Mental Health Act Monitoring Committee

Wed 07 December 2022, 14:00 - 17:00

Virtual Via Teams

Agenda

14:00 - 14:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

For Noting

1.3. Declarations of Interest

Chair

For Noting

14:00 - 14:00
0 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 12 October 2022

Chair

For Approval

2.1.1 Unconfirmed Minutes 12.10.22 MHAM Committee 7 December 2022.pdf (8 pages)

2.1.2. Committee Self Effectiveness Survey Outcome and Improvement Plan

Head of Corporate Governance & Board Business

For Approval

2.1.2 Outcome of Committee Self Effectiveness Survey MHAM Committee 7 December 2022.pdf (4 pages)
2.1.2a CTM IM Scrutiny Toolkitv7(inc all-Wales additions) APPROVED 23.2.22.pdf (21 pages)

2.1.3. Amendment to the Standing Orders - Schedule 2 MHAM Committee Terms of Reference

Head of Corporate Governance & Board Business

For Approval

2.1.3 Amendment to Standing Orders - Schedule 2 MHAMC ToR- Cover Paper 7 December 2022.pdf (3 pages)
2.1.3a Appendix 1 MHAMC TOR's MHAMC 7 December 2022.pdf (8 pages)

2.2. Items for Noting

2.2.1. Action Log

Chair

For Noting

2.2.1 Action Log MHAM Committee 7 December 2022.pdf (4 pages)

14:00 - 14:00
0 min

3. MAIN AGENDA

3.1. Matters Arising Not Previously Considered on the Action Log

3.2. GOVERNANCE

3.2.1. Organisational Risk Register

Director of Governance

There are currently no risks assigned to the Committee

14:00 - 14:00
0 min

4. IMPROVING CARE

4.1. MHA Operational Group Report

Robert Goodwin

For Discussion/Noting

4.1 Operational Group Report MHAM Committee 7 December 2022.pdf (9 pages)

4.2. . MHA Quarterly Activity Report /Breaches & Unlawful Detentions

For Discussion/Noting

4.2 Q2 2022-23 MHA Errors-Breaches MHAM Committee 7 December 2022.pdf (28 pages)

4.3. Risks Relating to the Monitoring of the MHA

Director of Primary, Community & Mental Health

For Discussion/Noting

4.3 Risks Related to the Monitoring of the MHA MHAM Committee 7 December 2022.pdf (5 pages)

4.4. HIW Report on CAMHS - Action Plan Progress Report

Dr Krishna Menon, Clinical Director

For Discussion/Noting

4.4 HIW Report on CAMHS Action Plan Progress MHAM Committee 7 December 2022.pdf (6 pages)
4.4a HIW Report on CAMHS Action Plan Progress MHAM Committee 7 December 2022.pdf (3 pages)

4.5. Crisis Care Concordat National and Local Update

Aaron Jones

For Discussion/Noting

4.5 Crisis Care Concordat National and Local Update 07 December 2022 [Draft].pdf (7 pages)
4.5.1 Appendix 1 Crisis Care Concordat MHAM Committee 7 December 2022.pdf (3 pages)
4.5.2 Appendix 2 Forum Structure MHAM Committee 7 December 2022.pdf (1 pages)
4.5.3 Appendix 3 Crisis Care Concordat MHAM Committee 7 December 2022.pdf (8 pages)
4.5.4 appendix 4 Crisis Care Concordat MHAM Committee 7 December 2022.pdf (7 pages)

4.5.5 Appendix 5 Crisis Care Concordat MHAM Committee 7 December 2022.pdf (8 pages)

4.6. Strategic Update from South Wales Police - To follow

SWP Colleagues

For Discussion/Noting

4.7. Strategic Update from Local Authority Partners - Oral

LA Partners

For Discussion/Noting

14:00 - 14:00
0 min

5. OTHER MATTERS

5.1. Committee Highlight Report to Board

Chair

5.2. Forward Work Plan

Chair

5.2 Forward Work Plan MHAM Committee 7 December 2022.pdf (3 pages)

5.3. Any Other Urgent Business

Chair

5.4. How did we do today?

Chair

14:00 - 14:00
0 min

6. DATE AND TIME OF NEXT MEETING

Chair

8 March 2023 at 2:00 pm

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT MONITORING COMMITTEE HELD ON 12 OCTOBER 2022, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Jayne Sadgrove	-	Independent Member/ Health Board Vice-Chair (Chair)
Mel Jehu	-	Independent Member

IN ATTENDANCE

Julie Denley	-	Director of Primary, Community & Mental Health
Philip Lewis	-	Head of Nursing, Mental Health
Robert Goodwin	-	Service Group Manager, Mental Health
Alyson Jones	-	Merthyr Tydfil County Borough Council
Angela Edavene	-	Merthyr Tydfil County Borough Council
Colin Hatherley	-	South Wales Police
Ana Llewellyn	-	Head of Nursing, Primary, Community, Mental Health & Learning Disabilities Care Service Group
Wendy Penrhyn-Jones	-	Head of Corporate Governance and Board Business

PART 1. PRELIMINARY MATTERS

MHA/22/10/1 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting.

MHA/22/10/2 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Geraint Hopkins, Independent Member, James Hehir, Independent Member, Aaron Jones, Clinical Service Group Manager, Benjamin Collins, Service Manager, Welsh Ambulance Services NHS Trust, Alexandra Beckham, RCT CBC, Dr. Mary Self, Consultant Psychiatrist, and Kathrine Davies, Corporate Governance Manager.

MHA/22/10/3 **DECLARATIONS OF INTERESTS**

There were no interests declared.

PART 2. CONSENT AGENDA

MHA/22/10/4 **'UNCONFIRMED' MINUTES OF THE MEETING HELD ON 8 JUNE 2022**

Resolution: The minutes were **APPROVED** as a true and accurate record.

MHA/22/10/5 **COMMITTEE DRAFT ANNUAL REPORT 2021-22**

Resolution: The Annual Report was **APPROVED.**

MHA/22/10/6 **HOSPITAL MANAGERS FEES REVIEW**

Resolution: The Report was **NOTED.**

MHA/22/10/7 **ACTION LOG**

The Chair made reference to the fact that some of the Actions had been on the Action Log for some time and required a definitive update. The Chair requested that all completed actions be removed from the summary for the next meeting.

Resolution: The Committee **NOTED** the Action Log.

Action: To update the live actions captured in the Action Log and delete completed items by the next meeting.

PART 3 - MAIN AGENDA

IMPROVING CARE

MHA/22/10/8 **MHA OPERATIONAL GROUP REPORT**

R Goodwin presented the report, which provided Members with an update on the work of the MHA Operational Group.

The process for reviewing policies and the appropriate route for them to be signed off either through the Operational Group or the Committee/Health Board was discussed. It was agreed that this would be clarified with the Assistant Director of Governance and Risk and the response shared with the Committee outside of the meeting.

A. Jones referred to page 5 of the report and the concerns raised with regard to the Place of Safety accommodation provided at Prince Charles Hospital and advised that they had undertaken a walkabout visit where it had been deemed as unsafe and unsuitable for patients and also for lone workers. P. Lewis, in response, advised that a risk assessment had been carried out and proposals made for a room without ligature points and with an adjacent room to allow staff to make required phone calls and arrangements whilst keeping people safe.

J. Denley advised that there were moves to not have the crisis team based in the emergency departments as the only people who should be attending the emergency departments were those who were medically unwell and required acute medical intervention. A broader re-think as to what the Health Board offered in terms of emergency access and places of safety was required. It was suggested that this medium term piece of work could be picked up via the Crisis Care Concordat, NHS 111 and the Operational Group around what the future should look like in terms of the emergency pathway and places of safety for the Health Board.

M. Jehu advised that he was a member of the Prince Charles Hospital Ground and First Floor Project Group and could follow this up at their next meeting.

C. Hatherley referred to the discussions with regard to the issues with the Place of Safety at Prince Charles Hospital and advised that he was pleased that this was being escalated as not fit for purpose and also that the Emergency Department not being a future place for the crisis team. He would be happy to attend any meetings on behalf of South Wales Police.

J. Sadgrove requested an update on progress in this matter at the next meeting.

J. Sadgrove referred to the request for additional Hospital Managers and queried whether it was this Committee that made those decisions. R. Goodwin advised that it was the Power of Discharge Committee and that reported into the Committee via the Operational Group report.

A. Llewellyn advised that it was quite difficult to recruit Hospital Managers as they tended to come from a particular demographic of society and did not necessarily represent the wider community. There were often risks of not having Managers in place when those

currently performing this role reached the end of their term. She advised that she would review the policy on this.

J. Sadgrove referred to paragraph 2.5 and queried whether there had been any progress on the adolescent bed on Ward 14 and if the statement of need had been submitted for Capital funding. R. Goodwin advised that further information was required from the Estates Department to complete the statement of need. J. Denley, in response, advised that she would escalate this.

J. Sadgrove referred to the Section 117 aftercare and noted the limited number of discharges and the legal advice that had recently been received and sought an update. R. Goodwin advised that the discharge required patient approval that sometimes could be difficult to obtain. A process was going to be re-introduced where there were regular reviews by the multi-disciplinary and clinical teams.

A. Jones advised that there should be at least a minimum of an annual review for any individuals who were subject to a Care Treatment Plan (CTP) and the commissioning team would make sure they were more frequent if they were out of area because of the costs associated to these. The difficulty in discharging they had found in Merthyr Tydfil, was due to the annual reviews being minimally set. If a patient was on a medication such as an anti-depressant they could not discharge.

J. Denley, in response, advised that it might be helpful as part of the review of the policy to look at this alongside the legal advice that had been received.

J. Denley referred to the Consent to Treatment policy and suggested that the review of this policy be given priority as it could have serious implications for people and their treatment.

Resolution: The Committee **NOTED** the Report.

Action: Clarify the position in relation to sign-off of policies and circulate response to the Committee.

Action: Statement of need for the Place of Safety at Prince Charles Hospital to be escalated.

Action: Broader piece of work around the crisis team to be picked up via the Crisis Care Concordat, NHS 111 and the Operational Group.

MHA/22/10/9 **MENTAL HEALTH ACT QUARTERLY ACTIVITY REPORT/ BREACHES/ANALYSIS OF UNLAWFUL DETENTIONS**

P. Lewis presented the report that provided the Committee with an overview of MHA activity for Adult, Older Persons and Child & Adult Mental Health Services (CAMHS) for Quarter 1 April – June 2022.

A. Llewellyn referred to the fundamentally defective errors and commented that it was good to see the outcome for the patient on the second case. However, she queried how the risk had been managed for the first patient and how they had reached the outcome. P. Lewis undertook to confirm the position and later in the meeting verbally confirmed the answer to this question.

M. Jehu referred to the decrease in Section 136 Detentions and applauded the work that had been undertaken in this area. He highlighted the legal difference between errors and breaches. J. Denley advised that the Committee at a previous meeting had received some all Wales benchmarking data where it showed that the Health Board was in a good position.

J. Sadgrove queried whether there would be a quality group set up within the new Care Group structure specifically for Mental Health. A. Llewellyn advised that they had drafted the quality governance arrangements for the Mental Health Care Group and there would be oversight at Care Group level.

J. Sadgrove advised that it was pleasing to see the performance improvements as set out within the report and queried whether the data could be presented as 3 localities and as CTM wide to enable the Committee to scrutinise the position across the health board area.

Resolution: The Committee **NOTED** the report.

Action: Graphs to show three locality areas and CTM wide position.

MHA/22/10/10 **RISKS RELATING TO THE MONITORING OF THE MENTAL HEALTH ACT**

J Denley presented the report that provided an overview of the current risks relating to the monitoring of the Mental Health Act for Quarter 1 April – June 2022.

J. Sadgrove thanked J. Denley for her report and advised that the Committee had noted the breaches and the work that was being done to prevent reoccurrence. She queried whether reviews were

undertaken for the previous two to three years to see if there was a particular pattern in breaches as opposed to errors. J. Denley advised that pre-pandemic they undertook a review to establish if there were any themes and suggested that this piece of work could be assigned to the new Care Group responsible for mental health services which could prepare a report for the Committee in six months time. J. Sadgrove advised that this could be added to the Forward Work Plan to receive a future update on this work in 2023.

Resolution: The report was **NOTED**

Action: Care Group to review back in relation to any themes and patterns in terms of breaches for six months time.

MHA/22/10/11 **USE OF THE MHA FOR PATIENTS WITH A LEARNING DISABILITY**

R. Goodwin provided the Committee with verbal update on the use of the MHA for patients.

J. Sadgrove thanked R. Goodwin for his report and advised that it was important that the Committee were sighted on this but also going to be received at the Quality & Safety Committee.

Resolution: The verbal update was **NOTED** and **AGREED** that a written report would be received at the next meeting.

MHA/22/10/12 **STRATEGIC UPDATE FROM SOUTH WALES POLICE**

C. Hatherley provided a verbal update to the Committee and advised that for future meetings of the Committee a report would be provided to review the statistics and set out performance from an all Wales perspective.

A. Llewellyn referred to the 80% figure that had been quoted and queried whether that was conversion from the S136 to admission. C. Hatherley advised that it was, however, he would look into the detail on the statistics outside of the meeting to confirm if it was correct.

M. Jehu thanked C. Hatherley for his verbal report and advised that he had been a constant on this Committee and his contribution was very much welcomed.

Resolution: The Committee **NOTED** the verbal update.

Action: Written Strategic Reports to be received at future meetings of the Committee.

MHA/22/10/13 **UPDATE FROM SOUTH WALES POLICE ON THE USE OF THE MH APP**

C. Hatherley provided a verbal update on progress on the use of the mental health App.

A. Jones advised that although the numbers were decreasing they had concerns around being unable to make contact with the Police when calling one on one and sometimes could be waiting over an hour to get through and then told to ring 999. She advised that the Police have to be present to execute the warrant. In response, C. Hatherley advised that NHS 111 were aware that they had changed their processes in terms of local policing and this had now been delegated to bronze inspectors, one in North Wales and one in South Wales and the new process had experienced teething problems which had been highlighted and escalated at a senior management team level.

Resolution: The Committee **NOTED** the verbal update.

MHA/22/10/14 **STRATEGIC UPDATE FROM LOCAL AUTHORITY PARTNERS**

A. Edavene provided the Committee with a verbal update.

A. Jones referred to the mental health assessments and advised that it was particularly difficult for Advanced Mental Health Practitioners (AMPs) with the lack of medical cover in Merthyr to be able to request doctors to come out to undertake Mental Health Act Assessments and any support from the local authority would be welcomed.

J. Denley, in response, advised that there were no immediate solutions to the medical issue but there were a couple of jobs out to advert which were attracting interest. She advised that the Operational Group could track this and scope the risks again to help articulate the extent of the issue to the relevant bodies.

Resolution: The Committee **NOTED** the verbal update.

Action: Operational Group to scope the risks around medical cover in Merthyr to articulate the extent of the issue to relevant bodies.

PART 4 – OTHER MATTERS

MHA/22/10/15 **TO DISCUSS AND AGREE THE COMMITTEE HIGHLIGHT REPORT TO BOARD**

Resolution: The Committee considered items to include within the report and **AGREED** that the report would be prepared by the Governance Team following the meeting.

MHA/22/10/16 **FORWARD WORK PLAN**

The Chair advised that if there were any suggested items for future meetings to relay these to the Governance Team. J. Denley suggested that once the Care Groups were fully set up and running that the Forward Work Plan be reviewed to set up a new work programme for the Committee for six months' time.

Resolution: The Forward Work Programme was **NOTED.**

MHA/22/10/17 **ANY OTHER URGENT BUSINESS**

MHA/22/10/18 **HOW DID WE DO TODAY**

The Chair invited members to comment and reminded them that they could also relay feedback outside of the meeting.

MHA/22/10/19 **DATE AND TIME OF NEXT MEETING**

- 7 December 2022 at 2:00 pm

AGENDA ITEM
2.1.2

MENTAL HEALTH ACT MONITORING COMMITTEE	
OUTCOME REPORT: MENTAL HEALTH ACT MONITORING COMMITTEE EFFECTIVENESS SURVEY	
DATE OF MEETING	7TH December 2022

PUBLIC OR PRIVATE REPORT	**PUBLIC**

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
EXECUTIVE SPONSOR APPROVED	Assistant Director Governance & Risk

REPORT PURPOSE	**FOR NOTING**

ACRONYMS	
Nil	

1. PURPOSE

1.1 The Chair of the Mental Health Act Monitoring Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, the Committee are required to undertake an annual self-assessment questionnaire.

1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relating to its activities and performance during 2021/22.

1.3 Members should note that nine responses were received.

2. SUMMARY REPORT

Positive Assurance	**1. Committee Effectiveness:** There was a clear consensus that Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee and were reviewed annually. • A Committee Annual Report was produced and reported to the Board to provide assurance that the Committee considers activity consistent with its remit. • A Committee Annual Cycle of Business had been established to be dealt with across the year. **2. Committee Business** • Members of the Committee felt that they met with sufficient frequency to deal with planned matters in an effective manner. • The Committee was felt to be adequately supported by the meeting secretariat. • The Committee felt that the meetings were effectively Chaired with clarity of purpose and outcome. Feedback reflected that the Chair was very proficient and facilitated discussion with Members being encouraged to participate. • It was felt in the main where meetings of the Committee were held in private that these had been used appropriately for items that should not be discussed in the public domain. Feedback reflected that these meetings were used sparingly and appropriately. • The Committee were of the opinion that each agenda item was 'closed off' appropriately so it was clear what the conclusion was. • Members felt that the boundaries between this Committee and other Committees were clearly defined with adequate cross-referral if required. **3. Behaviour, Culture and Values** • The meeting behaviours of Members/Attendees were considered to be courteous and professional. • It was felt that the atmosphere at the meetings were conductive to open and productive debate. **4. Welsh Language** • Meetings through the medium of Welsh was supported if it was the preferred language of any of the Members/Attendees. Appropriate

	arrangements for translation would be necessary in such circumstances.
Areas of Note	**1. Committee Effectiveness** • The Terms of Reference were reviewed and approved at its July 2022 meeting as part of the annual review basis prior to subsequent approval by the Health Board in September 2022. • The Committee **received** and approved its Annual Report for 2021-22 at its October 2022 meeting and was submitted to the Board in November 2022. • The Committee Cycle of Business has been implemented to further complement the Forward Work Programme and was approved by the Committee at their March 2022 meeting. **2. Committee Business** • The Mental Health Act Monitoring Committee utilises a Consent Agenda system for routine business consideration. Members are aware that should they consider that any item on consent requires further assurance and scrutiny then it will be moved to the main agenda for discussion. • As with all Board Committees, the Committee, where sufficiently urgent can consider any item 'Out of Committee' via 'Chairs Urgent Action'. • Highlight reports are produced following each meeting so that the Board is kept informed of the nature of the issues considered and any decisions reached. These reports are available as part of the 'public' Board papers to demonstrate the Health Board's commitment to openness and transparency. Feedback reflected that the Highlight reports were succinct and to the point.
Areas Requiring Further Consideration	**Committee Effectiveness - Areas for action/improvement** were identified as follows: • Whilst virtual meetings have been a positive experience **overall** and that it had been convenient in that they had enabled scrutiny to continue, feedback reflected that it also enabled better use of time and less harmful to the environment as Members were not travelling to the meeting. However, it was felt that it did reduce networking opportunities.

	• With regard to whether members felt that the Committee was adequately supported by Executive Directors in terms of attendance, quality and length of papers and responses to challenges and questions' feedback reflected that challenges and questions were welcomed and that whilst the quality of reports were improving more could be done to present information more succinctly. • There was, in the main, consensus that Members/Attendees considered that they had sufficient training and support to fulfil their role, however feedback reflected that ongoing briefings on matters relevant to the work of the Committee would be helpful and for new and external members commented that any training in relation to the Act would be beneficial.
Action Plan	In response to the areas of improvement identified the following actions are proposed: • The Committee could consider the possibility of holding a face to face meeting during the year to allow for networking and relationship building which is sometimes lost when meetings were held virtually. • Report authors needed to give consideration as to how they could present reports in as succinct a way as possible whilst retaining key points and relevant reference to trends etc. • Training for Members of the Committee on the Mental Health Act was offered to Members each year. Members may benefit from referencing the IM Scrutiny Toolkit particularly when mentoring new Members.
Appendices	Independent Member Scrutiny Toolkit.

3. Recommendation

3.1 The Committee is asked to **NOTE** the report.

INDEPENDENT MEMBER (IM) SCRUTINY & ASSURANCE TOOLKIT

BACKGROUND

- Health Boards are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties.
- Health Boards principle role is to ensure the effective planning and delivery of the local NHS system.
- Board membership comprises of Executive Directors & IMs, who form part of the corporate decision-making body and have equal voting rights.
- IMs are involved at a strategic level - responsibility for operational decisions sits below Board.
- Each organisation has a range of committees which are responsible for providing advice and assurance to the Board on areas within their remit. This is the primary area where scrutiny is focused.

OVERVIEW OF IM SCRUTINY ROLE

- To participate as members of identified Committees and Board with regular attendance, with the expectation that papers will be made available one calendar week before each meeting to allow them to be read ahead of the meeting
- Responsible for supporting the Chair in being clear about the information needed in order to discharge their role, including assurance and scrutiny
- Satisfying themselves of the integrity of financial and quality intelligence, including getting out and about, observing and talking to patients and staff (walkarounds/ambassadorial role).
- Sharing collective responsibility for decisions.

