# Mental Health and Learning Disabilities Committee

*Wed 09 April 2025, 10:30 - 13:30*

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

# Agenda

## 1. PRELIMINARY MATTERS

MH&LD 20250409 Agenda - Approved.pdf (2 pages)

### 1.1. Welcome and Introductions

*Oral* *Chair*

### 1.2. Apologies for Absence

*Oral* *Chair*

### 1.3. Declarations of Interest

*Oral* *Chair*

## 2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

### 2.1. Terms of Reference and Membership a) MH&LD Committee b) Power of Discharge Sub Committee

*Attached* *Director of Corporate Governance*

MHLD 20250409 2.1a Terms of Reference 2025.pdf (3 pages)
MHLD 20250409 2.1a Appendix A Committee ToR approved by Board Nov 2024.pdf (10 pages)
MHLD 20250409 2.1b PoD Sub Committee Terms of Reference.pdf (3 pages)
MHLD 20250409 2.1b Appendix A Power of Discharge Sub Committee ToR Revised Feb 2025.pdf (8 pages)

## 3. ITEMS FOR DISCUSSION

### 3.1. Overview of MH&LD Services and Improvement Journey

*Presentation* *Chief Operating Officer*

MHLD 20250409 3.1a Committee Slides overview 09 4 25 final.pdf (9 pages)
MHLD 20250409 3.1b PowerPoint for Committee 09 04 2025.pdf (38 pages)

### 3.2. ABUHB Mental Health Act Monitoring Report and HIW Mental Health Act Monitoring Annual Report

*Attached* *Chief Operating Officer*

MHLD 20250409 3.2a MHA Update Report Q3 2024-25 -SM amends (003).pdf (4 pages)
MHLD 20250409 3.2b HIW - Mental Health Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2023-24 - (E).pdf (42 pages)

### 3.3. Overview of CAMHS Services

*Attached* *Chief Operating Officer*

MHLD 20250409 3.3 Overview of CAMHS Services.pdf (36 pages)

### 3.4. Emerging Priority Areas for the Committee's Forward Workplan

*Oral Discussion* *Chair*

## 4. ITEMS FOR INFORMATION

### 4.1. Power of Discharge Sub-Committee Minutes 19th November 2024

*Attached* *Chair/PoD Chair*

MHLD 20250409 4.1 PODSC Meeting Minutes 19.11.24.pdf (5 pages)

### 4.2. Former Minutes and Action Log of the Mental Health Act Monitoring Committee held on 4th June 2024

*Attached* *Chair*

MHLD 20250409 4.2 MHAMC Final report.pdf (3 pages)
MHLD 20250409 4.2 Appendix A MHAMC Action Log- September 2024.mj RD.pdf (2 pages)
MHLD 20250409 4.2 Appendix B FINAL 4th June 2024 Mental Health Act Monitoring Committee TJ.mj RD PB (002).pdf (8 pages)

## 5. OTHER MATTERS

### 5.1. Items to be Brought to the Attention of the Board and Other Committees

*Oral* *Chair*

### 5.2. Any Other Urgent Business

*Oral* *Chair*

### 5.3. Date of the Next Meeting: Tuesday 17th June 2025, 1.30-4.30pm

# CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
# MENTAL HEALTH AND LEARNING DISABILITIES COMMITEE

| AGENDA | |
|---|---|
| **Date and Time** | 9th April 2025, 10.30am – 1.30pm |
| **Venue** | Executive Meeting Room at St Cadoc's Hospital |

