		Agenda Item	5.1 (iv)
Freedom of Information Status		Open	
Reporting Committee	Mental Health Legislation Committee		
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Chaired by	Emma Woollett, Vice-Chair		
Lead Executive Director (s)	Gareth Howells, Director of Nursing and Patient Experience		
Date of last meeting	09 May 2019		

Summary of key matters considered by the committee and any related decisions made.

- **Mental Health Legislation Committee Annual Report 2018/19 –** Over the year, the Committee has become more focused on its core remit of mental health legislation. The Committee is conscious that compliance is not as consistent as it needs to be across the Health Board. This is both distressing to patients and poses a reputational risk to the Health Board. Work is underway to improve accountability structures across the Health Board and the Committee has reflected on its own effectiveness including the need for more training for Committee members. Priorities for the Committee in 2019/20 will be to continue to encourage the establishment of a clear structure to achieve single accountability for mental health legislation across the Health Board, improvement of the DoLS process and compliance and greater focus on training requirements and compliance across the Health Board.

- **Powers of Discharge Committee Annual Report 2018/19 –** The committee heard that there were concerns surrounding the validity and quality of work arising from the Powers of Discharge Committee. Members agreed to consider the current workings of the committee, whether it was fit for purpose and also the current membership, with the aim to re-engineer the committee to ensure it is fully fulfilling its terms of reference.

- **Mental Health Act Monitoring Report –** illegal detentions under the Mental Health Act regularly number 4-5 per quarter. The Committee asked for a paper for the next meeting setting out what actions could be taken for illegal detentions to be eliminated.

  Mental Capacity Act/DoLs – the Committee noted that the report provided greater assurance. A key area of concern remains training. The Safeguarding Team will be undergo an intensive training needs analysis across each of units to establish the training need and will report findings to the committee in autumn 2019. It will then provide a baseline to map compliance.

- **Deprivation of Liberty Safeguards (DoLS) –** The committee heard that Internal Audit would be undertaking a repeated review of the DoLS process in May 2019. A transformational plan had been developed to improve performance in the DoLs process and the Primary Care and Community Delivery Unit were working through this in partnership with the Safeguarding Team and Service Delivery Units. The plan would be focusing on a number key areas; the completion of actions required under internal

audit, a reduction in un-necessary referrals, a referral prioritsiation tool and a dedicated DoLS team. Overall, members felt much more assured that work was underway to improve the health board DoLS position.

- **Use of adult beds for CAMHS –** It is all Wales policy for each health board to hold a designated adult bed for emergency use for adolescents when no CAMHS bed is available. Our emergency bed is at NPT hospital and appears to be required more regularly than would be justified by true emergency use and this continues to be a significant concern for the Committee. Work is ongoing to explore an alternative arrangement. The issue of the use of adult beds for CAMHs patients was formally referred into the Quality and Safety Committee for further monitoring.

Key risks and issues/matters of concern of which the board needs to be made aware:

None identified.

Delegated action by the committee:

Committee approved its annual report (appendix one).

Main sources of information received:

In addition to reports discussed above the following reports were considered by the committee:

- **Mental Health Measure Monitoring Report** – the committee received a report on compliance with the four parts of the Mental Health Measure. For services provided by ABMU, the health board showed strong performance across all measures.

Highlights from sub-groups reporting into this committee:

None received.

Matters referred to other committees

The issue of the use of adult beds for CAMHs patients was formally referred into the Quality and Safety Committee.

Date of next meeting	08 August 2019

Mental Health Legislation Committee Annual Report 2018-19

Contents

1. Introduction

The principle remit of the Mental Health Legislation Committee is to consider and monitor the use of the Mental Health Act 1983, Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) and the Mental Health (Wales) Measure 2010. A summary of the definitions of the legislation and a glossary of terms are appended at **appendix 1**.

During 2018-19, the committee met its responsibility by fulfilling its role as outlined in its terms of reference, and through the delivery of its work programme. A summary of key issues discussed was presented to the board following each committee meeting. The annual report summarises these.