DIVERSE NATURE OF IM ROLE


Strategy


Support


Stretch


Stakeholder


Scrutiny


Safety

The role can change from meeting to meeting as well as during a meeting as the agenda progresses

INDEPENDENT MEMBER FOCUS

Oversight	Insight	Foresight
Assurance and Compliance Systems and processes. Monitor performance and track how things are going. Understanding the risks inherent to the Health Board's activities– risk appetite and tolerance of failures.	What is going on and Why? Pause, step back and look at the big picture. Bring people together – look at the interactions between various parts of the organisation and its partners. Discover the Important things Determine What Indicators Matter. Real-time data driven decision-making.	What could happen in the future? Constant horizon scanning for opportunities and threats. Embrace multiple viewpoints and listen to diverse voices. Clear thinking about "what" must be anticipated or undertaken. Forecasting policy implications Leading for the Future – aligned to the strategic direction Scenario based decision making.

AGENDA PLANNING

- Maximise the use of the Consent Agenda to ensure that adequate time is made on the Main Agenda for business critical, strategic matters.
- Agenda planning meetings are key and include both Chairs and Vice-Chairs.
- Consider the length of the meeting – is adequate time aligned to each item to allow for appropriate focus on the issue – enabling appropriate challenge to gain assurance?
- Are there a mix of topics on the agenda (strategic / assurance) which balance the remit of the meeting?
- Ensure that each agenda item has a clear purpose and desired outcome.
- Use the Risk Register, Integrated Performance Dashboard, information gained from walkabouts and staff sessions plus stakeholder feedback, benchmarking and audit reports to steer and plan the agenda to focus on business critical activity.

FOCUS OF PAPERS

- Exception based reporting. Report templates are key as they guide to the purpose and the desired outcome.
- Is it clear why items are being presented? If not, make this point in the meeting. Focussed papers help manage the effectiveness of meetings avoiding them running over time.
- Ask yourself “so what?”. If this isn’t clear, let the presenter know.
- Appropriate challenge leads to assurance – acknowledging that some further actions may be necessary to manage risks
- Minimise duplication – ‘Less is More’ – avoid information overload i.e. discourage the use of appendices.
- Encourage visualisation tools by praising them when they are used – interactive, presentations, videos.
- Look for consistency across papers – aligned to strategic objectives, consistency of messaging and praise when you see this.

REPORT PRESENTERS

- Teeing-up discussion – be clear that you will be taking the paper as read and seek only new or changed information from the presenter over that which is covered in the report.
- Ensure a consistent approach. Some presenters are more engaging or have a topic that may interest you more – don't get swayed by this, manage the item for the purpose it is there.
- Is there contradictory evidence, are there clear logical explanations showing an improving trend?.
- Feedback / request changes if you consider that you are not receiving the right information at the right time in the right way – also use triangulation to help bolster the position – are all the necessary steps being taken to address the position?.

EXECUTIVE COLLABORATION

- Executive portfolio representation in meetings and integrated executive working - are the right people in the room? If not, why not? Bring other officers into the discussion to add their perspective on an issue out of their portfolio to add richness to the discussion.
- Encourage Executives to call upon one another to share presentations of items as appropriate.
- Consider if it would be helpful to have a meeting with the Executive lead prior to a Board Committee taking place to set out the points which may need further clarification at the Committee?

ROLE OF THE COMMITTEE CHAIR

- Setting the tone, tee-up the desired focus of discussion. Keep everyone focussed - Adhoc presenters may need support if not familiar with the setting.
- Consider if it would be helpful for the Committee Chair to have a pre-meet with other IMs ahead of the meeting to look at the issues and decide how these are best managed during the meeting?
- Ensure you have read the Chairs Brief and that it has been shared with the Vice Chair.
- Managing the Time – set clear expectations for presenters on timings. This can be planned at agenda planning stage by including timings on the agenda, and reiterated when introducing the agenda item at the meeting. Do not allow discussions to stray into operational territory.
- Lead by example and consider how other IM's can complement the Chair – tag team each other.
- Give the Vice-Chair an opportunity to Chair Committees under the guidance of the Committee Chair (at least once per annum)
- Clearly sum-up the conclusions of the discussion, suggest SMART objectives be used to measure delivery of actions, noting the resolution agreed to ensure everyone is clear on the outcome and next steps

MEETING CULTURE

- Commitment
- Enthusiasm
- Preparedness
- Style of contributions – scrutiny which constructive/supportive challenge, not criticism/deconstructive feedback.
- Use the right questions for the right circumstances – use powerful questions (e.g. what do we need to do to ensure….)
- Consider whether there are strong personalities influencing items.
- Create the right atmosphere in the room, encouraging openness and transparency with professionalism
- Adherence to Virtual Meeting Etiquette principles.

IM LISTENING

Passive listening (focusing on encouraging speaker to open up)

- Avoid being judgemental or defensive
- Avoid expressions like ‘that’s good’, ‘excellent’, ‘that’s right’,
- Instead use responses such as:
  - Tell me more about…
  - Is there something else we could be doing to improve…
  - I’m interested to hear what you think of …
  - I’d like to hear what you feel about …

Active listening (to check understanding)

- It seems that you…
- Let me see if I understand you

IM QUESTIONING

- Asking concise, strategic and purposeful probing questions to clarify issues. Your role is to scrutinise the information presented and seek assurance that the Health Board is achieving its strategic objectives.
- Recognise the difference between being reassured and receiving assurance
- Often the most 'obvious' or simple questions lead to the most insightful answers – remember to ask about the obstacles and risks to delivery and what can be done to support delivery.
- Avoid venturing into the operational detail, remain focussed on the what, why and when rather than the 'how'.
- Avoid commentary.
- Use secondary 'follow-up' questions to ensure you gain the assurance you need.
- Triangulation of intelligence – seek opportunities to cross-reference reports, comments made and different perspectives/contributions.
- Ensure questions are not just confined to the consent agenda.
- Questions asked on consent agenda may be worthy of exploring further in the main meeting.
- Equitable questioning / contributions are essential, mentor new Members as necessary.

EXAMPLES OF ISSUES TO CONSIDER AND QUESTIONS TO ASK;

Does the management response accurately reflect the audit recommendations?

How do we know that the assurances provided draw appropriate attention to risks, weaknesses and/or areas for improvement which should be addressed?

How is learning shared across the Health Board to avoid duplication and learn lessons?

What assurance is being provided that the recommendations are being implemented, monitored and followed up?

How was this issue escalated to ensure due process was followed?

What sources of secondary or independent evidence could support the perspective set out in the report?

What are the obstacles including risks to delivery and how can actions be supported?

ASSURANCE ‘V’ REASSURANCE

Assurance: being assured because the Committee/Board has *reviewed* reliable sources of information (evidence) and *is satisfied* with the course of action

Reassurance: being *told* by the Executive and staff that performance actions are satisfactory

ORGANISATIONAL INSIGHT

- What assurance can you provide that the plans are meaningful and underpinned by robust evidence?
- How do we know that we have an appropriate level of understanding of the purpose and work of the organisation when setting strategy?
- How do we know that the Board has clearly articulated and communicated its risk appetite?
- How do we know we are monitoring performance and quality against the most appropriate standards?
- How does the issue under discussion support the achievements of the Health Board's strategic goals?
- What assurance can you provide that demonstrates that there is effective and accurate budgeting and in-year forecasting?

ORGANISATIONAL INSIGHT

- Triangulate – what has been seen / heard during walkabouts and what appears in reports.
- Ensure regular contact and discussion with senior leaders at the organisational level
- Obtain softer intelligence outside of the meeting – e.g. site visits
- Where appropriate, consider a deep-dive – aligned to key indicators – risk register, integrated dashboard and audit reports (Internal & External), explore stakeholder feedback and benchmarking data.

CROSS-COMMITTEE WORKING

- Minimise cross-committee referrals to remove unnecessary duplication
- Referring where appropriate:
    - What are you referring?
    - Why are you referring it?
    - What is the outcome that you are anticipating from this referral?
- Regular catch-ups with other Committee Chairs

GOVERNANCE FRAMEWORK

- Standing Orders
- Standards of Behaviour Policy (Nolan Principles)
- IM Role Descriptions
- Board Secretary – is a source of advice and support to the Health Board Chair and other Board Members. Has the role of being the guardian of good governance.
- Business Intelligence – scrutiny of service delivery performance reports including the organisational annual report.
- Risk Register & Board Assurance Framework – aid understanding of issues requiring scrutiny.

ESCALATION TO THE BOARD

- The Committee Chair will approve the Highlight Report to the Board following each meeting
- Focussed updates – using the Highlight Report Template
- ‘Assurance’ versus ‘Reassurance’
- ‘Cascade’ versus ‘Escalate’
- Where ‘escalate’ it will ensure discussion on the main agenda at Board

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OUR VALUES HELP US BE AT OUR BEST

WE LISTEN, LEARN AND IMPROVE

WE TREAT EVERYONE WITH RESPECT

WE ALL WORK TOGETHER AS ONE TEAM

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
2.1.3

MENTAL HEALTH ACT MONITORING COMMITTEE

AMENDMENT TO STANDING ORDERS – SCHEDULE 2.

Date of meeting	7th December 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kathrine Davies, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Assistant Director of Governance & Risk
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

ACRONYMS	
SO	Standing Orders

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.2 **Standing Orders – Schedule 2. Mental Health Act Monitoring Committee Terms of Reference.** The Terms of Reference are included at Appendix 1. Proposed changes are identified in **red**. The Committee is asked to endorse for Board approval.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 If endorsed, the Standing Orders will be presented to the Board for approval at their meeting to be held on 26th January 2023.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **ENDORSE** for Board Approval:

- The amendments to the Health Board's Standing Orders as outlined in section 2 of this report.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 1

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

MENTAL HEALTH ACT MONITORING COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

INTRODUCTION

The CTMUHB Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **Mental Health Act Monitoring Committee**- "the Committee**"**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

CONSTITUTION AND PURPOSE

The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

SCOPE AND DUTIES

The Committee shall consider:

- how the delegated functions under the Mental Health Act are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the Mental Health Act 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice
- Develop an annual report for presentation to the Health Board.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Mental Health Act Monitoring Committee has a key role in assisting the Board to fulfil its oversight responsibilities to ensure it is operating effectively and in accordance with legislation.

Hospital Managers may arrange for their functions under the Mental Health Act to be carried out on a day to day basis by particular Officers on their behalf. (COP 11.7) The arrangements for authorising decisions has been set out in a Scheme of Delegation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
  - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

Related Sub Groups

- Mental Health Act Monitoring Operational Group

- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:
A minimum of **(4)** members, comprising

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board

The 1983 Act is operated by health and social care practitioners, in collaboration with a range of agencies including police and ambulance services, as well as third sector bodies such as advocacy providers. Membership of the Committee should reflect this, as different agencies and practitioners have differing responsibilities and duties under the Act.

The Vice Chair of the Health Board shall Chair the Committee given their specific responsibility for overseeing the Health Board performance in relation to mental health service.

Attendees

- Chief Operating Officer
- Director of Primary, Community & Mental Health
- Representative from South Wales Police
- Representative from Rhondda Cynon Taf County Borough Council
- Representative from Merthyr Tydfil County Borough Council
- Representative from Bridgend County Borough Council
- Chair of Mental Health Act Monitoring Operational Group
- Head Administrator - Mental Health Act Administration Team
- Carer Representative from the Together for Mental Health Partnership Board

- Representative from Welsh Ambulance Services Trust (minimum twice per annum)
- Clinical Director for Mental Health
- Head of Nursing for Mental Health Merthyr Cynon Locality Group (minimum twice per annum)
- Mental Health Clinical Service Group Manager Bridgend Integrated Locality Group
- Mental Health Clinical Service Group Manager Rhondda & Taff Ely Integrated Locality Group
- Clinical Director, Child & Adolescent Mental Health Service (CAMHS) (minimum twice per annum)
- Head of Nursing CAMHS

By Invitation:

- Other Directors /Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of training, specific support or organisational development for Committee Members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
This will comprise of ~~one~~ two Independent Members, the Director of Primary, Community and Mental Health or the Assistant Director; a representative from the partner organisations either from the South Wales Police, Local Authorities or the Welsh Ambulance Services NHS Trust and also at least one clinical representative.

Frequency of Meetings
Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the Health Board's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year

- bring to the Board's specific attention any significant matters under consideration by the Committee

- ensure appropriate escalation arrangements are in place to alert the LHB Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the LHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in relation to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board

Reviewed 8th June 2022 at the MHAM Committee and no changes made.

ACTION LOG - MENTAL HEALTH ACT MONITORING COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at November 2022)
MHA/22/10/8	October 2022	**Operational Group Report** Clarify Position in relation to sign-off of policies and circulate response to the Committee.	Head of Corporate Governance & Board Business/Chair/Clinical Lead Operational Group	October 2022	**Completed** Clarification sent via email on the 12.10.22
MHA/22/10/8	October 2022	**Operational Group Report** Statement of need for the Place of Safety at Prince Charles Hospital to be escalated	Director of Primary Care & Mental Health	December 2022	**Completed** Crisis Team Assessment room now identified and work will begin shortly to meet anti-ligature requirements. This is a temporary position to be reviewed in March 2023 with Locality Director of Nursing.
MHA/22/10/8	October 2022	**Operational Group Report** Broader piece of work around the crisis team to be picked up via the Crisis Care Concordat, NHS 111 and the Operational Group.	Director of Primary Care & Mental Health /Chair/Clinical Lead Operational Group	December 2022	**Completed** On Agenda for December 2022
MHA/22/10/9	October 2022	**MHA Quarterly Activity Report** Graphs to show three locality areas and CTM wide position.	Chair/Clinical Lead Operational Group	December 2022	**Completed** Activity and breaches report now includes timeline for each locality.

MHA/22/10/10	October 2022	**Risks Related to the Monitoring of the MHA** Care Group to review back in relation to any themes and patterns in terms of breaches for six months time.	Primary Community & Mental Health Care Group	April 2023	**In Progress** **Added to Forward Work Plan**
MHA/22/10/11	October 2022	**Use of the MHA for Patients with a Learning Disability** Written report to be received at the December 2022 meeting.	Chair/Clinical Lead Operational Group	December 2022	**Completed** Written update contained within Operational Group Report for December 2022 meeting.
MHA/22/10/12	October 2022	**Strategic Update from SWP** Written Strategic Reports to be received at future meetings of the Committee	SWP	December 2022	No report received as yet – update to be provided at meeting.
MHA/22/10/13	October 2022	**Strategic Update from LA Partners** Operational Group to scope the risks around medical cover in Merthyr to articulate the extent of the issue to relevant bodies.	Chair/Clinical Lead Operational Group	December 2022	**Completed** Operational group reviewing the assessments for each place of safety. New monthly group to be established to review each assessment with the police.

MHA/22/06/8	June 2022	**Mental Health Act Quarterly Activity Report/Breaches** Review the situation with regards to the lack of a computer on Ward 14 Princess of Wales Hospital.	Head of Nursing Mental Health	September 2022	**Completed** The issue has been address and the risk mitigated.
MHA/22/06/13	June 2022	**Processes for Learning Lessons incl. those related to the application of the MHA** Operational Group to consider and discuss a consultation of carers and their experiences of the assessment process.	Head of Nursing, Mental Health, Local Authority Partners	October 2022	**In progress** On Agenda for discussion at the next MHA Operational Group.
MHA/22/06/13	June 2022	**Processes for Learning Lessons incl. those related to the application of the MHA** Operational Group to consider and discuss a consultation of carers and their experiences of the assessment process.	Head of Nursing, Mental Health, Local Authority Partners	September 2022	**In progress** On Agenda for discussion at the next MHA Operational Group.
MHA/21/8/14	August 2021	**Strategic Update from SWP** Consideration to be given as to whether the Committee should receive an Annual Report from the Suicide Review Group	South Wales Police	November 2021	**In progress** SWP have an annual review of suicides March 2020 – 31st March 2021. The next one will be 2021/22 and would be provided to the Committee if so required. Update 2.8.22 – added to Forward Work Plan for June 2023.

MHA/21/011	May 2021	**Operational Group Report** Clinical Representation on the Committee to be sought from the Clinical Directors.	Chair/Clinical Lead Operational Group	March 2022	**In progress** Committee advised at November 2021 meeting that this would be considered with the new Associate Medical Director. Recruitment process underway. In the meantime Dr Paul Emmerson and Dr Krishna Menon are regular attenders at the meeting.

AGENDA ITEM
4.1

MENTAL HEALTH ACT MONITORING COMMITTEE

(MENTAL HEALTH ACT OPERATIONAL GROUP REPORT)

Date of meeting	07/12/2022
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Presented by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Approving Executive Sponsor	Julie Denley Director of Primary Care, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
	MHA – Mental Health Act
	AMHP – Approved Mental Health Practitioner
	EDT – Emergency Team
	SWP – South Wales Police
	CAMHS – Child and Adolescent Mental Health Service
	IMHA – Independent Mental Health Advocacy

1. SITUATION/BACKGROUND

1.1 The Operational Group has met on one occasion since the last meeting of the Mental Health Act Monitoring Committee which took place on 12 October 2022. The meeting on 04 November 2022 was well attended with representatives from across Adult Mental Health, CAMHs, the Mental Health Act team, Social Services and the South Wales Police.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Mental Health Act Activity Report July - September 2022

The group noted just one occasion when the nurse holding power under Section 5(4) had been applied reflecting improved accessibility to medical staff when detention decisions were required. Section 4 was also not applied during the quarter.

There was an increase in minor errors from 26 in Q1 to 36 in Q2. The main areas related to 9 errors on the HO2 AMHP Application Form mainly in relation to the failure to make appropriate selections. For example whether or not the nearest relative had been informed and if either medical officer had previous knowledge of the patient. There were also 9 errors on the Medical Recommendation Form HO4 covering use of abbreviations and inaccurate patient details. The MHA team were redesigning the check list for practitioners to help improve compliance.

There were 8 younger people detained in Ty Llidiard, none from CTMUHB. There were no adolescence admitted onto the Adult admissions ward at the Royal Glamorgan Hospital.

The group considered the 2 fundamental breaches in the quarter which involved medical recommendations failing to meet the necessary requirements for detention. It was noted that medical scrutiny of detention papers was required within 14 days. A meeting would be convened with representatives from the AMHP group to consider the development of some guidelines to help ensure medical recommendations were sufficient for the purposes of the Act.

It was noted that when there was a change in the Responsible Clinician there was a need to complete a new Consent to Treatment form. This was increasing workloads when locum medical staff were appointed without Approved Clinician status.

2.2 All Wales Benchmarking Report on errors and breaches for Q2

Mental Health Act team leaders across Wales had met on 20 October 2022 and discussed the variation in reporting minor errors within Health Boards. The group would work on a consistent approach across Wales to the recording of minor errors under Section 15 of the Mental Health Act. It was noted that all Health Boards across Wales had between 0 and 2 fundamental breaches in Q2.

2.3 Register of conditionally discharged patients

The Mental Health Act Team now maintain a Register of patients subject to Section 41 of the MHA 1983.

Table 1 – Register of Patients conditionally discharged into the Community

Area	Social Supervisor	Date of Conditional Discharge
RCT	✓	24.01.2022
RCT	✓	23.04.2015
RCT	✓	20.09.2019
RCT	✓	04.09.2018
RCT	✓	21.11.2007
RCT	✓	09.08.2017
RCT	✓	24.09.2012
Merthyr	✓	15.10.2008
Merthyr	✓	22.09.2014
Merthyr	✓	27.06.2022
Merthyr	✓	01.11.2022
Bridgend	✓	27.10.2020
Bridgend	✓	19.10.2020
Bridgend	✓	14.06.2019
Bridgend	✓	12.05.2020
Bridgend	✓	26.10.2010
Bridgend	✓	15.06.2022
Bridgend	✓	20.12.2011
TOTAL		18

2.3 Hospital Managers Power of Discharge Committee

Job description and person specifications agreed for Hospital Managers. Advertisements will be placed shortly for new members of the team. The appraisal documentation had also been agreed and a schedule of reviews was to be generated.

2.4 Review of the Cwm Taf Morgannwg Emergency Duty Team

The report described high levels of satisfaction with the AMHP service. There was discussion amongst Local Authority colleagues in the group about some occasions when the EDT did not respond in a timely way to requests for Mental Health Act assessments. This could lead to long waits before the assessment could be completed. It was agreed that the Head of Service for the EDT would be invited to the next meeting to further discuss the report.

2.5 Protocol for joint working between CAMHS and Adult Mental Health Services

This helpful document had been produced to improve transition arrangements between CAMHS and Adult services. The development of the document had helped to identify some improvement areas for example regular CAMHS attendance at local transition panels and consideration of arrangements when patients are discharged prior to their 18th birthday and require early reassessment from Adult services.

2.6 Monitoring of Section 17 Leave forms following HIW visit to Ty Llidiard

The group were updated on the progress with regard to the Section 17 Leave and Care Plan Improvement Actions. Weekly audits had been introduced for Section 17 Leave with improved process with regard to intended outcome and patient involvement in decision making. Patient views were also a key part of the new care plans which were also subject to audit. Information on the outcome of the audits would be considered at future meetings.

