an increased risk of suicide. Being admitted as an involuntary patient can have major impacts in all aspects of someone's life, including housing, employment, welfare benefits and childcare. The review recommends that discharge planning should be improved, as part of the care and treatment plan during detention, to ensure it is being considered from day one, and should be recorded and updated in the SCP post detention.

Hospital visitors

Associate hospital managers (AHMs) are local, lay people appointed by the hospital or trust who have the power, on the behalf of hospital managers, to discharge service users. The review heard that there is no national job description or framework for the role of AHMs. There is no formal or ongoing training, nor a requirement for updated knowledge on National Institute for Health and Care Excellence (NICE) treatment standards. Some areas face challenges in recruiting AHMs that have experience of the ethnicity, culture, age and gender of the service users they are dealing with.

AHMs are described as a scarce resource, "hard-working, and committed to the task of participating in improving the way those with the severest illnesses are looked after". The review suggests that "if their discharge hearing function is removed, we think that they would have capacity to take on a new role which would enable them to make the most of these qualities". The review goes further to say that there would be value in replacing the current AHM role with a new hospital visitors role, the main purpose of which would be to monitor day-to-day life in the hospital and ensure that service users are treated with dignity and respect, that they receive the treatment they need, and that their rights are protected.

The review recommends that the managers of the hospital should continue to have the duty to scrutinise applications for detention and a duty to scrutinise renewal documents. The power of AHMs to order discharge following a hearing should be removed.

Inpatient social environments

The review is clear that commissioners and providers must do more to improve the social environments of wards. In doing so, they should learn from co-produced and service-user led initiatives such as Starwards and the Dragon Café.

The review recommends that the CQC should develop new criteria for monitoring the social environments of wards. These criteria should be the yardstick against which wards are registered and inspected, plus this should be reflected in ratings and enforcement decisions. It further recommends that service users should have a daily one-to-one session with permanent staff in line with NICE guidelines.

Inpatient physical environments

The review states that "detained patients... are often placed in some of the worst estate that the NHS has, just when they need the best". They further observe that "the physical environment of wards has become affected by an increasingly risk- and infection-averse approach which can create the kind of institutional atmosphere that psychiatry has been trying to move away from for the last half century, because of its negative impact on patient experience. For example, rimless toilets, heavy wipe clean armchairs, hard flooring and bare walls that are easier to clean, but absorb little sound make buildings oppressively noisy".

The review recommends that the physical environment of wards needs to be improved, through co-design and co-production with people of relevant lived experience, to maximise homeliness and

therapeutic benefit and minimise institutionalisation. Risk assessments of issues such as infection control should be designed specifically for mental health inpatient care, and not lifted from other health settings. The unintended psychosocial effects must also be considered. Further, it is recommended that a review should be undertaken of the physical requirements for ward design for mental health units (e.g. the building notes, regulatory standards). The design of this review should be co-produced with people with lived experience.

The backlog of maintenance and repairs needs to be addressed so that mental health facilities are brought up to standard, and all dormitory accommodation should be updated without delay to allow service users to have their own room. Definitions of single sex accommodation should be tightened up. Lastly, and critically, the review recommends that "the government and the NHS should commit in the forthcoming spending review to a major multi-year capital investment programme to modernise the NHS mental health estate".

PRINCIPLE FOUR: THE PERSON AS AN INDIVIDUAL

Person-centred care

The review is clear about the need to recognise individual and cultural needs, as well as strengths. Care must also be trauma informed, and the review notes the work of the Women's Mental Health Taskforce in this area. Maintaining contact with family and the outside world is also seen as vitally important.

The review recommends that the CQC should review and update their inspection and monitoring of individual treatment and care to provide assurance that it meets the needs of different minority groups. Reasonable adjustments should be made to enable people to participate fully in their care, including in relation to communication abilities.

