Date	**11/03/2025**
Time	**10:30 - 12:00**
Location	**Ystwyth Board Room and Microsoft Teams**

Mental Health Legislation Committee Meeting

HDD_Mental Health Legislation Committee

NHS Wales

Agenda - 11 March 2025

1 Governance

1.1 Welcome and Apologies

2 min
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Declaration of Interests

2 min
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.3 Minutes of the meeting held on 2nd December 2024

5 min
All

1.4 Table of Actions from the meeting held on 2nd December 2024

5 min
All

2 Assurance and Risk

2.1 Power of Discharge Sub-committee

10 min
Ruth Bourke (Hywel Dda UHB - Mental Health Act Administration Lead)

2.2 Mental Health Act Report

10 min
Sarah Roberts (Hywel Dda UHB - Mental Health Legislation Manager)

2.3 Mental Health Legislation Scrutiny Group

10 min
Kay Isaacs (Hywel Dda UHB - Assistant Director of MH&LD)

2.4 Mental Health (Wales) Measure 2010 Report

10 min
Amanda Davies (Hywel Dda UHB - Head of Service, Adult Mental Health)

2.5 Risk Register

10 min
Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing MH&LD), Kay Isaacs (Hywel Dda UHB - Assistant Director of MH&LD), Warren Lloyd (Hywel Dda UHB - Consultant Psychiatrist)

3 Policies

3.1 Section 136 Joint Procedure

10 min
Sarah Roberts (Hywel Dda UHB - Mental Health Legislation Manager)

4 For Information

4.1 HIW Mental Health Annual Report 2023-2024

5 min
Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing MH&LD)

4.2 Mental Health Act Review

5 min
Sarah Roberts (Hywel Dda UHB - Mental Health Legislation Manager)

4.3 Schedule of Meetings 2025-2026

1 min
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

4.4 Annual Work Plan 2025-2026

1 min
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

5 Any Other Business

2 min
All

6 Matters for Escalation to Board

2 min
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

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7 **Date and Time of Next Meeting**

Table of contents

11/03/2025 10:30 - 12:00

1

10:30,

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1 - Governance

1.1 **2 Mins**

1.1 - Welcome and Apologies

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For information

1.2 **2 Mins**

1.2 - Declaration of Interests

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For information

1.3 **5 Mins**

1.3 - Minutes of the meeting held on 2nd December 2024

All

For approval

Attachments

003. Minutes of the meeting held on 2 December 2024.docx

003. Minutes of the meeting held on 2 December 2024

1.3 - Minutes of the meeting held on 2nd December 2024

Last modified: 04/03/2025

COFNODION Y CYFARFOD
PWYLLGOR SICRWYDD DEDDFWRIAETH IECHYD MEDDWL
HEB EU GYMERADWYO / UNAPPROVED
MINUTES OF THE
MENTAL HEALTH LEGISLATION COMMITTEE (MHLC)

Date and Time of Meeting:	10:30-12:00pm, Monday 2nd December 2024
Venue:	Ystwyth Board Room and Via MS Teams

Present:	Mr Iwan Thomas, Independent Member Ms Ann Murphy, Independent Member Ms Chantal Patel, Independent Member
In Attendance:	Ms Liz Carroll, Director of Mental Health & Learning Disabilities Mrs Becky Temple-Purcell, Assistant Director of Nursing MH&LD Dr Warren Lloyd, Associate Medical Director/Consultant Psychiatrist CAMHS Ms Kay Isaacs, Assistant Director of MH&LD Mrs Sarah Roberts, Mental Health Legislation Manager Ms Ruth Bourke, Mental Health Act Administration Lead Ms Jane Hitchings, Pembrokeshire Local Authority Mr Simon Thomas, Ceredigion Local Authority Ms Corinne Everett-Guy, Carmarthenshire Local Authority Ms Angie Darlington, West Wales Action for Mental Health Mr Neil Mason, Head of Service for Older Adult Mental Health Service Ms Amanda Davies, Head of Service for Adult Mental Health Service Ms Angela Lodwick, Assistant Director of MH&LD Secretariat: Ms Manon Horscroft, PA to Assistant Director of Nursing MH&LD

MHLC (24) 68	Introductions and Apologies for Absence	Action
	Mr Iwan Thomas introduced himself to committee and welcomed all attendees to the meeting. The following apologies for absence were received: • Ms Eleanor Marks, Vice Chair of Hywel Dda University Health Board • Mr Andrew Carruthers, Chief Operating Officer • Mr Winston Weir, Independent Member • Mr Richard Jones, Consultant Nurse/Responsible Clinician MH&LD • Mr Christian Newman, NHS Executive • Supt Chris Neve, Dyfed-Powys Police	

MHLC (24) 69	Declarations of Interests	
	No declarations of interest were made.	

MHLC (24) 70	**Minutes of the meeting held on 3rd September 2024**	
	The minutes of the meeting held on **3 September 2024** were **APPROVED** as an accurate reflection of the previous meeting.	
	The Committee **NOTED** and **APPROVED** the minutes from the previous MHLC meeting held on the **7 June 2024.**	

MHLC (24) 71	**Table of Actions from the meeting held on 3 September 2024**	
	The Table of Actions was reviewed, all actions were marked as completed and will be removed from the Table of Actions.	
	The Committee **NOTED** and **AGREED** the MHLC Table of Actions.	

MHLC (24) 72	**Annual Work Plan 2025-2026**	
	The Annual Work Plan 2025-2026 was shared with Committee prior to the meeting. Members of the Committee agreed on the Annual Work Plan 2025-2026 which will assist with administration of future meetings.	
	The Committee **NOTED** and **AGREED** the Annual Work Plan 2025-2026.	

MHLC (24) 73	**Mental Health Legislation Committee Self-Assessment 6 month review**	
	Mr Thomas highlighted the purpose of the report was to provide an update to the actions that were agreed by committee in response to the self-assessment process. The Committee took assurance from the progress made against the actions being undertaken to improve the effectiveness of the Committee.	
	The Committee **RECEIVED** and **ASSURED** Mental Health Legislation Committee Self-Assessment 6 month review.	

MHLC (24) 74	**Mental Health Legislation Scrutiny Group Terms of Reference**	
	The Mental Health Legislation Scrutiny Group Terms of Reference were up for their annual review in November. The membership of the group was updated to include GP Cluster representative. Mrs Sarah Roberts noted that the Terms of Reference now includes Right Care Right Person as a standard agenda item which is led by Dyfed-Powys Police. Committee received and ratified the Mental Health Legislation Scrutiny Group Terms of Reference.	
	The Committee **RECIEVED** and **RATIFIED** Mental Health Legislation Scrutiny Group Terms of Reference	

MHLC (24) 73	**Power of Discharge Sub-committee**	

	The Power of Discharge Sub-committee was stood down where Ms Ruth Bourke confirmed that the next report will be received in readiness to the Committee meeting in March 2025.	
	The Committee **RECEIVED** and **NOTED** the Power of Discharge Sub-committee.	
MHLC (24) 74	**Mental Health Act Report**	
	The Mental Health Act Report highlighted the usage of the act during quarter two. The extensive report had been previously shared with Committee ahead of the meeting. Mrs Roberts noted during quarter two there was a lower use of Section 136 and a higher increase of Section 3 and Dr Holding Power. Mrs Roberts also stated that Section 2 usage was lower than previous quarters. Mrs Becky Temple-Purcell noted that the reduction in overall activity that prior to the holiday season Dyfed-Powys Police had approached the Directorate to pre plan the impact on the amount of visitors that would be in the area with the ability to be able to respond in particular to Section 136. From the data within the report the spike from the holiday season is not seen but what is noticeable from the data within the report is the slight drop in activity. Mrs Roberts noted that during this holiday season the team did not see as many out of area people picked up by Section 136's as the previous summer. Mrs Temple-Purcell noted under page 64 of the report on the breakdown of Community Treatment Order activity within each county. Mrs Temple-Purcell noted on the ethnicity breakdown within the report and compared the data with Mental Health Act in general there is a higher representation of Community Treatment Order for people who are other than White British ethnicity. Ms Angie Darlington highlighted under page 12 of the report of the usage of restraints and how many times restrains were used in terms of Section 136. Ms Darlington noted that the five occasions where under 18's were detained under Section 136 handcuffs were used. These figures should be monitored through the Mental Health Legislation Scrutiny Group. Mrs Temple-Purcell updated Committee that some members were a part of the Mental Health Strategic Program meeting board where the Mental Health Bill was referenced. During the meeting there was acknowledgement of the movement where it is likely to be an engagement programme developed from an All Wales perspective with relevant stakeholder panels around the Mental Health Bill to develop a plan on what this would mean to Wales.	
	The Committee **RECEIVED** and **NOTED** the Mental Health Act Report.	

MHLC (24) 75	**Mental Health Legislation Scrutiny Group**	
	The previous Mental Health Legislation Scrutiny meeting occurred on 14th November which was well attended by members. There were two legislation risks that are still open and was highlighted during the meeting. One risk is in relation to the temporary closure of the place of safety in Aberystwyth and the other risk was identified at the Mental Health Legislation Scrutiny meeting in respect of a delay in a bed being available when someone has been detained in the community under the Mental Health Act. Section 135 warrant to search for and remove patients Interagency procedure and Information to Patients right procedure were reviewed during the meeting.	
	The Committee **RECEIVED** and **NOTED** the Scrutiny Group Update Report.	
MHLC (24) 76	**Mental Health (Wales) Measure 2010 Report**	
	Ms Liz Carroll stated within the Mental Health (Wales) Measure 2010 Report that CAMHS Part B has improved for October and now within target. This was an area that was targeted intervention for the Directorate. Ms Amanda Davies noted on the slight increase to the CMHT referrals made from people through the 111 option two service. A lot of promotion has been made for 111 option two service due to the closer of MIU in Llanelli. Ms Davies noted to Committee that the service has received additional funding from Welsh Government to create more social media and radio advertisement for the service.	
	The Committee **RECEIVED** and **NOTED** the Mental Health (Wales) Measure 2010 Report.	
MHLC (24) 77	**Operational Risk Register**	
	Ms Carroll raised that one additional risk has been to the operational Risk Register which is on the Capacity demand in terms of the inpatient pathway that's mitigated through the two day, twice daily bed conference meetings. The Community Place of Safety risk and the Section 136 risk remains on the Operational Risk Register. The CAMHS Section 136 is a mitigated risk but once the minor works are complete Ms Carroll believers that this risk will be closed.	
	The Committee **RECEIVED** and **ASSURED** the Risk Register update.	

MHLC (24) 78	**Policies for Approval**	
	The Section 135 warrant to search for and remove patients interagency procedure and Information to Patients right procedure was shared with Committee prior to the meeting. Both policies have been through the Health Board formal process. Both policies have been updated in line with the three yearly review. The Mental Health Legislation Committee received and approved both policies.	
	The Committee **RECEIVED** and **APPROVED** the Section 135 warrant to search for and remove patients interagency procedure. The Committee **RECEIVED** and **APPROVED** the Information to Patients right procedure.	

MHLC (24) 79	**Smoke Free NHS Policy**	
	Ms Darlington shared a presentation to Committee around feedback from patients on Smoke Free NHS legislation in Mental Health Settings. Ms Darlington has been working closely with Lucy Duncanson from Public Health Wales who is the lead for the Smoking and wellbeing team. The legislation was brought into Mental Health settings from September 2022. Ms Darlington shared the challenges, opportunities, general feedback and recommendations from patients in 2022-2023. The presentation was circulated to Committee following the meeting for full information. Ms Carroll noted that most people who come into the inpatient services under the Mental Health Act, there is an immediate deprivation of liberty that the indicial is subject to, but on top of this patients are taken away their decision of smoking.	
MHLC (24) 80	**MIND Cymru- Raising the Standard Improving Inpatient Mental Health Care in Wales**	
	Mrs Temple-Purcell shared the MIND Cymru- Raising the Standard Improving Inpatient Mental Health Care in Wales report with Committee as it is valuable to include on the agenda as it focuses on how to build and support the mental health workforce and how to engage people with lived experiences. The report gives an insight and useful on the themes and areas that is raised throughout. Within the report Mrs Temple-Purcell noted that care and treatment planning is included and it's not just the numbers. The Quality Assurance and Practice Development Team along with Service leads through the Directorate are looking at a new approach to audit of Care and Treatment plans that are more focused around quality.	

	Mrs Temple-Purcell assured Committee that as a Directorate the Reducing Restrictive Practice reports are received bi-monthly through the MH&LD Directorate Quality Safety and Experience group meeting. The report notes the patient safety programme that is happening across Wales where the programme has a number of focus areas one being the relational safety and within the work stream, there is a piece of work looking at what kind of activities and therapeutic activities are currently happening across wards in Wales.	
MHLC (24) 81	**Schedule of Meetings 2024-2025**	
	For information only.	
MHLC (24) 82	**Annual Work Plan 2024-2025**	
	For information only.	
MHLC (24) 83	**Schedule of Meetings 2024-2025**	
	For information only.	
MHLC (24) 84	**HIW Annual Plan 2023-2024**	
	For information only.	

MHLC (24) 85	**Any Other Business**	
	No updates for the meeting.	

MHLC (24) 86	**Matters for Escalation to Board**	
	Alert: • No items to raise. **Advise:** • No items to raise. **Assure:** • The Mental Health Legislation Committee Self-Assessment 6-month review was discussed at the December 2024 meeting. Actions that raised within the Self-Assessment were discussed. The Mental Health Legislation Committee took assurance from the progress being made against the actions undertaken to improve the effectiveness of the Committee. • The Mental Health Act Report focused on quarter 2 data. No specific trends were seen during this quarter. It was highlighted at Committee that there was lower usage of Section 136, with higher usage of Section 3 and Doctors Holding Power. • The Mental Health Legislation Scrutiny Group met on 11 November 2024, with the main discussions around the review of the Group's Terms of Reference. Membership of the Group was reviewed, with this now to include a GP	

	Cluster representative. Within the Terms of Reference, Right Care Right Person has now been included as a standard agenda item, to be led by Dyfed-Powys Police. The Mental Health Legislation Scrutiny Group focused discussions on the two legislation service risks on the Mental Health and Learning Disabilities Risk Register. Firstly ‘’The temporary closure of the Community Place of Safety at Gorwelion, Aberystwyth’’. This remains unchanged whilst the S136 Multi Agency Review Meeting progresses an option appraisal in respect of future S136 place of safety provision. The second risk is on ‘’Delayed admission to hospital posts recommended detention under the Act, following a Mental Health Act Assessment (MHAA)’’. • Section 135 warrant to search for and remove patients interagency procedure and Information to Patients right procedure policies were due for their three year renewal. Both policies had gone through the Health Board formal processes and were approved by the Committee. **Review of Risks:** • The corporate risk 1857 ‘Risk of significant delay in admission for individuals with medical recommendations for admission under the Mental Health Act’ was raised at the Committee meeting. The risk score has increased, as demand outweighs capacity at present, with delays possible for patients awaiting beds. • The Committee highlighted risk 1752, ‘Risk to Young People's privacy, dignity and Health and Safety due to the 136 suite on Morlais being unsuitable’, The risk is significantly reduced due to the relocation of the suite. Minor works are now required to provide a separate entrance for the 136 suite. • The Committee noted that there were no changes to the status of the 1781 ‘Risk of being unable to provide a Community Place of Safety (CPOS) to individuals detained under Section 136 in Ceredigion county’ Corporate Risk.	

MHLC (24) 87	**Date, Time and Venue of Next Meeting**	
	The next meeting of the Mental Health Legislation Committee will be held on Tuesday, 11th March at 10:30am. This may be in person and via MS Teams from 10:30am- 12:00pm. The venue for the in-person meeting will be notified nearer to the date of the meeting.	

1.4 **5 Mins**

1.4 - Table of Actions from the meeting held on 2nd December 2024

All

For assurance

Attachments

004. Table of Actions from the meeting held on 2 December 2024.docx

004. Table of Actions from the meeting held on 2 December 2024

1.4 - Table of Actions from the meeting held on 2nd December 2024

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TABLE OF ACTIONS FROM MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 2nd DECEMBER 2024

26 March 2024				
MINUTE REFERENCE	**ACTION**	**LEAD**	**TIMESCALE**	**PROGRESS**
MHLC (24) 05	**Mental Health Act Report:** **05. 02.** By looking at the report, Mrs Temple-Purcell suggested whether the Committee might want to commission a deep dive from Mental Health Legislation Scrutiny Group meeting around activity within general settings.	KI, SRo	February 2025	Update from 14th November- discussions occurred during the Mental Health Legislation Scrutiny Group that the Chair of the group Kay Isaacs undertook a deep dive for quarter one, however it was suggested that the deep dive should be looking into over a longer period of time. This will be extended to February 2025 Mental Health Legislation Scrutiny to then be shared at the March Committee. Update from 2nd December- Action to be closed and will be monitored through the MHLSG.

2

2 - Assurance and Risk

2.1 **10 Mins**

2.1 - Power of Discharge Sub-committee

Ruth Bourke (Hywel Dda UHB - Mental Health Act Administration Lead)

For assurance

Attachments

005. Power of Discharge Sub-committee.docx

005. 01. Apendix 1 Minutes Power of Discharge.doc

005. Power of Discharge Sub-committee

2.1 - Power of Discharge Sub-committee

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 March 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	The Power of Discharge Sub Committee Minutes
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operation
SWYDDOG ADRODD: REPORTING OFFICER:	Ruth Bourke, Mental Health Act Administration Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Mental Health Legislation Committee to be assured that the work undertaken by the Power of Discharge Sub Committee during the quarter are carried out correctly.

Cefndir / Background

This Report provides in respect of the work that has been undertaken by the Power of Discharge Sub-Committee during the quarter, that those functions of the Mental Health Act 1983 (the Act), as amended are being carried out correctly; and that the wider operation of the 1983 Act in relation to the Local Health Board's area is operating properly.

The hospital managers must ensure that patients are detained only as the Act allows, that their treatment and care fully comply with it, and that the patients are fully informed of, and are supported in exercising, their statutory rights. Hospital managers must also ensure that a patient's case is dealt with in line with other legislation which may have an impact, including the Mental Capacity Act 2005, the Human Rights Act 1998 and the Data Protection Act 1998.

Asesiad / Assessment

A copy of the Hospital Managers Power of Discharge Sub Committee minutes dated 09th December 2024 are submitted as appendix 1.

Argymhelliad / Recommendation

All other information is for information only

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	The Mental Health Legislation Committee provides an assurance to the Board of the organisation's compliance with primary legislation in Wales including the Mental Health Act (1983), with the 2007 amendments, and the Mental Health (Wales) Measure 2010
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Outlined in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Deddfwriaeth Iechyd Meddwl: Parties / Committees consulted prior to Mental Health Legislation Committee:	The Mental Health Legislation Scrutiny Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Non-compliance with the Mental Health Act could result in legal proceedings being brought against the Health Board who is the detaining authority

Ansawdd / Gofal Claf: **Quality / Patient Care:**	There is a patient representative on the Mental Health Legislation Committee
Gweithlu: **Workforce:**	N/A
Risg: **Risk:**	Risk of non-compliance with the 1983 Act and with the Welsh Government's *Mental Health Act 1983 Code of Practice for Wales* and with the *Good Governance Practice Guide – Effective Board Committees (Supplementary Guidance) Guidance*. Safety of patients Assurance – use of statutory mechanisms
Cyfreithiol: **Legal:**	As outlined above
Enw Da: **Reputational:**	Mental Health Act media focus
Gyfrinachedd: **Privacy:**	As above
Cydraddoldeb: **Equality:**	N/A

005. 01. Apendix 1 Minutes Power of Discharge

2.1 - Power of Discharge Sub-committee

Last modified: 05/03/2025

COFNODION Y CYFARFOD
PWYLLGOR HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE
DRAFT MINUTES OF THE
HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE MEETING

Date and Time of Meeting:	Monday 9th December 2024 at 13.30
Venue:	MS Teams

Present:	Mr Iwan Thomas, Independent Board Member (Chair to POD Sub-Committee) Mrs Eleanor Marks, Vice Chair Mr Rhodri Evans, Independent Member Prof Chantal Patel, Independent Member Mr Stephen Smedley, Member Appeals Panel Mrs Angela Brown, Member Appeal Panel Mrs Carol Williams, Member Appeal Panel Mr John Williams, Member Appeal Panel Mrs Julie James, Member Appeals Panel Mrs Sue Richards, Member Appeals Panel Mr Richard Griffith, Member Appeals Panel Mr Peter Thomas, Member Appeals Panel Mr Robert Lewis, Member Appeals Panel
In Attendance:	Sarah Roberts, Mental Health Legislation Manager Louise Howells, Mental Health Act Administrator Natalie Williams, Mental Health Act Administrator Helena Christopher, Mental Health Act Administrator Natasha Fox, Independent Mental Health Advocate, Advocacy West Wales

Governance:		
Agenda Item	**Item**	**Action**
HMPODSC (24) 1.1	Introductions and Apologies for Absence.	
	Apologies for Absence were received from: Ruth Bourke, Mental Health Act Administration Lead Mr Maynard Davies, Independent Member Mr Winston Weir Independent Member Mrs Jane Jannotti, Member Appeal Panel Mr Ian Rees, Member Appeal Panel Mr Owen Burt, Member Appeals Panel Mrs Sarah Burgess, Member Appeals Panel	
	Chair welcomed members.	

HMPODSC (24) 1.2	**Declarations of Interests**	
	No declarations declared.	

Hospital Managers Power of Discharge Sub-Committee
Part 1
Sub Committee Business and Information

	Minutes of Meeting Held on 6th August 2024	
HMPODSC (24) 1.3	Members in attendance confirmed the minutes as an accurate record of the meeting	

	Table of Actions	
HMPODSC (24) 1.4	Table of Actions from last meeting held now all completed	

	Discussion of Learning and Governance from panel hearings	
HMPODSC (24) 1.6	Discussion about matters arising from hearings during the last quarter:- Members in attendance had no comments to make from recent panel hearings Ruth asked that all panel members ensure that they bring their devices to hearings and attend in a timely manner as there have been a few occasions where panel members have arrived late and some occasions where there has been no attendance by a panel member at all. Chantal raised the issue with Wi-fi, which may have an affect on reviews, it was agreed that administrators would ensure attendees have access to wi-fi which is sufficient if attending reviews remotely. Helena reminded members of the importance of ensuring that they correctly record dates for reviews as there has been a few occasions where there has been no attendance by panel members, It was agreed that invites are sent to members for all reviews including those conducted in person.	

Received for Assurance – Operation of Section 23 Mental Health Act 1983		
HMPODSC (24) 2.1	Operation of S23 Mental Health Act 1983 Report on the use of the Mental Health Act 1983 – 1st July 2024 – 30th September 2024	
	Iwan summarised the report and noted that some reports are being submitted passed the due date, Sarah highlighted the pressure of beds and lack of Responsible Clinicians currently and also the movement of patients between wards which does have an impact on submission of both medical and nursing reports.	

	Sarah Roberts also confirmed that there has been an increase in the amount of MHRT's which are being held in person, the MHRT are continuing to offer hearings virtually or in person. The report showed that the number of applications made to hospital managers continue to remain low. Helena confirmed that all patients continue to be given the opportunity to request a hearing remotely or in person and they are given the option to have their review heard in English or Welsh Sarah noted to all members that the option to Chair reviews is available to them.	

For Discussion		
	MHRT Annual Report	
HMPODSC (24) 3.1	Louise confirmed that the Annual Report has not yet been published and will be circulated to members once it is available	LH

	HIW Annual Report	
HMPODSC (24) 3.2	Chair summarised the report, and noted that pages 35 to 36 where with regards to Mental Health and are of particular interest Chantal highlighted that it is noted within the report the inadequate nursing levels, and should this be included with the report submitted to board level. Julie asked if any HIW visits had taken place in Hywel Dda this passed year, Sarah confirmed that 3 sites had undergone inspections by HIW however there were no actions in relation to the Mental Health Act .	

	IMHA report (1st July 2024 – 30th September 2024)	
HMPODSC (24) 3.3	Members received the report provided by Nia Williams, Advocacy West Wales for information. Natasha confirmed that activity levels are up which is a result of having a full team which is enabling Advocates to be more present on wards The Henry Smith Foundation funding was due to come to an end however this has been extended for a further year. The IMHA contract has been extended for a further 2 years	

	The UK Government Budget will have an impact on services as the number of hours may have to be reduced. Natasha confirmed that there is a new IMCA service called Advocacy Support Cymru who have taken over the contract for Mental Health Matters Wales	

For Information		
	Minutes Mental Health Legislation Committee 03rd September 2024	
HMPODSC (24) 4.1	Provided for information.	

	Any Other Business	
HMPODSC (24) 5.0	Julie James asked if there was any update on payments for members, Sarah confirmed that notification has been sent to all members, and will ask Ruth Bourke to resend the confirmation email Louise informed members that due to a few requests for review papers and teams links to be sent to external email addresses, discussions had taken place with Information Governance who can confirmed that no papers are to be sent to external email addresses	SR/RB

	PART II TRAINING	
HMPODSC (24) 6.0	<u>Training</u> A training presentation on Community Treatment Orders was provided for all members by Richard Griffith <u>Further training requirements</u> Training to be provided on Information Governance at the next meeting	LH

	Date and time of next meeting	
HMPODSC (24) 7.0	Tuesday 26th November 2024 at 13.30 via MS Teams	

2.2

10 Mins

2.2 - Mental Health Act Report

Sarah Roberts
(Hywel Dda UHB -
Mental Health
Legislation Manager)

For assurance

Attachments

006. Mental Health Act Report.docx

006. 01. Appendix 1- Quarter 3.docx

006. Mental Health Act Report

2.2 - Mental Health Act Report

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 March 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health Legislation Scrutiny – Mental Health Act Data Performance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Roberts, Mental Health Act Administration Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the paper is to present to the Mental Health Legislation Committee the quarterly Mental Health Performance Report in relation to statutory mental health legislation in Wales including The Mental Health Act (1983), as amended.

The paper also includes assurance of other work carried out by the Mental Health and Learning Disabilities Directorate where related to mental health legislation.

Cefndir / Background

This Report provides assurance in respect of the work that has been undertaken by Mental Health and Learning Disabilities (MHLD) Services during the quarter, that those functions of the Mental Health Act 1983 (the Act) which have delegated to officers and staff, are being carried out correctly; and that the wider operation of the 1983 Act in relation to the Local Health Board's area is operating properly.

The hospital managers must ensure that patients are detained only as the Act allows, that their treatment and care is fully compliant, and that patients are fully informed of, and are supported in exercising, their statutory rights. Hospital managers must also ensure that a patient's case is managed in line with other legislation which may have an impact, including the Human Rights Act 1998 and the Data Protection Act 1998.

The Terms of Reference of the Committee require the submission of a quarterly report to the Board to summarise the work of the Committee and identify how it has fulfilled the duties required of it. Regulations permit the Hywel Dda University Health Board to delegate functions to committees or sub-committees whose members need not be members of the Board. However, the Board retains the ultimate responsibility for the hospital managers' duties.

This report is prepared following the quarterly meeting of the Mental Health Legislation Scrutiny Group. The purpose of this Group is to allow senior managers and clinicians from

Hywel Dda University Health Board, its partner agencies and other stakeholders to scrutinise the University Health Board's (UHB) performance, to highlight areas of good practice, and any areas of concern that must be brought to the Committee's attention.

A copy of the full report received to inform the MH Legislation Scrutiny Group has been included as appendix 1.

Asesiad / Assessment

The MH Scrutiny group received the above embedded report and paid particular attention to the following:

- Activity and detentions under the Mental Health Act during this quarter period were relatively unremarkable other than slight increase in use of Section 4 (emergency admission) within the county of Ceredigion. Likely result of the reduced doctors availability in this area.
- Low use of Section 136 – possibly a trend is starting to present as a result of the introduction of calls relating to mental health via 111. It was noted that A&E continues to be used as a place of safety and included within the report are when this occurs as a result of a general health reason. The group acknowledged the exemplary and improved rates of consultation between the police and health staff when contemplating use of Section 136. There was also a general acknowledgement of the additional work that goes on with between the MHA department and the Dyfed Powys Police in order to scrutinise S136 data in more detail on a weekly basis.
- Use of the Act within the general hospital wards also continues to occur on a regular basis which can present operational issues. One such example was the acknowledgement of a very poorly completed Holding Power (Section 5(2)) whereby the doctor had not named, timed nor dated the documentation.
- Three policies were reviewed within this quarter as part of the Written Control Documents process.
- The report has introduced some basic information relating to Section 117 (Aftercare) as requested via the MH Legislation Committee.

Argymhelliad / Recommendation

For discussion

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	1. Improve population health through prevention and early intervention 2. Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Mental Health Legislation Scrutiny Group
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Deddfwriaeth Iechyd Meddwl: Parties / Committees consulted prior to Mental Health Legislation Committee:	MH Legislation Scrutiny Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Risk of non-compliance with the 1983 Act and with the Welsh Government's *Mental Health Act 1983 Code of Practice for Wales*; the *Mental Health (Wales) Measure 2010 Code of Practice;* and with the *Good Governance Practice Guide – Effective Board Committees (Supplementary Guidance) Guidance*.

	Safety of patients Assurance – use of statutory mechanisms
Cyfreithiol: **Legal:**	As above
Enw Da: **Reputational:**	Not applicble
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

006. 01. Appendix 1- Quarter 3

2.2 - Mental Health Act Report

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Report on the

on the use of

The Mental Health Act, 1983

1st October 2024 – 31st December 2024

(Quarter 3)

Contents

1.0 Introduction

The Mental Health Legislation Scrutiny Group's principle purpose is to ensure that the Mental Health Act 1983 and Mental Health (Wales) Measure 2010 are being carried out and operating properly within the health board and to report to the Mental Health Legislation Committee allowing for inadequacies and extraordinary activity to also be reported.

This report provides information relating to the use of the Mental Health Act 1983 (the Act) within Hywel Dda University Board during Quarter 3, 2024/25.

In order to protect identity and comply with Information Governance any figures below 5 will not be disclosed.

A more detailed breakdown of the Act is as follows:

Mental Health Act, 1983 - Data Collection and Exception Reporting

2.0 Summary

Quarter 3, 2024/25 use of the Mental Health Act has been generally unremarkable with the a number of uses of the different sections being almost identical with the previous quarter period.

Whilst use of Section 4 was within the normal average range all uses resulted from the Ceredigion area. Each use referenced inability to obtain a second medical recommendation due to unavailability of doctors which ties in with the lack of doctors in the county and subject to the mental health services risk register.

Equally Section 136 uses remained lower than average this quarter however 19 out of the 34 were escorted to A&E settings. 8 were identified as having a clinical need. The majority of others were taken to A&E either because that is where the person already was upon being placed on the order or because of lack of staffing, beds or suite availability following consultation.

The MHA management team have continued to provide training in the health board and with key stakeholders. Work has been undertaken on a number of policies as required by the Code of Practice. Data relating to Section 117 aftercare is also provided within the report for the first time.

Use of the different sections in the table below are shown in comparison to average numbers based over the previous 3 years.

Section of MHA	Average use per Qtr	Qtr 3 activity	Notes
2	71	67 ↓	Slightly lower than average use of this section.
3	35	41 ↑	Slightly higher than the average use but consistent with the last quarter period.

4	3	Under 5	Consistent with average use per quarter. Use of Section 4 is quite infrequent and tends to fluctuate between 0 - 5 occasions per quarter
5(4)	1	Under 5	Use of this section of the Act is relatively rare however will fluctuate in use between zero to as many as 6
5(2)	20	24 ↑	A slightly higher than average use of this section but consistent with the last quarter period
17A (CTO)	6	6	Average use of this section and consistent with the last quarter period
135	3	Under 5	Use of this section of the Act is relatively rare and has been used an average number of occasions.
136	46	34 ↓	A much lower than average use this section but consistent with the last quarter period
Part III	2	Under 5	Average number of Part II patients during the quarter.

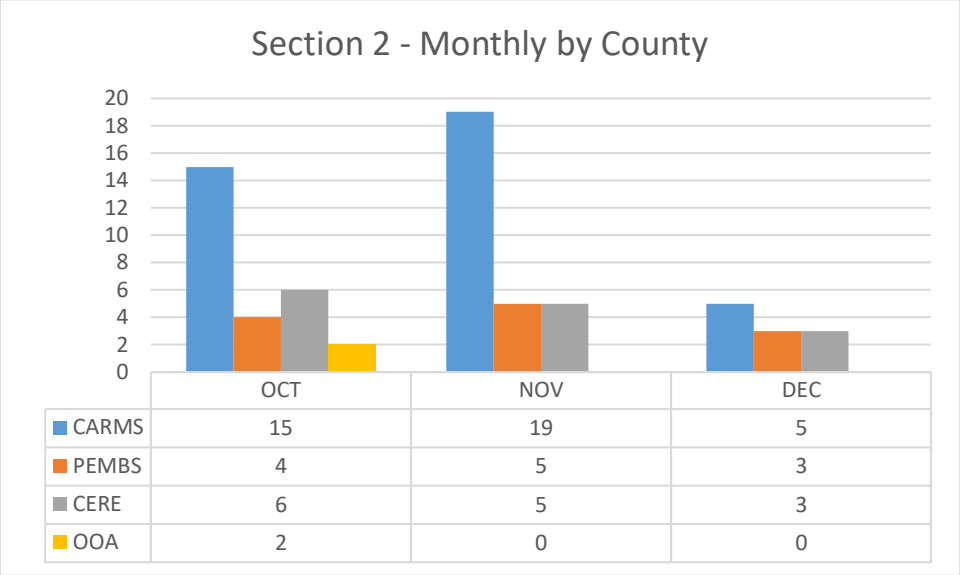
3.0 Findings and Information

3.1 Part II, MHA

3.1.1. Section 2 - Admission for Assessment

The use of Section 2 provides for someone to be detained in hospital for assessment and treatment of their mental disorder.

- Section 2 has been used on 67 occasions which is lower than the quarterly average based against the previous 12 quarters (October 2021 – September 2024) which is 71. It is in keeping with the last quarter period when it was used on 65 occasions.
- Its use within older adult services has dropped quite significantly during this quarter. The average use is 24 per quarter however during this period was only used on 16 occasions.
- 51 of the 67 patients were admitted to hospital directly from the community. i.e. they were not already in hospital when they were detained, community settings can be a patients home, care home or general hospital and can also include transfers from other hospitals outside of Hywel Dda UHB.
- There were 5 Section 2 detentions to the general hospital ward settings.
- There were less than 5 uses of Section 2 in both the CAMHS service and the Learning Disabilities service.
- The times the detention orders were “received on behalf of the hospital managers” (not necessarily when the assessment was conducted) is as follows:
    - Monday to Friday 9am to 5pm: 26/67
    - Friday 05.01pm to Monday 08.59am: 17/67
    - Weekday out of hours (5.01pm to 08.59am): 24/67
- 97% were of white British ethnicity which is consistent with previous quarters**.**
- The graph below show the usage across the three counties:



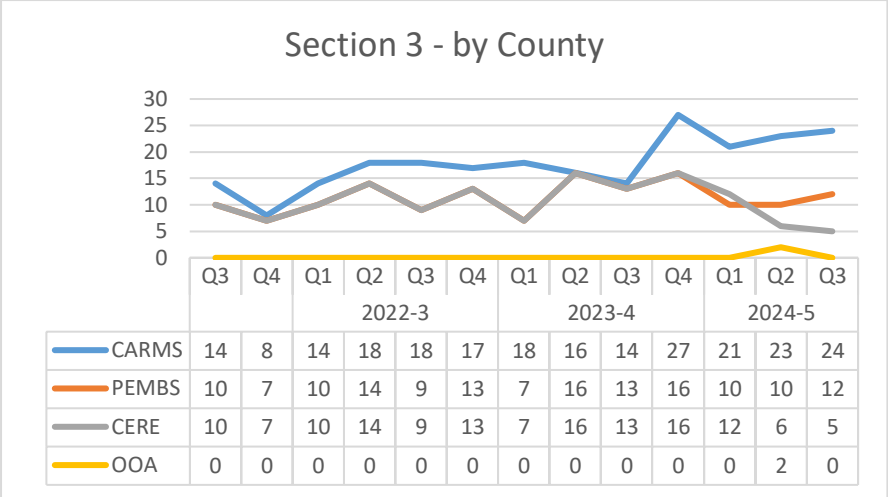
	OCT	NOV	DEC
CARMS	15	19	5
PEMBS	4	5	3
CERE	6	5	3
OOA	2	0	0

3.1.2. Section 3 - Admission for Treatment

The use of Section 3 provides for someone to be detained in hospital for treatment of their mental disorder.

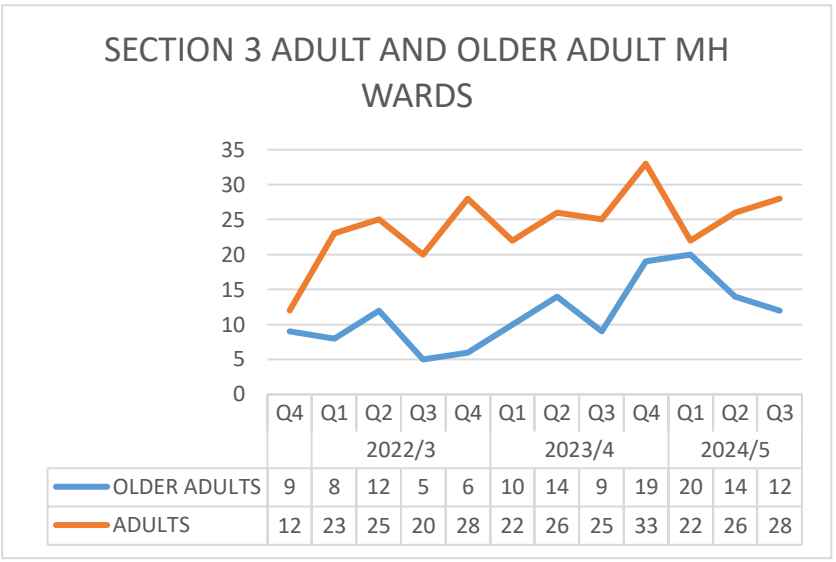
- Use of Section 3 occurred on 41 occasions which remains higher than the quarterly average (based across last 3 years) which is 35. However it is the same number as that of the previous quarter period. A chart to show a breakdown of Section 3 use in the different services and counties can be found below.
- Of the 41 instances 31 were changes in a legal status e.g. from informal or section 2. There were 10 direct admissions under this section, this would include transfers from other hospitals.
- Of the 41 overall section 3s 28 were detained to adult inpatient wards and 12 to older adult wards, the remaining to other areas within Hywel Dda hospital settings.
- 40 Section 3s were discharged during this quarter with the following outcomes - 20 regraded to informal status (which could include DoLS authority), 14 were discharged from hospital, 0 transfer out to another hospital and 6 placed in the community subject to a Community Treatment Orders.
- 98% were of white British ethnicity.

SECTION 3 QUARTERLY ACTIVITY BY COUNTY OVER 3 YEARS



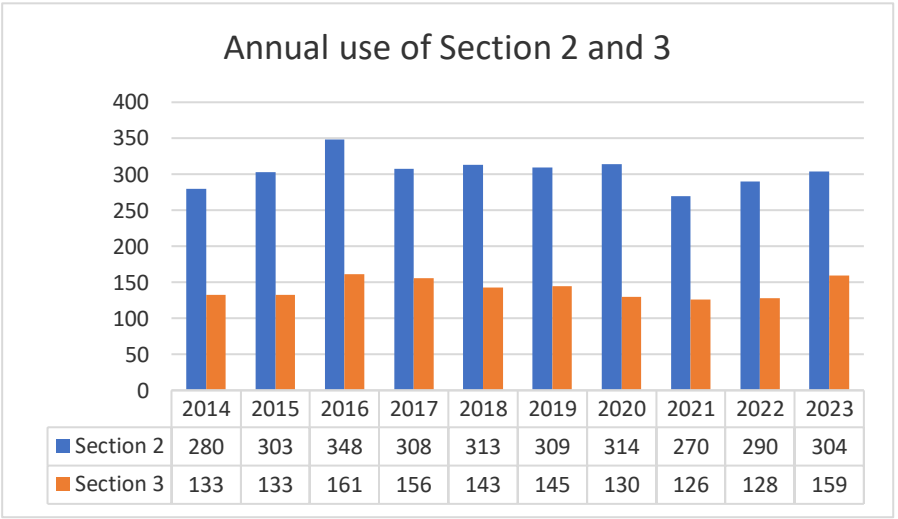
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
			2022-3				2023-4				2024-5		
CARMS	14	8	14	18	18	17	18	16	14	27	21	23	24
PEMBS	10	7	10	14	9	13	7	16	13	16	10	10	12
CERE	10	7	10	14	9	13	7	16	13	16	12	6	5
OOA	0	0	0	0	0	0	0	0	0	0	0	2	0

SECTION 3 QUARTERLY ACTIVITY - OLDER AND ADULT INPATIENT BEDS (MH)



	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
		2022/3				2023/4				2024/5		
OLDER ADULTS	9	8	12	5	6	10	14	9	19	20	14	12
ADULTS	12	23	25	20	28	22	26	25	33	22	26	28

TOTAL USE OF SECTION 2 AND SECTION 3 OVER THE LAST 10 YEARS



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Section 2	280	303	348	308	313	309	314	270	290	304
Section 3	133	133	161	156	143	145	130	126	128	159

3.1.3. Section 4 – Admission for Emergency

The use of Section 4 can be made on the basis of a single medical recommendation supported by the AMHP application and is used when the admission to hospital is urgent and would be unsafe to wait for a second medical recommendation for admission under section 2.

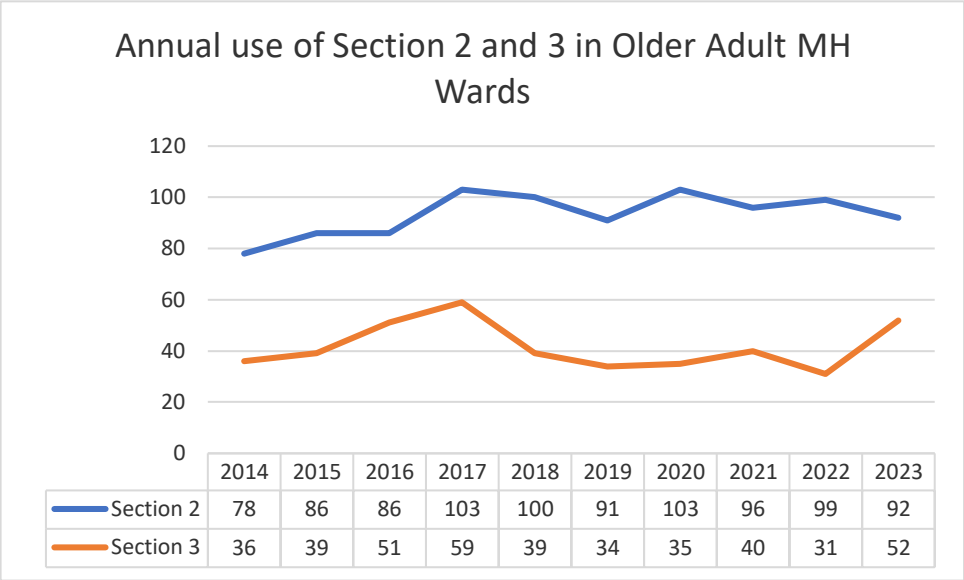
- On average it is used on three occasions per quarter. During this quarter it was used on less than five occasions within Ceredigion all of which were to adult wards.
- 50% were completed by a S12 approved doctor.
- Reasons for using Section 4 during this period were largely due to lack of available second doctors within the area as well as failed execution of Section 135.
- 100% Section 4s were converted to section 2 within 48 hours of admission to hospital.
- Ethnicity – 100% white British, Gender - 50% female.