2. Committee Structure

The membership of the Mental Health Legislation Committee during 2018-19 comprised:

Independent Members

- Emma Woollett, vice-chair (committee chair);
- Martin Waygood, independent member;
- Jackie Davies, independent member;
- Maggie Berry, independent member.

Executive Directors

- Angela Hopkins, Interim Director of Nursing and Patient Experience (until July 2018);
- Gareth Howells, Director of Nursing and Patient Experience (from July 2018)
- Chris White, Chief Operating Officer

David Roberts, Service Director for Mental Health and Learning Disabilities and Lynda Rogan, Mental Health Act Manager, also attended each meeting.

Committee support in terms of the circulation of the meeting papers and minute taking was undertaken by the corporate governance function to ensure continuity with other board committees. The secretaries to the committee were Liz Stauber, Committee Services Manager and Claire Mulcahy, Committee Services Officer

The terms of reference required the committee to meet quarterly during 2018-19, it met on four occasions.

2. Annual Overview

Over the year, the Committee has become more focused on its core remit of mental health legislation. The Committee is conscious that compliance is not as consistent as it needs to be across the Health Board. This is both distressing to patients and poses a reputational risk to the Health Board. Work is underway to improve accountability structures across the Health Board and the Committee has reflected

on its own effectiveness including the need for more training for Committee members. Priorities for the Committee in 19/20 will be to continue to encourage the establishment of a clear structure to achieve single accountability for mental health legislation across the Health Board, improvement of the DoLS process and compliance and greater focus on training requirements and compliance across the Health Board.

3. Reports Received

In March 2018, the committee agreed its work programme for the coming year, which was divided into a number of sections in addition to the standing preliminary matters:

- Mental Health Act 1983
- Mental Capacity Act 2005
- Mental Health (Wales) Measure 2010
- Committee Governance

The committee received a range of reports which have been summarised below according to their categories:

Mental Health Act 1983

A regular report was received on the use of the Mental Health Act. The report provided an update on the health board performance against the Act and gave an insight into the number of invalid detentions and exceptions and the reasons for their occurrence. A significant proportion of invalid detentions take place in general wards, rather than mental health wards, and the Committee is seeking greater assurance around the accountability for legislative compliance across the whole Health Board.

Another key issue of concern was the significant level of postponement/adjournment of the hospital manager hearings. The committee has requested further assurance around the robustness of the process and as this again was a reputational risk for the health board.

Mental Health Capacity Act 2005

i. Mental Capacity Act Performance Report

The Health Board supports a significant number of patients with impaired decision making, and the Committee received regular reports on the use of the Mental Capacity Act throughout the Health Board, including staff training, the use of the Independent Mental Capacity Advocacy Service (IMCAs) and Health Board involvement in Court of Protection cases. The Committee is receiving increasing assurance of the work underway to improve performance, and is very supportive of plans to review the model delivering against the Mental Capacity Act and DoLS.

ii. Deprivation of Liberty Standards (DOLS)

DoLs were introduced as an amendment to the Mental Capacity Act 2005 and came into force in April 2009 following the case HL vs United Kingdom. They aim to provide legal protection for vulnerable people who are deprived of their liberty as part of their care and to prevent arbitrary decisions about deprivations of liberty. In March 2014, a Supreme Court judgement in the case of Cheshire West clarified what constitutes a deprivation of liberty; consequently there has been a significant increase in the number of applications. Regular reports were received to the Committee providing an update on the health board's compliance with the deprivation of liberty standards and any breaches.

During 2018-19 the committee received the feedback from an Internal Audit follow up review of the DoLS process. Results from this showed the health board wide position remained at limited assurance. The Primary Care and Community Delivery Unit are working through the action plan in partnership with the Safeguarding Team and Service Delivery Units. The Committee felt that importance and relevance of DoLS was not understood across the health board and it was imperative that a designated DoLS structure is put in place.

