Bundle Mental Health Legislation Assurance Committee 17 December 2019

1	Governance
1.1	Welcome & Apologies *Presenter: Chair*
1.2	Declarations of Interest *Presenter: Chair*
1.3	MInutes of Previous Meeting held on 22nd September 2019 *Presenter: Chair* 1.3 DRAFT Minutes MHLAC 17.09.2019.docx
1.4	Matters Arising & Table of Actions from meeting held on 22nd September 2019 *Presenter: Chair* 1.4 Draft Table of Actions from MHLAC September 2019.doc
1.5	MHLAC Terms of Reference *Presenter: Chair* 1.5 MHLAC ToR - June 2019.doc
2	Presentation & Discussion
2.1	Presentation: Staff Story *Deferred to March 2020 meeting*
3	Performance
3.1	MH&LD Performance Paper Q2 *Presenter: Sarah Roberts* *link to performance team page: http://howis.wales.nhs.uk/sitesplus/862/opendoc/484641* 3.1 MHLAC SBAR Assurance Rpt 17 December 19.doc
4	Assurance
4.1	Scrutiny Group Performance *Presenter: Sara Rees* 4.1 SCRUTINY GROUP UPDATE - MHLAC 17th December 2019.docx
4.2	Report on Learning Disability Services *Presenter: Melanie Evans* 4.2 Hywel Dda Learning Disabilities Services Improvement programme.docx 4.2 TLD Presentation 4 12 2019.pptx
4.3	CAMHS Admission and Patient Pathways *Presenter: Angela Lodwick* 4.4 CYSUR Quarter 2 2019-2020.doc
5	Policies *No policies received*
6	Annual Workplan *Presenter: Chair* 6. MHLAC Annual Workplan 2019-20.doc
7	For Information
7.1	National Assembly for Wales Health, Social Care and Sport Committee - Mental Health in Policing and Police Custody - October 2019 *Presenter: Sarah Roberts* 7.1 Report - Mental health in policing and police custody.pdf
7.2	Mental Health Review Tribunal for Wales Practice Direction - October 2019 *Presenter: Sarah Roberts* 7.2 mhrt-practice-direction-2019.pdf
8	Any Other Business
9	Date & Time of Next Meeting

Tuesday 3rd March 2020, 9.30pm - 12.30pm.
Boardroom, Ystwyth Building, Hafan Derwen, St David's Park, Carmarthen.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

COFNODION Y CYFARFOD
PWYLLGOR SICRWYDD DEDDFWRIAETH IECHYD MEDDWL
HEB EU CYMERADWYO / UNAPPROVED
MINUTES OF THE
MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE MEETING

Date and Time of Meeting:	9.30 – 12.30, Tuesday 17th September 2019
Venue:	Board Room, Ystwyth, St David's Park, Carmarthen SA31 3BB

Present:	• Mrs Judith Hardisty, Vice Chair of Hywel Dda University Health Board (Chair) • Mrs Delyth Raynsford, Independent Member • Mr Mike Lewis, Independent Member • Mr Paul Newman, Independent Member • Mr Simon Hancock, Independent Member
In Attendance:	• Ms Angie Darlington, WWAMH • Mr Clive Smith, Carer Representative • Ms Jane Hitchings, Pembrokeshire Local Authority • Mr Joe Teape, Deputy Chief Executive and Executive Director of Operations • Mr John Forbes-Jones, Ceredigion Local Authority • Ms Kay Isaacs, Interim Head of Service, Adult Mental Health • Mr Ken Jones, CHC • Ms Liz Carroll, Interim Director of Mental Health & Learning Disabilities • Mrs Lynn Rees, PA to Director of Mental Health & Learning Disabilities (Secretariat) • Mr Mark Evans, Carmarthenshire Local Authority • Miss Melanie Evans, Head of Service, Older Adult Mental Health & Learning Disabilities • Mr Rob Jeffrey, Ambulance Operations Manager, WAST • Mrs Sarah Roberts, Mental Health Act Admin Manager • Mr Richard Jones, Head of Clinical Innovation and Strategy, MH&LD (part)

Agenda Item	Introductions and Apologies for Absence	Action
MHLAC(19)40	Mrs Judith Hardisty welcomed all to the meeting and introduced herself as Vice Chair of the Board. Mrs Hardisty noted her thanks to Mr Paul Newman for stepping in as Vice Chair and chairing MHLAC during her period of covering the role of Interim Chair. The following apologies for absence were received: • Ms Angela Lodwick, Head of S-CAMHS & Psychological Therapies • Ms Avril Bracey, Carmarthenshire Local Authority • Ms Carina Giannuzzi, Dyfed Powys Police • Ms Natasha Fox, Chief Officer, Advocacy West Wales • Mrs Sara Rees, Interim Head of Nursing, MH&LD • Dr Warren Lloyd, Associate Medical Director & Clinical Director Mental Health & Learning Disabilities Mrs Hardisty also formally noted her congratulations to Mrs Donna Pritchard on her new role as Corporate Lead Officer for Porth Ceredigion.	

MHLAC(19)41	**Declarations of Interests**	
	No declarations of interest were made.	

MHLAC(19)42		
	The minutes of the meeting held **on 24th June 2019** were **APPROVED** as an accurate reflection of the previous meeting save for the following amendment: • Typing error on page 3 within fifth paragraph of item MHLAC(19)30: 'Depravation' to be replaced with 'Deprivation'.	
	The Committee **NOTED** and **APPROVED** the minutes from the previous MHLAC meeting in June 2019.	

MHLAC(19)43	**Matters Arising, including Table of Actions from the Minutes of the Meeting held on 24TH June 2019**	
	The Table of Actions was reviewed and the following noted: **MHLAC(16)27 & (18)04 & (18)38 & (19)04 Locked Door Policy:** This has now gone via MH&LD Written Control Document Group (WCD). Action complete. **MHLAC (18) 43 & (19)07 & (19)17 Scrutiny Group Update:** An annual work plan is required for scrutiny group. Mr Paul Newman informed he had met with Mrs Judith Hardisty, Mr Joe Teape and Mrs Jo Wilson, Board Secretary to discuss shared concerns. Governance arrangements and sub-committee structures are being looked into, as well as assurance. There is a commitment to ensuring the right level of assurance and engagement is undertaken. Terms of Reference are being looked at from other committees across Wales and the intention is to be able to streamline the amount of meetings people are having to attend. Mrs Maria Battle, the new Chair of Hywel Dda University Health Board is examining the agendas for Board sub-committees. It is hoped more clarity will be available by the next MHLAC in December. Mr Teape suggested scrutiny group could be used to drill down some of the more qualitative data. Ms Carroll informed they had put in a bid for a legislation lead to Welsh Government and that this had been successful. This position should be going out to advert soon. Ms Darlington was pleased to hear this and Ms Carroll informed she was keen to work with Service Users moving forwards in this area. Mrs Hardisty informed all the health boards in Wales have very similar Terms of Reference for their mental health board meetings, with the exception of Aneurin Bevan and they will be picking that up with them. There is a meeting coming up with the Director of Nursing, Ms Carroll and Mrs Hardisty shortly, to discuss in terms of quality; information being submitted to the right place. Mr Smith added they need to ensure the service is working for the people that use it. Mr Teape informed at the next meeting they should have some clarity on what is being presented and will be able to use this committee to sign off the direction and what is agreed. Mr Smith informed resolution is required on establishing how this committee is planning to take information from other committees to obtain a full picture, to include respect and the involvement of patients, meeting legal requirements, safety and therapeutic care. Training needs should	

	match the requirements of the organisation. The committee is required to be assured in respect of the Mental Health Act and Measure. **MHLAC (18)41 Bespoke Repatriation:** On Agenda. **MHLAC (18)44 Connectivity of Committees and Sub-Committees:** Mr Teape informed work is being undertaken towards assurance being provided on each level and fed up to this committee. Mr Paul Newman informed the sub-committee structure and performance metrics need refining. Clarity is required as to what is recorded at what level and to what detail, as discussed above. **MHLAC (19)19 Datix exercise on availability of Section 12 Doctors:** Anecdotal evidence has been received from the local authority re lack of section 12 doctors. This has not been quantified previously however there is now a system in place for them to contact Sarah Roberts to submit a datix incident report. So far only seven incidents have been reported this way. SR has re-sent the process out to the three local authorities in the hope there will be an increase in reporting. **MHLAC(19)37 Thematic Review:** On Agenda. **MHLAC(19)40 Power of Discharge Sub-Committee:** On Agenda.	
	The Committee **NOTED** the MHLAC Table of Actions.	

MHLAC(19)44	**PRESENTATION & DISCUSSION** **Staff Story**	
	Deferred to December MHLAC.	

MHLAC(19)45	**PERFORMANCE** **MHLD Performance Paper Q1 2019-20** **Performance Dashboard**	
	Ms Liz Carroll presented the performance paper and performance dashboard for Quarter 1 (April 2019 – June 2019). Highlights include: • Use of Section 2 has increased (88 compared to 82 for the previous quarter). • Forty seven patients were admitted direct from the community. • Five patients were transferred in from other hospitals outside the health board. • Twenty nine patients went on to Section 3 for treatment, which is an increase on previous quarters. • Use of Section 3 has increased (35 compared to 27 for the previous quarter). • Twenty two patients subject to Section 2 had their sections converted to Section 3. • Six patients were detained to older adult wards. • Two patients were transferred out of Hywel Dda to specialist placements. • Use of Section 136 has decreased (48 occasions compared to 70).	

- Following Section 136 assessments; twelve patients were detained on further sections of the Mental Health Act.
- Twenty nine patients did not require admission and were discharged back into the community.
- Forty six assessments were carried out within twenty four hours
- Increased activity for S-CAMHS admission

Mrs Hardisty invited questions from the group.

Mr Simon Hancock queried the rectifiable errors referred to on page five of the report and whether this was par for the course? Mrs Sarah Roberts informed him it was and completion of documentation, such as consent to treatment forms, is monitored for quality purposes.

Mrs Hardisty queried whether there is a correlation with locum usage and such errors, whilst acknowledging current medical staffing issues. Mrs Roberts informed the Mental Health Act Department hold a database for monitoring such errors which informs the detail on whether they are errors made by AMHP's or external Doctors, among others.

Mrs Delyth Raynsford expressed concern and queried whether these errors cause harm to patients. Mrs Roberts informed they tend mostly to be spelling errors.

Mr Clive Smith made reference to page 7 of the report in relation to Part 3, self-referral to secondary care for former service users. The report indicates 100% compliance for individuals re-assessed in a timely manner; with a copy of a report to that individual being provided no later than 10 working days, indicating the total number of requests for re-assessment received.

Mr Smith queried the detail behind this percentage. Ms Carroll stated this information could be obtained and undertook to update the committee accordingly. Ms Angie Darlington stated she would welcome further detail of this area as the stories she receives from service users differ somewhat insomuch as they report to have requested re-assessment however were told to 'ring back' if they are struggling. It seems if they have specifically asked for reassessment under part 3 they are more likely to be reassessed. Ms Carroll agreed it would be a good time to look into this now and Mr Joe Teape informed such discussions in relation to use of the Act and Measure would meet concerns raised previously at this Committee in relation to the same. Mr Smith noted it was worth considering whether this information is being used to indicate the demand for service as there is a volume of people coming in voluntarily which inflates the situation and the need to be aware of that aspect. In terms of people coming back in to services it may be good to examine more closely the way part 3 is being undertaken.

LC

Mrs Hardisty informed if more detail is being requested; clarification is required as to for what purpose. Assurance is required on the pressure of people coming in to services and whether relevant resources are available within the Health Board in dealing with that pressure, not simply to inform compliance but to scrutinise the quality of service.

Mrs Hardisty made reference to the charts in the report relating to Section 3 and the rise in Carmarthenshire in May. The pattern in the chart indicates there should soon be a spike in Pembrokeshire. As the

chart indicates a similar pattern each year, Mrs Hardisty wondered what the reasons are for that and informed if officers could decipher the real pressures where the service is underperforming as well as understanding the reasons why, then that can then be highlighted to the Board.

Ms Carroll added what is reflected in the report in terms of Measure; does not inform the volume of people being assessed by the Community Mental Health teams as there is only a small cohort of people who go through care and treatment planning and there is an increase in demand.

Mr Smith added that he agreed with Ms Darlington's observation in that the information received from service users and carers does not match the detail discussed around meeting tables such as this, as only a small percentage speak up. In terms of quality, it should not require a high number of people to report issues. Issues should be considered by all and information received at this committee should have been received via the relevant subcommittees with recommendations so we can take it forwards. People are being misled by government targets and Mr Smith added we should not be substituting government targets for the content of requirements registered within the Act. It may seem on paper that we have succeeded however this is not a true reflection as the Delivery Unit report informs we do not have sufficient care and treatment plans.

Mrs Hardisty agreed there is risk involved when targets drive. Mrs Hardisty and Ms Darlington each attended a meeting the other day in relation to the next three years for Together for Mental Health, whereby it was made obvious to them how easy it was to 'tick a box' by slight manipulation. Mrs Hardisty and Ms Darlington related this information back to the relevant people involved in order to formally note their concerns.

Mr Smith referred to recent emphasis on enhanced notice whereby people can chose not to be treated if they become mentally unwell. Mr Smith was concerned about this legislation being passed at Westminster enabling patients to refuse treatment, adding that as a result there would be people wandering around the streets; a danger to themselves and to others around them. Mr Smith wanted this concern raised with government as it may suit Westminster to modify the Mental Health Act however this would be in direct contradiction to that which Wales would like to do. Ms Darlington informed they should know more about this by December, adding that there are already processes in place where advanced statements can be made but these also can be overridden if appropriate.

Mr Mark Evans noted that to enable sufficient monitoring of activity data and the Mental Health Act and to be able to properly analyse the full picture, information is required on people detained out of area also. Mr Evans suggested this information be reported via scrutiny. The difficult part is obtaining this information as it is often recorded differently in other areas.

Mrs Hardisty reported admission criteria at the S-CAMHs Unit in Bridgend had altered and queried whether this had had an impact on the Health Board's ability to admit patients to the S-CAMH's bed. Ms Carroll undertook to query this with Ms Angela Lodwick, Head of Service, who would be able to provide a report on S-CAMH's admissions and patient pathway to be brought to the next meeting. **LC/AL**

	To summarise, Mr Teape stated the recommendation is to undertake a drill down into looking at mental health advocacy and reasons this may or may not be done and move on to Care and Treatment Plans (CTP's) . Jo Wilson will separately speak to Independent Members outside of this meeting to establish any other areas upon which they would like a drill down, then request Scrutiny Group to look into this. Mrs Hardisty noted a lack of information on learning disability services and requested Miss Melanie Evans provide a report at the next meeting to assure the Committee of the new service model. Ms Darlington queried whether information was gathered on how many people under Sections 2 and 3 had learning disabilities. Mrs Roberts assured her this is reported on. **Action** • Ms Liz Carroll / Mrs Sarah Roberts to provide clarification of figures in relation to the 100% compliance for individuals re-assessed in a timely manner under Part 3, self-referral to secondary care for former service users. • Ms Liz Carroll to request Ms Angela Lodwick, Head of Service SCHAMS to provide a report on admissions and patient pathway to be brought to the Mental Health Legislation Assurance Committee in December. • Miss Melanie Evans to provide an update report on learning disability services for the Mental Health Legislation Assurance Committee in December.	**ME** **LC** **LC/AL** **ME**
	The Committee was **ASSURED** that MHLAC has complied with duties through the Terms of Reference set and identified key actions to address developments. The Committee was **ASSURED** that activity is closely monitored and that practice is compliant with the requirements of The Measure.	

MHLAC(19)46	**ASSURANCE** **Scrutiny Group Update Report, Minutes and Terms of Reference**	
	Mr Joe Teape provided an overview of the Scrutiny Group Update Report which had been prepared by Mrs Sara Rees, Interim Head of Nursing. Mr Teape informed he had met with Mrs Rees following his meeting with Mr Clive Smith and Ms Angie Darlington. The report provided by Mrs Rees discusses Care and Treatment Plans (CTP's) in terms of assessment processes, training, written control documents and so on. Mr Teape noted that whilst the report does not provide any dates or deadlines; it does provide an overall picture. Mr Mike Lewis queried the measures in place in terms of CTP. Ms Carroll informed audits are undertaken with a quality lens on them and any issues will be picked up with individual practitioners. Ms Darlington added it would be useful to have sight of quality outcomes. Ms Jane Hitchings informed regular audit samples are taken for Social Services and wellbeing in Pembrokeshire.	

	Mr Paul Newman queried whether there were any themes emerging from audits in terms of CTP quality. Mr Mark Evans noted one theme was the lack of joined up electronic systems as to where the CTP is held and how information is shared. Recommendation from the Delivery Unit audit is that they are integrated however hands are tied in terms of IT solution. It was agreed that some assurance is required around this. Mr Newman queried what the main issues reported are in relation to CTP. Ms Carroll undertook to speak with Gloria Trevis to establish the top three or four themes coming through. Ms Darlington noted the Delivery Unit picked up on lack of evidence and engagement with carers. Mr Smith stressed the importance of the assessment itself, its effect on outcomes and the significance of involving the carer in the assessment. Assessment should be facilitated to enable the situation be properly evaluated as the implications of certain aspects being overlooked could ruin lives. Mr Smith stated the relevance of being assured that assessment process is healthy, robust and suited to purpose. Ms Carroll informed the report addresses the importance of comprehensive triage and assessment. Ms Kay Isaacs added historically there were many different assessment tools being used within the crisis resolution and community mental health teams and timescales were varied however this has been amended so that all are using a more comprehensive assessment document. Ms Darlington requested Ms Isaacs share the document with her. Ms Isaacs undertook to do so. Discussion ensued around payment for service user and carer involvement. Ms Darlington was pleased that this has been established within learning disability services and queried how it had been resolved, as mental health services are still hoping to undertake the same. Mr Teape informed there is a meeting scheduled with Lisa Gostling. Mr Ken Jones queried the costs and Ms Darlington informed they were as recommended by the national government document however the stumbling block is that there has been no Health Board process set up in order to manage this in past. A paper has been submitted to Board in relation to the same. **Action:** • Ms Carroll undertook to speak with Gloria Trevis to establish the top three or four themes coming through from CTP audits. • Ms Kay Isaacs to share the CTP assessment document with Ms Angie Darlington	**KI** **LC** **KI**
	The Committee **NOTED** the content of the Scrutiny Group Update Report, Minutes and Terms of Reference and was **ASSURED** that the group is progressing well and processes are being duly monitored.	

MHLAC(19)47	**MH Power of Discharge Sub Committee Minutes - 9th April 2019** Mrs Sarah Roberts presented the draft minutes of the MH Power of Discharge Sub Committee and noted they are in draft format for formal approval at the next meeting in December. **Highlights include:** • IT solution for hospital managers looking for papers to be provided securely and electronically. Mrs Roberts requested Ms Darlington	

	provide a discussion on the use of devices at hearings at the next meeting in December. Ms Darlington agreed. • Breakdown of hospital manager activity. • IMHA report from Natasha Fox in relation to the hearings attended by advocates. • Presentation on deprivation of liberty safeguards. • Training. **Action:** • Ms Darlington to attend the MH Power of Discharge Sub Committee on 4th December 2019, to discuss use of electronic devices at Hearings.	**AD** **AD**
	The Committee **NOTED** the content of Draft Minutes of the MH Power of Discharge Sub Committee, dated 6th August 2019.	

MHLAC(19)48	**MH Power of Discharge Sub Committee Terms of Reference** Mrs Sarah Roberts presented the MH Power of Discharge Sub Committee Terms of Reference which had been brought to the committee for approval. The only revision related to lay membership being reviewed every three years as opposed to two. The committee approved the Terms of Reference.	
	The Committee **NOTED** the content of the revised MH Power of Discharge Sub Committee Terms of Reference and **APPROVED** the same.	

MHLAC(19)49	**POLICIES**	
	No policies were received.	
	The Committee **NOTED** there were no policies received for discussion.	

MHLAC(19)50	**Annual Work Plan**	
	The annual work plan was presented for information. Mrs Hardisty noted it was reflected in the work plan that the Mental Health Legislation Assurance Committee Terms of Reference are due for further review at the December meeting. No other comments were received.	
	The Committee **NOTED** the content of the Annual Work Plan.	

MHLAC(19)51	**For Information** **HIW Annual Report**	
	HIW Annual Report The HIW Annual Report was presented by Mrs Sarah Roberts for information.	
	The Committee **NOTED** the content of the HIW Annual Report.	

MHLAC(19)52	**Any Other Business**	
	Mrs Hardisty informed MH&LD have two entries shortlisted at the NHS Awards; the Dream Team from LD services and the vocational team working with MIND.	

MHLAC(19)53	**Date, Time and Venue of Next Meeting**	
	The next meeting of the Mental Health Legislation Assurance Committee will be held on **17th December 2019 at 14:00 – 17:00 at the Board Room, Ystwyth, St David's Park, Carmarthen SA31 3BB**. (*Please note this date has been changed from 10th December*)	

.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

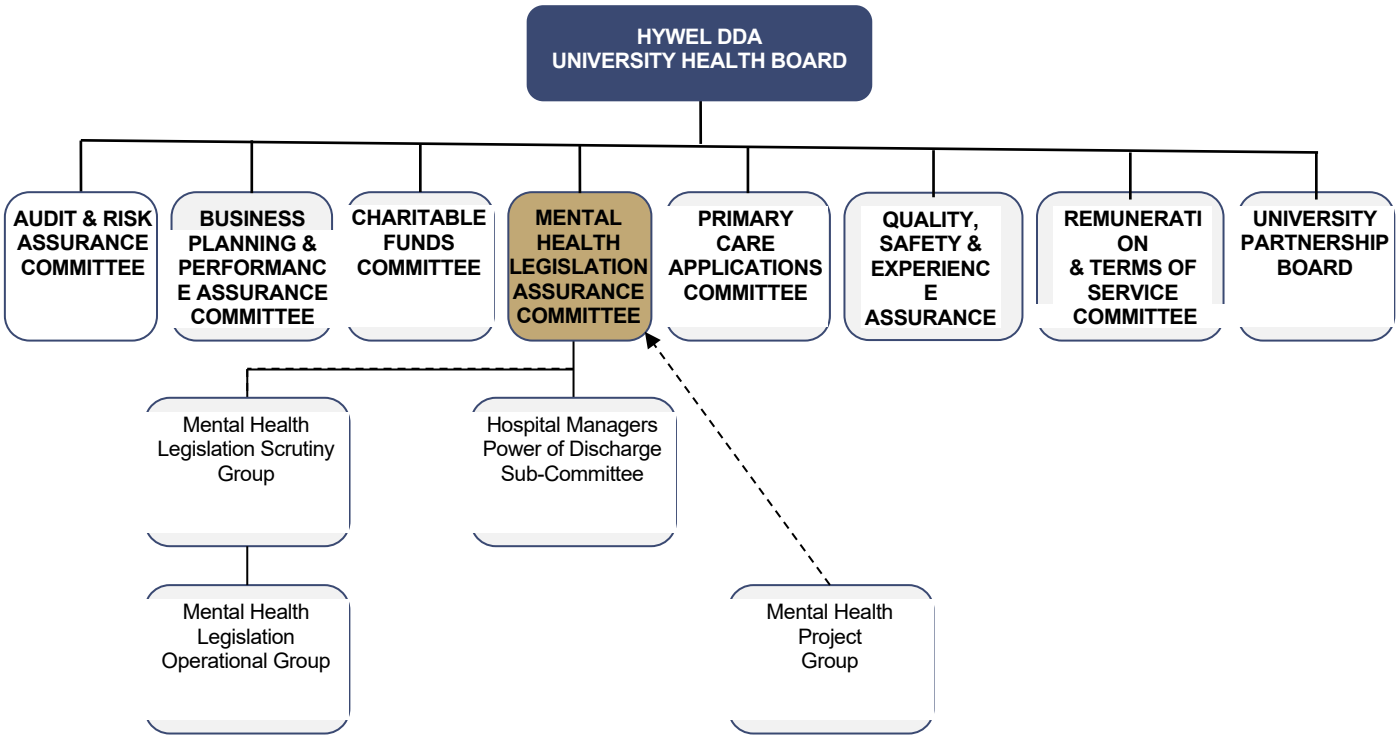
TABLE OF ACTIONS FROM
MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE MEETING
HELD ON 17th SEPTEMBER 2019

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
MHLAC(16)27 & (18)04 & (18)38 & (19)04	Locked Door Policy Explore putting together a formal document around the locking of doors. The policy is due to go to MH&LD Written Control Documents Group in February and will be brought to MHLAC in March.	LC SR		24/09/2019 – This has now gone via MH&LD Written Control Document Group (WCD). ACTION COMPLETE
MHLAC (18) 43 & (19)07 & (19)17	**Scrutiny Group update** • LC to pick up analysis of CTP audits with audit. QAPD team are working with audit to develop the reports. • Joe Teape and Paul Newman to discuss the direction of the Scrutiny Group and direction from the Mental Health Legislation Assurance Committee and to feedback at the next meeting.	LC JT/PN	~~March 2019~~ September 2019 December 2019	Update to be provided at March meeting. SR confirmed that the audit has now been collated and that further work is ongoing with the analysis of data. Action complete. PN & JT Joe Teape have met to discuss. JT has since met with LC and SR to note concerns. The Scrutiny Performance Report needs a level of drill down beneath it and SRo assured she will try and supply that in future however resource remains an issue. CS and AD have also met with PN. PN has spoken to Jo Wilson on clarification of how this committee links in to provide assurance.