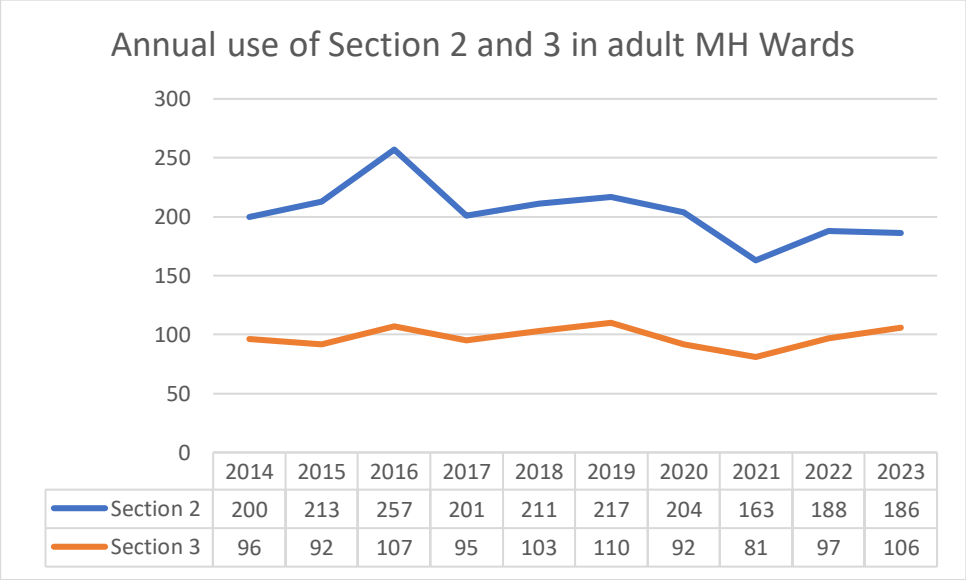
3.1.4. Section 5 – Holding Powers

Section 5(2) – used by Doctors in both mental health and general hospital settings to detain an in-patient for up to 72 hours to allow for a mental health act assessment to take place. Section 5(4) is used by mental health and learning disability nurses in mental health in-patient settings for up to 6 hours to allow for a further assessment to take place

- Use of the nurses holding power is rare and has been used on less than five occasions during this quarter.
- The doctors holding power was used on 24 occasions during this quarter which is higher than the quarterly average of 20 but consistent with the previous quarter period.
- Of the 24, 19 were used in adult MH acute wards. The rest were split between older adult MH wards, general ward settings and CAMHS inpatient beds.
- Detentions under Section 5(2) during this period for under 18s were less than 5.
- A holding power under Section 5(2) may be used within general hospital wards. During this quarter it was used lawfully and appropriately on less than 5 occasions. The outcomes of these holding powers were that all were regraded to voluntary status.
- 83% of assessments were carried out within 48 hours.
- 67% were further detained under Section 2 or 3 (lower than previous quarter at 75%)
- Statistics:
    - 100% white British, 46% male, 54% female.

3.1.5. Trends and Service Specific Information relating to Part II, MHA (Sections 2, 3, 4 and 5)





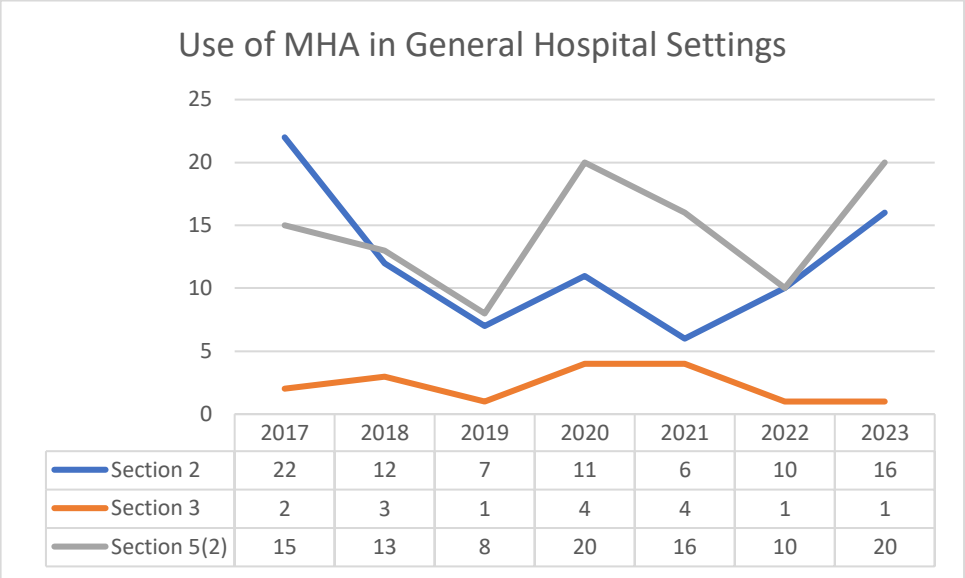
The table below demonstrates the % of which service both section 2 and section 3 were utilised. For example, it can be seen that in 2023 Quarter 4 57% of all section 2's were adult services with only 1% of its use in the general hospital setting.

% of Overall Activity	2023/2024		2024/2025		
	QTR 3	**QTR 4**	**QTR 1**	**QTR 2**	**QTR 3**
SECTION 2	**%**	**%**	**%**	**%**	**%**
Adult	48	57	56	58	60
Older Adult	38	39	31	37	24
General DGH	6	1	10	0	7
CAMHS	7	3	3	3	7
Learning Disabilities	1	0	0	2	2

SECTION 3					
Adult	74	62	51	63	68
Older Adult	26	36	47	35	29
General DGH	0	2	2	2	0
CAMHS	0	0	0	0	3
Learning Disabilities	0	0	0	0	0

The above table shows the ratio's in terms as a percentage tend to remain pretty consistent with small fluctuations now and again. However the proportions within the adult services of Section 3 last quarter was higher and older adults lower. Section 2s admitted to the General District Hospital was also a higher percentage of the overall Section 2's during this quarter.

Use of the Act within the General Hospital settings over the last 8 years



No of Detentions to the General Hospital Wards					
	Oct-Dec 23	Jan-Mar 24	Apr-June 24	July–Sept 24	Oct – Dec 24
Section 2	6	(1-5)	7	(1-5)	(1-5)
Section 3	0	(1-5)	(1-5)	(1-5)	0
Section 5(2)	(1-5)	(1-5)	7	(1-5)	(1-5)

Legal Status of Patients:
The table below is a snapshot the legal status's broken down as a % in each ward as of 31st December 2024

Ward	MHA includes home leave pts	DoLS	Informal	Home leave
Bryngofal	94%	6 % - Informal with a DOLS request awaiting assessment	0%	6%
Bryngolau	30%	50% - authorised DoLS 10% - Informal with a DoLS request – awaiting assessment	10%	0%
St Caradog	88%	6% - authorised DoLS	6%	25%
St Nons	23%	15% - authorised DoLS 15% - Informal with a DoLS request – awaiting assesment	47%	15%
Morlais	90%	0%	10%	10%
Enlli	20%	40% - authorised DoLS	40%	0%
Low Secure	100%	0%	0%	7%
PICU	100%	0%	0%	13%

3.2. Use of Police Powers Sections 135 & Section 136

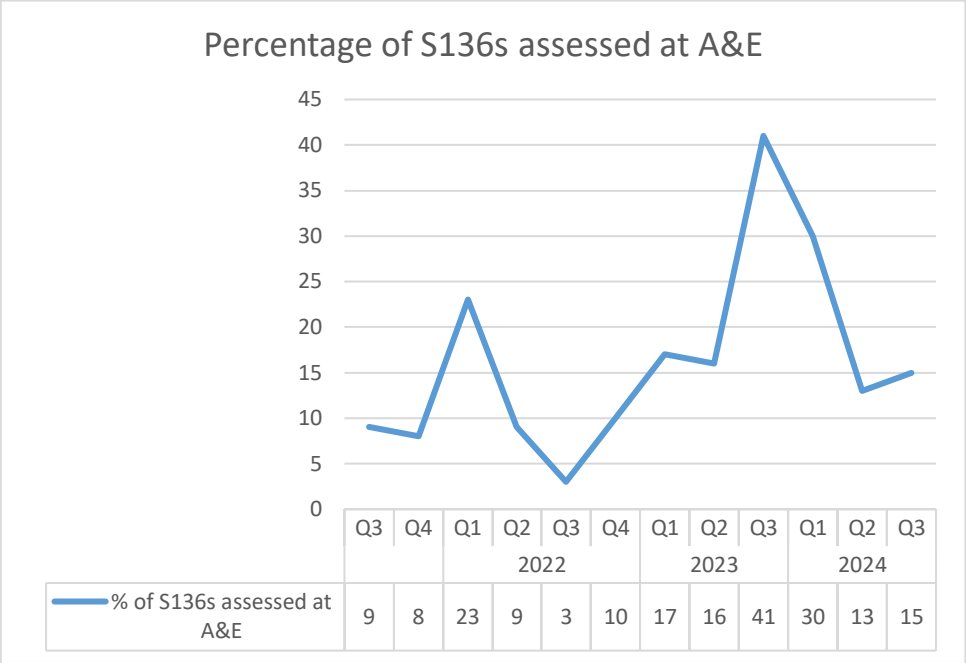
3.2.1. Section 136 – Removal of Mentally Disordered Persons to a place of Safety

The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in a place to which the public has access, to remove him to a place of safety if the person:

- Use of Section 136 remains lower than the quarterly average having been used on 34 occasions however consistent with the previous quarter when used on 31 occasions which was the lowest quarterly use in the last decade.
- 30 different individuals were placed on S136 during this quarter. There was a reduced number of individuals having undergone multiple S136 detentions during the same quarter period.
- The places of safety used for the MH assessment were as follows:-
  - 24 to Bryngofal
  - 3 to Morlais
  - 1 each to PICU and LSU
  - 5 to A&E
    - Withybush Hospital – 3
    - Glangwili Hospital – 2
- The use of A&E departments as places of safety where the assessment took place has remained significantly reduced this quarter. However in addition to the 5 cases listed above it was also used a further 14 times as the 1st place of safety before the persons were transferred to a MH health place of safety.
- Of the 19 occasions A&E was used as a place of safety 8 was due to a clinical need. Where A&E was used where no clinical need had been identified monitoring forms

submitted show A&E to be used due of lack of bed availability, S136 suite availability, lack of staffing or that the person had already been in an A&E setting awaiting assessment voluntarily.

- There has been no report of the designated mental health place of safety for admissions being closed for any period during this reporting quarter.
- The table below shows the % of overall S136s that were assessed in an A&E setting as opposed to a health based place of safety.



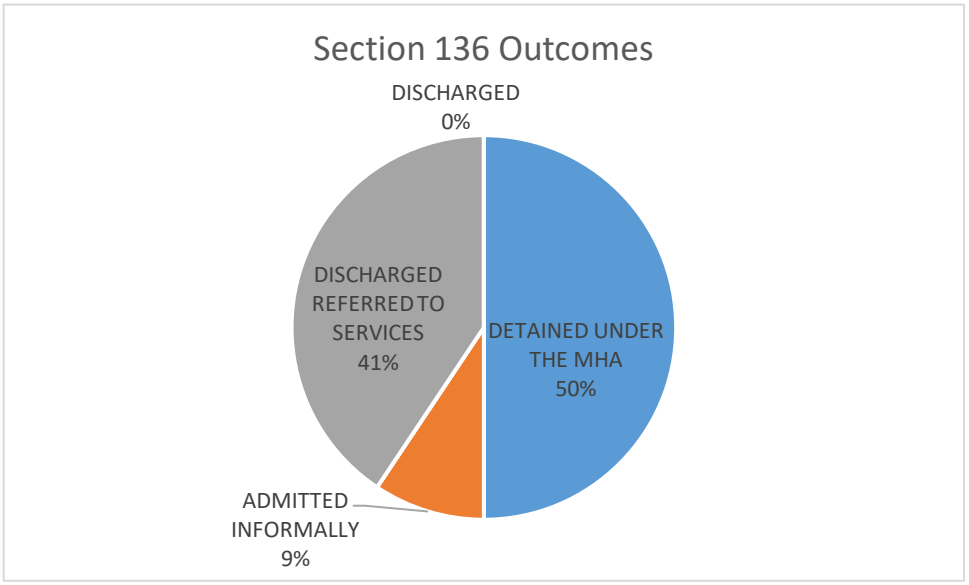
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q1	Q2	Q3
			2022				2023			2024		
% of S136s assessed at A&E	9	8	23	9	3	10	17	16	41	30	13	15

- Morlais Ward is a place of safety for the purpose of assessing under 18's subject to S136. It has not been used as a place of safety for an over 18s during this quarter.
- Custody has nor been used as a place of safety for assessment during this quarter. Custody can only be used for adults in exceptional cases.
- There were 7 under 18s detained on Section 136 during this quarter. It is reported that handcuffs were used during some of these detentions.
- In total it is recorded within the monitoring forms that some form of restraint were used on 16 occasions (47%) which is consistent with the previous quarter when it was 45%.
- The location of where S136 was applied was recorded as the following:
  - 30 x public place
  - 2 x outside persons residence
  - 2 x general hospital
- Consultation is recorded as having occurred in 28 out of the 34 occasions (82%) which is higher than the previous quarter at 71%. All consultations during this period was with a nurse.
- There have been no reports during this period of any health based place of safety closures.
- Common issues encountered with provision of data on the use of this area of the Act:
  - Monitoring forms not completed and submitted, therefore only minimal data captured.

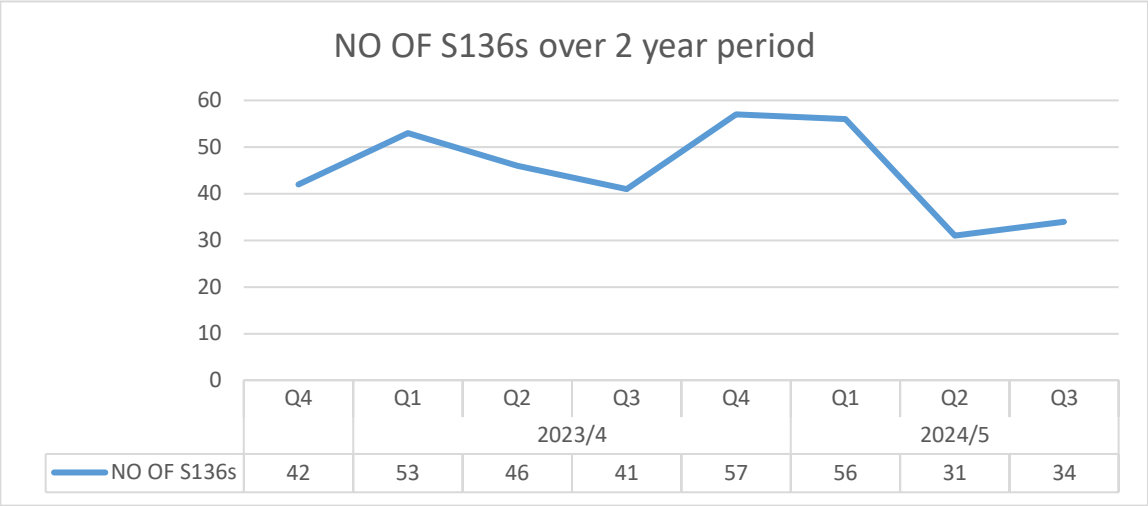
- Missing and factually incorrect information on monitoring forms including dates, times and places of arrival at first places of safety.
- Blank data on forms including surrounding circumstances and police officer details.
- No outcome recorded on the monitoring forms therefore MHA Administrators obtained the information from other sources.

- There is a report under the Out of Hours service that has a record of diverted S136s. There are 2 cases listed during the period of Quarter 3 (compared to 4 in previous). Records suggest that instead the majority were taken to A&E on informal basis.
- 32 of the 34 resided within Hywel Dda catchment area.
- During this period a deep dive exercise was conducted by the Chair of the MH Scrutiny Group relating to cases under Section 136 brought into A&E settings for assessment. The Scrutiny Group Chair will continue to monitor this area routinely.

Outcomes of the assessments as follows:



- A Section 136 pathway has been issued across the service to assist in a more consistent approach to assessments (the majority copied from the inter-agency procedure).
- Where the outcome of the assessment did not result in detention under the MHA – 12 of 16 utilised 2 doctors for the assessment.
- The duty to inform patients of their statutory rights was evidenced in 29 out of 34 cases overall. Within the A&E settings on 16 out of the 19 occasions.
- 33 assessments took over 4 hours. 1 assessments was extended and a further 2 lapsed without/incomplete assessment.
- Ethnicity statistics –
  - 100% White British
  - 62% Female 38% Male



3.2.2. Section 135 – Warrant to search and remove person

Section 135 empowers a magistrate to authorise a police constable to remove a person lawfully from private premises to a place of safety.

Section 135 is split into two categories as follows:

- Section 135(1) warrant applied for by an AMHP (the local authority) if reasonable cause to suspect that a person is suffering from a mental disorder.
- Section 135(2) warrant by any constable or other person authorised (*will generally be health professional)* to remove someone already liable to be detained and remove them to a place they are meant to be.

- Figures collated include both Section 135(1) and Section 135(2). During this period there were less than 5 and in keeping with average numbers.
- Ceredigion local authority applied Section 135 warrants during this period.
- 100% of assessments resulted in further detention under the Act.
- It is not known how many warrants are applied for but get refused by court or alternatively granted but then not executed under this section.

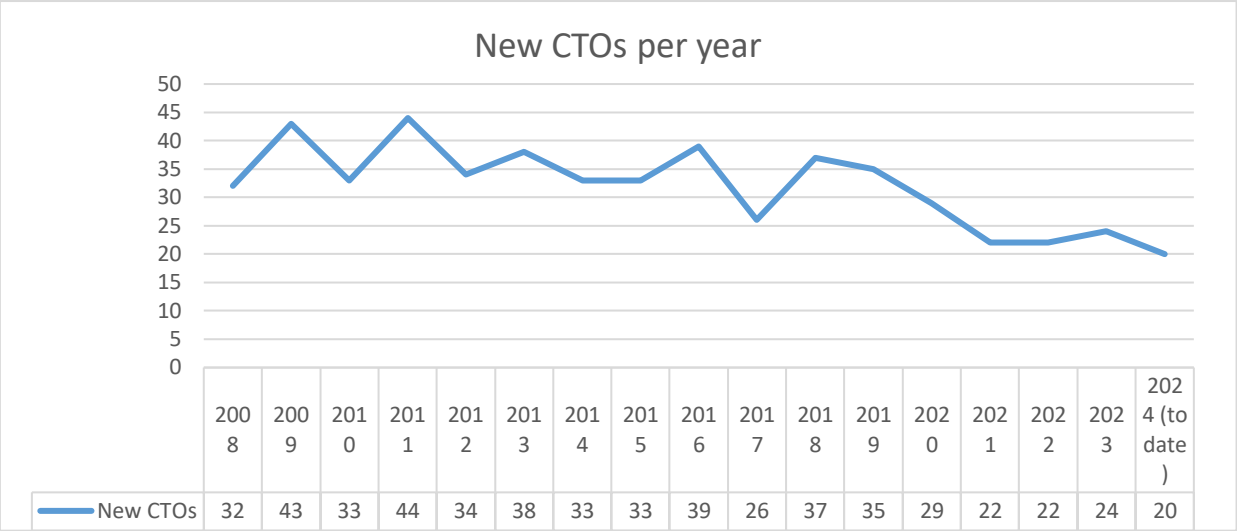
3.3. Section 17A - G, Community Treatment Orders

3.3.1. Community Treatment Order Activity

There were 30 Community Treatment Orders in place as at 31st December 2024.

County	Number of CTO's	Ethnicity
Carmarthenshire	15	White British – 100%
Ceredigion	Under 5	White British – 75% Other ethnicities – 25%
Pembrokeshire	11	White British – 83% Other ethnicities – 17%

- 6 new CTO's for the quarter.
- There were less than 5 recalls during this quarter.
- 3 CTO's were discharged by the Responsible Clinicians
- Since introduced into the Act in 2007 the popularity of Community Treatment Orders by clinicians appears to have reduced over recent years however seems to have stabilised over the past 3 years.



3.4 Part III

3.4.1. Patients Concerned in Criminal Proceedings or Under Sentence

Part III of the MHA deals with the circumstances in which patients may be admitted to or detained in hospital on the order of a court or by transfers from prisons.

- Use of this area of the Act is minimal within the Health Board. During this quarter it was used to admit a patient on less than five occasions
- Unrestricted patients can be made subject to Community Treatment Orders however 0-5 new CTO for Part III patients were made during this quarter.
- 0-5 restricted patients were discharged by the MHRTfW during this period.
- There were no unrestricted patient discharges.
- As of the 31st December 2024 the total number of Part III patients are split into the following – 60% restricted; 27% unrestricted; 13% CTOs.

3.5 Errors

3.5.1. Section 15 - Rectifiable Errors

Section 15, MHA allows corrections to be carried out within the statutory time limits (14 days).

- 112 statutory documents were medically scrutinised
- 52 rectifiable errors were made on medical documents.

- Common errors included not deleting areas of papers where prompted; names and/or addresses missing, spelling mistakes and ineligible handwriting.
- There were 15 errors recorded on HO14s by the nursing staff receiving papers on behalf of the Hospital Managers. There were also a number of occasions where detention papers were submitted to the MHA office which had not been received and the MHA administration team undertook this task on behalf of the hospital managers.
- There were 16 rectifiable errors relating to application made by the AMHP.
- The number of rectifiable errors made are consistent with the previous quarter.
- All other rectifiable errors related to medical recommendations.
- A more detailed breakdown of these rectifiable errors have been provided to team managers for future learning.

3.5.2. Section 15 - Non Rectifiable Errors

Where the error is so severe that the error cannot be rectified under Section 15 the appropriate action is taken.

- There were 0 detentions during this current quarter that were deemed to be non-rectifiable.

3.5.3. Other errors

Section 15 relates only to detentions under Section 2, 3 and 4 of the MHA. Errors under this heading of the report relate to other areas of the MHA including Section 5, Community Treatment Orders and Consent. Appropriate action is taken with relevant teams.

- HO12s are completed by a doctor for the purposes of Section 5(2).
    - HO12s – Of the 25 Section 5(2)s submitted during this quarter 3 had errors. These errors included insufficient / missing information and /or incorrect patient information.
    - There was an additional Section 5(2) holding powers not accepted on behalf of the Hospital Managers as the document was not timed nor dated. The doctor could not be located in order to confirm the detention period and no entry was located within the patients records.
- CP5s are completed by a doctor for the purposes of recalling a CTO patient back to hospital.
    - CP5 must state the hospital to which the person is being recalled to which in turn provides authority to convey that person. It does not allow for any alternative hospital to be used. Situation arose whereby a recalled person was taken to a hospital not identified on the recall notice.

Section 15	Jan- Mar 24	Apr – June 24	July- Sept 24	Oct – Dec 24
Detention Papers	129	116	109	112
Rectifiable Errors	55	41	59	52
Non Rectifiable Errors	Under 5	Under 5	Under 5	0

3.6. Code of Practice (Mental Health Act)

An annual report on the use of restrictive practice policies should be received and considered by the health board. This should include aggregated data. (CoP pg262)

3.6.1. Locked Door Activity (Chapter 26 CoP for Wales)

The Code of Practice provides guidance around the use of locked doors and recommends that a policy should be developed at an organisational level but may be adapted for specific locations. The policy should be considered as part of ward/unit management system.

The Health Board operates a locked door policy across all services however expects staff to ensure patients are aware of their rights, reasons for the locked door and options for access and exit are made clear to both patients and visitors.

Adherence to the "Locked Door and Associated Safeguards for Mental Health and Learning Disability Wards Policy" (321) is provided via the Mental Health's Ward Management Forum.

3.6.2. Exclusion of Visitors (Chapter 11, COP for Wales)

The Code of Practice states that Hospital Managers should regularly monitor the exclusion from the hospital of visitors to detained patients. "Any decision to exclude a visitor should be fully documented and available for independent scrutiny by HIW". Ward managers within the mental health services reported that there have not been any exclusion of visitors during this reporting period.

3.6.3. Withholding of postal packets (Sec 134 MHA)

Patients should have access to any correspondence they receive and send and their privacy respected. However, Section 134, MHA provides authority and withholding of a detained patient's outgoing and incoming mail. The procedure to be adopted is included in The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 where it provides occurrences should be reported upon.

There has not been any post withheld during this reporting period.

3.6.4. Information to Detained Patients and Nearest Relatives

The MHA monitor and contact wards and departments to help ensure all patients detained under the MHA are provided with information relating to the rights of detention.

The majority of patients are provided with rights during the first 72 hours of detention however there are occasions whereby this is not possible, for example due to a temporary loss of capacity to retain the information or that the risks are deemed too high to staff to do this safely.

3.7. Part IV / IVA Act (Sections 57 – 64) Consent to Treatment and SOAD (Second Opinion Appointed Doctor) requests to Healthcare Inspectorate Wales.

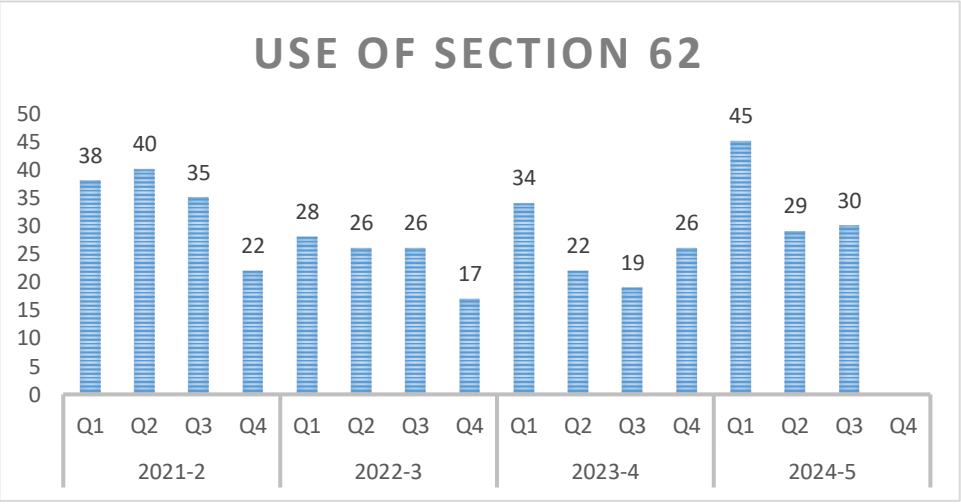
3.7.1. Certification for Treatment – Capacity and Consenting Status

During this quarter there have been 17 new treatment authorisation documents completed for consenting to treatment instances:-
9 x C02 – to certify person has capacity and consents to treatment (detained patients)
7 x C08 – as above (CTOs)
1 x CO4 – as above for the treatment of ECT
This compares with 12 new certificates issued during the last quarter.

3.7.2. Certification for Treatment – Non capacious or non-consenting status

When a detained patient requires authority for treatment to proceed but does not have the capacity to consent or refuses to consent then a Second Opinion Appointed Doctor must certify the treatment. SOADS are allocated through HIW.

- 35 SOAD requests were made (24 in Qtr 2, 31 in Qtr 1, 26 in Qtr 4, 2023) and the following certificates were completed:
  - 22 CO3s (detained patients)
  - 3 CO7s (CTOs)
  - 3 CO6s (ECT)
- Average waiting time for a SOAD (medication for inpatients) was 13 days (increase from 10 days last quarter).
- Of the 28 certificates issued by a SOAD 8 patients were seen in person with the remaining 20 reviews conducted remotely by a SOAD before issuing the relevant certificate to authorise treatment. HIW advised that this ratio is likely to remain.
- There were less than 5 authority certificates for Electro-convulsive therapy (ECT) during this quarter. The average wait for a SOAD to certify treatment for ECT was 4 days.
- Longest waiting time for a certificate was 42 days. HIW set KPI however they are set from the point they allocate a doctor to the issuing of the certificate as opposed from when the SOAD request is made to the certificate being issued.
- Section 62 and 64 (emergency) treatment allows for lawful and short term administration of treatment in the absence of a SOAD certificate. Use of this emergency treatment during this quarter was relatively average as can be seen from the line chart below showing its use over per quarter over the past 3 years. It was used on 30 occasions.



- Reasons for its use is as follows:
    - On 11 occasions to authorise ECT where a SOAD had been requested but not yet authorised treatment.
    - On 9 occasions to authorise medication because three month rule had expired and the SOAD had not yet authorised treatment.
    - On 4 occasions the patient changed their decision to consent to treatment.
    - On 4 occasions there was a change of medication or Responsible Clinician.
    - On the other occasions it was due to change in legal status (CTO revoked).

  Use of emergency Section 62 treatment could be reduced with more prompt SOAD requests or certificate being provided by the SOADs. There were 6 occasions during the last quarter when SOADs were requested by Responsible Clinicians within 3 days of the three month rule expiring or after the date had already expired.

3.7.3. Section 61, Review of Treatment

When a section is renewed under Section 15 or a Community Treatment Order is extended the Responsible Clinician is required to review the treatment and progress for patients that have been subject to a SOAD certificate during the previous period of detention. A report is sent to Healthcare Inspectorate Wales on each case (HIW1).
There were 12 records made during this quarter under Section 61 which is lower than the previous quarter when there 19 undertaken.

3.8. Sections 23, 24, 20/20A and 65-79 MHA – Discharge from Detention

3.8.1. Applications for Discharge to Hospital Managers

There have been 4 applications for discharge made to the hospital managers during this quarter compared to 6 in the same quarter last year indicating that applications continue to remain low despite returning to face to face reviews. During the same quarter in 2018 there were 15 applications made. Of the 4 applications, 1 applicant withdrew, 2 hearings took place with another due to take place in Quarter 4.

All applicants appealing their detention are given the choice to request whether they want a face to face or remote type hearing.

3.8.2. Renewals/ Extensions of Sections

The hospital managers heard 16 renewals compared to 18 in the previous quarter. This is slightly higher than the same quarter last year when 12 renewals were considered for the same period. The Code of Practice states renewal hearings should be held before the section expiry date. All renewals met this target.

3.8.3. Application for Discharge by Nearest Relative

For the fifth consecutive quarter there has been no applications for discharge by the nearest relative.

3.8.4. Hospital Managers Hearings

In total (all hearing types) the Hospital Managers held 18 reviews during this quarter. Of the 18 cases patients were present in 6 reviews, 4 of which were supported by an IMHA, 2 represented by a solicitor and 2 advocated themselves with no additional support. Of the 12 where patients did not attend 5 had either an IMHA, solicitor or relative present at the review.

No applications were made for a Welsh hearing. No use of translation services were requested.

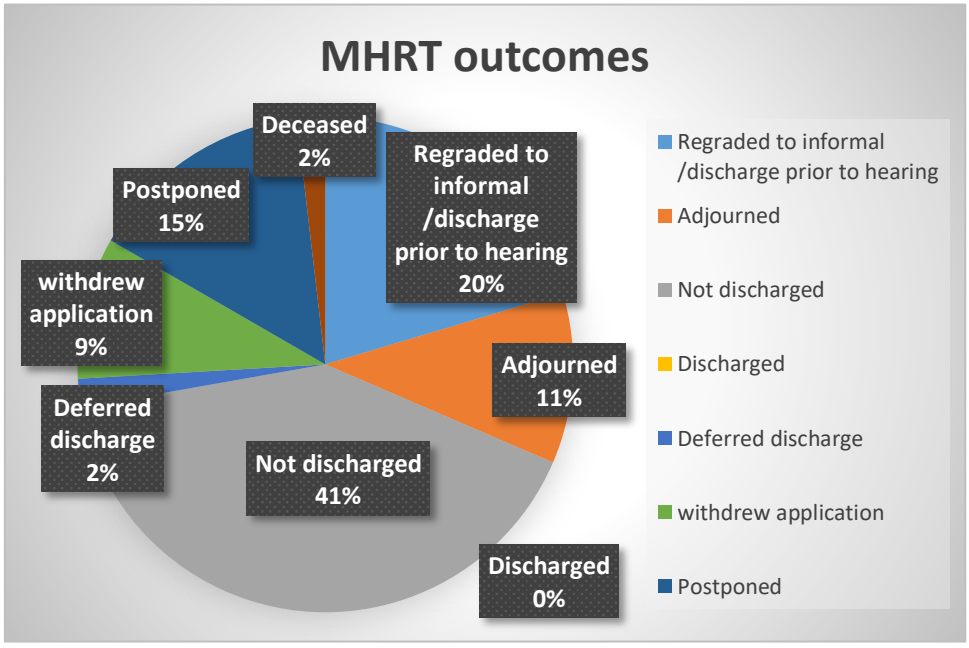
3.8.5. Applications, Referrals and Outcomes at the Mental Health Review Tribunal

There has been 45 applications/referrals to the Mental Health Review Tribunal (MHRTfW) during this quarter with 29 hearings conducted. The MHRTfW office offer the option of face to face or remote reviews based upon patient choice. Of the 29 hearings 19 occurred in person and 10 via MS Teams.

The tribunal ordered the discharge of less than five detained patients during this period.

No applications were made for a Welsh hearing. No use of translation services were requested.

The outcomes of the arranged tribunals during this quarter can be seen below:



3.8.6. Comparative Information relating to Hospital Managers and Tribunals processes

In order to determine whether activity deviates from the norm current quarterly activity can be found in the table below compared against average activity based over the previous 3 years.

Activity	Average per Qtr 2018/19	Average per Qtr	Qtr 3 activity	Notes
Applications to the Hospital Managers	14	6	4	Applications to hospital managers generally remain lower than pre-covid years.
Renewals / Extension reviews		18	16	Every renewal of section / extension of CTO must have a hospital manager review.
Applications by nearest relative	Less than 5	Less than 5	0	Figures are generally low
Applications/referrals to MHRTfW	44	47	47	Average number of applications
MHRT hearings held		24	29	Consistent with the average number of hearings held.

3.9. Miscellaneous

3.9.1. Policies

Policies referred to within the Code of Practice are "*Owned by*" the Mental Health Written Control Documents Group and are "*Approved by*" the Mental Health Legislation Committee (MHLC).
During this quarter the following policies were approved:
(321) Locked Door and Associated Safeguards – approved -*19.12.2024*
(741) Patient Rights procedure – approved *02.12.2024*
(743) Section 135 – Warrant to Search and Remove Patients – *02.12.2024*

3.9.2. Training

The Mental Health Act Team continues to provide training to services and partner Agencies on the use and processes in performing the functions of the Act. During Quarter 3 the following sessions have been provided either face to face or via MS Teams

Date	Group	Topic
01.10.24	Bryngofal	Community Treatment Order and processes
09.10.24	Low Secure Unit	Section 136 processes and guidance
15.10.24 29.10.24 31.10.24	Preceptorship Nurses	Basic introduction and MHA overview and processes internally
07.11.24	PICU and Low Secure Unit	MHRT and Hospital Managers processes
18.11.24	Commissioning Administration Team	MHA Overview
21.11.24	Wellfield Resource Centre Administration Team	MHA Overview and administrative roles
03.12.24	Bryngofal Ward	Section 136 processes and guidance

In addition a pre-recorded training presentation on both Section 136 and Section 5(2), MHA (particularly suitable for general hospital sites) has been uploaded to the MHA

Administration Sharepoint page - readily and easily accessible to all staff across the Hywel Dda sites. Further presentations to be developed and should be available in due course.

3.9.3. Operational

Lasting Power of Attorneys

The MHA department are required to notify the MHRTfW about any Powers of Attorneys/Deputies. This is in addition to any other responsibilities to Attorneys and Deputies as outlined in Code of Practice (Chapter 7). No details of LPA's have been provided for detained patients during this quarter to the MHA administration team.

CAMHS ASSESSMENTS

There has been a number of areas where the MHA has been utilised within this service during the last quarter - Section 136, Section 5(2) and Section 2 detentions have all been used. Where a CAMHS assessment is undertaken a specialist doctor in this field should make themselves available.

DATIX REPORTING

All incidents relating to breaches within the MHA are reported upon internally via the DATIX system by the MHA Administrator and reporting it to MHA Administration Lead.

3.9.4. Section 117 Aftercare

A centralised Section 117 register to serve both Health Board and the Local Authority is currently under review.

During this quarter there were 19 new S117 applicable persons detained to Hywel Dda Health Board under the Act. The total figure may be slightly more than that if persons within the area have been detained outside of the health board.

In addition to the above there were a further 11 persons detained under a qualifying section who were already on the Section 117 register.

During this quarter we have been notified of 4 persons who have been discharged from the centralised register.

The centralised register is under development within the MHA department currently. At the present time it shows that there are 1216 persons eligible for Section 117 aftercare within Hywel Dda.

4.0. Description of Sections

<u>Longer Term Sections</u> (medication can be given)

Section 2 Admission for assessment – up to 28 days

Mental Health Act assessment undertaken by 2 registered medical practitioners, where practicable by one who knows the patient. One must be Section 12(2) approved. An Approved Mental Health Professional (AMHP) must also assess, preferably at the same time as at least one registered medical practitioner.

Criteria needs to be met -

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

2 x medical recommendations (HO4), 1 x application from AMHP (HO2)

Section 3 Admission of treatment – up to 6 months, renewable for 6 months, 12 monthly thereafter

Mental health act assessment undertaken by 2 registered medical practitioners, where practicable by one who knows the patient. One must be Section 12(2) approved. An Approved Mental Health Professional (AMHP) must also assess, preferably at the same time as at least one registered medical practitioner.

Criteria needs to be met -

a) *is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and*
b) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
c) appropriate medical treatment is available for him.

2 x medical recommendations (HO8), 1 x application from AMHP (HO6)

<u>Short Term Sections</u> (medication cannot be given)

Section 4 Admission for emergency – up to 72 hours

mental health act assessment undertaken by a registered medical practitioner, where practicable by one who knows the patient
An Approved Mental Health Professional (AMHP) must also assess the patient – ideally at the same time

Criteria needs to be met -
"it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section *"would involve undesirable delay"*
1 x medical recommendation, (HO11) 1 x application from AMHP (HO10)

Section 5(2) Approved Clinician Holding Power – up to 72 hours

mental health act assessment undertaken by a registered medical practitioner. Criteria is - *that an application for compulsory detention "ought to be made".*

1 x Form HO12

Section 5(4) Nurses Holding Power – up to 6 hours

Criteria is: if it appears to a nurse of the 'prescribed class' firstly that *"…the patient is suffering from mental disorder to such a degree that it is necessary for his health and safety or for the protection of others for him to be immediately restrained from leaving the hospital".* Secondly the nurse must believe that *"…it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2)…"* In other words, the doctor or approved clinician (or their deputy) cannot attend in time to provide a report under section 5(2).

1 x Form HO13

***Community Treatment Order and related sections* (medication can be given)**

Section 17A Community Treatment Orders – up to 6 months, renewable for 6 months (17A+) 12 monthly thereafter (17A ++)

Criteria is:
the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
it is necessary for his health and safety or for the protection of other persons that he should receive such treatment;
subject to his being liable to be recalled ... such treatment can be provided without his continuing to be detained in a hospital;
it is necessary that the responsible clinician should be able to exercise the power under section 17E (1) below to recall the patient to hospital;
appropriate medical treatment is available for him

Form CP1

Section 17E Recall of a CTO. Duration is up to 72 hours, which starts once the patient has been admitted to the hospital.

Criteria is: *a change of mental state or increase in risk.*

Form CP5

Section 17F Revocation of a CTO patient who has been recalled to hospital – the section is the re-introduction of the Section 3 or Section 37 (depending on what section they were on previous to the CTO) - up to 6 months, renewable for 6 months, 12 monthly thereafter

Criteria needs to meet the same as Section 3 -

a) *is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and*

b) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
c) Appropriate medical treatment is available for him

Revocation requires the written agreement of an AMHP. Form CP7

***Places of Safety Sections* (medication cannot be given)**

Section 135 Warrant to search and remove

Section 135(1) – warrant to enter and remove
Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety.

A warrant may be issued if, on having information on oath from an approved mental health professional (AMHP), it appears to the magistrate that there is reasonable cause to suspect that a person believed to be suffering from mental disorder is:
Criteria is:
has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
being unable to care for himself, is living alone in any such place

Section 135(2) – warrant to enter and take or retake
Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

A magistrate can issue a warrant to take or retake the patient if it appears, on information on oath by any constable or any *"other person authorised by or under this Act… to take…or retake a patient who is liable under this Act*", that:

There is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and

That admission to the premises has been refused or that a refusal of such admission is apprehended

Section 136 Place of Safety – up to 24 hours

The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in a place to which the public has access, to remove him to a place of safety if the person:
Criteria is:

Appears to be suffering from mental disorder and to be in immediate need for care or control, the constable may, if he thinks necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…

Part 3 - Sections in relation to Patients concerned with criminal proceedings or under sentence

Section 35 Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks *(medication cannot be given)*

An approved clinician (at the hospital) is required to provide a report to the court. The court must be satisfied (on the written or oral evidence of any doctor) that:

(a) …there is reason to suspect that the accused person is suffering from mental disorder; and

(b) …it would be impracticable for a report on his mental condition to be made if he were remanded on bail

Section 36 Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks *(medication can be given)*

The Section 36 is to allow a Crown Court to remand an accused person to hospital for the purposes of treatment. The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:

(a) …is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and

(b) appropriate medical treatment is available for him

Section 37 Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter *(medication can be given)*

Section 37 enables a Crown Court or a magistrates' court to order a person to be detained in hospital for treatment (or make a person subject to guardianship) when otherwise they may have imposed a
prison sentence. The "hospital order" or a "guardianship order" is given as an alternative to imprisonment, a fine, or probation if appropriate.

The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:

is suffering from mental disorder and that either –

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or

(ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship…;and

…the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to all other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under [section 37]

Section 37/41 Hospital Order with Restrictions – made with no time limit *(medication can be given)*

A Crown Court may, if necessary for the protection of public from serious harm, place restrictions onto a hospital order at the time of making the order under section 37.

The restrictions, Section 41, sets out that the Court must have regard to *"…the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large…"* and if it is necessary *"for the protection of the public from serious harm…"* the Court can order that the patient is subject to the special restrictions of the section.

An order made under section 41 is known as "a restriction order", and is commonly referred to as "section 37/41" or a "hospital order with restrictions".

In addition to the requirements for making an order under section 37, the Court must receive oral evidence from at least one of the registered medical practitioners who gave evidence under section 37.

Section 38 Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months *(medication can be given)*

To allow a court to send a person who has been convicted but not yet sentenced to hospital, to assess the person's response to medical treatment. The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:

(a) …is suffering from mental disorder; and
(b) that there is reason to suppose that the mental disorder from which the offender is suffering is such that it may be appropriate for a hospital order to made in his case,

the court may, before making a hospital order or dealing with him in some other way, make an order (…referred to as "an interim hospital order") authorising his admission to … hospital…

Section 47 } Transfer of sentenced prisoners (including with restrictions) - Section 47/49} *(medication can be given)*

Allows the Secretary of State for Justice to order the transfer to hospital of a sentenced prisoner following conviction. The Secretary of State must be satisfied (from the reports of two doctors, one of whom must be section 12(2) approved) that the patient:

(a) … is suffering from mental disorder; and
(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
(c) that appropriate medical treatment is available for him

The Secretary of State must have *"…regard to the public interest and all the circumstances…"*

A direction made under section 47 is known as a 'transfer direction'. A transfer direction may be accompanied by the special restrictions of section 41, by virtue of section 49. Such a direction is known as a "restriction direction" and is commonly referred to as 'section 47/49' or a 'transfer and restriction direction'

Duration - the transfer direction (including a restricted section 47) ends at the earliest date of release (EDR). At this time the patient, unless discharged by the responsible clinician, will be treated as though a hospital order had been made (and is referred to as a 'notional section 37').