Further to the above, the physical health of service users should be monitored, so that physical illness and conditions (for example diabetes and asthma) can be identified and treated. The CQC should pay particular regard to obtaining service user (and carer) input from those who might find it difficult to articulate their views, including those in secure and out-of-area placements, those with learning disabilities or autism and children and young people.

Recognition of patient individuality at the tribunal

The review recommends that training should be developed for panel members in specialisms including children and young people, forensic, learning disability, autism, and older people. Further to this, statistics should be collected on the protected characteristics of those applying for a tribunal hearing, and their discharge rates.

The experiences of people from Black, Asian and minority ethnic (BAME) communities

The review highlights the unacceptable inequalities experienced by people from BAME communities in terms of access, experience and outcomes from mental health treatment and care. Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the MHA.[4]

The review describes its recommendations here as representing "a shift in tackling racial inequalities by accepting that the structure of existing systems needs to change gradually to improve overall quality of services. The input of service users, carers and communities is crucial in achieving this change".

The review's primary recommendation relating to this issue is for an organisational competence framework (OCF) and a patient and carer experience tool to be developed and implemented first by the NHS, but ultimately for rollout to wider public services. This follows the recommendation of the Crisp Commission to identify a clear and measurable set of race equality standards for acute mental health services, which it was suggested should be developed to test whether the Workforce Race Equality Standard (WRES) is improving services.

The review endorses ongoing work by NHS England to develop an OCF for mental health – the Patient and Carer Race Equality Framework (PCREF). The review states that it believes that goals should focus

on several core areas of competence: awareness, staff capability, behavioural change, data and monitoring, and service development.

The review further recommends that regulatory bodies such as the CQC should use their powers to support improvement in equality of access and outcomes. The Equality and Human Rights Commission should make use of their existing legal powers to ensure that organisations are fulfilling their public sector equality duty. In addition, culturally-appropriate advocacy should be provided consistently for people of all ethnic backgrounds and communities, in particular for individuals of black African and Caribbean descent and heritage. Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.

The review makes some very specific recommendations relating to the workforce and ensuring this is more representative of the communities served. In line with the NHS Workforce Race Equality Standard programme, the review calls for greater representation of people of black African and Caribbean heritage in all professions, in particular psychology and occupational therapy. Further, people of black African and Caribbean heritage should be supported to rise to senior levels of all mental health professions, especially psychiatry and psychiatric research, psychiatric nursing and management.

Children and young people

While many of the recommendations made in other areas of this report also apply to children and young people, the review focuses on two areas in making some recommendations relating specifically to the needs of children and young people. Those are the legal basis for admission and treatment and proper safeguards and procedures.

The review recommends that legislation and guidance should make clear that the only test that applies to those aged 16/17 to determine their ability to make decisions in relation to admission and treatment is contained in the MCA. In young people under 16, competence should be understood in this context as the functional test under the MCA, although without the presumption of capacity that applies in relation to those over 16. Young people aged 16 or 17 should not be admitted or treated on the basis of parental consent. The MCA (DoLs or LPS) or MHA should be used as appropriate if they are unable to consent to their treatment.

Further, government should consult on the ability of parents to consent to admission and treatment for those under 16. Every inpatient child or young person should have access to an IMHA who is trained to work with young people and their families. In addition, every inpatient child or young person should have a personalised care and treatment plan which records the views and wishes of the child or young person on each issue. Initial reviews should take place within five days of emergency admission (or three days if it is to adult facility) and at a minimum of four-to-six weekly intervals after that.

Amongst a range of other recommendations, it is suggested that for children and young people placed in an adult unit, or out-of-area, the CQC should be notified within 24 hours. The CQC should record both the reasons for placement and its proposed length.

People with learning disabilities and autism

The review highlights a range of concerns about the way the MHA works for people with learning disabilities, autism or both. In brief, those recommendations are that health and social care commissioners should have a duty to collaborate to ensure provision of community-based support and treatment for people with a learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community. The review also recommends that the MHA code of practice is amended to clarify best practice when the MHA is used for people with autism, learning disabilities or both.