MHLAC (18)44	LC and SR agreed to look into the connectivity of committees and sub committees and to feedback at the next meeting. Meeting has been held.	SR	December 2019	Mr Teape informed work is being undertaken towards assurance being provided on each level and fed up to this committee. An annual work plan is required for scrutiny group.
MHLAC (19)19	Sara Rees and Sarah Roberts to discuss how best to feedback results of the Datix exercise on the availability of Section 12 doctors to the Committee.	SR/SRo	~~June 2019~~ September 2019	Anecdotal evidence has been received from the local authority re lack of section 12 doctors. This has not been quantified previously however there is now a system in place for them to contact Sarah Roberts to submit a datix incident report.
MHLAC(19)30	All consider extensions to the MHLAC ToR and establish any new legislations the committee is obliged to adhere to. Mr Teape to liaise with Ms Wilson to verify the extent ToR are standard across all Wales. Mrs Rees to explore the options around Scrutiny Group being more workshop based.	All JT SR	December 2019 December 2019 December 2019	Update to be provided at December meeting. Update to be provided at December meeting. Update to be provided at December meeting.
MHLAC(19)39	Scrutiny Group Performance Report: Mrs Rees to highlight to Board lack of data analysis from the 3 local authorities and request this be taken to the Regional Partnership Board.	SR	December 2019	

MHLAC(19)45	Ms Liz Carroll to provide clarification of figures in relation to the 100% compliance for individuals re-assessed in a timely manner under Part 3, self-referral to secondary care for former service users.	LC	December 2019	
MHLAC(19)45	Ms Liz Carroll to request Ms Angela Lodwick, Head of Service SCHAMS to provide a report on admissions and patient pathway to be brought to the Mental Health Legislation Assurance Committee in December.	LC/AL	December 2019	
MHLAC(19)45	Miss Melanie Evans to provide an update report on learning disability services for the Mental Health Legislation Assurance Committee in December.	ME	December 2019	
MHLAC(19)46	Ms Carroll undertook to speak with Gloria Trevis to establish the top three or four themes coming through from CTP audits.	LC	December 2019	
MHLAC(19)46	Ms Kay Isaacs to share the CTP assessment document with Ms Angie Darlington	KI	December 2019	
MHLAC(19)47	Ms Darlington to attend the MH Power of Discharge Sub Committee on 4th December 2019, to discuss use of electronic devices at Hearings.	AD	December 2019	

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE

TERMS OF REFERENCE

Version	Issued To	Date	Comments
V0.1	Hywel Dda Health Board	27.09.2012	Approved
V0.2	Mental Health Act Monitoring Committee	27.11.2012	Membership amended
	Hywel Dda University Health Board	22.06.2014	In Standing Orders
V0.3	Mental Health Legislation Assurance Committee	10.09.2014	Approved
	Hywel Dda University Health Board	26.11.2015	Approved
V.0.4	Mental Health Legislation Assurance Committee	10.03.2016	Approved
V 0.5	Mental Health Legislation Assurance Committee	07.12. 2017	Amendments
V 0.6	Mental Health Legislation Assurance Committee	08.03.2018	Amendments
V 0.7	Mental Health Legislation Assurance Committee	17.09.2019	

MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE

1. Constitution

1.1 The Mental Health Legislation Assurance Committee (the Committee) has been established as a Committee of Hywel Dda University Health Board (HDdUHB) and constituted from 1st June 2015.

2. Membership

2.1 Formal membership of the Committee shall comprise of the following:

Member
Independent Member with responsibility for Mental Health (Board Vice-Chair) (Chair)
Independent Member (Vice Chair)
4 X Independent Members

2.2 The following should attend Committee meetings:

In Attendance
Deputy Chief Executive/ Director of Operations (Lead Director)
Director of Mental Health & Learning Disabilities Services (Lead Officer)
Associate Medical Director for Mental Health Services
Head of Nursing Mental Health & Learning Disabilities
Head of Older Adult and Learning Disability Services
Mental Health Act Administration Lead
Chair of Mental Health Legislation Scrutiny Group
Nominated representative from Dyfed/Powys Police
Nominated representative from Welsh Ambulance Services NHS Trust
Nominated representative from Carmarthenshire County Council
Nominated representative from Ceredigion County Council
Nominated representative from Pembrokeshire County Council
Nominated representative from West Wales Action for Mental Health (WWAMH)
2 x Nominated Service Users: patient representative and carer representative
Nominated representative from Primary Care: GP Lead
Nominated representative from Hywel Dda Community Health Council (not counted for quoracy purposes)
Nominated representative from Advocacy Network

2.3 The Vice-Chair of the University Health Board (UHB) shall undertake the role of Chair of the Mental Health Legislation Assurance Committee given their specific responsibility for overseeing the Board's performance in relation to mental health services.

2.4 Terms and conditions of appointment (including any remuneration and reimbursement) in respect of independent external members and service users will be determined by the Board.

2.5 Membership of the Committee will be reviewed on an annual basis.

3. Quorum and Attendance

3.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with a third of the In Attendance Members.

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

3.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

3.4 The Committee may also co-opt additional independent 'external' experts from outside the organisation to provide specialist skills.

3.5 Should any officer member be unavailable to attend, they may nominate a deputy with full voting rights to attend in their place, subject to the agreement of the Chair.

3.6 The Chairman of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.

3.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Mental Health Legislation Assurance Committee.

3.8 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

3.9 The Chair of the Mental Health Legislation Assurance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

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

4. Purpose

The purpose of the Mental Health Legislation Assurance Committee is to assure the Board on the following:

4.1 Those functions of the Mental Health Act 1983, as amended, which have been delegated to officers and staff are being carried out correctly; and that the wider operation of the 1983 Act in relation to the UHB's area is operating properly;

4.2 The provisions of the Mental Health (Wales) Measure 2010 are implemented and exercised reasonably, fairly and lawfully;

4.3 The UHB's responsibilities as Hospital Managers are being discharged effectively and lawfully;

4.4 The UHB is compliant with Mental Health Act, 1983 Code of Practice for Wales;

4.5 The Committee will also advise the Board of any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.

5. Key Responsibilities

In respect of its provision of advice to the Board, the Mental Health Legislation Assurance Committee shall:

5.1 Review reports from Healthcare Inspectorate Wales visits, the Delivery Unit and other external scrutiny bodies and approve the action plans for monitoring through its sub-committee structure;

5.2 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;

5.3 Receive Mental Health Legislation Scrutiny Group Update Report and Minutes from previous meeting.

5.4 Consider issues arising from its Sub-Committee and Group structure;

5.5 Receive the Hywel Dda Mental Health Partnership Board Annual Report and consider issues in relation to the implementation of the Mental Health Strategy across the Hywel Dda area;

5.6 Receive update reports from the Mental Health Programme Group on improvement programmes for high quality, safe and sustainable mental health services which are consistent with the Board's overall strategic direction.

5.7 Receive Hospital Manager's Power of Discharge Committee Update Report & Minutes from previous meeting. This report should ensure compliance with the Code of Practice.

In respect of its provision of assurance to the Board, the Mental Health Legislation Assurance Committee will seek assurances that:

5.8 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

5.9 The wider operation of the 1983 Act (the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

5.10 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated;

5.11 Arrangements for the delegated authority of approval for Approved Clinicians and Section 12 Doctors in Wales are compliant with the Directions and Guidance from Welsh Government, and are monitored through the Mental Health Legislation Scrutiny Group;

5.12 Policies and procedures are developed and approved in line with the organisation's Written Control Document Policy, through the Mental Health Legislation Scrutiny Group;

5.13 The training requirements of those staff who exercise the functions of mental health legislation have the requisite skills and competencies to discharge the Board's responsibilities, through the Mental Health Legislation Scrutiny Group;

5.14 Ensure that relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 1998, are adhered to.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice-Chair and Lead Director/Lead Officer at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead Officer.

6.4 The agenda and papers will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **ten** days to check the accuracy.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet quarterly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

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

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub-committees and groups, to provide advice and assurance to the Board through the:

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

10.1.2 sharing of information.

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee may establish Sub-Committees or Groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each Sub-Committee or Group meeting detailing the business undertaken on its behalf. The Sub-Committee reporting to this Committee is:

10.3.1 Hospital Managers Power of Discharge Sub-Committee

10.3.2 Mental Health Legislation Scrutiny Group

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update paper, as well as the presentation of an annual report within six weeks of the end of the financial year.

10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees, of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Lead Director (Deputy Chief Executive/Director of Operations) and will be supported by the Lead Officer (Director of Mental Health and Learning Disabilities).

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR MONITRO'R DDEDDF IECHYD MEDDWL
MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17th December 2019
EITEM AR YR AGENDA: TITLE OF REPORT:	Mental Health Legislation Assurance Committee Quarterly Performance Report. Quarter 2, July - September 2019
ARWEINYDD CYFARWYDDWR: EXECUTIVE LEAD:	Mr Andrew Carruthers, Director of Operations/Deputy Chief Exec
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Liz Carroll, Director MH&LD, Lead Officer

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 the paper is to present to the Mental Health Legislation Assurance 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 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 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), as amended, and the Mental Health (Wales) Measure 2010 (the Measure) which they have delegated to officers and staff, are being carried out correctly; and that the wider operation of the 1983 Act and the Measure 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 Human Rights Act 1998 and the Data Protection Act 1998.

The Terms of Reference of the Committee itself 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.

Assesiad / Assessment

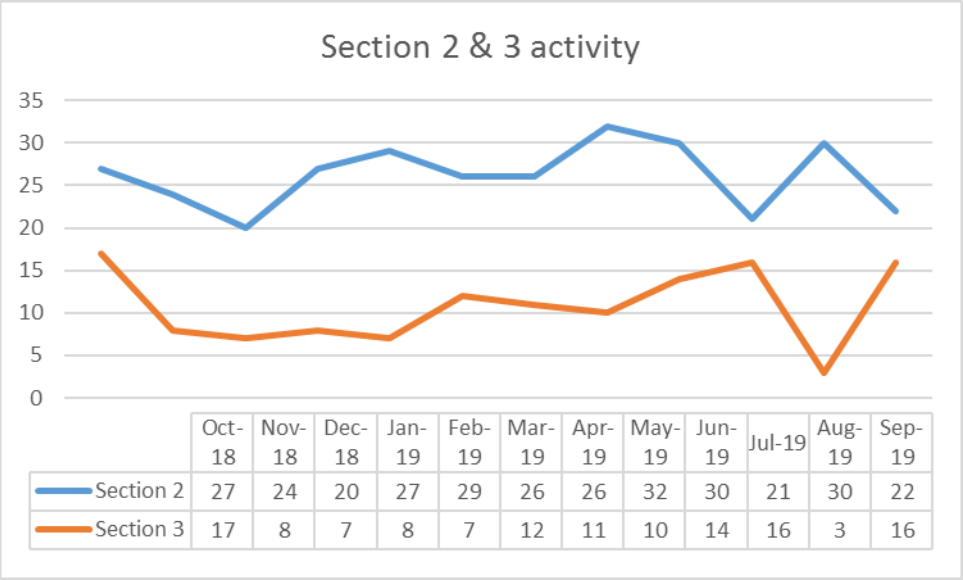
This Quarterly report outlines how the Mental Legislation Assurance Committee has complied with the duties through the Terms of Reference set, and also identifies key actions to address developments.

The Mental Health Act, 1983

Any exceptions highlighted in the Mental Health Act activity report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained in Hywel Dda University Health Board and those subject to a community treatment order is only as the Act allows. Rates of detention under different sections of the MHA typically fluctuate between each quarter therefore only significant points are highlighted here. A breakdown of MHA monthly performance can be seen in the performance dashboard to which there is a separate link.

Section 2[1] and Section 3[2] are the most commonly used sections of the Act in the detention for assessment and treatment of individuals suffering from a mental disorder.

Figure 1 - Numbers of detentions under S.2 and 3

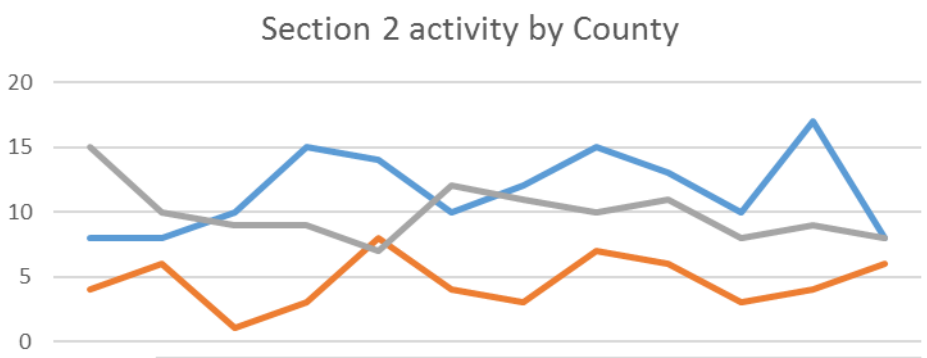


	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Section 2	27	24	20	27	29	26	26	32	30	21	30	22
Section 3	17	8	7	8	7	12	11	10	14	16	3	16

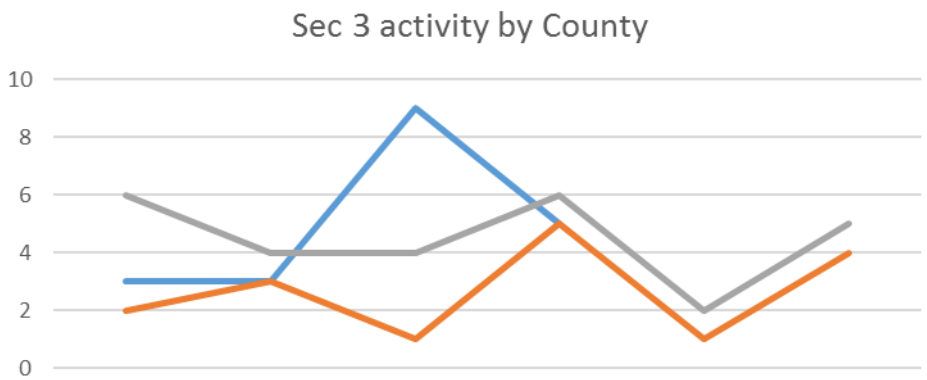
- Use of section 2 has decreased 73 compared to 88 for the previous quarter
- 33 patients were admitted to a ward directly from the community
- 6 patients were transferred in from another hospitals outside the health board
- 16 patients went on to Section 3 for treatment which is a decrease on previous quarters.

[1] Section 2 of the Act allows for a period of detention in hospital for up to 28 days for assessment and treatment.

[2] Section 3 of the Act allows for a period of detention in hospital for up to six months for treatment and may be renewed.



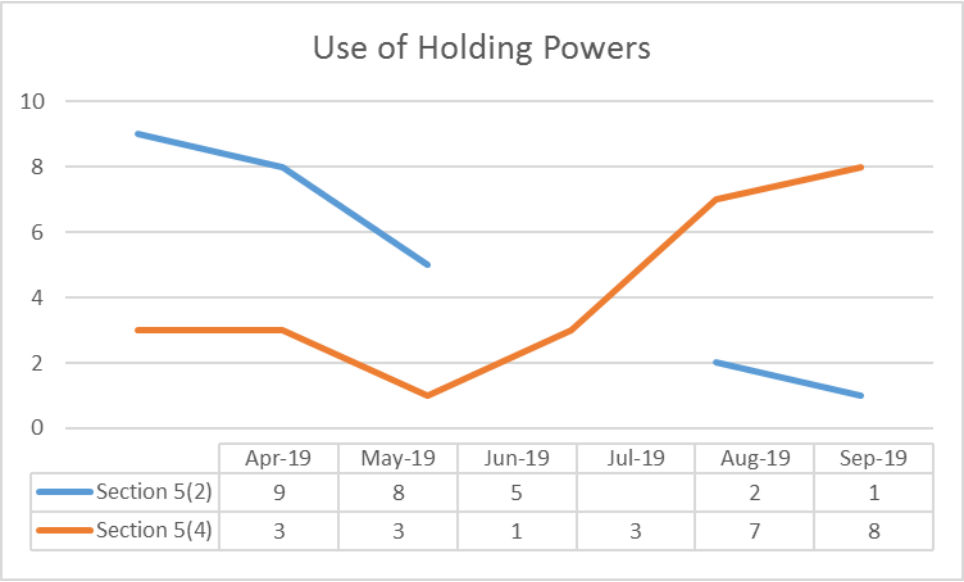
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Carms	8	8	10	15	14	10	12	15	13	10	17	8
Cered	4	6	1	3	8	4	3	7	6	3	4	6
Pembs	15	10	9	9	7	12	11	10	11	8	9	8

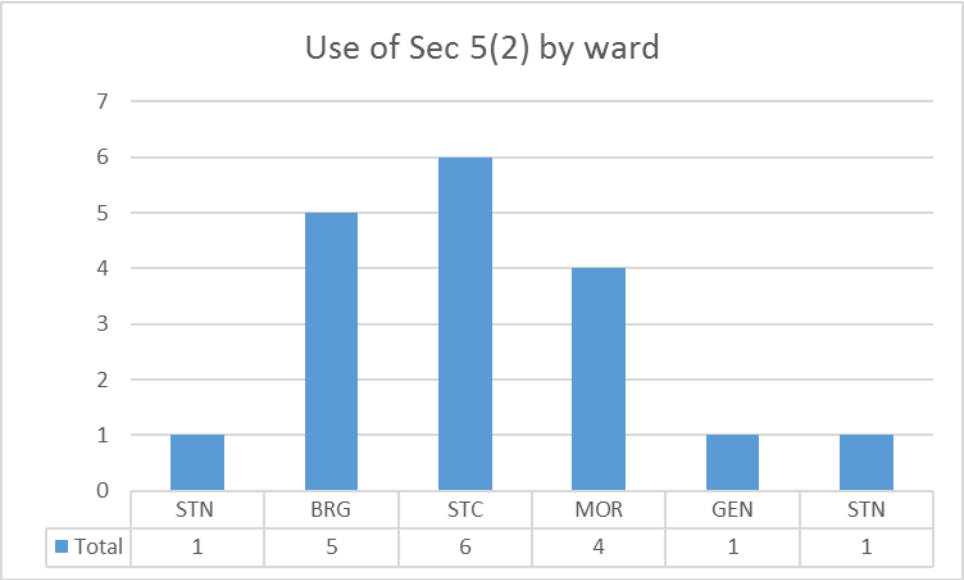


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Carms	3	3	9	5		7
Cered	2	3	1	5	1	4
Pembs	6	4	4	6	2	5

- Use of Section 3 has remained the same for the quarter at 35
- 16 patients subject to Section 2 had their sections converted to Section 3
- 9 patients were detained to older adult wards and 1 to learning disabilities
- 1 patient was transferred out of Hywel Dda to a specialist placement

Figure 2 – Number of detentions under Section 5





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.

- Use of this holding power has decreased 18 occasions compared to 22
- Used in a general hospital setting on 1 occasion
- 16 assessments were carried out within 60 hours
- 9 of those patients were further detained on Section 2 or 3

Section 5(4) – 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 this holding power has decreased to 3 occasions compared to 7
- All patients were further detained under the Mental Health Act following assessment

Detention without authority or Invalid Detentions

- 142 statutory documents were medically scrutinised
- 50 rectifiable errors were made on documents - corrections carried out within the statutory time limits (14 days) Nurses errors 15, NHS Doctors errors 14, external Doctors 6 and AMHP errors 15
- There was one invalid detention – Section 5(2) not fully completed

The use of Section 135/6[3]

The number of occasions that Section 135/6 has been used with the UHB has decreased compared to the previous quarter (75 occasions compared to 48). The Section 136 activity is discussed at the Section 136 review group. Section 135(1) was used on one occasion.

Figure 2 - Number of S.135/6 assessments

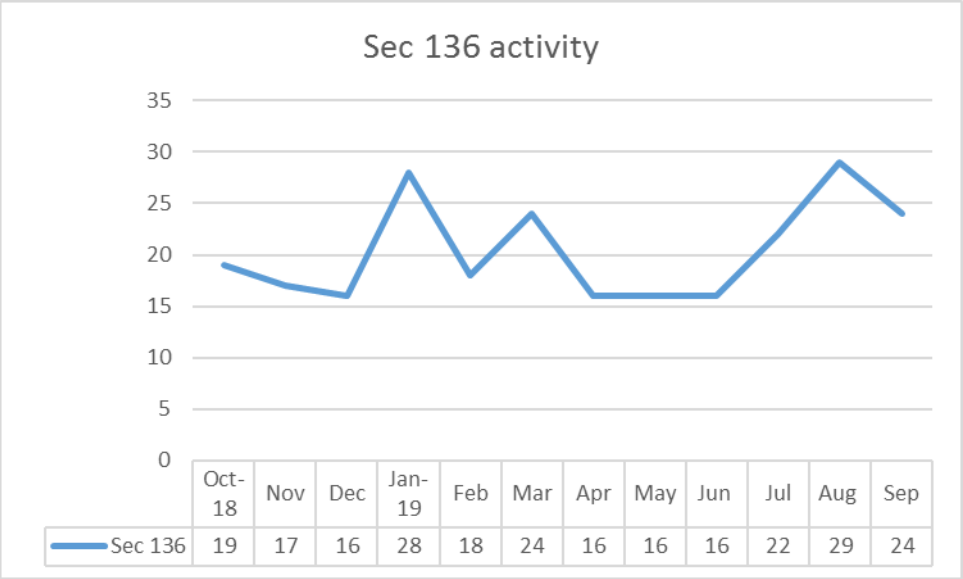
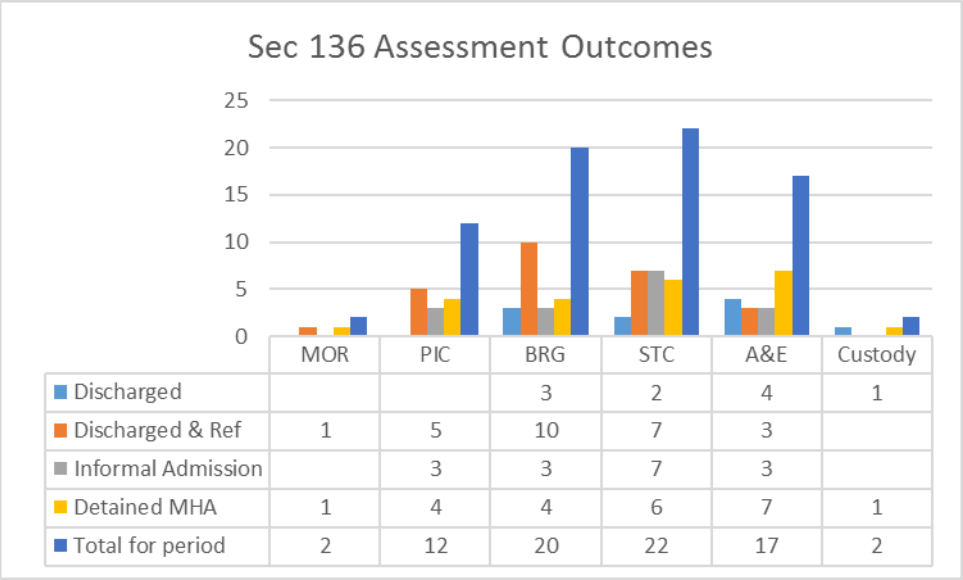


Figure 3 - Breakdown of S.136 assessments by Place of Safety



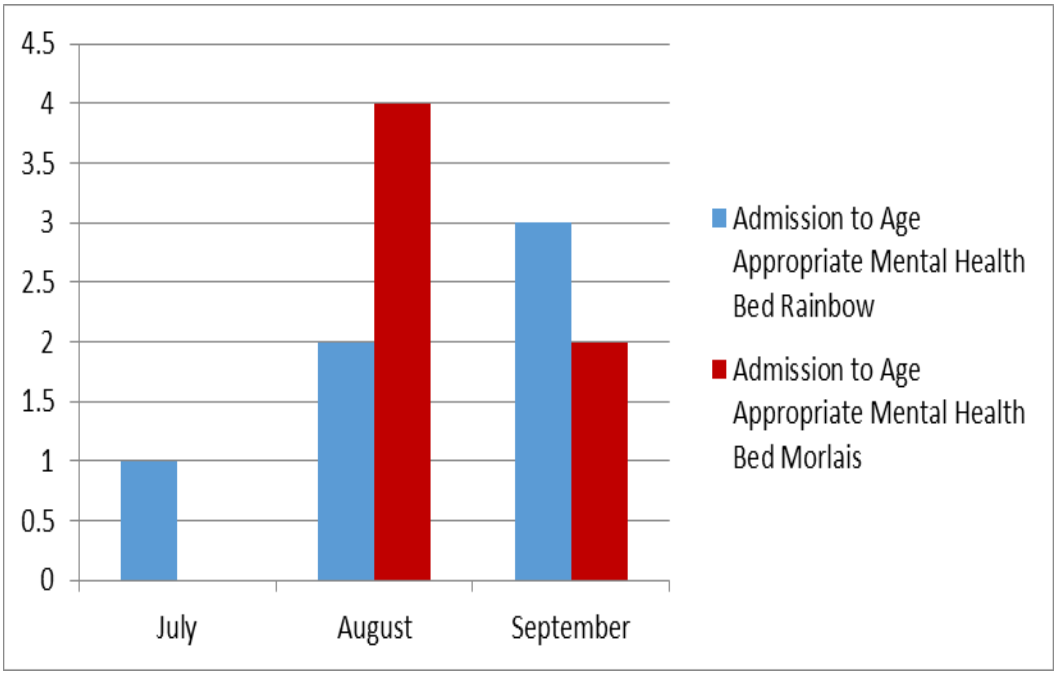
[3] Section 136 allows a police officer to remove a person to a place of safety, if the person appears to be suffering from a mental disorder and to be in immediate need of care or control.