Section 48 }Transfer of other prisoners (including with restrictions) for urgent Section 48/49 }treatment

Allows the Secretary of State for Justice to order the transfer to hospital of a prisoner who is not sentenced but in urgent need of treatment. The Secretary of State must be satisfied (from the reports of two doctors, one of whom must be section 12(2) approved) that the patient:

… is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
he is in urgent need of such treatment; and
appropriate medical treatment is available for him

The section only applies to:

- persons detained in a prison, not being a person serving a sentence of imprisonment or persons falling within the following groups
- persons remanded in custody by a magistrates' court;
- civil prisoners, that is to say, persons committed by a court to prison for a limited term, who are not persons falling to be dealt with under section 47;
- persons detained under the Immigration Act 1971 or under section 62 of the Nationality, Immigration and Asylum Act 2002 (detention by Secretary of State).

It is known as a 'transfer direction'. A transfer direction may be accompanied by the special restrictions of section 41, by virtue of section 49. Such a direction is known as a "restriction direction" and is commonly referred to as 'section 48/49' or a 'transfer and restriction direction'. A restriction direction must be given in respect of

- persons detained in a prison, not being a person serving a sentence of imprisonment
- persons remanded in custody by a magistrates' court;

Duration - the period of detention is variable and can continue to the time of sentence; the Secretary of State can also issue a warrant to return the person to prison at any before the Court disposes of the case.

5.0. GLOSSARY OF TERMS

Term	Description	Explanation/Link
MHA	Mental Health Act 1983	http://www.legislation.gov.uk/ukpga/1983/20/contents
Sections		Parts of the Mental Health Act 1983 which allow particular types of detention.
PICU	Psychiatric Intensive Care Unit	Severely ill patients who pose a risk in the short term.
CAMHS	Child and Adolescent Mental Health Services	Core age up to 18 years.
Part 2 of the Act	Part 2 of the Mental Health Act 1983	Deals with detention, guardianship, and supervised community treatment for civil (i.e. non-offender) patients.
Part 3 of the Act	Part 3 of the Mental Health Act 1983	Deals with mentally disordered offenders and defendants in criminal proceedings.
HIW	Healthcare Inspectorate Wales	Independent body which is responsible for monitoring the operation of the Act.
Secondary Care		Psychiatric inpatient or community mental health team input for adults.
SOAD	Second Opinion Appointed Doctor	Independent doctor employed by HIW who approves particular forms of medical treatment for a patient.
CTO	Community Treatment Order	Patients can be discharged from detention in hospital under the Act but remain subject to the Act in the community.
Formal admission		Patients admitted to hospital who are detained.
Exception Reporting		Section 5(2) over 60 hours; Hospital Managers' Hearings heard after one month.
MHRT	Mental Health Review Tribunal	A judicial body that has the power to discharge patients from detention,

		supervised community treatment, guardianship and conditional discharge.
Hospital Managers		**Independent individuals who carry out functions on behalf of the Board.**
Recall		**Where it is necessary for a CTO patient to be recalled into hospital.**
Revocation		**Patients for whom a CTO has been rescinded following recall.**
Application		**Request from a patient for the MHRT to consider discharge from section.**
Referral		**Hospital managers request the MHRT to consider a patients detention.**
AMHP	**Approved Mental Health Professional**	**Professional with training in the use of the Act, Approved by a local social services authority to carry out a number of functions under the Act.**

2.3 **10 Mins**

2.3 - Mental Health Legislation Scrutiny Group

Kay Isaacs (Hywel Dda UHB - Assistant Director of MH&LD)

For assurance

Attachments

007. Mental Health Legislation Scrutiny Group.docx

007. Mental Health Legislation Scrutiny Group

2.3 - Mental Health Legislation Scrutiny Group

Last modified: 04/03/2025

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 March 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health Legislation Scrutiny Group Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kay Isaacs, Chair, Mental Health Legislation Scrutiny Group

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Mental Health Legislation Scrutiny Group is a Sub-Group of the Mental Health Legislation Committee (MHLC).

The purpose of this paper is to present the Mental Health Legislation Committee an update from the Mental Health Legislation Scrutiny Group (MHLSG) meeting held on 13th February 2025.

Cefndir / Background

The following papers are submitted as standing items on the MHLSG agenda in line with the principal duty of the scrutiny group as described within the Terms of Reference alongside any other relevant reports.

- Mental Health Act Use which includes a Specialist Child & Adolescent Mental Health Service (SCAMHS) report on admissions to the designated bed on Morlais Ward
- Mental Health Measure performance report
- Three County Local Authority Mental Health Act Data reports
- Quality Assurance and Practice Development – Care and Treatment Plan Audit

Papers are sent out to members of the MHLSG seven days in advance of the meeting and members are expected to read all papers to allow for scrutiny and discussion in respect of information provided.

The February meeting welcomed good representation from agencies, reports were shared ahead of the meeting to facilitate discussion and scrutiny in respect of mental health legislation.

There were no outstanding actions from SG or committee and the group were able to finalise discussions in respect of the ‘S136 Frequently Asked Questions’ leaflet to progress this to the next phase, the Written Controlled Document Group for ratification.

S136 Review - Multi- Agency Meeting

A meeting is scheduled for late February to complete a Quality Impact Assessment document and then complete a final paper for board in May 2025.

Right Care Right Place

As agreed at committee, Right Care Right Person (RCRP) is now a standing MHLSG agenda item. To summarise, Right Care, Right Person is being implemented by police forces across England and Wales to enable them to undertake management of the highest risk of mental healthcare work enabling them to focus on maintaining community law and order. A national toolkit has been developed by the National Police Chiefs' Council (NPCC) and the College of Policing to support police forces in implementing Right Care Right Person, which will see vulnerable people receiving the specialist health support they need. Locally, there has been a high uptake on RCRP training and Dyfed Powys Police are now focusing now on the next phases, committee will be updated on progress by subsequent reports from MHLSG.

Risk Register

There are three legislation service risks on the MH&LD Risk Register which is an increase of one.

- The temporary closure of the Community Place of Safety at Gorwelion, Aberystwyth. This remains unchanged whilst the S136 Multi Agency Review Meeting progresses to a conclusion.

- Delayed admission to hospital post recommended detention under the Act, following a Mental Health Act Assessment (MHAA). This was added to the risk register last year as an action from MHLSG. There were some recent incidents highlighted by Carmarthenshire Local Authority, so this risk remains and continues to be reviewed in accordance with process.

- Medical and nursing staff deficits in Gorwelion Community Mental Health Centre have been added to the risk register. This situation is impacting compliance with part two of Mental Health (Wales) Measure and mental health act activity data shows an increase in S4 assessments. A paper has been submitted to the executive team to request approval for a temporary service change to the GP referral pathway for routine assessments to be assessed by the Single Point of Contact Service 111#2 to create service capacity for the community team and ensure timely assessment

Measure Report

The Measure report containing activity and performance data was shared prior to the MHLSG meeting. This report was scrutinised and debated and the Mental Measure report on the agenda will cover salient points.

Mental Health Act Report

The Mental Health Act report containing activity and performance data was shared prior to the MHLSG meeting. This report was scrutinised and debated and the Mental Health Act report on the agenda will cover the salient points arising from this.

Local Authority Reports

Pembrokeshire:
Mental Health Act data provided, but the prevailing concern noted was acute social work staffing deficits which are impacting on both MHA work and roles and responsibilities under Measure legislation. This has been escalated in the LA but no solution has been reached, this will be escalated further on an operational level between health and local authority.

Carmarthenshire:

Increase noted in the requirement for MHAA of children with a number of those living in residential homes, local authority is managing this situation with the support of CAMHS doctors to undertake the assessments required.

Ceredigion:

As referenced earlier under risk register, the deficit in medical staff has seen an increase in S4 activity, S4 allows an Approved Mental Health Professional (AMHP) to consult with one doctor not two when there is risk and an urgency to undertake a MHAA. The potential concern now is that one doctor is used due to lack of availability of a second doctor.
The AMHP service is reliant on agency staff, but an exciting development now enables AMHP students to complete training at Chester University which is expected to improve this situation. From 33 assessments in total and 21 detained in the last quarter, just under 50% were older adults, SG have noted this and will continue to monitor and explore further if a consistent pattern emerges.

Quality Assurance and Practice Development -Care and Treatment Plan Audit

A task and finish group from the Clinical Audit and Effectiveness Group have reviewed and improved the previous care & treatment plan audit. The revised audit now includes in the cycle an audit of the Comprehensive Assessment Tool, Wales Applied Risk Research Network, which is a risk assessment and management document and an audit of demographics and activity records, which are personal details held and ensuring standards are met in respect of record keeping.

Community team leaders will pilot the documentation March and then implement the new audit programme in April. Audit results will be reported to MHLSG for scrutiny and committee updated accordingly.

Argymhelliad / Recommendation

The Committee is asked to receive the Mental Health Legislation Scrutiny Group Update.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Scrutiny Groups activity. This

	includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Mental Health Legislation Scrutiny Group.
Rhestr Termau: Glossary of Terms:	MHLSG – Mental Health Legislation Scrutiny Group MHLOG – Mental health Legislation Operational Group CWCDG – Clinical Written Control Document Group MH/LD – Mental Health / Learning Disabilities WCDG – Written Control Document Group WMF – Ward Managers Forum CRHT – Crisis Resolution Home Treatment QAPD – Quality Assurance Practice Development AMH – Adult Mental Health IMHA – Independent Mental Health Advocate SSWA – Social Services and Wellbeing Act MHA – Mental Health Act MHM – Mental Health Measure DOL – Deprivation of Liberty HIW – Healthcare Inspectorate Wales CIW – Care Inspectorate Wales

	CHC – Community Health Council CTP – care and Treatment Plan CMHT – Community Mental Team CTLD – Community team Learning Disability OAMH – Older Adult Mental Health
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Deddfwriaeth Iechyd Meddwl: Parties / Committees consulted prior to Mental Health Legislation Committee:	MHLSG Mental Health Act Legislation Manager

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Non-compliance with Mental Health Legislation could result in legal proceedings being brought against the University Health Board.
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	Risk of non-compliance with the 1983 Act and with the Welsh Government's Mental Health Act 1983 Code of Practice for Wales; the Mental Health (Wales) Measure 2010 Code of Practice; and with the Good Governance Practice Guide – Effective Board Committees (Supplementary Guidance) Guidance. Safety of patients Assurance – use of statutory mechanisms
Cyfreithiol: Legal:	Not Applicable.

Enw Da: **Reputational:**	Not Applicable.
Gyfrinachedd: **Privacy:**	Not Applicable.
Cydraddoldeb: **Equality:**	Not Applicable.

2.4

10 Mins

2.4 - Mental Health (Wales) Measure 2010 Report

Amanda Davies (Hywel Dda UHB - Head of Service, Adult Mental Health)

For assurance

Attachments

008. Mental Health (Wales) Measure 2010 Report.docx

008. Mental Health (Wales) Measure 2010 Report

2.4 - Mental Health (Wales) Measure 2010 Report

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

MENTAL HEALTH SCRUTINY GROUP

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13th February 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health Scrutiny Group October 2024 – January 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Amanda Davies, Head of Adult Mental Health Community

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

For information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present to the Mental Health Scrutiny Group the Mental Health Performance Report in relation to:

- The Mental Health (Wales) Measure 2010.

The paper also includes assurance of other work carried out by the Mental Health and Learning Disabilities Directorate where related to mental health.

Cefndir / Background

The purpose of this Group is to allow senior managers and clinicians from Hywel Dda University Health Board, its partner agencies, and other stakeholders to scrutinise the University Health Board's (UHB) performance, to highlight areas of good practice, and any areas of concern that must be brought to the attention of the group. This paper summarises performance, and any actions that have been implemented, to ensure improvements in the identified areas.

The Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 is being reported to the Group on a quarterly basis in order to provide assurance that activity is closely monitored, and that practice is compliant with the requirements of The Code of Practice. This is primary legislation that was passed by the Welsh Government in 2010 and became operational during 2012. The intention of the legislation is to ensure that people are able to access appropriate mental health support services, receive care that is co-ordinated by a named person, enables direct access back to services following discharge and that the entitlement to independent mental health advocacy is increased.

To achieve this the Measure is divided into four Parts:

Part 1 - The expansion of mental health services within primary care settings

Part 2 - The introduction of the statutory Care and Treatment Planning for individuals receiving secondary mental health services
Part 3 - Enabling former users of secondary mental health services who have been discharged to refer themselves back for assessment without having to first go to their GP
Part 4 - Expanding the Independent Mental Health Advocacy (IMHA) to informal patients.

Part 1 – Local Primary Mental Health Support Services

Commencement of groups across the three counties will support Part 1 (b) and offer more choice for the population, however access to adequate accommodation to deliver groups can be challenging.

PART 1	Detail		Oct	Nov	Dec
Target a	80% of **assessments** by the LPMHSS undertaken within 28 days from date of receipt of referral	**Adult**	98.1%	98.0%	98.4%
		CAMHS	95.2%	87.0%	90.3%
Target b	80% of therapeutic **interventions** started within 28 days following an assessment by the LPMHSS	**Adult**	98.1%	97.2%	97.5%
		CAMHS	84.1%	98.0%	98.3%

Part 1 -All areas under Part One compliant

Part 2 – Care and Treatment Planning

PART 2	Detail		Oct	Nov	Dec
Measure 1	90% of LHB residents who are in receipt of secondary mental health services to have a valid CTP	**Adult**	97.0%	94.9%	93.7%
		OAMHS	95.5%	97.3%	97.1%
		LD	90.4%	94.7%	94.6%
		CAMHS	90.6%	93.6%	92.7%

S-CAMHS
CAMHS maintains over 90% compliance. Sickness rates in October meant the compliance margin was narrower, but slightly improved into November and December. CAMHS will continue to monitor compliance.

Older Adult Mental Health Services OAMH
Compliant

Learning Disabilities
Compliant

Adult Mental Health
Adult Mental Health maintains over 90% compliance. This will be continuing to be monitored to maintain compliance. Discussed that all areas compliant but informed that Adult Mental Health compliance may be impacted in the future by Ceredigion CMHT. The team is currently not compliant (currently 57% compliant), due to decreased medical and nursing cover. Currently the overall compliance is being maintained due to the other CMHT areas being over the 90% compliance .Also issues raised for the North Pembrokeshire CMHT ,when the local authority are unable to undertake the care coordination role for a large amount of patients ,due to vacancies and sickness, which may impact future compliance. Pembrokeshire Local authority have this on their risk register and are continuing to find attempt to resolve this.

New to secondary Mental Health services under CTP	Oct	Nov	Dec
Adult	15	11	14
Older	22	13	9
CAMHS	5	9	4
LD	3	4	3

Discharged from secondary Mental Health services	Oct	Nov	Dec
Adult	30	28	26
Older	11	21	31
CAMHS	9	16	8
LD	1	4	5

Part 3 – Referrals from the 111 option 2 (SPOC) Service

	Oct	Nov	Dec
Over All Monthly Total Calls Answered	1349	1534	974
Over all Referred to CMHT Sub to Measure	9	10	3
Over All Monthly Total Calls referred to CMHT	52	67	31
Over All Monthly Total Calls advised to self-refer to CMHT	0	0	0

Reduction in calls over December period noted ,no identified rational for this .

Part 3 – Self Referral to Secondary Care for Former Service Users

Adult Mental Health

Older Adult Mental Health Services OAMH

PART 3	Detail		Oct	Nov	Dec
Measure 1	Individuals are re-assessed in a timely manner; and a copy of a report to that individual is provided no later than 10 working days. (Total number of requests for re-assessment received) Target 100%	**Adult**	91.7%	83.3%	100%
		OAMHS	100%	100%	100%

Adult Mental health will be continuing to monitor the outcomes of part 3 assessments to improve compliance .This is now being closely monitored via the Business Manager and the Team Leaders.

	Oct	Nov	Dec
Average wait times in days for adult mental health	34	28	27

Detail	Oct	Nov	Dec
Amount of People who **have** self-referred under Part 3 of the Mental Health Measure (in Adult Mental Health).	15	9	11
Amount of People who **could have** self-referred under Part 3 of the Mental Health Measure but were referred by a GP (in Adult Mental Health).	2	3	5

Part 4 – Independent Mental Health Advocacy

Adult inpatient wards

Currently 100% compliant

Older Adult inpatient

Currently 100% compliant

Detail		Oct	Nov	Dec
100% of hospitals to have arrangements in place to ensure advocacy is available to all qualifying patients – Percentage of qualifying compulsory / voluntary patients have been offered advocacy services in the mental health services (Target 100%)	**Adult**	100%	100%	100%
	OAMHS	100%	100%	100%

Further breakdown from the IMHA Report is:

Age and Gender:	Oct	Nov	Dec
Under 18	6	9	6
18-29	20	18	19
30-49	31	39	37
50-64	26	26	19
65+	37	37	39
80+:	22	26	22
Total	**142**	**155**	**142**

Mental Health Ward	OCT	NOV	DEC
Bryngofal - Carms	36	34	32
Bryngolau - Carms	7	12	11
LSU - Carms	9	9	10
PICU - Carms	15	18	12
Morlais - Carms	11	15	15
Ty Bryn - Carms	0	0	0
Rainbow Suite/CAMHS - Carms	0	0	0
Bro Myrddin - Carms	0	0	0

St Caradog - Pembs	12	10	12
St Non - Pembs	17	18	20
Enlli - Ceredigion	11	10	9
Total Carmarthenshire	**78**	**88**	**80**
Total Pembrokeshire	**29**	**28**	**32**
Total Ceredigion	**11**	**10**	**9**
Total MH Units	**118**	**126**	**121**

General Hospital	OCT	NOV	DEC
Prince Phillip - Carms	2	1	2
Glangwili - Carms	1	4	1
Llandovery - Carms	0	0	0
Amman Valley - Carms	0	2	0
Withybush - Pembs	7	6	6
South Pembs - Pembs	0	0	0
Tenby Cottage - Pembs	0	0	0
Bronglais - Ceredigion	8	10	6
Tregaron - Ceredigion	1	0	0
Total Carmarthenshire	**3**	**7**	**3**
Total Pembrokeshire	**7**	**6**	**6**
Total Ceredigion	**9**	**10**	**6**
Total General Hospital	**19**	**23**	**15**

Community:	OCT	NOV	DEC
Carmarthenshire	3	3	3
Pembrokeshire	1	3	3
Ceredigion	1	0	0
Community Total:	**5**	**6**	**6**

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	1. Improve population health through prevention and early intervention 2. Support people to live active, happy and healthy lives 3. Improve efficiency and quality of services through collaboration with people, communities and partners

MHSG

Gwybodaeth Ychwanegol: Further Information:	
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working: Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term – can you evidence that the long term needs of the population and organisation have been considered in this work?
	Prevention – can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?
	Integration – can you evidence that this work supports the objectives and goals of either internal or external partners?
	Collaboration – The Mental Health Legislation Committee comprises external agencies, carer representatives and local authorities
	Involvement – can you evidence involvement of people with an interest in the service change/development and that this reflects the diversity of our population?

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Mental Health Legislation Committee and scrutiny group
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Mental Health Legislation Scrutiny Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Risk of non-compliance with the 1983 Act and with the Welsh Government's *Mental Health Act 1983 Code of Practice for Wales*; the *Mental Health (Wales) Measure 2010 Code of Practice;* and with the *Good Governance Practice Guide – Effective Board Committees (Supplementary Guidance) Guidance*. Safety of patients Assurance – use of statutory mechanisms
Cyfreithiol: **Legal:**	
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

2.5 **10 Mins**

2.5 - Risk Register

Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing MH&LD), Kay Isaacs (Hywel Dda UHB - Assistant Director of MH&LD), Warren Lloyd (Hywel Dda UHB - Consultant Psychiatrist)

For assurance

Attachments

009. 01. MHLC Operational Risk Report - February 2025.docx

009. 02. MHLC Risk Report Risk Register.pdf

009. 03. Appendix 1 MHLC Risk Register Mar 25.xlsx

009. 01. MHLC Operational Risk Report - February 2025

2.5 - Risk Register

Last modified: 05/03/2025

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 March 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Risk Register
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Liz Carroll, Director of Mental Health and Learning Disabilities

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

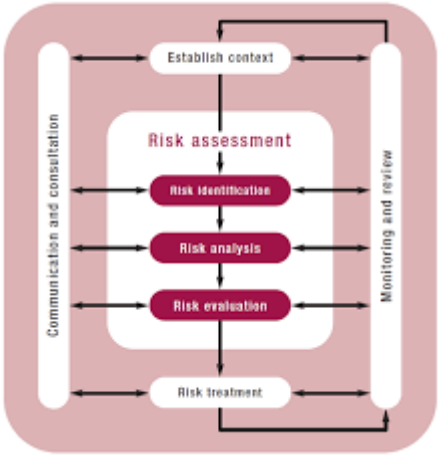
Sefyllfa / Situation

The Mental Health Legislation Committee (MHLC) is responsible for providing assurance to the Board that risks aligned to the Committee are being identified, assessed and managed effectively.

The Committee is asked to seek assurance from Lead Officers/representatives of the Mental Health and Learning Disabilities (MHLD) Directorate that the operational risks identified in the attached reports are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place, to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

Operational risks must be managed within Directorates under the ownership and leadership of individual Executive Directors, who must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks.

In addition to these local arrangements, formal monitoring and scrutiny processes are in place within Hywel Dda University Health Board (HDdUHB) to provide assurance to the Board that risks are being managed effectively.

All risks identified within the Datix Risk Module must be assigned to a formal Board Committee, Sub-Committee or Group which will be responsible for securing assurance that risks within their remit are being managed effectively.

Management Leads are asked to review risk assessments and risk actions in line with the following timescales for review:

RISK SCORE	DEFINITION	MINIMUM REVIEW FREQUENCY
15-25	**Extreme**	This type of risk is considered extreme and should be reviewed and progress on actions updated at least monthly.
8-12	**High**	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	**Moderate**	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	**Low**	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

In monitoring the risks associated with their respective areas of activity, each Committee and Sub-Committee is responsible for:

- Scrutinising operational risks within their remit; either through receiving the Risk Registers or through Service Reports.
- Gaining assurance that risks are being appropriately managed, effective controls are in place, and planned additional controls are being implemented.
- Challenging pace of delivery of actions to mitigate risk.
- Identifying, through discussions, new and emerging risks and ensuring these are assessed by those with the relevant responsibility.
- Providing assurance to its parent Committee, or to the Board, that risks are being managed effectively and reporting risks which have exceeded tolerance through its Committee/ Sub-Committee/ Group Update Report.
- Using Risk Registers to inform meeting agendas.

It is therefore essential that the membership of these Committees and Sub-Committees includes appropriate representation from Directorates and that they are in attendance to provide assurance and to respond to queries.

Relevant discussion should be reflected in the MHLC Update Report to the Board to provide assurance on the management of significant risks. This will include risks that are not being managed within tolerance levels (see Risk Appetite Statement) and any other risks, as appropriate.

Asesiad / Assessment

The MHLC's Terms of Reference state that it will:

- Review the Mental Health & Learning Disabilities Risk Register bi-annually to ensure that risks relating to compliance with mental health legislation are being appropriately managed by Mental Health Legislation Scrutiny Group;
- Identify matters of risk relating to compliance with mental health legislation are being appropriately mitigated.

There are currently 4 risks presented in the attached Risk Register as of 5th March 2025 which have been extracted from Datix, based on the following criteria:

- The Mental Health Legislation Committee has been selected by the Risk Lead as the 'Local management group' on Datix; and
- Risks are at operational level on Datix.

All risks have been scored against the *Safety – Patient, Staff or Public* domain.

Please refer to Appendix 1 for the full details of the risks assigned to the MHLC.

Changes since the previous report presented to MHLC at its meeting on 2nd December 2024:

Total Number of Risks	4	
New risks	2	*Note 1*
Risks that are no longer included in the report	1	*Note 2*
Increase in risk score ↑	0	
No change in risk score →	2	*Note 3*
Reduction in risk score ↓	0	
Extreme (red) risks (based on 'Current Risk Score')	2	
High (Amber) risks (based on 'Current Risk Score')	1	
Moderate (Yellow) risks (based on 'Current Risk Score')	1	

Note 1 - New Risks Being Reported

Since the previous report, the following risks have been added:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1612 - Risk to patient care at North Ceredigion Community mental health centre due to workforce capacity	10/01/25	Chief Operating Officer	**5x4=20** (Reviewed 26/02/25)	Risk has increased since November 2024 when Consultant vacated his post. Further increase in risk as attempts to recruit a Locum has been unsuccessful. Limited medical workforce. No identified dedicated Consultant cover. Increase in sickness and vacancies within the Community Mental Health Team. Escalated to Executive level regarding Locum Consultant medical	**2x3=6**

				cover in January 2025. Risk score increased to 20.	
1813 - Risk to patient care at Gorwelion Crisis Resolution and Home Treatment Team (CRHT) due to workforce capacity	10/01/25	Chief Operating Officer	**5x4=20** (Reviewed 26/02/25)	Risk has increased since November 2024 when Consultant vacated his post. Further increase in risk as attempt to recruit via Locum was unsuccessful. Limited medical workforce. No identified dedicated Consultant cover. Escalated to Executive level regarding Locum Consultant medical cover in January 2025. Risk score increased to 20. As of February 2025, situation remains unchanged. Unable to progress one practitioner appointment into the team due to issues with current workload. Continuing to work with HR and recruitment. Overnight cover is continuing to be offered for bank. Intermittent cover with this. Further impacted by gaps in Medical On-Call cover which is supported remotely from Carmarthen Medical On-Call when no cover is in situ on site	**2x3=6**

Note 2 - Risks that are no longer included in the report

Since the previous report, the following risk has been removed from the risk register:-

Risk Reference & Title	Date risk identified	Lead Director	Reason for Risk Closure or Removal
1752 - Risk to Young People's privacy, dignity and Health and Safety due to the 136 suite on Morlais being unsuitable	28/09/23	Chief Operating Officer	Risk closed on 8 January 2025 as the 136 suite has been relocated to an area of the ward that provides privacy and dignity and ensuite facilities.

Note 3 – No Change in Risk Score

Since the previous report, there has been no change in the score of the following risks:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Rationale for Current Risk Score	Target Risk Score
1857 - Risk of significant delay in admission for individuals with medical recommend-ations for admission under the Mental Health Act.	04/06/24	Chief Operating Officer	**3x3=9** (Reviewed 09/01/25)	Demand outweighs capacity at present with delays possible for patients awaiting beds.	**3x3=9**
1781 - Risk of being unable to provide a Community Place of Safety (CPOS) to individuals detained under Section 136 in Ceredigion count	28/11/23	Chief Operating Officer	**2x3=6** (Reviewed 31/10/24)	Likelihood score given is 3 as it is always possible that an individual in Ceredigion will need to be detained under Section 136. The current impact score given is 2 as minor intervention is sometimes required (i.e. moving an individual to a different county) with an increased length of time in care/delay in assessment being undertaken. The risk of having no facility in Ceredigion is outweighed by the fact that the facility was unfit for purpose and a much higher risk in itself. Review is ongoing, currently with a working group.	**2x2=4**

The heatmap below has been obtained from the Risk Performance dashboard. The information reflects the risk information extracted from Datix on 5th March 2025:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5					
MAJOR 4					1813 (NEW) 1612 (NEW)
MODERATE 3			1857 (→)		

MINOR 2			1781 (→)		
NEGLIGIBLE 1					

The table below details when the four operational risks assigned to MHLC were last updated on Datix. Risks are required to be updated along the following timescales, dependant on their risk level:

- Extreme Risks – Monthly
- High Risks – Bi-monthly
- Moderate Risks – Six-monthly
- Low Risks – Annually

	Risks updated in last month	**Risks updated within last 1-2 months**	**Risks updated within last 2-6 months**	**Risks updated within last 6-12 months**
Extreme	1612, 1813			
High		1857		
Moderate			1781	
Low				

Argymhelliad / Recommendation

The Mental Health Legislation Committee is asked to:

- **REVIEW** and **SCRUTINISE** the risks included within this report to **SEEK ASSURANCE** that all relevant controls and mitigating actions are in place; and
- **DISCUSS** whether the planned action will be implemented within stated timescales and will reduce the risk further and/ or mitigate the impact, should the risk materialise

This in turn will enable the Committee to provide the necessary **ASSURANCE** to the Board that these risks are being managed effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Review the Mental Health & Learning Disabilities Risk Register bi-annually to ensure that risks relating to compliance with mental health legislation are being appropriately managed by Mental Health Legislation Scrutiny Group; 3.8 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated;
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained in the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply

Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services, reviewed by risk leads/ owners
Rhestr Termau: Glossary of Terms:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009) Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol a Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report, however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report, however proactive risk management, including learning from incidents and events, contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.

Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

009. 02. MHLC Risk Report Risk Register

2.5 - Risk Register

Last modified: 05/03/2025

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
1612	Directorate Level Risk	Effective	MHLD: AMH Community services	Carroll, Mrs Liz	Davies, Amanda	10-Jan-25	There is a risk of of patient harm. Reduced capacity to undertake assessment of new patients and Care and Treatment Planning (CTP) of existing patients. This is caused by insufficient mental health practitioner and mental health nurse capacity and also no consultant medical cover within Gorwelion Community Mental Health Centre (CMHT). Inability to recruit to substantive posts. This is due to the rurality of the area and limited medical cover and no dedicated consultant cover. 25/2/25 -two practitioners are currently on long term sick -who have care coordination responsibility which is further impacting capacity within the team . This will lead to an impact/affect on timely assessment of patients (within 28 days). Accessibility to community mental health and Care and Treatment planning. Waiting list breaches (more than 28 days). Patient/carer experience and complaint rates. Numbers of near-miss and/or serious untoward incidents. General workforce confidence and morale. Remaining medical workforce burden of workload. Safe and effective business continuity and patient flow. Recruitment and retention of medical workforce and trainees. CTP compliance under Part 2 of the Welsh Measure is currently at 58% where the target is 90%, which could lead to targeted intervention of the NHS executive which could cause reputational damage to the Service and Health Board. Non compliance of Part 2 could result in patient harm and vulnerable to litigation (07/01/2025). Risk location, Gorwelion (MHLD).	1. Working with the 111 opt 2 service to lessen calls to service. 2. Joint working being promoted between Community Mental Health Team and Crisis Resolution Home Treatment staff by team leads. 3. Bank shifts have been offered to support the CMHT	Safety - Patient, Staff or Public	8	5	4	20	Team lead to start assessing new referrals to reduce waiting times and bring compliance to within the 28-day target	Davies, Amanda	Completed	Team lead currently assessing when possible.	Quality, Safety and Experience Sub Committee	3	2	6	Treat	26-Feb-25
														Team lead to advertise vacancies and a recruitment drive for Band 6 Nurses or Mental Health Practitioners.	Davies, Amanda	Completed	Staff Position has improved.						
														Team lead to promote Grow your own (GYO) to existing band 3/4 staff to see if we can upskill into substantive band 6 posts.	Davies, Amanda	Completed	One staff member has been accepted onto the grow your own scheme. No others qualify. Agreed to close						
														Senior Nurse to promote more joint work with Crisis team to ensure that urgent assessments are undertaken.	Davies, Amanda	Completed	Agreed with team leads that Crisis Team will take on urgent assessments to ensure that they are undertaken within a timely manner. 26/04/22 - Crisis Team						
														Senior Nurse to review 7 day working and generic assessment waiting list	Davies, Amanda	Completed	Andrew Littlejohns to review 7 day working and assessments undertaken on the weekend.						
														Educational work with General Practitioners needed. Senior Nurse and Team Lead to coordinate possible General Practitioner Link working	Davies, Amanda	~~30/09/2025~~ 31/03/2025	Currently on hold. Team lead has been recruited. Once staff member has commenced this will re-start (currently going through checks). GPs are being told to inform patients about 111 option 2						
														Service will look at employing Annexe 21 Band 6 staff or newly qualified nurse from March 2024. Recruitment drive needed.	Davies, Amanda	~~31/07/2025~~ 31/03/2025	Ongoing recruitment need, where there remains outstanding of 2 WTE, this is due to staff changing posts and that of resignations. ongoing process of recruitment process (checks) for B7 Team lead ongoing						
														Undergoing recruitment drive.	Davies, Amanda	~~30/06/2025~~ 30/05/2025	New Action						
														Escalate issues with limited medical cover to executive level (document attached)	Davies, Amanda	Completed	Completed						
														Bank shifts to be offered to staff to cover the deficit	Davies, Amanda	06-Oct-25	New action						

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
														Expedite senior nurse and team lead for team.	Davies, Amanda	Completed	Senior nurse has now started in post						
1813	Directorate Level Risk	Effective, Efficient, Safe	MHLD: AMH Community services	Carroll, Mrs Liz	Davies, Amanda	10-Jan-25	There is a risk of to delivery of patient care and crisis treatment planning within Gorwelion Crisis Resolution and Home Treatment Team and an increase in requested admissions. This is caused by insufficient capacity and also no consultant medical cover within Gorwelion Crisis Resolution and Home Treatment Team. The recruitment and retention of staff in north Ceredigion is challenging currently but without the Medical Leadership in place within the team. This will lead to an impact/affect on This will lead to an impact/effect on timely assessment of patients, accessibility to community crisis care management, reputational damage to the Service and Health Board, patient/carer experience and complaint rates, numbers of near-miss and/or serious untoward incidents, general workforce confidence and morale, remaining medical workforce burden of workload, safe and effective business continuity and patient flow and recruitment and retention of medical workforce and trainees. Reduced capacity to undertake assessment of new patients and to potentially take on any new patients for crisis care and home treatment. Increase in workload for out of hours medical staff (doctors and consultants). The retention of staff may become a worsening position due to lack of medical leadership causing time delays for patients to receive mental Health treatment and reduced medical input into crisis management plans and risk formulation thus creating a risk of patient harm and vulnerable to litigation. Risk location, Gorwelion (MHLD).	1. Utilising bank staff to cover the overnight shift which ensures that day staff can maintain home treatment for community patients. 2. Closure of the Community Place Of Safety (CPOS) suite temporarily following the 136 review (staffing and environmental issues).	Safety - Patient, Staff or Public	8	5	4	20	Band 6 Jobs to be sent to panel via Vacancy justification	Davies, Amanda	Completed	Completed 18/04/2024	Quality, Safety and Experience Committee	2	3	6	Treat	26-Feb-25
														Documents being drafted for an Occupational Change Process (OCP) to align all Crisis Resolution and Home Treatment Team working patterns. Once complete the OCP should help with working patterns and overnight cover.	Davies, Amanda	Completed	OCP agreed and due to commence 1/9/24, current levels of staff remain low, due to planned commencement of staff member in sept, plus current Safeguarding concern regarding appointed member of staff. Amendments to night shift cover have been instigated meaning, staff allocation is being managed focussing on day and evening shifts.						
														Andrew Littlejohns (senior nurse) overseeing rota to ensure effective staffing. Overtime is currently being offered in order to cover night shift	Davies, Amanda	Completed	New team leader commenced 08/04/2024						
														Recruitment needed as there are vacancies	Davies, Amanda	~~30/06/2025~~ 26/03/2025	Currently on going. Jobs advertised. Team leader started as of 24/02/2025. However this has created another CPN Vacancy.						
														Escalate issues with limited medical cover to executive level (document attached)	Davies, Amanda	Completed	Completed						

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
1857	Service or Department Level Risk	Person Centred	MHLD: AMH Inpatient Services	Carroll, Mrs Liz	Bassett-Gravelle, Ms Lisa	04-Jun-24	There is a risk of for individuals who are mentally unwell or who are assessed to possess a risk to themselves or others remaining in the community when it has been recommended by two medical professionals and an Approved Mental Health Professional that they require admission for further assessment, treatment or management of risk. This is caused by lack of available beds in the health board and being unable to safely deliver intensive home treatment as a least restrictive alternative. This is can also be caused by lack of transportation to transfer an individual from the community to hospital and no availability of a bed in a neighbouring health board or a time delay in locating and transferring to a commissioned bed outside of Wales. This will lead to an impact/affect on an absence or delay in further assessment, treatment and risk management and will result in an inability to deliver safe effective care to the individual concerned and further impact the wellbeing or resilience of family, friends or carers Risk location, .	Clinical demand and capacity position is managed dynamically at the twice daily week and once daily weekend bed conference in order to attempt to create capacity Crisis Team will monitor and support the individual and family even when home treatment not possible to be delivered. AMHP to be involved in a handover and development of a care plan with the CRT or CMHT. Process to obtain a bed outside of the health board will be instigated St John's ambulance will be prioritised	Safety - Patient, Staff or Public		3	3	9	Incidences will be monitored via Legislation group on a bi monthly basis over the next 6 months and risk score reviewed accordingly	Bassett-Gravelle, Ms Lisa	~~28/02/2025~~ 12/03/2025	Local authorities have agreed to include incidences in their reports to Legislation group	Mental Health Legislation Committee	3	3	9		09-Jan-25

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
1781	Service or Department Level Risk	Equitable, Safe, Timely	MHLD: AMH Community services	Carroll, Mrs Liz	Davies, Amanda	28-Nov-23	There is a risk of of individuals (potential patients) in Ceredigion not being provided with a Community Section 136 facility in their county (i.e. allowing them be taken to a place of safety if police are concerned that the individual may have a mental disorder and for an assessment to be undertaken). This is caused by the temporary closure of the existing room at the community mental health centre in Aberystwyth due to environmental issues and staff capacity which were highlighted in a recent internal review of Hywel Dda Section 136 provisions by Estates/Health & Safety. This will lead to an impact/affect on being able to provide a place of safety within a timely manner which results in a delay to patient care and additional duress to individuals who may already be experiencing distress. Patients have to travel further as any Section 136 patients have to be redirected to the nearest hospital place of safety which is currently Bryngofal Ward in Llanelli. Risk location, Ceredigion.	1. Bryngofal ward is used as the nearest place of safety as an alternative. 2. Clear consultation process in place between Dyfed Powys Police and designated manager in HB over 24 hour basis 3. Out of Hours SOP in place 4. Working groups regularly discuss Section 136: Legislation Scrutiny Group, Legislation Committee, Crisis Concordat Meeting (locally and national) and Police Joint Working groups in all 3 counties.	Safety - Patient, Staff or Public	6	2	3	6	Engage with stakeholders and complete review which will generate further actions	Temple-Purcell, Rebecca	31/03/2025 ~~01/02/2025~~ ~~01/09/2024~~	Multi agency Stakeholder Group formed and options for future S136 provision review completed.Â Equality Impact and Quality Impact assessment underway for proposed option.Â Timescales delayed by Right Care Right Person implementation, additional steps required to take recommendation through Health Board approval processes and identification of how capital and staffing costs are to be met.Â Revised date for completion 31/03/25.	Quality, Safety and Experience Sub Committee	2	2	4	Treat	31-Oct-24

009. 03. Appendix 1 MHLC Risk Register Mar 25

2.5 - Risk Register

Last modified: 05/03/2025

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
1612	Directorate Level Risk	Effective	MHLD: AMH Community services	Carroll, Mrs Liz	Davies, Amanda	10-Jan-25	There is a risk of of patient harm. Reduced capacity to undertake assessment of new patients and Care and Treatment Planning (CTP) of existing patients. This is caused by insufficient mental health practitioner and mental health nurse capacity and also no consultant medical cover within Gorwelion Community Mental Health Centre (CMHT). Inability to recruit to substantive posts. This is due to the rurality of the area and limited medical cover and no dedicated consultant cover. 25/2/25 -two practitioners are currently on long term sick -who have care coordination responsibility which is further impacting capacity within the team . This will lead to an impact/affect on timely assessment of patients (within 28 days). Accessibility to community mental health and Care and Treatment planning. Waiting list breaches (more than 28 days). Patient/carer experience and complaint rates. Numbers of near-miss and/or serious untoward incidents. General workforce confidence and morale. Remaining medical workforce burden of workload. Safe and effective business continuity and patient flow. Recruitment and retention of medical workforce and trainees. CTP compliance under Part 2 of the Welsh Measure is currently at 58% where the target is 90%, which could lead to targeted intervention of the NHS executive which could cause reputational damage to the Service and Health Board. Non compliance of Part 2 could result in patient harm and vulnerable to litigation (07/01/2025). Risk location, Gorwelion (MHLD).	1. Working with the 111 opt 2 service to lessen calls to service. 2. Joint working being promoted between Community Mental Health Team and Crisis Resolution Home Treatment staff by team leads. 3. Bank shifts have been offered to support the CMHT	Safety - Patient, Staff or Public	8	5	4	20	Team lead to start assessing new referrals to reduce waiting times and bring compliance to within the 28-day target	Davies, Amanda	**Completed**	Team lead currently assessing when possible.	Quality, Safety and Experience Sub Committee	3	2	6	Treat	26-Feb-25
														Team lead to advertise vacancies and a recruitment drive for Band 6 Nurses or Mental Health Practitioners.	Davies, Amanda	**Completed**	Staff Position has improved.						
														Team lead to promote Grow your own (GYO) to existing band 3/4 staff to see if we can upskill into substantive band 6 posts.	Davies, Amanda	**Completed**	One staff member has been accepted onto the grow your own scheme. No others qualify. Agreed to close						
														Senior Nurse to promote more joint work with Crisis team to ensure that urgent assessments are undertaken.	Davies, Amanda	**Completed**	Agreed with team leads that Crisis Team will take on urgent assessments to ensure that they are undertaken within a timely manner.						
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														Educational work with General Practitioners needed. Senior Nurse and Team Lead to coordinate possible General Practitioner Link working	Davies, Amanda	~~30/09/2025~~ 31/03/2025	Currently on hold. Team lead has been recruited. Once staff member has commenced this will re-start (currently going through checks). GPs are being told to inform patients about 111 option 2						
														Service will look at employing Annexe 21 Band 6 staff or newly qualified nurse from March 2024. Recruitment drive needed.	Davies, Amanda	~~31/07/2025~~ 31/03/2025	Ongoing recruitment need, where there remains outstanding of 2 WTE, this is due to staff changing posts and that of resignations. ongoing process of recruitment process (checks) for B7 Team lead ongoing						
														Undergoing recruitment drive.	Davies, Amanda	~~30/06/2025~~ 30/05/2025	New Action						
														Escalate issues with limited medical cover to executive level (document attached)	Davies, Amanda	**Completed**	Completed						
														Bank shifts to be offered to staff to cover the deficit	Davies, Amanda	6-Oct-25	New action						

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
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														Documents being drafted for an Occupational Change Process (OCP) to align all Crisis Resolution and Home Treatment Team working patterns. Once complete the OCP should help with working patterns and overnight cover.	Davies, Amanda	Completed	OCP agreed and due to commence 1/9/24, current levels of staff remain low, due to planned commencement of staff member in sept, plus current Safeguarding concern regarding appointed member of staff. Amendments to night shift cover have been instigated meaning, staff allocation is being managed focussing on day and evening shifts.						
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1857	Service or Department Level Risk	Person Centred	MHLD: AMH Inpatient Services	Carroll, Mrs Liz	Bassett-Gravelle, Ms Lisa	4-Jun-24	There is a risk of for individuals who are mentally unwell or who are assessed to possess a risk to themselves or others remaining in the community when it has been recommended by two medical professionals and an Approved Mental Health Professional that they require admission for further assessment, treatment or management of risk. This is caused by lack of available beds in the health board and being unable to safely deliver intensive home treatment as a least restrictive alternative. This is can also be caused by lack of transportation to transfer an individual from the community to hospital and no availability of a bed in a neighbouring health board or a time delay in locating and transferring to a commissioned bed outside of Wales. This will lead to an impact/affect on an absence or delay in further assessment, treatment and risk management and will result in an inability to deliver safe effective care to the individual concerned and further impact the wellbeing or resilience of family, friends or carers Risk location, .	Clinical demand and capacity position is managed dynamically at the twice daily week and once daily weekend bed conference in order to attempt to create capacity Crisis Team will monitor and support the individual and family even when home treatment not possible to be delivered. AMHP to be involved in a handover and development of a care plan with the CRT or CMHT. Process to obtain a bed outside of the health board will be instigated St John's ambulance will be prioritised	Safety - Patient, Staff or Public		3	3	9	Incidences will be monitored via Legislation group on a bi monthly basis over the next 6 months and risk score reviewed accordingly	Bassett-Gravelle, Ms Lisa	~~28/02/2025~~ 12/03/2025	Local authorities have agreed to include incidences in their reports to Legislation group	Mental Health Legislation Committee	3	3	9		9-Jan-25

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
1781	Service or Department Level Risk	Equitable, Safe, Timely	MHLD: AMH Community services	Carroll, Mrs Liz	Davies, Amanda	28-Nov-23	There is a risk of of individuals (potential patients) in Ceredigion not being provided with a Community Section 136 facility in their county (i.e. allowing them be taken to a place of safety if police are concerned that the individual may have a mental disorder and for an assessment to be undertaken). This is caused by the temporary closure of the existing room at the community mental health centre in Aberystwyth due to environmental issues and staff capacity which were highlighted in a recent internal review of Hywel Dda Section 136 provisions by Estates/Health & Safety. This will lead to an impact/affect on being able to provide a place of safety within a timely manner which results in a delay to patient care and additional duress to individuals who may already be experiencing distress. Patients have to travel further as any Section 136 patients have to be redirected to the nearest hospital place of safety which is currently Bryngofal Ward in Llanelli. Risk location, Ceredigion.	1. Bryngofal ward is used as the nearest place of safety as an alternative. 2. Clear consultation process in place between Dyfed Powys Police and designated manager in HB over 24 hour basis 3. Out of Hours SOP in place 4. Working groups regularly discuss Section 136: Legislation Scrutiny Group, Legislation Committee, Crisis Concordat Meeting (locally and national) and Police Joint Working groups in all 3 counties.	Safety - Patient, Staff or Public	6	2	3	6	Engage with stakeholders and complete review which will generate further actions	Temple-Purcell, Rebecca	31/03/2025 ~~01/02/2025~~ ~~01/09/2024~~	Multi agency Stakeholder Group formed and options for future S136 provision review completed.Â Equality Impact and Quality Impact assessment underway for proposed option.Â Timescales delayed by Right Care Right Person implementation, additional steps required to take recommendation through Health Board approval processes and identification of how capital and staffing costs are to be met.Â Revised date for completion 31/03/25.	Quality, Safety and Experience Sub Committee	2	2	4	Treat	31-Oct-24

3

3 - Policies

3.1

10 Mins

3.1 - Section 136 Joint Procedure

Sarah Roberts
(Hywel Dda UHB -
Mental Health
Legislation Manager)

For assurance

Attachments

010. Section 136 Joint Procedure.docx

010. Section 136 Joint Procedure

3.1 - Section 136 Joint Procedure

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 March 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	395 – Section 136 Joint Procedure
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Executive Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sarah Roberts, Mental Health Legislation Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The current Section 136 Policy has it's three yearly review date of 24 March 2025 as part of the Health Boards Policy process.