Further, the mental health services dataset should include specific data to monitor the number of detentions and circumstances surrounding that detention of people with autism, learning disabilities or both.

Policing and the Mental Health Act

The review notes that the use of police cells as places of safety has reduced by 95 per cent over the period

from 2011/12 to 2017/18. This is positive progress. We must build on this and strive to ensure that people experiencing a mental health crisis are treated with dignity and respect.

The review recommends that by 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the act and ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health-based places of safety being available.

Further to this, ambulance services should establish formal standards for responses to section 136 conveyances and all other mental health crisis calls. Ambulance commissioners and ambulance trusts should improve the ambulance fleet, including commissioning bespoke mental health vehicles. Equality issues, particularly police interactions with people from ethnic minority communities under the MHA, should be monitored and addressed. This should be under the proposed Organisational Competence Framework where possible.

Criminal justice system

A large number of recommendations are made by the review relevant to the provision of care of service users in the criminal justice system. These can be read in full in the report, but in part relate to the powers of magistrates' courts and tribunals. Further, it is recommended that prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the MHA. In addition, it is recommended that a new statutory, independent role should be created to manage transfers from prisons and immigration removal centres. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days.

System-wide enablers

In addition to the recommendations outlined above, the review also highlights a number of additional points where it calls for better use of data and leveraging digital technology to support efficiency and effectiveness. Specifically, the review recommends that an agreed, accurate national baseline of the use of mental health services should be established, following a pilot programme to develop robust methodology. Amongst other recommendations, it suggests that a national MHA data hub should be established to pull together and routinely analyse MHA data across NHS services, exploring possibilities for developing linkages across the various datasets, local authorities and policing.

In addition, NHS Improvement and NHS England should fund the establishment of a national quality improvement (QI) programme relating specifically to the MHA.

The review also makes a thoughtful consideration about the workforce and how this can be best supported. The review recommends the factors that affect the timely availability of section 12-approved doctors and AMHPs should be reviewed and addressed. The government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.

NHS England and NHS Improvement should consider the implications of the evidence linking staff morale and patient experience in the context of detained patients, and take action accordingly.

"The review recommends that by 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety"

The government's response

Responding to the publication of the report, Prime Minister Theresa May said:

"The disparity in our mental health services is one of the burning injustices this country faces that we must put right. For decades it has somehow been accepted that if you have a mental illness, you will not receive the same access to treatment as if you have a physical ailment. Well, that is not acceptable.

"I commissioned this review because I am determined to make sure those suffering from mental health issues are treated with dignity and respect, with their liberty and autonomy respected.

"By bringing forward this historic legislation – the new Mental Health Bill – we can ensure people are in control of their care, and are receiving the right treatment and support they need.

"I'm grateful to Prof Sir Simon Wessely and his team for their tireless work on this vitally important review".[5]

The government has stated it will issue a formal response to the review's recommendations in the new year before preparing to bring forward legislation.

On publication, the government said it accepts two of the review's recommendations to modernise the MHA. Those detained under the act will be allowed to nominate a person of their choice to be involved in decisions about their care. Currently, they have no say on which relative is contacted. This can lead to distant or unknown relatives being called upon to make important decisions about their care when they are at their most vulnerable. People will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.[6]

Mental Health Network viewpoint

On behalf of Mental Health Network members, we have previously shared our deep concerns relating to rising numbers of people being detained under the MHA and of the over-representation of people from BAME communities. We very much welcomed the announcement of this review in October 2017.

During the second phase of the review we were impressed by the strong focus on improving the patient experience and the level of engagement that was undertaken with a wide variety of stakeholders.

We welcome the recommendations that, if implemented, would allow patients a greater say in the care they receive while detained, and will provide alternatives to detention following years of rises in detention rates. Taken as a whole, the recommendations will also start to address the unacceptable disparity of rates of detention between different BAME groups.