2.7 Schedule of Learning Disability patients detained in hospital under the Mental Health Act 1983

The following 4 facilities provide care and treatment to CTM patients with Learning Disability:

- Priory Hospital, Llanarth Court
- Hafod y Wennol, Swansea Bay University Health Board
- Cefn Carnau, Elysium Healthcare
- Pinetree Court, Ludlow Street Healthcare

Each was asked for information on:

- The number of detentions on 30 September 2022
- The number of fundamental and rectifiable breaches
- The MHA Audit Tool used
- MHA activity reports for the period

Table 2 – Detention of Patients with a Learning Disability – 30 September 2022. **(Please note that the embedded Audit Tool documents can be sent to Members to review on request).**

Facility	Number of patients	Section	Breaches of the MHA	Frequency of Audit	Audit Tool	Is a MHA Activity report compiled?	Is data focussed on CTM patients able to be shared
Priory Hospital, Llanarth Court	1	S37(n)	0	Annual full MHA, Monthly section & consent	Healthcare MHA and MCA Audit Tool	Yes, as electronic patient records	Not easily accessible
Hafod y Wennol SBUHB	1	S37/41x 1	0	We have not carried out any physical on-site audits of paperwork on wards since Covid, however we are currently speaking to wards & SMT about starting this up again – our audit checklist is attached however we acknowledge that it needs refreshing and are working on this using examples from HIW	Checklist Audit.pdf	Yes, quarterly MHA Activity reports for Legislative Committee and Power of Discharge Committee	Does not include specific CTMUHB data
Cefn Carnau, Elysium Healthcare	0	0	0	Audits are carried out yearly by the MHA Manager	Copy of MHA Audit Tool 2021.v3.xlsm	No we not currently compile an activity reports	n/a
Pinetree Court, Ludlow Street Healthcare	3	S3 x 2 S47/49 x 1	0	Mental Health Act Manager completes quarterly	Section 37n audit.doc Section 37-41 Audit.doc Section 37 audit.doc Section 3 audit.doc	Yes , on a quarterly basis	Does not include specific CTMUB data

2.8 Review of Section 3 patients detained in Older Peoples Mental Health Services who are transferred onto a DoLS

The Mental Health Act Team were collecting this information across our Older Peoples Services in order to help understand how many patients had been detained under Section 3 who were subsequently

transferred on to a DoLs without the detention being tested by a Tribunal.

2.9 Section 135 and Section 136 - A review of place of safety assessments

The Mental Health Act Team were preparing a report on Place of Safety assessments in each of the three DGH's. After 12.00 p.m. each day crisis assessments may be transferred from PCH to RGH. This information would be included within the report. Discussions were ongoing about improvements to the place of safety room within the Accident and Emergency Department at PCH with arrangements being finalised for a temporary solution pending the completion of upgrading work to the hospital. A meeting had been convened on 22/11/22 in the Bridgend Custody Suite with the South Wales Police to discuss the renewal of the policy and operational arrangements for Section 135 and 136. It is proposed that a monthly Section 135/136 meeting be held with the South Wales Police to discuss individual cases.

2.10 Independent Mental Health Advocacy – Q2 Report

The report identified 60 referrals from Royal Glamorgan Hospital, 9 from Prince Charles Hospital and just 2 from Princess of Wales Hospital. The group asked Advocacy Support Cymru to review the return from Bridgend which seemed low given the known activity in the area. It would be helpful for Advocacy Support Cymru to develop a plan to improve referral rates from the Bridgend locality.

2.11 Role and function of the Mental Health Casework Section within the Ministry of Justice

The group reviewed the role of the above Ministry of Justice department which provided oversight for Restricted Patients. The primary concern of the department was protection of the public from harm recognising the importance of maintaining public confidence in the system of diverting offenders from punishment into treatment. The decision making process is based on risk assessment which involves a clinical assessment of the patient together with an account of the type, nature and seriousness of the offence(s). The team aims to balance patient's right to treatments with public protection measures.

2.12 Mental Health Act Training

The group reviewed the Sharepoint training page and welcomed the development of content to improve staff access to training. A joint Nearest Relative training event held on 13 October was well attended. Professor Richard Griffiths had been asked to provide training on Part 3 of the Act on 6 December 2022. It was suggested that Hospital Managers and members of the Mental Health Act committee could be invited. The Hospital Managers at the Power of Discharge meeting

have also asked for Medication Awareness Training. This is to be delivered by Dr Kim Kendall (ST4) and Dr Bethany Ranjit, Consultant Psychiatrist.

2.13 Operational Policy Review

The MHA team have applied the Health Board's Risk Assessment Tool to each of the policies listed in the table below. Those highlighted in red have been identified as a priority for review.

Table 3 – Schedule of Operational Policies

REF NUMBER	TITLE	LEAD PERSON	PROGRESS
MH04	Community Treatment Policy	Alison Thomas	Agreed 15/10/2021
MH09	Hospital Managers Operational Procedure	Alison Thomas	Agreed 09/07/2021
MH12	Section 17 leave policy	Jeremy Burgwyn	Agreed 09/07/2021
MH28	Hospital Managers Scheme of Delegation	Alison Thomas	Agreed 09/07/2021
New	Allocation of Responsible Clinician	Alison Thomas	Agreed 05/08/2022
MH17	Section 132&133 patient's rights procedure	Jeremy Burgwyn	Agreed 06/05/22
MHA117	Section 117 Policy	Jeremy Burgwyn	In progress- next meeting of the working group on 12/12/22
MH03	Section 136	Jeremy Burgwyn	Awaiting Police to update national policy- 23/08/2022
MH02	Section 135(1) Section 135(2)	Jeremy Burgwyn	Awaiting Police to update national policy-23/08/2022
MH16	IMHA Procedure	Alison Thomas	For review Lapsed 18/07/2021-AT awaiting Policy update from LD
MH29	Applying to become an Approved Clinician	Alison Thomas	For review Lapsed 18/07/2021
MH06	Section 5 (4)	Alison Thomas	Complete - for ratification in the next Operational Group meeting 27/01/23
MH07	Section 5 (2)	Jeremy Burgwyn	In progress- for ratification in next Operational Group meeting on 27/01/23
MH08	Consent to Treatment Sec 58 and Sec 58a	Alison Thomas	In progress- for ratification in next Operational Group meeting on 27/01/23

AGREED FOR REVIEW FOR PRIORITY REVIEW

2.14 Operational Group Work Plan

The group considered a proposed work plan including the following items:-

Table 4 – Operational Group Work Plan

Activity	Progress	Timescale
Service user feedback	Advocacy Support Cymru to circulate CTO Questionnaire through the MHA Team. Report back to the Operational Group.	January 2023
Audit	MHA Team to complete audit of Inpatient Statutory Documentation and report to Operational Group.	January 2023
Policy Work	Timetable to be agreed with the newly established Operational Policy Sub Group for review of prioritised policies.	November 2022
Review of Sections 135 & 136 Assessments	Monthly meetings to be convened to consider individual cases and data set to review.	January 2023
Nominated Adolescent Bed on Adult MH Wards	Monitor activity in RGH Assessment Ward and submit Statement of Need for ensuite bedroom in Ward 14 POWh	January 2023

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Review of Cwm Taf Morgannwg Emergency Duty Team

AMHPs have asked to discuss concerns about some delays in assessments being delivered by the EDT. To be discussed at the next Operational Group.

3.2 Learning Disability Patients detained in hospital under the Mental Health Act 1983

Information and assurance provided from hospitals providing care to our detained patients with a learning disability.

3.3 Register of Conditionally Discharged Patients

The Mental Health Act Team have developed and will maintain a register identifying names social supervisors.

3.4 A Review of Place of Safety Section 135 & 136 Assessments

Information is being collated on the use being made of the 3 DGH based places of safety. This will help inform a wider discussion on future provision across the region.

4. IMPACT ASSESSMENT

5. Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The MHA Operational Group meets bi-monthly to review the application of the Act across CTMUHB
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

6. RECOMMENDATION

6.1 The Committee is asked to note the work of the MHA Operational Group.

AGENDA ITEM
4.1

MENTAL HEALTH ACT MONITORING COMMITTEE

ACTIVITY REPORT AND BREACHES AND ERRORS FOR QUARTER 2 (JULY-SEPTEMBER 2022)

Date of meeting	07 December 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mrs Alison Thomas -Mental Health Act Team Manager Jeremy Burgwyn – Mental Health Act Team Leader
Presented by	Mr Robert Goodwin- Service Group Manager, Bridgend
Approving Executive Sponsor	Executive Director of Primary, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act office staff		SUPPORTED

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board
CAMHS	Child & Adolescent Mental Health Services
CTO	Community Treatment Order
RC	Responsible Clinician
AC	Approved Clinician
AMHP	Approved Mental Health Professional
CoPW	Code of Practice for Wales
PICU	Psychiatric Intensive Care Unit
POW	Princess of Wales Hospital
RCT	Rhondda Cynon Taf
CMHT	Community Mental Health Team
WCCIS	Welsh Community Care Information System

Summary

In the reporting period, there has been an increase in detentions within the Adult and Older Persons services between Q1 and Q2 in the current year whilst the CAMHS service has witnessed a decrease in detentions.

Section 4 was not applied during the quarter. The nurse holding power under Section 5(4) was applied once during the quarter.

There were 2 fundamentally defective errors, the details of which are included at the end of this report and which will be considered by the monitoring committee when it meets on 7th December 2022.

In Quarter 2, there were 36 minor errors on section papers, all of which were rectified within the fourteen day limit as per Section of the MHA. This compares with 26 in Q1, which represents an increase of 33%

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present activity data including errors and breaches regarding the application of the Act within CTMUHB. This report presents the MHA activity to the MHA Monitoring Committee in respect of Q2 (July –September 2022).

1.2 Section 15 of the Act allows for the rectification of statutory detention documentation completed by Doctors and AMHPs within 14 days of admission to hospital. While the minor errors are defined by "principal de minimus" (meaning they are immaterial and too small to be of any consequence), the fundamental errors (breaches) are more serious and require further attention and scrutiny to ensure that lessons are learned and the breach does not reoccur.

1.3 The report covers Adult, Older Persons Mental Health and CAMHS services managed by CTMUHB.

1.4 This activity is monitored in the MHA Operational Group, which is supported by the MHA Administration team.

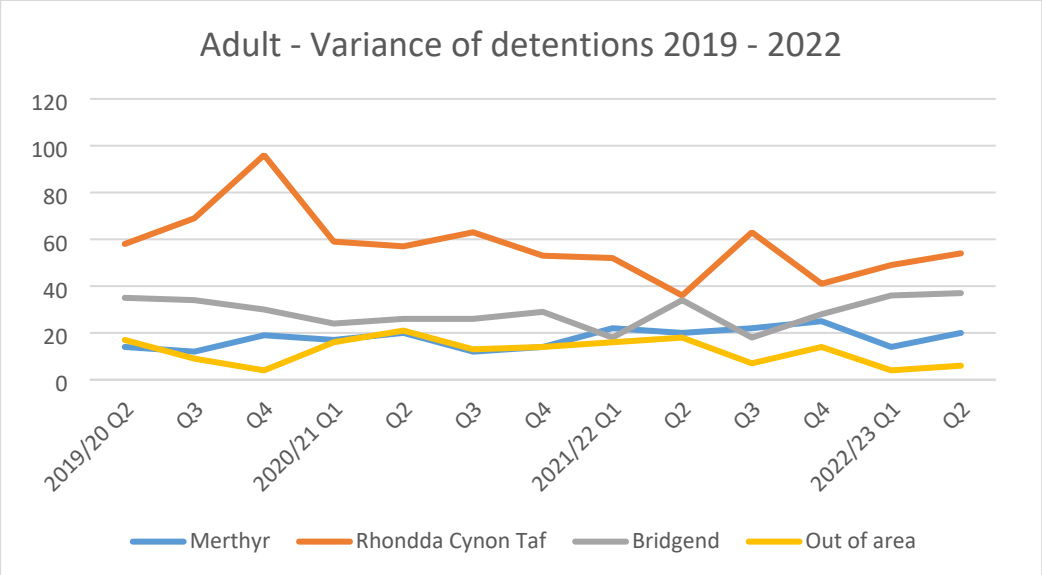
1.5 A Glossary of terms is attached for ease of reference (Appendix 2.)

2. SPECIFIC MATTERS FOR CONSIDERATION BY THE COMMITTEE (ASSESSMENT)

2.1 This quarterly MHA activity report is distributed to members of the MHA Operational Group Meeting and is considered at individual Clinical Service Group Quality & Risk meetings. Trends are monitored to highlight and manage any risks to the organisation.

2.2 Adult Detentions

There has been a marginal increase of 15.53% in the total number of detentions, which has risen from 103 to 119 between Q1 and Q2. The number of detentions under S5 (2) increased from 8 to 23. Section 2 detentions increased from 62 to 64 with the number of Section 3 detentions decreasing from 30 to 27.



The mean figures for each area during 2019 and 2022 are shown below, along with the figures for Q2.

Locality	Mean 2019/22	Q2 2022/23
Merthyr	18	20
Rhondda Cynon Taff	58	54
Bridgend	29	37
Out of area	12	6

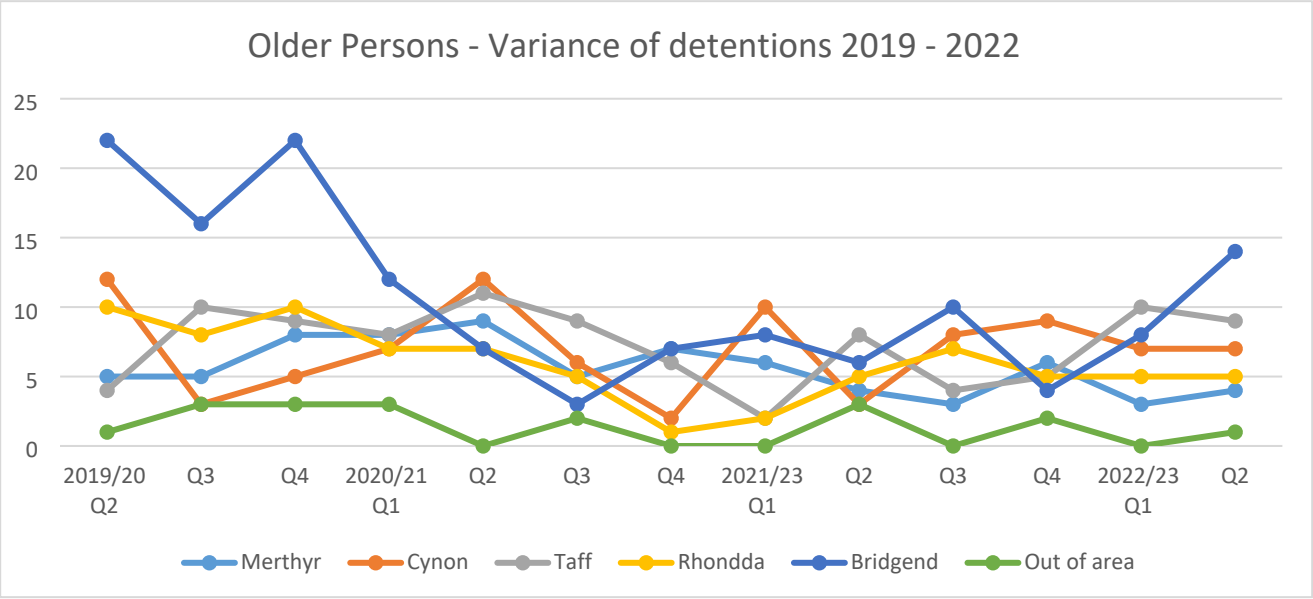
2019/22 Mean to Q2 shifts as follows:

- In Merthyr detentions increased from baseline mean by 2 (11%) from 18 to 20
- In Rhondda Cynon Taff detentions decreased from baseline mean by 4 (6%) from 58 to 54.
- In Bridgend detentions increased from baseline mean by 8 (27%) from 29 to 37.
- Out of area detentions decreased from baseline mean by 6 (50%) from 12 to 6.

In Q2, there was 1 occasion when the nurses' holding power under Section 5(4) was utilised in the Royal Glamorgan Hospital. This patient was assessed by a doctor within the 6-hour period and regraded to Informal status, in line with the guidance in the Code of Practice for Wales.

2.3 Older Persons Detentions

The total number of detentions in Older Persons witnessed a 5% increase from the baseline mean 38 to 40 in Q2, with variance across the localities as below:



The mean figures for each area during this period are shown below, along with the figures for Q2.

Locality	Mean 2019/22	Q2 2022/23
Merthyr	6	4
Rhondda Cynon Taf	20	21
Bridgend	11	14
Out of area	1	1

2019/22 Mean to Q2 shifts are as follows:

In Merthyr detentions decreased from baseline mean by 2 (33%) from 6 to 4.

In Rhondda Cynon Taff detentions increased from baseline mean by 1 (5%) from 20 to 21.

In Bridgend detentions increased from baseline mean by 3 (27%) from 11 to 14.

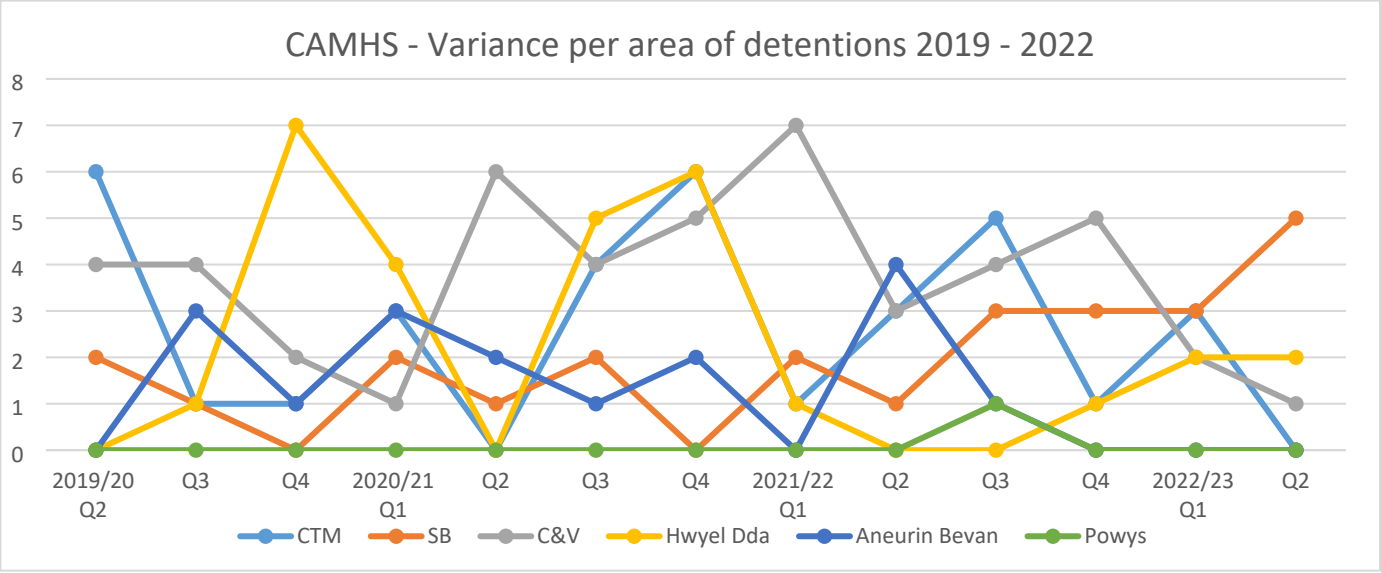
Out of area, detentions remained the same

2.4 CAMHS Detentions

CAMHS detentions witnessed a decrease.

In Q2, there were 8 detentions (5 from Swansea Bay UHB, 2 from Hywel Dda UHB and 1 from Cardiff and Vale UHB).

All 8 younger persons were detained in Ty Llidiard.



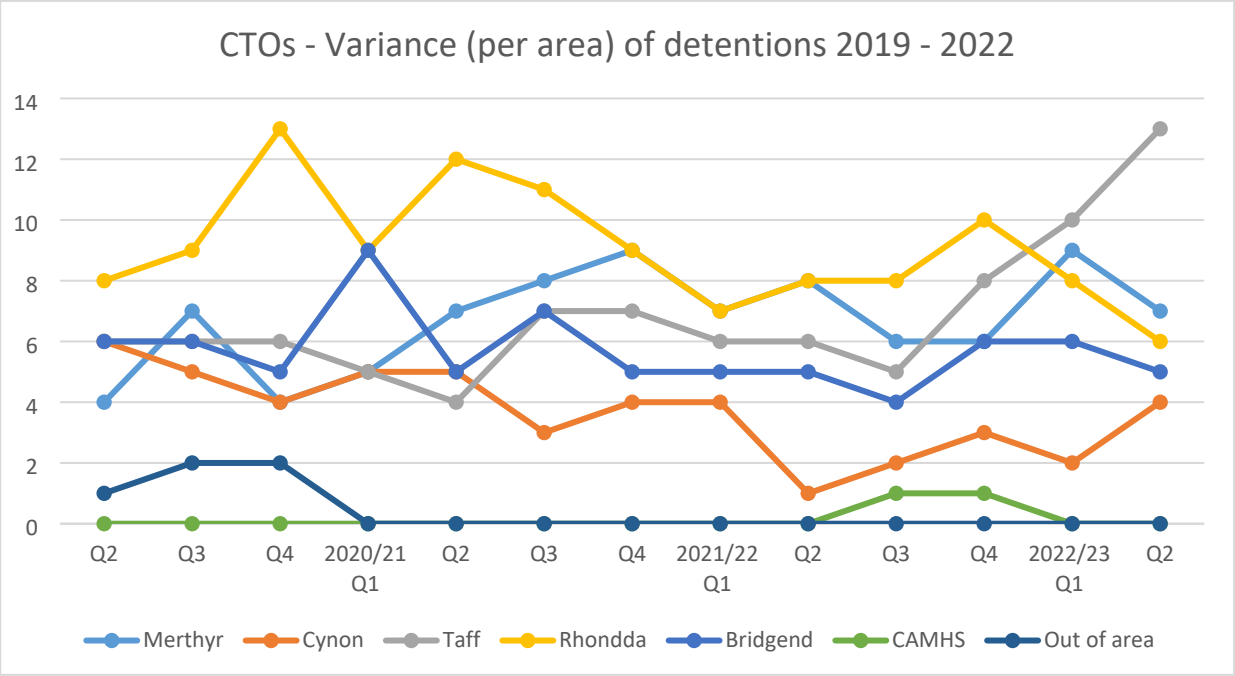
The mean figures for each area during this time period are shown below, along with the figures for Q2.