Cefndir / Background

Policy 190 – Written Control Documentation has been adhered to in the review of the Policies and that the documents are in line with legislation/regulations and can be implemented within the Health Board.

The Section 136 policy is due for its 3 yearly review by 24 March 2025 and following discussion within Mental Health Services we requested that the policy is given a 6 month extension which the Written Control Document Group agreed to on the 28th January.

Asesiad / Assessment

There have been no changes to legislation since the policy was last updated and the appendices and Section 136 forms are still in use by Dyfed Powys Police. The request is because of the implementation of Right Care Right Person Phase 4 which covers Section 136. At this point in time Dyfed Powys Police do not have a definite date for implementation and when that happens it will change processes relating to Section 136.

There is also a current review being undertaken of the Hywel Dda Places of Safety and following an options appraisal this work is still ongoing

Argymhelliad / Recommendation

This update is for information only.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.16 Approve organisational policies, procedures, guidelines and codes of practice (policies within the scope of the Committee)
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The content of this policy is developed utilising expert advice, with reference to legislation and guidance documentation.
Rhestr Termau: Glossary of Terms:	Contained within the body of the policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Deddfwriaeth Iechyd Meddwl: Parties / Committees consulted prior to Mental Health Legislation Committee:	MH Scrutiny Group Written Control Documents Group Medical Staff Committee Ward Managers Forum Community Mental Health Team Forum Global email consultation WWAMH Reading Group Senior Nurse Management Team

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	To support patients seeking advocacy support under the Independent Mental Health Advocacy service
Gweithlu: **Workforce:**	Direct legal responsibilities for staff associated with use of Mental Health Act
Risg: **Risk:**	HDdUHB must have an up to date and accurate written policies to avoid risk
Cyfreithiol: **Legal:**	Mental Health Act 1983 Mental Health (Wales) Measure 2010
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Equality Impact Assessments undertaken in collaboration with Senior Equality and Diversity Officer.

4

4 - For Information

4.1

5 Mins

4.1 - HIW Mental Health Annual Report 2023-2024

Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing MH&LD)

For information

Attachments

011. 01. 25.01.29 Alun Jones, HIW to Health Boards and Trusts Wales - Menta~.pdf

011. 02. HIW - Mental Health, Learning Disability, Hospitals and Mental Hea~.pdf

011. 03. HIW - Mental Health, Learning Disability, Hospitals and Mental Hea~.pdf

011. 01. 25.01.29 Alun Jones, HIW to Health Boards and Trusts Wales - Menta~

4.1 - HIW Mental Health Annual Report 2023-2024

Last modified: 04/03/2025

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Chief Executives and Chairs
Health Boards and NHS Trusts Wales
Via Email

29 January 2025

EMBARGOED: Healthcare Inspectorate Wales (HIW)
Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2023-2024

Dear Chief Executive and Chair

I would like to inform you that HIW will be publishing its 2023-2024 Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report at 00:01 on Friday 31 January 2025. Please find a copy of our report attached.

The report sets out our assurance activity and findings during the period from April 2023 to March 2024, and explores the standards of care being delivered by mental health and learning disability healthcare services across Wales during this time.

Should you wish to follow up on anything contained within the report then please get in touch with your HIW Relationship Manager or me directly.

Yours sincerely

Alun Jones
Chief Executive
Healthcare Inspectorate Wales

Llywodraeth Cymru / Welsh Government
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011. 02. HIW - Mental Health, Learning Disability, Hospitals and Mental Hea~

4.1 - HIW Mental Health Annual Report 2023-2024

Last modified: 05/03/2025

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Monitro Ysbytai Iechyd Meddwl, Ysbytai, Anableddau Dysgu a'r Ddeddf Iechyd Meddwl

Adroddiad Blynyddol 2023-24

Mae'r adroddiad hwn hefyd ar gael yn Saesneg. Os hoffech gael copi mewn iaith neu fformat amgen, cysylltwch â ni.

Mae copïau o bob adroddiad, pan gaiff ei gyhoeddi, ar gael ar ein gwefan neu drwy gysylltu â ni:

Yn ysgrifenedig:

Arolygiaeth Gofal Iechyd Cymru
Parc Busnes Rhyd-y-car
Merthyr Tudful
CF48 1UZ

Neu:

Ffôn: 0300 062 8163

E-bost: **agic@llyw.cymru**

Gwefan: **www.agic.org.ukk**

Er mwyn helpu darllenwyr, mae rhestr o'r termau technegol a ddefnyddir yn yr adroddiad hwn ac esboniad ohonynt wedi'u cynnwys yn Atodiad B.

Arolygiaeth Gofal Iechyd Cymru (AGIC) yw arolygiaeth a rheoleiddiwr annibynnol gofal iechyd yng Nghymru

Ein diben

Sicrhau bod gwasanaethau gofal iechyd yn cael eu darparu mewn ffordd sy'n mwyafu iechyd a llesiant pobl

Ein gwerthoedd

Mae pobl wrth wraidd yr hyn a wnawn

Rydym yn:

Annibynnol – rydym yn ddiduedd, yn penderfynu pa waith rydym yn ei wneud a lle rydym yn ei wneud.

Gwrthrychol – rydym yn rhesymol ac yn deg ac yn gweithredu ar sail tystiolaeth.

Pendant – rydym yn gwneud dyfarniadau clir ac yn cymryd camau i wella safonau gwael ac amlygu'r arferion da rydym yn dod ar eu traws.

Cynhwysol – rydym yn gwerthfawrogi ac yn annog cydraddoldeb ac amrywiaeth drwy ein gwaith.

Cymesur – rydym yn ystwyth ac yn gwneud ein gwaith lle mae o'r pwys mwyaf.

Ein nod

Bod yn llais dibynadwy sy'n ysgogi gwelliant mewn gofal iechyd ac yn dylanwadu arno..

Ein blaenoriaethau

Byddwn yn canolbwyntio ar ansawdd y gofal iechyd a ddarperir i bobl a chymunedau wrth iddynt gyrchu gwasanaethau, eu defnyddio a symud rhyngddynt.

Byddwn yn addasu ein dull gweithredu i sicrhau ein bod yn ymatebol i risgiau i ddiogelwch cleifion sy'n dod i'r amlwg.

Byddwn yn cydweithio er mwyn ysgogi'r gwaith o wella systemau a gwasanaethau ym maes gofal iechyd.

Byddwn yn cefnogi ac yn datblygu ein gweithlu i'w galluogi nhw, a'r sefydliad, i gyflawni ein blaenoriaethau

1. Crynodeb Gweithredol

Mae'r adroddiad hwn yn nodi'r gweithgarwch a'r canfyddiadau ar gyfer gwasanaethau iechyd meddwl ac anableddau dysgu yn ystod y cyfnod rhwng mis Ebrill 2023 a mis Mawrth 2024.

Mae'r adroddiad yn rhoi gwybodaeth am yr heriau a wynebir gan wasanaethau iechyd meddwl ac anableddau dysgu, gan gynnwys gwasanaethau cymunedol. Fodd bynnag, er gwaethaf yr heriau hyn, mae llawer o ganfyddiadau cadarnhaol ac mae'n amlwg bod cleifion ac eraill yn gwerthfawrogi ymdrech y gweithlu i roi gofal a thriniaeth mewn amgylchiadau heriol.

Yn y mwyafrif o'n harolygiadau, rydym yn parhau i gael adborth cadarnhaol gan gleifion am y gofal a roddir a'r rhyngweithio rhyngddynt a'r staff. Mae staff AGIC yn parhau i weld ymgysylltu cadarnhaol â chleifion ac mae hyn yn gyson â chanfyddiadau'r flwyddyn ddiwethaf. At hynny, roedd llawer o enghreifftiau o arferion da mewn perthynas â monitro'r Ddeddf Iechyd Meddwl a'i rhoi ar waith, gan gynnwys dogfennau trefnus, hawdd eu defnyddio ac wedi'u storio'n ddiogel, a gweinyddwyr y Ddeddf Iechyd Meddwl a oedd yn llywodraethu ac yn goruchwylio cofnodion cleifion o dan y Ddeddf Iechyd Meddwl yn dda er mwyn monitro cydymffurfiaeth â chanllawiau cenedlaethol ac adolygu terfynau amser a oedd ar ddod i sicrhau bod cleifion yn cael eu cadw'n gyfreithlon o hyd. Gwelsom dystiolaeth dda bod cleifion yn ymwybodol o'u hawliau, a bod hyn yn cael ei gofnodi'n dda. Roedd gwelliannau wedi'u gwneud hefyd o ran arsylwi ar gleifion, gyda nifer bach iawn o broblemau wedi'u nodi yn ein hadroddiadau unigol.

Fodd bynnag, fel y nodwyd uchod, mae rhai meysydd yn parhau i beri pryder i ni, yn enwedig lle bu fawr ddim gwelliant ers ein hadroddiad, os o gwbl. Roedd heriau'r gweithlu mewn perthynas â recriwtio a chadw staff yn un o ganfyddiadau nifer sylweddol o arolygiadau ac roedd swyddi gwag mewn amrywiaeth eang o ddisgyblaethau. Mae rheoli meddyginiaethau hefyd yn thema o hyd, ynghyd â'r problemau penodol sydd wedi'u nodi a'u trafod yn adran 5 o'r adroddiad hwn.

Mae asesiadau risg a chynllunio gofal yn parhau i fod yn un o ganfyddiadau ein harolygiadau hefyd, ac un enghraifft sy'n peri pryder mawr oedd claf nad oedd ganddo ond cynllun llwybr 72 awr a oedd ond wedi'i gwblhau'n rhannol, er ei fod wedi'i dderbyn ers dros dair wythnos.

Mewn dau o'n harolygiadau y flwyddyn hon, gwnaethom nodi problemau yn ymwneud â chadw cleifion ar wahân a darparu gweithgareddau ystyrlon a therapiwtig. Roedd yr amgylchedd gofal hefyd yn destun pryder ac yn ystod nifer o'n hymweliadau, gwnaethom nodi problemau yn ymwneud â diogelwch cleifion a staff. Nodwyd un enghraifft lle na allai'r cleifion gyrraedd y clychau galw yn hawdd, a oedd yn golygu na allai cleifion yr oedd angen cymorth arnynt alw'r staff yn hawdd.

Rydym hefyd wedi nodi canfyddiadau penodol yn yr adroddiad hwn mewn perthynas â'n harolygiadau o wasanaethau anableddau dysgu a Gwasanaethau Iechyd Meddwl Plant a'r Glasoed (CAMHS).

Gwnaethom hefyd nodi diffyg systemau archwilio a llywodraethu cadarn yn ystod rhai o'n harolygiadau o wasanaethau iechyd meddwl ac anableddau dysgu. Ymddengys hefyd nad yw gwersi i'w dysgu yn cael eu rhannu o fewn byrddau iechyd a darparwyr annibynnol pan fydd problemau a nodwyd mewn un maes yn codi mewn ysbyty arall yn yr un bwrdd iechyd neu ddarparwr annibynnol.

Yn ystod saith o'n hymweliadau, gwnaethom nodi problemau difrifol iawn a arweiniodd at anfon llythyrau sicrwydd ar unwaith at fyrddau iechyd, neu hysbysiadau diffyg cydymffurfio at ddarparwyr annibynnol. Mae'r bwrdd iechyd/ darparwr annibynnol yn ymateb i'r llythyrau neu hysbysiadau hyn drwy lunio cynllun gwella ar unwaith y mae'n rhaid i AGIC gytuno arno. Gwnaethom ddefnyddio'r prosesau hyn yn dilyn tri arolygiad o fyrddau iechyd a phedwar arolygiad o ddarparwyr annibynnol.

Mae pennod 6 yr adroddiad hwn yn nodi'r broses a'r meysydd rydym yn canolbwyntio arnynt er mwyn cael sicrwydd bod gwasanaethau yn defnyddio eu pwerau ac yn cyflawni eu dyletswyddau'n gywir o dan Ddeddf Iechyd Meddwl 1983 yng Nghymru.

Yn 2023-24, gwnaethom gynnal cyfanswm o 26 o arolygiadau ar y safle o amrywiaeth o leoliadau gofal iechyd yn y GIG ac ysbytai annibynnol. Roedd y wardiau a arolygwyd yn rhoi gofal i amrywiaeth o gleifion, gan gynnwys:

- Oedolion â phroblemau iechyd meddwl
- Pobl hŷn
- Anableddau Dysgu
- CAMHS

Yn ystod y 26 o arolygiadau ar y safle, gwnaethom ymweld ag un Tîm Anableddau Dysgu Cymunedol (TADC) ar y cyd ag Arolygiaeth Gofal Cymru (AGC). Gwnaethom hefyd gynnal un ymweliad â Thîm Iechyd Meddwl Cymunedol (TIMC). Mae ein canfyddiadau yn seiliedig ar yr arolygiadau hyn.

At ei gilydd, cafwyd 199 o gwynion a phryderon am wasanaethau iechyd meddwl ac anableddau dysgu, o gymharu â 164 yn y flwyddyn flaenorol.

At hynny, yn ystod y cyfnod rhwng mis Ebrill 2023 a mis Mawrth 2024, cafodd y Gwasanaeth Adolygu ar gyfer Iechyd Meddwl 733 o geisiadau am ymweliad gan Feddyg a Benodwyd i Roi Ail Farn. Mae'r ffigur hwn yn gynnydd o gymharu â'r ceisiadau a gafwyd rhwng mis Ebrill 2022 a mis Mawrth 2023.

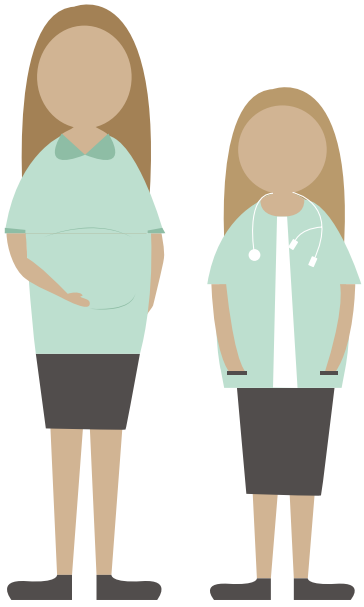
Gellir dadansoddi'r ffigurau hyn fel a ganlyn:

roedd **665** o geisiadau yn ymwneud ag ardystio meddyginiaeth

roedd **44** o geisiadau yn ymwneud ag ardystio ECT

roedd **24** o geisiadau yn ymwneud â meddyginiaeth ac ECT.

I grynhoi, er ein bod yn parhau i nodi meysydd o arferion da, mae'r problemau sydd wedi'u nodi yn yr adroddiad hwn yn destun pryder ac mae angen i fyrddau iechyd a darparwyr annibynnol wella eu prosesau archwilio a llywodraethu er mwyn sicrhau yr eir i'r afael â'r meysydd a nodwyd.



2. Cyd-destun

Drwy gydol 2023-24, wynebodd ysbytai a gwasanaethau iechyd meddwl ac anableddau dysgu cymunedol lawer o heriau wrth ddarparu gwasanaethau. Mae heriau'r gweithlu o ran recriwtio a chadw staff gwybodus a hyfforddedig sy'n meddu ar y sgiliau priodol mewn disgyblaethau allweddol yn parhau i gael effaith andwyol ar allu byrddau iechyd a darparwyr annibynnol i ddiwallu anghenion niferoedd cynyddol o gleifion y mae angen gofal a thriniaeth arnynt.

Nid yw cleifion yn cael cymorth iechyd meddwl mewn modd amserol o hyd, a phan fyddant yn cael eu derbyn i wardiau cleifion meddwl, mae'r wardiau hyn yn brysur iawn ac mae galw eithafol am welyau. Nid yw cleifion bob amser yn treulio digon o amser gyda staff oherwydd y pwysau staffio a amlinellir uchod.

At hynny, ym mis Medi 2023, gwnaethom gyhoeddi'r Cynllun Gwella – adolygiad o drefniadau rhyddhau cleifion sy'n oedolion o wasanaethau iechyd meddwl cleifion mewnol ym Mwrdd Iechyd Prifysgol Cwm Taf Morgannwg. Roedd y cynllun hwn yn cyd-fynd â'r adroddiad ei hun, a gyhoeddwyd ym mis Mawrth 2023 ac a oedd yn cynnwys nifer sylweddol o argymhellion ar gyfer y byrddau iechyd.

Rydym yn parhau i fonitro'r ffordd y caiff darnau allweddol o ganllawiau, Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru (Diwygiedig 2016) a'r Cod Ymarfer ar Rannau 2 a 3 o Fesur Iechyd Meddwl (Cymru) 2010, ar waith. Mae Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru yn ddogfen allweddol sy'n sicrhau bod hawliau cleifion yn cael eu hyrwyddo a'u diogelu. Mae'r Cod yn darparu fframwaith cymorth sy'n helpu i sicrhau bod gofal yn cael ei roi ar sail tystiolaeth ac yn hyrwyddo gofal a thriniaeth effeithiol lle mae'r person sy'n cael ei gadw wrth wraidd y broses gwneud penderfyniadau.

Mae'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn bellach yn fodel hybrid gyda chymysgedd o gyswllt o bell ac wyneb yn wyneb â chleifion y mae angen ail farn feddygol arnynt o dan y Ddeddf. Fodd bynnag, byddai'n well gennym i gleifion gael eu gweld wyneb yn wyneb, ond nid yw hyn yn bosibl weithiau. Pan fydd cais yn cael ei wneud am feddyg a benodwyd i roi ail farn, rhaid i fyrddau iechyd a darparwyr annibynnol anfon dogfennaeth allweddol atom o hyd er mwyn i'r meddyg a benodwyd i roi ail farn allu gweld gwybodaeth allweddol am hanes a thriniaeth y claf.

Rydym yn parhau i weithio gyda nifer o randdeiliaid ar gyfer iechyd meddwl ac mae'r rhanddeiliaid hyn wedi'u rhestru yn adran 3 o'r adroddiad hwn. Gan fod Cynllun Cyflawni Law yn Llaw at Iechyd Meddwl Llywodraeth Cymru wedi dod i ben yn 2022, disgwylir i Lywodraeth Cymru gyhoeddi strategaeth iechyd meddwl newydd yn 2024.

3. Ein rôl ym maes gofal iechyd meddwl ac anableddau gofal

Mae gan AGIC nifer o rolau allweddol ym maes gofal iechyd yng Nghymru a chaiff y rhain eu hamlinellu isod:

- rydym yn arolygu holl wasanaethau iechyd meddwl ac anableddau dysgu'r GIG
- ni yw'r rheoleiddiwr a'r arolygiaeth ar gyfer pob gwasanaeth gofal iechyd meddwl ac anableddau dysgu
- rydym yn gweithio gyda nifer o randdeiliaid allweddol
- mae gennym gyfrifoldeb statudol i fonitro'r defnydd a wneir o'r Ddeddf Iechyd Meddwl ar ran Gweinidogion Cymru
- rydym yn darparu gwasanaeth Meddygon a Benodwyd i Roi Ail Farn
- rydym yn monitro rhannau 2 a 4 o Fesur Iechyd Meddwl (Cymru) 2010
- rydym yn monitro'r broses o roi Trefniadau Diogelu wrth Amddifadu o Ryddid (DoLS) ar waith.

Arolygu a rheoleiddio

Y GIG a Gofal Iechyd Annibynnol

Cyflwynodd Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 ddyletswydd ansawdd. Mae'r Ddeddf yn gosod dyletswydd ansawdd gyffredinol ar Weinidogion Cymru mewn perthynas â'u swyddogaethau sy'n gysylltiedig ag iechyd. Diben y ddyletswydd ansawdd yw sicrhau bod Gweinidogion Cymru a chyrff y GIG yn sicrhau gwelliannau o ran ansawdd y gwasanaethau y maent yn eu darparu. At hynny, mae AGIC, ar ran Gweinidogion Cymru, yn ystyried y Safonau Ansawdd Iechyd a Gofal wrth gynnal adolygiadau o'r gofal iechyd a ddarperir gan gyrff y GIG, ac ar eu rhan, o dan adran 70 o Ddeddf Iechyd a Gofal Cymdeithasol (Iechyd Cymunedol a Safonau) 2003, ac wrth ymchwilio i'r gofal iechyd hwnnw.

AGIC yw'r corff cofrestru ar gyfer pob darparwr gofal iechyd annibynnol yng Nghymru. Rydym yn cofrestru, yn arolygu, yn ystyried gwybodaeth am gwynion a phryderon, ac yn gorfodi yn unol â Deddf Safonau Gofal 2000, Rheoliadau Gofal Iechyd Annibynnol (Cymru) 2011 a'r 25 o Safonau Gofynnol Cenedlaethol ar gyfer Gwasanaethau Gofal Iechyd Annibynnol yng Nghymru.

Gwnaethom ddefnyddio cyfuniad o arolygiadau dirybudd cyffredinol ar safle ysbytai ac arolygiadau â phwyslais penodol yn ystod 2023-24. Caiff canfyddiadau'r arolygiadau hyn eu crynhoi yn adran 5 o'r adroddiad hwn. At hynny, mae rhestr o'r gweithgareddau a gynhaliwyd gennym a dolenni i'r adroddiadau ar gyfer lleoliadau unigol wedi'u cynnwys syn Atodiad A.

Monitro'r defnydd a wneir o Ddeddf Iechyd Meddwl 1983

Mae gan Weinidogion Cymru ddyletswydd i fonitro i ba raddau y mae gwasanaethau yn defnyddio eu pwerau ac yn cyflawni eu dyletswyddau mewn perthynas â Deddf Iechyd Meddwl 1983. Mae AGIC yn cyflawni'r ddyletswydd hon ar eu rhan. Mae gennym nifer o adolygwyr gwybodus a phrofiadol o dan y Ddeddf Iechyd Meddwl sy'n rhan o'r tîm arolygu ar y safle Mae'r adolygwyr hyn yn monitro'r ffordd y mae byrddau iechyd a darparwyr annibynnol yn cyflawni eu dyletswyddau o dan y Ddeddf. Mae ein hadolygwyr o dan y Ddeddf Iechyd Meddwl yn archwilio'r gwaith papur mewn perthynas â chadw cleifion er mwyn sicrhau ei fod yn cydymffurfio â'r gyfraith, ac maent yn ymgynghori â gweinyddwyr y Ddeddf Iechyd Meddwl a gyflogir gan fyrddau iechyd a darparwyr annibynnol er mwyn deall sut

mae'r Ddeddf yn cael ei gweinyddu a'r prosesau llywodraethu sydd ar waith. Mae gennym hefyd rôl benodol mewn perthynas ag ymchwilio i gwynion, yn benodol mewn perthynas â chadw cleifion yn gyfreithlon a chydymffurfio â'r Ddeddf Iechyd Meddwl a'r Cod Ymarfer cysylltiedig.
Yn ystod ein harolygiadau, rydym yn ystyried nifer o feysydd allweddol fel mater o drefn, er mwyn gwneud yn siŵr:

Bod gwaith papur mewn perthynas â chadw cleifion o dan y Ddeddf Iechyd Meddwl yn sicrhau bod cleifion yn cael eu cadw'n gyfreithlon ac yn cael gofal da.

Bod statws cyfreithiol cleifion yn cael ei gofnodi'n briodol ar ddogfennau, gan gynnwys ar gofnodion rhoi cyffuriau unigol.

Bod ffurflenni cydsynio i driniaeth yn cael eu cwblhau mewn modd amserol.

Bod cleifion yn cael eu parchu am eu rhinweddau, eu galluoedd a'u cefndiroedd amrywiol fel unigolion, a bod eu hanghenion o ran oedran, rhyw, cyfeiriadedd rhywiol a chefndir cymdeithasol, ethnig, diwylliannol a chrefyddol yn cael eu hystyried.

Bod dogfennau absenoldeb adran 17 yn cynnwys amodau a chanlyniadau a'u bod yn cael eu defnyddio fel mater o drefn pan fydd hynny'n briodol i gynorthwyo cleifion ar eu llwybr gofal/adsefydlu.

Bod Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru (Diwygiedig 2016), a baratowyd ac a gyhoeddwyd o dan adran 118 o Ddeddf Iechyd Meddwl 1983, yn cael ei ddilyn.

Bod cynlluniau manwl yn cael eu gwneud ar gyfer cleifion cyn iddynt gael eu rhyddhau o'r ysbyty a bod meysydd allweddol yn cael eu hystyried, megis dangosyddion atglafychu.

Yn gyffredinol, roedd canfyddiadau ein harolygiadau o brosesau'r Ddeddf Iechyd Meddwl a'r ffordd y caiff ei chymhwyso yn gadarnhaol, ond gwnaethom nodi nifer o feysydd i'w gwella. Ceir crynodeb o'n canfyddiadau ar gyfer y cyfnod rhwng mis Ebrill 2023 a mis Mawrth 2024 yn adran 6 o'r adroddiad hwn.

Gwasanaeth Adolygu ar gyfer Iechyd Meddwl

Mae Gwasanaeth Adolygu ar gyfer Iechyd Meddwl AGIC yn cwmpasu nifer o feysydd allweddol o'r Ddeddf Iechyd Meddwl, gan gynnwys:

Y gwasanaeth Meddygon a Benodwyd i Roi Ail Farn yng Nghymru. Mae'r gwasanaeth hwn yn diogelu hawliau pobl sydd, wrth gael eu cadw o dan y Ddeddf Iechyd Meddwl, wedi gwrthod triniaeth a ragnodwyd neu na allant, ar sail asesiad, gydsynio i'r driniaeth a ragnodwyd.

Adolygiad o driniaeth o dan Adran 61 o'r Ddeddf Iechyd Meddwl. Pan fydd meddyg a benodwyd i roi ail farn wedi awdurdodi cynllun triniaeth, rhaid i'r meddyg sy'n gyfrifol am ofal a thriniaeth y claf (y Clinigydd Cyfrifol) gyflwyno adroddiad ar gyflwr a thriniaeth y claf i'r Gwasanaeth Adolygu ar gyfer Iechyd Meddwl ei adolygu.

Rhoddir gwybod i'r Gwasanaeth Adolygu ar gyfer Iechyd Meddwl hefyd am farwolaeth pob claf a gedwir sy'n cael triniaeth yn y GIG. Rydym yn ystyried yr hysbysiadau a manylion digwyddiadau a arweiniodd at farwolaeth y claf.

Ceir crynodeb o'r gwaith a wnaed gan feddygon a benodwyd i roi ail farn a chanfyddiadau ein hadolygiadau o dan adran 61 rhwng mis Ebrill 2023 a mis Mawrth 2024 yn adran 7 o'r adroddiad hwn.

Monitro Mesur Iechyd Meddwl (Cymru) 2010

Mae Mesur Iechyd Meddwl (Cymru) 2010 yn cynnwys pedair rhan wahanol:

Rhan 1 – Gwasanaethau cymorth iechyd meddwl sylfaenol.

Rhan 2 – Cydgysylltu a chynllunio gofal ar gyfer defnyddwyr gwasanaethau iechyd meddwl eilaidd.

Rhan 3 – Asesiadau ar ddefnyddwyr blaenorol o wasanaethau iechyd meddwl eilaidd.

Rhan 4 – Eiriolaeth iechyd meddwl.

Yn ystod ein harolygiadau, rydym yn canolbwyntio ar gynlluniau gofal a thriniaeth cleifion unigol a'r meysydd a nodir yn adran 18 o'r Mesur, sef:

- cyllid ac arian
- llety
- gofal personol a llesiant corfforol
- addysg a hyfforddiant
- gwaith a galwedigaeth
- rhianta neu gydberthnasau gofalgar
- dewisiadau cymdeithasol, diwylliannol neu ysbrydol
- triniaeth feddygol a mathau eraill o driniaeth, gan gynnwys ymyriadau seicolegol.

Rydym hefyd yn ystyried rôl y Cydgysylltydd Gofal ac i ba raddau y mae'n ymgysylltu â'r cleifion. Yn adran 5 o'r adroddiad hwn, rydym wedi nodi ein canfyddiadau mewn perthynas ag asesiadau risg a chynllunio gofal lle rydym yn ystyried agweddau amrywiol ar y Mesur. Rydym hefyd yn ystyried rôl gwasanaethau eirioli a mynediad cleifion atynt.

Monitro'r defnydd a wneir o Drefniadau Diogelu wrth Amddifadu o Ryddid

Bob blwyddyn, rydym yn cyhoeddi adroddiad blynyddol, ar y cyd ag AGC, ar y defnydd a wneir o'r Trefniadau Diogelu wrth Amddifadu o Ryddid (DoLS). Mae DoLS yn rhan o Ddeddf Galluedd Meddyliol 2005. Roedd disgwyl i'r Trefniadau Amddiffyn Rhyddid gael eu cyflwyno yn lle DoLS yn 2024, ond ni ddigwyddodd hyn ac nid oes dyddiad diwygiedig ar gyfer eu rhoi ar waith. Gellir defnyddio DoLS pan na fydd yn briodol cadw claf o dan Ddeddf Iechyd Meddwl 1983. Mae adroddiadau monitro blynyddol DoLS ar gael ar wefan AGIC.

Dull Atal Cenedlaethol y DU

Mae AGIC yn un o 21 o gyrff dynodedig Dull Atal Cenedlaethol y DU, a sefydlwyd ym mis Mawrth 2009 yn dilyn cadarnhau Protocol Dewisol y Cenhedloedd Unedig i'r Confensiwn yn erbyn Artaith (OPCAT) yn y DU yn 2003. Mae aelodau'r Dull Atal Cenedlaethol yn cynnwys sefydliadau o bedair gwlad y Deyrnas Unedig, sef Cymru, Lloegr, yr Alban a Gogledd Iwerddon. Mae AGC, arolygiaeth arall yng Nghymru, hefyd yn aelod o'r Dull Atal Cenedlaethol. Mae sefydliadau eraill sy'n rhan o'r Dull Atal Cenedlaethol yn cynnwys y Comisiwn Ansawdd Gofal ac Arolygiaeth Cwnstabliaeth Ei Fawrhydi yn yr Alban. Ymhlith yr aelodau eraill y mae AGIC yn gwneud gwaith ar y cyd â nhw mae Arolygiaeth Cwnstabliaeth a Gwasanaethau Tân ac Achub Ei Fawrhydi ac Arolygiaeth Carchardai Ei Fawrhydi.

Mae AGIC yn un o gyrff dynodedig Dull Atal Cenedlaethol y DU oherwydd ei rôl benodol wrth fonitro lleoedd lle y gall cleifion gael eu cadw o dan y Ddeddf Iechyd Meddwl. Ystyrir y rôl hon ymhellach yn adran 6 o'r adroddiad hwn.

Mae Dull Atal Cenedlaethol y DU yn cydweithio'n uniongyrchol â Phwyllgor y Cenhedloedd Unedig yn erbyn Artaith a'r Is-bwyllgor ar Atal Artaith, sef corff rhyngwladol a sefydlwyd gan OPCAT.

Rydym yn mynychu cyfarfodydd busnes y Dull Atal Cenedlaethol, ac mae cynrychiolydd AGIC yn aelod o'r pwyllgor llywio.

Gwasanaethau Cyfiawnder Ieuenctid

Ym mis Ionawr a mis Chwefror 2024, ymunodd AGIC ag Arolygiaeth Prawf Ei Fawrhydi i gynnal arolygiad ar y cyd o Wasanaethau Cyfiawnder Ieuenctid Conwy a Sir Ddinbych. Nodwyd meysydd allweddol i'w gwella ar gyfer Bwrdd Iechyd Prifysgol Betsi Cadwaladr (BIPBC). Ymhlith yr arolygiaethau eraill a gymerodd ran yn yr arolygiad ar y cyd hwn roedd AGC, Estyn ac Arolygiaeth Cwnstabliaeth a Gwasanaethau Tân ac Achub Ei Fawrhydi. Cylch gwaith penodol AGIC oedd ystyried y gwasanaethau a ddarperir gan Wasanaethau Cyfiawnder Ieuenctid o safbwynt gofal iechyd. Cyfwelwyd ag aelodau allweddol o staff a gyflogir gan y bwrdd iechyd fel rhan o'r broses hon.

Roedd gwelliannau'n cynnwys bod angen i BIPBC sicrhau bod nyrs CAMHS ac arbenigwyr CAMHS eraill ar gael i'r Gwasanaeth Cyfiawnder Ieuenctid am nifer dynodedig o oriau. Nodwyd oedi clir cyn i bobl ifanc gael lefel briodol o gymorth amserol a phriodol gan CAMHS. At hynny, roedd diffyg cymorth amserol gan wasanaethau Therapi Lleferydd ac Iaith ac roedd angen i'r bwrdd iechyd gynnal adolygiad llywodraethu ac ansawdd o'r cymorth sydd ei angen ar gyfer y Gwasanaeth Cyfiawnder Ieuenctid.

Gofal Iechyd mewn Carchardai

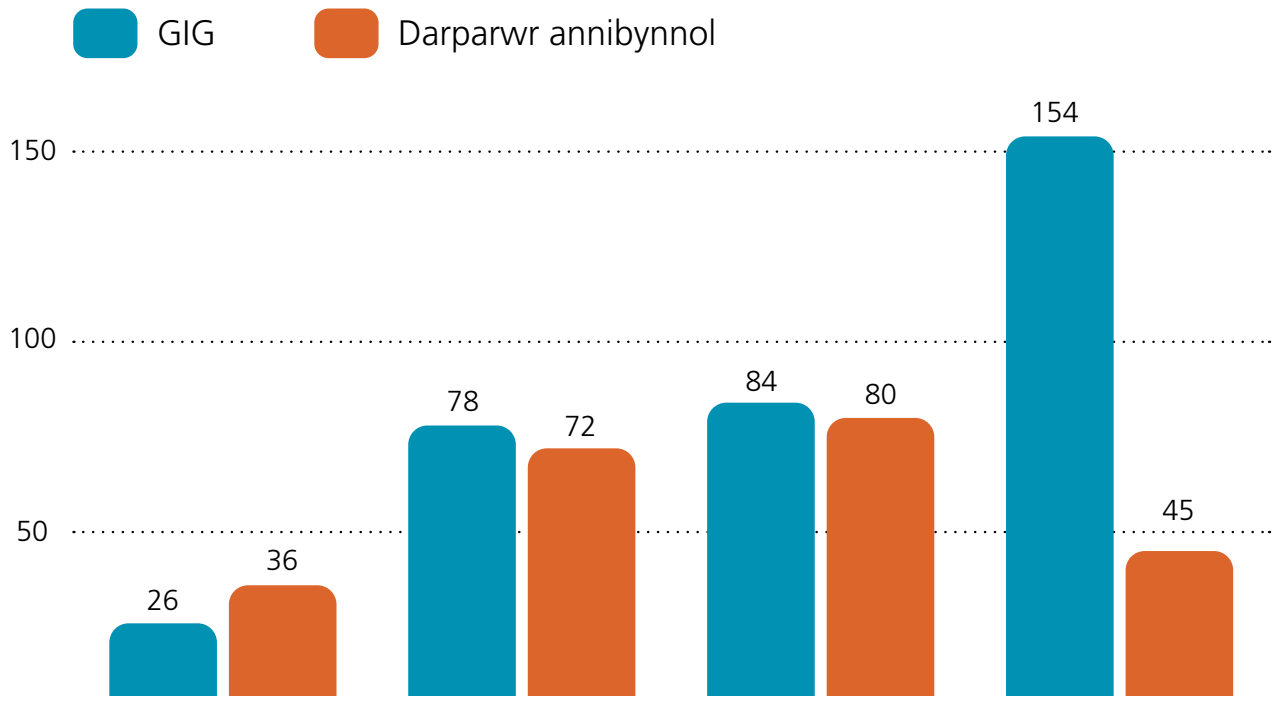
Ym mis Chwefror 2024, cynhaliodd AGIC, ar y cyd ag Arolygiaeth Carchardai Ei Fawrhydi ac arolygiaethau eraill, gan gynnwys Estyn, arolygiad o CEF Caerdydd. Ffocws yr ymweliadau hyn, o safbwynt AGIC, yw helpu i arolygu gwasanaethau iechyd o safbwynt Cymru. Yn gyffredinol, roedd gwasanaethau iechyd wedi gwella ers yr arolygiad diwethaf, a dywedodd 41% o'r carcharorion wrth y tîm arolygu fod y gwasanaeth bellach yn dda. Roedd gwasanaethau i garcharorion â phroblemau iechyd meddwl wedi gwella hefyd, ac roedd mynediad gwell at therapïau ac amrywiaeth ehangach ohonynt o gymharu â'r hyn a welwyd yn ystod yr arolygiad blaenorol. Fodd bynnag, nodwyd nifer o feysydd allweddol i'w gwella, ac mae'r rhain wedi'u hamlinellu isod:

- Nid oedd prosesau llywodraethu a chynllunio gofal digonol ar waith ar gyfer cleifion â chyflyrau hirdymor
- Roedd y rhestrau aros am ofal deintyddol brys yn rhy hir
- Nid oedd rhai o'r arferion fferyllol yn gyson ag arferion da, gan gynnwys y trefniadau ar gyfer rheoli a defnyddio meddyginiaethau stoc, y broses o ailbecynnu meddyginiaethau a roddwyd eisoes gan fferyllydd, a'r diffyg cyfyngiadau ar ardaloedd storio cyffuriau.

Grŵp Llywio Cenedlaethol Partneriaid Dementia

Rydym yn parhau i fynychu cyfarfodydd Grŵp Llywio Cenedlaethol Partneriaid Dementia, sydd â chysylltiadau uniongyrchol â Grŵp Goruchwylio Gweithrediad ac Effaith ym maes Dementia. O fewn y grŵp hwn, caiff mentrau arferion da eu rhannu a chaiff y canlyniad cadarnhaol i gleifion â dementia a'u priod neu bartner eu nodi. Mae'r byrddau iechyd yn rhoi diweddariadau rhanbarthol o fewn y grŵp.

Nifer y cleifion sy'n cysylltu ag AGIC gyda phryderon a chwynion am ofal iechyd ar gyfer anableddau dysgu ac iechyd meddwl



4. Gwrando ar bryderon

Yn ystod y cyfnod rhwng 1 Ebrill 2023 a 31 Mawrth 2024, cawsom:

614 o gwynion a phryderon am ddarparwyr gofal iechyd yng Nghymru, sef 45 yn llai na'r flwyddyn flaenorol

roedd **199** o'r rhain yn ymwneud â gwasanaethau iechyd meddwl ac anableddau dysgu, o gymharu â 164 yn y flwyddyn flaenorol

roedd **154** yn ymwneud â gwasanaethau iechyd meddwl ac anableddau dysgu'r GIG, sef 70 yn fwy na'r flwyddyn flaenorol

roedd **45** yn ymwneud â gwasanaethau iechyd meddwl ac anableddau dysgu annibynnol, sef 35 yn llai na'r flwyddyn flaenorol.

Mae'r tabl isod ar gyfer 2023/24 yn dadansoddi'r pryderon a'r cwynion yn ôl pwnc

Pynciau pryderon a chwynion	Y GIG	Gofal Iechyd Annibynnol
Mynediad, Derbyn, Trosglwyddo, Rhyddhau (gan gynnwys cleifion coll)	12	2
Asesiad Clinigol (gan gynnwys diagnosis, sganiau, profion, asesiadau)	15	3
Cyfathrebu	9	2
Rheoli Cwynion	5	3
Cydsyniad a Chyfrinachedd	5	0
Seilwaith (gan gynnwys staff, cyfleusterau, yr amgylchedd)	19	11
Rheoli Meddyginiaethau	16	4
Y Ddeddf Iechyd Meddwl	12	4
Arall	9	3
Rheoli Cofnodion	13	0
Diogelu	8	7
Ymddygiad Hunan-niweidiol	5	3
Triniaeth/Gweithdrefnau	16	2
Chwythu'r chwiban	6	5
Cyfanswm	**150**	**49**

Roedd y nifer mwyaf o bryderon a chwynion mewn perthynas â'r GIG yn ymwneud â:

- Seilwaith, (gan gynnwys staff, cyfleusterau a'r amgylchedd). Mae hyn yn cyd-fynd â chanfyddiadau ein harolygiad yn adran 5 lle y cafodd seilwaith ei nodi yn ystod nifer sylweddol o'n harolygiadau ar y safle.
- Roedd rheoli meddyginiaethau hefyd yn un o ganfyddiadau allweddol ein harolygiadau a nodwyd amrywiaeth o broblemau, sydd hefyd wedi'u nodi yn adran 5 o'r adroddiad hwn. Roedd triniaeth ymysg y prif bryderon hefyd ac unwaith eto, mae nifer sylweddol o ganfyddiadau wedi'u nodi yn yr adroddiad hwn.

- Roedd y categori â'r nifer mwyaf o bryderon a chwynion mewn perthynas â darparwyr gofal iechyd annibynnol yn ymwneud â seilwaith (gan gynnwys staff, cyfleusterau a'r amgylchedd). Mae hyn yn dangos bod y GIG a darparwyr gofal iechyd annibynnol yn wynebu problemau tebyg a all effeithio ar ofal cleifion.
- Mae cleifion yn cwyno pan fydd diffyg cyfathrebu am eu llwybr gofal a thriniaeth. Er y cydnabyddir mai dim ond 11 o bryderon a chwynion oedd yn ymwneud â chyfathrebu, roedd elfennau o gyfathrebu annigonol yn un o'r themâu a nodwyd mewn nifer o'r meysydd eraill a nodwyd uchod.