- Use of Section 136 has increased - 75 occasions compared to 48 (28 to Bryngofal, 5 to St Caradog, 7 to PICU, 2 to Morlais, 1 to LSU and 5 to DGHs.
- Following assessment 23 patients were detained on further sections of the Mental Health Act.
- 35 patients did not require admission and were discharged back into the community
- 72 assessments were carried out within 24 hours

S-CAMHS admissions to age-appropriate beds

All admissions to the mental health bed must be reported, initially internally as a DATIX, and followed by a Serious Untoward Incident report to Welsh Government in line with the Welsh Governments Admission Guidance Document. All admissions receive a follow up appointment within five working days to monitor risk and provide support.

Figure 5 – Comparison Data Qtr 2 - Age Appropriate Bed



Admission Outcomes

	Discharged Home	Onward Admission
Rainbow	6	1 (admission to Morlais Ward)
Morlais	4	1 (admission to Tier 4 bed)

One young person was placed on Section 2 of the Mental Health Act at 00.40hrs on 21/08/2019 which ended at 17.15hrs on 21/08/2019.

Exclusion of Visitors

There were no visitors excluded from visiting detained patients during Qtr 2.

Applications for Discharge to Hospital Managers and Mental Health Review Tribunal
15 applications were made to the hospital managers resulting in 4 hearings taking place, two of which were from applications received the previous quarter and 1 application made during this quarter will be held in quarter 3. Of the four hearings held the hospital managers discharged one patient.

The hospital managers heard 21 renewal hearings compared to 25 last quarter. The Code of Practice states renewal hearings should ideally be held before the section expiry date. 5 out of 21 renewal hearings were not listed before the section expiry date

1 application for discharge was made by a nearest relative during this quarter – this was barred by the RC which the hospital managers heard but did not discharge the patient.

- There were 80 applications/referrals to the Mental Health Review Tribunal (compared to 63 in last quarter). 36 hearings taking place during this quarter.
- There were 3 applications to the MHRT classed as ineligible during this period – in that they were outside the 14 day limit for section 2 applications.
- There has been 1 discharge by the MHRT (section 2)

The Mental Health (Wales) Measure 2010
The Mental Health (Wales) Measure 2010 is reported to the Committee on a quarterly basis in order to provide assurance that activity is closely monitored and that practice is compliant with the requirements of The Measure. 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
Part 1 of the Measure is monitored in two parts, Target 1 and Target 2 as detailed in the table below. Performance is being monitored by the Head of Adult Mental Health Services with the LPMHSS Team Leaders.

PART 1	Detail	JUL 2019	AUG 2019	SEPT 2019
Target 1	80% of assessments by the LPMHSS undertaken within 28 days from date of receipt of referral	**85.8%** 261 service users	**82.3%** 305 service users	**91.3%** 206 service users
Target 2	80% of therapeutic interventions started within 28 days following an assessment by the LPMHSS	**90.6%** 181 service	**87%** 177 service	**83.6%** 122 service

		users	users	users

Part 2 – Care and Treatment Planning

PART 2	Detail	JUL 2019	AUG 2019	SEPT 2019
Measure 1	90% of LHB residents who are in receipt of secondary mental health services (all ages) to have a valid CTP	**92%** 2165 service users	**94.5%** 2146 service users	**92.7%** 2136 service users

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

PART 3	Detail	JUL 2019	AUG 2019	SEPT 2019
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%	**100%** 9 service users	**100%** 8 service users	**64.3%** 14 service users

Part 4 – Independent Mental Health Advocacy

PART 4	Detail	JUL 2019	AUG 2019	SEPT 2019
	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%)	**96.2%**	**100%**	**98.2%**

The UHB was not compliant with part 4 of the Measure for two months. There have been several vacancies within community teams and high absence rates. Health and local authority staff are taking joint responsibility for meeting targets. Learning Disability and CAMHS numbers are very low.

Argymhelliad / Recommendation

- To discuss the Mental Health Legislation Assurance Committee Quarterly Performance Paper.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Risk Register Reference:	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 Statement	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
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 Assurance 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 Assurance Committee, Power of Discharge sub 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 Mental Health Operational 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:**	Non-compliance with the Mental Health Act could result in legal proceedings being brought against the Health Board who is the detaining authority.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Item

PWYLLGOR MONITRO'R DDEDDF IECHYD MEDDWL
MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17th December 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health Legislation Scrutiny Group Update
ARWEINYDD CYFARWYDDWR: **EXECUTIVE LEAD:**	Andrew Carruthers
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sara Rees Interim Head of Nursing MH/LD Directorate

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 (the Group) was established as a Sub-Group of the Mental Health Legislation Assurance Committee (MHLAC) and was constituted from 14th July 2014. The group was re-established in November 2017 whereby Sara Rees, Head of Service Adult Mental Health took over Chairing duties. Sara Rees is now in the Interim Head of Nursing MH/LD post but will retain the Chair of MHLSG until a new substantive AMH Head of Service is appointed at which point Sara Rees will stand down as chair but will continue to attend as a member of the group. As yet a vice chair has not been agreed by the group.
The purpose of the paper is to present to the Mental Health Legislation Assurance Committee an update from the Mental Health Legislation Scrutiny Group meeting held on Tuesday 19th November 2019 and any subsequent work that has been undertaken since that meeting. This paper will focus on the workshop that was undertaken aimed at setting the priorities for scrutiny and the development of an assurance plan for MHLAC. Draft minutes of the MHLSG will be attached for information.

Cefndir / Background

The following papers are submitted as regular items on the MHLSG agenda in line with the principal duty of the scrutiny group as described within the Terms of Reference.

- IMHA Report
- Mental Health Act Use
- SCAMHS Update Report on admissions to the designated bed on Morlais Ward
- Mental Health Measure performance report
- Mental Health Triage update
- Local Authority Data (no analysis)
- Deprivation of Liberty Report
- Notes of the Section 136 Review Group
- CTP Audit Report
- Any other relevant report or memorandum of understanding

Papers are sent out to members of the MHLSG at least seven days in advance of the meeting and members are expected to read and submit agenda items should further scrutiny of the papers be required.

Asesiad / Assessment:

Three agenda items were nominated for further discussion at the meeting prior to a workshop facilitated by Angie Darlington to set the priorities/work plan for the next four MHLSG and develop the assurance plan for MHLAC.

Firstly Lack of Section 12 Doctors and the mechanism that was put in place to try and quantify the challenge of accessing these by local authority when required. Unfortunately only one local authority submitted incident reports via the MHA team as such the members of the group agreed that this reporting mechanism should stop as it did not provide the intelligence upon which action could be built. The directorate will need to consider how best to take this issue forward. A request has been made to the Chair of the MH/LD Medical Staffing Committee (MSC) that the Chair of the MHLSG and Mental Health legislation Lead (once appointed) be given a regular quarterly slot on the MSC agenda. This will be incorporated into the MH/LD risk register under the sub-title of medical recruitment.

Secondly Care and Treatment Planning Audit Report which was presented to the meeting. The scrutiny group acknowledged the progress that has been made in developing the report in conjunction with the audit department. AE gave an update on the roll out of the audit across services. CMHT's in AMH and OAMH are submitting audit data as are CTLD. The system is ready for the implementation of the audit by SCAMHS and EIP. The next phase of implementation will be inpatient areas once the system for collating the information for submission has been strengthened. The report will be further developed to demonstrate comparative performance not just a position statement. Whilst the audit does highlight engagement with Professional, family and carers supporting the relevant patient we acknowledge that we need to strengthen systems to ensure that patient and carers voice is heard. We do not anticipate that this would be achieved through the CTP audit process and as such will be working in partnership with WWAMH to develop this. Also relating to CTP SR and AD have been discussing the potential for developing an information leaflet on CTP for patients and carers so that they will have greater understanding of what they can expect from CTP. The report needs to demonstrate improved analysis of the data and AD has advised that WWAMH would be able to support this. ME raised an issue within Carmarthenshire LA that some LD patients care coordinated under CTP are not currently on Care Partner. An action for ME was to confirm whether this is the case and if there are relevant patients not on care partner that are subject to CTP a meeting will be arranged to ensure this is rectified.

Thirdly NF presented the IMHA Report, key issues raised were the merger of Advocacy West Wales and Eiriol this should be completed by 31st December 2019. At this stage the services will continue to operate as usual and all contact information remains the same for referrals and queries to ensure continuity and minimise disruption. The IMHA report is an important source of feedback about the patients experience of our services, not just related to rights under the mental health act, as such NF also presents this report to the Ward Manager forum on a regular basis and to address issues directly with operational services but also meets with the QAPD Team to influence the quality improvement agenda within the MH/LD directorate.

Workshop on key issues for MHLSG for the next twelve months
This workshop was facilitated by AD and SR. The purpose was to prioritise what needs to be scrutinised by the MHLSG to provide assurance to MHLAC over the next twelve months. All members of the group were invited to participate.

- All agreed that the meetings need to be more effective and to enable this commitment needs to be made by all members to ensure that papers are read and any issues highlighted prior to the meeting with members requesting agenda items. This would ensure less debate and more focus in the meeting. Also task and finish work outside the meeting
- Clear reporting structures and metrics to provide assurance on.
- Monitoring and scrutiny of incidents – this is currently reported through MH/LD QSEASC, this meeting function will be changing as such it is an opportunity to consider this in relation to the role of the scrutiny group. There is a meeting scheduled for the 16th December to discuss this.
- What is the data telling us – the narrative behind the data, informed by patient experience.
- Scrutinise, advise and assure.
- Qualitative outcomes need to be collected, MH/LD QAPD team, what is role of the team in this.

Five priority areas agreed at the meeting

- Analyse and understand the current data, includes MHA report and MHM performance data and consider how to develop a systematic approach that captures the patient and carer experience in the analysis of the data.
- There is soon to be national guidance on reducing restrictive practice across all age groups this needs to be scrutinised and considered in relation to the use of the MHA.
- Sources of data ie readmission rates, frequent attenders, street triage need to be considered and scrutinised as a whole system.
- Part 1 MHM scheme needs to be reviewed
- Request report from MH/LD Commissioning regarding those patients sectioned under the MHA to Independent providers.

Codes of Practice MHA and MHM will be the standards utilised for scrutiny.

Next meeting: Information for scrutiny at the meeting: question how do we understand the patients experience behind the data.
HB – Readmission data for quarter three
Police – 136/triage data – with particular scrutiny around those already known to the MH service, quarter three.

In November 2019 the Mental Health Review Tribunal for Wales issued a Practice Direction which relates to the content of MHRT reports and additional information it requires. The Practice Direction has been circulated to the three local authorities and the IMHA service for information and a briefing was circulated to Heads of Service to cascade to service areas.

The MHA Administration team will devise report layouts for Responsible Clinicians, Social Circumstances Reports and Nursing Reports to ensure the points required by the MHRT are covered. The same format for reports will also then be required for Hospital Managers hearings. The MHA Administration Team Lead will attend Service Dashboards and the Nurse Managers Forum to provide an update on the requirements.

The November Medical Staff Committee meeting discussed how best to support all the clinical staff that will be expected to provide reports to the MHRT. One suggestion was to arrange a session within the Post Grad programme for doctors, nurses and care co-ordinators. Further training will then be arranged with a planned roll out across MH&LD by 01 April 2020.

The following papers were not scrutinised during the meeting, members have been asked to submit any questions to the chair of the scrutiny group, at the time of writing this report none had been received.

- Mental Health Act Data
- CAMHS Data
- Mental Health Measure Data
- Mental Health Triage Data Qtr 2
- Local Authority Data collection
- DoLS Report
- Section 136 meeting notes
- National Assembly for Wales Mental Health in Policing and Police Custody Oct 19

Argymhelliad / Recommendation

To acknowledge 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 Risk Register Reference:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve population health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working:	**Long term - the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs** **Prevention – the importance of preventing problems occurring or getting worse**

	Integration - the need to identify how the Health Board's well-being objectives may impact upon each of the well-being goals, on its other objectives, or on the objectives of other public bodies
	Collaboration – acting in collaboration with anyone else (or different parts of the organisation itself) which could help the Health Board to meet its well-being objectives
	Involvement - the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the Health Board serves

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 – Health 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
Parties / Committees consulted prior to the Mental Health Legislation Assurance Committee:	MHLSG Mental Health Act Legislation Administration Lead

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/Cyfreithiol: **Risk/ Legal:**	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
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Transforming Learning Disabilities

Update October 2019

"Our focus is to ensure that adults with learning disabilities are able to access enhanced and varied support services within appropriate settings, which help them to achieve the greatest possible quality of life."

Stakeholder engagement

A key focus of our stakeholder engagement has been to encourage people with learning disabilities to be at the centre of our future planning.

The Dream Team is a stakeholder group of people with learning disabilities that fully engage with the Learning Disabilities Programme Group (LDPG) - a 3 County multi agency strategic group of senior health and social service managers.

The team is a group of 10 people from across the 3 Counties who represent the wider learning disabilities population. The group is made up of Health Board volunteers (with learning disabilities), LD Champions and members of Pembrokeshire and Carmarthenshire People First.

The Dream Team lead alternate meetings of the LDPG. This means that the group is 'Chaired' by James Dash a member of the Dream Team and that the agenda and matters discussed are set by the Dream Team.

Since being formed last year the Dream Team have quickly developed a Meetings Agreement paper which specifies how meetings are run so as to ensure that the level of communication is appropriate, that papers are produced in an Easy Read format, that there are breaks during the meeting and that people are given time to be heard.

The Dream Team have now developed a Charter for people with learning disabilities to explain what matters to them.

Below are some of the issues the Charter talks about

My Life My Rights - having more choices and treating us with dignity and respect
My Communication – making everything easy read
My Support – give us the support we need when we need it
My Community – Give us paid jobs
My Health – We need health staff to be trained by us
My Independence – Hate crime and bullying must stop
My Social Life – We want have activities in the evenings and weekends too
My Relationships – We want the right to have a family

The LDPG have taken on board the Charter and have ensured that all the Integrated Care Fund (ICF) bids from Welsh Government are in line with this Charter.

The Dream Team met the NHS Awards judging panel in early July and they signed up to the Charter. The team are shortlisted for the 'Empowering People' NHS Award

The next step is to form an audit team of people with learning disabilities who can check whether the desired changes identified in the Charter have taken effect.

If you want more info on the Charter and to see the Team in action then click on the following link

https://vimeo.com/337960189

We are very proud to announce that the 'Dream team' won an NHS Award for Empowering People to co-produce their care' at the 2019 NHS Awards in September this year.

Intermediate Care Fund

A total allocation of 1.7 million revenue allocation was made available by Welsh Government this year and through the LDPG it was agreed that any project proposals would have to link back to the Charter and describe how the outcomes would help people with learning disabilities. The summary below details the bids and how they demonstrate their link to the Charter:

Project	LD Charter Element
Pembrokeshire LD employment project - this programme of supported employment and the LD Champions will be rolled out across the 3 Counties. Supporting people with LD into paid employment.	My life. My rights; My community; My independence
Advocacy (non-statutory, peer, group, self)	My support; My community; My independence
Positive Behavioural Intervention service for children and young people with an LD	My communication; My support; My health; My relationships
Exercise buddies – helping people to increase their uptake of leisure and activities to promote exercise.	My community; My health; My social life; My relationships
Development of supported accommodation, developing community based accommodation options, moving away from Residential Care.	My life. My rights; My independence
Progression project, ensuring people are receiving the right care in the right place and where we can move people closer to home.	My life. My rights; My independence
Charter implementation and audit	All charter elements
Accessible and involved annual health checks - providing support to primary care to improve services for people with LD, this will include peer support.	My life. My rights; My communication; My support; My health; My independence
Tech solutions – including developing apps that help people access their care records and transport information.	My communication; My community; My health; My independence; My social life

LD Health Liaison Service

The team was established at the beginning of December 2018 with 3 nurses appointed to posts within Bronglais Hospital, Glangwilli and Prince Phillip the post for Withybush was not filled. All posts are part time with post holders working 18.75 hrs per week. We have established a working rota with the nurses working two days one week and three the next which overlap to ensure liaison nurse cover for the HB 5 days per week, there is currently no cover provided over weekends or outside office hours.

The key aim of this service is to ensure reasonable adjustments are made in hospital settings to support people with learning disabilities and their families to access mainstream services.

Most recently we have been successful in securing funding from Welsh Government to increase the service provided this money has been allocated to allow the Withybush post to be increased to 1

wte, the Bronglais post to be increased to 0.8 wte and the creation of a band 5 development role working across the Carmarthen hospitals. These posts will be advertised in the near future.

The team have provided training sessions to preceptors, junior doctors, nursing and various wards and departments, in total they have trained 255 staff across the acute service.

- Learning Disability champion training sessions have been run with the Paul Ridd Foundation for each hospital site with staff volunteering for the roles.
- They have also provided training to both the University of South Wales and Swansea university student nurses.
- The team have presented at 2 national conferences on constipation awareness in people with a learning disability
- Have helped develop a training package for GP's with Public Health Wales which will be presented at a conference in Sept for feedback from primary health staff and will then be formally launched by Public Health Wales

Long stay patient's re-settlement

Good progress has been made in finding independent living accommodation for the patients who had been accommodated on Ty Bryn and Tudor House. Families and patients are really happy with the new arrangements and one patient story is detailed below:

'He has been to the cinema, seen a musical, loves the beach walks and has overcome a long standing fear of dogs, tolerating them in his vicinity in the local cafes that he frequents. His elderly parents were anxious about the move but are now happy with his new home and are 40 minutes car journey closer each way to him.'

'He is fully engaged with his new social life. He loves arts and crafts, gardening, bird watching and also has made new friends with peers who join him to watch music concerts. His parents are overjoyed to have him nearer the family home and are happy with all aspects of the move.'

We are now considering the future model of inpatient care for LD and will begin to look at long term options; this will include consultation with people with learning disabilities and will be a key work stream within the transformation programme.

In the interim a LD Intensive Support Team has been created, with staff from Ty Bryn and Tudor House with the aim of people being supported at home to avoid inpatient admissions. This will be a 12 month 'proof of concept' pilot with built in evaluation as part of the Bevan Commission Exemplar Programme. The Team of nurses and support workers will provide support for people that require an increased level of input for a short and focused amount of time.

Residential Care Services

Patients living with our long stay residential services have received independent assessments as part of the National Commissioning Programme. 3 patients will move to alternative accommodation from Bro Myrddin, due to increasing health needs, but also for one person they are moving to a more independent living with greater access to the community and activities.

The 2 units in Pembrokshire have also been reviewed and again we are identifying some patients experiencing a decline in their general health, so we are exploring where their long term needs can be met. We are also ensuring that appropriate staffing levels are maintained to meet current needs.

Longer term options will need to be considered following advice from Court of Protection, submissions have been completed and we are awaiting the relevant hearings.

Long term NHS has been subject to National scrutiny and further advice from Welsh Government, linked to reducing restrictive practice is expected in the Autumn.

Community Teams for Learning Disabilities

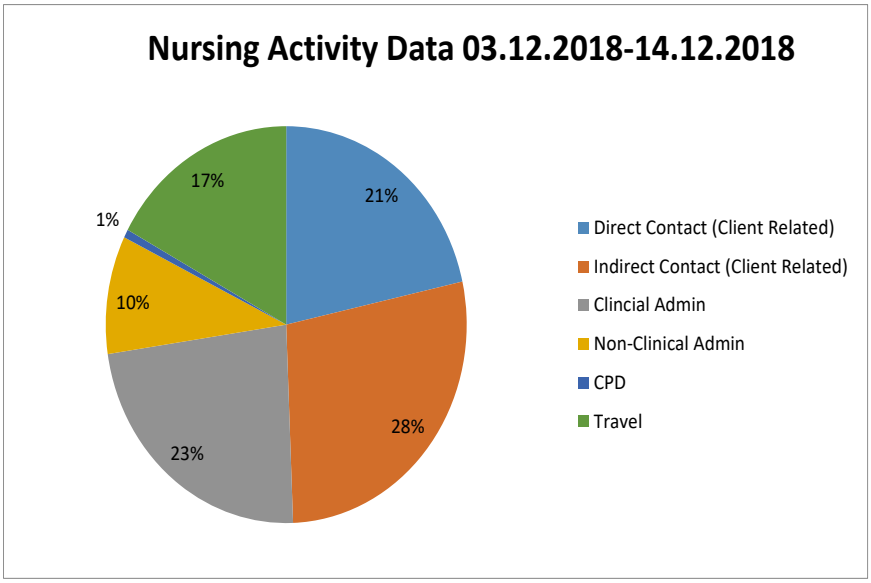
A full service review, encompassing:

- Capacity and demand planning and management
- Best practice review of service models across the UK which may be developed within West Wales.
- Required skill-mixes and training needs.
- Developing discipline specific scopes of practice and CTLD service specifications.
- Pathway development :
    - Behaviours that Challenge
    - Dementia
    - Epilepsy
    - Mental Health
    - Physical Health
    - Profound and Multiple Learning Disabilities
    - Reduction of restrictive practice (e.g. venepuncture procedure)

This review has been undertaken in order to inform any required re-structuring teams to future proof service provision and ensure relevant governance and accountability is in place.

Draft proposals for restructure have been developed and costed. Further work with Finance Department is to take place to ensure the new service proposals fit within the current budget.

An analysis of CTLD activity was undertaken at the end of 2018, to help us understand whether we have the right capacity against current demand and what future requirements may be. The analysis detailed below was for nursing staff (all staff groups were surveyed) it is interesting to note how much time is taken up with travel and the relatively low direct patient contact.

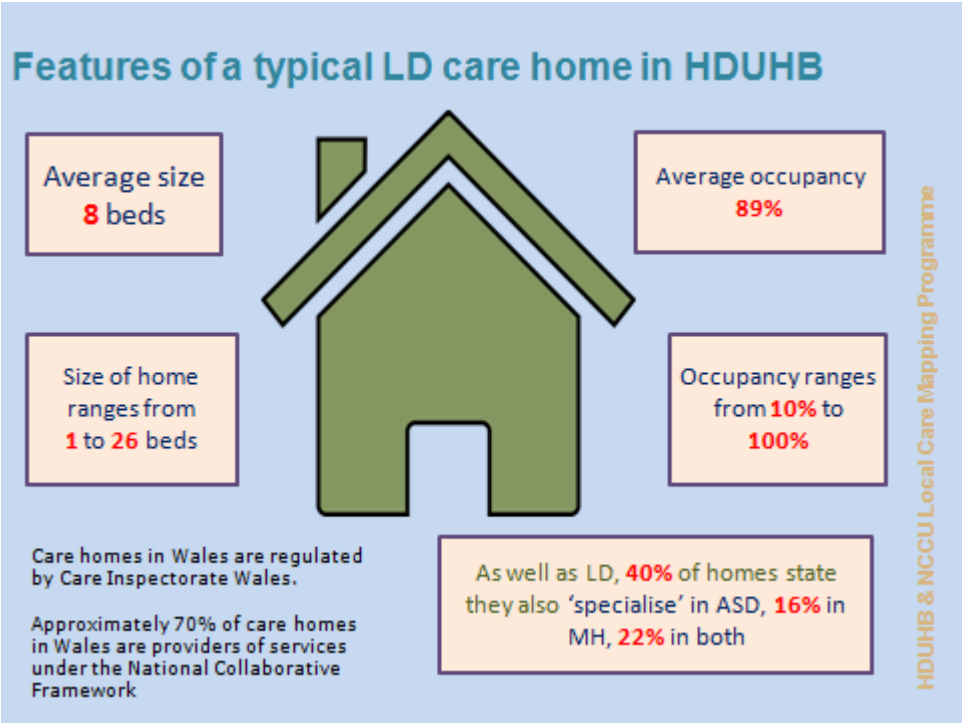


This exercise is being repeated, as there are some concerns around the validity of the data and interpretation of the survey. But, it is important we reflect our current workforce activity, whilst planning future service needs.

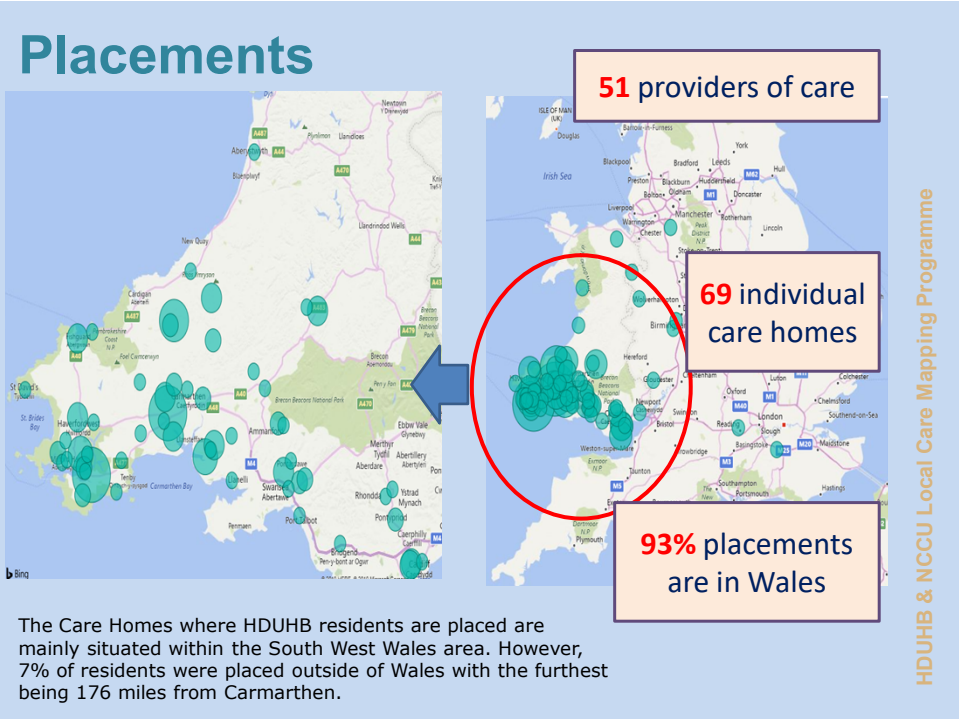
A Caseload management tool has also been built for each CTLD staff member. This will help us understand patient demand, this tool will be launched (December 2019).