Health Board	Mean 2019/22	Q2 2022/23
Cwm Taf Morgannwg	3	0
Swansea Bay	2	5
Cardiff & Vale	4	1
Hywel Dda	2	2
Aneurin Bevan	1	0
Powys	0	0

2.5 Community Treatment Orders (CTO)

There were 8 new CTOs applied in Q2 of the current reporting period, which was the same figure as in Q1.

In Q2, there were 7 CTOs extended, 1 recalled, 3 recalled and revoked.
5 patients were discharged from detention under CTO in the quarter.



The mean figures for each area during this time period are show below.

Locality	Mean 2019/22	Q2 2022/23
Merthyr	7	7
Rhondda Cynon Taf	20	23
Bridgend	6	5
CAMHS	0	0
Out of area	0	0

There were 35 CTOs in place as at the end of Q2.

2.6 Use of Section 135/136 Police Powers

Section 136 detentions increased from 40 in Q1 to 73 in Q2. A 82% increase.
Section 135 detentions decreased from 5 in Q1 to 3 in Q2. A 40% decrease.

Use of Section 135 and 136 by area for Q2 2022/2023

Area	Q1 2022/23	Q2 2022/23
Merthyr	5	15
Rhondda Cynon Taf	19	38
Bridgend	18	22
Out of area	3	1
Total	**45**	**76**

The triage scheme that works alongside SWP should ensure that patients are being appropriately signposted to the correct service rather than receiving a crisis assessment.
The new electronic forms are helping police officers ask the right questions to patients, which may possibly lead to an increase in informal crisis assessments.

The use of Section 136 will continue to be monitored in the MHA Operational Group meeting. Any trends will be discussed and reported back to the Committee.

- There was one lapse of a S136 detention in the reporting period.
- A person was taken to the Accident & Emergency department in the Royal Glamorgan Hospital on 28/08/2022 at 15.00 hours.
- As the patient was being treated for medical reasons and not assessed by a Doctor during the 24 hour period, the S136 lapsed.
- The registered medical practitioner, who was responsible for the examination of the person detained under the S136, could have requested an extension of a further 12 hours.
- The MHA team have circulated the guidance in the Policing and Crime Act 2017 to all AMHPs and RCs

2.7 Current Challenges

The MHA team are still experiencing problems with the constant turnover of medical personnel, especially when an appointed locum does not have Approved Clinician status. This means that they are unable to perform the functions of the Responsible Clinician and are unable to complete some of the statutory documentation for detained patients.

This is proving to be a challenge for the MHA team, who need to ensure that patients, who are subject to the Consent to Treatment provisions of Part 4 of the MHA 1983, are being treated with a valid form of authority. in line with the statutory requirements of Chapter 25.84 of the Code of Practice for Wales.

In order to mitigate the potential risk of non compliance with the statutory requirements of Chapter 25.84 of the Code of Practice for Wales, the MHA team seek clarification from senior management and the Clinical Directors as to which RC is responsible for performing the statutory obligations of the Act. When there is a change of RC, the transferring RC informs the MHA office via email.

When a patient is transferred from one ward to another, which also impacts on the change of RC, the nursing staff inform the MHA team as part of their patient transfer protocol.

2.8 Errors and Breaches

In Quarter 2, there were 36 minor errors on section papers, all of which were rectified within the 14 day time limit as per S15 of the MHA. This compares with 27 in Q1, which represents an increase of 33%.

A meeting held in October 2022 by Mental Health Act team leaders across Wales highlighted there are different reporting formats for minor errors within Health Boards. All MHA teams were required to submit a list of what each constitutes a minor error. A uniformed all Wales approach to the recording of minor errors under S15 of the Act was agreed. This would avoid confusion for the Members of the MHAMC when they analyse the error and breaches section of the All Wales quarterly benchmarking report.

A further meeting is in the process of being arranged to agree the way forward.

There were 2 fundamentally defective errors during Q2, which is the same as in Q1.

- 2 Invalid Section 2s

<u>Rectifiable Errors</u>

These are minor errors resulting from inaccurate recordings, which can be rectified under Section 15 of the Act. Examples include incomplete addresses and misspelled names.

The application or medical recommendation, if found to be incorrect or defective, may, within that period, be amended by the person by whom it was signed. Upon such amendments being made the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made.

Fundamentally Defective

These are errors, which cannot be rectified under Section 15 and render the detention unlawful, therefore resulting in a breach of the Act.

Examples include unsigned section papers, incorrect hospital details or the wrong form being used. Medical recommendations and applications that are not signed cannot be remedied under Section 15 and therefore render the detention invalid.

Administrative and medical scrutiny of section documentation is carried out by the MHA Office and medical staff approved under Section 12 of the Act to ensure compliance and to identify any amendments needed within the target time limit. The majority of errors recorded within this report are minor, relating to demographics.
All breaches are reported via DATIX to enable monitoring and for training to be put in place as necessary.

2.9 The total number of minor errors across all services was 36, all of which were rectified within the time limit. This can be broken down further into detaining hospitals and wards.

	Angelton	**POW**			**RGH**					**YCC**	**YGT**	**Ty Llidiard**	
Sections	**2**	**14**	**PICU**	**4**	**Adm.**	**21**	**22**	**PICU**	**St David's**	**7**	**Seren**	**Enfys**	**Total**
Section 2	2	4	1	1	5	0	0	0	1	2	2	1	19
Section 3	0	1	2	0	1	1	2	5	1	2	0	0	15
Section 4	0	0	0	0	0	0	0	0	0	0	0	1	1
Section 5(2)	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	**3**	**5**	**3**	**1**	**6**	**1**	**2**	**5**	**2**	**4**	**2**	**2**	**36**

2.10 The table below provides a more detailed breakdown of the type of error-

Rectifiable Errors		Angelton	POW			RGH					YCC	YGT	Ty Llidiard	
Responsible for Error	Forms	2	14	PICU	4	Admissions	21	22	PICU	St David's	7	Seren	Enfys	Total
AMHP	HO2	2	1	1	0	1	0	0	3	0	0	**0**	**1**	9
AMHP	HO6	0	0	0	0	1	0	1	0	0	2	**0**	**0**	4
Doctor	HO3	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0
Doctor	HO4	0	2	0	1	3	0	0	1	1	0	**0**	**1**	9
Doctor	HO8	0	0	1	0	0	1	1	0	1	0	**0**	**0**	4
Doctor or Nurse	HO12	1	0	0	0	0	0	0	0	0	0	**0**	**0**	1
Nurse	HO14	0	2	1	0	1	0	0	1	0	2	**2**	**0**	9
Other UHB	TC1	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0
	Total	**3**	**5**	**3**	**1**	**6**	**1**	**2**	**5**	**2**	**4**	**2**	**2**	**36**

**** Some detentions contain multiple errors on the section papers**

2.12 The breakdown of errors will assist the MHA team in identifying areas of concern, which will highlight the priority areas for MHA training

2.13 The overall aim is to reduce the number of minor errors and eliminate any fundamental breaches of the Act.

2.14 The total number of fundamentally **defective** errors across all services in Q2 was 2 as there were in Q1.

This is broken down below into hospitals and wards.

Invalid Section 2

Fundamental Errors	POW	Ty Llidiard	
Sections	**PICU**	**Enfys**	
Section 2	1	1	
Total	**1**	**1**	**2**

2.15 The patient was detained under S2 of the MHA on 04/08/2022.

2.16 The Form HO3 was sent for medical scrutiny to a different Responsible Clinician.

2.17 On 16/08/2022, the reasons on the joint medical recommendation (Form HO3) were found to be insufficient to warrant detention under the Act. This rendered the detention invalid.

2.18 Following emailed confirmation that the medical recommendation had failed medical scrutiny, the MHA team advised the RC to formally discharge the patient, by completion of a Form HO17.

2.19 The nursing staff were requested by the team to orally inform the patient that they were no longer detained under S2 of the Act and the MHA team formally wrote to the patient.

2.20 On 16/08/2022, the patient agreed to remain on the ward as an informal patient but on 18/08/2022, as the patient was asking to leave, the doctor's holding power under S5(2) was applied. A new MHA assessment was completed and the patient further detained under S2.

2.21 As a joint medical recommendation form had been completed, this could not be rectified under S15.

2.22 If the AMHP's application had been based on two medical recommendations and one of those medical recommendation were found to be insufficient, it would have been possible to correct the error with the completion of a fresh medical recommendation.

2.23. The MHA team liaised with local authority team leaders to discourage the use of joint medical recommendations for the above reasons.

<u>Invalid Section 2</u>

2.24 The patient was detained under S2 of the MHA on 18/08/2022.

2.25 As above, the joint medical recommendation Form HO3 failed medical scrutiny on 23/08/2022 as the reasons for detention were insufficient to warrant detention under the Act.

2.26 The MHA team advised the RC to formally discharge the patient, by completion of a Form HO17.

2.27 When the nursing staff informed the patient, they were no longer detained under the Act but were of informal status, they asked to leave the ward.

2.28. On 23/08/2022, the doctor's holding power under S5 (2) was applied. Following a MHA assessment on the same day, the patient was further detained under S2.

2.29. The MHA team informed the patient by letter of the discharge and redetention.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Until the introduction and roll out of WCCIS, all data relating to MHA detentions, applications and referrals under the MHA 1983 are recorded on an Excel spreadsheet.

All further options of using different electronic systems, such as the PIMS+ to record and monitor MHA activity, which allows for the production of accurate reports, have been dismissed.

3.2 The second audit of statutory documentation for detained patients has commenced, which has highlighted that the wards across CTMUHB are using different types of health records; Adult wards in old Cwm Taf use Care Partner, whereas older persons Mental Health, CAMHS and Bridgend wards, all use paper based records.

To date, three wards have been audited, which has highlighted that compliance is higher with those wards, which use electronic patient records.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The MHA Operational Group meets bi-monthly to review the application of the Act across CTMUHB
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue	There is no direct impact on resources as a result of the activity outlined in this report.

£/Workforce) implications / Impact	
Link to Strategic Goals	Improving Care

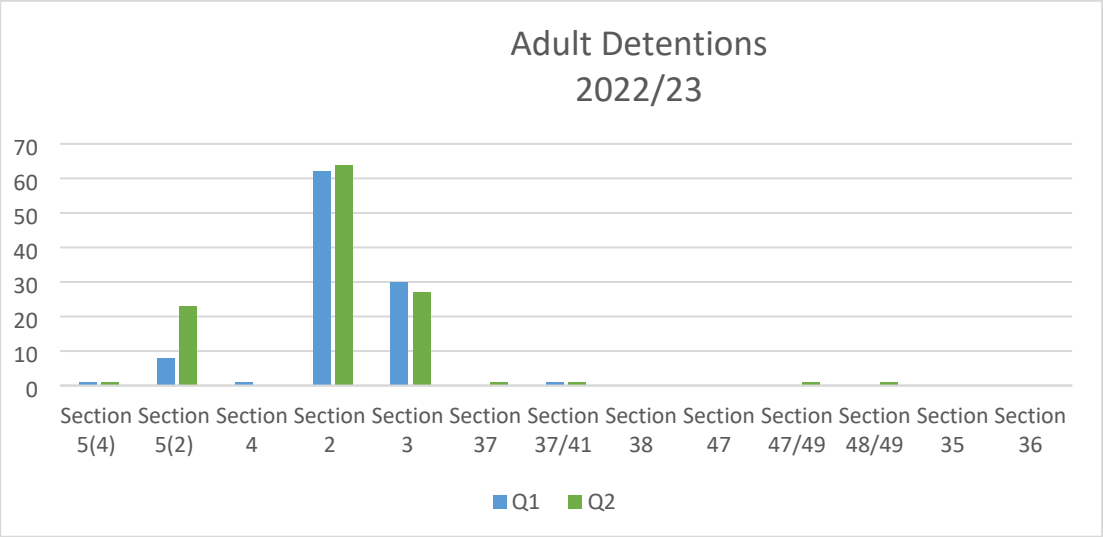
5. RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

- **DISCUSS** and **NOTE** the report

Appendix 1.

Quarter 2 MHA Adult Activity 2022/2023

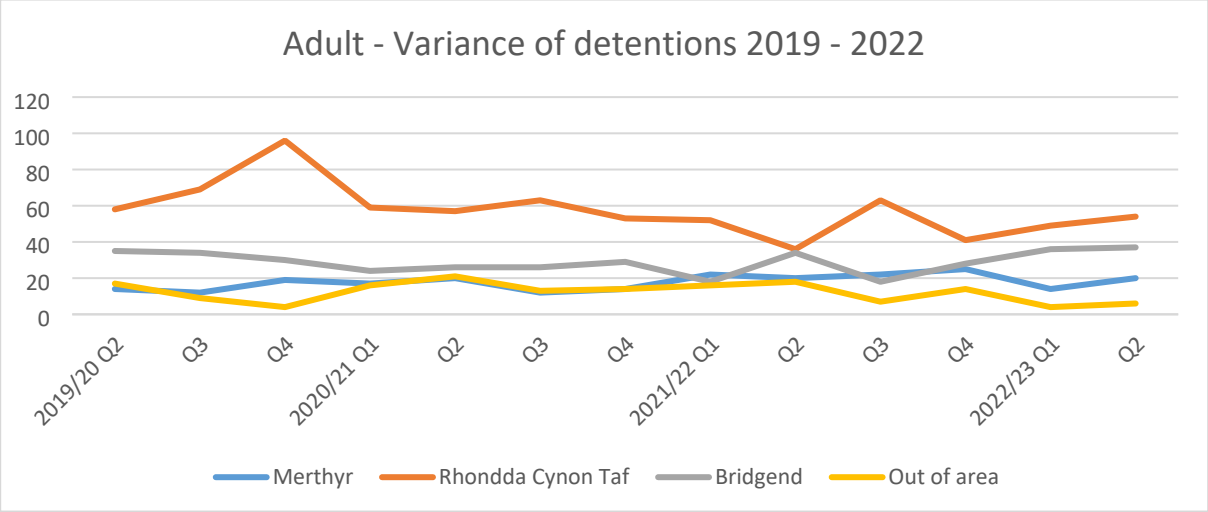


Quarter 2 MHA Adult Activity 2022/2023

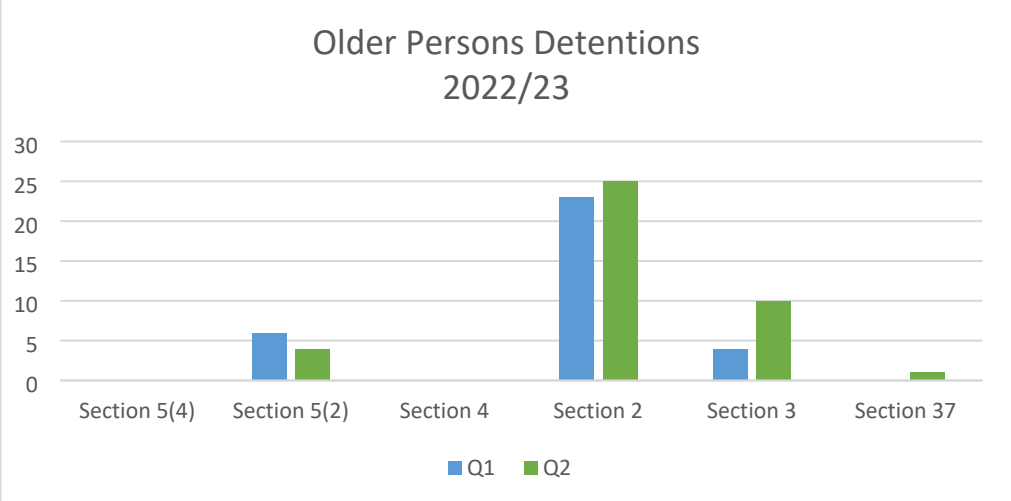
Section	Q1	% of total	Q2	% of total
Section 5(4)	1	0.97%	1	0.84%
Section 5(2)	8	7.77%	23	19.33%
Section 4	1	0.97%	0	0.00%
Section 2	62	60.19%	64	53.78%
Section 3	30	29.13%	27	22.69%
Section 37	0	0.00%	1	0.84%
Section 37/41	1	0.97%	1	0.84%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	1	0.84%
Section 48/49	0	0.00%	1	0.84%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**103**	**100%**	**119**	**100%**

Number of Adult MHA detentions per locality

Area	Q1 2022/23	Q2 2022/23
Merthyr	14	21
Rhondda Cynon Taf	49	55
Bridgend	36	37
Out of area	4	6



Quarter 2 MHA Older Persons Activity 2022/2023

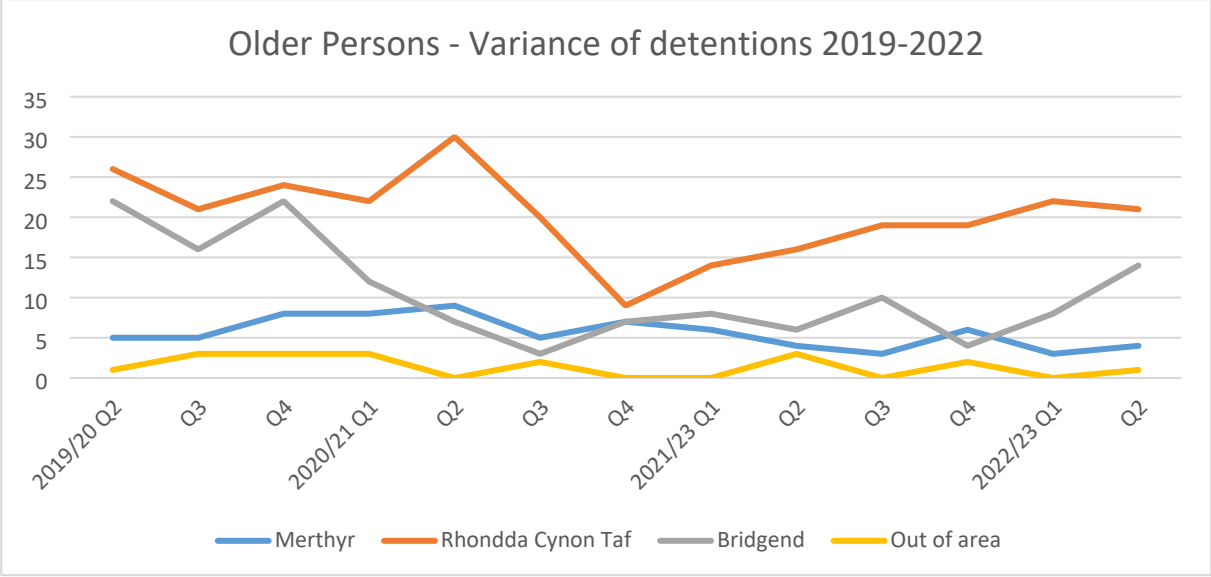


Quarter 2 MHA Older Persons Activity 2022/2023

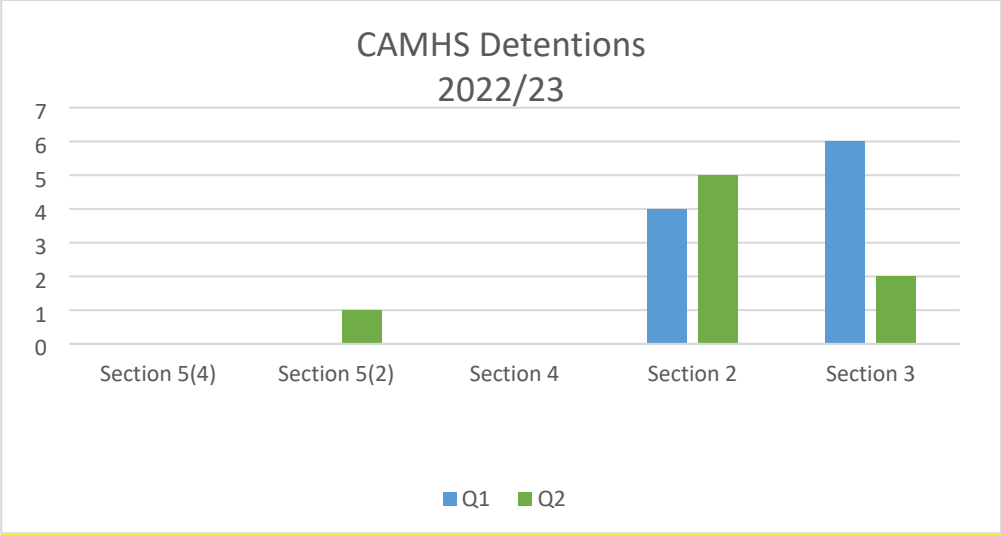
Section	Q1	% of total	Q2	% of total
Section 5(4)	0	0.00%	0	0.00%
Section 5(2)	6	18.18%	4	10.00%
Section 4	0	0.00%	0	0.00%
Section 2	23	69.70%	25	62.50%
Section 3	4	12.12%	10	25.00%
Section 37	0	0.00%	1	2.50%
Section 37/41	0	0.00%	0	0.00%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	0	0.00%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**33**	**100%**	**40**	**100%**