Pryderon staff

Mae chwythu'r chwiban yn wahanol i wneud cwyn neu gŵyn cyflogaeth. 'Chwythwr chwiban' yw rhywun sy'n gwneud 'datgeliad cymwys' am bryder yn y gwaith. Mae AGIC yn 'gorff rhagnodedig' o dan gyfreithiau chwythu'r chwiban. Mae hyn yn golygu y gall chwythwr chwiban wneud 'datgeliad cymwys' i ni a bydd ganddo rai amddiffyniadau cyflogaeth o dan Ddeddf Hawliau Cyflogaeth 1996, a ddiwygiwyd gan Ddeddf Datgelu er Lles y Cyhoedd (PIDA) 1998.

Mae PIDA yn amddiffyn lles y cyhoedd drwy ddarparu camau unioni i unigolion sy'n cael eu cosbi yn y gweithle am godi pryder gwirioneddol, p'un a yw'n bryder am ddiogelwch cleifion, diogelu, camarfer ariannol, perygl, anghyfreithlondeb neu gamwedd arall.

Ceir gwybodaeth ychwanegol am chwythu'r chwiban ar ein **www.agic.org.uk/**.

Y flwyddyn hon, rydym wedi gweld nifer sylweddol llai (fel yr amlinellir isod) o chwythwyr chwiban yn codi pryderon gydag AGIC o gymharu â blynyddoedd blaenorol. Mae'n anodd esbonio'r duedd hon ond un esboniad posibl yw bod gan y byrddau iechyd a'r darparwyr annibynnol weithdrefnau chwythu'r chwiban mwy effeithiol ar waith, sydd wedi golygu nad oes angen i chwythwyr chwiban gysylltu ag AGIC am fod prosesau mewnol y byrddau iechyd a'r darparwyr annibynnol wedi mynd i'r afael â'u pryderon chwythu'r chwiban mewn modd digonol.

- 42 yn 2020-21
- 15 yn ymwneud â gwasanaethau'r GIG
- 27 yn ymwneud â gwasanaethau annibynnol
- 28 yn 2021-22
- 10 yn ymwneud â gwasanaethau'r GIG
- 18 yn ymwneud â gwasanaethau annibynnol
- 28 yn 2022-23
- 18 yn ymwneud â gwasanaethau'r GIG
- 20 yn ymwneud â gwasanaethau annibynnol
- 11 yn 2023-24
- 6 yn ymwneud â gwasanaethau'r GIG
- 5 yn ymwneud â gwasanaethau annibynnol.

Hysbysiadau Rheoliadau 30 a 31

Mae'r tabl isod yn dangos nifer yr hysbysiadau Rheoliad 30 a Rheoliad 31 a gafwyd rhwng 1 Ebrill 2023 a 31 Mawrth 2024. Yn unol â Rheoliadau 30 a 31 o Reoliadau Gofal Iechyd Annibynnol (Cymru) 2011, mae'n ofynnol i berson cofrestredig ysbyty annibynnol, clinig annibynnol neu asiantaeth feddygol annibynnol roi gwybod i ni am ddigwyddiadau penodol sy'n ymwneud â diogelwch cleifion.

Mae hyn yn ofynnol yn ôl y gyfraith ac mae'n cynnwys.

- Marwolaeth claf.
- Absenoldeb heb awdurdod claf a gedwir o dan Ddeddf Iechyd Meddwl 1983 neu a allai gael ei gadw o dan y Ddeddf honno.
- Anaf difrifol.
- Brigiad o achosion o glefyd heintus.
- Honiad o gamymddwyn yn erbyn staff.
- Unrhyw gais i gorff goruchwylio gan y person cofrestredig am awdurdodiad Amddifadu o Ryddid safonol.

Yn ystod y cyfnod adrodd, cawsom 821 o hysbysiadau am ddigwyddiadau mewn lleoliadau gofal iechyd meddwl ac anableddau dysgu annibynnol, sef 81 yn llai na'r nifer a gafwyd yn 2022-23. Mae'r siart isod yn dangos dosbarthiad yr hysbysiadau yn ôl thema.

Tabl yn dangos y math o hysbysiad ar gyfer Rheoliad 30/Rheoliad 31

Math o hysbysiad	Cyfanswm
Marwolaeth claf	9
Absenoldeb heb awdurdod	140
Anaf difrifol	462
Brigiad o Achosion o Glefyd Heintus	22
Honiad o gamymddwyn yn erbyn staff	161
Amddifadu o Ryddid	27
Cyfanswm	**821**

Cawsom lai o hysbysiadau am anafiadau difrifol o gymharu â'r flwyddyn flaenorol, ond cawsom fwy o hysbysiadau am absenoldebau heb awdurdod, i fyny o 100 i 140, ar gyfer cleifion a oedd yn cael eu cadw o dan y Ddeddf Iechyd Meddwl o gymharu â'r flwyddyn flaenorol. Rydym yn parhau i weld cynnydd yn nifer y cleifion sy'n hunan-niweidio ac mae hyn yn dangos cymhlethdod ac aciwtedd y cleifion yn y sector annibynnol. Gall yr amrywiaeth o broblemau a nodir yn yr adroddiad hwn, megis prinder staff, cynlluniau rheoli risg a chynlluniau gofal a thriniaeth gwael, yn ogystal â phroblemau o ran arsylwi ar gleifion, fod yn ffactorau sy'n cyfrannu at anafiadau difrifol. Mae AGIC wedi cynyddu'r cyfathrebu â'r sector annibynnol ynglŷn â chwblhau'r hysbysiadau hyn a bu mwy o ymgysylltu gan ddarparwyr.

5. Arolygu gwasanaethau iechyd meddwl ac anableddau dysgu

Yn 2023-24, gwnaethom gynnal cyfanswm o 26 o arolygiadau ar y safle o amrywiaeth o leoliadau gofal iechyd yn y GIG ac ysbytai annibynnol. Roedd y wardiau a arolygwyd yn rhoi gofal i amrywiaeth o gleifion, gan gynnwys:

- Oedolion â phroblemau iechyd meddwl.
- Pobl hŷn.
- Anableddau Dysgu.
- CAMHS.

Ymhlith y cyfanswm o 26 o arolygiadau, gwnaethom ymweld ag un TIMC ac ymweld ag un TADC ar y cyd ag AGC.

Yn ystod ein harolygiadau ar y safle, gwnaethom:

- Siarad â nifer o gleifion ac ymwelwyr er mwyn casglu eu barn am ansawdd y gofal a'r driniaeth a roddwyd.
- Siarad ag amrywiaeth o staff o dimau amlddisgyblaethol i gasglu eu barn am effeithiolrwydd eu rolau a ffyrdd o oresgyn unrhyw heriau.
- Edrych ar amrywiaeth o ddogfennau gofal, gan gynnwys asesiadau risg a'r trefniadau ar gyfer rhoi rhan 2 o Fesur Iechyd Meddwl (Cymru) 2010 ar waith a'i hadolygu, ac ystyried rôl y Cydgysylltwyr Gofal ac aelodau eraill o'r tîm amlddisgyblaethol.
- Gwnaethom hefyd edrych ar amrywiaeth o ddogfennau eraill cleifion, gan gynnwys cofnodion arsylwadol, unrhyw gofnodion o ddulliau atal, a chofnodion o unrhyw achosion o gadw claf ar wahân.
- Ystyried a oedd llwybr rhyddhau effeithiol ar waith a'r trefniadau i sicrhau bod cynllun rheoli argyfwng yn cael ei ystyried fel rhan o'r broses ryddhau.
- Archwilio canfyddiadau archwiliadau a phrosesau llywodraethu.
- Ystyried i ba raddau yr oedd yr amgylcheddau gofal yn briodol, a sicrhau bod risgiau wedi'u nodi a bod camau priodol wedi'u cymryd i liniaru'r risgiau hynny.
- Ystyried y broses o weinyddu'r Ddeddf Iechyd Meddwl a chydymffurfiaeth â Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru (2016).

Ceir rhestr o'r byrddau iechyd a'r darparwyr cofrestredig annibynnol y gwnaethom eu harolygu yn Atodiad A, ynghyd â dolenni i'r adroddiadau ar ganfyddiadau.

Ein canfyddiadau

Yn yr adran hon, mae ein canfyddiadau wedi'u rhannu'n dri maes penodol:

Canfyddiadau yn ymwneud yn benodol ag iechyd meddwl, yn cynnwys pobl hŷn a phobl ifanc a'r TIMCau.

Canfyddiadau yn ymwneud yn benodol ag Anableddau Dysgu.

Canfyddiadau yn ymwneud yn benodol â CAMHS.

Mae'r canfyddiadau manwl yn seiliedig ar ein hadroddiadau yn dilyn ein harolygiadau ar y safle a gynhaliwyd yn 2023-24. Pan fydd AGIC yn nodi problemau sylweddol, byddwn yn anfon llythyrau sicrwydd ar unwaith at fyrddau iechyd, a hysbysiadau diffyg cydymffurfio at ddarparwyr annibynnol. Caiff y llythyrau neu'r hysbysiadau hyn eu hanfon o fewn deuddydd i gynnal yr

arolygiadau. Mae'r bwrdd iechyd/darparwr annibynnol yn ymateb i'r rhain drwy lunio cynllun gwella ar unwaith y mae'n rhaid i AGIC gytuno arno. Gwnaethom gyhoeddi cyfanswm o saith llythyr neu hysbysiad yn ystod y cyfnod rhwng 1 Ebrill 2023 a 31 Mawrth 2024. Roedd hyn yn cynnwys tri ar gyfer byrddau iechyd a dau ar gyfer darparwyr annibynnol.

Canfyddiadau yn ymwneud yn benodol ag iechyd meddwl, yn cynnwys pobl hŷn a phobl ifanc a'r TIMCau

Un o ganfyddiadau cadarnhaol y mwyafrif o'n harolygiadau oedd yr adborth cadarnhaol gan gleifion am y gofal a roddwyd a'r rhyngweithio rhyngddynt a'r staff. Mae ein staff yn parhau i weld ymgysylltu cadarnhaol â chleifion ac mae hyn yn gyson â chanfyddiadau y flwyddyn ddiwethaf. At hynny, nodwyd nifer o arferion da mewn perthynas â monitro'r Ddeddf Iechyd Meddwl a'i rhoi ar waith a chaiff y rhain eu harchwilio ymhellach yn adran 6 o'r adroddiad hwn.

Gofal lleiaf cyfyngol

Mae'r rhan hon o'r adroddiad yn ymdrin â thri maes penodol, sef dulliau atal, cadw ar wahân a gwahanu. Yn ystod ein harolygiadau, ni chawsom sicrwydd bod yr arferion lleiaf cyfyngol bob amser yn cael eu defnyddio ac mae ein canfyddiadau wedi'u nodi yn yr adrannau isod.

Defnyddio dulliau atal

Mae Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru 2016 yn cynnwys adran sy'n ymwneud yn benodol â dulliau atal a rheoli ymddygiad heriol. Mae adran 26.7 yn nodi "Wrth wneud penderfyniadau ynghylch unrhyw ymyriadau a gyflawnir wrth reoli gofal a thriniaeth claf, rhaid ystyried yr egwyddorion sydd i'w gweld ym Mhennod 1 y Cod hwn. Dylai unrhyw benderfyniadau ynghylch ymyriadau gael eu trafod a'u cytuno gyda'r claf hyd y bo hynny'n bosibl. Gall ymyriadau gynnwys atal ymddygiad heriol, arsylwi ar gleifion, atal cleifion yn gorfforol a/neu gadw cleifion ar wahân".

Egwyddorion arweiniol y Cod yw:

- Urddas a pharch.
- Yr opsiwn lleiaf cyfyngol a chynyddu annibyniaeth i'r eithaf.
- Tegwch a chydraddoldeb.
- Grymuso cleifion a'u cynnwys.
- Cadw pobl yn ddiogel.
- Effeithiolrwydd ac effeithlonrwydd.

Mae dulliau atal yn cwmpasu nifer o feysydd allweddol, gan gynnwys rhai corfforol, cemegol, amgylcheddol a mecanyddol. Dim ond fel dewis olaf a phan fydd pob ymyriad arall wedi methu y dylid defnyddio dulliau atal bob amser, ac mae'n rhaid bod asesiad risg a chynllun gofal a thriniaeth cynhwysfawr ar waith ar gyfer pob achos o atal. Rhaid i asesiadau risg ystyried pob ffactor sbarduno a strategaeth amgen yn lle defnyddio dull atal.

O ran dulliau atal mecanyddol, mae'r Cod yn nodi bod yn rhaid ymgynghori ag AGIC os yw hyn yn cael ei ystyried. Prin iawn y caiff dull atal mecanyddol ei ddefnyddio mewn ysbytai ond, pe bai'n cael ei ystyried, ein rôl yw cadarnhau bod asesiad risg a chynllun gofal trylwyr ar waith ar gyfer y math hwn o ddull atal, ac mai dyma yw'r opsiwn olaf sydd ar gael i reoli ymddygiad heriol tu hwnt cleifion, boed hynny'n drais yn erbyn pobl eraill neu'n hunan-anaf. Rhaid i'r math hwn

o ddull atal, fel pob math arall, gael ei adolygu'n rheolaidd a dylai fod ar waith am y cyfnod byrraf posibl o amser.

Rhaid i unrhyw ddull atal a ddefnyddir ddilyn y canllawiau cenedlaethol a'r polisïau a gweithdrefnau lleol, ac ystyrir y maes hwn yn ystod ein proses arolygu. Mae'r **canllawiau** a gyhoeddwyd gan Lywodraeth Cymru (Hydref 2022) ar fframwaith ar gyfer lleihau arferion cyfyngol mewn lleoliadau gofal plant, addysg, iechyd a gofal cymdeithasol yn ddogfen allweddol sy'n ymdrin â defnyddio dulliau atal corfforol, cemegol, amgylcheddol a mecanyddol. Ystyrir y canllawiau hyn yn ystod ein proses arolygu.

Yn ystod chwech o'n harolygiadau, gwnaethom nodi problemau o ran atal, gan gynnwys staff nad oeddent wedi cael hyfforddiant neu nad oeddent yn cydymffurfio â'u hyfforddiant gorfodol ar Ymyriadau Corfforol Cyfyngol, yn defnyddio dulliau atal. Mae staff nad ydynt wedi cael hyfforddiant ar ddefnyddio dulliau atal yn peri risg sylweddol i gleifion a staff eraill ac ni ddylent fod yn rhan o achosion o atal cleifion nes iddynt gael yr hyfforddiant angenrheidiol.

At hynny, yn ystod dau o'n harolygiadau, gwelsom nad oedd polisïau 'Defnyddio Ymyriadau Corfforol Cyfyngol' wedi cael eu hadolygu a'u bod wedi dyddio. Hefyd, yn ystod dau o'n harolygiadau, gwelsom nad oedd achosion o atal wedi cael eu cofnodi'n gywir neu nad oedd modd eu hidlo i gynhyrchu data penodol ar ddulliau atal. O ganlyniad, nid oedd data cywir ar ddulliau atal ar gael ac roedd hi'n anodd iawn i staff goruchwylio lywodraethu a goruchwylio achosion o atal cleifion mewn ffordd gadarn. Felly, ni chawsom sicrwydd bod cleifion a staff yn cael eu hamddiffyn yn llawn rhag niwed yn yr ysbytai hyn.

Yng nghofnod un claf yr edrychwyd arno, nid oedd unrhyw fanylion disgrifiadol am ystumiau'r claf a'r staff wrth ddefnyddio daliad diogel. At hynny, nid oedd dim wedi'i gofnodi ar gyfer arsylwadau ar ôl ymyriad ar ôl i'r claf gael meddyginiaeth fewngyhyrol.

Cadw claf ar wahân

Mae Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru 2016 yn cynnwys adran sy'n ymwneud yn benodol â chadw claf ar wahân. Yn ôl y Cod, ystyr cadw claf ar wahân yw ei "gadw'n gaeth dan oruchwyliaeth mewn ystafell, a allai fod ar glo". Mae'n ddiddorol nodi bod y Cod yn defnyddio'r term "a allai fod ar glo", gan awgrymu ei bod yn bosibl i glaf gael ei gadw ar wahân mewn ystafell lle mae'r drws ar gau ond heb ei gloi. Mae'r Cod hefyd yn nodi cyfnodau amser ar gyfer adolygu'r angen i barhau i gadw claf ar wahân, sef "bob dwy awr gan ddwy nyrs" a "bob pedair awr gan feddyg, neu glinigydd cymeradwy â chymwysterau addas". Mae'r Cod hefyd yn nodi mai dim ond fel y dewis olaf y caiff claf ei gadw ar wahân, a hynny am y cyfnod byrraf posibl. Mae'n rhaid bod polisïau a gweithdrefnau ar waith ar gyfer cadw claf ar wahân, a ddylai adlewyrchu canllawiau'r Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE) a chanllawiau eraill.

Yn ystod dau arolygiad, gwnaethom nodi problemau o ran cadw cleifion ar wahân, gan gynnwys claf yn cael ei gadw ar wahân mewn rhan arall o'r ward. Gwnaethom edrych ar y trefniadau a oedd ar waith i reoli'r claf hwn a nodwyd sawl pryder:

- Nid oedd yr ardal a oedd yn cael ei defnyddio i gadw'r claf ar wahân yn cydymffurfio â safonau arferion gorau na pholisi a gweithdrefnau'r bwrdd iechyd ar gyfer cadw cleifion ar wahân. Yn benodol, nid oedd cloc yn weladwy ac nid oedd ffordd o reoli'r tymheredd y tu allan i'r ardal.

- Nid oedd y toiled ar wahân a oedd yn cael ei ddefnyddio gan y claf wedi cael ei addasu ar gyfer cleifion risg uchel.
- Roeddem yn pryderu nad oedd y claf yn cael cyfle i gael awyr iach yn rheolaidd.
- Nid oedd cynllun gofal ar gyfer cadw claf ar wahân ar waith ar gyfer y claf a oedd yn mynd yn groes i bolisi'r bwrdd iechyd.
- Dywedwyd wrthym nad oedd digon o adnoddau ar gael i'r cleifion a oedd yn cael eu cadw ar wahân gymryd rhan mewn gweithgareddau.

Yn ystod yr arolygiad, nid oedd y polisi ar gadw cleifion ar wahân wedi cael ei adolygu yn ystod y cyfnod a nodwyd ac roedd wedi dyddio.

Gweithgareddau ystyrlon a therapiwtig

Mae gweithgareddau yn rhan bwysig o'r broses trin, ac yn ystod ein harolygiadau, rydym yn ystyried y maes hwn fel mater o drefn er mwyn sicrhau bod amrywiaeth o weithgareddau ystyrlon a therapiwtig ar gael. Mae toreth o waith ymchwil wedi'i gyhoeddi sy'n cadarnhau pwysigrwydd gweithgareddau therapiwtig, cymdeithasol a hamdden ystyrlon a'r effaith gadarnhaol y mae hyn yn ei chael ar lesiant cleifion a'u llwybr adfer.

Yn ystod llawer o'n harolygiadau, gwelsom enghreifftiau o weithgareddau therapiwtig priodol ac ystyrlon ar gyfer y cleifion. Fodd bynnag, yn ystod chwech arolygiad, gwelsom amrywiaeth o broblemau, gan gynnwys diffyg tystiolaeth o raglenni gweithgareddau cleifion therapiwtig ar wardiau, a diffyg staff i gefnogi a goruchwylio gweithgareddau cleifion oddi ar y wardiau. Yn ystod un arolygiad, gwelsom fod y cyfarpar campfa a'r peiriannau ymarfer corff yn yr ystafell gweithgareddau wedi'u hamgylchynu ag arwyddion yn gwahardd cleifion rhag eu defnyddio. Ymhlith y problemau eraill a nodwyd roedd diffyg tystiolaeth bod y gweithgareddau'n cael eu cynnal yn yr ysbyty a'u cofnodi'n amlwg yng nghofnodion y cleifion, a diffyg cyllid ar gyfer cyfarpar a gweithgareddau galwedigaethol i gleifion. Roedd problemau hefyd yn ymwneud â'r ardaloedd awyr agored a'r defnydd ohonynt i gynnal gweithgareddau therapiwtig ychwanegol ar gyfer cleifion.

Gwnaethom barhau i nodi problemau mewn perthynas ag absenoldeb Adran 17 o dan y Ddeddf Iechyd Meddwl, ond ymdrinnir â'r rhain yn adran 6 o'r adroddiad hwn, Monitro'r Ddeddf Iechyd Meddwl.

Rheoli Meddyginiaethau

Unwaith eto y flwyddyn hon, gwnaethom barhau i nodi problemau yn ymwneud â rhoi, storio ac archebu meddyginiaeth mewn modd diogel ac effeithiol. Mae'r maes hwn yn parhau i fod yn thema gyson yn y mwyafrif o'n harolygiadau. O blith 19 o ysbytai ac un TIMC, gwnaethom nodi problemau yn ymwneud â rheoli meddyginiaethau mewn 16 o ysbytai ac un TIMC. Mae hon yn thema gyson yn ein harolygiadau ac mae'n gynyddol siomedig nodi nad oes unrhyw welliant wedi'i weld yn y maes hwn ers ein hadroddiad blynyddol diwethaf. Roedd y problemau a nodwyd yn ymwneud â nifer o agweddau gwahanol ar reoli meddyginiaethau, ac roedd y rhai mwyaf sylweddol fel a ganlyn:

- Roedd yr adran o'r Cofnod Rhoi Meddyginiaeth ar statws cyfreithiol y claf o dan y Ddeddf Iechyd Meddwl wedi'i gadael yn wag yn gyson.
- Nid oedd ffurflenni Cydsynio i Driniaeth wedi'u hatodi i siartiau Cofnodion Rhoi Meddyginiaeth na'u hadolygu'n rheolaidd.
- Roedd mewnbwn ac archwiliadau'r fferyllfa yn gyfyngedig.
- Roedd diffyg prosesau llywodraethu mewn perthynas â rheoli meddyginiaethau.

- Roedd trolïau meddyginiaeth wedi'u gadael heb eu cloi pan nad oeddent yn cael eu defnyddio.
- Roedd eitemau o gyfarpar meddygol heb eu defnyddio, gan gynnwys chwistrellau a chyfarpar gofal clwyfau, wedi'u tynnu o'u blychau/cynwysyddion gwreiddiol a'u rhoi mewn basgedi plastig a oedd yn golygu na ellid gweld dyddiad dod i ben pob eitem.
- Roedd nifer o lofnodion ar goll ar y siartiau Cofnodion Rhoi Meddyginiaeth.
- Roedd cyffuriau a reolir yr oedd eu dyddiad defnyddio wedi mynd heibio yn y cabinet cyffuriau a reolir.
- Roedd polisïau meddyginiaeth wedi dyddio ac nid oedd staff yn gallu cael gafael ar bolisïau.

Dim ond enghreifftiau o'r problemau a nodwyd yn ystod ein hymweliadau yw'r rhai a restrir uchod; nodwyd nifer o broblemau eraill. Nid yw'r amrywiaeth o ganfyddiadau yn dangos prosesau goruchwylio, archwilio a llywodraethu effeithiol mewn perthynas â rheoli meddyginiaethau mewn byrddau iechyd na darparwyr annibynnol.

Asesiadau risg a chynlluniau gofal

O blith 19 o ysbytai ac un TIMC, gwnaethom nodi problemau mewn 16 o'r 20. Mae proses rheoli risg gadarn a phroses cynllunio gofal glir a chywir yn allweddol i sicrhau bod anghenion gofal a thriniaeth cleifion yn cael eu nodi a bod unrhyw risgiau'n cael eu nodi a bod strategaeth ar waith i fynd i'r afael â nhw. O ran cynlluniau gofal a thriniaeth, mae gan AGIC gyfrifoldeb penodol i fonitro Rhan 2 o Fesur Iechyd Meddwl (Cymru) 2010. Yn ôl Rhan 2 o'r Mesur, mae'n rhaid bod cynllun gofal a thriniaeth ar waith ar gyfer pob claf sy'n cael gofal iechyd meddwl eilaidd. Dylai cynlluniau gofal a thriniaeth fod yn gynhwysfawr ac yn gyfannol, a dylent ganolbwyntio ar y claf.

Mae rôl y Cydgysylltydd Gofal wedi'i hamlinellu yn y Cod Ymarfer ar Rannau 2 a 3 o Fesur Iechyd Meddwl (Cymru) 2010.

Ym mhennod 3 y Cod Ymarfer, mae cyfrifoldebau'r cydgysylltydd gofal wedi'u nodi ar gyfer y meysydd canlynol:

- cydweithio â'r claf perthnasol a darparwyr gwasanaethau iechyd meddwl y claf perthnasol gyda'r nod o gytuno ar y canlyniadau y mae'r gwasanaethau iechyd meddwl wedi'u cynllunio i'w cyflawni;
- sicrhau bod cynllun gofal a thriniaeth yn cael ei ddatblygu a'i lunio;
- sicrhau bod cynlluniau gofal a thriniaeth yn cael eu hadolygu a'u diwygio;
- rhoi cyngor i ddarparwyr gwasanaethau ar gydgysylltu'r gofal a ddarperir yn effeithiol;
- cadw mewn cysylltiad â'r claf perthnasol. Gall y cydgysylltydd gofal hefyd ddewis cadw mewn cysylltiad â theulu a gofalwyr lle y bo hynny'n briodol neu'n angenrheidiol.

Fel y nodwyd uchod, mae cydgysylltwyr gofal yn unigolion allweddol ac mae eu mewnbwn yn ganolog i gefnogi'r claf ar ei daith drwy wasanaethau iechyd meddwl eilaidd. Mae hwn yn faes arall a gaiff ei asesu yn ystod ein harolygiadau.

Yn ystod ein harolygiadau, rydym hefyd yn cyfweld â chleifion a staff er mwyn meithrin dealltwriaeth o effeithiolrwydd y cynlluniau gofal a thriniaeth. Roedd yn dda nodi rhai enghreifftiau o ymarfer da o ran cynlluniau gofal a thriniaeth a'r asesiadau risg y gwnaethom eu hystyried fel rhan o'r broses arolygu. Roedd rhai o'r enghreifftiau o ymarfer da a nodwyd yn cynnwys tystiolaeth bod cynlluniau gofal yn canolbwyntio ar yr unigolyn a bod cymorth yn cael ei roi mewn ffordd strwythuredig er mwyn galluogi cleifion i gyflawni eu nodau unigol. Roedd y cynlluniau gofal yn

fanwl iawn ac wedi'u personoli, a oedd yn helpu'r ysbytai i ddarparu gofal cynhwysfawr i'r cleifion. At hynny, gwelsom enghreifftiau o gofnodion trefnus a oedd yn hawdd eu defnyddio am fod yr adrannau wedi'u nodi'n glir. Roedd gwybodaeth yn cael ei chofnodi'n gynhwysfawr yn y cofnodion ac roeddent yn cael eu storio'n briodol ac yn ddiogel. Gwelsom hefyd enghreifftiau o gleifion yn cael eu cynnwys yn y broses o gynllunio a darparu eu gofal eu hunain, cyn belled ag y bo modd, a lle na allai cleifion wneud penderfyniadau drostynt eu hunain, gwelsom dystiolaeth bod gwasanaethau yn ymgynghori â'u perthnasau. Fodd bynnag, gwnaethom hefyd nodi nifer o feysydd yr oedd angen eu gwella yn ystod nifer o'r arolygiadau a gynhaliwyd gennym. Roedd y materion a nodwyd gennym yn cynnwys y canlynol:

- Gwelsom enghraifft o glaf nad oedd ganddo ond cynllun llwybr 72 awr a oedd ond wedi'i gwblhau'n rhannol, er ei fod wedi'i dderbyn ers dros dair wythnos.
- Ni chawsom sicrwydd bod trefniadau priodol ar waith i ddiwallu anghenion gofal iechyd corfforol cleifion.
- Ni chawsom sicrwydd bod y trefniadau gofal a thriniaeth a oedd ar waith yn unol â Mesur Iechyd Meddwl (Cymru) 2010.
- Ni welsom dystiolaeth yng nghofnodion y cleifion eu bod yn cael eu cefnogi i ddiwallu eu hanghenion deietegol unigol.
- Yn ystod un o'n harolygiadau, gwelsom wybodaeth anghywir yng nghynlluniau gofal a thriniaeth cyfredol dau glaf.
- Nid oedd y cynlluniau gofal a thriniaeth bob amser wedi'u llofnodi gan yr aelod o'r staff a gynhaliodd yr adolygiad, ac nid oedd dyddiad wedi'i nodi arnynt bob amser.
- Prin oedd y wybodaeth am y claf a oedd wedi'i chofnodi ar y system electronig (WCCIS).
- Nid oedd unrhyw dystiolaeth bod asesiad risg Rhwydwaith Ymchwil Risg Gymhwysol Cymru (WARRN) wedi cael ei ddiweddaru i ddangos bod y claf wedi cael ei dderbyn i'r ysbyty.
- Nid oedd unrhyw dystiolaeth o waith cynllunio gofal cyfredol i ymdrin â risgiau ac anghenion yr unigolyn.
- Nid oedd llais y claf bob amser wedi'i adlewyrchu ym mhob un o'r cynlluniau gofal a thriniaeth a welsom. Roedd tuedd hefyd i gynlluniau ganolbwyntio ar risg ac anghenion yn hytrach na bod yn seiliedig ar gryfderau.
- Nid oedd cynlluniau gofal a thriniaeth cleifion wedi'u hadolygu i sicrhau eu bod yn cynnwys yr holl wybodaeth berthnasol yn unol â chanllawiau a deddfwriaeth.
- Nid oedd asesiadau risg Brysbennu, Asesu a Thriniaeth Gyflym wedi'u cwblhau'n llawn i sicrhau diogelwch cleifion, staff ac ymwelwyr a chynllunio gofal ar gyfer y dyfodol.

Mae'r problemau a nodir uchod yn cwmpasu amrywiaeth eang o ddogfennau ac asesiadau risg cleifion. Nid yw AGIC wedi cael sicrwydd bod yr asesiadau risg a'r cynlluniau gofal a thriniaeth bob amser yn effeithiol o ran lliniaru'r risgiau sy'n gysylltiedig â chleifion sy'n ddifrifol wael a all ymddwyn mewn modd heriol. Mae'n hanfodol bod y byrddau iechyd a'r darparwyr gofal iechyd annibynnol unigol yn datblygu archwiliadau a phrosesau llywodraethu effeithiol i sicrhau bod pob cynllun gofal a thriniaeth ac asesiad risg yn gadarn a helpu i ddarparu llwybr gofal effeithiol i bob claf.

Yr amgylchedd gofal

Rydym yn mynd ar daith o amgylch y wardiau fel mater o drefn er mwyn ystyried priodoldeb a diogelwch yr ardaloedd a ddefnyddir gan gleifion. Gwnaethom nodi problemau o ran yr amgylchedd gofal yn ystod 17 o'n harolygiadau o 19 o ysbytai

ac un TIMC. Ymdrinnir â'r broblem yn ymwneud ag asesu risg pwyntiau clymu ac argaeledd torwyr clymau yn yr adran ar ddiogelwch staff a chleifion isod.

Nodwyd amrywiaeth o broblemau amgylcheddol eraill, gan gynnwys diffyg gwaith cynnal a chadw ac ailaddurno, a'r angen i osod eitemau newydd yn lle rhai a oedd wedi torri. At hynny, yn ystod un arolygiad, nid oedd digon o ystafelloedd ar gael i Seiciatryddion Ymgynghorol gael sgyrsiau cyfrinachol â chleifion ac yn ystod arolygiad arall, roedd llwydni ac awyru gwael yn yr ystafelloedd cawod a'r toiledau ar bob un o'r tair ward. Yn ystod arolygiad arall, gwelsom nad oedd canllawiau yn ardal y ward nac yn yr ystafelloedd golchi ac yn ystod arolygiad arall, ni chawsom sicrwydd bod proses effeithlon ar waith a oedd yn sicrhau bod materion heb eu datrys o ran yr ystâd yn cael eu nodi, eu datrys a'u cymeradwyo fel materion a gwblhawyd fel bod y staff yn ymwybodol ohonynt.

Diogelwch staff a chleifion

Yn ystod pob un o'n 20 o arolygiadau (19 o ysbytai ac un TIMC), gwnaethom nodi amrywiaeth o broblemau yn ymwneud â diogelwch cleifion a staff. Roedd y problemau a nodwyd yn ymwneud ag amrywiaeth eang o feysydd ac mae rhai o'r canfyddiadau o bwys yn cynnwys y canlynol:

- Drwy gydol yr arolygiad gwelsom nad oedd y staff yn gwisgo larymau personol na setiau radio.
- Nid oedd polisi ar ddefnyddio larymau personol ar waith.
- Ni allai'r cleifion gyrraedd y clychau galw yn hawdd.
- Gwelsom enghreifftiau amgylcheddol o risgiau posibl i ddiogelwch y cleifion fel a ganlyn: roedd gwydr wedi'i ddifrodi a'i orchuddio â bordiau ac roedd system ddiogelwch electronig y drws wedi'i chyfaddawdu.
- Nid oedd torwyr clymau ar gael/mewn man lle y gallai pob aelod o'r staff gael gafael arnynt yn hawdd.
- Nid oedd adweithiau andwyol cleifion nac asesiadau thrombosis gwythiennol yn cael eu cwblhau'n briodol.
- Roedd gwaith atal pwyntiau clymu wedi cael ei argymell yn 2020 mewn perthynas â rhai risgiau yn ymwneud â phwyntiau clymu ond nid oedd y gwaith hwn wedi cael ei gwblhau o hyd.

Preifatrwydd ac urddas cleifion

O fewn y maes hwn, gwnaethom nodi nifer o broblemau gan gynnwys diffyg polisi preifatrwydd ac urddas a'r ffaith na allai cleifion fynd a dod o'u hystafelloedd gwely yn ystod y dydd. Yn bwysig, yn ystod un arolygiad, gwelsom ddau achos lle roedd preifatrwydd cleifion wedi'i beryglu; un achos lle roedd gofal personol yn cael ei roi gyda drysau'r ystafell wely ar agor ac achos arall lle roedd y bleinds ar ffenestr gwydr clir ystafell wedi torri. Roedd y ffenestr a oedd yn edrych dros orsaf nyrsio'r ward yn gadael golau i mewn i'r ystafell wely hyd yn oed pan oedd y bleinds wedi cau. Roedd hyn yn peryglu preifatrwydd ac urddas y claf ac yn peri risg y gellid tarfu arno.

Y Gweithlu

Mae heriau sylweddol o ran y gweithlu yn parhau ledled Cymru. Mae'r darlun yn gymysg iawn gyda rhai byrddau iechyd a darparwyr annibynnol yn fwy llwyddiannus nag eraill wrth recriwtio a chadw niferoedd digonol o staff wedi'u hyfforddi'n dda. Roedd prinder staff yn effeithio ar amrywiaeth o ddisgyblaethau, gan gynnwys staff meddygol, nyrsys cofrestredig, seicolegwyr a therapyddion galwedigaethol. Roedd prinder staff yn cael effaith andwyol ar staff, ac yn ystod un arolygiad, dywedodd y staff wrthym eu bod yn teimlo nad oedd y templed staffio presennol yn ddigon i sicrhau gofal diogel ac effeithiol. Yn ystod arolygiad arall, cododd sylwadau'r staff,

a'r anawsterau a welsom, amheuon ynghylch a oedd y trefniadau staffio presennol yn ddigon i ddarparu gofal diogel ac effeithiol i gleifion bob amser.

Er gwaethaf heriau sylweddol o ran y gweithlu, rydym yn parhau i gael adborth cadarnhaol gan gleifion am agweddau'r staff a'u parodrwydd i helpu cleifion ar eu llwybr gofal. At hynny, rydym yn parhau i weld llawer o ryngweithio cadarnhaol gan weithlu prysur iawn sydd dan bwysau.

Nodwyd problemau o ran y gweithlu mewn 14 o'r 20 o arolygiadau ar draws amrywiaeth o ddisgyblaethau ac mae rhai o'r rhain wedi'u hamlinellu isod:

- Roedd swyddi gwag ar gyfer amrywiaeth o ddisgyblaethau, gan gynnwys cydgysylltydd gweithgareddau, gweithiwr cymorth therapi galwedigaethol, seiciatrydd ymgynghorol dynodedig, seicolegydd a nyrs gofrestredig.
- Dywedodd y staff wrthym nad oedd y lefelau staffio wedi cael eu hadolygu ers cryn amser a bod yr amgylchedd roeddent yn gweithio ynddo yn mynd yn fwy heriol a chymhleth. Roedd rhai aelodau o'r staff yn teimlo bod eu gwaith, yn gyffredinol, yn cael effaith andwyol ar eu hiechyd.
- Roedd y Therapydd Lleferydd ac Iaith (SALT) yn cwblhau ymgyngoriadau â chleifion dros y ffôn ac nid oedd wedi ymweld â'r cleifion ar y ward.
- Dywedwyd wrthym nad oedd yr adnoddau staffio wedi cael eu hadolygu i fynd i'r afael â'r cynnydd hwn yn y llwyth gwaith o ganlyniad i nifer y defnyddwyr gwasanaethau â diagnosis o ADHD sy'n cael eu hatgyfeirio at y tîm ac nad oedd polisi rheoli llwyth gwaith ar waith i gefnogi hyn.
- Dywedodd y staff wrthym fod diffyg cymorth gweinyddol yn y tîm i alluogi gwasanaeth effeithiol.

Dim ond enghreifftiau yw'r canfyddiadau uchod o'r amrywiaeth o broblemau a nodwyd gennym yn ystod ein hymweliadau arolygu. Mae'r sector gofal iechyd yn parhau i wynebu heriau sylweddol wrth recriwtio a chadw niferoedd digonol o staff gwybodus a hyfforddedig i ddarparu gwasanaethau effeithiol i rai o'r cleifion mwyaf agored i niwed mewn ysbytai iechyd meddwl. Felly, mae'n hollbwysig bod gan fyrddau iechyd a darparwyr annibynnol amrywiaeth o strategaethau i sicrhau eu bod yn recriwtio staff ac yn eu cadw.

Llywodraethu

Mae'r problemau a nodir yn yr adroddiad hwn yn awgrymu nad yw'r prosesau llywodraethu mewn byrddau iechyd a darparwyr gofal annibynnol yn effeithiol. Felly, ymddengys nad yw gwersi i'w dysgu yn cael eu rhannu o fewn byrddau iechyd a darparwyr annibynnol pan fydd problemau a nodwyd mewn un maes yn codi mewn ysbyty arall yn yr un bwrdd iechyd neu ddarparwr annibynnol. Mae prosesau llywodraethu ac archwilio cadarn yn allweddol i nodi, ar gam cynnar, lle mae angen gwella trefniadau darparu gwasanaeth er mwyn diwallu anghenion y grŵp cleifion yn fwy effeithiol. At hynny, nid yw'n ymddangos bod gwersi a ddysgwyd yn cael eu hymgorffori'n ddigonol i atal problemau rhag codi eto. Yn anffodus, yn ystod 19 o'n 20 o ymweliadau, gwnaethom nodi problemau yn ymwneud ag archwilio a llywodraethu, sy'n peri pryder mawr. Mae rhai o'r meysydd yn cynnwys:

- Diffyg system gadarn i oruchwylio prosesau llywodraethu sy'n sicrhau bod prosesau rheoli meddyginiaethau'r ysbyty yn cefnogi diogelwch cleifion.

- Yn ystod un arolygiad, gwelsom nad oedd prosesau llywodraethu yn cael eu goruchwylio'n ddigonol a bod diffyg cyfathrebu rhwng uwch-aelodau o'r staff a staff y wardiau mewn perthynas â systemau ar y wardiau, prosesau archwilio a chyfleoedd i rannu gwersi a ddysgwyd. Felly, ni chawsom sicrwydd bod ymchwiliadau effeithiol yn cael eu cynnal i broblemau allweddol, eu bod yn destun gwaith craffu a'u bod yn cael eu huwchgyfeirio a'u goruchwylio er mwyn eu hatal rhag digwydd eto a sbarduno gwelliannau o ran ansawdd.
- Yn ystod un ymweliad, gwnaethom nodi nad oedd proses ffurfiol ar waith i gasglu adborth gan gleifion neu berthnasau/gofalwyr.
- Yn ystod ymweliad arall, ni welsom unrhyw dystiolaeth bod newidiadau wedi'u gwneud o ganlyniad i adborth ffurfiol gan gleifion.
- Nid oedd cyfarfodydd staff ffurfiol dynodedig yn cael eu cynnal i gynnwys y staff, trafod problemau ac annog y staff i roi adborth.
- Nid oedd y polisïau yn gyfredol.
- Archwiliadau bwrdd iechyd cyffredinol oedd yr archwiliadau cadw cofnodion, a oedd yn amhriodol ar gyfer y lleoliad iechyd meddwl.
- Nid oedd yr uwch-reolwyr yn craffu'n barhaus ar systemau a phrosesau archwilio'r ysbyty er mwyn sicrhau eu bod yn cael eu cwblhau mewn modd amserol ac effeithiol a sbarduno gwelliannau o ran ansawdd.
- Roedd diffyg prosesau llywodraethu ansawdd ac arwain er mwyn sicrhau cyfathrebu effeithiol rhwng yr uwch-reolwyr a staff y wardiau.
- Yn ystod un ymweliad, gwnaethom nodi y dylai'r darparwr cofrestredig roi mesurau ar waith i gryfhau ei systemau arweinyddiaeth a llywodraethu a darparu hyfforddiant ychwanegol er mwyn sicrhau bod y staff yn cydymffurfio â gweithdrefnau gweinyddol yr ysbyty.
- Rhaid i'r gwasanaeth safoni systemau a phrosesau ym mhob rhan o'r ysbyty er mwyn rhannu arferion da a sicrhau prosesau gwella ansawdd.

Canfyddiadau yn ymwneud yn benodol ag Anableddau Dysgu

Yn ystod 2023/24, gwnaethom gynnal tri arolygiad o sefydliadau anableddau dysgu ac un gwiriad sicrwydd o TIMC ar y cyd ag AGC. Yn ystod yr arolygiadau hyn, gwnaethom nodi rhai canfyddiadau cadarnhaol, gan gynnwys gwasanaethau eirioli i gleifion. Gwelsom hefyd y staff yn rhyngweithio â'r cleifion mewn modd rhagweithiol a brwdfrydig, a dangosodd y staff y gwnaethom siarad â nhw ffocws gwirioneddol ar y cleifion. Roedd y cleifion hefyd yn hapus i siarad â'r tîm arolygu, ac ar y cyfan, roedd y safbwyntiau a fynegwyd ganddynt yn gefnogol i'r gofal y maent yn ei gael.

Yn ystod pob un o'r arolygiadau, ni phennwyd unrhyw gamau gweithredu mewn perthynas â materion lle roedd angen sicrwydd ar unwaith, ond nodwyd nifer o feysydd i'w gwella

Diogelwch cleifion a staff

Mae diogelwch cleifion a staff yn bwysig ac yn ganolog i unrhyw ofal a thriniaeth a roddir. Os bydd claf yn teimlo'n ddiogel, bydd yn ymateb yn llawer gwell i unrhyw driniaeth ac yn teimlo ei fod wedi'i rymuso i wireddu ei botensial i'r eithaf. Os bydd staff yn teimlo'n ddiogel, byddant yn gallu gofalu am y cleifion yn eu gofal a'u grymuso yn well.

Yn ystod ein harolygiad o TADC, gwnaethom nodi oedi cyn dyrannu, asesu ac awdurdodi ceisiadau am Drefniadau Diogelu wrth Amddifadu o Ryddid (DoLS) i Gyngor Bwrdeistref Sirol Rhondda Cynon Taf a BIPCTM. Mae'r oedi hwn yn parhau i olygu bod llawer o bobl yn cael eu hamddifadu o'u rhyddid heb fod unrhyw amddiffyniad cyfreithiol ar waith nac unrhyw gyfle i herio wrth aros i benderfyniad gael ei wneud. Mae angen gwneud rhagor o waith i sicrhau bod hawliau pobl yn cael eu hamddiffyn a bod trefniadau gofal a chymorth/ triniaeth yr ystyrir eu bod yn amddifadu o rhyddid yn cael eu hawdurdodi'n briodol. Rhaid i uwch-reolwyr sicrhau bod digon o gapasiti i gyflawni cyfrifoldebau statudol.