Commissioned Services

A review of the care home 'market' within Hywel Dda has been undertaken by the National Commissioning Collaborative, that informs us that the 'market' is predominantly residential care, detail of provision in the diagram below:



The location of this provision is largely within the Hywel dda footprint:



The National Collaborative produced a detailed report with several areas for further investigation required; to address these the following actions have been identified:

- Review of LD clients in high-cost and out of area placements jointly with LA's, to progress less restrictive and community based options- ICF revenue funded repatriation and progression project : 4 Commissioning staff recruited
- Regional development of the market in partnership with LA's to ensure a range of community options are available– ICF capital funded development of LD supported living accommodation: first property has been purchased in Carmarthen to enable step down for 4 people from residential care
- Pharmacy support to review medication use in residential care
- Regional review of MDT and funding processes to strengthen decision making
- Support to discharge LD inpatients to commissioned options and exploring potential for repatriation of complex cases for re assessment and step down.

Partnership working to increase engagement opportunities for People with Learning Disabilities on the TMH&LD Programme.

It is very important people with learning disabilities are able to access MH services. The newly appointed project leads within Transformation are to attend the LD Dream Team meeting taking place in October 2019. The aim is to discuss reasonable adjustments to be made for People with Learning Disabilities wishing to attend events planned for TMH&LD. It is also hoped that the Dream Team will be able to inform us of how best to reach the wider population of People with Learning Disabilities and how they would most likely wish to engage with the Programme, including how they

would like to receive feedback on how their ideas have informed the Health Board's decision making.

Next Steps:

- **Implementation of the LD Charter and audit**
- **LDPG to continue to scrutinise the ICF Projects and outcomes**
- **LD Intensive support pilot to commence under the Bevan Commission Exemplar Programme.**
- **Define future options for consultation around the provision of in-patient care for people with LD.**
- **Feedback from CoP around required placements for the patients in Pembrokeshire residential care. This will inform the future provision, required registration and staffing model required for the long term.**
- **Undertaking capacity and demand planning and forecasting work to reinforce business case for additional staffing resource, which will inform the definition of roles required within the CTLD structure and development of an OCP**
- **Development of Service Specifications and Pathways/procedures for sign off via Written Control Group.**
- **Commissioning actions detailed above.**
- **Continue to link with TMH to ensure the needs of people with a LD are met within the new model.**

Report completed by:

M Evans

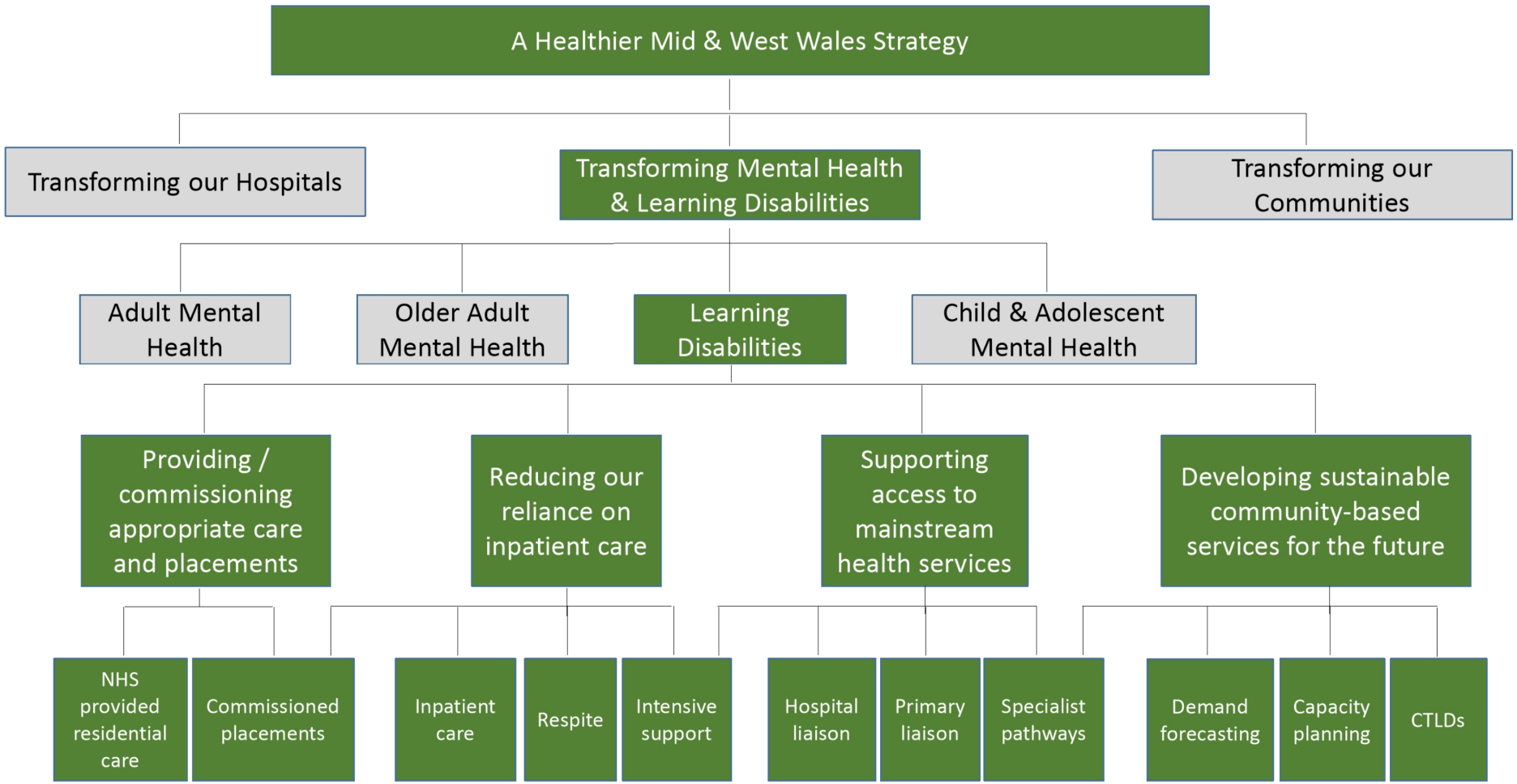
Melanie Evans, Head of Learning Disabilities and Older Adult Mental Health Services
Hywel Dda Health Board
1st October 2019

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Building together the future of Learning Disability Services: a Summary of Hywel Dda University Health Board's Improvement Programme

"Our focus is to ensure that adults with learning disabilities are able to access enhanced and varied support services within appropriate settings, which help them to achieve the greatest possible quality of life."

Programme Overview



Summary

1. Stakeholder Engagement
2. Integrated Care Fund
3. Inpatient & Intensive Support Services
4. Residential Care Services
5. Community Teams for Learning Disabilities
6. Commissioned Services
7. Next Steps

Stakeholder Engagement - Update

- Community Health Council – Regular updates
- Regional Learning Disabilities Programme Group - Monthly
- Staff engagement - throughout
- Service user, family and advocate engagement – throughout
- Dream team established and award winning ☺

NHS Wales Awards

Empowering People to Co-produce their Care

Learning Disabilities Charter

- My Life, My Rights
- My Community, My Relationships
- My Social Life
- My Support
- My Health
- My Independence
- My Communication

Integrated Care Fund - Update

- Links between outcomes from ICF bids and the principles of the LD Charter have been identified (August 2019).

Project	LD Charter Element
Pembrokeshire LD employment project	My life. My rights; My community; My independence
Advocacy (non-statutory, peer, group, self)	My support; My community; My independence
Positive Behavioural Intervention service for children and young people with an LD	My communication; My support; My health; My relationships
Exercise buddies	My community; My health; My social life; My relationships
Development of supported accommodation, developing community based accommodation options, moving away from Residential Care.	My life. My rights; My independence
Progression project, ensuring people are receiving the right care in the right place and where we can move people closer to home.	My life. My rights; My independence
Charter implementation and audit	All charter elements
Accessible and involved annual health checks	My life. My rights; My communication; My support; My health; My independence
Tech solutions - apps	My communication; My community; My health; My independence; My social life

Inpatient & Intensive Support Services

- Review of current inpatient service provision with a view to developing intensive community based support to better meet needs of LD population when nearing crisis.

Patient Stories following Resettlement

- The first person to move out from Ty Bryn is doing really well, he has been to the cinema, seen a musical, loves the beach walks. His elderly parents were highly anxious about the move but are now happy with his new home and are 40 minutes car journey closer each way to him.

- The second person has moved with support from Ty Bryn staff to continue his complex medication regime until new staff were familiar and confident. He is described by the CTLD team members to be more relaxed than ever before and is now making choices about his daily routine by initiating communication which is new. He is now in contact with his gran who he had not seen since the age of 12 yrs.

- The third person is fully engaged with his new social life. He loves arts and crafts, gardening, bird watching and also has made new friends with peers who join him to watch music concerts. His parents are overjoyed to have him nearer the family home and are happy with all aspects of the move.

Intensive Support Services - Update

- The pilot of the intensive support team has begun, with the team manager beginning to train staff in:
  - Intensive interactions
  - Supporting mental health staff to make reasonable adjustments

- The Bevan Commission has agreed to support this pilot via the Exemplar Programme. This will help us evidence the impact of the new Team.

Residential Care Services - Update

- Bro Myrddin Resettlements
  - One patient in long-term nursing care
  - One patient to be in supported living
  - Remaining 2 patients exploring move one

- Begelly and Greville Court
  - Assessment of changing / growing needs
  - Do patients require care in alternate placements, or;
  - Do we need to change / increase our staffing establishments to care for them in their current homes?

Community Teams for Learning Disabilities

Full service review, encompassing:

- Capacity and demand planning and management
- Best practice review of service models across the UK which may be developed within West Wales.
- Assessing required skill-mixes and training needs.
- Developing discipline specific scopes of practice and CTLD service specifications.
- Restructuring teams to futureproof service provision.

Community Teams for Learning Disabilities - Update

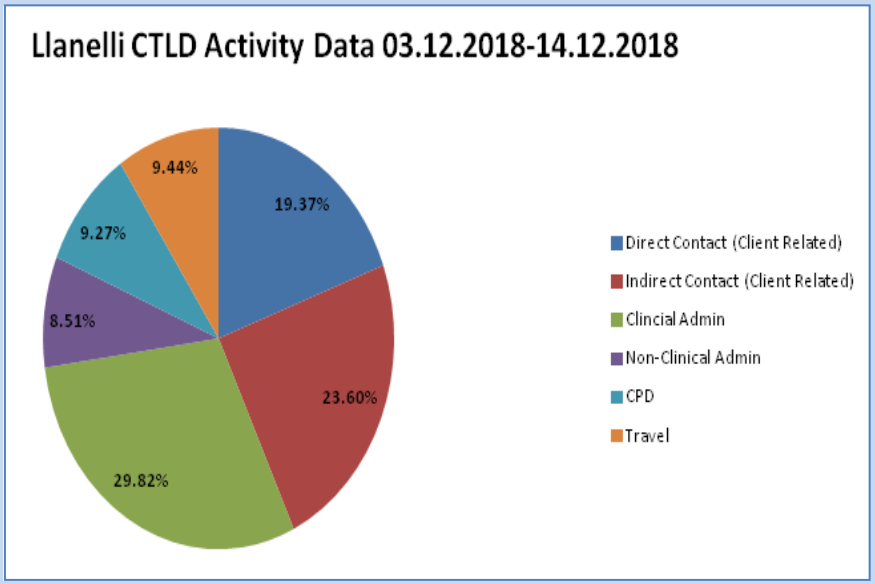
- Required pathways have been identified and are to be developed by our professional leads and team managers:
  - Behaviours that Challenge
  - Dementia
  - Epilepsy
  - Mental Health
  - Physical Health
  - Profound and Multiple Learning Disabilities
  - Venepuncture

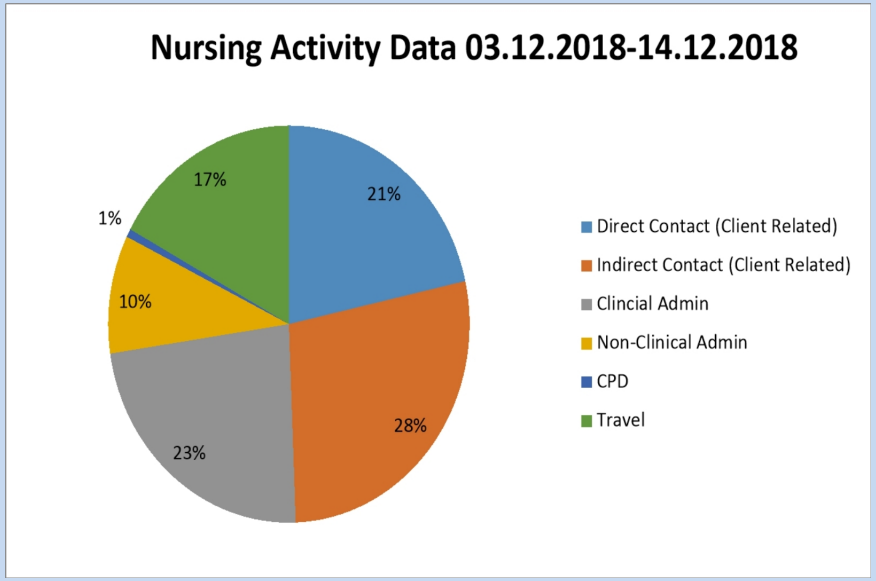
Community Teams for Learning Disabilities - Update

- Draft proposals for restructure have been developed and costed. Further work with Finance Dept. to take place.
- Caseload management tool has been built for each CTLD staff member. Once capacity and demand planning functions have been built in, this tool will be launched (December 2019).

CTLD Activity Data

- An audit of activity took place in December 2018. We will be re-running this audit at a later date, using feedback to improve it.





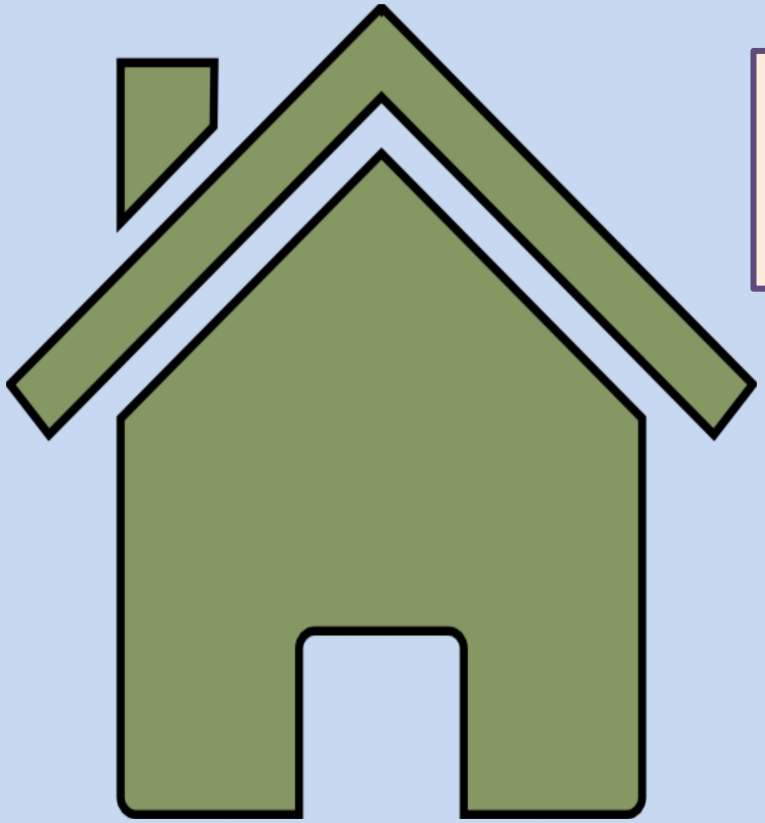
Commissioned Services

- Review of clients in residential care and in high -cost, out of area placements, with a view to (safely) repatriating as many as possible.
- Development of the Regional market for care and accommodation, in partnership with the Local Authorities, Third Sector and Private Providers.

Features of a typical LD care home in HDUHB

Average size
8 beds

Average occupancy
89%



Size of home ranges from **1** to **26** beds

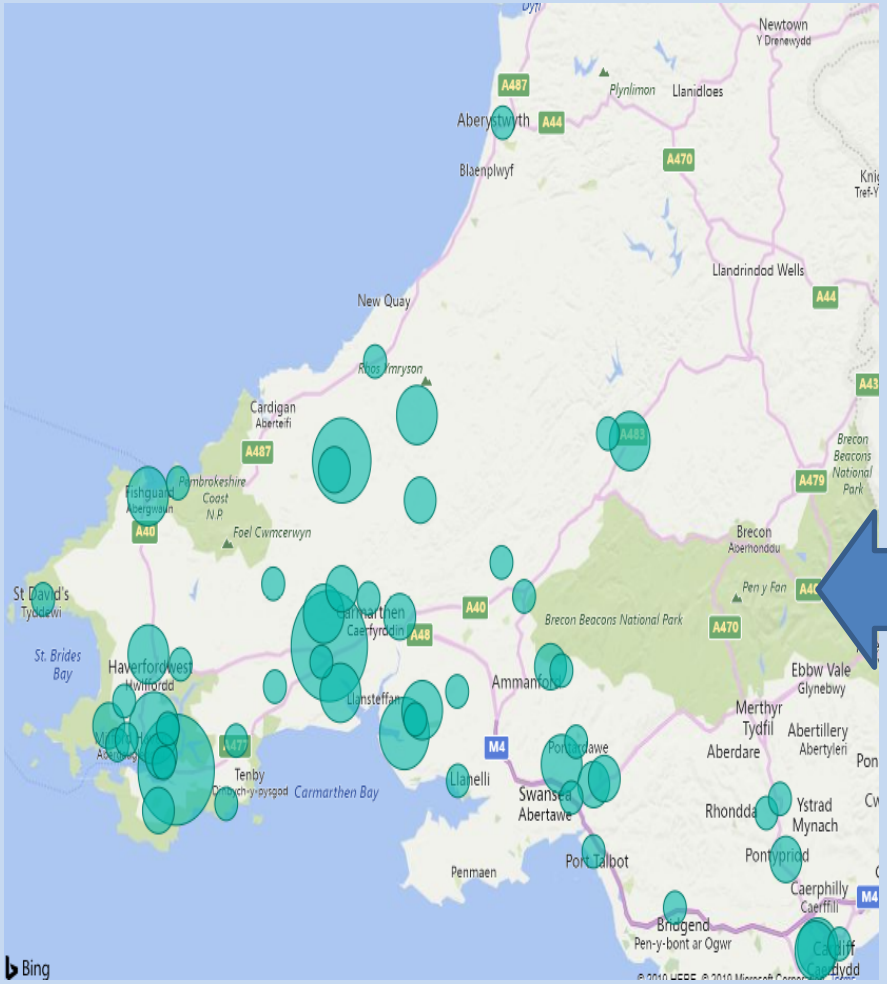
Occupancy ranges from **10%** to **100%**

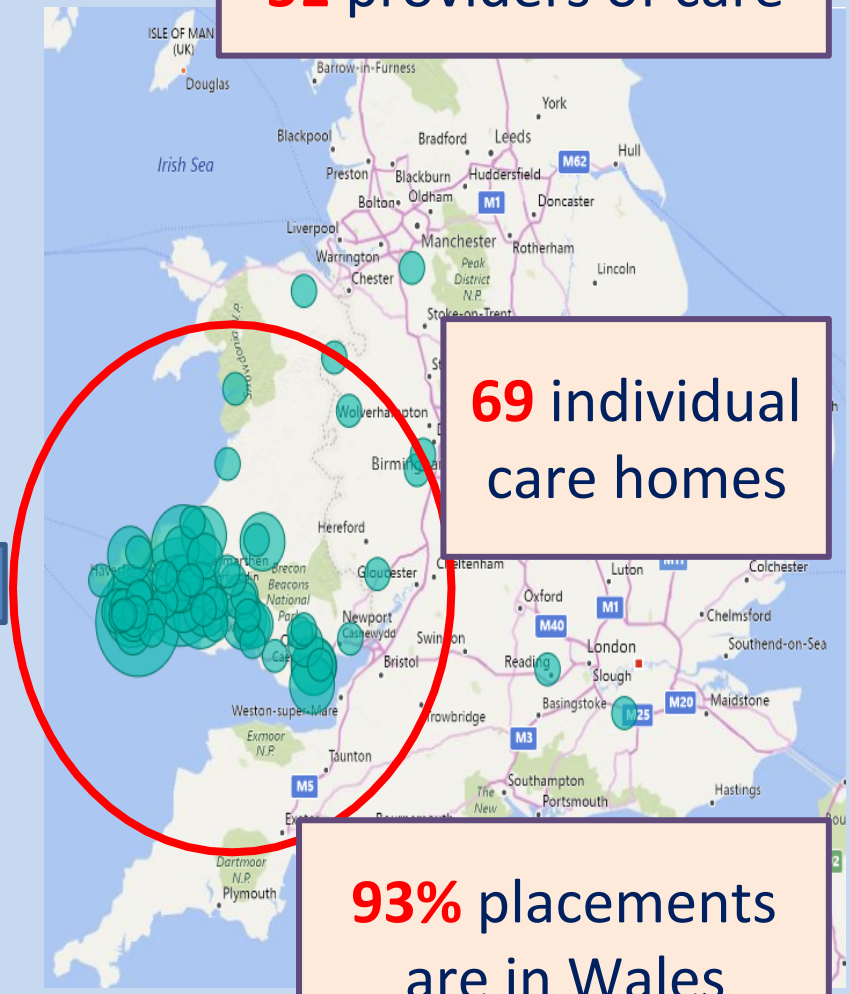
Care homes in Wales are regulated by Care Inspectorate Wales.

Approximately 70% of care homes in Wales are providers of services under the National Collaborative Framework

As well as LD, **40%** of homes state they also 'specialise' in ASD, **16%** in MH, **22%** in both

Placements





51 providers of care

69 individual care homes

93% placements are in Wales

The Care Homes where HDUHB residents are placed are mainly situated within the South West Wales area. However, 7% of residents were placed outside of Wales with the furthest being 176 miles from Carmarthen.

Commissioned Services - Update

- Review of LD clients in high-cost and out of area placements jointly with LA's, to progress less restrictive and community based options- ICF revenue funded repatriation and progression project : 4 Commissioning staff recruited
- Regional development of the market in partnership with LA's to ensure a range of community options are available– ICF capital funded development of LD supported living accommodation: first property has been purchased in Carmarthen to enable step down for 4 people from residential care

Commissioned Services – Update

- Pharmacy support to review medication use in residential care
- Regional review of MDT and funding processes to strengthen decision making
- Support to discharge LD inpatients to commissioned options and exploring potential for repatriation of complex cases for re assessment and step down.

Priority Next Steps

- Decision around future of care provision for patients currently within Res Care Units.
- Engagement around the future provision of inpatient/crisis care and specialist secondary care.
- Defining roles required within the CTLD structure and development of an OCP
- Undertaking capacity and demand planning and forecasting work to reinforce business case for additional staffing resource.
- Continue to link with TMH to ensure the needs of people with a LD are met within the new model.

S-CAMHS Update Report for CYSUR

In line with the Welsh Government document "Admission Guidance", HDUHB has in place a robust Admission Policy/Pathway outlining the process for admitting any young person into an Adult Mental Health Ward. The Guidance stipulates that the Health Board must have a designated Unit and within HDUHB this is Morlais Ward on the Glangwili Hospital campus.

A new Protocol has been approved to meet this statutory requirement which will ensure compliance against Welsh Government expectations.