The successful implementation of the review's recommendations is reliant on extra revenue and capital funding for mental health services, and we hope to see this reflected in the upcoming NHS long-term plan funding settlement and spending review. We welcome the government's initial response and look forward to working with them on plans to take these important recommendations forward.

References

1. HM Government (May 2018), ***The independent review of the Mental Health Act: Interim report***, [online pdf], accessed November 2018.
2. HM Government (December 2018), ***Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion. Final Report of the Independent Review of the Mental Health Act***, [online pdf], accessed December 2018.
3. NHS Digital (October 2018), ***Mental Health Act Statistics: Annual Figures 2017–18***, [online pdf], accessed November 2018.
4. Ibid.
5. HM Government (December 2018), ***Government commits to reform the Mental Health Act***, [online], accessed December 2018.
6. Ibid.

The Mental Health Network is the voice of mental health and learning disability service providers for the NHS in England. We represent providers from the not-for-profit, commercial and statutory sectors – including more than 90 per cent of NHS trusts and foundation trusts providing secondary mental health services. We work with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of our members and to influence policy on their behalf.

For more about our work, visit **www.nhsconfed.org/mhn** or email **mentalhealthnetwork@nhsconfed.org**

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Power of Discharge Sub Committee

29 March 2019

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

To improve health and provide excellent care

Report Title:	**Mental Health Act Committee and Power of Discharge Sub-Committee – future arrangements**
Report Author:	Dawn Sharp, Assistant Director and Deputy Board Secretary
Responsible Director:	Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	Following the request to examine the role and remit of the Health Board's Mental Health Act Committee (MHAC) and the Power of Discharge (POD) Sub-Committee this report sets out the background, legal advice and options available for the Committee to determine.
Approval / Scrutiny Route Prior to Presentation:	Director of Mental Health and Learning Disabilities and Chairman of the Committee.
Governance issues / risks:	No significant risks identified.
Financial Implications:	No additional funding currently required in respect of this paper.
Recommendation:	**That Members** **(1) agree to proceed with Option 3 and ask the Deputy Board Secretary to amend the Terms of Reference and cycle of business and seek approval of the Board with a view to implementing the new arrangements from September 2019;** **(2) consider options regarding future Chairing of the POD; and** **(3) consider the future frequency of meetings.**

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* – leadership and governance.			
Equality Impact Assessment An Equality Impact Assessment is not considered necessary for a paper of this type.			

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

Mental Health Act Committee and Power of Discharge Sub-Committee – future arrangements

1 Members will be aware of previous discussions and the request to examine the role and remit of the Health Board's Mental Health Act Committee (MHAC) and the Power of Discharge (POD) Sub-Committee essentially to ascertain what alternative solutions could be considered to address duplication in reporting between the two bodies. The suggestion from the Members was to give consideration to some form of merger.

2 As a result, a scoping exercise was undertaken to establish the arrangements in other Health Boards in Wales. The majority currently have both a MHAC and a POD with broadly similar business being presented.

3 Legal advice was sought in terms of options available and whether it would be permissible to disband the Mental Health Act Committee and transfer its responsibilities to the Quality, Safety and Experience (QSE) Committee, retaining the Power of Discharge Sub-Committee as a Sub-Committee of QSE.

4 The guidance issued by Welsh Government in 2010 (and model terms of reference) clearly states (in the footnotes):

'*LHB's may determine that the functions set out within the 'Mental Health Act Monitoring Committee' should be incorporated within the remit of the standing committee established to oversee all aspects of quality & patient safety. Alternatively it may be established as a sub-committee of that broader standing committee. The 'Hospital Managers Power of Discharge Committee' may also be set up as a sub-committee of that standing committee, although, unlike the Monitoring Committee, LHB's must establish a specific committee or sub-committee to perform this role'.*