Mewn un ysbyty cleifion mewnol, gwelsom na allai'r cleifion gyrraedd y clychau galw yn eu hystafelloedd gwely yn hawdd.

Rheoli meddyginiaeth

Mae rhoi, storio ac archebu meddyginiaethau'n ddiogel ac yn effeithiol yn faes pwysig iawn rydym yn canolbwyntio arno yn ein harolygiadau. Roedd yn galonogol nodi mai dim ond yn ystod un o'n pedwar arolygiad y gwnaethom nodi problemau yn ymwneud â rheoli meddyginiaethau; roedd yr achos hwn mewn ysbyty annibynnol lle mae'n rhaid i'r rheolwr cofrestredig sicrhau y dilynir y prosesau ar gyfer cysoni stoc meddyginiaeth bob amser.

Hyfforddiant

O ran hyfforddiant, gwnaethom nodi un mater yn yr adolygiad o sicrwydd TADC mewn perthynas â hyfforddiant penodol ar y Ddeddf Iechyd Meddwl. Nid oedd yr hyfforddiant yn cael ei ddarparu'n rheolaidd i holl ymarferwyr y bwrdd iechyd. Gwnaethom ofyn i'r bwrdd iechyd gynnal adolygiad a sicrhau bod yr ymarferwyr hynny sy'n rhoi gofal i bobl o dan y Ddeddf Iechyd Meddwl yn cael y wybodaeth ddiweddaraf am y Ddeddf a'i goblygiadau i'r bobl a gefnogir. Yn ystod arolygiad arall, gwnaethom nodi bod y bwrdd iechyd yn parhau i ddefnyddio arbenigedd y Tîm Amlddisgyblaethol i ddarparu hyfforddiant ar Gefnogi Ymddygiad yn Gadarnhaol sy'n benodol i'r unigolyn a'i fod yn cefnogi'r staff i gwblhau'r hyfforddiant hwn yn ôl yr angen.

Cynlluniau gofal ac asesiadau risg

Mae cynlluniau gofal, yn enwedig cynlluniau Cefnogi Ymddygiad yn Gadarnhaol, yn elfen bwysig o ddarparu gofal effeithiol a sicrhau bod y claf wrth wraidd yr holl ofal a thriniaeth a roddir. At hynny, rhaid i unrhyw risgiau i gleifion gael eu disgrifio'n llawn, gan nodi ffactorau sbarduno ac amrywiaeth o strategaethau i liniaru'r risgiau a nodwyd. Rydym yn archwilio dogfennau gofal a risg fel mater o drefn fel rhan o'r broses arolygu. Yn ystod pob un o'n pedwar ymweliad, gwnaethom nodi problemau yn ymwneud â'r dogfennau gofal, gan gynnwys y canlynol;

- nid oedd gan fwrdd iechyd broses archwilio ac adolygu ar gyfer cofnodion gofal a chymorth er mwyn sicrhau eu bod yn gywir ac yn gyson
- nid oedd bwrdd iechyd yn sicrhau bod y cynllun cefnogi ymddygiad diweddaraf ar gael yn y ffeil weithredol a ddefnyddiwyd gan y staff.
- gwnaethom argymell y dylid cofnodi gwybodaeth ychwanegol am y rheswm/ rhesymau dros ddefnyddio ymyriad penodol a'r hyn a wnaed i gyfiawnhau'r ymyriad hwnnw fel dewis olaf.

Gwybodaeth i gleifion

Dylai gwybodaeth i gleifion fod mewn fformat addas er mwyn helpu unigolion i wneud dewisiadau ar sail gwybodaeth. Yn ystod un arolygiad, nid oedd y bwrdd gwybodaeth i gleifion yn gyfredol ac, felly, nid oedd yn sicrhau bod gwybodaeth briodol ar gael i'r cleifion.

Cadw cleifion ar wahân

Mae gwybodaeth am y Ddeddf Iechyd Meddwl a chadw cleifion ar wahân wedi'i chynnwys yn gynt yn yr adran hon o'r adroddiad. Yn ystod un o'n harolygiadau, nid oedd y dogfennau yn ymwneud â chadw cleifion ar wahân wedi'u cwblhau'n gywir.

Y Gweithlu

Mae'r gweithlu a recriwtio a chadw staff priodol sy'n meddu ar gymwysterau addas yn parhau i fod yn broblem. Yn ystod un arolygiad, nid oedd y bwrdd iechyd yn sicrhau bod y staff yn cael eu cefnogi os oedd unrhyw newidiadau i'w rolau o ganlyniad i'r newid o wasanaeth asesu a thrin i wasanaeth adsefydlu.

Yr amgylchedd gofal

Yn ystod pob un o'n tri ymweliad â lleoliadau cleifion mewnol, gwnaethom nodi problemau yn ymwneud â'r amgylchedd gofal, a bod angen gwneud gwelliannau amgylcheddol mewn perthynas â gwaith adnewyddu, ailaddurno ac atgyweirio ar y wardiau, ac yn ystod un o arolygiad, roedd angen i'r bwrdd iechyd sicrhau bod yr amgylchedd gofal yn diwallu anghenion cleifion sy'n cael gofal adsefydlu. Ymhlith y materion amgylcheddol penodol eraill roedd problemau gwresogi a diffyg gwaith i ddatblygu cegin i'r cleifion fel rhan o raglen therapi sgiliau bywyd. Yn olaf, roedd angen i'r rheolwr cofrestredig sicrhau bod materion cynnal a chadw yn cael eu datrys yn unol â'u blaenoriaeth a'u risg.

Llywodraethu

Nodwyd amrywiaeth o faterion llywodraethu yn ystod tri o'n pedwar ymweliad. Roedd y rhain yn cynnwys y canlynol:

- Yr angen i fwrdd iechyd sefydlu proses archwilio ac adolygu ar gyfer cofnodion gofal a chymorth er mwyn sicrhau eu bod yn gywir ac yn gyson.
- Yr angen i fwrdd iechyd roi pwyslais ar sicrhau bod y materion yn ymwneud â'r newid i'r gwasanaeth yn parhau i gael eu hystyried a bod camau'n cael eu cymryd i fynd i'r afael â nhw mewn modd amserol a chadarn.
- Yr angen i'r darparwr cofrestredig sicrhau bod pob polisi yn cael ei ddiweddaru a'i adolygu.
- Rhaid i fyrddau iechyd sefydlu prosesau amserol ac effeithiol a'u rhannu er mwyn sicrhau nad yw'r bobl a gefnogir gan y TADC yn wynebu oedi hir na biwrocratiaeth wrth gael gafael ar gyfarpar meddygol.

Canfyddiadau yn ymwneud yn benodol â CAMHS

Yn ystod 2023-24, gwnaethom arolygu dwy o'r tair uned CAMHS i gleifion mewnol yng Nghymru. Nodwyd rhai canfyddiadau cadarnhaol, gan gynnwys bod yr amgylcheddau gofal mewn cyflwr da ar y cyfan a bod y cynlluniau gofal o safon dda ar y cyfan, er bod rhai meysydd i'w gwella wedi'u nodi. Fodd bynnag, nododd ein harolygiadau hefyd amrywiaeth o broblemau ac yn dilyn un arolygiad, cyhoeddwyd llythyr sicrwydd ar unwaith mewn perthynas â sicrhau bod y broses o lywodraethu achosion o atal cleifion yn cael eu cofnodi'n briodol a bod ymchwiliadau priodol yn cael eu cynnal, gan gynnwys manylion am y canlynol:

- Ffactorau sbardun a'r hyn a ddigwyddodd cyn yr achos o atal y claf .
- Cofnod cywir o'r cyfnod o amser y cafodd y claf ei atal.
- Dadansoddiad ac ymchwiliad dilynol er mwyn sicrhau bod gwersi'n cael eu dysgu a bod y dulliau atal yn cael eu dadansoddi er mwyn nodi unrhyw themâu, a ellid bod wedi osgoi atal y claf yn ac a oedd y dull atal a ddefnyddiwyd yn briodol.

Ymhlith y problemau eraill a nodwyd roedd nifer o swyddi gwag ar gyfer addysgwr, seicolegydd a therapydd galwedigaethol, a oedd yn golygu nad oedd pobl ifanc yn cael yr addysg a'r therapïau yr oedd eu hangen arnynt. At hynny, gwnaethom nodi amrywiaeth o broblemau yn ymwneud â rheoli meddyginiaethau, gan gynnwys y canlynol:

Roedd y polisi rheoli meddyginiaethau wedi dyddio.

- Roedd bylchau ar daflen cofnodi tymheredd yr oergelloedd yn yr ystafell glinig.
- Roedd yr ystafell glinig yn boeth iawn ac nid oedd tymheredd yr ystafell yn cael ei wirio er mwyn sicrhau ei fod bob amser islaw'r tymheredd storio a argymhellir ar gyfer y feddyginiaeth yn yr ystafell.
- nid oedd y staff y gwnaethom siarad â nhw yn ystod yr arolygiad yn gwybod beth i'w wneud pe bai rhywun yn cael adwaith andwyol i gyffur.

Yn olaf, yn ystod un o'n hymweliadau, gwelsom nad oedd llwybr triniaeth wedi cael ei roi ar waith ar gyfer person ifanc a oedd wedi cael diagnosis o gyflwr wrth gael ei dderbyn.

6. Monitro Deddf Iechyd Meddwl 1983

Mae AGIC yn monitro'r ffordd y mae byrddau iechyd a darparwyr annibynnol yn arfer eu pwerau ac yn cyflawni eu dyletswyddau o dan Ddeddf Iechyd Meddwl 1983 a'r fersiwn ddiwygiedig yn 2007, ar ran Gweinidogion Cymru. Rhan o'n cyfrifoldebau statudol yw rhoi sicrwydd i'r cyhoedd am ansawdd, diogelwch ac effeithiolrwydd gwasanaethau gofal iechyd meddwl yng Nghymru.

Mae unigolion sy'n defnyddio gwasanaethau iechyd meddwl ac anableddau dysgu yn gwneud hynny fel cleifion anffurfiol, cleifion a all gael eu cadw, neu gleifion sy'n cael eu cadw. Mae cleifion anffurfiol yn cael triniaeth ar sail wirfoddol, mae cleifion sy'n cael eu cadw yn cael eu hasesu a/neu'n cael triniaeth drwy'r darpariaethau a nodir yn Neddf Iechyd Meddwl 1983.

Y Ddeddf Iechyd Meddwl yw'r fframwaith cyfreithiol sy'n darparu awdurdod i gadw a thrin pobl sydd â salwch meddwl ac sydd angen eu hamddiffyn er eu hiechyd a'u diogelwch eu hunain, neu ddiogelwch pobl eraill. Mae'r Ddeddf Iechyd Meddwl yn darparu fframwaith cyfreithiol i ddiogelu hawliau cleifion, ac mae'n ei gwneud yn ofynnol bod lefel briodol o ofal, triniaeth effeithiol, ac amgylchedd sy'n hybu adferiad yn cael eu darparu.

Sut mae Deddf Iechyd Meddwl 1983 yn cael ei monitro

Mae AGIC yn un o nifer o unigolion a sefydliadau sydd â phwerau a chyfrifoldebau o dan y Ddeddf Iechyd Meddwl. Mae'r unigolion a'r sefydliadau eraill yn cynnwys swyddogion a staff byrddau iechyd, gwasanaethau cymdeithasol ac ysbytai annibynnol, Gweinidogion Cymru, y llysoedd, swyddogion yr heddlu, eiriolwyr, a pherthnasau pobl sy'n cael eu cadw. Mae AGIC yn cynnal nifer o ymweliad arolygu lle rydym yn ystyried y ffordd y mae sefydliadau gofal iechyd yn arfer eu pwerau a'u cyfrifoldebau o dan y Ddeddf. Mae'r adran hon o'r adroddiad blynyddol yn nodi'r ffordd y mae'r Ddeddf Iechyd Meddwl yn cael ei rhoi ar waith a'r ffordd y mae'r pwerau a roddir yn cael eu harfer a'u monitro yng Nghymru. Mae AGIC hefyd yn gweithredu'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn ac yn ystyried y ffordd y mae byrddau iechyd a darparwyr annibynnol yn ymchwilio i gwynion. O dan rai amgylchiadau, os na fydd AGIC yn fodlon ar ymchwiliad, gall gynnal ei hymchwiliad ei hun.

Yn ystod ein hymweliadau arolygu yn 2023-24, gwnaethom ganolbwyntio ar nifer o feysydd allweddol, gan gynnwys:

- A yw cleifion yn cael eu cadw'n gyfreithlon ac ai eu cadw o dan y Ddeddf yw'r dewis mwyaf priodol.
- O dan adran 132, a yw cleifion yn cael gwybodaeth am eu hawliau pan fyddant yn cael eu cadw, ac yn rheolaidd wedi hynny. A gaiff cofnod ei wneud o ran p'un a yw cleifion wedi deall eu bod yn cael eu cadw ai peidio.
- A oes cynllun gofal a thriniaeth ar waith sy'n ystyried ôl-ofal y claf.

Rydym yn ystyried y broses o gadw cleifion drwy nifer o fethodolegau, gan gynnwys cyfweliadau â'r cleifion ac aelodau o'r tîm amlddisgyblaethol. Rydym hefyd yn defnyddio arsylwadau ac yn edrych ar y gwaith papur mewn perthynas â chadw cleifion er mwyn sicrhau eu bod yn cael eu cadw'n gyfreithlon. At hynny, rydym yn ymgynghori â gweinyddwyr y Ddeddf Iechyd Meddwl.

Adolygwyr y Ddeddf Iechyd Meddwl

Yn ystod ein harolygiadau, rydym yn defnyddio sgiliau a gwybodaeth ein Hadolygwyr o dan y Ddeddf Iechyd Meddwl, sy'n gyfrifol am ystyried y broses o gadw cleifion o dan y Ddeddf. Maent yn penderfynu a ddylid bod wedi cymhwyso'r Ddeddf, ac a oedd yn cael ei chymhwyso'n gyfreithlon ac a oedd Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru yn cael ei ddilyn. Creffir ar nifer o adrannau allweddol o'r Ddeddf, gan gynnwys adran 132 sy'n sicrhau bod cleifion a gedwir yn cael gwybod am eu hawliau pan fyddant yn cael eu cadw a bod proses barhaus i sicrhau bod cleifion yn ymwybodol o'u hawliau. Mae'r adolygwyr hefyd yn ystyried y ddogfennaeth ar gyfer absenoldeb adran 17 ac a yw unrhyw absenoldeb yn ystyried dymuniadau'r claf a dymuniadau gofalwyr, perthnasau a ffrindiau. Mae'n rhaid i absenoldeb ystyried unrhyw risgiau i iechyd a diogelwch y claf a phobl eraill hefyd. Eir ati i graffu ar unrhyw amodau sy'n gysylltiedig â'r absenoldeb hefyd.

Mae ein hadolygwyr hefyd yn ystyried mynediad at wasanaethau cyfreithiol ac eirioli er mwyn helpu i sicrhau hawliau cleifion a gedwir. Yn ogystal, maent yn ystyried a yw cleifion yn ymwybodol o'u hawliau i wneud cais i Dribiwnlys Adolygu Iechyd Meddwl Cymru. Maent hefyd yn ystyried dyletswydd rheolwyr ysbytai i atgyfeirio achosion at Dribiwnlys Adolygu Iechyd Meddwl Cymru.

Ein Canfyddiadau

Galluedd Meddyliol

Nodwyd amrywiaeth o arferion da ac, mewn llawer o'n harolygiadau, roedd tystiolaeth bod asesiadau o alluedd cleifion i gydsynio i driniaeth yn cael eu cwblhau pan fyddent yn cael eu derbyn a bod galluedd meddyliol pob claf wedi'i asesu a'i ddogfennu'n glir.

Fodd bynnag, yn ystod un o'n hymweliadau, gwnaethom nodi nad oedd galluedd cleifion a galluedd i gydsynio yn cael eu hasesu a'u cofnodi fel mater o drefn yn ystod tri mis cyntaf y driniaeth ac nad oedd ffurflenni'n cael eu defnyddio fel mater o drefn mewn perthynas â chleifion nad oedd ganddynt alluedd i wneud penderfyniadau penodol am agweddau ar eu gofal a'u triniaeth a oedd y tu hwnt i ddarpariaethau'r Ddeddf yn ystod eu harhosiad ar y ward. Yn ystod un ymweliad arall, gwnaethom nodi nad oedd asesiadau galluedd meddyliol yn cael eu cwblhau'n llawn a'u hadolygu a'u diweddaru'n rheolaidd.

Mewn un achos, nid oedd galluedd cleifion i gydsynio i driniaeth yn cael ei asesu'n rheolaidd gan ddefnyddio'r fframwaith a nodir yn y Ddeddf Galluedd Meddyliol a'r canllawiau a nodir yn Deddf Iechyd Meddwl 1983 – Cod Ymarfer Cymru (13.8) a'i gofnodi yng nghofnodion y cleifion.

Cadw'n gyfreithlon/rhoi triniaeth yn gyfreithlon

Mae dyletswydd ar AGIC i fonitro'r Ddeddf Iechyd Meddwl er mwyn sicrhau bod cleifion yn cael eu cadw'n gyfreithlon a bod systemau a phrosesau ar waith i wneud yn siŵr bod y Ddeddf yn cael ei harchwilio a'i llywodraethu'n effeithiol. Un o elfennau allweddol ein proses arolygu yw adolygu dogfennau cadw statudol er mwyn sicrhau bod y cleifion dan sylw wedi cael eu cadw'n gyfreithlon. Gwelsom nifer o enghreifftiau

o arferion da, gan gynnwys bod dogfennaeth o dan y Ddeddf Iechyd Meddwl yn drefnus, yn hawdd ei defnyddio ac yn cael ei storio'n ddiogel a bod gweinyddwyr y Ddeddf Iechyd Meddwl yn goruchwylio'r broses o lywodraethu cofnodion cleifion o dan y Ddeddf Iechyd Meddwl yn dda i fonitro cydymffurfiaeth â chanllawiau cenedlaethol ac adolygu terfynau amser sydd ar ddod er mwyn sicrhau bod cleifion yn cael eu cadw'n gyfreithlon o hyd.

Fodd bynnag, yn ystod un ymweliad, gwnaethom nodi bod angen adolygu defnydd yr ysbyty o driniaeth frys o dan Adran 62 o'r Ddeddf Iechyd Meddwl er mwyn sicrhau cydymffurfiaeth lawn â'r Ddeddf a bod y dogfennau perthnasol yn cael eu cwblhau'n llawn.

At hynny, yn ystod un ymweliad, gwnaethom hefyd nodi bod angen rhoi prosesau cadarn ar waith i archwilio a goruchwylio'r broses o lywodraethu'r Ddeddf Iechyd Meddwl.

Hefyd, rhaid i ffurflenni Cydsynio i Driniaeth gael eu cwblhau a'u storio gyda chofnodion meddyginiaeth cyfatebol y cleifion er mwyn sicrhau bod y staff yn ymwybodol ohonynt, a rhaid i'r ffurflenni tystysgrif gydsynio statudol bob amser nodi'r math cywir o feddyginiaeth a'r dos cywir a ragnodwyd i'r cleifion.

Absenoldeb Adran 17

Mae absenoldeb Adran 17 yn rhan bwysig o daith claf tuag at gael ei ryddhau o'r ysbyty meddwl i'r gymuned. Rhaid i'r broses hon gael ei rheoli'n ofalus gydag amodau clir o ran yr absenoldeb, gan ystyried unrhyw ffactorau risg a chydbwyso anghenion y claf â'r risgiau hyn. Nodwyd amrywiaeth o bryderon yn ystod ein harolygiadau, gan gynnwys y canlynol:

Yr angen i adolygu absenoldeb adran 17 cleifion er mwyn sicrhau bod yr absenoldeb wedi'i bersonoli a'i deilwra at anghenion y claf unigol a bod cleifion, eu teuluoedd a'u gofalwyr yn cael eu cynnwys wrth wneud penderfyniadau ynghylch y broses absenoldeb.

- Niferoedd annigonol o staff i sicrhau bod cleifion yn gallu cymryd eu habsenoldeb Adran 17.
- Gwelsom enghreifftiau lle roedd ffurflenni absenoldeb Adran 17 cleifion wedi cael eu llofnodi ond heb eu dyddio. Nid oedd blychau ticio'r rhestr ddosbarthu yn y ffurflenni absenoldeb Adran 17 wedi cael eu cwblhau'n llawn er mwyn nodi pwy oedd wedi cael copi o'r ffurflen,
- Ffurflenni absenoldeb Adran 17 anghyflawn nad oeddent yn cynnwys y dyddiad Na manylion pob unigolyn a oedd yn eu derbyn, fel mater o arfer da.
- Gwnaethom nodi y gellid cryfhau amodau a chanlyniadau'r absenoldeb Adran 17 ar gyfer rhai cleifion er mwyn rhoi mwy o eglurder i'r staff o ran disgwyliadau'r trefniadau absenoldeb.
- Gwelsom nad oedd trefniadau absenoldeb Adran 17 ar waith ar gyfer pob claf i awdurdodi absenoldeb annisgwyl neu frys o'r ysbyty.
- Pan fydd absenoldeb o fwy na 7 diwrnod yn cael ei ganiatáu, rhaid i'r bwrdd iechyd sicrhau bod y clinigydd cyfrifol yn ystyried a allai'r Gorchymyn Triniaeth Gymunedol fod yn opsiwn mwy addas, yn unol â pharagraff 27.8-27.9 o'r Cod Ymarfer.

Gwrandawiadau rheolwyr

O ran gwrandawiadau rheolwyr, gwnaethom nodi dau fater yn ystod ein harolygiadau, yr oedd y naill yn ymwneud â'r angen i sicrhau bod gwrandawiadau Rheolwyr yr Ysbyty yn cael eu cynnal mewn modd amserol a'r llall yn ymwneud ag un o'r cofnodion welsom, lle roedd oedi o bum mis. Maes arall a nodwyd oedd bod yn rhaid rhoi mesurau ar waith i sicrhau bod rheolwyr yr ysbyty yn cael eu harfarnu'n rheolaidd mewn perthynas â gweinyddu'r Ddeddf Iechyd Meddwl.

Diogelu hawliau cleifion

Mae Adrannau 132 a 132A o'r Ddeddf Iechyd Meddwl yn gosod dyletswydd ar reolwyr ysbytai i sicrhau bod cleifion sy'n cael eu cadw yn deall sut mae'r Ddeddf yn gymwys iddynt a pha hawliau sydd ganddynt. Rhaid rhoi gwybodaeth i'r claf sy'n cael ei gadw, ar lafar ac yn ysgrifenedig mewn fformatau hygyrch fel mater o frys. Mae fformatau hygyrch yn cynnwys fersiynau hawdd eu deall, iaith y mae'r claf yn ei deall a Braille.

Yn ystod ein harolygiadau, gwelsom dystiolaeth dda fod cleifion yn ymwybodol o'u hawliau a bod hyn wedi'i gofnodi'n dda. Dim ond yn ystod un arolygiad y gwnaethom fethu â chanfod tystiolaeth bod hawliau'r cleifion wedi'u hailgyflwyno'n rheolaidd ac nad oedd copïau o'r dogfennau wedi'u darparu i'r partïon perthnasol fel sy'n ofynnol.

Ymgyngoreion statudol

Mae'n rhaid i'n meddygon a benodwyd i roi ail farn ymgynghori â dau berson, a elwir yn ymgyngoreion statudol, cyn rhoi tystysgrifau yn cymeradwyo triniaeth. Pan fydd Adrannau 57, 58 neu 58A yn gymwys, rhaid i un o'r ymgyngoreion fod yn nyrs, ac ni ddylai'r llall fod yn nyrs nac yn feddyg. Bydd cydgysylltydd gofal claf mewn sefyllfa arbennig o dda i fod yn ymgynghorai statudol.

Yn ystod dau o'n hymweliadau, gwelsom nad oedd barn yr ymgyngoreion statudol yn cael eu casglu'n rheolaidd i gefnogi'r broses o drin cleifion yn feddygol a awdurdodwyd gan y meddyg a benodwyd i roi ail farn.

Trefniadau archwilio a llywodraethu

Drwy gydol ein hymweliadau, rydym yn ystyried trefniadau byrddau iechyd a darparwyr gofal iechyd annibynnol ar gyfer archwilio a llywodraethu'r broses o fonitro'r Ddeddf Iechyd Meddwl. Yn ystod tri o'n hymweliadau monitro, gwnaethom nodi problemau o ran archwilio a goruchwylio'r broses o lywodraethu'r Ddeddf Iechyd Meddwl.

Mae'r canfyddiadau yn yr adran hon o'r adroddiad yn dangos bod angen i fyrddau iechyd a darparwyr annibynnol sicrhau bod proses archwilio a llywodraethu gadarn ar waith.

7. Gwasanaeth Adolygu ar gyfer Iechyd Meddwl

Mae gan y Gwasanaeth Adolygu ar gyfer Iechyd Meddwl nifer o swyddogaethau allweddol a gaiff eu hystyried yn yr adran hon o'r adroddiad. Rôl allweddol y Gwasanaeth Adolygu yw monitro sut mae gwasanaethau'n arfer eu pwerau ac yn cyflawni eu dyletswyddau o dan Ddeddf Iechyd Meddwl 1983 a gweinyddiaeth y gwasanaeth Meddygon a Benodwyd i Roi Ail Farn. Rydym yn gwneud y gwaith hwn ar ran Gweinidogion Cymru er mwyn diogelu buddiannau pobl y mae eu hawliau wedi cael eu cyfyngu o dan y Ddeddf.

Mae ein Gwasanaeth Adolygu ar gyfer Iechyd Meddwl hefyd yn cynnal adolygiad o Adran 61 a marwolaeth unrhyw gleifion sy'n cael eu cadw yn y GIG. Gallwn hefyd ymchwilio i fathau penodol o gwynion, a siarad â chleifion sy'n cael eu cadw, rheolwyr ysbytai a staff eraill am faterion sy'n effeithio ar ofal a thriniaeth unigolion sy'n cael eu cadw.

Y Gwasanaeth Meddygon a Benodwyd i Roi Ail Farn

Mae meddygon a benodwyd i roi ail farn yn wasanaeth hollbwysig i amddiffyn hawliau cleifion sy'n cael eu cadw o dan y Ddeddf ac nad ydynt yn cydsynio, neu yr asesir na allant gydsynio, i'r driniaeth sydd wedi cael ei rhagnodi ar gyfer eu salwch meddwl.

Mae meddyg a benodwyd i roi ail farn yn ymarferydd meddygol cofrestredig annibynnol, a benodir gan AGIC, a all gymeradwyo mathau penodol o driniaeth. Rôl y meddyg hwn, o dan rannau 4 a 4A o'r Ddeddf, yw darparu mesur diogelu ychwanegol i amddiffyn hawliau cleifion unigol.

Mae triniaethau penodol yn galw am gydsyniad y claf ac ail farn o dan Adran 57 o'r Ddeddf. Mae Adran 57 yn gymwys i driniaethau mewnwthiol fel seicolawdriniaeth neu fewnblaniadau llawfeddygol at ddiben lleihau ysfa rywiol dynion.

Yn ogystal, mae angen cael ail farn mewn perthynas â chleifion o unrhyw oedran sy'n cael eu cadw ac nad ydynt yn cydsynio, neu nad oes ganddynt y galluedd i gydsynio, i feddyginiaeth (Adran 58) a therapi electrogynhyrfol (ECT) (Adran 58A) a ragnodir ar gyfer anhwylder meddyliol. Rhaid cael ail farn gan feddyg a benodwyd i roi ail farn ar gyfer pob claf o dan 18 oed, gan gynnwys y rhai nad ydynt yn cael eu cadw, ac y cynigir y dylid rhoi ECT iddynt.

Mae gan feddygon a benodwyd i roi ail farn gyfrifoldeb i sicrhau bod y driniaeth arfaethedig yn briodol, er budd pennaf y claf, a bod safbwyntiau a hawliau'r claf wedi cael eu hystyried. Os bydd yn fodlon bod hynny wedi digwydd, bydd y meddyg a benodwyd i roi ail farn yn rhoi tystysgrif statudol sy'n darparu'r awdurdod cyfreithiol i roi'r driniaeth.

Mae'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn yn gweithredu fel gwasanaeth hybrid. Mae ein methodoleg wedi'i nodi'n fanwl yn ein canllawiau i feddygon a benodwyd i roi ail farn ac mae ar gael i holl Weinyddwyr y Ddeddf Iechyd Meddwl ar ein gwefan. Rydym hefyd yn llunio taflen gwybodaeth i gleifion, sydd hefyd ar gael er ein gwefan, er mwyn i bob claf ddeall ei hawliau a rôl y gwasanaeth Meddygon a Benodwyd i Roi Ail Farn.

Eleni, gwnaethom ddiwygio ein methodoleg er mwyn ymgorffori a manteisio'n llawn ar fuddiannau'r fethodoleg hybrid sydd wedi bod ar waith ers 2021. Un o'r prif newidiadau rydym wedi ei wneud yw y dylid cynnal ymweliadau meddygon a benodwyd i roi ail farn yn bersonol at ddibenion cyfweld â chlaf. Fodd bynnag, mewn

achosion penodol, sef rhai Gorchymyn Triniaeth Gymunedol, rydym wedi dewis methodoleg o bell yn gyntaf. Bydd y tîm clinigol dan sylw yn ymgynghori â phob claf cyn i geisiadau gael eu cyflwyno er mwyn cadarnhau ei fod yn fodlon i'w achos Gorchymyn Triniaeth Gymunedol gael ei drin ar sail o bell y gyntaf. Ym mhob achos, mae cleifion yn cadw'r hawl i wneud cais penodol am ymweliad ar y safle gan feddyg a benodwyd i roi ail farn. Mae ein ffurflenni wrthi'n cael eu diweddaru i adlewyrchu'r newidiadau hyn a byddant yn cael eu cyhoeddi yn ystod haf 2024. Rydym hefyd yn diwygio ac yn ailddrafftio ein cyfres o ganllawiau a phecynnau cymorth ar bob mater yn ymwneud â'r Gwasanaeth Adolygu ar gyfer Iechyd Meddwl, gan gynnwys y gwasanaeth Meddygon a Benodwyd i Roi Ail Farn. Rydym wrthi'n ymgynghori â rhanddeiliaid allanol ar y diwygiadau hyn ac yn bwriadu cyhoeddi ein cyfres o ganllawiau a phecynnau cymorth diwygiedig ar ein gwefan yn ddiweddarach yn y flwyddyn.

Ym mhob achos, mae'n rhaid i'r meddyg a benodwyd i roi ail farn arfer ei farn a'i ddisgresiwn proffesiynol a bydd yn gwneud hynny i ystyried a yw'n bosibl ardystio yn ddiogel ac yn hyderus mewn achosion o bell, a dylid bob amser gofnodi'r dull o gyfweld â'r claf fel rhan o'r rhesymau ar ei ffurflenni tystysgrif gydsynio.

Mae cyngor llawn ar ein methodoleg ar gael ar ein gwefan ac mae wrthi'n cael ei ddiweddaru i adlewyrchu'r newidiadau rydym wedi'u gwneud yn 2023-24.

Recriwtio meddygon a benodwyd i roi ail farn

Rydym bellach wedi penodi Meddyg Arweiniol a Benodwyd i Roi Ail Farn ac yn bwriadu penodi Dirprwy Feddyg Arweiniol a Benodwyd i Roi Ail Farn yn gynnar yn 2025. Rydym yn parhau i benodi meddygon a benodwyd i roi ail farn ychwanegol i atgyfnerthu'r gwasanaeth ymhellach.

Gweithgarwch meddygon a benodwyd i roi ail farn

Rhwng mis Ebrill 2023 a mis Mawrth 2024, cafodd y Gwasanaeth Adolygu ar gyfer Iechyd Meddwl 733 o geisiadau am ymweliad gan feddyg a benodwyd i roi ail farn. Mae'r ffigur hwn yn gynnydd o gymharu â'r ceisiadau a gafwyd rhwng mis Ebrill 2022 a mis Mawrth 2023.

Gellir dadansoddi'r ffigurau hyn fel a ganlyn:

- Roedd 665 o geisiadau yn ymwneud ag ardystio meddyginiaeth.
- Roedd 44 o geisiadau yn ymwneud ag ardystio ECT.
- Roedd 24 o geisiadau yn ymwneud â meddyginiaeth ac ECT.

Yn y tabl isod, mae'n ymddangos bod nifer y ceisiadau am ymweliad gan feddyg a benodwyd i roi ail farn wedi sefydlogi ar ôl cyrraedd lefel frig o 954 o ymweliadau yn 2019-20.

Ceisiadau am ymweliadau gan feddyg a benodwyd i roi ail farn, 2006-07 i 2023-24[1]

Blwyddyn	Meddyginiaeth	ECT	Meddyginiaeth ac ECT	Cyfanswm
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694
2023-24	665	44	24	733

1 Ffynhonnell: Ceisiadau am feddyg a benodwyd i roi ail farn a wnaed i AGIC

Asesiadau amserol gan feddygon a benodwyd i roi ail farn

Er mwyn sicrhau bod cleifion yn cael gofal a thriniaeth briodol, mae'n bwysig iawn bod asesiad y meddyg a benodwyd i roi ail farn yn cael ei gwblhau'n brydlon. Felly, datblygwyd tri dangosydd perfformiad allweddol, ynghyd ag amserlenni manwl, i sicrhau bod asesiadau'n cael eu cwblhau cyn gynted â phosibl, ac o fewn:

- Dau ddiwrnod gwaith ar gyfer atgyfeiriad yn ymwneud ag ECT.
- Pum diwrnod gwaith ar gyfer atgyfeiriadau yn ymwneud â meddyginiaeth a ragnodwyd pan fydd y claf yn yr ysbyty.
- Seg diwrnod gwaith pan fydd yr atgyfeiriad yn ymwneud â rhywun sy'n destun Gorchymyn Triniaeth Gymunedol.

Mae nifer o resymau pam nad ydym yn bodloni terfynau amser o bryd i'w gilydd, gan gynnwys argaeledd y Clinigydd Cyfrifol neu'r Ymgyngoreion Statudol y mae'n rhaid i'r meddyg a benodwyd i roi ail farn ymgynghori â nhw. Yn ogystal, mae'r gofyniad i gyflwyno'r holl ddogfennau perthnasol i'r meddyg a benodwyd i roi ail farn cyn yr ymgyngoriadau wedi parhau i gynnal y gwelliannau i amseroldeb y broses asesu. Fodd bynnag, mae oedi'n digwydd weithiau am nad yw'r claf ar gael, neu am nad oedd yn glir a oedd y claf am gael ei gyfweld gan y meddyg a benodwyd i roi ail farn ai peidio.

Mae'n rhaid ailbwysleisio bod ein canllawiau, yn gyntaf oll, yn nodi y dylid cynnig cyfweliad wyneb yn wyneb i bob claf, oni bai bod y claf yn nodi ei fod yn fodlon cael ymgynghoriad o bell, neu y byddai'n well ganddo wneud hynny. Erys anawsterau wrth asesu dewisiadau cleifion ac rydym yn bwriadu ymgynghori â rhanddeiliaid perthnasol, yn benodol Gweinyddwyr y Ddeddf Iechyd Meddwl ym mhob lleoliad er mwyn ceisio sicrhau ein bod yn gwella'r broses hon y flwyddyn nesaf.

Adolygiad o driniaeth (Adran 61)

Ar ôl i ymarferydd meddygol awdurdodedig (meddyg a benodwyd i roi ail farn) sydd wedi cael ei benodi gan AGIC awdurdodi cynllun triniaeth, rhaid i'r clinigydd sy'n gyfrifol am driniaeth y claf ddarparu adroddiad ar y driniaeth a chyflwr y claf i AGIC. Darperir y ffurflen benodedig i swyddfa gweinyddwyr y Ddeddf Iechyd Meddwl ar gyfer pob bwrdd iechyd lleol a lleoliad annibynnol er mwyn i'r Clinigydd Cyfrifol ei llenwi. Am yr wythfed flwyddyn yn olynol, archwiliodd AGIC y ffurflenni hyn er mwyn sicrhau bod mesurau digonol ar waith i ddiogelu cleifion. Caiff y triniaethau eu hadolygu'n fisol gan ein meddyg arweiniol a benodwyd i roi ail farn yng Nghymru fel mater o drefn. Rydym yn categoreiddio ac yn nodi unrhyw faterion o ran cydymffurfiaeth ac yn defnyddio'r wybodaeth hon i nodi tueddiadau ac anghysondebau o ran gweinyddu Deddf Iechyd Meddwl 1983. Bwriedir i'r broses hon ychwanegu haen ychwanegol o ddiogelwch i'r cleifion hynny sy'n cael eu trin o dan y Ddeddf ac mae'n bodloni'r gofynion a osodir ar AGIC fel y'u hamlinellir yn y Cod Ymarfer (Cymru) a ddiwygiwyd yn 2016.

Erys nifer bach iawn o achosion lle y caiff anghysondebau eu nodi gan yr adolygydd. Mae gwelliannau pellach o'n hadroddiad blaenorol i'w gweld o hyd yn y meysydd canlynol:

- Mae nifer bach o achosion o hyd lle y caiff mwy o feddyginiaeth ei rhestru o dan y disgrifiad o'r driniaeth na'r hyn a awdurdodwyd ar y ffurflen CO3[1]. Yn yr achosion hyn, mae'r adolygydd yn pwysleisio bod angen i'r lleoliad gyflwyno cais am feddyg a benodwyd i roi ail farn, gan arwain at nifer o geisiadau newydd am ardystiad gan feddyg a benodwyd i roi ail farn.
- Erys mân anghysondebau mewn perthynas â materion cymhleth yn ymwneud â chyfeiriad y claf fel y'i rhestrir ar y ffurflenni tystysgrif gydsynio. Mae hyn yn ymwneud yn bennaf â'r rhai nad oes ganddynt gartref sefydlog. Mae AGIC wedi llunio canllawiau i weinyddwyr y Ddeddf Iechyd Meddwl mewn perthynas â hyn er mwyn lleihau nifer yr achosion hyn.

8. Ein Data

I baratoi'r adroddiad hwn gwnaethom ddadansoddi data o'n gwaith rhwng mis Ebrill 2022 a mis Mawrth 2023, gan gynnwys ein gweithgareddau monitro o dan y Ddeddf Iechyd Meddwl a'n harolygiadau o wasanaethau gofal iechyd meddwl a gwasanaethau i bobl ag anableddau dysgu ac awtistiaeth. Hefyd, gwnaethom ddadansoddi pryderon a godwyd â ni gan gleifion, perthnasau, staff a'r cyhoedd, a data hysbysiadau statudol a gyflwynwyd gan ddarparwyr annibynnol gwasanaethau gofal iechyd meddwl ac anableddau dysgu.