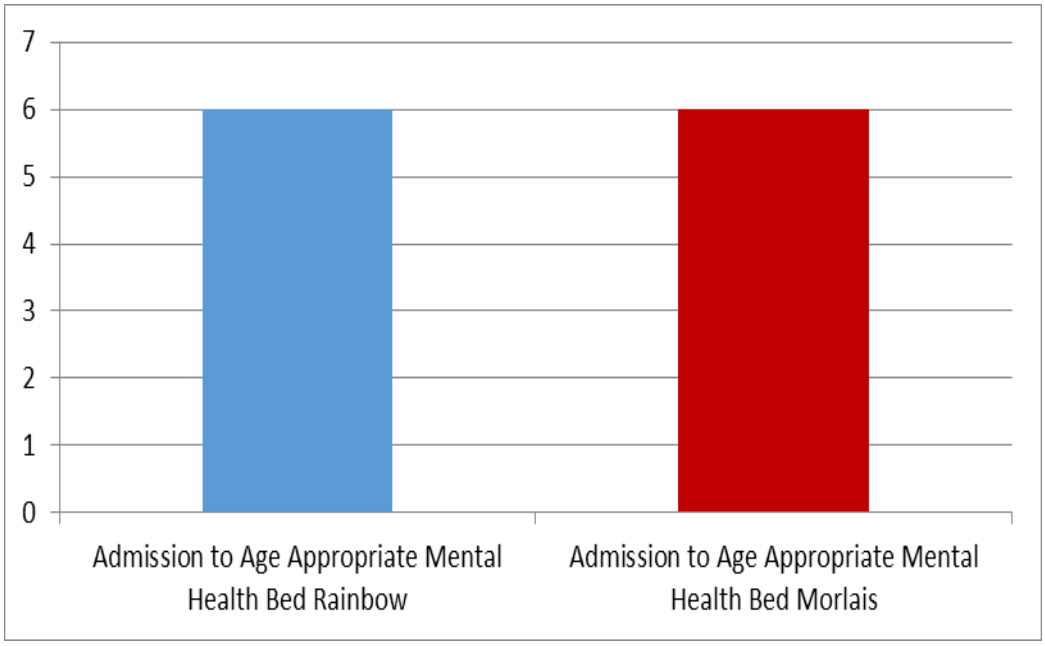
Admission to an adult mental health ward can be a frightening experience and every attempt is made to consider the least restrictive alternative for admission. In the majority of cases a young person is admitted to the designated unit on Cilgerran Ward supported by staff from the mental health unit.

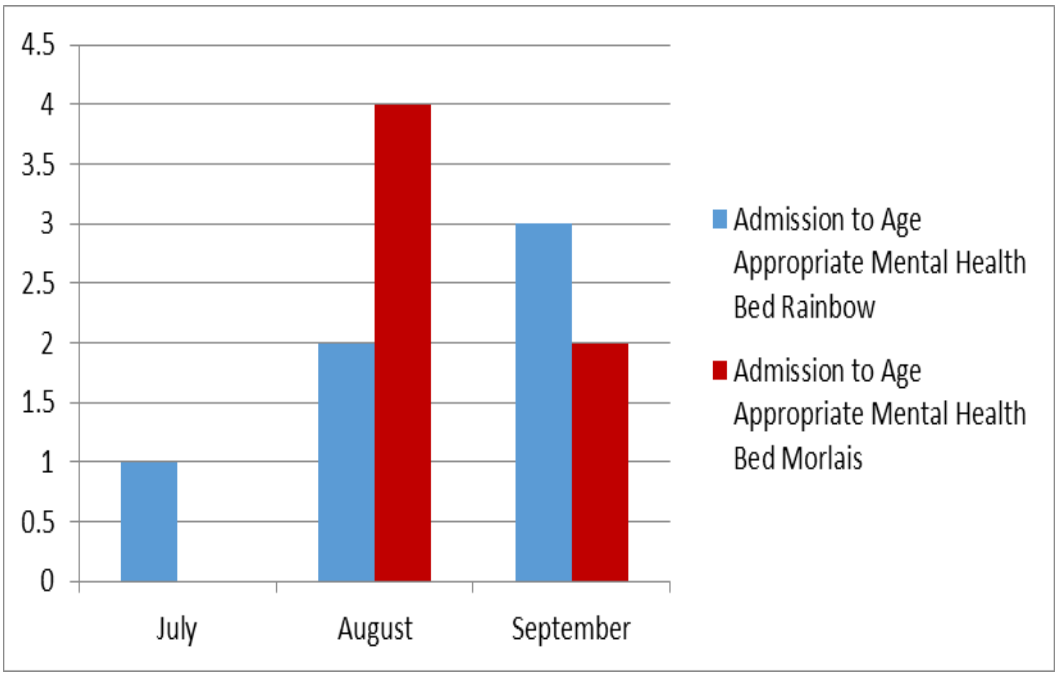
In line with the guidance, the staff have received additional training in safeguarding young people and in addition the staff on Morlais ward have all undertaken the following:

- Safeguarding Children Level 3 Training
- Have a valid Enhanced DBS in place
- Undertaken specific training on the emotional and mental health needs of children and young people
- Training on the Mental Health Act and Social Services and Wellbeing (Wales) Act 2014

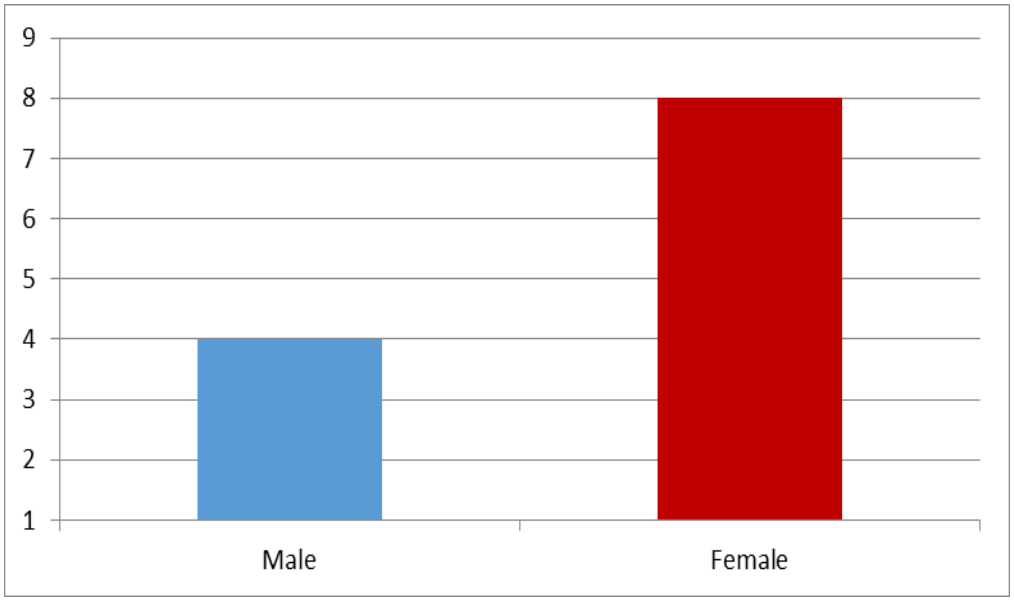
All admissions to the mental health bed must be reported, initially internally as a DATIX, and followed by a Serious Untoward Incident report to Welsh Government in line with the Welsh Governments Admission Guidance Document.

Q2 Admissions to the age appropriate bed on the Rainbow bed and Morlais Adult Mental Health Ward Glangwili Hospital site:

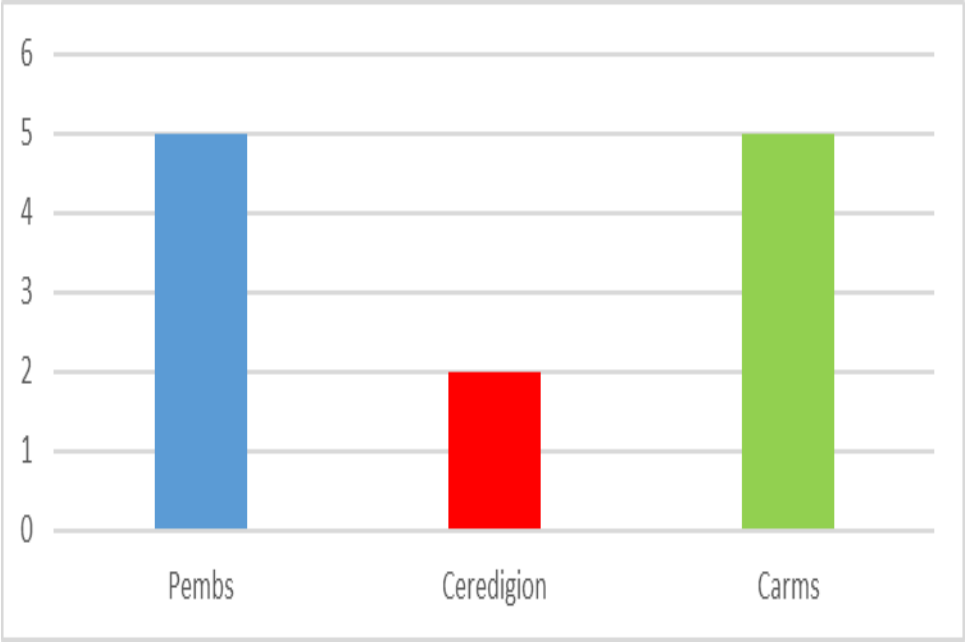




Q2 Admission to Age Appropriate Mental Health Bed Rainbow / Morlais Bed by gender:



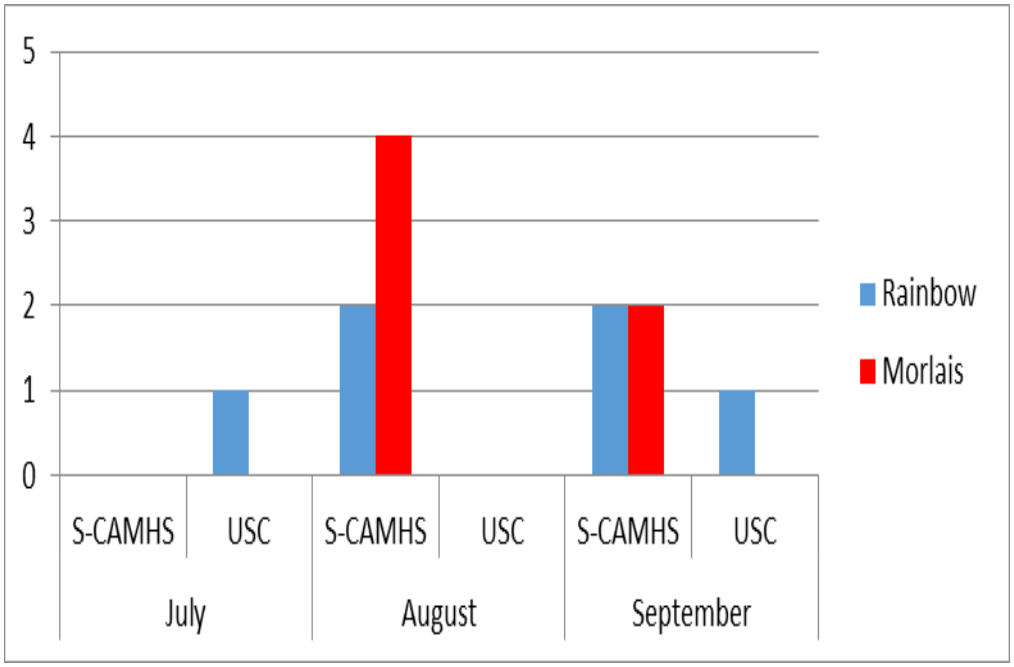
Q2 Admissions to Rainbow / Morlais Bed according to Locality:



Admissions to Paediatric Age Appropriate Bed (Rainbow Unit, Non reportable)

Specialist CAMHS records for Quarter 2 are outlined above with 12 Admissions in total with 6 admissions to the Paediatric bed and 6 Admissions to the Adult Mental Health Ward (Morlais).

Q2 Admissions to Rainbow / Morlais split by admitting team:



Mental Health Status

One young person was placed on Section 2 of the Mental Health Act at 00.40hrs on 21/08/2019 which ended at 17.15hrs on 21/08/2019.

Admission Outcomes

	Discharged Home	Onward Admission
Rainbow	6	1 (admission to Morlais Ward)
Morlais	4	1 (admission to Tier 4 bed)

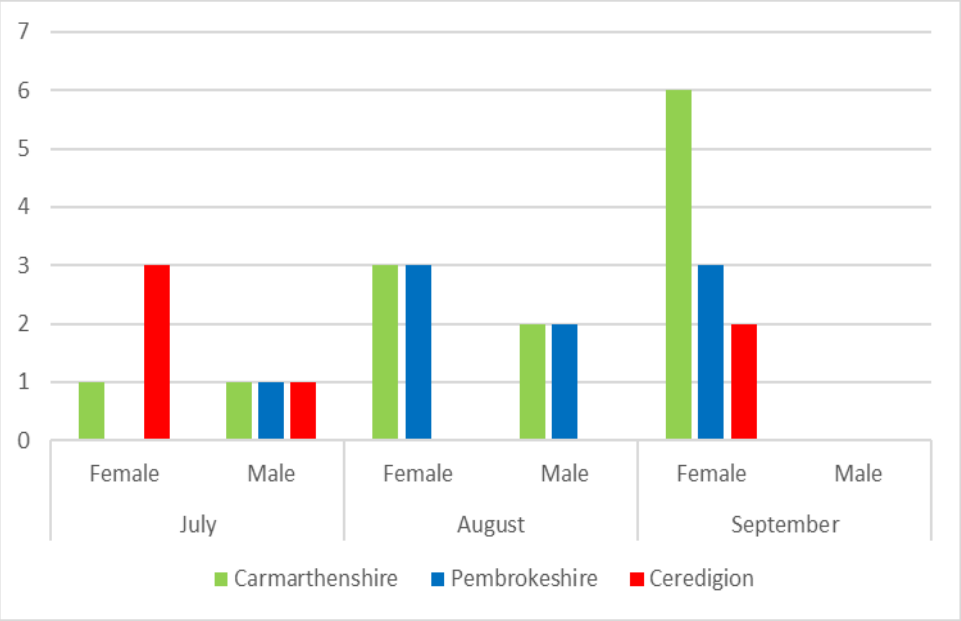
Admissions relating to Self-Harm

Within HDUHB there are robust systems in place for S-CAMHS to provide a mental health assessment, following referral from the Paediatric ward where any young person is admitted following an episode of self harm. The reason for admission is generally following an overdose but, on occasions, it can be following deliberate cutting or an attempted hanging.

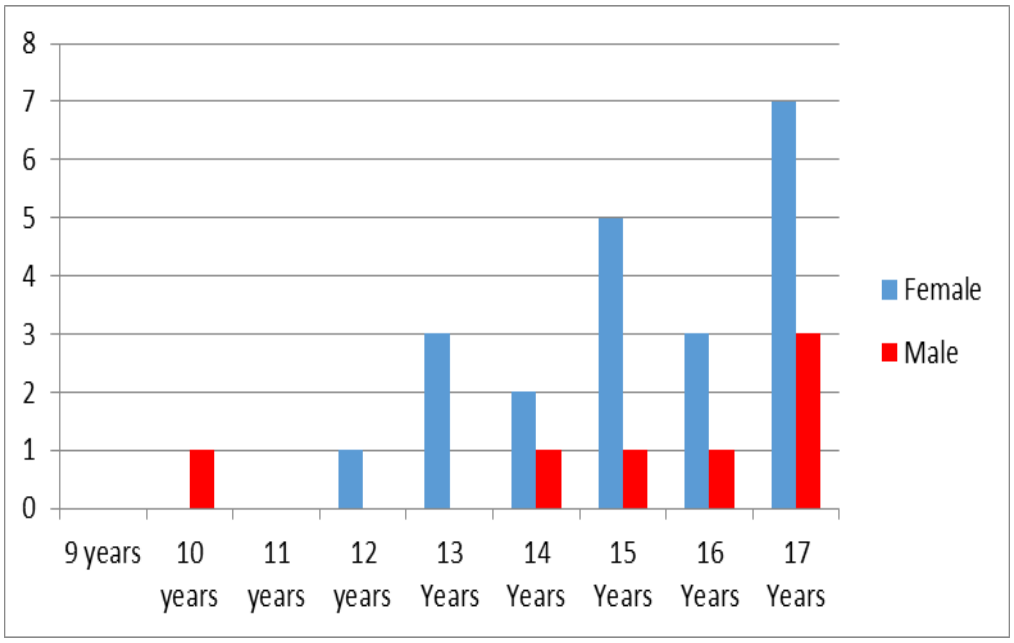
All overdose/self harm admissions receive a follow up appointment within three working days to monitor risk and provide support. There is a robust Pathway in place along with Guidance for admission of all young people who present following self harm in order that a comprehensive mental health assessment and risk management plan can be agreed. Where appropriate, referral to the Safeguarding team and/or Social Services may be considered.

The following table details the numbers of admissions following Deliberate Self Harm (DSH) Quarter 2 2019-2020 for the 3 Local Authority Areas:

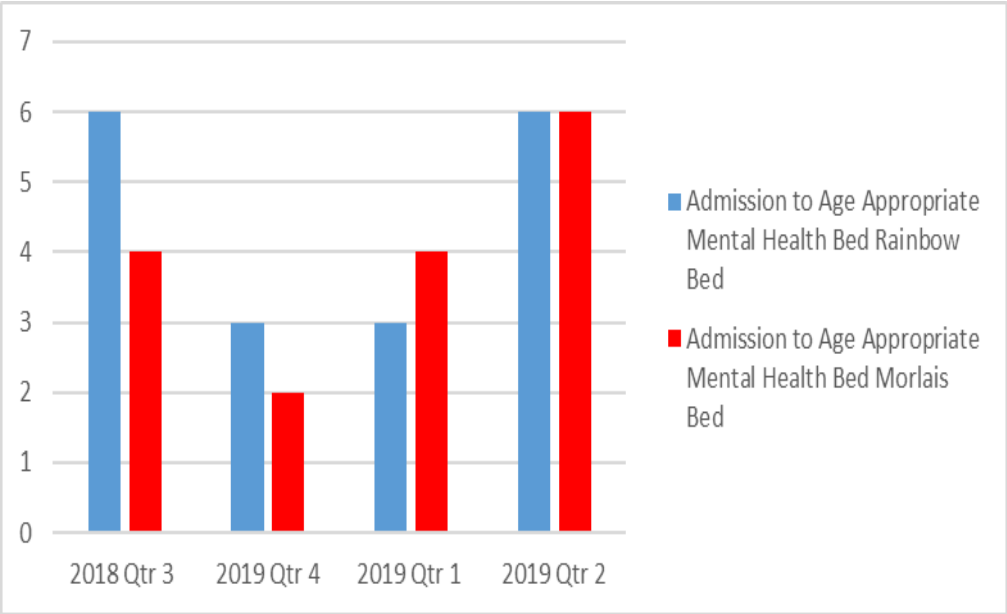
Q2 Self-harm / Overdose Statistics split by gender and locality:



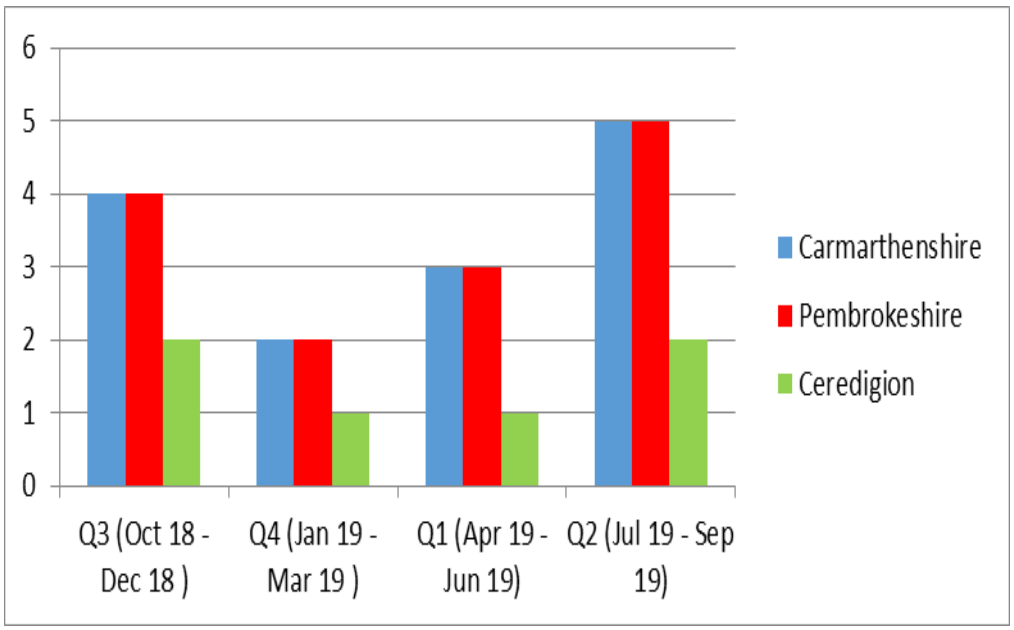
Q2 Self-harm / Overdose Statistics split by gender and age profile:



Comparison Data (last 12 months) - Age Appropriate Bed

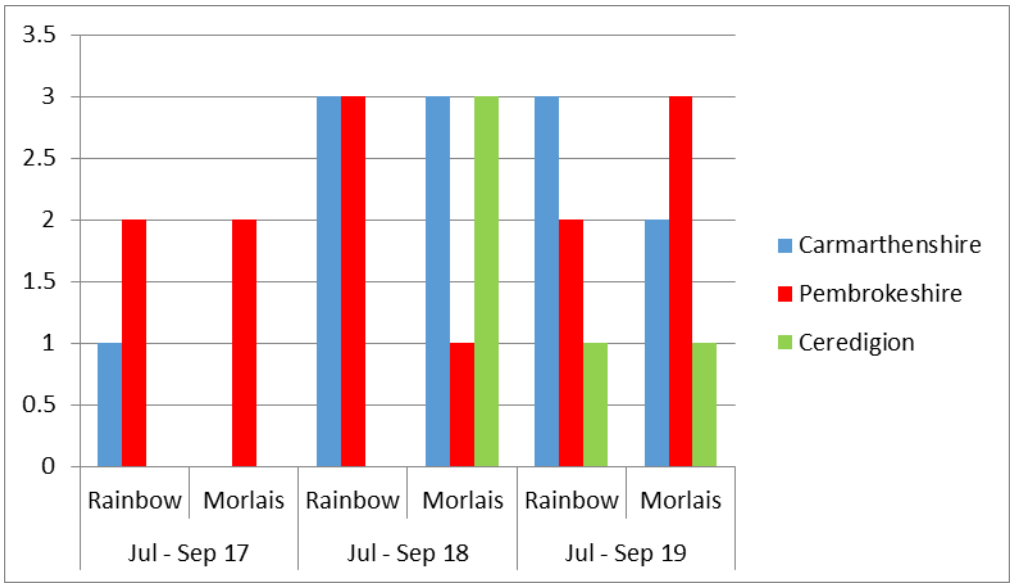


Admission Trend comparison by locality (last 12 months)



Annual Admission Comparison by locality

The following graph compares the numbers of admissions for Quarter 2 2019/2020 against the number of admissions for the same quarter of 2018/2019 and 2017/2018, further defined by locality.



Advocacy

In line with the Mental Health (Wales) Measure 2012, Health Boards are expected to ensure that access to Advocacy Services is in place, as per Part 4 of the Measure, for any individual admitted into hospital. All young people admitted to Morlais Ward are asked on admission if they would like access to an Independent Mental Health Advocate. The expected performance target is that 100% of clients are offered this and this information is recorded and reported via our Information Analyst.

On Cilgerran ward, information is provided to young people on admission on the availability of access to the Advocacy Service. However, the above performance standard is not applicable therefore data is not routinely collated.

GIG CYMRU NHS WALES | Bwrdd Iechyd Hywel Dda Health Board

HYWEL DDA HEALTH BOARD – MENTAL HEALTH LEGISLATION ASSURANCE COMMITTEE 2019/20

The following table sets out the Mental Health Legislation Assurance Committee's Business for 2019/20, including standing agenda items (denoted by*).

Agenda Item /Issue	Lead	Responsible Officer	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
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**		✓				✓
Annual Work Plan*	**Lead Director**	**Lead Officer**		✓				✓
MHLAC Annual Report detailing work undertaken throughout year	**Lead Director**	**Lead Officer**			✓ (draft)	✓ (final)		
Review of Effectiveness	**Lead Director**	**Lead Officer**			✓			

Presentation Good Practice/Patient Story*	**Lead Director**	**Lead Officer**	Patient Story	Good Practice/ Staff Story	Patient Story	Good Practice/ Staff Story	Patient Story	Good Practice/ Staff Story
PERFORMANCE								
Receive HIW MHA Inspection, Delivery Unit or external scrutiny body reports, management responses & approve associated action plans (for monitoring by MHL Scrutiny Group)	**Lead Officer**	**Heads of Services**	✓ (when received)	✓ (when received)	✓ (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)	✓ (when identified)	✓ (when identified)
Receive the Hywel Dda Mental Health Partnership Annual Report from the Mental Health Partnership Board	**Lead Officer**	**Lead Officer**				✓ (via presentation)		
This should include*: - Assurance on implementation of HIW, DU & other external scrutiny bodies Action Plans - Review the MH& LD risk register bi-annually - Receive update report & minutes from MHL Scrutiny Group - Consider issues of concern arising from the Sub-Committee and group structure - Receive update reports from Mental Health Programme Group - Assurance on compliance with MH Legislation - Assurance on Approved Clinicians and Sec 12 doctors arrangements - Assurance on development & implementation of policies & procedures - Assurance re training requirements for staff re MH legislation - 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*	**MH POD Committee Chair**	**MH POD Committee Chair**	✓	✓	✓	✓	✓	✓

FOR INFORMATION								
Receive and review HIW MHA Annual Report	**Lead Officer**	**MHA Admin Lead**				✓		
Mental Health Law Briefings * (when applicable)	**MHA Admin Lead**	**MHA Admin Lead**	✓	✓	✓	✓	✓	✓
New legislation/Measure/Policy Implementation Guidance (when applicable)	**MHA Admin Lead**	**MHA Admin 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**	✓ (for Dec Board)	✓ (for March Board)	✓ (for June Board)	✓ (for Sept Board)	✓ (for Dec Board)	✓ (for March Board)
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**				✓		✓

Chair – Judith Hardisty	MHA Administration Lead – Sarah Roberts
Lead Exec – Joseph Teape	Committee Secretary – Lynn Rees
Lead Officer – Liz Carroll	

National Assembly for Wales
Health, Social Care and Sport Committee

Mental health in policing and police custody

October 2019

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales, agrees Welsh taxes and holds the Welsh Government to account.