5 NHS Wales Legal and Risk Services have confirmed that they have not been able to locate any updated guidance from Welsh Government since that issued in 2010. Whilst the Mental Health Act Code of Practice was updated in 2016, they have not been able to trace any updated guidance to accompany the 2016 Code of Practice. The 2016 Code of Practice does not provide the level of clarity produced in the 2010 guidance in respect of the two separate committees, however it says nothing that leads inevitably to the conclusion that the position has changed since 2010. Legal and Risk Services also reviewed the 2014 Mental Health Act Manual by Richard Jones and noted the following:

'special rules apply to the exercise of the hospital managers' power to discharge patients from detention or SCT...Otherwise, hospital managers (meaning the organisation, or individual, in charge of the hospital) may arrange for their functions to be carried out, day to day, by particular people on their behalf...unless the Act or regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way which their constitution or (in the case of NHS bodies) NHS legislation allows them to delegate their other functions...it is for the organisation (or individual) concerned to decide what arrangements to put into place to monitor and review the way in which functions under the Act are exercised in its behalf-but many organisations establish a Mental Health Act steering or scrutiny group especially for that task'.

6 In light of this, they concluded that it would be acceptable to disband the MHAC so long as its functions were transferred to the Quality, Safety and Experience Committee.

7 With respect to the Power of Discharge Committee, Legal and Risk Services believe that it is still the intention that this Committee stands alone. The 2008 Code of Practice clearly states:

'Section 23 (Mental Health Act 1983) gives hospital managers the power to discharge an unrestricted patient from detention or supervised community treatment (SCT). Discharge of a restricted patient requires the consent of the Secretary of State for Justice.

The power may be exercised on behalf of the hospital managers by three or more members of a committee or sub-committee ***formed for that purpose****. It is helpful to patients and staff that any such committee is referred to in a way which clearly indicates that the* ***committee is formed solely to consider whether hospital managers' power of discharge should be exercised'****.*

8 Whilst the above content is not repeated in the 2016 Code of Practice, they would not advise the Health Board to steer away from the guidance.

9 It would appear that this then leaves three potential options:-

- to retain the status quo
- to retain the POD Sub-Committee and disband the MHAC and incorporate
- the substantive business of the MHAC into QSE
- to retain both the MHAC and the POD but to rationalise the business
- currently being presented.

10 With regard to **Option 1,** members have already raised concerns about duplication and time constraints.

11 **Option 2** - Whilst the Health Board could move to a different model, Members of the Board may be concerned about doing this at a point when the Health Board remains in Special Measures, particular if then viewed as an outlier in Wales. Furthermore, the current workload of QSE is extensive and given it has only recently moved to bi-monthly meetings this arrangement needs to stabilise before QSE's workload is expanded.

12 **Option 3 – Preferred option** - Retain both the MHAC and the POD but rationalise the business currently being presented and hold both meetings on the same day (in a condensed timeframe of morning or afternoon). This would potentially mean changes to the agenda in the following areas:-

- Cease submitting separate IMHA, S136 and CAMHS reports as the data is already incorporated into the overarching performance activity report.

- Remove the MHM compliance section from the performance report as this is already presented to QSE.
- HIW updates – only present these to MHAC not the POD. These reports should only be where HIW have specifically made recommendations concerning the Mental Health Act. NB the wider HIW reports are presented to QSE.

Other Considerations

- Not all Health Boards have the Vice-Chairman of the Board acting as the Chair of the POD, some nominate another IM and Members may therefore wish to consider this further.
- Members may wish to reduce the frequency of meetings perhaps meeting three times per year instead of quarterly as at present.

RECOMMENDED: That Members

(1) Agree to proceed with Option 3 and ask the Deputy Board Secretary to amend the Terms of Reference and cycle of business and seek approval of the Board with a view to implementing the new arrangements from September 2019;
(2) Consider options regarding future Chairing of the POD; and
(3) Consider the future frequency of meetings.