Adborth ar yr adroddiad hwn

Os oes gennych unrhyw sylwadau neu ymholiadau am y cyhoeddiad hwn, cysylltwch â ni

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Atodiad A

Gwaith perthnasol 2022-23

	Ysbyty	Dyddiad	Math
Byrddau Iechyd			
1	Uned Asesu a Thrin, Bwrdd Iechyd Prifysgol Abertawe	17 - 19 Ebrill 2023	Arolygiad
2	Uned Hergest, Bwrdd Iechyd Prifysgol Betsi Cadwaladr	15 - 17 Mai 2023	Arolygiad
3	Ward F, Ysbyty Castell-nedd Port Talbot Bwrdd Iechyd Prifysgol Bae Abertawe	22 - 24 Mai 2023	Arolygiad
4	Tŷ Llewelyn, Ysbyty Bryn y Neuadd, Bwrdd Iechyd Prifysgol Betsi Cadwaladr	3 - 5 Gorffennaf 2023	Arolygiad
5	Uned Ablett, Ysbyty Glan Clwyd, Bwrdd Iechyd Prifysgol Betsi Cadwaladr	17 - 19 Gorffennaf 2023	Arolygiad
6	Ward Cedar Parc, Ysbyty'r Tri Chwm, Bwrdd Iechyd Prifysgol Aneurin Bevan	7 - 9 Awst 2023	Arolygiad
7	Tŷ Llidiard Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	11 - 13 Medi 2023	Arolygiad
8	Clinig Caswell, Bwrdd Iechyd Prifysgol Bae Abertawe	11 - 13 Medi 2023	Arolygiad
9	Canolfan Bro Cerwyn, Ysbyty Llwynhelyg, Bwrdd Iechyd Prifysgol Hywel Dda	16 - 18 Hydref 2023	Arolygiad
10	Clinig Angelton, Ysbyty Glanrhyd, Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	13 - 15 Tachwedd 2023	Arolygiad
11	Ysbyty Brenhinol Morgannwg, Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	20 - 22 Tachwedd 2023	Arolygiad

Ysbyty		Dyddiad	Math
12	Tîm Iechyd Meddwl Cymunedol Nant y Glyn, Bwrdd Iechyd Prifysgol Betsi Cadwaladr	23 a 24 Ionawr 2024	Arolygiad
13	Ward Talygarn, Ysbyty'r Sir, Bwrdd Iechyd Prifysgol Aneurin Bevan	5 - 7 Chwefror 2024	Arolygiad
14	Arolygiaeth Gofal Cymru (AGC) ac Arolygiaeth Gofal Iechyd Cymru (AGIC) – Arolygiad o Dîm Anableddau Dysgu Cymunedol Cyngor Bwrdeistref Sirol Rhondda Cynon Taf/Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg/Bwrdd Iechyd Prifysgol Bae Abertawe.	13-15 Chwefror 2024	Arolygiad
Darparwyr Gofal Iechyd Annibynnol			
15	Tŷ Cwm Rhondda	17 - 19 Ebrill 2023	Arolygiad
16	Ysbyty Hillview	9 a 10 Mai 2023	Arolygiad
17	Ysbyty Annibynnol St David's	19 - 21 Mehefin 2023	Arolygiad
18	Ysbyty Aber-bîg	10 - 12 Gorffennaf 2023	Arolygiad
19	Ysbyty Iechyd Meddwl Rushcliffe, Aberdâr	25 - 27 Medi 2023	Arolygiad
20	Ysbyty Neuadd Tŷ Gwyn l	2 - 4 Hydref 2023	Arolygiad
21	Ysbyty Annibynnol New Hall	24 - 26 Hydref 2023	Arolygiad
22	Tŷ Grosvenor	6 - 8 Tachwedd 2023	Arolygiad
23	Ysbyty Heatherwood Court, Ffordd Llantrisant, Pontypridd	4 - 06 December 2023	Arolygiad
24	Ysbyty Priory Caerdydd	8 - 10 Ionawr 2024	Arolygiad
25	Ysbyty St Peter	26 - 28 Chwefror 2024	Arolygiad
26	Ysbyty Coed Du Hall	25 - 27 Mawrth 2024	Arolygiad

Atodiad B: Rhestr Termau

Eiriolaeth	Help a chefnogaeth annibynnol i ddeall materion a chymorth i fynegi eich safbwyntiau, eich teimladau a'ch syniadau eich hun. Gweler hefyd eiriolwr iechyd meddwl annibynnol.
Clinigydd Cymeradwy	Gweithiwr iechyd meddwl cymeradwy sydd wedi'i gymeradwyo gan Weinidogion Cymru (neu'r Ysgrifennydd Gwladol) i weithio fel clinigydd cymeradwy at ddibenion y Ddeddf. Yn ymarferol, mae byrddau iechyd lleol yn gwneud y penderfyniadau hyn ar ran Gweinidogion Cymru. Dim ond pobl sy'n glinigwyr cymeradwy a all wneud rhai penderfyniadau o dan y Ddeddf. Rhaid i glinigydd cyfrifol fod yn glinigydd cymeradwy.
Asesiad	Archwilio claf i benderfynu a oes gan y claf anhwylder meddyliol ac, os felly, pa driniaeth a gofal sydd eu hangen arno. Caiff ei ddefnyddio hefyd fel modd o archwilio neu gyfweld â chlaf er mwyn penderfynu a ddylid gwneud cais i'w gadw neu gais am warcheidiaeth.
Galluedd	Y gallu i wneud penderfyniad am fater penodol ar yr adeg y mae angen gwneud y penderfyniad hwnnw. Efallai na fydd gan rai pobl alluedd meddyliol i wneud penderfyniad penodol am na allant ddeall, cofio na phwyso a mesur y wybodaeth sy'n berthnasol i'r penderfyniad. Ceir Fdiffiniad cyfreithiol o ddiffyg galluedd ar gyfer pobl sy'n 16 oed a throsodd yn Adran 2 o Ddeddf Galluedd Meddyliol 2005.
Deddf Safonau Gofal 2000	Deddf Seneddol sy'n darparu fframwaith deddfwriaethol ar gyfer darparwyr gofal annibynnol
Ffurflen CO2	Tystysgrif cydsynio i driniaeth (Adran 58(3) (a))
Ffurflen CO3	Tystysgrif ail farn (Adran 58(3) (b))
Ffurflen CO7	Tystysgrif priodoldeb triniaeth i'w rhoi i glaf yn y gymuned
Ffurflen CO8	Tystysgrif cydsynio i driniaeth ar gyfer claf yn y gymuned

Gorchymyn Triniaeth Gymunedol	Awdurdodiad ysgrifenedig ar ffurflen ragnodedig i ryddhau claf o gyfnod cadw mewn ysbyty i driniaeth dan oruchwyliaeth yn y gymuned. Mae'n ffordd o alluogi unigolion sy'n cael eu cadw mewn ysbyty ar gyfer triniaeth (o dan adran tri o'r Ddeddf neu bŵer cyfatebol o dan ran tri heb gyfyngiadau) i gael eu rhyddhau o'r ysbyty er mwyn cael gofal a thriniaeth fwy priodol gartref neu mewn lleoliad cymunedol. Pan fydd gan unigolyn Orchymyn Triniaeth Gymunedol, gall yr ysbyty sy'n ei ryddhau adalw'r claf i'r ysbyty am hyd at 72 awr, ac ar ôl hynny gellir ei ryddhau'n ôl i'r gymuned, ei dderbyn i'r ysbyty'n anffurfiol neu ddiddymu'r Gorchymyn ac ailgyflwyno'r trefniadau cadw blaenorol.
Triniaeth Orfodol	Triniaeth feddygol ar gyfer anhwylder meddyliol a roddir o dan y Ddeddf
Cydsyniad	Cytuno i ganiatáu i rywun arall wneud rhywbeth i chi neu ar eich rhan, yn enwedig cydsynio i driniaeth.
Amddifadu o Ryddid	Term a ddefnyddir yn Erthygl 5 o'r Confensiwn Ewropeaidd ar Hawliau Dynol i olygu'r amgylchiadau pan benderfynir y dylai person golli ei ryddid. Mae ei ystyr yn ymarferol wedi cael ei ddatblygu drwy gyfraith achosion.
Trefniadau Diogelu wrth Amddifadu o Ryddid	Y fframwaith o drefniadau diogelu o dan y Ddeddf Galluedd Meddyliol i bobl y mae angen eu hamddifadu o'u rhyddid er eu budd pennaf er mwyn rhoi gofal neu driniaeth iddynt nad oes ganddynt y galluedd i gydsynio iddynt eu hunain.
Claf sy'n cael ei gadw	Oni nodir yn wahanol, claf a gaiff ei gadw yn yr ysbyty o dan y Ddeddf, neu a allai gael ei gadw yn yr ysbyty ond nad yw yn yr ysbyty ar hyn o bryd (am ryw reswm).
Cadw	Oni nodir yn wahanol, cael eich cadw yn orfodol yn yr ysbyty o dan y Ddeddf am gyfnod er mwyn cael eich asesu neu gael triniaeth ar gyfer anhwylder meddyliol. Cyfeirir ato weithiau fel “gorfodi i gadw ar wahân” neu “wedi'i orfodi i'w gadw ar wahân” (sectioning/sectioned yn Saesneg)
Rhyddhau	Oni nodir yn wahanol, penderfyniad na ddylai claf gael ei gadw mwyach, cael triniaeth gymunedol dan oruchwyliaeth, bod o dan warcheidiaeth neu fod wedi'i ryddhau'n amodol. Mae rhyddhau claf o gyfnod cadw yn wahanol i ryddhau claf o'r ysbyty. Gall claf fod wedi gadael yr ysbyty'n barod neu gall gytuno i aros yn yr ysbyty fel claf anffurfiol.
Meddyg	Ymarferydd meddygol cofrestredig.
Therapi Electrogynhyrfol (ECT)	Math o driniaeth feddygol ar gyfer anhwylder meddyliol sy'n ysgogi ffitiau drwy basio trydan drwy ymennydd claf dan anaesthetig; caiff ei defnyddio fel triniaeth ar gyfer iselder difrifol fel arfer.

Gwarcheidiaeth	Penodi gwarcheidwad i helpu a goruchwylio cleifion yn y gymuned er eu lles eu hunain neu i amddiffyn pobl eraill. Y gwarcheidwad fydd yr awdurdod gwasanaethau cymdeithasol lleol neu rywun arall sydd wedi'i gymeradwyo gan yr awdurdod hwnnw (gwarcheidwad preifat).
AGIC	Arolygiaeth Gofal Iechyd Cymru yw arolygiaeth a rheoleiddiwr annibynnol gofal iechyd yng Nghymru.
Rheolwyr ysbytai	Y sefydliad (neu'r unigolyn) sy'n gyfrifol am roi'r Ddeddf ar waith mewn ysbyty penodol (e.e., Ymddiriedolaeth GIG neu Fwrdd Iechyd) Mae gan reolwyr ysbytai swyddogaethau amrywiol o dan y Ddeddf, gan gynnwys y pŵer i ryddhau claf. Yn ymarferol, caiff y rhan fwyaf o benderfyniadau rheolwyr ysbytai eu gwneud ar eu rhan gan unigolion (neu grwpiau o unigolion) sydd wedi'u hawdurdodi gan y rheolwyr i wneud hynny. Gall hyn gynnwys staff clinigol.
Eiriolwr Galluedd Meddyliol Annibynnol	Rhywun sy'n cynrychioli ac yn rhoi cymorth i berson nad oes ganddo'r galluedd i wneud penderfyniadau penodol, os nad oes gan y person hwnnw unrhyw un arall i'w gefnogi. Mae gwasanaeth eiriolwyr galluedd meddyliol annibynnol wedi'i sefydlu o dan y Ddeddf Galluedd Meddyliol. Mae'n wahanol i wasanaeth eirioli arferol neu wasanaeth eiriolwr iechyd meddwl annibynnol.
Claf anffurfiol	Rhywun sy'n cael ei drin am anhwylder meddyliol yn yr ysbyty ac nad yw wedi'i gadw o dan y Ddeddf; fe'i gelwir weithiau hefyd yn glaf gwirfoddol.
Anabledd dysgu	Yn y Ddeddf, mae anabledd dysgu yn golygu bod ataliad yn natblygiad y meddwl neu fod datblygiad y meddwl yn anghyflawn, sy'n cynnwys nam sylweddol o ran deallusrwydd a gweithrediaeth gymdeithasol. Mae'n fath o anhwylder meddyliol at ddibenion y Ddeddf.
Absenoldeb gyda chaniatâd (absenoldeb adran 17)	Caniatâd ffurfiol i glaf sy'n cael ei gadw yn yr ysbyty fod yn absennol o'r ysbyty am gyfnod o amser; mae'r claf o dan bwerau'r Ddeddf o hyd pan fydd yn absennol a gall gael ei adalw i'r ysbyty, os oes angen, er budd ei iechyd neu ddiogelwch neu er mwyn amddiffyn pobl eraill. Cyfeirir ato weithiau fel 'Absenoldeb Adran 17'.
Claf a allai gael ei gadw (Liable to be detained)	Mae'r term hwn yn cyfeirio at unigolion a allai gael eu cadw yn gyfreithlon ond nad ydynt, am ryw reswm, yn cael eu cadw ar hyn o bryd
Deunydd clymu	Deunydd clymu yw eitem neu eitemau y gellir eu defnyddio i gywasgu'r llwybrau anadlu, gan arwain at fygu a marwolaeth. Mae Asesiad Risg (Pwyntiau) Clymu yn nodi pwyntiau clymu posibl a'r camau y dylai'r darparwr gofal iechyd eu cymryd i symud neu reoli'r rhain er diogelwch cleifion

Tribiwnlys Adolygu Iechyd Meddwl	Mae Tribiwnlys Adolygu Iechyd Meddwl Cymru yn diogelu cleifion y mae eu rhyddid wedi cael ei gyfyngu o dan y Ddeddf Iechyd Meddwl. Mae'r Tribiwnlys yn adolygu achosion cleifion sy'n cael eu cadw yn yr ysbyty neu sy'n byw yn y gymuned o dan orchymyn rhyddhau amodol, triniaeth gymunedol neu warcheidiaeth.
Triniaeth feddygol	Yn y Ddeddf mae hyn golygu ystod eang o wasanaethau. Yn ogystal â'r math o ofal a thriniaeth a ddarperir gan feddygon, mae hefyd yn cynnwys nyrsio, therapïau seicolegol, ac ymyriadau iechyd meddwl arbenigol, adsefydlu, a gofal.
Triniaeth feddygol ar gyfer anhwylder meddyliol	Triniaeth feddygol, er mwyn lliniaru, neu atal yr anhwylder meddyliol, neu un neu fwy o'i symptomau neu arwyddion, rhag gwaethygu.
Deddf Galluedd Meddyliol 2005	Deddf Seneddol sy'n llywodraethu prosesau gwneud penderfyniadau ar ran pobl nad oes ganddynt alluedd, gan gynnwys pobl sy'n colli galluedd ar ryw adeg yn eu bywyd a phobl sydd wedi cael eu geni â chyflwr analluogi.
Salwch meddwl	Salwch sy'n effeithio ar y meddwl. Mae'n cynnwys cyflyrau cyffredin fel iselder a gorbryder a chyflyrau llai cyffredin fel sgitsoffrenia, anhwylder deubegynol, anorecsia nerfosa a dementia.
Tîm Amlddisgyblaethol	Tîm Amlddisgyblaethol yw grŵp o weithwyr proffesiynol o un neu fwy o ddisgyblaethau clinigol sy'n gwneud penderfyniadau ar y cyd ynghylch y triniaethau a argymhellir.
Claf	Person sy'n dioddef o anhwylder meddyliol neu sy'n ymddangos fel pe bai'n dioddef o anhwylder meddyliol. Nid yw'r ffaith bod y term yn cael ei ddefnyddio yn golygu ein bod yn argymell y dylai'r term 'claf' gael ei ffafrio uwchlaw termau eraill fel 'defnyddiwr gwasanaeth', 'cleient' neu derm tebyg. Dim ond adlewyrchiad o'r derminoleg a ddefnyddir yn y Ddeddf ei hun ydyw.
Corff rhagnodedig	Rôl person neu gorff rhagnodedig yw darparu mecanwaith i weithiwr gyflwyno ei ddatgeliad er lles y cyhoedd i gorff annibynnol os nad yw'r gweithiwr yn teimlo y gall ei ddatgelu'n uniongyrchol i'w gyflogwr a gall y corff fod mewn sefyllfa i gymryd rhyw fath o gamau pellach mewn perthynas â'r datgeliad.
Deddf Datgelu er Lles y Cyhoedd	Mae Deddf Datgelu er Lles y Cyhoedd 1998 yn rhoi diogelwch i "weithwyr" sy'n gwneud datgeliadau er lles y cyhoedd ac yn galluogi unigolion o'r fath i hawlio iawndal am erledigaeth yn dilyn datgeliadau o'r fath. Darparwyd mwy o ddiogelwch gan Ddeddf Menter a Diwygio Rheoleiddio 2013 a ddaeth i rym ym mis Gorffennaf 2013.

Galw'n ôl (ac wedi galw'n ôl)	Gofyniad i glaf sy'n ddarostyngedig i'r Ddeddf ddychwelyd i'r ysbyty. Gall fod yn gymwys i gleifion sy'n absennol â chaniatâd, neu sy'n cael triniaeth gymunedol dan oruchwyliaeth, neu sydd wedi cael eu rhyddhau'n amodol o'r ysbyty.
Rheoliadau	Is-ddeddfwriaeth a wnaed o dan y Ddeddf. Yn y rhan fwyaf o achosion, mae'n golygu Rheoliadau Iechyd Meddwl (Ysbyty, Gwarcheidiaeth, Triniaeth Gymunedol a Chydsynio i Driniaeth) (Cymru) 2008.
Diddymu	Defnyddir y term hwn i ddisgrifio'r broses o ddirymu GTG pan fydd angen i glaf sy'n cael triniaeth gymunedol dan oruchwyliaeth gael mwy o driniaeth yn yr ysbyty. Os caiff GTG claf ei ddirymu, caiff y claf ei gadw o dan yr un pwerau o'r Ddeddf a ddefnyddiwyd cyn i'r GTG gael ei wneud.
Clinigydd Cyfrifol	Y clinigydd cymeradwy â chyfrifoldeb cyffredinol dros achos y claf.
Claf dan gyfyngiadau	Claf Rhan 3 sydd, yn dilyn achos troseddol, yn cael gorchymyn cyfyngu o dan Adran 41 o'r Ddeddf, cyfarwyddyd cyfyngiad o dan Adran 45A neu gyfarwyddyd cyfyngiad o dan Adran 49. Caiff y gorchymyn neu'r cyfarwyddyd ei gyflwyno i droseddwr os yw'n ymddangos bod ei angen er mwyn diogelu'r cyhoedd rhag niwed difrifol. Un o effeithiau'r cyfyngiadau a gyflwynir gan yr adrannau hyn yw na all cleifion o'r fath gael cyfnodau o absenoldeb â chaniatâd na chael eu trosglwyddo i ysbyty arall heb gydsyniad yr Ysgrifennydd Gwladol dros Gyfiawnder, a dim ond Tribiwnlys Adolygu Iechyd Meddwl Cymru a all eu rhyddhau heb gytundeb yr Ysgrifennydd Gwladol.
Meddyg a Benodwyd i Roi Ail Farn (SOAD)	Meddyg annibynnol a benodir gan Gomisiwn y Ddeddf Iechyd Meddwl sy'n rhoi ail farn ar b'un a ddylai mathau penodol o driniaeth feddygol ar gyfer anhwylder meddyliol gael eu rhoi heb gydsyniad y claf
Adran 3	Mae Adran 3 o'r Ddeddf Iechyd Meddwl yn rhoi'r pŵer i gadw claf er mwyn ei drin mewn ysbyty am gyfnod o hyd at 6 mis i ddechrau. Gellir adnewyddu hyn am 6 mis arall ac yn flynyddol wedi hynny
Meddyg Adran 12	Gweler meddyg cymeradwy o dan Adran 12.
Adran 17A	Gorchymyn Triniaeth Gymunedol yw hwn
Adran 37	Gorchymyn ysbyty yw hwn, sy'n ddewis amgen i ddedfryd o garchar.
Adran 41	Mae hwn yn cyd-fynd â gorchymyn Adran 37 a dim ond Llys y Goron a all ddefnyddio Adran 37 (41). Rhaid bod gan y claf salwch meddwl sy'n golygu bod angen iddo gael triniaeth yn yr ysbyty. Gorchymyn cyfyngu yw Adran 41 ac fe'i defnyddir os ystyrir bod claf yn peri risg i'r cyhoedd.
Triniaeth Adran 57	Mae triniaethau Adran 57 yn golygu seicolawdriniaeth neu fewnblaniadau llawfeddygol i newid gweithrediad rhywiol gwrywaidd.

Adran 58 a 58A	Mae triniaethau Adran 58 yn cyfeirio at feddyginiaeth ar gyfer anhwylder meddyliol ac mae triniaethau Adran 58A yn cynnwys therapi electrogynhyrfol ar gyfer anhwylder meddyliol. Mae Rhan 4A o'r Ddeddf yn rheoleiddio'r math o driniaethau y gellir eu rhoi o dan Adran 58 a 58A i'r rhai sy'n cael triniaeth gymunedol.
Adran 61	Mae'r Adran hon yn darparu ar gyfer rhoi adroddiadau mewn perthynas â thriniaethau a roddir o dan Adrannau 57, 58, 58A neu 62B.
Adran 132	Mae'r Adran hon yn rhoi cyfrifoldeb ar reolwyr ysbytai i gymryd pob cam cyfrifol i sicrhau bod yr holl gleifion a gedwir yn cael gwybodaeth am eu hawliau
Adran 135	Mae Adran 135 yn rhoi pwerau mynediad i swyddog yr heddlu gan ddefnyddio gwarant a gafwyd gan Ynad Heddwch. Defnyddir y warant hon i gael mynediad at berson y credir bod ganddo anhwylder meddyliol nad yw mewn man cyhoeddus ac, os oes angen, ei symud i le diogel
Adran 136	Mae Adran 136 o'r Ddeddf yn caniatáu i unrhyw berson gael ei symud i le diogel (ystafelloedd Adran 136) os caiff ei ganfod mewn man cyhoeddus a'i fod yn ymddangos i swyddog yr heddlu ei fod yn dioddef anhwylder meddyliol a bod angen ei reoli a rhoi gofal iddo ar unwaith
Tystysgrif Meddyg a Benodwyd i Roi Ail Farn	Tystysgrif a roddir gan feddyg a benodwyd i roi ail farn sy'n cymeradwyo mathau penodol o driniaeth feddygol ar gyfer claf.
Ymgyngoreion Statudol	Mae'n ofynnol i feddyg a benodwyd i roi ail farn ymgynghori â dau berson (ymgyngoreion statudol) cyn rhoi tystysgrifau yn cymeradwyo triniaeth. Rhaid i un o'r ymgyngoreion statudol fod yn nyrs a rhaid bod y llall wedi chwarae rôl broffesiynol yn nhriniaeth feddygol y claf. Ni all y clinigydd sy'n gyfrifol am y driniaeth arfaethedig na'r clinigydd cyfrifol fod yn un o'r ymgyngoreion statudol.
Mesur Iechyd Meddwl (Cymru) 2010	Deddfwriaeth sy'n cynnwys pedair rhan wahanol. Rhan 1 – Gwasanaethau cymorth iechyd meddwl sylfaenol Rhan 2 – Cydgysylltu a chynllunio gofal ar gyfer defnyddwyr gwasanaethau iechyd meddwl eilaidd Rhan 3 – Asesiadau ar ddefnyddwyr blaenorol o wasanaethau iechyd meddwl eilaidd Rhan 4 – Eiriolaeth iechyd meddwl
Claf gwirfoddol	Gweler claf anffurfiol.
Gweinidogion Cymru	Gweinidogion yn Llywodraeth Cymru.

011. 03. HIW - Mental Health, Learning Disability, Hospitals and Mental Hea~

4.1 - HIW Mental Health Annual Report 2023-2024

Last modified: 05/03/2025

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Mental Health, Learning Disability, Hospitals and Mental Health Act Monitoring

Annual Report 2023-24

This report is also available in Welsh. If you would like a copy in an alternative language or format, please contact us.

Copies of all reports, when published, are available on our website or by contacting us:

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To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people.

Our values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective – we are reasoned, fair and evidence driven.

Decisive – we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive – we value and encourage equality and diversity through our work.

Proportionate – we are agile and we carry out our work where it matters most.

Our goal

To be a trusted voice which influences and drives improvement in healthcare.

Our priorities

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.

We will adapt our approach to ensure we are responsive to emerging risks to patient safety.

We will work collaboratively to drive system and service improvement within healthcare.

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

1. Executive Summary

This report sets out the activity and findings for mental health and learning disability services during the period April 2023 to March 2024.

The report provides an insight into the challenges faced by mental health and learning disability services including community services. However, in spite of these challenges, there are many positive findings and it is clear that the workforce is appreciated by patients and others, in their endeavour to continue to deliver care and treatment in a changing landscape.

We continue, in the majority of our inspections, to receive feedback from patients who are complimentary about the care provided and about their interactions with staff. HIW staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many examples of good practice within the monitoring and implementation of the Mental Health Act (MHA) including documentation which was well organised, easy to navigate and securely stored, and MHA administrators demonstrating good governance and oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful. On our inspections, there was good evidence that patients were aware of their rights, and this was well recorded. There had also been improvements with patient observations, with very few issues being identified within our individual reports.

However, as mentioned above some areas continue to cause concern for us, particularly where there has been little or no improvement since our previous report. Workforce challenges in relation to recruitment and retention of staff was a finding in a significant number of inspections and there were vacancies across a wide range of disciplines. Medicines management also continues to be a theme, and the specific issues identified are discussed within section 5 of this report.

Risk assessments and care planning also continue to be a significant finding in our inspections and one very worrying example was of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan which had only been partially completed.

In two of our inspections this year, we identified issues with the seclusion of patients and the provision of meaningful and therapeutic activities. The environment of care provision was also concerning and in a number of our visits, we identified patient and staff safety issues. In one example, patient call bells were not easily accessible which meant that patients who required assistance were not easily able to summon staff.

We have also detailed, within this report, specific findings in relation to our learning disability and Children & Adolescent Mental Health Services (CAMHS) inspections.

We also identified, in some of our inspections, a lack of a robust system of audit and governance in our mental health and learning disability inspections. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider.

In seven of our visits, we identified very serious issues which led us to issue immediate assurance letters for health boards, or non-compliance notices for independent providers. The health board/independent provider responds to these letters or notices with an immediate improvement plan that HIW must agree. We made use of these processes following three health board inspections and four inspections of independent providers.

Chapter 6 of this report identifies the process and areas we focus on to be assured that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues
- Older persons
- Learning Disabilities
- CAMHS

Within the total of 26 we jointly visited one Community Learning Disability Team (CLDT) with Care Inspectorate Wales (CIW). We also undertook one visit to a Community Mental Health Team (CMHT). Our findings are drawn from these inspections.

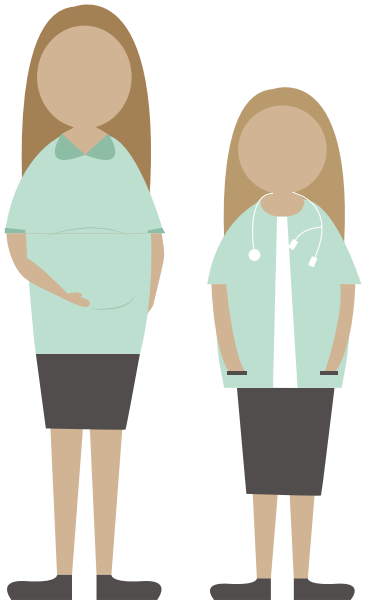
Overall, there were 199 complaints and concerns about mental health and learning disability healthcare services. This is an increase on the previous year from 164.

In addition, during the period April 2023 to March 2024, the Review Service for Mental Health (RSMH) received 733 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

665	requests related to the certification of medication
44	requests related to the certification of ECT
24	requests related to medication and ECT.

In conclusion, whilst we continue to identify areas of good practice the issues identified within this report are concerning and health boards and independent providers of healthcare need to improve upon their audit and governance processes to ensure that the areas identified are addressed.



2. Context

Throughout 2023-24 mental health and learning disability hospitals and community services faced many challenges in delivering services. Workforce challenges in the recruitment and retention of appropriately skilled, knowledgeable and trained staff in key disciplines continue to have a detrimental impact on the ability of health boards and independent providers to meet the needs of increasing numbers of patients who require care and treatment.

Patients continue to experience a lack of mental health support in a timely manner and when they are admitted to in-patient wards these are very busy places with extreme pressure on beds. Patients do not always have sufficient time with staff due to staffing pressures as outlined above.

In addition, in September 2023 we published the Improvement Plan – review of discharge arrangements for adult patients from inpatient health services in Cwm Taf Morgannwg University Health Board (CTMUHB). This followed the report itself which was published in March 2023 and contained a significant number of recommendations for the health board.

We continue to monitor the implementation of some key pieces of guidance and the Mental Health Act 1983 Code of Practice for Wales (revised 2016) and the Code of practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. The Mental Health Act 1983 Code of Practice for Wales is a key document to ensure patients' rights are promoted and protected. The Code provides a support framework that helps to ensure the delivery of care is evidenced-based and promotes effective care and treatment with the detained person at the centre of the decision-making process.

The SOAD service remains a hybrid model with a mixture of remote and face to face contact with patients who require a second medical opinion under the Act. However, our preference is for patients to be seen face to face but sometimes this is not possible. When a request for a SOAD is made there is still the requirement for health boards and independent providers to send key documentation to us to enable the SOAD to have access to key information in relation to the history and treatment for the patient.

We continue to work with a number of stakeholders for mental health and these stakeholders are listed within section 3 of this report. Following the end of Welsh Government's Together for Mental Health Delivery Plan in 2022, a new mental health strategy is expected from the Welsh Government to be in 2024.

3. Our role in mental health and learning disability care

HIW has a number of key roles within healthcare in Wales which are outlined below:

- we inspect all NHS mental health and learning disability services
- we are the regulator and inspectorate of all independent mental health and learning disability healthcare services
- we work with a number of key stakeholders
- we have a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers
- we provide a SOAD service
- we monitor parts 2 and 4 of the Mental Health (Wales) Measure 2010
- we monitor the implementation of the Deprivation of Liberty Safeguards (DoLS).

Inspection and regulation

NHS and Independent Healthcare

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduced a duty of quality. The Act places an overarching duty of quality on the Welsh Ministers regarding their health-related functions. The purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. Furthermore, HIW, on behalf of Welsh Ministers, considers the Health and Care Quality Standards when conducting reviews of, and investigation into, the provision of health care by and for NHS bodies under section 70 of the Health and Social Care (Community Health and Standards) Act 2003.

HIW is the registering body for all independent healthcare providers in Wales. We register, inspect, consider intelligence on complaints and concerns and enforce in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the 25 National Minimum Standards for Independent Health Care Services in Wales.

We made use of a combination of routine unannounced on-site hospital and focused inspections during 2023-24. The findings from these inspections are summarised in section 5 of this report. In addition, a list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring use of the Mental Health Act 1983

The Welsh Ministers have a duty to monitor how services discharge their powers and duties in relation to the Mental Health Act (MHA) 1983. This duty is undertaken by HIW on their behalf. We have a number of knowledgeable and experienced MHA reviewers who form part of the on-site inspection team. These reviewers monitor how the health boards and independent providers discharge their duties under the Act. Our MHA reviewers examine detention paperwork to ensure legal compliance and consult with the MHA administrators employed by Health Boards and independent providers, to gain an insight into how the Act is administered and the governance processes in place. We also have a specific role in relation to the investigation of complaints, specifically in regard to legal detention and compliance with the MHA and the associated Code of Practice. During our inspections we routinely review a number of key areas as outlined below:

MHA detention paperwork ensures patients are lawfully detained and well cared for.

The legal status of patients is appropriately recorded on documentation including on individual drug administration records.

Consent to treatment forms are completed in a timely manner.

patients are given respect for their qualities, abilities, and diverse backgrounds as individuals, and that their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds are taken into account.

Section 17 leave documentation contains conditions and outcomes and is routinely utilised when appropriate and to assist patients in their care/rehabilitation pathway.

The MHA Code of Practice for Wales (Revised 2016), that has been prepared and issued under section 118 of the MHA 1983 is being followed.

Detailed plans are made for patients before they are discharged from hospital and consider key area such as relapse indicators.

In general, the findings from our inspections of the processes and application of the MHA were positive, however, we did find a number of areas for improvement. Our findings for the period April 2023 to March 2024 are summarised in section 6 of this report.

Review Service for Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the MHA, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.

A review of treatment under Section 61 of the MHA. When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.

The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2023 and March 2024 is provided in section 7 of this report.

Monitoring the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 consists of four distinct parts:

Part 1 – Primary mental health support services

Part 2 – Coordination of, and care planning for, secondary mental health service users

Part 3 – Assessment of former users of secondary mental health services

Part 4 – Mental health advocacy.

During our inspections we routinely focus on individual patients' care and treatment plans and the areas as set out within section 18 of the Measure, namely:

- finance and money
- accommodation
- personal care and physical wellbeing
- education and training
- work and occupation
- parenting or caring relationships
- social, cultural or spiritual
- medical and other forms of treatment including psychological interventions ensure it for patients.

We also consider the role of the Care Coordinator and their level of engagement with the patients. Within section 5 of this report, we have detailed our findings on risk assessment and care planning where we consider various aspects of the Measure. We also consider the role and access for patients to advocacy services.

Monitoring use of the Deprivation of Liberty Safeguards

Each year, we jointly publish, with CIW, an annual report on the use of the Deprivation of Liberty Safeguards (DoLS). DoLS is a part of the Mental Capacity Act 2005. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024, but this did not happen and there is no revised date for its implementation. DoLS can be used when detention under the Mental Health Act 1983 is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM comprises of organisations from the four nations that make -up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), and His Majesty's Inspectorate of Constabulary in Scotland. Other members that HIW undertakes joint work with include, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

We attend NPM business meetings and HIW's representative is a member of the steering committee.

Youth Justice Services

In January and February 2024, HIW joined His Majesty's Inspectorate of Probation (HMI Probation) on the joint inspection of Conwy & Denbighshire Youth Justice Services (YJS). Key areas identified for improvement were for Betsi Cadwaladr University Health Board (BCUHB). Other inspectorates that participated in the joint inspection include, CIW, Estyn and HMICFRS. HIW's specific remit was to consider the services received by the YJS from a healthcare perspective. Key members of staff employed by the health board were interviewed as part of this process.

The improvements included for BCUHB to provide a designated number of hours of a CAMHS nurse and other CAMHS specialists available to the YJS. Clear delays were identified in young people having access to timely and an appropriate level of CAMHS support. In addition, there was lack of timely access to Speech and Language Therapy (SALT) services and the health board needed to undertake a governance and quality review of the support required for the YJS.

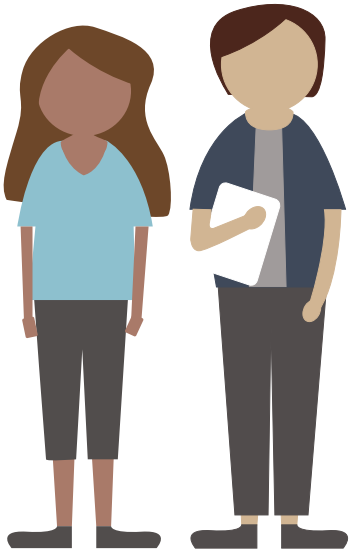
Prison Healthcare

In February 2024, HIW undertook a joint inspection of HMP Cardiff with HMI Prisons and other inspectorates including Estyn. The focus of these visits, from an HIW perspective, is to support the inspection of health services from a Welsh perspective. Generally, health services had improved since the last inspection, with 41% of prisoners telling the inspection team that the quality of the service was now good. In addition, services for prisoners with mental health problems had improved, with better access and a wider range of therapies than at the previous inspection. However, a number of key areas for improvement were identified as outlined below;

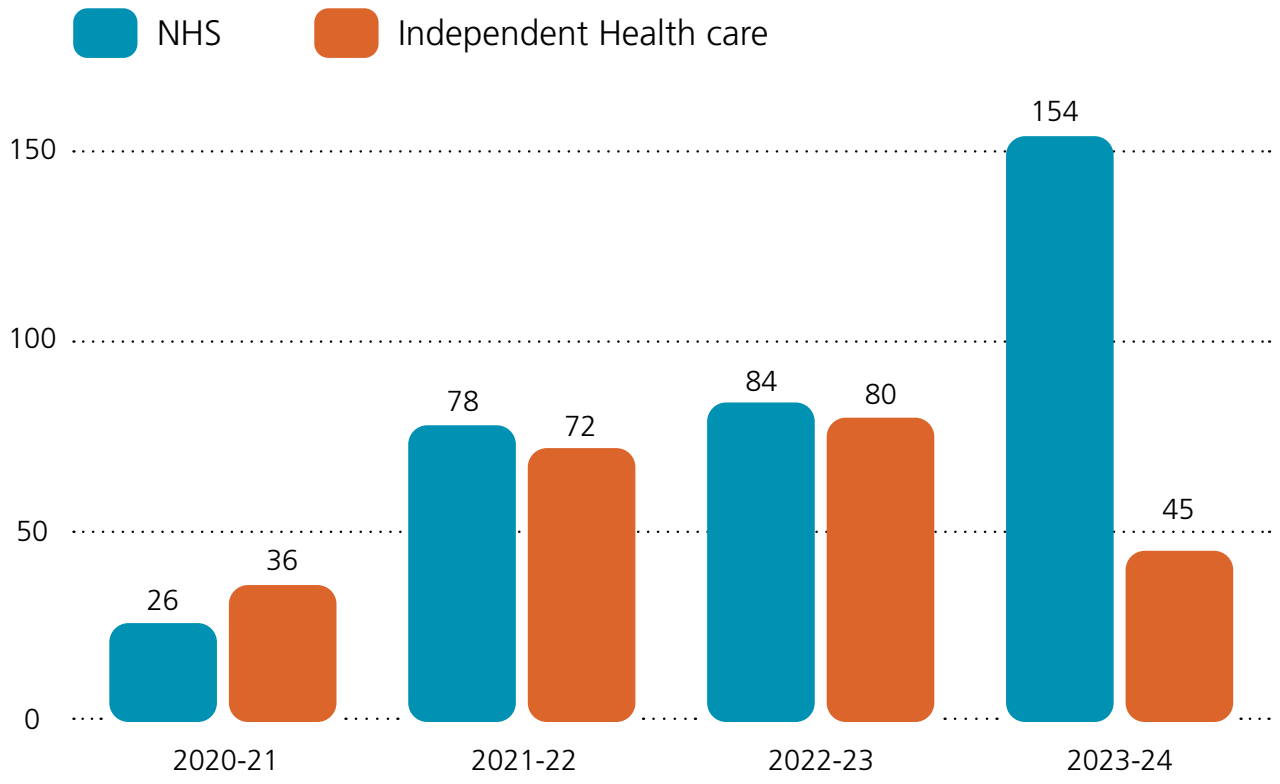
- There was inadequate oversight and planning of care for patients with long term conditions.
- Dental waits for urgent and emergency care were too long.
- Some pharmacy practices were not in line with good practice such as the management and use of stock medicines, secondary dispensing, and the lack of restrictions to drug storage areas.

Dementia Partners National Steering Group.

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). Within this group good practice initiatives are shared and the positive outcome for patients with a dementia and their significant others are identified. The health boards provide regional updates, within the group.



Number of patients contacting HIW with concerns and complaints about mental health care



4. Listening to concerns

During the period 1 April 2023 – 31 March 2024 we received:

614 complaints and concerns about healthcare providers in Wales, this is a reduction of 45

199 of these were about mental health and learning disability healthcare services. This is an increase on the previous year from 164

154 were in relation to NHS mental health and learning disability services and increase of 70

45 were in relation to independent mental health and learning disability services and this represents a decrease of 35.

The table below for 2023/24 shows a breakdown of concerns and complaints by their subject

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	12	2
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	15	3
Communication	9	2
Complaints Management	5	3
Consent & Confidentiality	5	0
Infrastructure (including staff facilities, environment)	19	11
Medication Management	16	4
Mental Health Act	12	4
Other	9	3
Records Management	13	0
Safeguarding	8	7
Self-harming Behaviour	5	3
Treatment/Procedure	16	2
Whistleblowing	6	5
Total	**150**	**49**

The highest number of concerns and complaints for the NHS was in relation to:

- Infrastructure (including staff facilities and the, environment). This concurs with our inspection findings in section 5 where infrastructure was identified in a considerable number of our on-site inspections.
- Medication management was also a key finding in our inspections and a range of issues were identified and these again can be located within section 5 of this report Treatment was also amongst the top concerns and again we have a considerable number of findings detailed within this report.
- The highest category of concerns and complaints for the Independent Healthcare providers was in relation to Infrastructure (including staff facilities and the environment). This demonstrates that both the NHS and independent providers of healthcare are having similar issues that can impact on patient care.

- Patients complain when there is a poor level of communication about their care and treatment pathway. Whilst it is acknowledged that there were only 11 concerns and complaints in relation to communication, elements of inadequate communication was also a theme in many of the other areas identified above.

Staff concerns

Whistleblowing is different to making a complaint or a grievance. A 'whistleblower' is somebody who makes a 'qualifying disclosure' about a concern at work. HIW is a 'prescribed body' under whistleblowing laws. This means that a whistleblower can make a 'qualifying disclosure' to us and will have certain employment protections under the Employment Rights Act 1996, which was amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA protects the public interest by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern, whether it is a concern about patient safety, safeguarding, financial malpractice, danger, illegality, or other wrongdoing.

Additional information in relation to whistleblowing can be found at **www.hiw.org.uk**.

This year we have seen a significant decrease (as outlined below) in the number of whistleblowers raising concerns with HIW compared to previous years It is difficult to explain this trend but maybe one explanation is that the health boards and independent providers have in place more effective whistleblowing procedures that has resulted in whistleblowers not contacting HIW because their whistleblowing concerns have adequately been addressed within the health boards and independent providers.

- 42 in 2020-21
- 15 in relation to NHS services
- 27 in relation to independent services
- 28 in 2021-22
- 10 in relation to NHS services
- 18 in relation to independent services
- 28 in 2022-23
- 18 in relation to NHS services
- 20 in relation to independent services
- 11 in 2023-24
- 6 in relation to NHS services
- 5 in relation to independent services.

Regulation 30 and 31 Notifications

The table below reflects the number of Regulation 30 and 31 notifications received between 1 April 2023 – 31 March 2024.
The registered person of an independent hospital, independent clinic, or independent medical agency is required by Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 to notify us of specific patient safety-related events.

This is required by law and includes:

- Death of a patient.
- Unauthorised absence of a patient who is detained or liable to be detained under the Mental Health Act 1983.
- Serious injury.
- Outbreak of an infectious disease.
- Alleged staff misconduct.
- Any request to a supervisory body, by the registered person, for a standard authorisation of a Deprivation of Liberty.

During the reporting period, we received 821 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was 81 less than the notifications received in 2022-23. The classification of the notifications were themed as shown in chart below.

Table of notification type for Regulation 30/31s

Notification Type	Total
Death of a Patient	9
Unauthorised Absence	140
Serious Injury	462
Outbreak of an Infectious Disease	22
Allegation of Staff Misconduct	161
Deprivation of Liberty	27
Total	**821**

There was a decrease in the number of serious injuries reported to us from the previous year, however, there was an increase from 100 to 140 of unauthorised absence notifications, for patients detained under the MHA, when compared to the previous year. We continue to identify an increase in the numbers of patients self-harming and this illustrates the level of complexity and acuity of patients accommodated within the independent sector. The range of issues identified within this report, such as a lack of staff, poor risk management plans and care and treatment plans as well as issues with patient observation may be contributory factors in relation to serious injury. HIW has increased communication with the independent sector around the completion of these notifications and there has been increased engagement from providers.

5. Inspecting mental health and learning disability healthcare services

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- CAMHS.

Within the total of 26 we visited one CMHT and jointly visited one CLDT with CIW.

During our onsite inspections we:

- Spoke with a number of patients and visitors to ascertain their thoughts on the quality of care and treatment provided.
- Spoke with a range of staff from multi-disciplinary teams to ascertain their thoughts on the effectiveness of their roles and how any challenges were overcome.
- Examined a range of care documentation, including risk assessments and how part 2 of the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the role of the Care Coordinators and other members of the multi-disciplinary team.
- We also examined a range of other patient documentation including, observational records, any records of restraints, and records of any seclusion undertaken.
- Considered if there was an effective discharge pathway in place and the arrangements put in place to ensure there was a crises management plan considered as part of the discharge process.
- Examined audit findings and governance processes.
- Considered the appropriateness of the environments of care, and ensured that risks had been identified and appropriate action taken to mitigate against those risks.
- Reviewed administration of the Mental Health Act and compliance with the Mental Health Code of Practice for Wales (2016).

A list of the health boards and independent registered providers we inspected is included as Appendix A, along with links to the reports of findings.

Our findings

Within this section our findings are broken down into three specific areas:

Findings specific to mental health, including older and younger persons and the CMHTs.

Findings specific to Learning Disabilities.

Findings specific to CAMHS.

The detailed findings are drawn from our reports following our onsite inspections carried out in 2023-24. Where HIW identifies significant issues we send immediate assurance letters for health boards, and non-compliance notices for the independent providers. These letters or notices are sent within two days of the inspections being undertaken. The health board/ independent provider responds to these with an immediate improvement plan that HIW must agree. We issued a total of seven letters or notices between the period 1 April 2023 and the 31 March 2024. This comprised of three for health boards and four for the independent providers.

Findings specific to mental health, including older and younger persons and the CMHTs

A positive finding in the vast majority of our inspections was the feedback from patients who were complimentary about the care provided and about their interactions with staff. Our staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many areas of good practice with the monitoring and implementation of the Mental Health Act (MHA) and these will be further explored within section 6 of this report.

Least restrictive care

This part of the report covers three distinct areas, restraint, seclusion and segregation. During our inspections we were not assured that the least form of restrictive practice was always being utilised and our findings are identified within the sections below.

Use of restraint

The MHA 1983 - Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. Section 26.7 states that "when making decisions about any interventions undertaken during the management of a patient's care and treatment, the principles set out in Chapter 1 of the Code must be taken into consideration. Decisions about interventions should be discussed and agreed with the patient as far as possible. Interventions may include prevention, observation, restraint and/or seclusion".

The guiding principles of the Code are:

- Dignity and respect.
- Least restrictive option and maximising independence.
- Fairness, equality and equity.
- Empowerment and involvement.
- Keeping people safe.
- Effectiveness and efficiency.

Restraint covers a number of key areas including, whether it is physical, chemical, environmental, or mechanical. Any form of restraint should always be a last resort when all other interventions have failed, a risk assessment and a comprehensive care and treatment plan must be in place for all incidents of restraint. Risk assessments must consider all triggers and alternative strategies to a restraint being undertaken.

In terms of mechanical restraint, the Code stipulates that HIW must be consulted if this is being considered. The use of mechanical restraint in hospitals is very rare but in the event it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patients' extreme challenging behaviour, whether that is violence directed at others or self-injury. This form of restraint, as with all restraints, must be regularly reviewed and be in place for the shortest possible period of time.

Any restraints undertaken must follow national guidelines and local policies and procedures and this area is considered within our inspection process. The Welsh Government published **guidance** (October 2022) on a framework for reducing restrictive practices in childcare, education, health and social care settings is a key document that covers the use of physical, chemical, environmental and mechanical restraint.

This guidance is considered within our inspection process.

In six of our inspections, we found issues with restraint, these issues included staff undertaking restraint who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training. Staff who have not received training in restraint pose a significant risk to patients and fellow staff and they should not be used in restraint until they have received the necessary training.

In addition, 'Use of Restrictive Physical Intervention' policies had not been reviewed in two of our inspections and were out of date. Also, on two inspections, we found that restraint incidents were not correctly recorded or could not be filtered to produce specific restraint data. Therefore, as a result, accurate restraint data was not available. and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents. We were not, therefore, assured that patients and staff were being fully protected from harm within these hospitals.

One patient record reviewed contained no descriptive details on what positions the patient and staff were in when utilising a safehold. In addition, there was nothing recorded for post intervention observations after the patient had received intramuscular medication.