Number of Older Persons MHA detentions per locality

Area	Q1 2022/23	Q2 2022/23
Merthyr	3	4
Rhondda Cynon Taf	22	21
Bridgend	8	14
Out of area	0	1



Quarter 2 CAMHS Activity 2022/2023

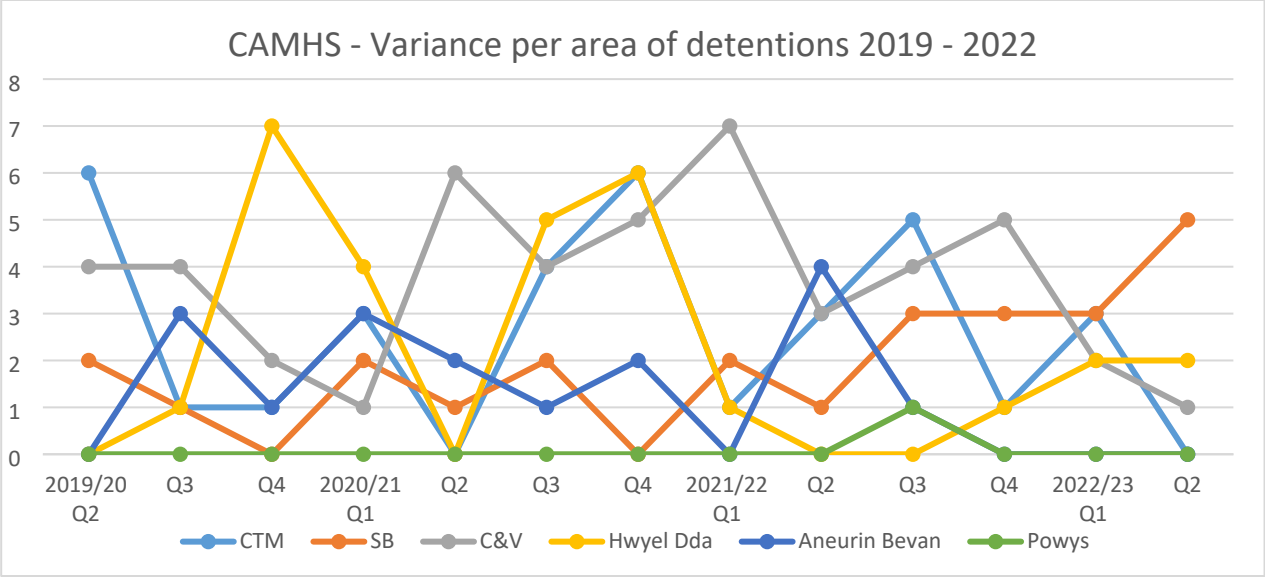


Quarter 2 CAMHS Activity 2022/2023

Section	Q1	% of total	Q2	% of total
Section 5(4)	0	0.00%	0	0.00%
Section 5(2)	0	0.00%	1	12.50%
Section 4	0	0.00%	0	0.00%
Section 2	4	40.00%	5	62.50%
Section 3	6	60.00%	2	25.00%
Section 37	0	0.00%	0	0.00%
Section 37/41	0	0.00%	0	0.00%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	0	0.00%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**10**	**100%**	**8**	**100%**

Number of CAMHS MHA detentions per locality

Health Board	Q1 2022/23	Q2 2022/23
Cwm Taf Morgannwg	3	0
Swansea Bay	3	5
Cardiff & Vale	2	1
Hywel Dda	2	2
Aneurin Bevan	0	0
Powys Teaching	0	0



Out of the 8 detentions for Q2, all were detained in Ty Llidiard**.**

USE OF SECTIONS AND OUTCOMES for April – September 2022

Section 5(2) of the Mental Health Act 1983

A 'holding power' can be used by doctors to detain an inpatient in hospital for up to 72hrs for assessment under the Act. This cannot be used in A&E because the patient is not an inpatient. A non-psychiatric doctor on a general medical ward can use this section.

S5(2) OUTCOMES	April 22	May 22	June 22	July 22	Aug 22	Sept 22
Section 2	3	2	1	6	6	5
Section 3	0	0	0	3	2	0
Informal	1	2	5	2	2	2
Lapsed	0	0	1	0	0	0
Invalid	0	0	0	0	0	0

Section 2 of the Mental Health Act 1983

The power to detain someone believed to be suffering mental disorder for assessment (and treatment). The order lasts for up to 28 days and cannot be extended or renewed. The patient has a right of appeal against detention to a Mental Health Review Tribunal.

S2 OUTCOMES	April 22	May 22	June 22	July 22	Aug 22	Sept 22
Section 3	6	9	8	10	7	4
Informal	16	8	17	15	13	21
Discharged	13	6	0	4	8	12
Lapsed	0	0	1	1	0	0
Invalid	0	0	0	0	0	0
Transfer	0	2	1	0	1	0

Section 3 of the Mental Health Act 1983

The power to detain someone for treatment of mental disorder. This section lasts for up to 6 months and can be renewed for another six months and then annually. Patient has the right of appeal against detention to a Mental Health Review Tribunal.

S 3 OUTCOMES	April 22	May 22	June 22	July 22	Aug 22	Sept 22
Section 3 renewed	2	1	0	0	4	2
Informal	3	6	7	3	11	6
Discharged	3	3	5	4	1	3
Lapsed	0	**0**	0	0	0	0
Invalid	0	0	0	0	0	0
Transfer	2	3	0	2	1	3
CTO	1	1	2	0	0	1

Number of compulsory admissions under the Mental Health Act 1983 (Section 2, 3, 4 and 37 only)

	Q1 2022/23	Q2 2022/23
Adult Detentions	92	91
Older Persons detentions	27	36
CAMHS detentions	10	7
TOTAL	**129**	**134**

SECTION LAPSING

Detentions under the Mental Health Act can lapse for the following reasons:

- A section expires without the Responsible Clinician exercising their power to discharge under Section 23 MHA or the patient is not further detained under Section 3 of the MHA.
- The AMHP and Responsible Clinician have a difference of opinion on the appropriateness of further detention under Section 3 of the MHA.
- No further assessment by an AMHP and/or Responsible Clinician has taken place in respect of the next steps in relation to the patient's detention status.
- Although it is permitted to allow the section to lapse near the end of the section when no further detention is required, it is good practice for the Clinician to complete a discharge form.

- It is particularly poor practice to allow the section to lapse when the Responsible Clinician has not seen the patient. In this instance, the issue is reported to the Clinical Director and monitored to avoid re-occurrence.

Section lapses	Section	Q1 2022/23	Q2 2022/23
	2	0	0
	3	0	0
	4	0	0
	CTO	0	1
	136	0	1
Older Persons	2	1	1
	3	0	0
	4	0	0
CAMHS	2	0	0
	3	0	0

TRANSFER BETWEEN HOSPITALS

Section 19 of The Mental Health Act allows for the transfer of Part 2 (Section 2, 3 and CTO Patients) and some Part 3 (Section 37,37/41, 47, 47/49 and 48/49) detained patients from a hospital under one set of managers to a hospital under a different set of managers. For restricted patients transfers are subject to the prior agreement of the Secretary of State.

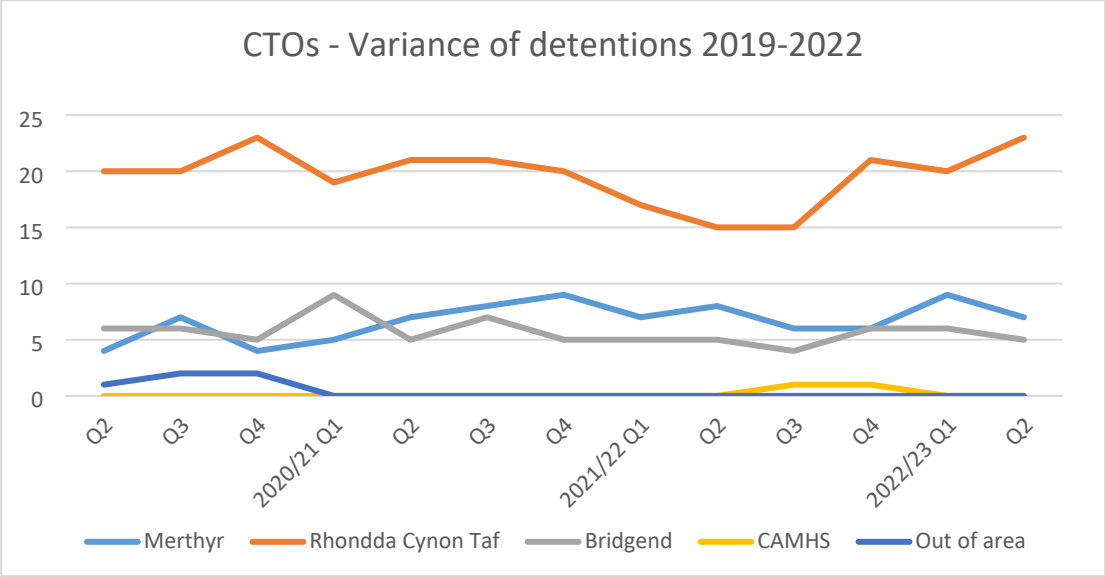
SECTION	Q1 2022/23	Q2 2022/23
Part 2 Patients to CTUHB	10	9
Part 3 patients to CTUHB	0	1
Part 2 patients from CTUHB	9	10
Part 3 patients from CTUHB	1	1
TOTAL	**20**	**21**

COMMUNITY TREATMENT ORDER, Section 17A (CTO)
Q2 CTO Activity 2022/2023

SECTION	Power	Q1 2022/23	Q2 2022/23
17A	Community Treatment Order made	8	8
	Community Treatment order extended	8	7
	Recalled to hospital and not revoked	2	1
	Recalled to hospital and revoked	4	3
	Discharged from CTO	0	5
	Transferred	0	0
	Other (Deceased)	0	0

Current CTO by area

Area	Q1 2022/23	Q2 2022/23
Merthyr	9	7
Rhondda Cynon Taf	20	23
Bridgend	6	5
CAMHS	0	0
Out of area	0	0
Total	**35**	**35**



USE OF SECTION 135 AND SECTION 136
Police powers under the MHA to authorise removal to a Place of Safety.

Section 135

Warrants under the Act for (1) assessments on private premises and (2) recovering patients who are absent without leave. Lasts for up to 36hrs.

Section 135 of the Mental Health Act	Q1 2022/23	Q2 2022/23
Assessed and admitted informally	0	0
Assessed and Discharged	1	0
Assessed and detained under Section 2	3	2
Assessed and detained under Section 4	0	0
Assessed and detained under Section 3	1	1
TOTAL	**5**	**3**

Section 136

Power to detain someone in immediate need of care or control and remove him or her to a place of safety. Power to detain lasts for up to 24hrs.

Section 136 of the Mental Health Act	Q1 2022/23	Q2 2022/23
Assessed and admitted informally	9	8
Assessed and detained under Section 2	9	11
Assessed and detained under Section 4	0	0
Assessed and detained under Section 3	0	0
Discharged with no follow up required	5	13
Discharged referred to community services	16	39
Section 136 lapsed	1	1
Other /(Recall from CTO)/ or transfer	0	0
TOTAL	**40**	**73(1 no outcome)**

HOSPITAL MANAGERS HEARINGS

Under the provisions of the Mental Health Act 1983, detained patients have a right to have their detention reviewed by the Hospital Managers. The Hospital Managers responsibilities are as follows:

- Undertake a review of detention at any time
- Must review a patient's detention when Responsible Clinician (RC) submit a report under Section 20/20A renewing detention and extending CTOs
- Must consider holding a review when a patient requests it
- Must consider holding a review when the RC makes a report under Section 25 (1) barring a nearest relative application for the patient's discharge.

Hospital Managers Hearings	Q1 2022/23	Q2 2022/23
Number of Hearings held	13	5
Number of Referrals by Hospital Managers	20	14
Number of Appeals to Hospital Managers	0	0
Number of Detentions upheld by Hospital Managers	13	5
Number of detentions discharged by Hospital Managers	0	0
Number of patients discharged by RC prior to Hearing	0	2

Q2:

5 hearings were postponed
1 hearing was adjourned

1 CTO revoked

TRIBUNAL HEARINGS

The Mental Health Review Tribunal for Wales (MHRT) is a statutory body that works independently of the Health Board to review appeals made by detained patients for discharge from their detention and community orders under the Mental Health Act 1983. Patients are also automatically referred by the Hospital Managers in certain circumstances.

MHRT Hearings	Q1 2022/23	Q2 2022/23
Number of Hearings held	33	23
Number of Referrals by Hospital Managers	13	8
Number of referrals by Ministry of Justice	2	2
Number of referrals by Welsh Ministers	0	0
Number of Appeals to MHRT	47	42
Number of Detentions upheld by MHRT	31	21
Number of detentions discharged by MHRT	2	2
Number of Hearings adjourned/postponed	5	7
Number of Hearings cancelled by patient	10	10
Number of patients transferred to another Health Board prior to Hearing	4	0
Number of patients discharged by RC prior to Hearing	10	12

OTHER ACTIVITY

Death of a Detained Patient

The Hospital Managers have a duty to report to Healthcare Inspectorate Wales (HIW) any patients deceased who are subject to the Mental Health Act within 72 hours of death. This applies to in-patients as well as community treatment order and guardianship patients. The Coroner must also be informed.

Q2: There were no deaths of detained patients during this quarter.

EXAMPLES OF GOOD PRACTICE

- On 29/11/2022, the MHA team are attending a demo of the WCCIS system, which has recently gone live in Aneurin Bevan Health Board.

- The MHA team have booked multiple Overview of the Mental Health Act sessions across the Health Board between October 2022- March 2023, same face- to face, some via MS Teams. This training has been offered to a wide variety of health professionals including liaision nurses and nurse practitioners on the general wards

TRAINING

- A joint training event on the subject of Nearest Relative has been booked for 13th October 9.30-12.30 on Microsoft Teams.

- A free two day on line course is available on 17-18th October facilitated by Northumbria University, to include discussion on the Draft MHA Bill

- Joint training event on Part 3 of the MHA has been booked for 6th December 9.30-12.30 on Microsoft Teams

Appendix 2

MENTAL HEALTH ACT (1983)

GLOSSARY OF TERMS

SUMMARY OF COMMON SECTIONS OF THE MENTAL HEALTH ACT 1983

Section 5(4) Nurse holding power.	This means that if a Nurse feels that a patient suffers from a mental disorder and should not leave hospital s/he can complete this form allowing detention for 6 hours pending being seen by doctor or Approved Clinician (*1 holding power form required*)
Section 5(2) Doctor's or Approved Clinician's Holding power	This means that an inpatient is being detained for up to 72 hours by a doctor or Approved Clinician if appears to suffer from mental disorder and patient wishes to leave hospital. (*1 holding power form required*)
Section 4 Admission for assessment in cases of emergency	Individual is detained for up to 72 hours if Doctor believes person is suffering from mental disorder and seeking another Doctor will delay admission in an emergency. *(1 Medical Recommendation and AMHP assessment required)*
Section 2 Admission for assessment	Individual is detained in hospital for up to 28 days for assessment of mental health. **Criteria:** Suffering from mental disorder of a nature or degree that warrants the detention of the patient in hospital for assessment for at least a limited period. And it is necessary that patient ought to be detained in the interests of own health, own safety, protection of other persons *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*
Section 3 Admission for Treatment	Individual is detained in hospital for up to 6 months for treatment of mental disorder. **Criteria:** Suffering from mental disorder of a nature or degree which makes it appropriate for patient to receive medical treatment in hospital Moreover, it is necessary for the patient's own health, safety, protection of other persons that patient receive treatment in hospital. In addition, such treatment cannot be provided unless the patient is detained under Section 3 of the Mental Health Act. *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*

Section 7 Guardianship	Individual who suffers from mental disorder can be given a guardian to help them in the community. Guardianship runs for six months and can be renewable. **<u>Criteria:</u>** Live in a particular place Attend for medical treatment, occupational; education or training at set places and at set times. Allow a doctor, an approved mental health professional or other named person to see patient *(2 Medical recommendations (or one joint recommendation) and AMHP assessment required)*
Section 37 Guardianship by Court Order	Court can make an order (6 months) that patient be given a guardian if needed because of mental disorder. The guardian is someone from social services. **<u>Criteria:</u>** Live in particular place Attend for medical treatment, occupational education or training at set places and times Allow a doctor or an approved mental health professional or other named person to see you *(Court Order required)*
Section 37/41 Admission to hospital by a Court Order with restrictions	Individual admitted to hospital on the order of the Court. This means that the Court on the advice of two doctors thinks that patient has mental disorder and need to be in hospital for treatment. The Court makes restrictions and as such, patient cannot leave hospital or be transferred without the Secretary of state for Justice agreement. *(Court Order with restrictions required)*
Section 135 Admission of patients removed by Police under a Court Warrant	Individual brought to hospital by a Police Officer on a warrant from Justice Of Peace, which means that an AMHP feels that individual is suffering from mental disorder for which s/he must be in hospital. Warrant last for 24 hours (but can be extended up to 36 hours). *(Section 135 (1){**non-detained patient**} warrant required or Section 135 (2){ **sections and CTO patients**} required)*
Section 136 Admission of mentally disordered persons found in a public place	Individual brought to hospital by Police Officer if found in public place and appears to suffer from mental disorder. Assessment by Section 12 Approved Doctor and Approved Mental Health Professional. Section 136 last for 24 hours (but can be extended up to 36 hours). *(Police Service Section 136 monitoring form required)*
Section 17 A Community Treatment Order (CTO)	CTO allows patients to be treated in the community rather than detention in hospital. Order last 6 months and is renewable. There are conditions attached which are: Be available to be examined by Responsible Clinician for review of CTO and whether should be extended.

	Be available to meet with Second Opinion Doctor or Responsible Clinician for the purpose of certificate authorising treatment to be issued. The Responsible Clinician may also set other conditions if relevant to individuals, carers and/or family. (*CP1 Form to be completed by Responsible Clinician and AMHP)*
Section 17 leave	Allows Responsible Clinician (RC) to grant day and/or overnight leave of absence from hospital to patient liable to be detained under the Mental Health Act 1983.Leave can have set of conditions attached for the patient's protection as well as protection of others. Leave can be limited to specific occasions or longer-term. There is a requirement for RC to consider CTO if overnight leave will be over 7 days. Patients can be recalled to hospital if they do not comply with the requirement of their leave. *(Section 17 leave non-statutory form required)*
Section 117 aftercare	This section applies to persons who are detained under Section 3, 37, 45 A, transferred direction under section 47 or 48 and who cease to be detained after leaving hospital. It is the duty of the Health Board and Local Authorities to provide aftercare under Section 117 free of charge to patients subject to the above sections. Patients can be discharged from Section 117 aftercare if they no longer receiving services.
MHAM Hearings (Mental Health Act Managers)	Patients detained under sections of the Mental Health Act are entitled to appeal against their detention to the Hospital Managers several times during their period of detention. Patients are also referred to the Hospital Managers by the Mental Health Act Administrators when the Responsible Clinician (RC) submits a report renewing the section.
MHRT Hearings (Mental Health Review Tribunal)	Patients detained under Sections of the Mental Health Act are entitled to appeal against their detention to the Mental Health Review Tribunal for Wales once in each period of detention. If a patient decides to withdraw their appeal, they can appeal again at a later date and do not lose the right of appeal. Patients are also automatically referred to the Mental Health Review Tribunal by the Mental Health Act Administrators if they have not exercised their right of appeal after a set period. Mental Health Act Administrators also automatically refer patient subject to a CTO, which has been revoked by the Responsible Clinician, to MHRT.

AGENDA ITEM
4.3

MENTAL HEALTH ACT MONITORING COMMITTEE

RISKS RELATED TO THE MONITORING OF THE MENTAL HEALTH ACT

Date of meeting	07/11/2022
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Julie Denley Director Primary Care & Mental Health
Presented by	Julie Denley Director Primary Care & Mental Health
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act Team	(DD/MM/YYYY)	SUPPORTED

ACRONYMS	
MHA	Mental Health Act
UHB	University Health Board
RC	Responsible Clinician

ILG	Integrated Locality Group
AMHP	Advanced Mental Health Practitioner
GDPR	General Data Protection Regulation
HIW	Healthcare Inspectorate Wales
DGH	District General Hospital

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present risks related to the monitoring of the Mental Health Act (MHA) evident in quarter 2 2022/23 and for discussion and scrutiny related to actions and key milestones related to mitigating these risks.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The number of minor errors on section papers rose to 36 in quarter 2 from a typical picture of – circa 25 in previous quarters. It is good to see the operational group focusing in on the rectifiable errors by AMHP's and the assessing doctor, it is important for the operational group to continue to monitor the impact of this and working nationally to ensure all Health Boards are recording these in the same way to enable benchmarking and learning of actions that have the most impact. In preparing this risk report it is evident that many actions to address this area of practice have been implemented previously and the real impact of these is not really known.

2.2 There were 2 fundamentally defective errors during quarter 2, both related to Section 2, one in adult and one in CAMHS.

In both instances the primary issues was on the joint medical recommendation (Form HO3) was found was the reason for detention was found to be insufficient to warrant the use of the Act. This rendered the detention invalid. The action to reduce the likelihood of recurrence was noted.