An electronic copy of this document can be found on the National Assembly website: **www.assembly.wales/SeneddHealth**

Copies of this document can also be obtained in accessible formats including Braille, large print, audio or hard copy from:

Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Tel: **0300 200 6565**
Email: **SeneddHealth@assembly.wales**
Twitter: **@SeneddHealth**

National Assembly for Wales
Health, Social Care and Sport Committee

Mental health in policing and police custody

October 2019

About the Committee

The Committee was established on 28 June 2016. Its remit can be found at: www.assembly.wales/SeneddHealth

Committee Chair:

Dai Lloyd AM
Plaid Cymru

Current Committee membership:

Jayne Bryant AM
Welsh Labour

Angela Burns AM
Welsh Conservatives

Helen Mary Jones AM
Plaid Cymru

Lynne Neagle AM
Welsh Labour

David Rees AM
Welsh Labour

The following Members attended as substitutes during this inquiry.

Vicki Howells AM
Welsh Labour

Darren Millar AM
Conservative Party

The following Members were also members of the Committee during this inquiry.

Dawn Bowden AM
Welsh Labour

Neil Hamilton AM
UKIP Wales

Contents

Recommendations

1. Background

1. During two recent Assembly Committee inquiries (the Emotional and Mental Health of Children and Young People, and Suicide Prevention), Assembly Members heard from police representatives that an increasing amount of police resource is being used on managing mental health crises. This was also raised in a thematic review[1] by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) in November 2018.

2. The Committee therefore agreed to hold a short inquiry with a focus on partnership working between the police, health and social care services and others to consider how effectively services are working together in Wales to prevent people with mental health problems being taken into police custody, and to help ensure vulnerable people in mental health crisis get the care and support they need.

Terms of reference

3. The terms of reference for the inquiry were to consider:

- Whether there are sufficient services (i.e. health and social care services) available to support police officers in Wales to divert people with mental health problems away from police custody;
- The number of people arrested under section 136 of the Mental Health Act 1983, and the extent to which police custody is being used as a place of safety for people in mental health crisis;
- Whether local authorities and health services are meeting their duties and complying fully with legislative requirements to provide appropriate places of safety to which the police may take people detained under section 136 of the Mental Health Act 1983;
- Adherence to the Code of Practice to the Mental Health Act 1983 which requires that people detained under that Act should always be conveyed to hospital in the manner most likely to protect their dignity and privacy, taking account of any risks (i.e. by ambulance which should be made available in a timely way, as opposed to police transport);

[1] Policing and Mental Health: Picking Up the Pieces, November 2018

- How effectively police forces in Wales work with partners (such as health or social care services) to safeguard vulnerable people in police custody, and how well the police themselves identify and respond to vulnerable people detained in custody, specifically those arrested under section 136 of the Mental Health Act 1983;
- The effectiveness of multi-agency care planning for people with mental health problems when leaving custody, specifically for those detained in police custody under section 136 of the Mental Health Act 1983 to help to prevent repeat detentions;
- Whether effective joint working arrangements are in place, with a specific focus on implementation of the Mental Health Crisis Care Concordat, including whether the Welsh Government is providing sufficient oversight and leadership.

4. Between 13 February and 15 March 2019, the Committee conducted a public consultation to inform its work, based on the agreed terms of reference. The Committee received 28 responses, which are published on the Committee's website.[2] In addition, the Committee heard oral evidence from a number of witnesses on 4 April. Details of those who gave evidence are also available on the Committee's website.[3]

[2] Evidence submitted in response to the consultation

[3] Witnesses to the inquiry

2. Mental health and police custody

5. The Policing and Crime Act 2017 made some significant changes to section 135 and section 136 of the Mental Health Act 1983. The legal changes introduced by the 2017 Act were intended to improve responses to people in mental health crises who need urgent help with their mental health in cases where police officers are the first to respond.

6. Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear to be, mentally disordered.

7. Police officers may use powers of entry under Section 135 of the Mental Health Act to gain access to a mentally disordered individual who is not in a public place. If required, the police officer can remove that person to a place of safety.

8. Section 136 of the Act enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an Approved Mental Health Professional (for example a specially trained social worker or nurse), and for the making of any necessary arrangements for treatment or care.

9. Previously, section 136 of the Mental Health Act explicitly applied to people encountered in a public place, with section 135 requiring a magistrate-issued warrant for a police officer to enter private premises to remove a person to a place of safety for assessment. The 2017 Act introduced changes to allow an assessment to take place in the premises/home under certain circumstances (s135) and removing the need to be in a place to which the public has access (s136).

10. Other changes include:

- Police must consult mental health professionals, if practicable, before using section 136;
- police stations cannot be used as a place of safety for people under the age of 18;

- police stations can only be used as a place of safety in specific "exceptional" circumstances for adults;
- the period of detention for people held under S135/136 is reduced from 72hrs to 24hrs with the possibility of a 12hr extension under certain defined circumstances.

11. The purpose of the Committee's short inquiry was, in part, to satisfy ourselves that police custody is no longer being used as a place of safety for those detained under section 136 of the Mental Health Act except in exceptional circumstances. Whilst the Committee recognises that the police frequently respond to people with mental health problems, we have focused on the use of section 136s in particular, because these powers are usually exercised when people are at their most vulnerable.

12. Witnesses to our inquiry were clear, and in agreement, that it is unacceptable to hold mentally ill individuals in police custody, and that the practice of detaining people under section 136 of the Mental Health Act should only occur in exceptional circumstances. The Royal College of Nursing (RCN) Wales made the point that "people in mental health crisis are amongst the most vulnerable in our society, and sufficient investment must be made in services to meet their needs".[4]

13. The use of police custody as places of safety has fallen significantly over the past four years. The publication of the Crisis Care Concordat in 2015 and subsequently the passage of the Policing and Crime Act in 2017 marked significant reductions in the use of police stations as places of safety, despite the general trend of rising section 136 detentions.

14. In written evidence, Dr Gaynor Jones, Consultant Forensic Psychiatrist and Chair of South Wales Police Partnership Group, provided assurance that police custody being used as a place of safety for people in mental health crisis, "is now a rare event and when it happens is discussed at senior levels".[5]

15. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Assurance Group (MHCCCAG) told us that there has been a 90 per cent reduction in the number of individuals detained in police cells who are in mental health crisis since the introduction of the Concordat.[6]

[4] Written evidence, MHP02

[5] Written evidence, MHP01

[6] RoP, 4 April 2019, paragraph 352

16. Written evidence submitted by the National Police Chief Council also confirmed that "the number of people detained under section 136 of the Mental Health Act 1983 being conveyed to police custody as a place of safety has reduced year on year".[7]

17. Assistant Chief Constable (ACC) Jonathan Drake told us:

> "… one of the significant things that has progressed is the detention of people in police custody with mental health issues. Even for as large a force as ourselves, that's into single figures for the year—you know, under 1 per cent of people would end up in police custody, and normally it's because of extreme violence or it could be that they present with something slightly different than mental health to begin with. So, it's very, very rare."[8]

18. In a joint written submission, Cais, Hafal and Morgan Academy welcomed the progress that had been made in reducing the use of police custody for those arrested under section 136, but stated that "a challenge remains to ensure this practice is fully implemented and maintained".[9]

19. Specifically in relation to children and young people under the age of 18, the Minister told us that although the law changed in 2017 to prevent a police station being used as a place of safety for anyone under the age of 18:

> "… in Wales, this policy intention was realised much sooner and no child or young person has been taken to a police station as a place of safety since 2015."[10]

Our view

20. Too often and for too long vulnerable people experiencing mental health crisis, who have committed no crime, have found themselves in a police cell because there is nowhere else to go.

21. We therefore welcome the assurances we have received from senior police officers, inspectors and Welsh Government officials that police custody is no

[7] Written evidence, MHP03

[8] RoP, 4 April 2019, paragraph 99

[9] Written evidence, MHP11

[10] HSCS Committee, 4 April 2019, Paper 7

longer being used as a place of safety for those detained under section 136 of the Mental Health Act, apart from in exceptional circumstances.

22. Further, we were reassured to hear that there have been no cases of a police cell being used as a place of safety for a person aged under 18 in Wales since 2015.

23. We were pleased to hear from Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Healthcare Inspectorate Wales (HIW) that their joint inspections of police custody in Wales have generally found that where adults are detained in police custody for exceptional circumstances, the provision of mental health care is good.

3. Use of section 136 of the Mental Health Act 1983

25. While the number of people in mental health crisis being held in police custody has decreased, the number of detentions under section 136 of the Mental Health Act 1983 appears to be increasing. According to data published by the Home Office[11], there were 2,256 detentions in Wales under section 136 in 2018/19, compared to 1,955 in 2017/18. The police also report an increase in demand from people in mental health crisis.

26. According to the National Police Chiefs Council:

> "Policing is currently experiencing unprecedented levels of mental health related demand, which continues on an upward trajectory. The police service has become the 'de facto' agency and the first point of contact for many persons suffering with mental ill health. This is unsustainable with finite police resources and diminishing budgets; whilst dealing with the proliferation of new emerging crime types and other increased demand."[12]

27. ACC Jonathan Drake on behalf of the National Police Chiefs Council told us:

> "… most of the cases we deal with—up to 98 per cent—don't actually result in section 136 detentions. They're much more around health and welfare concerns, but the police—we're an agency that are there 24/7, and often the first people to be phoned about issues or come across issues in the street. [ ] … in summation, I'd say that the police, at present, are involved in too many issues that are purely health concerns, or may be linked to social care, as opposed to fitting that definition of an immediate risk to themselves or others."[13]

28. Dr Gaynor Jones, Consultant Forensic Psychiatrist and Chair of the South Wales Police Partnership Group agreed that "many hours of police time is taken up with mental health issues and those in crises".[14] Written evidence from the RCN Wales points to data collected across all Welsh police forces as part of Mental

[11] Detentions under the Mental Health Act (1983) - Police powers and procedures, year ending March 2019

[12] Written evidence, MHP03

[13] RoP, 4 April 2019, paragraph 89

[14] Written evidence, MHP01

Health Demand Day in 2018, where 200 mental health incidents requiring police involvement were recorded, representing 9.5% of all police incidents that day.[15]

29. However, the Minister for Health and Social Services told us:

> "I don't think it's as simple as drawing a line and saying, 'Police on this side, health on the other.' It's actually about, when someone presents with a potential crisis, depending on where they present as well, what the role and responsibility is."
>
> "... we are reviewing current provision, so I'd say it's an open question, but one for partners to address together, rather than pointing the finger at each other and saying, 'It's you, not me,' because that's actually the wrong approach to take for the agencies, and crucially the wrong approach to take for the person in the middle of it."[16]

30. Figures show the use of section 136 varies by police force in Wales. Data compiled by Mind Cymru from the National Police Chiefs' Council (2014-15 and 2015-16) and published by the Home Office (2016-17 to 2018-19) shows the number of section 136 detentions by police force area from 2014-15 to 2018-19:

Number of section 136 detentions by police force area: 2014-15 to 2018-19

	2014-15	2015-16	2016-17	2017-18	2018-19
Dyfed-Powys	197	226	270	239	270
Gwent	310	266	287	237	278
North Wales	466	323	589	680	795
South Wales	749	710	679	799	913
Total	1,722	1,525	1,825	1,955	2,256

(Sources: 2014-15 National Police Chiefs' Council, 2015-16 National Police Chiefs' Council, 2016-17 Home Office statistics, 2017-18 Homes Office statistics, 2018-19 Home Office statistics)

31. Mind Cymru stated that when taking into account population estimates for each police force area, it is clear that some forces account for a disproportionate number of detentions in relation to others. It also suggests that further evidence and analysis is required to identify the reasons behind the significant geographical variations.

[15] Written evidence, MHP02

[16] RoP, 4 April 2019, paragraph 435

32. In response to questions regarding the ratio of detentions in some force areas versus their populations, ACC Jonathan Drake told us:

> "... clearly, there are issues around density and sparsity of population, (...) around the services that are available in individual areas. (...) I couldn't explain why one area would have a disproportionate rate of 136 detentions to anywhere else."[17]

Mental health triage

33. Mental health triage schemes are intended to bring police and mental health practitioners together to jointly assess a mental health incident in order to reduce use of Section 136, and/or use of police cells, and hospitalisation via the emergency department or acute mental health services. There is wide diversity in these models and little evidence of what works in what circumstances.

34. There are different models of mental health triage in place across the four police force areas in Wales. Generally, triage involves a Community Psychiatric Nurse (CPN) or Approved Mental Health Professional (AMHP) based in the police control room, or sometimes out on the street, providing advice to police officers about support services. Independent evaluations are being carried out to assess the benefits of the different models but there is currently no common approach across Wales.

35. The National Police Chiefs' Council believe that the police benefit from more consistent advice as a result of having access to a triage team. However, in their written evidence, Cardiff and Vale University Health Board questioned whether this model actually helps the police more than the health services.

36. The National Police Chiefs' Council also said that triage services are variable and not consistently funded across Wales. At the time of the Committee's inquiry, the South Wales police triage model, for example, was funded entirely by the police, which led the National Police Chiefs' Council to question its sustainability. It believed that the Welsh Government should fund a national triage model for Wales[18], which it estimated would cost under £2.5m.[19]

[17] RoP, 4 April 2019, paragraph 125

[18] RoP, 4 April 2019, paragraph 110

[19] RoP, 4 April 2019, paragraph 199

37. In response, the Minister for Health and Social Services told us that the Welsh Government was not in a position to direct the police to act in a certain way because it is not a devolved service. In respect of funding, he said:

> "... it isn't just money, although, of course, how services are funded is, of course, a consideration that everyone will want to know about, but it is still about how does that work and what's the appropriate model for that particular part of the country? Because I can understand there could be some variance, but I hope we'll get to a point where there are some principles of how people should behave and how partners would want to work together that would help us to deliver the right sort of service."[20]

Our view

38. We have heard that the police are challenged by the number of people with serious mental illness who have crises. The data suggests that the use of section 136 is increasing, with many people being taken to a place of safety to protect themselves or others around them. We are pleased to hear that it is now rare for these vulnerable people to end up in police custody, which can be a frightening experience. However, we are concerned about the increase in detentions, which suggests that services are not acting early enough to prevent crisis.

39. We are also concerned that there is significant geographical variation in the use of section 136 detentions across the Welsh police forces, and that the National Police Chiefs' Council was not able to fully explain the reasons behind this.

40. It is unclear from the evidence we heard whether the increase in detentions reflects more individuals being detained, or whether the same people are being detained more often. It is important that both the police and Welsh Government demonstrate a better understanding of the cause for the rise in rates in detentions and the possible explanations.

41. Further, we would like to see the different mental health triage schemes properly evaluated so that their impact in reducing use of section 136, and hospitalisation via the emergency department or acute mental health services can be evidenced, helping to inform future decisions about what model might work best for Wales.

Recommendation 1. We recommend that the Welsh Government works with the police to seek evidence about why the number of detentions under the

[20] RoP, 4 April 2019, paragraph 466

Mental Health Act is increasing, and to provide some analysis of national and local data to explain the regional variations.

Recommendation 2. We recommend that the Welsh Government works in partnership with the police to review the emerging evidence on the effectiveness of the different triage schemes in Wales. Better understanding is needed on which model of joint working between the police and health staff is helping to provide people in crisis with the right help and support, and which can contribute to reducing the use of section 136 overall.

Recommendation 3. We recommend that the Welsh Government should work with its partners to ensure all services are playing a key role in intervening early to prevent a mental health crisis escalating in the first place. Greater accountability for the implementation of Local Health Board improvement plans for crisis and out of hours services is needed, ensuring that funding is being targeted at actions that will help individuals to access support before crisis point.

4. Police response to people experiencing crisis

42. A number of stakeholders who submitted written evidence were very positive about the contact people had with the police when experiencing a mental health crisis. According to Mind Cymru, many individuals and their families who have been in mental health crisis and called the police have been grateful for the support they received. This, it said, "challenges the general assumption that people experiencing a mental health crisis have negative views of being detained by police".[21]

43. Written evidence from the Wallich states:

> "In my experience the police have always been very helpful when a resident is in crisis, but they are obviously frustrated with the way mental health issues are handled. The police are far more helpful and responsive when a client is in crisis than the Crisis Team. Police help staff to look for solutions so that a person in crisis can access treatment. The Crisis Team just seem to put up barriers preventing people in need from accessing their services."[22]

44. West Wales Action for Mental Health, however, told us that while they had received good feedback about the kindness and compassion shown by the police, there had been occasions where service users had been told that "mental health is not a police matter, and it is taking important police time".[23]

45. Written evidence submitted by a retired police officer, outlining his "frontline" perspective states:

> "There will always be a role for the police to play in dealing with people who are in crisis [...]. However, once the immediate emergency has passed the police are often left abandoned by others agencies caring for a person without the relevant training, skills or resources. This does not mean the police should be given more training or resources; the gaps need to be filled by the correct and proper agencies."[24]

[21] Written evidence, MHP14

[22] Written evidence, MHP16

[23] Written evidence, MHP08

[24] Written evidence, MHP20

Health-based places of safety

46. To adhere to the Mental Health Act Code of Practice for Wales guidance in relation to the use of powers of detention under section 135 and 136, health and local authority partners must ensure adequate provision of facilities for both adults and young people.

47. According to Mind Cymru, "in the majority of cases, people detained under section 136 are brought to a health-based place of safety". However, it does raise concerns about evidence gaps for 2017-18, namely the significant number of "not known" locations.[25]

48. Data published by the Home Office (2016-17 to 2018-19) shows the type of place of safety used following a section 136 from 2016-17 to 2018-19.

Place of safety used following a section 136 detention, Wales; 2016-17 to 2018-19

	Health-based place of safety	Police Station	A&E	Private Home	Other	Not known	Total
2016-17	1536	117	41	29	6	96	1825
2017-18	1333	53	96	0	2	471	1955
2018-19	1,428	20	7	-	5	796	2,256

(Sources: 2016-17 Home Office statistics, 2017-18 Home Office statistics, 2018-19 Home Office statistics)

49. Local Health Boards confirmed that health-based places of safety are provided in their local areas, though the arrangements are different in each Health Board area. Evidence from the National Police Chiefs' Council suggests that provision of health-based facilities is patchy and varies across the country. It is difficult to assess whether the provision available is sufficient to meet the needs of local populations because there are significant gaps in the data.

50. The data for 2018-19 shows that there was a significant reduction in the number of detentions where people were taken to an emergency department. However, in 2018-19 the "place of safety used" was recorded as "Not known" in 796 cases.

[25] Written evidence, MHP14

51. Evidence from ACC Drake highlighted the important role of police service Mental Health Liaison Officers who know their local areas, and can advise police officers on where to access local health-based places of safety:

> "We employ mental health liaison officers as well so that they really know how to access places of safety and build up trust and relationships with the health staff who are there. But it is very variable, particularly in rural areas and out-of-hours as well. That's a real challenge for some of my colleagues across Wales."[26]

52. It is unclear from the evidence we heard why provision other than health-based places of safety are being used. While this may be completely appropriate, it is difficult to understand how often health-based places of safety turned people away, and the reasons for this.

Sufficiency of provision

53. Whilst we were told by Health Boards that there is sufficient provision of health-based places of safety to meet demand, concerns were raised about inadequate staffing, the place of safety environment, and the lack of provision for people who were intoxicated, or where there was a risk of violence. Details of the health-based places of safety in each health board can be found at Annex A.

54. Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site. Hywel Dda UHB suggested that support for those experiencing mental health crisis could be improved if Health Boards developed community based places of safety and not just ward-based section 136 options. Richard Jones, Head of Clinical Innovation and Strategy at Hywel Dda, told us that plans were being considered for a dedicated section 136 facility, staffed adequately to manage people with more acute needs, with a further three community mental health centres that have a non-health-based place of safety to manage lesser needs.

55. The appropriateness and environment of the health-based places of safety is something that has been highlighted by HIW in their inspection reports. The Chief Executive of HIW, Kate Chamberlain, told us section 136 facilities in some Health Boards may not be ideal "in terms of geographical location, but also sometimes in terms of where they're located alongside mental health facilities or otherwise".[27]

[26] RoP, 4 April 2019, paragraph 148

[27] RoP, 4 April 2019, paragraph 18

56. Kate Chamberlain went on to tell us:

> "The other challenge that comes about in terms of the use of these suites is that, very often, because they're not in continuous use, their staffing may require the drawing of staff from the wards, and it may impact upon staffing levels on the wards. That, obviously, would be a concern to us."[28]

57. While acknowledging the point made by HIW about staffing section 136 suites, Phil Lewis, Cwm Taf UHB, made the point that there was a need to balance capacity with demand. He told us that the number of people needing high levels of intervention in Cwm Taf was not high therefore it was difficult to justify the provision of a fully staffed crisis suite. However, he recognised the potential for a regional approach, for example, for the South Wales police force where a regional facility could work across the different Health Boards. He said that discussions had taken place on what a regional approach of that kind might look like.[29]

Complexity of care

58. Concern was also raised about the complex range of issues presented by people being detained under section 136.

59. Phil Lewis, representing Cwm Taf UHB told us:

> "... what we are seeing more and more is a complex mixture of people who are in emotional mental health distress, unfortunately often with alcohol involvement, drug involvement. So, the complexity of their care prior to undertaking an assessment has changed somewhat in the sense that we might have facilities, but we haven't necessarily staffed those areas to deal with a complex mixture of intoxication, potential violence and aggression. And that has a huge impact on our interface with our police colleagues, because they're often better equipped to deal with that level of violence and aggression."[30]

60. Dr Chris O'Connor confirmed a similar situation in Aneurin Bevan UHB. He noted a change in the presentation of individuals to the place of safety, with significantly more individuals engaging in aggressive behaviour and intoxication,

[28] RoP, 4 April 2019, paragraph 19

[29] RoP, 4 April 2019, paragraph 320

[30] RoP, 4 April 2019, paragraph 307

and said that the UHB was looking at changing the skill mix of staff to ensure they are safely supported in providing this service.[31]

61. ACC Jonathan Drake echoed these concerns, stating that there are occasions when the police have to stay with people for longer because they are intoxicated and so they cannot have an assessment. He said the health service is not staffed to deal with people who are intoxicated, particularly if dealing with violence and aggression.

Crisis care and out of hours provision

62. The Mental Health Crisis Care Concordat states that health-based places of safety should be provided at a level that allows for around the clock availability.

63. Access to support was highlighted by the Chair of the Mental Health Crisis Care Concordat Advisory Group and Health Board representatives, who told us "whether it's the individual who's trying to access support or the people around them, it's absolutely vital that people are able to access that support".[32]

64. Mind Cymru's evidence states that access to crisis care services in Wales is limited and geographically varied. It also says that in recent years the number of people referred for support from mental health crisis teams has risen sharply, with a 17 per cent increase in referrals over the four years to 2018.[33]

65. Dr Chris O'Connor, Aneurin Bevan UHB, outlined work being undertaken in Gwent to develop "a single point of contact that would be accessible for individuals themselves, family members or professionals to be able to access support 24 hours a day, seven days a week, to be able to have a meaningful conversation with somebody who can help think about the best way to support that person at that point in time".[34]

66. In their evidence, HIW stated that their Joint Thematic Review of Community Mental Health Teams[35] published in February 2019 by themselves and Care Inspectorate Wales (CIW) highlighted inconsistencies and variability in crisis care provision, particularly where people are experiencing mental health crisis or in urgent need.

---

[31] RoP, 4 April 2019, paragraph 310

[32] RoP, 4 April 2019, paragraph 261

[33] Written evidence, MHP14

[34] RoP, 4 April 2019, paragraph 262

[35] Joint Thematic Review of Community Mental Health Teams – February 2019

67. It found that some service users receive immediate intervention and support but others experience a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours. A significant number of people did not know who to contact out of hours and were not satisfied with the help offered. Rhys Jones, Head of Escalation and Enforcement, HIW, told us:

> "… there are some startling numbers, certainly in the report, in terms of the surveys that we undertook and that nearly half of people didn't know who to contact during crisis, and the fact that these MHT services tend to operate to a fixed time schedule and, clearly, crises can happen any time of the day."[36]

68. He went on to say that this variability in provision across Wales was particularly concerning and had led HIW to commit to undertake a thematic review of crisis care during 2019/20. Work is due to start early in 2020and an overarching stakeholder group will be convened to inform the study.

Alternative places of safety

69. In terms of demand and capacity planning, HIW said that the answer to pressure on services does not necessarily mean that more health-based places of safety are needed. It said that pressure could be diverted from those services if there were more alternative places of safety available.[37]

70. Dr Chris O'Connor of Aneurin Bevan UHB told us that some of the evaluations of sanctuary provision elsewhere in the UK show that they have a real impact on the demand and individuals presenting to emergency services such as the police and A&E.[38]

71. Under the changes to the legislation, anywhere can be a place of safety and so there is scope to develop non health-based places of safety.