Mental Health (Wales) Measure 2010

Reports were received at each meeting outlining performance against the Mental Health (Wales) Measure 2010. For adult services (generally provided by the Mental Health and Learning Disability Delivery Unit) the health board showed strong performance across all measures. For CAMHS services (which are provided by Cwm Taf as a commissioned service), performance has been more variable. The greatest challenge to CAMHS performance is the small size of the delivery teams and their vulnerability to staff shortages. However, the Committee has received assurances that robust plans are in place with Cwm Taf to deliver a more sustainable service.

Governance of Other Groups and Committees

i. *Minutes of the Power of Discharge Committee*

The committee received and reviewed the minutes of the Power of Discharge Committee following each meeting.

ii. *Matters Arising from the Operational Group*

The committee received verbal updates from the operational group within the Mental Health and Learning Disabilities Unit.

Other Reports

i. Care and Treatment Plans (Including Children And Adolescent Mental Health Services (CAMHS))

The committee received reports following a recent All Wales review of Care and Treatment Plans (CTPs) by the NHS Wales Delivery Unit. The review set out a

number of key recommendations for care and treatment planning across Wales and the health board. Locality action plans have been developed which incorporate the recommendations, and the Committee will continue to monitor the progress of the action plans through 2019/20..

Other Matters

i. Committee's Self-Assessment

In February 2019, the results of the committee's self-assessment were received Feedback from the self-assessments suggested a number of measures for improving the committee's effectiveness:

- Single accountability for mental health legislation compliance and training across the health board;
- Clear and resourced structure for DoLs, reporting through safeguarding;
- Greater organisational ownership of mental health issues reflected through more explicit consideration of mental health questions in other committees, rather than an assumption that all mental health issues should come to MHLC.
- Focused training for committee members (this is being arranged through Blake Morgan solicitors).

The committee have agreed they will review the Terms of Reference in order to ensure a link with other boards and committees and also to ensure it properly fulfils its role in monitoring performance against the legislation.

ii. Training

Across all the legislative areas, the committee still has great concern over the coverage and compliance with mental health training, particularly outside the mental health delivery unit. This underpins our performance under the Mental Health Act and the Mental Capacity Act. The matter has been referred to the Workforce and OD Committee for assurance.

4. Conclusion

This report demonstrates that the committee fulfilled its responsibilities through the reports it had received during the year from various services and sources.

Appendix 1

Mental Health and Capacity Legislation - Definitions

Mental Health Act

1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

1.5 The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.

1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

Mental Health Measure

1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

1.10 The MCA came into force mainly in October 2007. It was amended by the

Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

1.11 The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus the scope of MCA extends beyond those patients who have a mental disorder.

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital eg on Section 17 leave
Section 135	Allows for magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he/she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135 (2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety for up to 72 hours so that he can/she can be examined by a doctor and interviewed by an Approved Mental Health Professional in order that arrangeme4nts can be made for his/her treatment or care. The detailed person can be transferred to another place of safety as long as the 72 hour period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detailed or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act. As part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical

	recommendations.
Section 5(4)	Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required. During this period the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2). Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.
Section 5(2)	Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports than an application under section 2 or 3 ought to be made. The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.
Section 4	In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours. An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor. A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of: • An immediate and significant risk of mental or physical har to the patient or to others • And/or the immediate and significant danger of serious harm to the property • And/or the need for physical restraint of the patient. Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of

	these sections are different.
Section 2	Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under Section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstance in which the county court has the powers to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the County Court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Supervised Community Treatment (SCT)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. SCT provides clear criteria for eligibility and

	safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto SCT.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section17B (3)
Revocation	Is the rescinding of a CTO when a SCT patient needs further treatment in hospital under the Act. If as patient's CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court, It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be restricted, which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or Magistrates Court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for

	people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the powers of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers the treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State for Justice to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of un-sentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a S.47 or S.48
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for supervised Community Treatment (SCT)
Administrative Scrutiny	To be confirmed
Section 58(3) (a)	Certificate of consent to treatment (RC)
Section 58 (3) (b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the

	treatment) (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent Treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2) If an ay time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or SCT is due to expire.
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under se3ction 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients as well as those who have been absolutely discharged.