Use of seclusion

The MHA1983, Code of Practice for Wales 2016, has a section dedicated to the use of seclusion. Seclusion is described within the Code as "the supervised confinement of a patient in a room which may be locked". It is interesting to note that the Code uses the term "may be locked", implying that it is possible for a patient to be secluded within a room behind a door that is closed but not locked. The Code also sets out timeframes for when continued seclusion should be reviewed, these are, "every two hours by two nurses" and "every four hours by a doctor, or a suitably qualified approved clinician". The Code also states that seclusion is used as a last resort and for the shortest possible time. Policies and procedures must be in place for the use of seclusion and should reflect the National Institute for Health and Care Excellence (NICE) and other guidelines.

In two of our inspections, we identified issues with seclusion including, a patient being secluded in a separate area of the ward. We looked at the arrangements in place to manage this patient and identified a number of concerns:

- The area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area.
- The separate toilet facility being used by the patient had not been adapted for high risk patients.
- We were concerned that the patient was not having access to regular periods of fresh air.
- There was no seclusion care plan in place for the patient which contravened the health board policy.
- We were informed that there were not enough resources available for patients in seclusion to participate in activities.

In another inspection, the policy on seclusion had not been reviewed within the identified timescales and was out of date.

Meaningful and therapeutic activities

Activities play an important part in the treatment process, and during our inspections we routinely review this area to ensure a range of meaningful and therapeutic activities are available. There is an abundance of published research that confirms

the importance of meaningful therapeutic, social and recreational activity and the positive impact this has on patient wellbeing and their recovery pathway.

In many of our inspections we found examples of appropriate and meaningful therapeutic activities available for the patients. However, in six of our inspections we found a range of issues including no evidence of a dedicated therapeutic patient activity programmes on wards, and no dedicated staff available to support and supervise off-ward patient activities. In one inspection we found that the gym equipment and exercise machines in the activities room were cordoned off with signs forbidding their use. Other issues identified included little evidence that the activities on offer were being delivered in the hospital nor recorded prominently within patient records, and a lack of funding for patient occupational activities and equipment. There were also issues with the outside spaces and their utilisation to provide additional therapeutic activities for patients.

We continued to identify issues with section 17 leave under the Mental Health Act, but these will be addressed within section 6, Monitoring the Mental Health Act, of this report.

Medication Management

Again, this year we continued to identify issues with the safe and effective administration, storage and ordering of medication. This area continues to be a recurring theme in the majority of our inspections. Out of 19 hospitals and one CMHT we identified issues with medicines management in 16 hospitals and the one CMHT. This is a reoccurring theme in our inspections and it is increasingly disappointing to note that there has been no improvement on this area since our last annual report. Issues identified covered many different aspects of medicines management with the most significant being:

- The Mental Health Act legal status section of the Medicine Administration Record (MAR) was consistently left blank.
- A lack of Consent to Treatments forms attached to MAR charts and a lack of regular reviews.
- Limited pharmacy input and audit activity undertaken.
- A lack of governance of medicines management.
- Medication trolleys were not locked and secure when not in use.
- Unused medical equipment including wound care equipment and syringes had been removed from their original boxes/containers and placed in plastic baskets that prevented the expiry date of each item being viewed.
- Multiply missing signatures on the MAR charts.
- Out of date controlled drugs in the controlled drugs cabinet.
- Medication policies out of date and a lack of staff access to policies.

The issues listed above are only examples of the issues identified within our visits; many more were identified. The range of findings do not demonstrate effective oversight, audit and governance of medicines management for both health boards and independent providers.

Risk assessment and care planning

Out of 19 hospitals and one CMHT we identified issues in 16 of the 20. A robust risk management process and a clear and accurate care planning process is key to ensure patients' care and treatment needs are identified and any risks identified and a strategy in place to address these risks. In terms of care and treatment plans, HIW has a specific responsibility in monitoring part 2 of

the Mental Health (Wales) Measure 2010. Part 2 of the Measure requires all patients receiving secondary mental health care to have a care and treatment plan in place. Care and treatment plans) should be comprehensive, holistic, and patient focused.

The role of the Care Coordinator is outlined within the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

In chapter 3 of the Code of Practice the responsibilities of the care coordinator is set out for the following areas:

- working collaboratively with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
- ensuring that a care and treatment plan is developed and written;
- ensuring care and treatment plans are reviewed and revised;
- providing advice to service providers on the effective coordination of the care which is delivered;
- keeping in touch with the relevant patient. The are coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

As identified above, care coordinators are key individuals, and their input is central to assisting the patient with their journey through secondary mental health services. This is another area that is assessed within our inspections.

During our inspections we also interview patients and staff to get an understanding of the effectiveness of the care and treatment plans. It was good to note some good practice examples for the care and treatment plans and risk assessments we considered as part of the inspection process. Some examples of good practice identified included, seeing evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, helping to support hospitals in being able to deliver comprehensive care to the patients. In addition, we found examples of well-organised records completed, which were easy to navigate through clearly marked sections. Information was being captured comprehensively within the records and they were appropriately and securely stored. We also found examples of patients being involved in the planning and provision of their own care, as far as possible, and where patients were unable to make decisions for themselves, we saw evidence that relatives were consulted. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- We saw an example of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan and that had only been partially completed.
- We were not assured that appropriate arrangements were in place to meet the physical health care needs of patients.
- We were not assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010.
- We did not find evidence within patient records that patients were being supported to meet their individual dietary needs.
- In one of our inspections, we found incorrect information on the current care and treatment plans for two patients.
- Care and treatment plans had not always been signed by the staff member undertaking the review and were not always dated.

- The electronic system (WICCIS) had limited recorded entries for the patient.
- There was no evidence of a Wales Applied Risk Research Network (WARRN) risk assessment being updated to reflect the patient's admission.
- No evidence of current care planning to address the risks and needs of the individual.
- The patients' voice was not always reflected in all of the care and treatment plans viewed. There was also a tendency for plans to be risk and needs focused rather than strengths based.
- A lack of a review of patient care and treatment plans to ensure that all relevant information is included in accordance with guidance and legislation.
- START risk assessments were not fully completed to ensure the safety of patients, staff and visitors and to plan future care.

The issues identified above cover a wide range of patient documentation and risk assessments. HIW is not assured that the risk and care and treatment plans are always effective in mitigating the risks associated with acutely unwell patients who may display challenging behaviour. It is vital that the individual health boards and independent health providers develop effective audits and governance processes to ensure all care and treatment plans and risk assessments are robust and assist in an effective care pathway for all patients.

Environment of care

We routinely undertake a tour of the wards to consider the appropriateness and safety of the areas that patients are accommodated within. We identified issues with the environment of care during seventeen of our nineteen hospital and one CMHT inspections. The issue of ligature risk assessments and availability of ligature cutters will be addressed within the staff and patient safety section below.

A range of other environmental issues were identified including, a lack of maintenance, redecoration and replacement of broken items. In addition, during one inspection, there were insufficient rooms available for Consultant Psychiatrists to hold confidential conversations with patients and in another inspection, there was mould and poor ventilation in shower rooms and toilets on all three wards. In another inspection there was a lack of handrails in the ward area and in bathrooms and in another inspection we were not assured there was an efficient process in place which ensured that outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.

Staff and patient safety

In all of our twenty inspections (nineteen hospitals and one CMHT) we identified a range of patient and staff safety issues. The issues identified covered a wide range of areas and some of the significant findings include:

- We noted throughout the inspection that staff were not wearing personal alarms or radios.
- No policy on the use of personal alarms was in place.
- Patient call bells were not easily accessible.
- We saw environmental examples of potential risks to patient safety as follows: glass damaged and boarded up and the electronic security of the door had been compromised.
- Ligature cutters were not available/easily accessible to all staff.
- Patient adverse reactions and venous thrombosis assessments were not being appropriately completed.

- Some ligature risks had been recommended for anti-ligature work in 2020 but still hadn't been completed.

Privacy and dignity of patients

Within this area we identified a number of issues including no privacy and dignity policy in place and patients could not freely access their bedrooms during the day. Significantly, during one inspection, we observed two instances compromising patient privacy: personal care given with bedroom doors open and a patient's room with a clear glass window and broken blinds. The window overlooked the nursing station of the ward and allowed light into the bedroom even with the blinds closed. This compromised patient privacy and dignity and posed a risk of potentially disturbing the patient.

Workforce

Significant workforce challenges persist across Wales. The picture is very mixed with some health boards and independent providers having more success than others with recruiting and retaining sufficient and well-trained staff. Staff shortages were affecting a range of disciplines including, medical staff, registered nurses, psychologists and occupational therapists. Staff shortages were having a detrimental effect on staff, and during one inspection, we were told that they felt that the current staffing template was not sufficient to support safe and effective care. In another inspection the comments from staff, and the difficulties we observed, raised doubts about whether the current staffing establishments were sufficient to provide safe and effective care to patients at all times.

In spite of extensive workforce challenges we continue to receive positive feedback from patients on staff attitudes and their willingness to assist patients on their care pathway. In addition, we continue to observe many positive interactions by a very busy workforce under pressure.

Workforce issues were identified in fourteen of the twenty inspections across a range of disciplines and some of these are outlined below:

- There were staffing vacancies for a range of disciplines including an activity coordinator. OT support worker, a dedicated consultant psychiatrist, a psychologist and a registered nurse.
- Staff told us that staffing levels had not been reviewed for some time and the environment, they were working in was becoming more challenging and complex. Some staff members felt that in general, their job was detrimental to their health.
- The Speech and Language Therapist (SALT) was completing telephone consultations with patients and had not visited the patients on the ward.
- We were told that staffing resources had not been reviewed to meet this increase in workload resulting from the number of service users diagnosed with ADHD being referred to the team and there was no workload management policy in place to support this.
- Staff told us that there was a lack of administrative support within the team to enable an effective service.

The above findings are only a sample of the range of issues that we identified during our inspection visits. The healthcare sector continues to experience significant challenges in the recruitment and retention of a sufficient number of knowledgeable and trained staff to deliver an effective service for some of the most vulnerable patients in mental health hospitals. It is therefore imperative that health boards and independent providers have a range of strategies to ensure the recruitment and retention of staff.

Governance

The issues identified within this report suggest that governance processes within health boards and independent providers of care are not effective. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider. Robust governance and audit processes are key to identifying, at an early stage, where the delivery of a service needs to improve to meet the needs of the patient group more effectively. In addition, lessons learnt do not appear to be embedded sufficiently to prevent issues reoccurring. Unfortunately, in nineteen out of twenty of our visits, we identified issues in relation to audit and governance, this is very worrying. Some of the areas include,

- A lack of a robust system of governance oversight which ensures that the hospital's medications management processes support patient safety.
- During one inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.
- In one visit we identified that there was no formal process in place to obtain patient or family carer feedback.
- In another visit we did not see any evidence of changes that had been made as a result of formal patient feedback,
- There was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback,
- Policies were found to be out of date.
- Record keeping audits were generic health board audits, which were inappropriate for the mental health setting.
- A lack of ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement.
- A lack of quality governance and leadership to ensure effective communication between senior management and ward staff.
- In one visit we identified that the registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.
- The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.

The above issues were identified within our health boards and independent provider inspections and must be addressed as a matter of priority. Many of the issues above can be easily addressed with strengthened governance processes. In one of the most significant failures of governance, a health board did not ensure that robust processes were in place to correctly record restraint incidents within Datix to support effective investigation, supervision and governance oversight.

Findings specific to Learning Disabilities

During 2023/24 we undertook three inspections of learning disability establishments and one assurance check to a CLDT jointly with CIW. Within these inspections, we noted some positive findings including, patients having access to advocacy services, and we observed staff interacting with patients in a proactive and engaging manner, and staff we spoke with demonstrated a genuine patient focus. Patients were also happy to engage with the inspection team and the views expressed to us were overall supportive of the care they receive.

In all four inspections no immediate assurances actions were requested, however, there were a number of areas for improvement identified.

Patient and staff safety

Patient and staff safety is an important issue and central to any care and treatment delivered. If patients feel safe, they will respond much better to any treatment and will feel empowered to maximise their full potential. If staff feel safe, then they will be better equipped to care and empower patients in their care.

In our CLDT inspection we identified delays in allocating, assessing and authorisation of the Deprivation of Liberty Safeguards (DoLS) applications to both Rhondda Cynon Taf County Borough Council (RCT) and CTMUHB. This delay continues to result in many people being deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. Further work is required to ensure people rights are protected and care and support/treatment arrangements amounting to deprivation of liberty are appropriately authorised. Senior Managers must ensure there is sufficient capacity to meet statutory responsibilities.

In an inpatient hospital we found that the call bells in patient bedrooms were not easily accessible for patients.

Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. It was pleasing to note that we only identified issues with the management of medication in one of our four inspections; this being in an independent hospital where the registered manager must ensure that medication stock reconciliation processes are always adhered to.

Training

In terms of training, we identified one issue in the CLDT assurance review in relation to specific training related to the Mental Health Act. The training was not routinely delivered to all health board practitioners. We asked the health board to review and ensure that those practitioners delivering care to people subject to the Mental Health Act receive up to date knowledge of the act and its implications for the people supported. In another of our inspections we identified that the health board continues to utilise the expertise held within the Multidisciplinary Team (MDT) to provide person specific Positive Behavioural Support (PBS) training and supports staff to attend as required.

Care plans and risk assessments

Care plans, in particular PBS plans, are an important component in delivering effective care and ensuring the patient is at the centre of all care and treatment delivered. In addition, any patient risks must be fully described with triggers identified and a range of strategies identified to mitigate against identified risks. We routinely examine care and risk documentation as part of the inspection process. In all four of our visits,

we identified issues with the care documentation including;

- a health board did not have an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board did not ensure that the latest behaviour support plan was available in the active file used by staff.
- We recommended additional information was documented relating to the reason(s) for why a particular intervention was implemented and what was done to justify that intervention as last resort.

Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. In one of our inspections the patient information board was not up to date and therefore did not ensure that patients had access to appropriate information.

Use of seclusion

The Mental Health Act and information position on seclusion is documented earlier in this section of the report. In one of our inspections the documentation relating to the use of seclusion was not completed accurately.

Workforce

Workforce and the recruitment and retention of suitably qualified and experienced staff continues as an issue. In one of our inspections the health board did not ensure that staff were supported in any changes to their roles aligned with the service change from assessment and treatment to that of rehabilitation.

Environment of care

In all three of our visits to in-patient settings we identified issues with the environment of care, environmental improvements were required in relation to the refurbishment, redecoration and repairs on wards and in one of our inspections the health board was required to ensure that the physical environment meets the needs of patients in receipt of rehabilitative care. Other specific environmental issues included heating problems and the lack of the development of a patient kitchen as part of a life skills programme of therapy. Lastly the registered manager needed to ensure that maintenance issues were resolved according to their level of priority and risk.

Governance

A range of governance issues were identified in three of our four visits. These included:

- a health board needing to set up an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board needing to place emphasis on ensuring that issues relating to service change continue to be explored and acted upon in a timely and robust manner.
- The registered provider making sure that all policies are updated and reviewed.
- Health boards must establish and communicate timely and effective processes to ensure people who are supported by the CLDT, do not experience lengthy delays and bureaucracy in accessing medical equipment.

Findings specific to CAMHS

During 2023-24 we inspected two of the three in-patient CAMHS units in Wales. Some positive findings were identified including, the environments of care was generally well maintained internally and care plans were generally of a good standard, but with some areas for improvement required. However, our inspections also identified a range of issues and following one of our inspections an immediate assurance letter was issued in relation to ensuring that the governance of restraints was appropriately reported and investigated including details on:

- triggers and build up to the restraint
- Accurate recording of the length of time of restraint.
- Subsequent analysis and investigation of the restraints to ensure lessons are learnt and that the restraints are analysed to identify any themes and whether the restraint could have been avoided and whether the type of restraint used was appropriate.

Other issues identified included, a number of vacant posts of educator, psychologist and occupational therapist that resulted in young people not having access to the education and therapies that they needed. In addition, we identified a range of issues with medicines management including:

- The medicines management policy was out of date.
- Gaps on the fridge temperature recording sheet in the clinic room.
- The temperature inside the clinic room was very hot and no room temperature checks were being undertaken to ensure that the temperature remained below the advised storage temperatures for the medication in the room.
- Staff we spoke with during the inspection were unclear about what to do in the event of an adverse drug reaction.

Lastly, on one of our visits we saw that a treatment pathway had not been put in place for a young person with a diagnosed condition on admission.

6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act (MHA) 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the MHA1983.

The MHA is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The MHA provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the MHA. Other individuals and organisations include, officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under The Act. This section of the annual report details how the MHA is being implemented and how the powers granted are being exercised and monitored in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2023-24 we focused on a number of key areas including:

- Are patients lawfully detained and is the detention under the Act the most appropriate.
- Under section 132 are patients informed about their rights, at the point of detention, and then at regular intervals. Is it recorded if patients have understood the detention or not.
- Is there a care and treatment plan in place that considers aftercare of the patient

We consider the detention of patients through a number of methodologies including interviews with patients and members of the multi-disciplinary team. We also use observation and we examine the detention paperwork to ensure patients are lawfully detained. In addition, we consult with the MHA administrators.

Mental Health Act Reviewers

During our inspections we utilise the skills and knowledge of our MHA Reviewers whose purpose is to consider the detention of patients under the MHA. They make a judgement on the application of the MHA and whether it was being lawfully applied and the MHA 1983 Code of Practice was being adhered too. A number of key sections are scrutinised including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the

patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

Our Findings

Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity of each patient had been assessed and clearly documented.

However, on one of our visits, we identified that patient capacity and capacity to consent was not routinely assessed and recorded during the first three months of treatment and proformas were not routinely used in relation to patients that lacked capacity to make specific decisions about aspects of their care and treatment that were outside of the provisions of the act during their stay on the ward. In another of our visits we noted that mental capacity assessments were not fully completed and regularly reviewed and updated

In one case, the capacity to consent to treatment for patients was not regularly assessed using the framework set out in the Mental Capacity Act and guidance set out in the MHA Code of Practice for Wales (13.8) and recorded within their patient records.

Lawful detention/treatment

HIW has a duty to monitor the MHA to ensure that the detention of patients is lawful and there are systems and processes in place to ensure audits and effective governance of the Act. A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. We found many examples of good practice including the MHA documentation was well organised, easy to navigate and securely stored and MHA administrators demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful.

However, during one of our visits, we identified that a review of the hospital's use of urgent treatment under Section 62 of the MHA was required, in order to ensure full compliance with the Act and full completion of relevant documentation.

In addition, we also identified in one of our visits that implementation of a robust system of audit and governance oversight in respect of the MHA was required.

In addition, Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness and the statutory certificate of consent forms must always state the correct type and dosage of medication that has been prescribed to patients.

Section 17 (leave)

Section 17 leave is an important part of a patients journey to discharge from their section and back into the community. This process must be carefully managed with clear conditions of leave taking into account any risk factors and balances the needs of the patient with these risks. A number of areas of concern were identified during our inspections including:

- A review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in the decision-making process in relation to the leave process.
- Insufficient numbers of staff available to ensure patients are able to take their Section 17 leave.
- We saw examples where the patient Section 17 leave forms had been signed but not dated. The 'circulation list' tick boxes within the Section 17 leave forms were not fully completed to indicate who had been provided with a copy of the form.
- Incomplete Section 17 leave forms that did not include the date and details of all recipients, as a matter of good practice.
- We noted the conditions and outcomes of the section 17 leave for some patients could be strengthened to provide more clarity to staff on the expectations of the leave arrangements.
- We found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.
- The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the Community Treatment Order (CTO) might be more suitable option in accordance with paragraph 27.8-27.9 of the Code of Practice.

Managers hearings

In terms of managers hearings, we identified two issues during our inspections, one was to ensure Hospital Managers Hearings are held in a timely manner as in one record we reviewed, we noted a delay of five months. Another area was that action must be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.

Ensuring patients' rights

Section 132 and 132A of the MHA places a duty upon hospital manager to ensure detained patients understand how the MHA applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

On our inspections there was good evidence that patients were aware of their right and this was well recorded. Only on one of our inspections we did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.

Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

In two of our visits we identified that that the views of the statutory consultees were not being routinely captured to support the medical treatment of patients authorised by the SOAD.

Audit and governance arrangements

Throughout our visits we consider the audit and governance arrangements for the monitoring of the MHA by the health boards and independent providers of healthcare. During three of our monitoring visits we identified issues in the audit and governance oversight in respect of the

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the Second Opinion Appointed Doctor SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH also undertake a review of section 61 and any deaths that occur of detained patients within the NHS. We can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The SOAD is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

The SOAD service operates as a Hybrid service. Our methodology is set out in detail in our guidance to all SOADs and provided to all MHA Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021. One of the main changes we have implemented is that whilst all SOAD visits should occur in person for the purposes of interviewing the patient for most cases. However, in specific cases, namely Community Treatment Order (CTO cases), we have opted for a remote first methodology. All patients are to be consulted by their clinical team prior to the submission of requests if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right in all cases to specifically request an onsite visit from a SOAD. Our forms are being updated to

reflect these changes and will be published in the summer of 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the RSMH services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their certificate of consent CO forms.

Full advice on our methodology is available on our website and is currently being updated to reflect the changes we have made in 2023-24 this year.

SOAD Recruitment

We have now recruited into the role of a Lead SOAD and plan to recruit to the role of Deputy Lead SOAD in early 2025. We continue to recruit additional SOADs to provide further resilience to the service.

SOAD activity

During the period April 2023 to March 2024, the RSMH received 733 requests for a visit by a SOAD. This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

- 665 requests related to the certification of medication.
- 44 requests related to the certification of ECT.
- 24 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

Requests for visits by a SOAD, 2006-07 to 2023-24[1]

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694
2023-24	665	44	24	733

1 Source: SOAD requests to HIW

Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

- Two working days for a referral in relation to ECT.
- Five working days for referrals about prescribed medication when the patient is in hospital.
- Ten working days when the referral is in relation to someone subject to a Community Treatment Order.

There are a number of reasons when on occasions we do not meet the above timescales including, the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

It must be reiterated that our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the MHA Administrators for all settings to try and ensure improvements in this process next year.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the MHA administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW has produced guidance to MHA administrator in relation to this subject to minimise these instances.

8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff, and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Feedback on this report

If you have any comments or queries regarding this publication, please contact us

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Appendix A

Relevant work 2022-23

	Hospital	Date	Type
Health Boards			
1	Assessment and Treatment Unit, Swansea Bay University Health Board	17 - 19 April 2023	Inspection
2	Hergest Unit Betsi Cadwaladr University Health Board	15 - 17 May 2023	Inspection
3	Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board	22 - 24 May 2023	Inspection
4	Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board	3 - 5 July 2023	Inspection
5	Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board	17 - 19 July 2023	Inspection
6	Cedar Parc Ward, Ysbyty'r Tri Chwm, Aneurin Bevan University Health Board	7 - 9 August 2023	Inspection
7	Tŷ Llidiard Cwm Taf Morgannwg University Health Board	11 - 13 September 2023	Inspection
8	Caswell Clinic, Swansea University Health Board	11 - 13 September 2023	Inspection
9	Canolfan Bro Cerwyn, Withybush Hospital, Hywel Dda University Health Board	16 - 18 October 2023	Inspection
10	Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board	13 - 15 November 2023	Inspection
11	Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board	20 - 22 November 2023	Inspection

Hospital		Date	Type
12	Community Mental Health Team Nant y Glyn Team, Betsi Cadwaladr University Health Board	23 and 24 January 2024	Inspection
13	Talygarn Ward, County Hospital, Aneurin Bevan University Health Board	5 - 7 February 2024	Inspection
14	Care Inspectorate Wales (CIW) & Healthcare Inspectorate Wales (HIW) – Inspection of Rhondda Cynon Taf County Borough Council/ Cwm Taf Morgannwg University Health Board/Swansea Bay University Health Board Community Learning Disability Team (CLDT)	13-15 February 2024	Inspection
Independent Healthcare Providers			
15	Ty Cwm Rhondda	17 - 19 April 2023	Inspection
16	Hillview Hospital	9 and 10 May 2023	Inspection
17	St David's Independent Hospital	19 - 21 June 2023	Inspection
18	Aberbeeg Hospital	10 - 12 July 2023	Inspection
19	Rushcliffe Mental Health Hospital Aberdare	25 - 27 September 2023	Inspection
20	Ty Gwyn Hall Hospital	2 - 4 October 2023	Inspection
21	New Hall Independent Hospital	24 - 26 October 2023	Inspection
22	Tŷ Grosvenor	6 - 8 November 2023	Inspection
23	Heatherwood Court Hospital Llantrisant Road, Pontypridd	4 - 06 December 2023	Inspection
24	Priory Hospital Cardiff	8 - 10 January 2024	Inspection
25	St Peter's Hospital	26 - 28 February 2024	Inspection
26	Coed Du Hall Hospital	25 - 27 March 2024	Inspection

Appendix B: Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also independent mental health advocate.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers.
CO2 form	Certificate of consent to treatment (Section 58(3) (a)).
CO3 form	Certificate of second opinion (Section 58(3) (b)).
CO7 form	Certificate of appropriateness of treatment to be given to a community patient.
CO8 form	Certificate of consent to treatment for a community patient.

Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory Treatment	Medical treatment for mental disorder given under the Act.
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned".
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.

Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence (section 17 leave)	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as 'Section 17 leave'.

Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time.
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.
Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar. It is simply a reflection of the terminology used in the Act itself.

Prescribed body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49. The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.

Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually.
Section 12 doctor	See doctor approved under Section 12.
Section 17A	This is a Community Treatment Order.
Section 37	This is a hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function.
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 61	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B.
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights.
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety.

Section 136	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts: Part 1 – Primary mental health support services. Part 2 – Co-ordination of and care planning for secondary mental health service users. Part 3 – Assessment of former users of secondary mental health services. Part 4 – Mental health advocacy.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

4.2

5 Mins

4.2 - Mental Health Act Review

Sarah Roberts
(Hywel Dda UHB -
Mental Health
Legislation Manager)

For information

Attachments

012. Mental Health Act Review.docx

012. Mental Health Act Review

4.2 - Mental Health Act Review

Last modified: 04/03/2025

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL
MENTAL HEALTH LEGISLATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 March 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of the Mental Health Act Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Executive Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Roberts, Mental Health Legislation Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As part of the annual review of the Terms of Reference for MH Scrutiny Group it was agreed that an update report on the review of the Mental Health Act would be provided on a regular basis to both MH Scrutiny Group and Mental Health Legislation Committee as it progresses through Parliament.

Cefndir / Background

In 2017 the UK Government commissioned an Independent Review of the Mental Health Act by Sir Simon Wessely. Following the review a White Paper was published in 2021; the review had made 154 recommendations.

In 2022 UK Government published the draft MH Bill which underwent pre-legislative scrutiny. The joint committee published their report in January 23 making 55 recommendations and in March 2024 the previous UK Government published its response to the Joint Committee report.

In November 24 the MH Bill was introduced via the Kings speech to Parliament. It is currently at Committee stage in the House of Lords before it's read in the House of Commons. Further dates are yet to be confirmed.

Asesiad / Assessment

Some of the suggested areas for review are: -

There is to be a revision of the detention criteria, risk of serious harm either to themselves or others and treatment must be of therapeutic benefit. Subject to Parliamentary approval it will no longer be possible to detain a person with a learning disability or autistic person under Part II Section 3 unless they have a co-occurring mental disorder which requires hospital treatment. Length of initial Sec 3 will also be shortened.

More frequent reviews of detention and increased access to Mental Health Review Tribunal are proposed with increased powers to make recommendations regarding a patient's care to facilitate timely discharge.

A revision of the criteria for Community Treatment Orders and to enhance the professional oversight required for any CTO and nominated person to be consulted prior to implementing.

Strengthen the voice of patients, bringing England in line with Wales and the Welsh Measure, i.e. access to IMHAs for informal patients and Care and Treatment Plans.

Abolishing the current role of Nearest relative and replacing it with a nominated person, which the patient can chose, although the AMHP can chose if the patient lacks capacity.

Ending the use of police cells as a place of safety, though this is already a never event following the amendments to Policing and Crime Act in 2017.

To enable discharge the Responsible Clinician is to consult another professional involved in the patients care before discharging.

Introduction of Advance Choice Documents – provide appropriate help to create them

Criminal Justice system – introduction of a 28-day time limit for transfers to hospital from prison.

To draft, consult and publish new Codes of Practice for both Wales and England.

It has been suggested that full implementation of all changes could take approximately 10 years, to enable additional clinical and judicial staff to be trained.

Argymhelliad / Recommendation

This update is for information only.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Provide regular updates on review of Mental Health Act 1983
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	Not applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The content of this policy is developed utilising expert advice, with reference to legislation and guidance documentation.
Rhestr Termau: Glossary of Terms:	Contained within the body of the policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Deddfwriaeth Iechyd Meddwl: Parties / Committees consulted prior to Mental Health Legislation Committee:	MH Scrutiny Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	To support patients seeking advocacy support under the Independent Mental Health Advocacy service
Gweithlu: Workforce:	Direct legal responsibilities for staff associated with use of Mental Health Act
Risg: Risk:	HDdUHB must have an up to date and accurate written policies to avoid risk
Cyfreithiol: Legal:	Mental Health Act 1983 Mental Health (Wales) Measure 2010
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable

Cydraddoldeb: Equality:	Equality Impact Assessments undertaken in collaboration with Senior Equality and Diversity Officer.

4.3

1 Mins

4.3 - Schedule of Meetings 2025-2026

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For information

Attachments

013. Schedule of Meetings 2025-26.pdf

013. Schedule of Meetings 2025-26

4.3 - Schedule of Meetings 2025-2026

Last modified: 04/03/2025

Schedule of Meetings for Board, Committee and Advisory Groups 2025/26 v2

MEETING	2025	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	2026	JANUARY	FEBRUARY	MARCH
PUBLIC BOARD Chair: Neil Wooding Lead Executive: Philip Kloer			THURSDAY 29 MAY 9.30am - 4.00pm	THURSDAY 26 JUNE 2.00pm - 3.00pm (Sign-off Annual Report and Accounts)	THURSDAY 31 JULY 9.30am - 4.00pm		THURSDAY 25 SEPTEMBER 9.30am - 3.00pm		THURSDAY 27 NOVEMBER 9.30am - 4.00pm			THURSDAY 29 JANUARY 9.30am - 4.00pm		THURSDAY 26 MARCH 9.30am - 4.00pm
AUDIT & RISK ASSURANCE COMMITTEE (ARAC) Chair: Rhodri Evans Lead Executive: Joanne Wilson		TUESDAY 15 APRIL 9.30am - 1.30pm	THURSDAY 8 MAY 9.30am - 12.30pm (Review of Draft Accounts)	TUESDAY 24 JUNE 9.30am - 1.30pm (Incl Review of Final Annual Report and Accounts)		TUESDAY 12 AUGUST 9.30am - 1.30pm		TUESDAY 14 OCTOBER 9.30am - 1.30pm		TUESDAY 9 DECEMBER 9.30am - 1.30pm			TUESDAY 10 FEBRUARY 9.30am - 1.30pm	
REMUNERATION & TERMS OF SERVICE COMMITTEE (RTSC) Chair: Neil Wooding Lead Executive: Lisa Gostling			THURSDAY 15 MAY 9.30am - 11.30am			THURSDAY 7 AUGUST 9.30am - 11.30am			THURSDAY 6 NOVEMBER 9.30am - 11.30am				THURSDAY 5 FEBRUARY 9.30am - 11.30am	
DIGITAL, DATA AND INNOVATION COMMITTEE (DDIC) Chair: Maynard Davies Lead Executive: Huw Thomas		TUESDAY 22 APRIL 9.30am - 12.30pm			TUESDAY 22 JULY 1.00pm - 4.00pm			TUESDAY 7 OCTOBER 9.30am - 12.30pm				THURSDAY 15 JANUARY 9.30am - 12.30pm		
FINANCE AND PERFORMANCE COMMITTEE (FPC) Chair: Michael Imperato Lead Executive: Huw Thomas		TUESDAY 29 APRIL 9.30am - 12.30pm		THURSDAY 26 JUNE 9.30am - 12.30pm		TUESDAY 26 AUGUST 9.30am - 12.30pm		TUESDAY 21 OCTOBER 9.30am - 12.30pm		TUESDAY 16 DECEMBER 9.30am - 12.30pm			TUESDAY 24 FEBRUARY 9.30am - 12.30pm	
CHARITABLE FUNDS COMMITTEE (CFC) Chair: Delyth Raynsford/ NEW IM Lead Executive: Sharon Daniel				TUESDAY 17 JUNE 9.30am - 12.30pm			TUESDAY 16 SEPTEMBER 9.30am - 12.30pm			MONDAY 8 DECEMBER 9.30am - 12.30pm				TUESDAY 17 MARCH 9.30am - 12.30pm
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE (PODCC) Chair: Eleanor Marks Lead Executive: Lisa Gostling			TUESDAY 27 MAY 9.30am - 12.30pm			TUESDAY 19 AUGUST 9.30am - 12.30pm			TUESDAY 4 NOVEMBER 9.30am - 12.30pm				TUESDAY 17 FEBRUARY 9.30am - 12.30pm	
HEALTH & SAFETY COMMITTEE (HSC) Chair: Ann Murphy Lead Executive: James Severs			TUESDAY 6 MAY 9.30am - 11.30am		THURSDAY 3 JULY 9.30am - 11.30am		TUESDAY 9 SEPTEMBER 9.30am - 11.30am		TUESDAY 11 NOVEMBER 9.30am - 11.30am			TUESDAY 13 JANUARY 9.30am - 11.30am		TUESDAY 10 MARCH 9.30am - 11.30am
BOARD SEMINAR Chair: Neil Wooding Lead Executive: Philip Kloer		THURSDAY 17 APRIL 9.30am - 1.00pm		THURSDAY 19 JUNE 9.30am - 1.00pm		THURSDAY 21 AUGUST 9.30am - 1.00pm		THURSDAY 23 OCTOBER 9.30am - 1.00pm		THURSDAY 11 DECEMBER 9.30am - 1.00pm			THURSDAY 19 FEBRUARY 9.30am - 1.00pm	
STRATEGY AND PLANNING COMMITTEE (SPC) Chair: Winston Weir Lead Executive: Lee Davies		THURSDAY 24 APRIL 9.30am - 12.30pm			TUESDAY 1 JULY 9.30am - 12.30pm	THURSDAY 28 AUGUST 9.30am - 12.30pm		THURSDAY 30 OCTOBER 9.30am - 12.30pm		THURSDAY 18 DECEMBER 9.30am - 12.30pm			THURSDAY 26 FEBRUARY 9.30am - 12.30pm	
STAKEHOLDER REFERENCE GROUP (SRG) Chair: Jeremy Hockridge Lead Executive: Alwena Hughes-Moakes			THURSDAY 1 MAY 9.30am - 12.00pm		TUESDAY 8 JULY 9.30am - 12.00pm				THURSDAY 6 NOVEMBER 1.30pm - 4.00pm			THURSDAY 8 JANUARY 9.30am - 12.00pm		
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) Chair: Anna Lewis Lead Executive: Sharon Daniel		TUESDAY 8 APRIL 9.30am - 12.30pm		TUESDAY 10 JUNE 9.30am - 12.30pm		THURSDAY 14 AUGUST 9.30am - 12.30pm		THURSDAY 9 OCTOBER 9.30am - 12.30pm		THURSDAY 4 DECEMBER 9.30am - 12.30pm			THURSDAY 12 FEBRUARY 9.30am - 12.30pm	
QUALITY & SAFETY EXPERIENCE SUB COMMITTEE (QSESC) Chair: James Severs			TUESDAY 13 MAY 9.30am - 12.00pm		TUESDAY 15 JULY 9.30am - 12.00pm		THURSDAY 11 SEPTEMBER 9.30am - 12.00pm		THURSDAY 13 NOVEMBER 9.30am - 12.00pm			THURSDAY 15 JANUARY 9.30am - 12.00pm		THURSDAY 12 MARCH 9.30am - 12.00pm
ANNUAL GENERAL MEETING (AGM) Lead Executives: Alwena Hughes-							THURSDAY 25 SEPTEMBER 3.30pm – 5.15pm							
MENTAL HEALTH LEGISLATION COMMITTEE (MHLC) Chair: Chantal Patel Lead Executive: Andrew Carruthers				THURSDAY 5 JUNE 10.30am - 12.00pm			TUESDAY 2 SEPTEMBER 10.30am - 12.00pm			MONDAY 1 DECEMBER 10.30am - 12.00pm				TUESDAY 3 MARCH 10.30am - 12.00pm
STAFF PARTNERSHIP FORUM (SPF) Chairs: Lisa Gostling/ Anthony Dean			TUESDAY 20 MAY 10.00am - 12.30pm		TUESDAY 15 JULY 10.00am - 12.30pm		TUESDAY 16 SEPTEMBER 10.00am - 12.30pm		TUESDAY 18 NOVEMBER 10.00am - 12.30pm			TUESDAY 20 JANUARY 10.00am - 12.30pm		
HEALTHCARE PROFESSIONALS FORUM (HPF) Acting Chair/Lead Executive: James Severs		FRIDAY 25 APRIL 9.30am - 11.30am		FRIDAY 6 JUNE 9.30am - 11.30am		FRIDAY 15 AUGUST 9.30am - 11.30am		FRIDAY 3 OCTOBER 9.30am - 11.30am		FRIDAY 5 DECEMBER 9.30am - 11.30am			FRIDAY 6 FEBRUARY 9.30am - 11.30am	
ETHICS PANEL Chair: Chantal Patel Lead Executive: Mark Henwood		FRIDAY 11 APRIL 12.00pm - 1.00pm	TUESDAY 6 MAY 11.00am - 12.00pm	MONDAY 2 JUNE 1.00pm - 2.00pm	TUESDAY 1 JULY 9.00am - 10.00am	THURSDAY 7 AUGUST 2.00pm - 3.00pm	TUESDAY 9 SEPTEMBER 9.00am - 10.00am	TUESDAY 7 OCTOBER 9.00am - 10.00am	TUESDAY 4 NOVEMBER 9.00am - 10.00am	THURSDAY 4 DECEMBER 2.00pm - 3.00pm				
Click here to contact Corporate Governance Team CorporateGovernance.HDD@wales.nhs.uk		School Holidays				GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Hywel Dda University Health Board				3 meetings in a week				

4.4

1 Mins

4.4 - Annual Work Plan 2025-2026

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For information

Attachments

014. Annual Work Plan 2025-2026.docx

014. Annual Work Plan 2025-2026

4.4 - Annual Work Plan 2025-2026

Last modified: 04/03/2025

HYWEL DDA HEALTH BOARD – MENTAL HEALTH LEGISLATION COMMITTEE 2025/2026

The following table sets out the Mental Health Legislation Committee's Business for 2025/26, including standing agenda items (denoted by*).

Agenda Item /Issue	Lead	Responsible Officer	June 2025	Sept 2025	Dec 2025	March 2026
GOVERNANCE						
Apologies*	**Chair**	**All**	✓	✓	✓	✓
Declaration of Interests*	**Chair**	**All**	✓	✓	✓	✓
Minutes of previous meeting *	**Chair**	**Committee Secretary**	✓	✓	✓	✓
Table of Actions *	**Chair**	**Committee Secretary**	✓	✓	✓	✓
Review of ToR's/Membership	**Lead Director**	**Lead Officer**	✓			
Review of ToR's/ Membership of MHLSG	**Lead Director**	**Deputy Lead Officer**			✓	
Review of ToR's/ Membership of Power Discharge Sub-committee	**Lead Director**	**MHA Administration Lead**	✓			
Annual Work Plan*	**Lead Director**	**Lead Officer**			✓	
MHLC Annual Report detailing work undertaken throughout year	**Lead Director**	**Lead Officer**	✓ (final)			
Committee Self-Assessment	**Lead Director**	**Lead Officer**		✓		
MHLC Self-Assessment Action Plan	**Lead Director**	**Lead Officer**				✓

Presentation Good Practice/Patient Story*	**Lead Director**	**Lead Officer**		✓		✓
PERFORMANCE						
Receive HIW MHA Inspection, Delivery Unit or external scrutiny body reports, management responses & approve associated action plans where the actions relate to MH legislation only (for monitoring by MHL Scrutiny Group)	**Lead Officer**	**Heads of Services**	✓ (when received)	✓ (when received)	✓ (when received)	✓ (when received)
ASSURANCE						
Receive reports on identified matters of risk relating to the compliance with MH legislation for assurance that risks are being appropriately mitigated	**Lead Officer**	**Heads of Services**	✓ (when identified)	✓ (when identified)	✓ (when identified)	✓ (when identified)
Assurance on implementation of HIW, DU & other external scrutiny bodies Action Plans	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Review the MH& LD risk register bi-annually	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Receive update report from MHL Scrutiny Group	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Consider issues of concern arising from the Sub-Committee and group structure	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Assurance on compliance with MH Legislation	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Assurance on development & implementation of policies & procedures	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Assurance on Out of Area Placements	**Lead Director**	**Lead Officer**	✓	✓	✓	✓
Receive Hospital Manager's Power of Discharge Committee Update Report & Minutes from previous meeting. This report should ensure compliance with the Code of Practice*	**MHA Admin Lead**	**MHA Admin Lead**	✓	✓	✓	✓
FOR INFORMATION						
Receive and review HIW MHA Annual Report	**Lead Officer**	**Lead Officer**		✓		
Mental Health Law Briefings * (when applicable)	**MH Legislation Lead**	**MH Legislation Lead**	✓ (when applicable)	✓ (when applicable)	✓ (when applicable)	✓ (when applicable)
New legislation/Measure/Policy Implementation Guidance (when applicable)	**MH Legislation Lead**	**MH Legislation Lead**	✓	✓	✓	✓
Schedule of Meetings for forthcoming year	**Lead Officer**	**Committee Secretary**				✓
ADMINISTRATION						

Agenda Setting Meeting with Chair, Lead Exec & Lead Officer (at least 6 weeks prior to meeting)	**Lead Officer**	**Committee Secretary**	✓	✓	✓	✓
Quality check agenda & papers before dissemination & upload to Web	**Lead Exec**	**Lead Officer**	✓	✓	✓	✓
Disseminate agenda & papers seven days prior to meeting	**Lead Officer**	**Committee Secretary**	✓	✓	✓	✓
Minutes and action log to be circulated within 14 days of the meeting to members for accuracy check & final version forwarded Chair & Lead Exec within the following 7 days to sign off as 'Unapproved' minutes (to be presented & formally 'approved' at next meeting)	**Lead Officer**	**Committee Secretary**	✓	✓	✓	✓
Prepare Update Report to Board (must be signed off by Chair & Lead Exec prior to submission)	**Lead Officer**	**Committee Secretary**	✓	✓	✓	✓
Prepare Forward Schedule of Meeting Dates for next financial year & forward dates to Head of Corporate Governance	**Lead Officer**	**Committee Secretary**			✓	
Prepare Forward Annual Work Plan for next financial year	**Lead Officer**	**Committee Secretary**			✓	
POLICIES			**EXPIRY DATE**			
The provision and access to the IMHA service policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry Date: 15th June 2026			
Section 5(4) Nurses holding power policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 15th June 2026			
Section 5(2) Dr holding power policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 18th December 2026			
Community treatment order policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 18th December 2026			
Hospital manager scheme of delegation	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 26th March 2027			
Section 17 leave of absence Policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 6th October 2027			

Information to Patients right procedure	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 2nd December 2027			
Section 135 warrant to search for and remove patients interagency procedure	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 2nd December 2027			
Section 136 – Mentally disordered persons found in public places inter agency policy	**MH Legislation Lead**	**MHA Admin Lead**	Expiry date: 24th March 2025			

Chair – Eleanor Marks	MHA Administration Lead – Ruth Bourke
Lead Exec – Andrew Carruthers	MH Legislation Lead – Sarah Roberts
Lead Officer – Liz Carroll	Committee Secretary – Manon Horscroft
Deputy Lead Officer- Kay Isaacs	

5

2 Mins

5 - Any Other Business

All

No updates for the meeting

For information

6

2 Mins

6 - Matters for Escalation to Board

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For information

7

7 - Date and Time of Next Meeting

Thursday 5th June at 10:30am via MS Teams and Ystwyth Board Room