72. We heard that there are pockets of good practice in terms of provision of crisis cafes and sanctuary houses. ACC Jonathan Drake told us:

> "So, in various areas, those already exist. Parts of Dyfed-Powys, for instance, already have that. We're looking to develop a sanctuary at Swansea at the moment, again, working with third sector partners in

[36] RoP, 4 April 2019, paragraph 42

[37] RoP, 4 April 2019, paragraph 17

[38] RoP, 4 April 2019, paragraph 298

> doing that. Sometimes, there's opportunities there such as buildings that aren't used—public buildings but they're not used out of hours. So, in an evening they could be used to convert into a sanctuary or crisis cafe."[39]

73. Written evidence from Aneurin Bevan UHB stated that a work stream, led by third sector organisations, has been established to review the need for sanctuary provision within Gwent and is currently developing a proposal to seek funding to support a pilot of sanctuary provision in three different areas across the county.[40] Plans are also in place to develop a sanctuary in Swansea, working with third sector partners.[41]

74. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, believed this was an area that would benefit from some targeted resourcing. She said:

> "… if we had an understanding that that was the kind of community-based support that we wanted everywhere, and it's very much in line, (…) with 'A Healthier Wales' and the general direction of travel of the Government in terms of more preventative community-based closer to home services. And I think it's quite a good idea to take it out of statutory services and normalise it and make it much more of a place where people feel safe, rather than a place of safety."[42]

75. The Minister for Health and Social Services, however, told us that it should not be the default position that the Welsh Government would be in a position to provide funding and in the first instance it would be for local partners to determine how they would fund the provision of sanctuary/places of safety to meet the needs of their local population.[43]

Our view

76. We understand why people turn to the emergency services during an episode of crisis and we believe that the police will always have a role to play in dealing with people in such situations. However, once the immediate emergency has passed, responsibility must pass to the appropriate healthcare professional.

---

[39] RoP, 4 April 2019, paragraph 152

[40] Written evidence, MHP06

[41] RoP, 4 April 2019, paragraph 152

[42] RoP, 4 April 2019, paragraph 402

[43] RoP, 4 April 2019, paragraph 462

77. We welcome the assurance that all Health Boards have designated health-based places of safety, and that some places of safety are working effectively, with examples of good practice. However, we are concerned at suggestions that provision is patchy and varies across the country. We are further concerned that differences in access to places of safety can make it difficult for people to know who to contact for support and where to go to access help. It is particularly important that frontline staff such as police officers have access to services at any time.

78. Providing sufficient health-based places of safety is not the only answer. We heard that there is a wide range of services that can respond to people experiencing a mental health crisis, such as crisis houses and crisis helplines, which can all help to provide an effective response. We believe that effective partnership working can help to reduce the use of section 136 and, as a result, the demand for places of safety.

79. We recognise the difficulties associated with staffing a crisis suite that is not in continuous use. However, we are concerned that the drawing of staff from other wards during times of need is having an adverse impact upon staffing levels on those wards. We think there is potential in exploring the provision of regional options.

80. We believe that the care pathway for people detained under section 136 needs to be reviewed from the individuals' perspective; from the point the person is detained by police under section 136, through being conveyed to hospital, transferred into the care of place- of- safety staff, and waiting to be assessed under the Mental Health Act and beyond. For most, this is likely to be a distressing experience. This can only be made worse when a place of safety cannot be accessed, when a person has a long wait in the back of a police car, or when they have a long wait to be assessed.

81. The development of crisis houses/ sanctuary provision to offer safe, short-term accommodation and support to people experiencing a mental health crisis is something we believe needs further exploration. We believe the potential of crisis houses to provide a short-term alternative to hospital admission, and/or to provide support, particularly for people at risk of suicide should be examined. There is currently no mention of alternative places of safety in the Welsh Government's consultation document, Together for Mental Health Delivery Plan 2019-22.

Recommendation 4. The Welsh Government should work with Healthcare Inspectorate Wales to ensure its thematic review of crisis and out of hours care

includes a review of the care pathway for people detained under section 136, looking at the quality, safety and responsiveness of the care provided to people detained under section 136.

Recommendation 5. The Welsh Government should work with its partners to develop additional health-based places of safety if required. It should also explore the benefits of adopting regional models to address the concerns raised about staff being drawn from other wards, and to ensure section 136 facilities are staffed appropriately to deal with those who may be intoxicated.

Recommendation 6. The Welsh Government should work with Regional Partnership Boards and the third sector to develop sanctuary provision in local areas for people experiencing mental health crisis.

Recommendation 7. We recognise that data collection is improving, and that the Welsh Government intend to publish a new section 135/136 data set, but there are still difficulties in getting a full picture of the use of section 136sbecause of the availability and quality of data. We recommend that the Welsh Government works with its partners to ensure the data set it publishes on the use of section 136 includes the type of place of safety people are taken to, and the outcomes for people subject to it.

5. Care planning

82. In addition to enabling a police officer to remove a person to a place of safety if they believe they are suffering from a mental disorder and in need of immediate care and control, section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specially trained social worker or nurse), and for the making of any necessary arrangements for treatment or care.

83. According to Mind Cymru, the majority of people detained under section 136 are discharged following assessment. In figures provided as part of their written evidence, 68 per cent of those assessed in 2016-17 were not admitted to hospital for treatment. This accounted for two thirds of the overall number of section 136 detentions that year. Mind Cymru suggested that there could be a number of reasons for this., including people experiencing high levels of distress or being under the influence of alcohol or other substances(see table below).[44]

Outcomes of completed Mental Health Act assessment in hospital under section 136, 2014-15 to 2016-17

	2014-15	2015-16	2016-17
Discharged from Section 136	861	976	1,211
Informally admitted to hospital	292	271	245
Detained under Section 2	209	207	296
Detained under Section 3	16	14	16
Other	20	11	11
All outcomes	1,398	1,479	1,779

(Source: Welsh Government)

84. Richard Jones, Hywel Dda UHB, told us that an exercise undertaken in the Hywel Dda area had shown that, even where people were not being directly admitted to hospital care, many of those people had needs and went on to receive other forms of support that they needed. He went on to say that more

[44] Written evidence, MHP14

needed to be done to prevent people getting into crisis in the first place, particularly in terms of future investment in services.[45]

85. According to the Police Federation of England and Wales:

> "NHS and Social Services as public services use the police as its backstop, often releasing people back into the public domain, having been given advice to seek medical care from say a GP, only for them to once again – and often shortly thereafter – be rearrested under s136."[46]

86. ACC Jonathan Drake made a similar point, raising concerns about "a revolving door". He said that while he couldn't say whether the services put in place for people once they have been released were sufficient or consistent, it was of some concern that 50 per cent of the people dealt with were already patients in some form.[47]

87. Mind Cymru suggested that better data collection could allow services to identify individuals repeatedly detained under section 136, which would provide an opportunity for learning and to ensure adequate preventative support is put in place for the individual.[48]

88. The joint submission from Cais, Hafal and the Morgan Academy stated that "we have observed particular problems with 'revolving door' repeat detentions of individuals which requires special attention on a multi-agency basis".[49]

89. RCN Cymru's written evidence suggested that further work is needed in terms of care planning to better protect vulnerable people. It stated:

> "… there is no built-in mechanism in the existing system whereby multi-agency reviews are automatically triggered for individuals who are repeatedly referred by the police to mental health teams. This means that agencies are not always routinely working together with individuals to achieve the best outcomes for those with mental health problems, and that repeat detentions are not always avoided."[50]

---

[45] RoP, 4 April 2019, paragraph 297

[46] Written evidence, MHP25

[47] RoP, 4 April 2019, paragraph 131

[48] Written evidence, MHP14

[49] Written evidence, MHP11

[50] Written evidence, MHP02

90. Evidence from Cardiff & Vale UHB, however, stated that people arrested under section 136 who are known to local mental health services should have a care and treatment plan which reflects the action to be taken in a crisis relapse by the individual and the agencies involved in their care and treatment.

91. Similarly, Richard Jones, Hywel Dda UHB, told us:

> "Anyone in receipt of care from statutory mental health services will have a care and treatment plan, and that will include a crisis and contingency plan that will identify, in collaboration with that individual and their carer, exactly what steps would help them alleviate a crisis and what they could do about it rather than finding themselves in positions where they do end up with the police."[51]

92. He did, however, acknowledge a need to improve the quality of those care and treatment plans to make them more meaningful for service users and carers.[52]

93. HIW's Joint Thematic Review of Community Mental Health Teams (CMHTs) also found that whilst care planning and legislative documentation were, in most CMHTs, being completed in a timely manner, there were concerns that service users and their families / carers were not always as involved in developing the care and treatment plan as they would like to be.

94. Further, it raised concerns that not all CMHTs routinely offer advocacy services on assessment or at significant points during a service user's care, and carers' assessments are not undertaken routinely to identify if and what information, advice, assistance or support they may need to care for the service user.

95. The Minister for Health and Social Services told us that, where a care and treatment plan was in place, he wanted to establish the adequacy of it, how well people are being engaged in it, and whether it was making a difference. He had therefore commissioned the NHS Delivery Unit to undertake a review of the quality of care and treatment planning, the findings of which would help inform the consultation on the next stage of the "Together for Mental Health" delivery plan.[53]

---

[51] RoP, 4 April 2019, paragraph 254

[52] RoP, 4 April 2019, paragraph 301

[53] RoP, 4 April 2019, paragraph 451

Our view

96. It is worrying that the majority of people detained under section 136 are discharged following assessment because they do not need urgent mental health inpatient treatment. Clearly, this raises questions as to whether section 136 is being used because of an absence of other, more appropriate support services for someone who is experiencing a mental health crisis.

97. Of further concern are the numbers of repeat detentions, under section 136, following release – described to us as the "revolving door". Whether this is as a result of people being discharged too early or poor discharge planning, it suggests a lack of adequate care and support in the community. To help avoid repeat detentions, individuals and their families need to know where to go for help and support as a crisis is approaching.

98. Improving access to crisis care services, particularly out-of-hours services, is key to both reducing the overall use of section 136 and ensuring those discharged from section 136 following assessment go on to receive adequate care and support in the community. We therefore believe there should be greater monitoring of readmissions and repeat detentions to better inform crisis planning.

Recommendation 8. The Welsh Government should publish the NHS Delivery Unit's recommendations for improving care and treatment planning following its review (a) to help ensure there is greater transparency in holding Health Boards to account for the quality of these plans, and (b) to give assurances to the Committee that individuals who are already known to mental health services have a care and treatment plan in place in line with the Mental Health Wales Measure.

6. Conveyance to a place of safety

99. The Code of Practice to the Mental Health Act 1983 requires that people detained under the Act should always be conveyed to hospital in the manner most likely to protect their dignity and privacy, taking account of any risks (i.e. by ambulance which should be made available in a timely way, as opposed to police transport).

100. However, evidence received by the Committee suggested this is not happening. The South Wales Police Partnership Group told us that "the vast majority of S.136's are still being brought to place of safety by the Police".[54]

101. Evidence from the National Police Chiefs' Council stated that, across Wales, partner agencies appear to be failing to meet the needs of persons that require conveyance to a mental health establishment. It goes on to say that operational pressures on the Welsh Ambulance Services NHS Trust (WAST) and mental health services mean that policing is filling the vacuum that is left and police vehicles are consistently being used to transport persons to mental health establishments.[55]

102. ACC Jonathan Drake told us:

> "... the reason why we primarily take people in police cars, and it's unusual that people detained don't travel in police cars, in truth, is simply because of delays in waiting for WAST. It would be a significant delay, and there's a delay because of how busy they are, and, in truth, if you were to triage a call, if someone was suffering a medical emergency versus a case of transport, I can see why there's a real challenge there and a wait."[56]

103. WAST response times were cited as the reason for over-reliance on the police by all the health board representatives we spoke to. Health boards are exploring alternative options of patient transport but there is no consistent approach.[57] Richard Jones, Hywel Dda UHB, described it as "an enormous challenge" because:

[54] Written evidence, MHP01

[55] Written evidence, MHP03

[56] RoP, 4 April 2019, paragraph 182

[57] RoP, 4 April 2019, paragraph 183

> "... part of the problem we have is we haven't accurately mapped our transport need. We simply don't know what the real demand is out of hours, and that's been very difficult to gather."[58]

104. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Assurance Group told us: "this has been on the agenda as one of the long-standing, intractable issues". She went on to say that what is needed is:

> "something that's responsive, quick, not necessarily fully equipped as an ambulance is, and you need it to be more discreet and less stigmatising than being picked up by a police car in your community."[59]

105. ACC Drake told us that there are examples of good practice and initiatives being piloted across Wales but these are not being rolled out everywhere so there is no consistency. He was, however, very clear that police funding should not be used to invest in alternative transport arrangements.[60]

106. The Minister for Health and Social Services confirmed that the Mental Health Crisis Care Concordat Assurance Group had been looking at this issue and had asked the NHS Collaborative Commissioning Unit to undertake a mental health urgent access and conveyance review to look at how and where access is provided. He also said that, in addition to the review, there are pilots underway in Aneurin Bevan and Hywel Dda health board areas to look at non-emergency conveyance:

> "I recognise from the Welsh ambulance service's point of view, as a national organisation they're dealing with a variance in how that is organised between different police force areas, different health board areas, and also 22 local authorities as well. So, actually, it's in everyone's interest, not just the ambulance service's but everyone's interest, to have some more consistency around that. So, whether that is a single, once-for-Wales model or whether it's something with more flexibility is something that we'll be looking at, following that review."[61]

Our view

107. The Code of Practice to the Mental Health Act 1983 requires that people detained under the Act should always be conveyed to hospital in the manner

[58] RoP, 4 April 2019, paragraph 329

[59] RoP, 4 April 2019, paragraph 408

[60] RoP, 4 April 2019, paragraph 183

[61] RoP, 4 April 2019, paragraph 440

most likely to protect their dignity and privacy. However, it is clear that this is not happening and in the vast majority of cases people are still being transported to a place of safety by the police.

108. While we recognise the need for the prioritisation of ambulance calls, it is extremely distressing for the person experiencing a mental health crisis and their family for them to be taken away in a police car.

109. We are aware of examples of good practice and initiatives being piloted across Wales but are concerned that these are not being rolled out everywhere so there is no consistency of practice. We believe this needs to be addressed as a matter of urgency.

Recommendation 9. The Welsh Government should implement, as a matter of urgency, its conveyance review and state how it will ensure that alternative patient transport will be provided for individuals experiencing mental health crises, thereby limiting the use of police vehicles in the conveyance of individuals detained under the Mental Health Act 1983 to hospital.

7. Mental Health Crisis Care Concordat

110. Published in 2015, the Mental Health Crisis Care Concordat[62] is a national agreement between health, criminal justice and social care agencies that sets out how services and agencies involved in the care and support of people in a mental health crisis will work together to provide the necessary support. It includes arrangements for more joint work and better information sharing between agencies.

Progress in implementation

111. The Crisis Care Concordat is generally seen as a positive step. Evidence from Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFS) says that:

> "... the concordat is an excellent first step and an early evaluation indicates that it has made some improvements. The most significant is the reduction in the use of police cells as a place of safety. This is undoubtedly positive."[63]

112. However, it went on it say that while the concordat is a step in the right direction, there is still further work to be done.

113. Mind Cymru told us:

> "Whilst progress has been made, a focused approach and greater urgency is needed if we are to truly deliver the Concordat in full and transform the way in which we help those experiencing a mental health crisis."[64]

114. We also heard there is a need to scale up good practice to ensure a consistent approach across Wales. According to Kate Chamberlain, Healthcare Inspectorate Wales:

> "... one of the things we're very good at in Wales is innovative projects and pilots and trying new things. What I don't think we are as strong at

[62] Mental Health Crisis Care Concordat

[63] Written evidence, MHP26

[64] Written evidence, MHP14

> is taking the learning from those pilots and projects and spreading them so that we have a consistent approach across Wales."[65]

115. While ACC Jonathan Drake told us "there are examples of good practice and initiatives that are piloted [...] but they don't seem to then roll out everywhere. They seem to be in individual areas, and, to me, that's such a shame".[66]

Leadership / governance

116. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, stated that stronger central leadership is needed from the Welsh Government to accelerate implementation of the concordat, as well as to increase accountability and transparency.[67]

117. A joint written submission from Cais, Hafal and Morgan Academy questioned whether the Mental Health Crisis Care Concordat Advisory Group has the authority and capacity to drive improvement and hold organisations to account . It suggested that the concordat does not have "high status" in mainstream targets for health and social care agencies or for the police and goes on to say:

> "In our experience effective joint working has depended on local relationships and on local initiative and good will more than on national leadership. The result is great inconsistency and in many instances police and health staff still effectively work in isolation."[68]

118. The Office of the Police and Crime Commissioner for Gwent and Public Health Wales also suggested that increased and robust leadership by the Welsh Government and increased accountability by agencies is needed to achieve the objectives and aims of the Concordat. Evidence from the Office of the Police and Crime Commissioner for Gwent states:

> "Gwent has a robust partnership working group that oversees the Mental Health Crisis Care Concordat. This is a very proactive group with excellent working relationships. However, its ability to influence across all agencies at the levels required is limited due to a lack of consistent and cohesive partnership outcomes."[69]

---

[65] RoP, 4 April 2019, paragraph 30

[66] RoP, 4 April 2019, paragraph 185

[67] RoP, 4 April 2019, paragraph 374

[68] Written evidence, MHP11

[69] Written evidence, MHP13

119. Public Health Wales told us:

> "... mental health as an ACE [Adverse Childhood Experience] is so prevalent within communities that it is worthy of this having relevant staffing within Welsh Government to oversee the implementation of the concordat rather than this being a small add-on part of a wider portfolio of responsibilities on an operational level."[70]

120. Sara Moseley, Chair of the Mental Health Crisis Care Concordat Advisory Group, told us that there are clear assurance mechanisms in place. However, she suggests that transparency could be improved if the Welsh Government published the six-monthly assurance reports the Group provides to it, as well as the regional action plans for each area.[71]

121. Matt Downton, Head of Mental Health and Vulnerable Groups at the Welsh Government advised that the Advisory Group had moved from a task and finish group into an assurance group, in recognition of the need to strengthen governance arrangements, because, as a task and finish group, it did not have a formal reporting mechanism into Welsh Government.

122. The Minister for Health and Social Services told us:

> "I think the governance and oversight for the concordat is appropriate. We have an assurance group and regional partnerships report directly into that. The important thing is making sure that it works so people can understand where the governance lies."[72]

123. He also confirmed that the chairing of the advisory group would shortly move to the national health service, which would "reinforce the role of the health service as a key partner to make sure it is not seen as just a health issue or just a police issue, but, actually, the NHS are there to work with other partners and to make sure that they are always present".[73]

Our view

124. We welcome the publication of the Mental Health Crisis Care Concordat, particularly in terms of its contribution in successfully implementing the legislative changes in relation to the use of police custody as a place of safety. We

[70] Written evidence, MHP04

[71] RoP, 4 April 2019, paragraph 354

[72] RoP, 4 April 2019, paragraph 475

[73] RoP, 4 April 2019, paragraph 475

do not believe that further legislation is necessary in this area but do think that more focus and urgency is needed to drive forward full delivery of the Concordat.

125. The Concordat was established to promote local multi-agency arrangements to improve the quality of care for people experiencing a mental health crisis and ensure that they are diverted to health rather than police settings. It is our view that a greater focus on early intervention is needed to ensure people are getting the help they need for their mental health problems early enough so that they do not reach crisis point. We believe that the chairing of the Mental Health Crisis Care Concordat Advisory Group should reflect that ambition.

Recommendation 10. As an immediate action, the Welsh Government should publish the six-monthly assurance reports provided to Welsh Government by the Mental Health Crisis Concordat Assurance Group to help increase transparency and drive service improvement.

Recommendation 11. The Welsh Government should, in consultation with members of the Mental Health Crisis Care Concordat Assurance Group, review the role, purpose and governance arrangements of the Mental Health Crisis Care Concordat Assurance Group, in order to satisfy itself that there is sufficient focus on implementation; increased accountability in terms of ensuring that learning from pilots and projects is shared and good practice is scaled up so that there is a more consistent approach to mental health crisis care provision and services across Wales.

ANNEX A – Health based places of safety

Health Board Name	Name of Hospital where S136 Locally Designated Place of Safety is Located	Name of Ward/Unit used as the S136 place of safety within the hospital site
Abertawe Bro Morgannwg	**Cefn Coed Hospital**	Fendrod Ward
	Neath Port Talbot Hospital	Ward F
	Princess of Wales Hospital, Coity Clinic	Ward 14, Coity Clinic
Aneurin Bevan	**St Cadocs Hospital Caerleon NP18 3XQ**	Adferiad Ward
Powys	**Bronllys Hospital**	Felindre Ward
Betsi Cadwaladr	**Ysbyty Gwynedd**	Hergest Unit
	Ysbyty Glan Clwyd	Ablett Unit
	Wrexham Maelor Hospital	Heddfan Adult Mental Health Unit
Cwm Taff	**Royal Glamorgan Hospital Llantrisant**	Crisis Team Mental Health Unit A&E
	Prince Charles Hospital Merthyr Tydfil	Crisis Resolution Home Treatment Team A&E
Cardiff and Vale	**Hafan Y Coed University Hospital Llandough**	Emergency Assessment Suite
Hywel DDa	**Hafan Derwen, Carmarthen**	Cwm Seren PICU
	Prince Philip, Llanelli	Bryngofal Ward
	Bro Cerwyn, Haverfordwest	St Caradog Ward
	Glangwili Hospital Carmardden	Morlais Ward (under 18 only)

MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

PRACTICE DIRECTION

STATEMENTS AND REPORTS FOR MENTAL HEALTH REVIEW TRIBUNALS IN WALES

---

1. In this Practice Direction "the Act" refers to the Mental Health Act 1983 (as amended by the Mental Health Act 2007). "The Rules" refer to the Mental Health Review Tribunal for Wales Rules 2008.

2. Rule 15 of the Rules sets out the steps that the Tribunal, a Responsible Authority and the Secretary of State must take when the Tribunal receives an application or a reference under the Act by reference to the Schedule to the Rules Parts A, B, C and D. *(Rule 15 and the Schedule are set out in full in the Appendix to the Practice Direction).*

3. This Practice Direction is intended to clarify the requirements of Rule 15 and the Schedule to the Rules and sets out the additional information that the Tribunal requires by reference to the following categories of patient:

   (A) IN-PATIENTS (NON-RESTRICTED AND RESTRICTED)

   (B) COMMUNITY PATIENTS

   (C) GUARDIANSHIP PATIENTS

   (D) CONDITIONALLY DISCHARGED PATIENTS

   (E) PATIENTS UNDER THE AGE OF 18.

4. In addition to the Rules this Practice Direction also takes into account the provisions of the Mental Health (Wales) Measure 2010, the Social Services and Well-being (Wales) Act 2014 and the Mental Health Act 1983 Code of Practice for Wales 2016.

CAROLYN KIRBY OBE

PRESIDENT, MHRT FOR WALES

SIR WYN WILLIAMS

PRESIDENT OF WELSH TRIBUNALS

OCTOBER 2019

GENERAL REQUIREMENTS

5. The authors of all reports should have personally met and be familiar with the patient. If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place, the author of the report should send to the tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria.

6. All reports must be up-to-date, be specifically prepared for the Tribunal and have numbered paragraphs and pages. Reports should be signed and dated. The sources of information for the events and incidents described must be made clear. Reports should not recite details of medical records or be an addendum to (or reproduce extensive details from) previous reports.

7. All medical reports should specifically address the relevant statutory criteria relied upon to support continued detention under the Act.

8. The purpose of this Practice Direction is to ensure that all persons providing or adducing evidence to the Tribunal shall be aware of a duty to assist the Tribunal in achieving the Overriding Objective set out in Rule 3 of the MHRT Wales Rules 2008 and in carrying out its statutory duties. Any failure to provide the information required by this Practice Direction within the time limits specified, may result in the Tribunal issuing further Directions in accordance with Rules 18 or 19 requiring specified information to be provided and/or by Summons requiring the attendance of a person to appear before the Tribunal.

(A) IN-PATIENTS (NON-RESTRICTED AND RESTRICTED)

9. For the purposes of this Practice Direction, a patient is an in-patient if they are detained in hospital to be assessed or treated for a mental disorder, whether admitted through civil or criminal justice processes, including a restricted patient (i.e. subject to special restrictions under the Act), and including a patient transferred to hospital from custody. A patient is to be regarded as an in-patient detained in a hospital even if they have been permitted leave of absence, or have gone absent without leave.

10. In the case of a restricted patient detained in hospital, the tribunal may make a provisional decision to order a Conditional Discharge but may defer its decision until satisfactory arrangements can be made. The patient will remain an in-patient unless and until the tribunal finally grants a Conditional Discharge, so this part of the Practice Direction applies.

11. In addition to the information set out in Part A of the Schedule to the Rules the responsible authority must provide the following:

    (a) details of any previous tribunal hearings and the outcome thereof;

    (b) whether the patient suffers from any disability which will mean he requires assistance to take part in the tribunal process

(c) in the event that the patient lacks capacity to object to the nearest relative being informed of the hearing, a statement to that effect and details of the nearest relative;

(d) the name and address of any legal representative of the patient;

(e) a nursing report.

Responsible Clinician's Report – In-patients

12. The report should be written or countersigned by the patient's Responsible Clinician. It must briefly describe the patient's recent relevant medical history and current mental health presentation, and must include:

(a) whether there are any factors that may affect the patient's understanding or ability to cope with a hearing and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly and in particular whether the patient has the capacity to attend and be represented at a tribunal hearing;

(b) details of any index offence(s) and other relevant forensic history;

(c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;

(d) reasons for any previous admission or recall to hospital;

(e) the circumstances leading up to the patient's current admission to hospital;

(f) the strengths or positive factors relating to the patient;

(g) a summary of the patient's current progress, behaviour, capacity and insight;

(h) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is or might be made available;

(i) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(j) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;

(k) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;

(l) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;

(m) any recommendations to the tribunal, with reasons.