2.3 The significant increase in the use of Section 136 in quarter 2 is noted and if the same is evident next quarter a further review of the changes should be undertaken by the operational group. The lapse in one Section 136 and associated action was noted.

2.4 It was good to see the Register of Conditionally Discharged Patients was now in place and being maintained.

2.5 Risk of the need to validate the section 117 register and develop a register of social and clinical supervisors is being progressed by the Operational Group.

2.6 It was pleasing to see a risk identified last time in relation to corresponding electronically with the Nearest Relative of patients detained under the Act is now assessed as fully compliant with the GDPR process.

2.7 The HIW Unannounced Inspection of Ty Llidiard highlighted some improvements being required in relation to Section 17 Leave and is good to see these have all been addressed and completed.

2.8 The constant turnover of medical personnel and appointing of locums who do not always have Approved Clinician status is clearly a challenge not easily fixed due to workforce availability. This clearly puts pressures on others with the required RC status and the MHA team particularly in relation to Consent to Treatment provisions of Part 4 of the MHA 1983.

2.9 The Review of Cwm Taf Morgannwg Emergency Duty Team appears to be mostly positive with high levels of satisfaction with the AMHP. It was noted that there were some concerns about some delays in assessments and the tie back into the Operational Group.

2.10 It was reassuring to see good audit processes across the breadth of Learning Disability services as the commissioner.

2.11 Following the discussion at the last Committee it was good to see a Review of Place of Safety Section 135 & 136 Assessments and the use of the 3 DGH based places of safety is being undertaken to inform a wider discussion on future provision across the region.

2.12 It is noted that as per the discussion last meeting the longest lapsed policy, Consent to Treatment Section 58 and Section 58a has been reviewed earlier.

2.13 Although this paper focuses on risks for balance, a few key positive highlights in other papers are noted below:

- Progress on the policies review is very evident.
- The link into referrals to advocacy is an important step for the operational group to be able to triangulate peoples experience.
- The broadening of training to cover a greater range of topics.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The real impact of actions to reduce the numbers of rectifiable errors is not known and it would be worth the Committee considering this and alternatives and the impact measurement of these.

3.2 The Medical Director is asked to consider are there any other actions that could help support part 4 RC requirements whilst there are locums in place who are not Approved Clinician related work.

3.3 The Committee are asked to discuss whether there is any valid reason for the use of joint medical recommendations forms that warrant their continued circulation given two almost identical errors related to their use that resulted in invalid detentions that would have been rectifiable issues if on individual medical recommendation forms.

3.4 The lack of a bespoke system to record and monitor MHA activity, which allows for the production of accurate reports on the wards across CTMUHB using different types of health records remains a concern and patient safety concern.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The issue of a lack of a single clinical record system stems from patient safety concerns and learning from events.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.

Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Mental Health Act Monitoring Committee is asked to:

DISCUSS and **NOTE** the report and the areas for reporting through to Board.

AGENDA ITEM
4.4

MENTAL HEALTH ACT MONITORING COMMITTEE

HIW REPORT ON CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) – ACTION PLAN AND PROGRESS REPORT

Date of meeting	(07/12/2022)
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Lisa Davies, Clinical Service Group Manager
Presented by	Dr Krishna Menon, Clinical Director
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
HIW	Healthcare Inspectorate Wales

1. SITUATION/BACKGROUND

1.1 Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Ty Llidiard within Cwm Taf Morgannwg University Health Board on 08 – 11 November 2021.

1.2 Ty Llidiard consists of two wards, the Enfys Ward and Seren Ward. Care is predominately provided to patients on the larger Enfys Ward, and the smaller Seren Ward is used to provide short periods of acute

care to patients who may require it. This inspection focused solely on the Enfys Ward.

1.3 During this inspection, HIW reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act. HIW also considered how the service complies with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

1.4 HIW made two recommendations for improvement in relation to the application of the use of the Mental Health Act and monitoring of the Mental Health Measure.

1.5 The first recommendation for improvement was in relation to Section 17 leave forms with the following reported:

"We saw that Section 17 leave was suitably risk assessed for each patient. However, we noted that the leave forms did not:
- Describe the intended outcome or purpose of the leave, or review how it went upon the patient's return
- Contain a section for the patient to sign to indicate their involvement and agreement to their leave
- Contain a photograph or description of the patient to enable safe return if the patient fails to return from their leave."

1.6 The second recommendation for improvement was in relation to care planning noting the need to co-produce these plans with young people with the following reported:

"we found that the care plans we reviewed:
- Appeared to be developed from a generic and standardised template; the patient's views and contribution to their own care plans was not evident, and therefore the patient's voice was not visible
- in one care plan, the name of the patient was not mentioned throughout, and in another, the name of a different patient was incorrectly included in one section
- Were not written using child friendly language that reflected the voice of the patient
- Did not have consideration of the eight areas of a person's life as set out in the Mental Health (Wales) Measure 2010
- Were not signed by the patient to evidence that they had agreed to it and received a copy

- Did not contain evidence to show whether patients had been assessed for capacity for a range of needs during their stay at the unit, for example, use of their mobile phone or handling their finances.

1.7 A monthly Ty Llidiard Improvement Board has been established since July 2022. This Board is chaired by the Executive Director of Therapies and Health Science (DoTHS). An integrated improvement plan has been developed incorporating the action plans and recommendations from reviews of the service, including the improvement actions outlined by HIW. The Board oversees the progress of the improvement plan.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Appendix 1** outlines the two areas for improvement in relation to the application of the Mental Health Act and monitoring of the Mental Health Measure and the actions taken by the service. The service reported back to HIW in June 2022 and these two actions have been assessed and reported as completed.

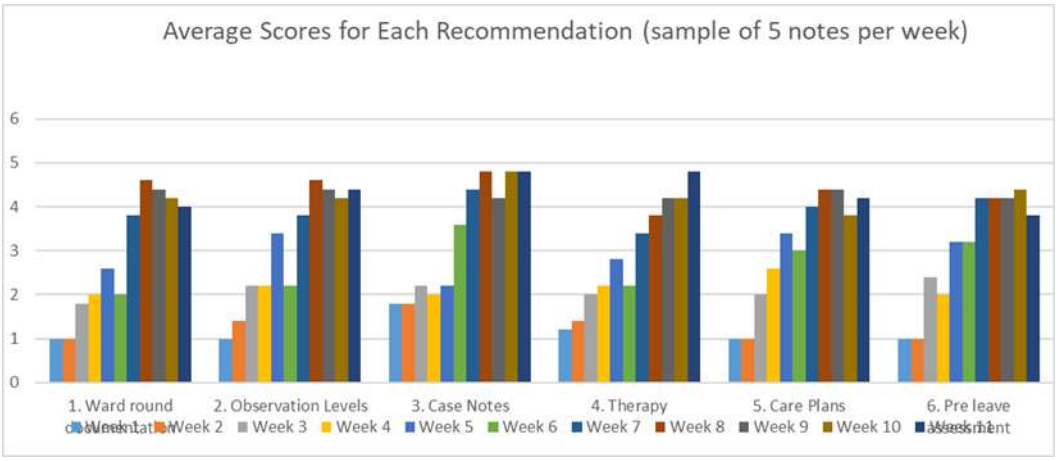
2.2 The actions taken in relation to implementation of the recommendations for Section 17 leave forms include the Clinical Lead ensuring the medical staff in the unit are aware of the requirements and the need to include the purpose of the leave and expected outcomes, and where appropriate these forms need to be signed by the young person.

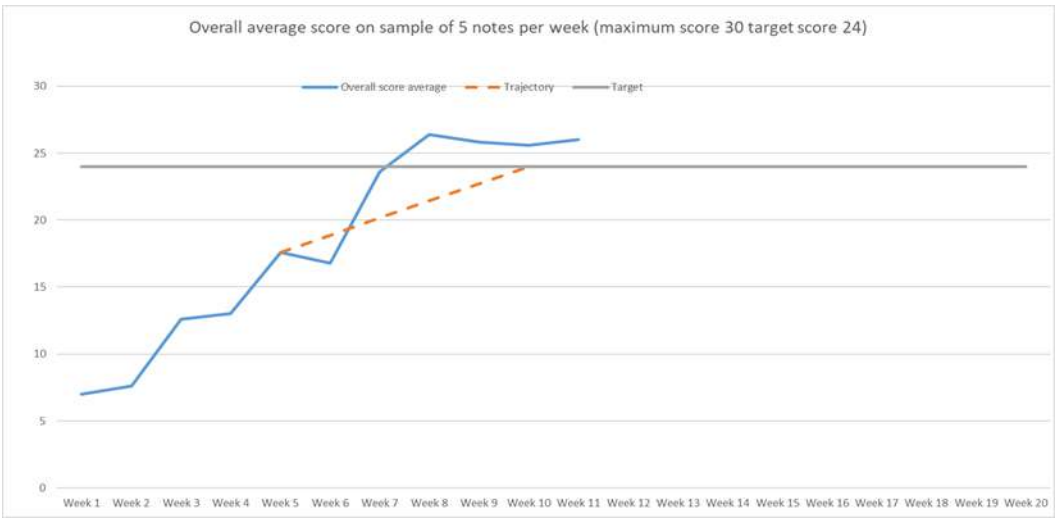
2.3 The actions taken in relation to ensuring the ward care planning documentation reflect the voice of the young person and are co-produced have included training and awareness with staff; alongside benchmarking with other units and ongoing audit and development of the care plans. The clinical team have met with the young people on a weekly basis to develop the approach to the ward care planning and documentation. The current ward care plan has been co-produced with the young people.

2.4 To support the progress of the integrated improvement plan in Ty Llidiard and improvement in the quality of the ward management plans, a weekly audit has been implemented and this reviews the quality of the Section 17 forms as well as the ward management plans.

2.5 The target is to achieve an average score of 4 out of 5 for each of the 6 categories, and an average total score of 24 out of 30. The audits will continue until there is adequate assurance that the improvements consistent are embedded in practice (minimum of 12 weeks after compliance).

2.6 The following graphs demonstrate the improvement in the average scores for each area including care planning and pre leave assessment (incorporating section 17):





2.7 To ensure that the improvement work for the individual ward management plans continues to reflect the input of our young people, the clinical team have also been asking the young people to assess their plan. This is in the early stages but initial feedback has been positive as shown below.

Initial feedback from the YP

YP	Ward Management Plan	New Care Plan
1	2/5	5/5
2	2/5	4/5
3	1/5	3/5
4	n/a	5/5

Scale
Are you happy with your care plan?
1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 There are no risks for escalation to the Committee in relation to the improvement work in Ty Llidiard. The actions identified from the unannounced HIW inspection in November 2021 have been assessed and reported as completed. To ensure the improvements are embedded and sustained a quality improvement programme is in place to monitor the quality of the clinical documentation.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required as no changes to service provision articulated.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 Members are asked to **NOTE** the progress outlined in this report

HIW – Improvement plan

Service: Ty Llidiard

Ward: Enfys

Date of inspection: 08-10 November 2021

The table below includes the improvements identified during the inspection in relation to the Mental Health Act where the service was required to complete an improvement plan outlining the actions being taken to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Status, timescale and latest position
Delivery of safe and effective care				
The health board must ensure that Section 17 leave forms are completed accurately and in full, and address the issues we identified in this report.	Application of the Mental Health Act	All section 17 documents are checked for completion and accuracy by the Mental Health Act Department. The Mental Health Act Department will report any issues with any paperwork submitted to the ward manager and clinical lead. The Clinical Lead has ensured that medical staff involved are aware of the requirement to complete Section 17 leave forms accurately and to include	Clinical Lead	Completed

Improvement needed	Standard	Service action	Responsible officer	Status, timescale and latest position
		the purpose of the leave and expected outcomes, and where appropriate these forms need to be signed by the young person. The quality of all MHS documentation is reported to and monitored by the Mental health Act Management Committee.		
The health board must ensure that the issues we identified in this report in relation to care plans are rectified going forward to meet the best practice guidelines for care and treatment planning as set out in the Mental Health (Wales) Measure 2010.	Monitoring the Mental Health Measure	Information has been shared with all staff on the importance and approach to developing and co-producing goal orientated care plans with patients. This has included ensuring the care plans are written in child friendly language and consider the 8 areas as outlined via the Mental Health measure. An additional audit using the Delivery Units all Wales CTP and documentation audit tool has been introduced and coordinated by the Nurse Audit Lead. A sample of the Care Plans, risk assessments and other documentation is audited using the tool every month. The audit is in depth and focusing on	Head of Nursing, Ward Manager and Nurse Audit Lead	Completed June 2022 See Appendix 6

Improvement needed	Standard	Service action	Responsible officer	Status, timescale and latest position
		the quality, co-production and personalisation of individual care plans. (see Appendix 8) These audits are discussed in the monthly Band 6 senior staff nurse meetings. Examples of good practice and areas identified as needing improvement are discussed. Examples of recognised high quality Care and Treatment Plans from both CAMHS inpatient, community and Adult Mental health Services have been shared with all staff to highlight good practice and share learning. The Head of Nursing; Ward Manager and Nurse Audit Lead will undertake an assessment of training needs for staff in relation to care plans and if required put in place specific training to support staff with care plans.		See Appendix 8

AGENDA ITEM
4.5

MENTAL HEALTH ACT MONITORING COMMITTEE

Crisis Care Concordat National and Local Update

Date of meeting	(07/12/22)
FOI Status	Open/Public
If closed, please indicate reason	Not Applicable - Public Report
Prepared by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Presented by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board
CCC	Crisis Care Concordat

CCAAB	Crisis Care Assurance and Advisory Board

This paper is presented to the committee to provide an update on progress in relation to the National and Local Crisis Care Concordat groups tasked with the successful implementation of the Wales Crisis Care Concordat National Action Plan 2019 – 2022 across the Cwm Taf Morgannwg region in collaboration with partner agencies and third sector organisations.

1. SITUATION/BACKGROUND

1.1 The Mental Health Crisis Care Concordat (the 'Concordat') is structured around six main principles and sets out twenty actions to support the successful implementation in practice. This was published by the Welsh Government and partners in 2015 as a shared statement of commitment by senior leaders from the organisations most involved in responding to and supporting people who experience a significant deterioration in their mental health that results in a mental health crisis.

1.2 Assurance related to progress against the action plan is provided to the national group and partners quarterly and to Welsh Government on a six-monthly basis via the Chair of the national group.

1.3 It is anticipated nationally that due to the pandemic there will be a significant and sustained increase in demand for mental health support where the causal factors are due to socio-economic impacts of Covid-19, as opposed to a medical or specialised mental health need.

1.4 Following publication of NHS Wales's National Collaborative Commissioning Unit report, 'Beyond the Call – National Review of Access to Emergency Services for those Experiencing Mental Health and/or Welfare Concerns' in October 2020, a sub-group of the national Concordat Assurance Group reviewed its findings and recommendations and has developed a 'Multi-Agency Interim Plan for Crisis Care 2021 to 2022.

1.5 Regional Crisis Care Concordat Forums will be required to work collaboratively now, more than ever to ensure that care pathways are effective for patients and timely but also develop plans to respond to the increasing demands of services, address the recommendation of the updated Multi-Agency Interim Plan for Crisis Care 2021 to 2022.

1.6 A new interim Crisis Care National Action Plan has been developed and shared across all regions (Appendix 1) This replaces the current national Action Plan 2019 - 2022. This new interim plan has 8 actions with each regional forum expected to oversee delivery. These have been aligned and allocated to the work streams of the CTM forum. A new national reporting template has been developed and will issued for implementation from January 2022.

2. SPECIFIC MATTERS FOR NOTING OR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Noting - Structure** of the forum to deliver against the Crisis Care Concordat action plan has been updated to reflect work stream lead changes (**Appendix 2**). The data information and outcomes measures and Secondary Care & Hospital based crisis pathway work streams have are currently without leads due to recent staffing changes and retirement. The chair and vice-chairs of the Regional Concordat will seek nominations for new leads and commence handover of objectives to new leads once appointed.

2.2 **Noting - Quality, Safety, Risk and Experience** is prioritised within the updated structure outlined in **Appendix 2**. Work streams are now aligned to the action plan. Reporting templates are also aligned to the national reporting template. This provides assurance and routes of escalation into the National Crisis Care Assurance and Advisory Board and the Mental Health Act Monitoring Committee. There is also a feedback mechanism in place for the regional group to receive updates directly from the Crisis Care Concordat National Co-ordinator. **Appendix 3** is the October 2022 submitted progress report to the CCAAB.

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Pilot Details
Weekend Out of hours

- Friday 18:30 to 22:00
- Saturday & Sunday 14:30 to 22:00

Notable outcomes of pilot to date

- Call durations range from 15-60 minutes.
- Peak times Saturday and Sunday evening.
- No outcomes to date have been referred to A&E or Mental Health Crisis.

A draft 111 pilot evaluation report with further outcomes from the pilot is provided in **Appendix 5**.

Phase 2 – 15 Hour 7 Day Service. Planned go live 30th January 2023. The 111#2 project is now working towards the implementation of a 7-day 15-hour service.

Notable updates are

- Staffing model agreed and signed off by National Programme Team.
- Recurrent funding for 15-hour service secured.
- Location agreed and secured to co-locate service with 111 physical health.
- Pathways reviewed, updated, and submitted to Delivery Unit for sign off. All pathways updated to include timeframes agreed with Mental Health Triage Scale and Principles of 111#2 including warm handover between services to reduce Patients need to repeat discussions, improving patient experience.
- Communications plan created and signed off by National Programme.

2.6 **Noting - Collaboration & Partnership Working**
Despite the challenges of the ongoing increased operational pressures that is presenting across all sectors, engagement with this work is positive and representation from across partners within region is noted.

The chair of the CCC forum will work to identify those less involved in the forum work to establish and supportively address and challenges or obstacles for attendance / engagement with the regional approach. Any obstacle to working collaboratively across with region will have a significant and detrimental impact on the pace with which this work will proceed.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Increased operational demands on all partners contributing to slower than anticipated progress within workstreams.

3.2 The regional CCC Forum will need to continue to work with colleagues across the region and nationally to address wider issues linked to the implementation of the concordat delivery plan. Lack of engagement from any partner will impact on the effectiveness and speed at which progress can be made. This will be monitored by the chair of the forum and escalated accordingly if concerns are identified.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

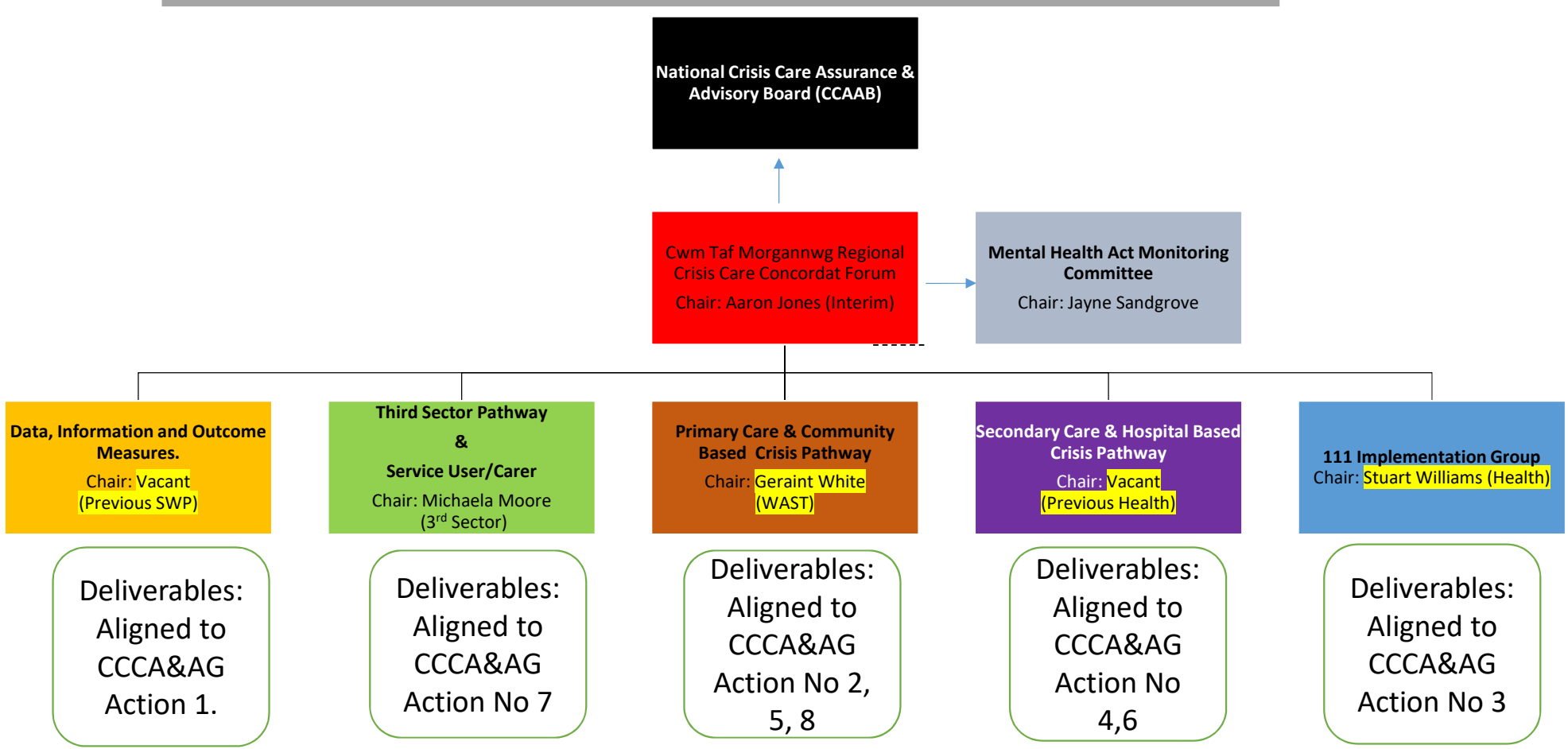
- **DISCUSS** the content of report
- **NOTE** key matters for escalation
- **APPROVE** receipt of a further update report in six months