| Item | Title | Format | Presenter |
|---|---|---|---|
| **1** | **PRELIMINARY MATTERS 10.30 – 10.35** | | |
| 1.1 | Welcome and Introductions | Oral | Chair |
| 1.2 | Apologies for Absence | Oral | Chair |
| 1.3 | Declarations of Interest | Oral | Chair |
| **2** | **ITEMS FOR APPROVAL/RATIFICATION/DECISION 10.35-10.50** | | |
| 2.1 | Terms of Reference and Membership<br>a) MH&LD Committee<br>b) Power of Discharge Sub Committee | Attached *(15 mins)* | Director of Corporate Governance |
| **3** | **ITEMS FOR DISCUSSION 10.50 – 1.30** | | |
| 3.1 | Overview of MH&LD Services and Improvement Journey | Presentation *(45 mins)* | Chief Operating Officer |
| 3.2 | ABUHB Mental Health Act Monitoring Report and HIW Mental Health Act Monitoring Annual Report | Attached *(45 Mins)* | Chief Operating Officer |
| **12.20 – 12.30 Comfort Break** | | | |
| 3.3 | Overview of CAMHS Services | Attached *(45 mins)* | Chief Operating Officer |
| 3.4 | Emerging Priority Areas for the Committee's Forward Workplan | Attached *(15 Mins)* | Committee Chair |
| **4** | **ITEMS FOR INFORMATION** | | |
| 4.1 | Power of Discharge Sub-Committee Minutes 19th November 2024 | Attached | Chair/PoD Chair |
| 4.2 | Former Minutes and Action Log of the Mental Health Act Monitoring Committee held on 4th June 2024 | Attached | Chair |
| **5** | **OTHER MATTERS** | | |
| 5.1 | Items to be Brought to the Attention of the Board and Other Committees | Oral | Chair |
| 5.2 | Any Other Urgent Business | Oral | Chair |
| 5.3 | Date of the Next Meeting:<br>• Tuesday 17th June 2025, 1.30-4.30pm | | |

**Motion to Exclude Members of the Public and the Press**

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:
"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".
*Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960*

**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**
**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 09 April 2025 |
| **CYFARFOD O:**<br>**MEETING OF:** | Mental Health and Learning Disabilities Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Terms of Reference** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Bryony Codd, Head of Corporate Governance |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Er Gwybodaeth/For Information

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board has established a Mental Health and Learning Disabilities Committee, to assist the Board in discharging its functions and meeting its responsibilities with regard to mental health and learning disabilities issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 and associated legislative and statutory frameworks.

**Asesiad / Assessment**

The Terms of Reference were approved by the Board in November 2024, when it agreed to establish a Mental Health and Learning Disabilities Committee, to replace the existing Mental Health Act Monitoring Committee.

The Committee is asked to note the Terms of Reference. In line with good governance principles, these will be reviewed on an annual basis.

**Argymhelliad / Recommendation**

The Committee is asked to **NOTE** the Terms of Reference for the Mental Health and Learning Disabilities Committee.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Enabler |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | None |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | None |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb**<br>**Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk |
| **Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |


# Mental Health and Learning Disabilities Committee Terms of Reference

Version: Approved

Date: November 2024

| | |
|---|---|
| **Document Title:** | Mental Health and Learning Disabilities Committee<br>Terms of Reference |
| **Date of Document:** | November 2024 |
| **Current version:** | Approved |
| **Previous version:** | N/A |
| **Approved by:** | Board |
| **Review date:** | November 2025 |

# 1. Introduction

1.1 The Health Board's Standing Orders provide that:-

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

1.2 In line with Standing Orders (and the Board's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health and Learning Disabilities Committee**. This Committee will focus on all aspects of the Health Board's activities to contribute to the agreement of a strategic direction for mental health, learning disabilities and child and adolescent mental health services (CAMHS) in the areas of Gwent.

1.3 It will monitor the effectiveness and efficiency of service delivery for mental health, learning disabilities and CAMHS services and identify areas for improvement; and will also monitor the appropriate delivery of the functions of Hospital Managers in response to Chapter 11 of the Mental Health Act 1983 (co-ordinated on behalf of the Committee by the Mental Health Act Managers Group).

The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are provdied below.

# 2. Purpose of the Committee

The purpose of the Mental Health and Learning Disabilities Committee, "the Committee" is to:

- **Advise** the Board to assist it in discharging its functions and meeting its responsibilities with regard to mental health, learning disabilities and CAMHS issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks.