Nursing Report – In-Patients

13. The report should be written or countersigned by the patient's named nurse. In relation to the patient's current in-patient episode, the report must briefly describe the patient's current mental health presentation and must include:

(a) Whether there are any factors that may affect the patient's understanding or ability to cope with a hearing and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

(b) the nature of nursing care and medication currently being made available;

(c) the level of observation to which the patient is currently subject;

(d) whether the patient has contact with relatives, friends or other patients, the nature of the interaction, and what community support the patient has;

(e) strengths or positive factors relating to the patient;

(f) a summary of the patient's current progress, engagement with nursing staff, behaviour, cooperation, activities, self-care and insight;

(g) any occasions on which the patient has been absent without leave whilst liable to be detained, or occasions when the patient has failed to return as and when required, after having been granted leave;

(h) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or treatment for mental disorder that is or might be made available;

(i) details of any incidents in hospital where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(j) any occasions on which the patient has been secluded or restrained, including the reasons why such seclusion or restraint was necessary;

(k) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;

(l) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;

(m) any recommendations to the tribunal, with reasons.

Social Circumstances Report – In-Patients

14. The report should where possible be written or countersigned by the patient's Care Coordinator. Where the Social Circumstances Report is not written by the Care Coordinator a separate report by the Care Coordinator should be provided giving the information set out in s.18 of the Mental Health (Wales) Measure 2010 including an up-to-date Care and Treatment Plan. The Social Circumstances Report must briefly

describe the patient's recent relevant history and current presentation, and must include:

(a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

(b) details of any index offence(s) and other relevant forensic history;

(c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;

(d) the patient's previous response to community support or Section 117 aftercare;

(e) so far as is known, details of the care pathway and Section 117 after-care to be made available to the patient, together with details of the proposed care plan;

(f) the likely adequacy and effectiveness of the proposed care plan;

(g) whether there are any issues as to funding the proposed care plan and, if so, the date by which those issues will be resolved;

(h) the strengths or positive factors relating to the patient;

(i) a summary of the patient's current progress, behaviour, compliance and insight;

(j) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(k) the patient's views, wishes, beliefs, opinions, hopes and concerns;

(l) except in restricted cases, the views of the patient's Nearest Relative unless (having consulted the patient) it would be inappropriate or impractical to consult the Nearest Relative, in which case reasons for this view must be given and any attempts to rectify matters described;

(m) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;

(n) whether the patient is known to any MAPPA meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;

(o) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;

(p) in the case of an eligible compliant patient who lacks capacity to agree or object to their detention or treatment, whether or not deprivation of liberty under the Mental Capacity Act 2005 (as amended) would be appropriate and less restrictive;

(q) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;

(r) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;

(s) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;

(t) any recommendations to the tribunal, with reasons.

(B) COMMUNITY PATIENTS

15. For the purposes of this Practice Direction a patient is a Community Patient if the patient has been discharged from hospital under s.17A of the Act subject to the power of recall in accordance with s.17E. It includes a patient who has been recalled to hospital but whose CTO has not been revoked in accordance with s.17F.

16. In addition to the reports required in accordance with Schedule 1 Part B to the Act the responsible authority must provide a Nursing Report in relation to all community patients. The Nursing Report should be written by the professional person with the main responsibility for supervising the patient's treatment in the community. In the event that neither the Social Circumstances Report nor the Nursing Report are written by the patient's Care Coordinator the responsible authority should also provide a report by the Care Coordinator giving full details of the performance of their functions under s.18 of the Mental Health (Wales) Measure 2010 together with the up-to-date Care and Treatment Plan for the patient.

Statement of Information about the Patient – Community Patients

17. In addition to the information required under Part A of the Schedule to the Rules the Statement should also include;

(a) a chronological table listing;

(i) the dates of any previous admissions to, discharge from, or recall to hospital, stating whether the admissions were compulsory or voluntary, and including any previous instances of discharge on to a Community Treatment Order (CTO);

(ii) the date of the underlying order or Direction for detention in hospital prior to the patient's discharge onto the current CTO;

(iii) the date of the current CTO;

(iv) the dates of any subsequent renewal of, or change in, the authority for the patient's CTO, and any changes in the patient's status under the Act;

(v) the dates and outcomes of any tribunal hearings over the last three years;

(b) where the patient has made any request that their Nearest Relative should not be consulted or should not be kept informed about the patient's care or treatment, the details of any such request, whether the Responsible Authority believes that the patient has capacity to make such a request and the reasons for that belief;

(c) the name and address of any other person who plays a significant part in the care of the patient but who is not professionally involved;

(d) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report – Community Patients

18. The report must include, so far as it is applicable the information set out above in relation to in-patients and, in addition;

(a) where the patient is aged 18 or over and the case is a reference to the tribunal, whether the patient has capacity to decide whether or not to attend or be represented at a tribunal hearing;

(b) the circumstances leading up to the patient's discharge onto a CTO;

(c) the conditions to which the patient was made subject under Section 17B when the CTO was put in place and details of any variation of those conditions since then;

(d) details of the patient's compliance with the conditions imposed under s.17B together with details of any recalls to hospital under s.17E which have not resulted in a revocation of the CTO;

(e) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Community Patients

19. The report must include the information set out in Part B of the Schedule to the Rules, so far as applicable the information required in relation to in-patient reports as set out in paragraph 12 above and, in addition, must include:

(a) The professional status of the report writer (e.g. AMHP, CPN), their position in relation to the patient's care and treatment in the community and details of the contact between the report writer and the patient since implementation of the CTO;

(b) the views of any other person professionally involved in the care and treatment of the patient in the community;

(c) details of the patient's compliance with the conditions imposed under s.17B and of any incidents where the patient has been recalled to hospital under s.17E but where the CTO has not been revoked under s.17F;

(d) whether the patient, if discharged from the CTO, would be likely to act in a manner dangerous to themselves or others;

(e) whether, in the professional opinion of the report writer, it continues to be necessary that the Responsible Clinician should be able to exercise the power of recall and, if so, why;

(f) any recommendations to the tribunal, with reasons.

(C) GUARDIANSHIP PATIENTS

20. For the purposes of this Practice Direction a Guardianship Patient is any patient who has been received into Guardianship in accordance with s.7 of the Act and where the

Guardianship Order has not been discharged either in accordance with s.23 or s.6 (4) of the Act. For the avoidance of doubt it includes a patient who, during the currency of a Guardianship Order, is admitted to hospital informally for treatment or is admitted to hospital under ss. 2 or 4 of the Act.

21. In addition to the Statement of Information required by Part A of the Schedule to the Rules and the reports required in accordance with Part B the responsible authority are also required to provide a Nursing Report by the Managers of any residential facility in which the patient is required to live as a condition of the Guardianship Order.

Statement of Information about the Patient – Guardianship Patients

22. The statement provided to the tribunal should, in addition to the information required by Part A of the Schedule to the Rules, also include;

(a) a chronological table listing:

(i) the dates of any previous admissions to, discharge from or recall to hospital, stating whether the admissions were compulsory or voluntary;

(ii) the dates of any previous instances of reception into guardianship;

(iii) the dates and outcomes of any tribunal hearings over the last three years;

(b) whether the patient has made any request that their Nearest Relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the details of any such request, whether the Responsible Authority believes that the patient has capacity to make such a request and the reasons for that belief;

(c) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report – Guardianship Patients

23. In addition to the information required by Part B of the Schedule to the Rules the report must include:

(a) whether there are any factors that may affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

(b) details of any index offence(s), and other relevant forensic history;

(c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital, and any previous instances of reception into guardianship;

(d) the circumstances leading up to the patient's reception into guardianship;

(e) any requirements to which the patient is subject under Section 8(1), and details of the patient's compliance,

(f) the strengths or positive factors relating to the patient;

(g) a summary of the patient's current progress, behaviour, capacity and insight;

(h) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is, or might be, made available;

(i) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(j) whether it is necessary for the welfare of the patient, or for the protection of others, that the patient should remain under guardianship and, if so, why;

(k) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Guardianship Patients

24. In addition to the information required under Part B of the Schedule to the Rules the report should include;

(a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

(b) details of any index offence(s), and other relevant forensic history;

(c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital, and any previous instances of reception into guardianship;

(d) any requirements to which the patient is subject under Section 8(1), and details of the patient's compliance,

(e) the patient's previous response to community support;

(f) details of the community support that is being, or could be, made available to the patient, together with details of the current care plan;

(g) the current adequacy and effectiveness of the care plan;

(h) whether there are any issues as to funding the current or future care plan and, if so, the date by which those issues will be resolved;

(i) the strengths or positive factors relating to the patient;

(j) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(k) the patient's views, wishes, beliefs, opinions, hopes and concerns;

(l) the views of the guardian;

(m) the views of the patient's Nearest Relative unless (having consulted the patient) it would be inappropriate or impractical to consult the Nearest Relative, in which case reasons for this view must be given and any attempts to rectify matters described;

(n) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;

(o) whether the patient is known to any MAPPA meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;

(p) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;

(q) whether, and if so how, any risks could be managed effectively in the community;

(r) whether it is necessary for the welfare of the patient, or for the protection of others, that the patient should remain under guardianship and, if so, why;

(s) any recommendations to the tribunal, with reasons.

Nursing report – Guardianship Patients

25. The report should be prepared by the Manager of any residential facility in which the patient is required to live as a condition of the Guardianship Order and should include:

(a) the nature of any nursing or other care and medication currently being made available to the patient;
(b) the level of observation to which the patient is currently subject if any;
(c) whether the patient has contact with relatives, friends or other patients, the nature of the interaction, and what community support the patient has;
(d) strengths or positive factors relating to the patient;
(e) a summary of the patient's current progress, engagement with staff, behaviour, cooperation, activities, self-care and insight;
(f) any occasions on which the patient has been absent without leave whilst subject to the Guardianship Order;
(g) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication care or treatment that is or might be made available;
(h) any recommendations to the tribunal, with reasons.

(D) CONDITIONALLY DISCHARGED PATIENTS

26. For the purposes of this Practice Direction a conditionally discharged patient is a restricted patient who has been discharged from hospital into the community, subject to a condition that the patient will remain liable to be recalled to hospital for further treatment, should it become necessary. Other conditions may, in addition, be imposed by the tribunal, or by the Secretary of State (Ministry of Justice).

27. This part only applies to restricted patients who have actually been granted a Conditional Discharge and who are living in the community. In the case of a restricted

patient detained in hospital, the tribunal may make a provisional decision to order a Conditional Discharge. Before it finally grants a Conditional Discharge, the tribunal may defer its decision so that satisfactory arrangements can be put in place. Unless and until the tribunal finally grants a Conditional Discharge, the patient remains an in-patient, and so the in-patient part of this Practice Direction (and not this part) applies.

28. Upon being notified by the Minister of Justice of an application or reference, the Responsible Clinician must send or deliver to the Minister of Justice the Responsible Clinician's Report, and any Social Supervisor must send or deliver to the Minister of Justice the Social Circumstances Report. If there is no Social Supervisor, the Responsible Clinician's report should also provide the required social circumstances information. In addition the Responsible Clinician may send any further report if in the opinion of the Responsible Clinician such reports are likely to help the Tribunal when they consider the matter. The reports of the Responsible Clinician and Social Supervisor should address the criteria set out in paragraph 57 in **R(SC) v. MHRT [2005] EWHC 17 (Admin).**

Statement of Information – Conditionally Discharged Patients

29. The statement provided to the Tribunal should include the information set out in Part C of the Schedule to the Rules.

Responsible Clinician's Report – Conditionally Discharged Patients

30. The report should be written or counter-signed by the patient's Responsible Clinician. If there is no Social Supervisor, the Responsible Clinician's report should also provide the required social circumstances information. In addition to the information set out in Part D of the Schedule to the Rules, the report must include:

    (a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

    (b) details of the patient's index offence(s), and any other relevant forensic history;

    (c) a chronology listing the patient's involvement with mental health services including any admissions to, discharge from and recall to hospital;

    (d) reasons for any previous recall following a Conditional Discharge and details of any previous failure to comply with conditions;

    (e) the circumstances leading up to the current Conditional Discharge;

    (f) any conditions currently imposed (whether by the tribunal or the Secretary of State), and the reasons why the conditions were imposed;

    (g) details of the patient's compliance with any current conditions;

    (h) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs;

    (i) the strengths or positive factors relating to the patient;

    (j) a summary of the patient's current progress, behaviour, capacity and insight;

(k) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder;

(l) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(m) an assessment of the patient's prognosis, including the risk and likelihood of a recurrence or exacerbation of any mental disorder;

(n) the risk and likelihood of the patient re-offending and the degree of harm to which others may be exposed if the patient does re-offend;

(o) whether the patient, if absolutely discharged, would be likely to act in a manner harmful to themselves or others, whether any such risks could be managed effectively in the community and, if so, how;

(p) whether it continues to be appropriate for the patient to remain liable to be recalled for further medical treatment in hospital and, if so, why;

(q) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;

(r) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Conditionally Discharged Patients

31. In addition to the information required by Part D of the Schedule to the Rules the report should also include the following:

(a) the patient's full name, date of birth, and current address;

(b) the full official name of the Responsible Authority;

(c) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;

(d) details of the patient's index offence(s), and any other relevant forensic history;

(e) a chronology listing the patient's involvement with mental health services including any admissions to, discharge from and recall to hospital;

(f) any conditions currently imposed (whether by the tribunal or the Secretary of State), and the reasons why the conditions were imposed;

(g) details of the patient's compliance with any past or current conditions;

(h) the patient's home and family circumstances;

(i) the housing or accommodation currently available to the patient;

(j) the patient's financial position (including benefit entitlements);

(k) any employment or available opportunities for employment;

(l) details of the community support or Section 117 after-care that is being, or could be made available to the patient, together with details of the current care plan;

(m) whether there are any issues as to funding the current or future care plan and, if so, the date by which those issues will be resolved;

(n) the current adequacy and effectiveness of the care plan;

(o) the strengths or positive factors relating to the patient;

(p) a summary of the patient's current progress, compliance, behaviour and insight;

(q) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(r) the patient's views, wishes, beliefs, opinions, hopes and concerns;

(s) the views of any partner, family member or close friend who takes a lead role in the care and support of the patient but who is not professionally involved;

(t) whether the patient is known to any Multi Agency Public Protection Arrangements (MAPPA) meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;

(u) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;

(v) whether the patient, if absolutely discharged, would be likely to act in a manner harmful to themselves or others, whether any such risks could be managed effectively in the community and, if so, how;

(w) whether it continues to be appropriate for the patient to remain liable to be recalled for further medical treatment in hospital and, if so, why;

(x) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;

(y) any recommendations to the tribunal (with reasons).

Reports from the Ministry of Justice in Respect of Conditionally Discharged Patients

32. In accordance with Part D of the Schedule to the Rules the report will include the following;

(a) The view of the Secretary of State as to the suitability of the patient for absolute discharge.

(b) Any other observations on the application which the Secretary of State wishes to make.

(E) PATIENTS UNDER THE AGE OF 18

33. All the above requirements in respect of statements and reports apply, as appropriate, depending upon the type of case.

34. In accordance with the Code of Practice for Wales 2016, if the patient is under 18 and the RC is not a CAMHS specialist, the RC will need to ensure a report from such a specialist is provided to the Tribunal.

35. In addition, *for all patients under the age of 18*, the **Social Circumstances Report** must also state:

(a) the names and addresses of any people with parental responsibility, and how they acquired parental responsibility;

(b) which public bodies either have worked together or need to liaise in relation to after-care services that may be provided under Section 117 of the Act;

(c) the outcome of any liaison that has taken place;

(d) if liaison has not taken place, why not – and when liaison will take place;

(e) the details of any multi-agency care plan in place or proposed;

(f) whether there are any issues as to funding the care plan and, if so, the date by which those issues will be resolved;

(g) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, Social Worker/AMHP or Social Supervisor;

(h) whether the patient's needs have been assessed under the Children Act 1989, the Chronically Sick and Disabled Persons Act 1970 or the Social Services and Wellbeing (Wales) Act 2014 and, if not, the reasons why such an assessment has not been carried out and whether it is proposed to carry out such an assessment;

(i) if there has been such an assessment, what needs or requirements have been identified and how those needs or requirements will be met;

(j) if the patient is subject to or has been the subject of a Care Order or an Interim Care Order:

(i) the date and duration of any such order;

(ii) the identity of the relevant local authority;

(iii) the identity of any person(s) with whom the local authority shares parental responsibility;

(iv) whether there are any proceedings which have yet to conclude and, if so, the court in which proceedings are taking place and the date of the next hearing;

(v) whether the patient comes under the Children (Leaving Care) Act 2000 or the Social Services and Well-being (Wales) Act 2014.

(vi) whether there has been any liaison between, on the one hand, social workers responsible for mental health services to children and adolescents and, on the other hand, those responsible for such services to adults;

(vii) the name of the social worker within the relevant local authority who is discharging the function of the Nearest Relative under Section 27 of the Act;

(k) if the patient is subject to guardianship under Section 7 of the Act, whether any orders have been made under the Children Act 1989 in respect of the patient, and what consultation there has been with the guardian;

(l) if the patient is a Ward of Court, when the patient was made a ward of court and what steps have been taken to notify the court that made the order of any significant steps taken, or to be taken, in respect of the patient;

(m) whether any other orders under the Children Act 1989 are in existence in respect of the patient and, if so, the details of those orders, together with the date on which such orders were made, and whether they are final or interim orders;

(n) if a patient has been or is a looked after child under either Section 20 of the Children Act 1989 or under Section 76 of the Social Services and Well-being (Wales) Act, when the child became looked after, why the child became looked after, what steps have been taken to appoint an independent visitor for the child under Section 16 of the Children and Young Persons Act 2008 or under Section 98 of the Social Services and Wellbeing (Wales) Act 2014 and what steps are being taken (if required) to discharge the obligations of the local authority under Paragraph 10 (b) of Schedule 2 of the Children Act 1989 or Section 39 (2) of the Social Services and Wellbeing (Wales) Act 2014.

(o) if a patient has been treated by a local authority as a child in need (which includes a child who has a mental disorder) under Section 17(11) of the Children Act 1989, the period or periods for which the child has been so treated, why they were considered to be a child in need, what services were or are being made available to the child by virtue of that status, and details of any assessment of the child;

(p) if a patient has been the subject of a secure accommodation order under Section 25 of the Children Act 1989, the date on which the order was made, the reasons it was made, and the date it expired;

(q) if a patient is a child provided with accommodation under Sections 85 and 86 of the Children Act 1989, what steps have been taken by the accommodating authority or the person carrying on the establishment in question to discharge their notification responsibilities, and what steps have been taken by the local authority to discharge their obligations under Sections 85, 86 and 86A of the Children Act 1989.

APPENDIX

RULE 15 Statements, reports and documents

(1) Subject to Rule 17 (withholding documents or information likely to cause harm), when the Tribunal receives a document from any party it must send a copy of that document to each other party.

(2) When the Tribunal receives an application or reference it must send to the responsible authority or the Secretary of State, as the case may be, a request for the documents and information required to be provided under paragraph (3), (4) or (5).

(3) In proceedings under section 66 (1) (a) of the Act (application for admission for assessment), on the earlier receipt of the copy of the application or receipt of a request from the Tribunal, the responsible authority must send or deliver to the Tribunal by the commencement of the hearing –

(i) the application for admission;

(ii) the written medical recommendation or recommendations, as the case may be, of the registered medical practitioners on which the application is founded;

(iii) such of the information specified in Part A of the Schedule as is within the knowledge of the responsible authority and can reasonably be provided in the time available; and

(iv) such of the reports specified in Part B of the Schedule as can reasonably be provided in the time available.

(4) If the patient is a conditionally discharged patient the Secretary of State shall send to the Tribunal as soon as practicable, and in any event within 6 weeks of receipt by the Secretary of State of a copy of the application or request from the Tribunal, a statement which shall contain –

(a) the information specified in Part C of the Schedule, in so far as it is within the knowledge of the Secretary of State; and

(b) the reports specified in Part D of the Schedule, in so far as it is reasonable practicable to provide them.

(5) If neither paragraph (3) nor (4) applies, the responsible authority must send a statement to the Tribunal as soon as reasonably practicable, and in any event within 3 weeks of receipt by the responsible authority of a copy of the application or receipt of a request from the Tribunal, a statement which shall contain –

(a) the information specified in Part A of the Schedule, in so far as it is within the knowledge of the responsible authority;

(b) the report specified in paragraph 1 of Part B of that Schedule; and

(c) the other reports specified in Part B of the Schedule, in so far as it is reasonably practicable to provide them.

(6) If the patient is a restricted patient the responsible authority must also send the statement under paragraph (5) to the secretary of State, and the Secretary of state must send a statement of any further relevant information to the Tribunal as soon as reasonably practicable and in any event –

(a) in proceedings under section 75 (1) of the Act, within 2 weeks of receipt by the Secretary of State of the relevant authority's statement; or

(b) otherwise, within 3 weeks of receipt by the Secretary of State of the relevant authority's statement.

(7) If the Welsh Ministers or Secretary of State wish to seek the approval of the Tribunal under section 86 (3) of the Act, the Welsh Ministers or Secretary of State, as the case may be, must refer the patient's case to the Tribunal and the provisions of these Rules applicable to references under the Act apply to the proceedings.

SCHEDULE

STATEMENTS BY THE RESPONSIBLE AUTHORITY AND THE SECRETARY OF STATE

Part A Information about patients (other than conditionally discharged patients)

1. The patient's full name (and any alternative names used in patient records).
2. The patient's date of birth and age.
3. The patient's language of choice and, if it is not English or Welsh, whether an interpreter is required.
4. The application, order or direction made under the Act to which the tribunal proceedings relate and the date on which that application, order or direction commenced.
5. Details of the original authority for detention or guardianship of the patient, including the statutory basis for that authority and the details of any subsequent renewal of or change in that authority.
6. In cases where a patient has been transferred to hospital under section 45A, 47 or 48 of the Act, details of the order, direction or authority under which the patient was being held in custody before his transfer to hospital.
7. Except in relation to a patient subject to guardianship or after-care under supervision, or a community patient, the hospital or hospital unit at which the patient is presently liable to be detained under the Act, and the ward or unit on which he is presently detained.

8. If a condition or requirement has been imposed that requires the patient to reside at a particular place, details of the condition or requirement and the address at which the patient is required to reside.
9. In the case of a community patient, details of any conditions attaching to the patient's community treatment order under section 17B (2) of the Act.
10. The name of the patient's responsible clinician and the length of time the patient has been under their care.
11. Where another approved clinician is or has recently been largely concerned in the treatment of the patient, the name of that clinician and the period the patient has spent in that clinician's care.
12. The name of any care coordinator appointed for the patient.
13. Where the patient is subject to the guardianship of a private guardian, the name and address of that guardian.
14. Where there is an extant order of the superior court of record established by section 45 (1) of the Mental Capacity Act 2005, the details of that order.
15. Unless the patient requests otherwise, the name and address of the person exercising the functions of the nearest relative of the patient.
16. Where a local health board, a National Health Service trust, a primary care trust, a NHS Foundation Trust, a Strategic Health Authority, the Welsh Ministers or the Secretary of State has or have a right to discharge the patient under the provisions of section 23 (3) of the Act, the name and address of such board, trust, authority, person or persons.
17. In the case of a patient subject to after-care under supervision, the name and address of the local social services authority and NHS body that are responsible for providing the patient with after-care under section 117 of the Act, or will be when he leaves hospital.
18. The name and address of any person who plays a substantial part in the care of the patient but who is not professionally concerned with it.
19. The name and address of any other person who the responsible authority considers should be notified to the Tribunal.

Part B Reports relating to patients (other than conditionally discharged patients)

1. An up to date clinical report, prepared for the Tribunal, including the relevant clinical history and a full report of the patient's mental condition.
2. An up to date social circumstances report prepared for the Tribunal including reports on the following –

   (a) the patient's home and family circumstances, including the views of the patient's nearest relative or person so acting;

   (b) the opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged;

   (c) the availability of community support and the relevant medical facilities;

   (d) the financial circumstances of the patient.

3. The views of the responsible authority on the suitability of the patient for discharge.
4. Where the provisions of section 117 of the Act may apply to the patient, a proposed after-care plan in respect of the patient.
5. Any other information or observations on the application which the responsible authority wishes to make.

Part C Information about conditionally discharged patients

1. The patient's full name (and any alternative names used in patient records).
2. The patient's date of birth and age.
3. The patient's language of choice and, if it is not English or Welsh, whether an interpreter is required.
4. The history of the patient's present liability to detention including details of the offence or offences, and the dates of the original order or direction and of the conditional discharge.
5. The name and address of any clinician responsible for the care and supervision of the patient in the community, and the period that the patient has spent under the care and supervision of that clinician.
6. The name and address of any social worker or probation officer responsible for the care and supervision of the patient in the community and the period that the patient has spent under the care and supervision of that person.

Part D Reports relating to conditionally discharged patients

1. Where there is a clinician responsible for the care and supervision of the patient in the community, an up to date report prepared for the Tribunal including the relevant medical history and a full report on the patient's mental condition.
2. Where there is a social worker, probation officer or community psychiatric nurse responsible for the patient's care and supervision in the community, an up to date report prepared for the Tribunal on the patient's progress in the community since discharge from hospital.
3. A report on the patient's home circumstances.
4. The views of the Secretary of State on the suitability of the patient for absolute discharge.
5. Any other observations on the application that the Secretary of State wishes