No.	Action	Timescale	Led By	Outcome and output indicators
1	Each Region to have a multi-agency protocol in place between health, local authorities, the police and the third sector, published (on partners' websites) and updated every year setting out: • How the public should access care when in a crisis • Each agencies' role and responsibility relating to providing crisis care services • Criteria for accessing services in a timely manner • The arrangements in place for the appropriate and safe transfer of people between and across services • The service arrangements in place to meet the specific needs of people from minority and ethnic communities • How information will be shared across agencies, to help inform the delivery and improve outcomes for people presenting in crisis • Arrangements for how people affected by alcohol or drugs, and who have a mental health condition, will receive a timely and appropriate service	By June 2022	Regional multi-agency crisis care boards/forums	• Each Region to have standardised multi agency working methods in place for providing crisis care services that is described in a multi-agency protocol • An agreed arrangement in place for the sharing of information between agencies. • When a person is in police custody, each police service to have in place, systems and processes that help inform on the early identification of mental health needs and the methods for timely referring /signposting of people to the appropriate support service. (Timescales should be included within the regional protocol) • Feedback systems in place that inform on the appropriateness of care and its timeliness from people who have used crisis care services, including specific feedback from people from ethnic communities and from people affected by alcohol or drugs
2	Health Boards and local authorities develop joint plans, working with the third sector and other partners, to ensure that people of all ages who are experiencing early signs of a personal, emotional, or early-stage mental health crisis have 'out of hours' access to a 'safe place to go' service/facility, and an online or telephone based service, for respite, safety, or to help avert a crisis (Beyond the Call Rec.8)	Plan in place by March 2022 Service in place October 2022	HBs and LAs report progress quarterly to regional multi-agency crisis care boards/forums	• Each Region to have a plan in place that reflects local needs and informs on the services in place 'out of hours', and the model of delivery • Plans to include: ➢ How 'out of hours' service is shared/promoted ➢ How this provision fits in to wider local service models ➢ How service can be accessed

3	All organisations to engage with the 111 pilots and ensure that people of all ages with an urgent need have 24/7 access to mental health support, and that clear referral/signpost pathways are available for people where required, e.g., out of hours social services, welfare support, finance/debt, domestic abuse support, etc. (Beyond the Call Rec.6)	By October 2022	Unscheduled Care Board	• Reduction in number of people with mental health problems contacting emergency services through 999 • Reduction in the inappropriate use of s136 • 111 service in place with a single point of access across Wales with clear multi agency links to its method of working
4	People of all ages receiving a secondary mental health service have a high quality 'Crisis Plan' in place, reflecting Welsh Government requirements, that includes a mutually agreed advance statement, and details of planned support to help prevent and/or mitigate any future potential crisis (Beyond the Call Rec.4)	By June 2022	HBs report to regional multi-agency crisis care boards/forums	• Evidence through regular audit of crisis plans (as part of CTP audit) with findings reported quarterly to multi-agency crisis care board/forum • 'Service user' feedback at CTP review • Reduction in admissions to hospital • Reduced demand on 999 services for people known to mental health services
5	'All agencies will ensure that those who are in contact with people in distress have the necessary knowledge, skills, and attitudes to ensure compassionate and supportive care is delivered' *(Talk2Me2 Objective 2vi)*	By March 2022	Regional multi-agency crisis care boards/forums	• Agencies to have a training programme in place that reflects the 'Talk2 me2 Objective 2vi'. Uptake on training to be reported annually to regional multi-agency crisis care boards/forums • Post training, implement an evaluation process with: - The staff who have been trained People that have used the services
6	People discharged from psychiatric in-patient care should be followed up by the service within 72 hours of discharge and a comprehensive care plan should be in place at the time of discharge and during pre-discharge leave (National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH report 2019 p6) display.aspx (manchester.ac.uk)	By June 2022	HBs report to regional multi-agency crisis care boards/forums	• Operational working practices in place that reflect NCISH guidance • Information to be communicated to the individual and their GP within 24 hours following discharge and where appropriate copied to the community team and other specialist services • Revised CTP to be in place to reflect any change in a persons' care needs

7	Feedback and views will be systematically sought and captured from people of all ages who have used crisis care services, and acted upon, including specific feedback from people from minority and ethnic communities	By June 2022	All partners	• Service user feedback mechanism introduced and reported quarterly to multi-agency crisis care boards/forums
8	Public sector services that manage or commission facilities caring for vulnerable persons will have a robust 'missing person' protocol in place. These protocols should specify preventative measures to reduce missing person's calls to the Police, such as the proactive management of risk (Beyond the Call' Rec. 5)	By June 2022	All partners	• Missing persons protocol implemented in all Regions • Reduced number of people reported missing • Reduced missing persons calls to the police

CWM TAF MORGANNWG REGIONAL CRISIS CARE CONCORDAT FORUM STRUCTURE



Mental Health Crisis Care Concordat - Assurance Report

Partnership area:	Cwm Taf Morgannwg	**Reporting period:**	August 2022 – October 2022
Actions set out in the Crisis Care Concordat National Action Plan are being implemented through regional action plans and monitored at a regional level		**Assurance provided by:** Aaron Jones, Interim Chair, CTM Crisis Care Concordat Forum	**Date completed:** July 2022

Key achievements in this reporting period Include details of how any transformation or service improvement funding is helping achieve results	**Challenges and remedial action**	**Priorities for next 3 months**
A presentation was given at the last CCCF meeting on the CAMHS Crisis Liaison service. The service is based in the Royal Glamorgan Hospital and covers the three acute hospital sites. From October the service hours have been extended to cover 5 days a week, 24 hours a day. The service is planned to be 24/7 from 2023. Positive feedback has been received from the emergency department. CTM will be developing a WG funded pilot to provide a wraparound service to children and young people in addition to the liaison service. A multi-agency Crisis Data Dashboard has been developed to track trends in existing services, monitor the implementation of the Action Plan and the resulting benefits to service users. The proof of concept was received positively at the July CTM regional Crisis Care Forum meeting and continues to be refined . CTM Crisis Dashboard October 2. Mental Health 111 project group established and meeting fortnightly. Recruitment is being progressed for phase 2.	Increasing operational demands on all agencies. Ongoing challenges of capacity to progress work at pace. Regular changes to meeting attendance effects continuity and progress. Thorough handovers requested between personnel. Workstream lead for Action 1 has moved to another role and awaiting a new workstream lead.	Work stream leads to progress the development of their multi-agency groups and work plans. Elect new workstream lead for Action 1 and continue to develop the multi-agency protocol. Develop plans with local authorities for a 'safe to go' service in Merthyr and in the Rhondda & Taff Ely locality (Action 2). Continue to develop the CTM Crisis Care multi-agency dataset/dashboard. This data set will include collection and analysis to evidence outcomes from implementation of the 111#2 project.

Discussions regarding a third sector post Crisis follow-up service are in their early stages. It is intended that the service will connect those who have had contact with Health Board Crisis services with non-statutory services that may help address the person's needs. Further updates will be given as these plans progress.		

	Action	By when	What to report	Update
1	Each Region to have a multi-agency protocol in place between health, local authorities, the police and the third sector setting out: • How the public should access care when in a crisis • Each agencies' role and responsibility relating to providing crisis care services • Criteria for accessing services in a timely manner • The arrangements in place for the appropriate and safe transfer of people between and across services • The service arrangements in place to meet the specific needs of people from minority and ethnic communities • How information will be shared across agencies, to help inform the delivery and improve outcomes for people presenting in crisis • Arrangements for how people affected by alcohol or drugs, and who have a mental health condition, will receive a timely and appropriate service	By June 2022	**Regional forum to confirm whether multi-agency protocol is being developed. If not, what is the plan for managing the risks of non-delivery?** Also consider output and outcome indicators detailed in National Action Plan	A multi-agency protocol is being developed and a draft has been shared with CCCF members and wider in the Health Board for feedback. Feedback received has been incorporated into the draft Protocol for discussion and agreement. A mapping exercise setting out current local access points has been undertaken as part of the MH 111#2. The protocol will be updated with MH 111#2 as it transitions from Pilot to core service. It is proposed that there is a public facing version of the protocol and then a version for statutory/ other partners which includes the more detailed policies that sit behind the protocol. The review of all agencies operational policies is continuing to ensure all pathways are known and included in the overarching protocol.

2	Health Boards and local authorities develop joint plans, working with the third sector and other partners, to ensure that people of all ages who are experiencing early signs of a personal, emotional, or early-stage mental health crisis have 'out of hours' access to a 'safe place to go' service/facility, and an online or telephone-based service, for respite, safety, or to help avert a crisis	Plan: By March 2022 Service: By Oct 2022	**Regional forum to confirm whether joint plans are being developed** Also consider output and outcome indicators detailed in National Action Plan	Mental Health Matters Wales, South Wales Police, Social Services (Bridgend CBC) and CTMUHB have partnered to develop a pilot Wellbeing Retreat in Bridgend. The service was launched in December 2020 and continues to be evaluated on an ongoing basis. A multi-agency group consisting of Cwm Taf Morgannwg Health Board, South Wales Police, Bridgend Social Services, ARC and key third sector partners meet regularly to jointly plan. Access is through a "single point of access" referral system. The service is available between the hours of 5:00pm and 11:00 p.m. Wedesday and Friday to Sunday each week. The Operations Manager for the Wellbeing service in Bridgend presented to the CTM Crisis Care Forum on the 1st April to ensure members are kept informed. Referral data will routinely be included in the Performance Dashboard embedded. Learning from the Bridgend Wellbeing Retreat is being considered in planning to roll a 'safe place to go' service out across the CTM footprint. Joint plans are being developed for a Wellbeing Retreat, to be located as part of a a wider wellbeing hub, in Merthyr. Timescales are dependent on the outcome of a bid submitted by Merthyr County Borough Council. Joint plans are in the early stages for Rhondda and Taff Ely locality. A mapping exercise is being undertaken with Rhondda Cynon Taff CBC of the current services and times of operation to support people in a crisis in Rhondda, Taff and Cynon localities to better understand the gaps in services. The planning and development of the 'safe place to go' model in Rhondda and Taff Ely is being used as an action

				research project to engage/ involve service users and co-produce the service and develop engagement and involvement pathways in CTM.
3	All organisations to engage with the 111 pilots and ensure that people of all ages with an urgent need have 24/7 access to mental health support, and that clear referral/signpost pathways are available for people where required, e.g., out of hours social services, welfare support, finance/debt, domestic abuse support, etc.	By Oct 2022	**Regional forum to confirm plan for 24/7 access to services via 111** *For Feb to March 2022:* **Report on number of people contacting 111 for MH issue** **Report on number of people contacting 999 with MH issue** **Report number of people detained under s135 and s136** Also consider output and outcome indicators detailed in National Action Plan	Mental Health 111 project group established and meeting fortnightly. Pilot is currently active and operational Friday 18.30 – 10.30 p.m., Saturday 18.30 a.m. – 22.00 p.m., Sat and Sunday 14.30 -22.00 p.m. subject to staffing availability. A 15 hour a week service model from 9.00 – 12.00 p.m. has been agreed in the interim and plans are progressing for a 24/7 service co-located with the GP OOH service at Ty Elai, Williamstown. Recruitment is underway for key posts but filling psots remains a challenge nationally. CTM are working with the National Programme team in relation to training and induction plans. Robust data collection and analysis is being established to be able to evidence outcomes from implementation of 111 project. Quarterly updates on progress will be provided to the CTM Crisis Care Forum. **See the Performance Dashboard embedded above for output and outcome indicators.**
4	People of all ages receiving a secondary mental health service have a high quality 'Crisis Plan' in place, reflecting Welsh Government requirements, that includes a mutually agreed advance statement, and details of	By June 2022	**Organisations to confirm that crisis plans are internally audited as part of CTP audit, and that crisis**	CTM continue to have undertake specific audit relating to crisis contingency planning. This audit has a focus on co-produced contingency plans to support people where relapse signatures are becoming evident with a view to

	planned support to help prevent and/or mitigate any future potential crisis		**plans include mutually agreed advance statements** **Organisations to confirm what feedback mechanisms are in place** Also consider output and outcome indicators detailed in National Action Plan	reduce relapse in to crisis and the need for emergency services. Reporting is through The Mental Health Measure Operational Group. The development of good quality co-produced care plan is also a major focus of CTP training for CTMUHB HB staff. **See the Performance Dashboard embedded above for output and outcome indicators.**
5	'All agencies will ensure that those who are in contact with people in distress have the necessary knowledge, skills, and attitudes to ensure compassionate and supportive care is delivered' (Talk2Me2 Objective 2vi)	By March 2022	**Organisations to confirm the training programmes in place, including uptake and attendee feedback** Also consider output and outcome indicators detailed in National Action Plan	It has been agreed through NAG that the Suicide & Self Harm Prevention (SSHP) Coordinator team will produce a series of workshops and training webinars nationally. Work is underway with the national SSHP coordinator team to build an online platform to ensure that training, guidance, and a competency framework is available, accessible & user friendly. Training Providers are currently being supported to upload details of their training offers onto the platform. A training and development audit tool is currently being built, and piloted, with the support of the data analyst team in the Collaborative to help identify key groups of learners across the system, their needs, and the training products available to upskill across sectors. The survey will be deployed to establish a baseline, prior to the launch of the training and development platform. Members of the CCCF will be invited to compelte the survey. The Regional SSHP is a member of the CCCF and will attend meetings to give regular updates on work being undertaken.

				Invitations to future training will be shared with CTM Crisis Care Forum members and members will be invited to suggest topics of interest through the SSHP Coordinator. A local assessment of the training available across regional organisations is being undertaken to identify gaps. Organisations will share training opportunities where appropriate.
6	People discharged from psychiatric in-patient care should be followed up by the service within 72 hours of discharge and a comprehensive care plan should be in place at the time of discharge and during pre-discharge leave	By June 2022	*For Jan to March 2022:* **Report number of people discharged from in-patient care** **Report what arrangements are in place to follow up within 2-3 days of discharge from in-patient care** Also consider output and outcome indicators detailed in National Action Plan	Operational Policies are clear in describing the process for 72 hour follow up post discharge Any individual discharged into secondary care services has a full care and treatment plan at the point of discharge. This is reviewed and updated where needed prior to discharge. Audit work is done on this and presented to Patient safety and quality group Discharge Advice information is sent electronically to GP's at the point of discharge
7	Feedback and views will be systematically sought and captured from people of all ages who have used crisis care services, and acted upon, including specific feedback from people from minority and ethnic communities	By June 2022	**Organisations to confirm system/process in place for service user feedback, and provide updates to regional crisis care forums** Also consider output and outcome indicators detailed in National Action Plan	The lead Mental Health Service User Involvement Officer (SUIO) for BAVO (CVC) is now leading on this workstream alongside SUIO's in VAMT and Interlink. A number of system/ processes are in place across the pathway in order to obtain feedback and views from people who have used crisis care services. Whilst this is embedded in some areas of crisis services further work is required to ensure it is systematically embedded across all areas of the Crisis Pathway. • Feedback collected from third sector organisations varies often due to requirements from funders.

				• Feedback is sought and captured routinely in relation to multi-agency Wellbeing Retreat in Bridgend. • Feedback currently not routinely captured for HB Crisis Care services. Civica System is being rolled out in the Health Board with a view to being implemented in Mental Health.
8	Public sector services that manage or commission facilities caring for vulnerable persons will have a robust 'missing person' protocol in place. These protocols should specify preventative measures to reduce missing person's calls to the Police, such as the proactive management of risk	By June 2022	**Organisations to confirm there is a 'missing person' protocol agreed and in place** *For 1st Jan to 31st March 2022:* **Report number of people reported missing** **Report number of missing persons calls to the Police** Also consider output and outcome indicators detailed in National Action Plan	• The list of missing persons from all hospitals are reviewed at monthly Police Liaison Meetings. Any issues are identified and actioned. • There is an existing Health Board policy for persons missing from care settings. The policy covers specific measures to take before contacting the police. • Health Board policy is included within the police's MH and Missing Person policies. SWP policies are currently being transferred onto a new template and being made public as they come up for review - both of these are due for review in the coming months. • LA's use the Herbert Protocol. See the Data Dashboard embedded above for missing person numbers reported to the police.

AGENDA ITEM
4.5

MENTAL HEALTH ACT MONITORING COMMITTEE

Crisis Care Concordat National and Local Update

Date of meeting	(07/12/22)
FOI Status	Open/Public
If closed, please indicate reason	Not Applicable - Public Report
Prepared by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Presented by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
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- No outcomes to date have been referred to A&E or Mental Health Crisis.

A draft 111 pilot evaluation report with further outcomes from the pilot is provided in **Appendix 5**.

Phase 2 – 15 Hour 7 Day Service. Planned go live 30th January 2023. The 111#2 project is now working towards the implementation of a 7-day 15-hour service.

Notable updates are

- Staffing model agreed and signed off by National Programme Team.
- Recurrent funding for 15-hour service secured.
- Location agreed and secured to co-locate service with 111 physical health.
- Pathways reviewed, updated, and submitted to Delivery Unit for sign off. All pathways updated to include timeframes agreed with Mental Health Triage Scale and Principles of 111#2 including warm handover between services to reduce Patients need to repeat discussions, improving patient experience.
- Communications plan created and signed off by National Programme.

2.6 **Noting - Collaboration & Partnership Working**
Despite the challenges of the ongoing increased operational pressures that is presenting across all sectors, engagement with this work is positive and representation from across partners within region is noted.

The chair of the CCC forum will work to identify those less involved in the forum work to establish and supportively address and challenges or obstacles for attendance / engagement with the regional approach. Any obstacle to working collaboratively across with region will have a significant and detrimental impact on the pace with which this work will proceed.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Increased operational demands on all partners contributing to slower than anticipated progress within workstreams.

3.2 The regional CCC Forum will need to continue to work with colleagues across the region and nationally to address wider issues linked to the implementation of the concordat delivery plan. Lack of engagement from any partner will impact on the effectiveness and speed at which progress can be made. This will be monitored by the chair of the forum and escalated accordingly if concerns are identified.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

- **DISCUSS** the content of report
- **NOTE** key matters for escalation
- **APPROVE** receipt of further update report in six months.

Appendix 2 – Updated CTM CCC Forum Structure

CTM CCC Forum Structure Nov 22.pptx

Mental Health 111 Press 2

Pilot Evaluation Report

Version 3.0

Document Author: Danielle Hooper

Date: April 2022

Introduction

Background

In May 2019 the Welsh Government, through the National Crisis Care Concordat Group, commissioned the Director of Quality & Mental Health/Learning Disabilities at the NHS Wales National Collaborative Commissioning Unit to undertake a National Review to achieve greater understanding of the issues leading the public to access emergency services when experiencing mental health and/or welfare concerns. In October 2020 the 'Beyond the Call' National Review was published by Welsh Government. Some of the findings of the publication were:

- In Primary Care one of the biggest gaps in provision reported by GPs is the increasing number of people who do not fit a clear referral pathway because of the complexity of their needs. Increasing complexity is one of the major factors responsible for the 'rising workload' in general practice.
- A recent review of Community Mental Health Teams in Wales found many areas of good practice in Wales but also 'variability' in access to crisis care. This Review found that 51% of people receiving care from these services did not know who to contact when in crisis 'out of hours' and 57% were 'not satisfied' with the 'help' offered 'out of hours'.
- The Welsh Ambulance Service answered nearly 112,965, '999' calls in the first three months of 202,053 and internal reports show 'mental health demand' to be between 7% and 10% of calls, with about third of calls resulting in conveyance to a hospital or emergency department.
- In Wales the NHS 111 service is not currently designed to provide specialised mental health support but, during the in the first three months of 2020, circa 1% of the 170,875 calls received, in the areas where the NHS '111' service is available, were classed as mental health calls.

Evaluation of pilot projects have found that having mental health professionals as part of the NHS 111 service resulted in '25% fewer' people needing to attend an emergency department for mental health concerns. Another pilot evaluation found that, of the people triaged by mental health professionals through a NHS 111 Service, 3% needed a police or ambulance response, 17% needed a 'face to face' crisis assessment and the other 80% were signposted to third sector partners, crisis sanctuaries or were referred to primary or community services.

Assessment

In May 2021 a project group was formed for MH111 in CTM with the objectives to implement a Mental Health 111 service. This project works in collaboration with the National 111 Programme team. This project will be delivered in 3 phases.

Phase 1 – Planned Pilot Go Live
Weekend Out of hours 111 MH Service.

- Friday 18:30 – 22:00
- Saturday 14:30 – 22:00
- Sunday 14:30 – 22:00

Phase 2 – Extend hours to include week day evenings
As above but include: -

- Monday to Thursday 18:30 – 22:00
- Recruit substantive staff

Phase 3 – Implement 24/7 model

Phase 1 pilot expectations.