- **Hold to account and provide assurance** to the Board that in relation to the health board's arrangements for responding to the above legislation that this is being undertaken appropriately in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales. In undertaking this work the Committee will have close liaison with other committees of the Board, especially the Patient Quality, Safety and Outcomes Committee.

- **Hold to account and provide assurance** to the Board that the National Dementia Standards are being implemented within the health board.

## 3. Delegated Powers and Authority

3.1 Committee will, in respect of its provision of advice and assurance to the Board:

(a) Advise on the development and delivery of high quality and safe mental health and learning disabilities services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

(b) consider the implications for mental health and learning disabilities care, this will include the implications for the Mental Capacity Act and Dementia Standards, arising from the development of the Board's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board and statutory partnerships;

3.2 The Committee will, in respect of its assurance role, seek assurances that governance arrangements (including risk management and integration of the Equality Act and Accessibility Standards) are appropriately designed and operating effectively to ensure the provision of high quality, safe and accessible mental and learning disabilities health care and services across the whole of the Board's activities including those services provided for the Board by third sector providers and service provision made by the independent sector.

3.3 To achieve this, the Committee will continually monitor, and seek assurance that the Health Board is complying with legislation to ensure that in relation to all aspects of mental health and learning disabilities provision:

(a) there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

(b) that the Health Board, at all levels (strategic, directorate/division/clinical) has a citizen centred approach, putting patients, patient safety, well-being and safeguarding above all other considerations;

(c) that the care planned or provided across the breadth of the organisation's functions (including directorate/division/ clinical and partnership steams and those provided by the independent or third sector) are consistently applied, based on sound evidence, are clinically effective and meet agreed standards and legal frameworks;

(d) that the Health Board, at all levels (directorate/division/clinical/partnership teams) has the right systems and processes in place to deliver, from a patients perspective - efficient, effective, timely and safe services;

(e) there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;

(f) there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;

(g) risks are actively identified and robustly managed at all levels of the organisation and that key risks are escalated appropriately to the Committee and included on a Committee risk register;

(h) decisions are based upon valid, accurate, complete and timely data and information;

*(i)* there is continuous improvement in the standard of quality and safety of mental health and learning disabilities care across the whole organisation and that these are continually monitored;

(j) all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of mental health and learning disabilities care provided;

(k) Sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver and support mental health and learning disabilities services;

(l) Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and

(m) Lessons are learned from patient safety incidents, complaints, concerns and claims and that these, together with good practice are shared across and out with the organisation; the impact of learning should be measured.

3.4 The Committee will advise the Board of key indicators of mental health and learning disabilities provision against which the Board's performance will be regularly assessed and reported on through Annual Reports.

## Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Board and primary care practitioners relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee or Group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from external agencies with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

## Access

3.7 The Chair of the Mental Health and Learning Disabilities Committee shall have reasonable access to Executive Directors and all other relevant staff, any other Committees, and Groups deemed appropriate by the Committee, and to primary care practitioners.

## Sub Groups

3.8 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

In this respect a ***Power of Discharge Sub-Committee*** will be created. The Health Board, as Hospital Managers, may arrange for their functions under the Mental Health Act to be performed on a day-to-day basis by an Officer or Lay Member on their behalf. These individuals appointed by the Health Board will be known as Associate Hospital Managers and will form the membership of the Power of Discharge Sub-Committee.

The Sub-Committee will report routinely to the Committee for assurance and developmental purposes.

# 4. Membership

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## 4.1. Members

The Committee shall comprise a minimum of four (4) members:

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|---|---|
| Chair | Independent member of the Board |
| Vice Chair | Independent member of the Board |
| Members | At least 2 other independent members of the Board. |

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

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## 4.2. Attendees

**In attendance**

Chief Operating Officer

Executive Director of Nursing or Nominated Representative

Medical Director or Nominated Representative

Director of Public Health or Nominated Representative

Divisional Director, Mental Health and Learning Disabilities

Divisional Nurse, Mental Health and Learning Disabilities

General Manager, Mental Health and Learning Disabilities

Clinical Director, CAMHS

General Manager, Families and Therapies Division

Divisional Director, Families and Therapies Division

Head of Nursing Person Centred Care

**Others by invitation**

The Committee Chair may invite any other Health Board officials and / or any others from within or outside the organisation to attend all or

part of a meeting to assist it with its discussions on any particular matter.