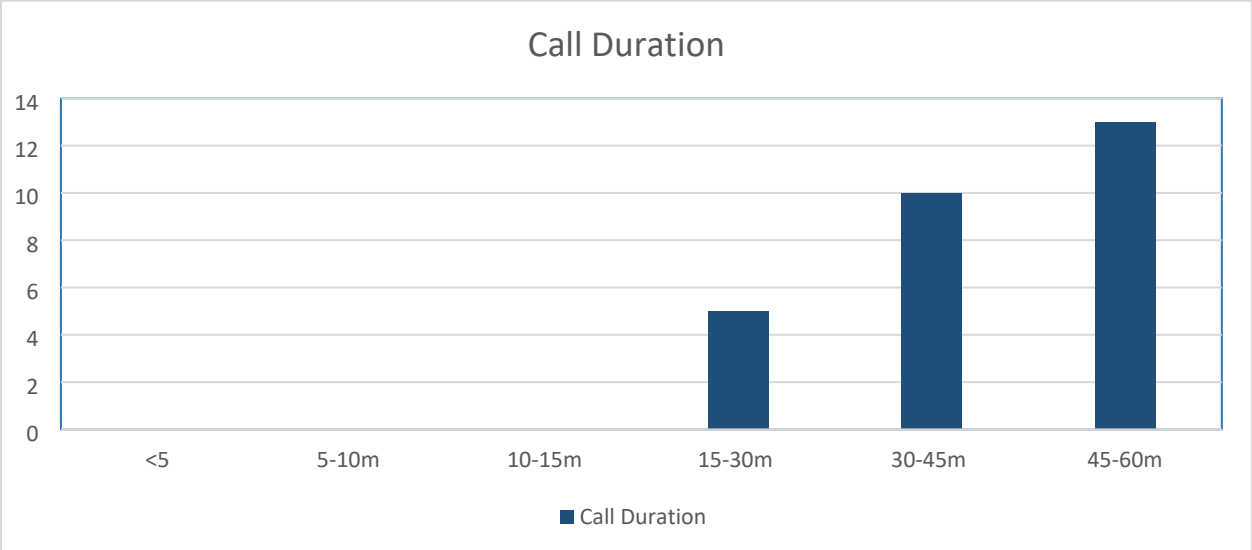
- Improved Patient Experience / Patient Centered Approach
  - No Wrong Door – When a person contacts CTM 111 MH Service they will receive an inclusive response and assisted with their current presentation and arrangements made for further/different support if needed.
  - Right Help, Right Time – By working towards a 24/7 approach, we will respond effectively to urgent mental health needs.
  - Reducing Duplication – Users of CTM Mental Health Service should not have to repeat their story. The person completing referrals will be a trusted assessor, therefore further assessments should only be additive to the patients care.
- Correct care for the current CTM 111 Mental Health users
  - CTMs current 111 call center is not skilled to deal with calls categorized as Mental Health, meaning the majority of Mental Health categorized calls are referred to Mental Health Crisis Teams, Hospital Emergency departments or GP Out of Hours teams. The pilot CTM 111 MH service will be able to correctly deal with the current CTM 111 Mental Health calls freeing up resources in the current referral pathways.

The pilot commenced in November 2021 with shifts being covered by Mental Health staff already in existing substantive roles. Working closely between the 111 call centre staff and Mental Health practitioners, calls with an identified mental health issue were transferred to the 111 (press 2) service. Prior to the pilot calls would have been directed to Mental Health Crisis teams, Hospital Emergency departments or GP Out of Hours teams. This evaluation report presents data collected during the pilot period in order to inform the Project Board and support them in the development of the 111 (press 2) project.

Statistics – Call outcomes

An outcome evaluation was developed to help us understand the nature, frequency, need of calls & the outcomes of the pilot between November 2021 – March 2022.

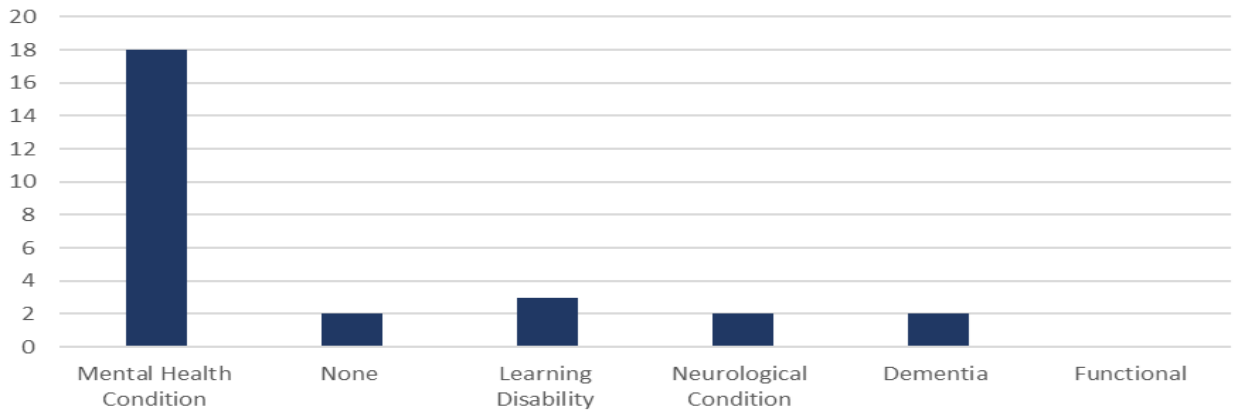
Call Duration



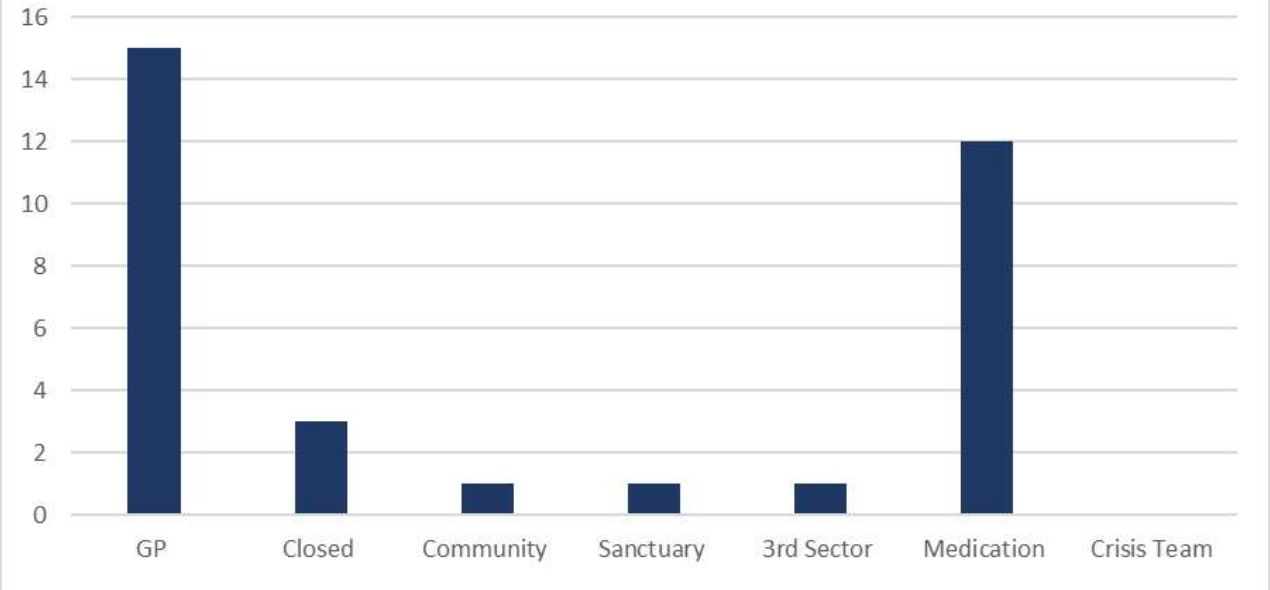
Call Peak Times

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
14:00-18:00						**Low**	**Low**
18:00-22:00					**Low**	**High**	**High**

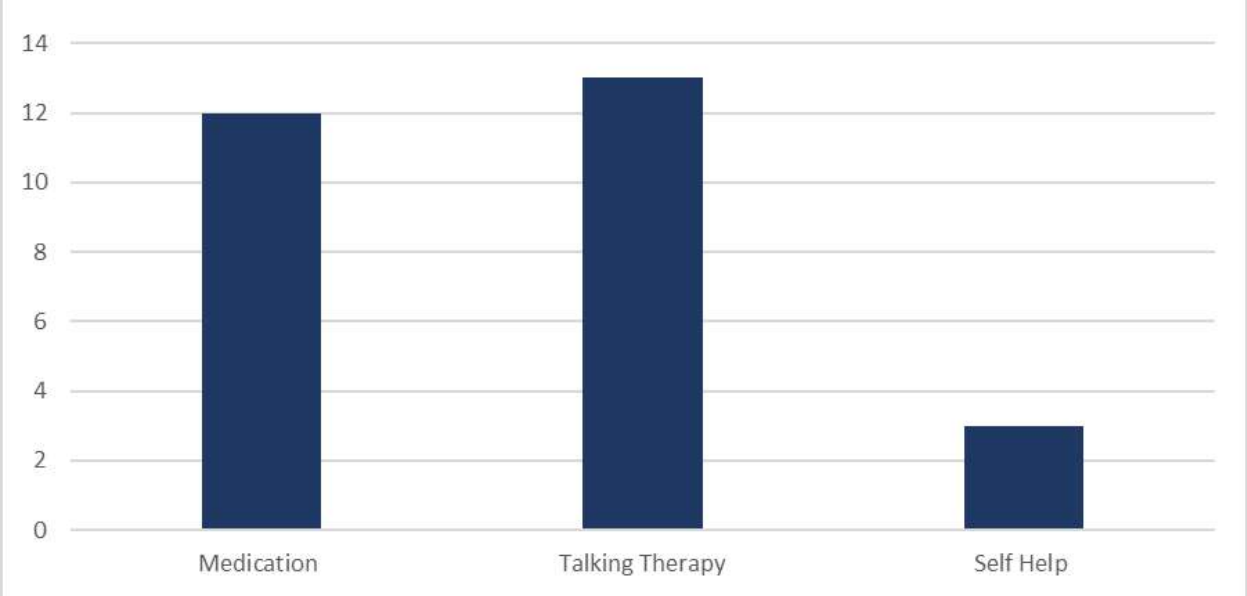
DEMOGRAPHICS: PREMORBID DIFFICULTIES



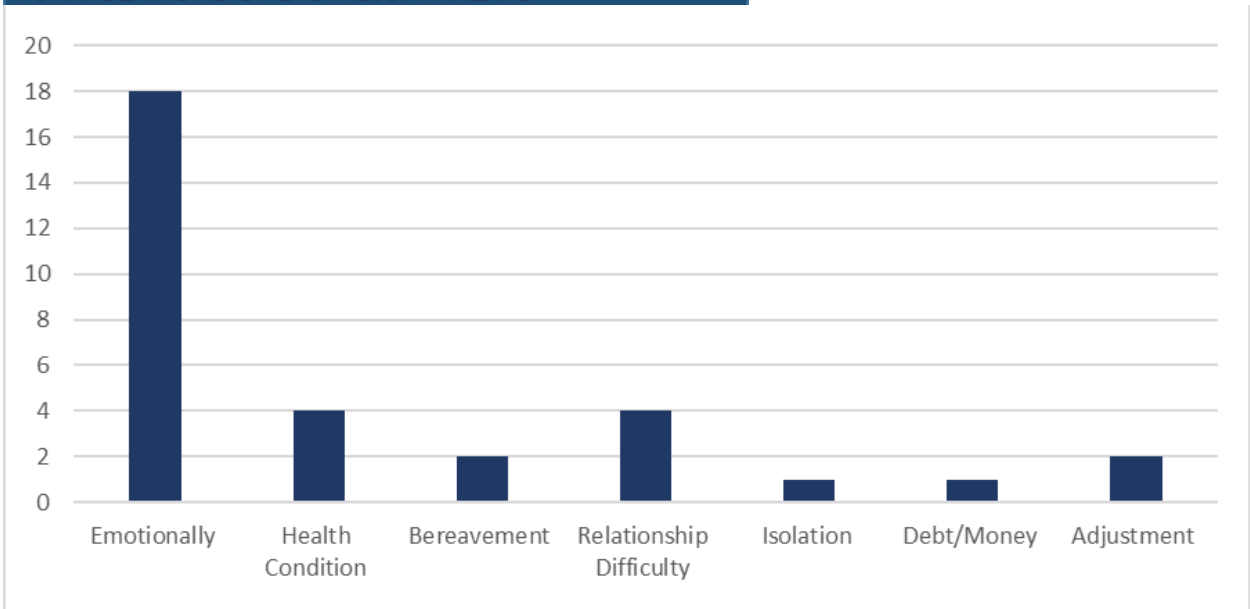
Call Outcomes – what happened next?



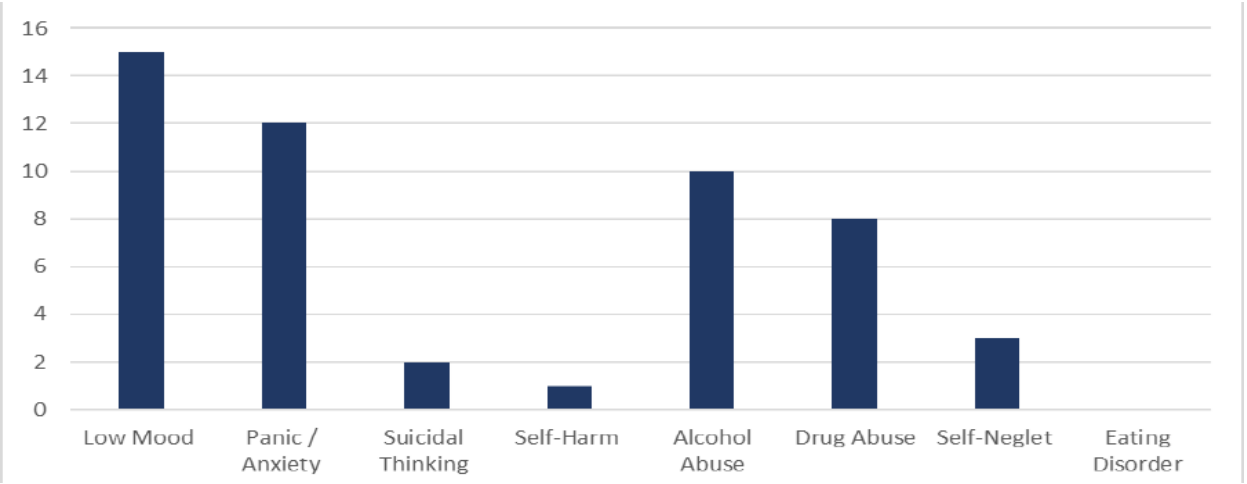
Treatment & Interventions



FORMULATIONS OF DISTRESS: THREATS

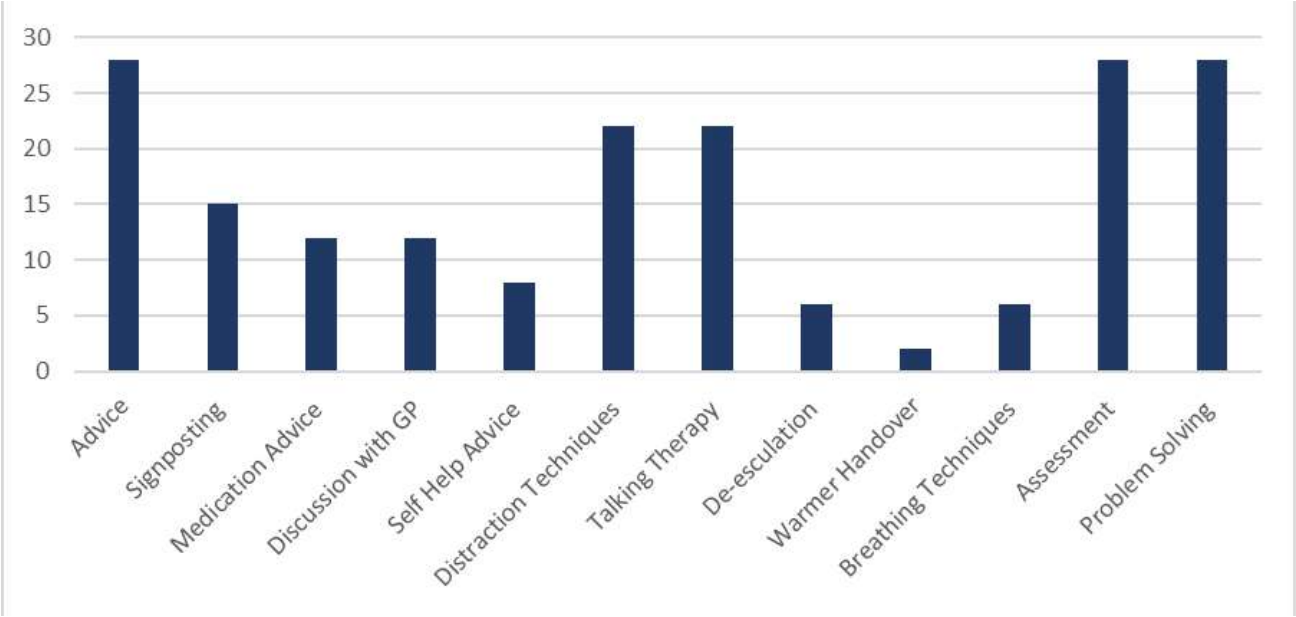


FORMULATION OF DISTRESS: THREAT REPONSES



Threat responses refer to 'symptoms' or reactions to the threats that people experience. Multiple responses were applicable to callers. Many callers described difficulties with low mood and anxiety.

OUTCOME OF CALLS: SKILLS NEEDED BY MENTAL HEALTH PRACTITIONERS



Discussion

Whilst the data represents a relatively small sample of people requesting mental health support, the data suggests that the role of a 111 (press 2) mental health call handler is more involved than following any pre-defined algorithm and then diverting calls to the most appropriate service for further help. Key findings from the pilot shows the majority of calls last between 30 – 60 minutes, knowledge of pharmacology and psychological therapies are essential skills together with the ability to support people who present in distress. Of note, the national evaluation also supports the finding that call handlers are needing to support people in distress who sometimes do not require further support but are helped by the call handler.

Given the above findings, an agreement is needed on a staffing model and whether this is made up of unqualified staff with clinical support, qualified staff only or a mix of both.

With regards to outcomes, a significant number of these are directed to the GP. It is not clear from the data what is the 'ask' of the GP but we would need to be assured that people are not being directed to primary care to access other services. For example, Local Primary Mental Health Support Services. Given the pressures primary care services are currently under, a better understanding is needed of this outcome. Particularly if demand is being shifted from one clinical area to another, i.e. Emergency Departments to Primary Care.

Recommendations

The author requests that this evaluation report is submitted to the next Project Board meeting to form part of the wider discussion to decide on the staffing model of the 111 (press 2) service which is due to go live in the summer of 2022.

In addition, approval is needed to move into 'Phase 2' of the pilot. Phase 1 of the pilot was a weekend only service which members of staff worked;

Friday: 18:30-22:00
Saturday & Sunday: 14:00-22:00

Phase 2 will extend the service providing the following;

Monday-Friday 18:30-22:00
Saturday & Sunday 14:00-22:00

If approved, Phase 2 will commence in May to allow the project team enough time to do further evaluations and work to ensure our 24/7 service will be robust and run to its best potential.

We are very grateful to those who have taken part in this pilot to allow us to gain the knowledge and understanding of how a Mental Health 111 service with run. We are thankful for their skilful and compassionate response to each caller.

MENTAL HEALTH ACT – FORWARD WORK PLAN 2022				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request made by the Committee at its meeting held in October 2022 for a written report.	Additional Item	Use of the MHA for patients with a Learning Disability – Activity and Compliance against Code of Practice	Chair/Clinical Lead Operational Group	7 December 2022 **Update to be provided within the Operational Group Report.**
Request made by DPCMH at agenda planning meeting 2.8.22 to be added to the agenda for six months' time.	Additional Item	CAMHS – HIW Report and Update on Action Plan.	Chair/Clinical Lead Operational Group	7 December 2022
Action following the October 2022 meeting to review the number of IM's to be quorate.	Additional Item	Amendment to the Standing Orders – Schedule 2 – MHAMC Terms of Reference	Director of Governance	7 December 2022
Action from August 2021 Meeting to receive an	Additional Item	Annual Review of Suicides 2021-22	South Wales Police	8 March 2023

annual review of suicides.				
Action following the October 2022 meeting to receive a report from the Care Group on the review of breaches	Additional Item	Outcome from Review of Breaches from the previous two years in relation to themes and trends	Primary Care, Community & Mental Health Care Group	8 March 2023

Completed Activity from the Forward Work Programme

Originally on forward work programme for March 2022 deferred to October 22	Additional Item	SWP Update on the Use of the Mental Health APP	South Wales Police	A verbal update was provided at the 12 October 2022 meeting - **Completed**
Request made by Committee at November 2021 meeting to receive further written reports to future meetings on the Mental Health and Learning Disability	Additional Item	Individually Commissioned Placements, NHS Use and Assurance	Director of Primary, Community & Mental Health	8 June 2022 - **Completed**

aspect of the commissioned placements				
Originally requested at August 2021 meeting for November 2021.	Additional Item	Data on Section 135/136 from the 2019/2020 activity to review as an example of a more typical year.	Head of Nursing, MH	8 June 2022 - **Completed**
Committee advised at the March 2022 meeting that an In Committee meeting would be held in June 2022	Additional Item	Conclusion of the review into the Fundamental Breach of the MHA	Director of Primary, Community & Mental Health	8 June 2022 - **Completed**