### 4.3. Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair and Director of Corporate Governance (Board Secretary), taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

## 5. Support

### 5.1. Secretariat

Secretariat arrangements will be determined and arranged by the Director of Corporate Governance.

### 5.2. Advice and Member Support

The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for the committee itself and committee members.

## 6. Committee Meetings

### 6.1. Quorum

At least three of the selected members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

### 6.2. Frequency of Meetings

Meetings will be held quarterly per annum and otherwise as the Chair of the Committee deems necessary consistent with the Health Boards plan of Board business.

**6.3. In Committee and withdrawal of individuals in attendance**
The Committee Chair may ask any or all of those who normally attend but who are not members of the Committee to withdraw to receive information which may include matters of a sensitive and/or confidential nature.

**6.4. Record of the Committee Meeting**
A record of the meeting will be presented as notes and action points.

**6.5. Public Meetings**
The Committee will be open to the public.

# 7. Relationship and Accountabilities with the Board and its Committees

**6.1** 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.

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

**6.2** The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes 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.

**6.3** The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

# 8. Reporting and Assurance Arrangements

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Accountability Report and the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

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

The Director of Corporate Governance, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

# 9. Applicability of Standing Orders to Committee Business

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

- Quorum

# 10. Review

These terms of reference shall be reviewed annually by the Committee with reference to the Board.

**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**
**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 09 April 2025 |
| **CYFARFOD O:**<br>**MEETING OF:** | Mental Health and Learning Disabilities Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Power of Discharge Sub Committee: Terms of Reference** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Bryony Codd, Head of Corporate Governance |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

In accordance with Standing Orders (and the Board's Scheme of Delegation), the Board has established a **Mental Health and Learning Disabilities Committee**. This Committee will focus on all aspects of the Health Board's activities to contribute to the agreement of a strategic direction for mental health, learning disabilities and child and adolescent mental health services in the areas of Gwent and South Powys.

In line with its Terms of Reference, the Mental Health and Learning Disabilities Committee has established a Hospital Managers Power of Discharge Sub Committee to carry out specific aspects of the Mental Health and Learning Disabilities Committee's business on its behalf.

The purpose of the Hospital Managers Power of Discharge (PoD) Sub-Committee is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 (the 1983 Act) and the Code of Practice are being exercised; and to provide assurance to the Mental Health and Learning Disabilities Committee (and ultimately to the Board) that the processes employed by the Sub-Committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.

## Asesiad / Assessment

The current Terms of Reference for the PoD Sub Committee were approved in February 2015. A full review of the current Terms of Reference has therefore been undertaken to ensure clarity on the role of the sub-Committee in providing assurance to the Board regarding the exercise of section 23 of the Mental Health Act.

The MH&LD Committee is requested to review and approve the revised Power of Discharge sub Committee Terms of Reference.

## Argymhelliad / Recommendation

The Committee is asked to **APPROVED** the revised Terms of Reference for the Power of Discharge Committee.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Enabler |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | None |

| | |
|---|---|
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | None |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk |
| **Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio<br>Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |


# HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE

Terms of Reference & Operating Arrangements

Version: Draft

Date: February 2025

| | |
|---|---|
| **Document Title:** | Hospital Managers Power of Discharge Sub Committee |
| **Date of Document:** | March 2025 |
| **Version:** | Draft |
| **Previous version:** | February 2015 |
| **Approved by:** | |
| **Review date:** | |

## 1. Introduction & Constitution

1.1 The Mental Health and Learning Disabilities Committee, established as a Committee of Aneurin Bevan University Health Board, has established a Hospital Managers Power of Discharge Sub Committee to carry out specific aspects of the Mental Health and Learning Disabilities Committee's business on its behalf.

1.2 The Chair of the Hospital Managers Power of Discharge Sub Committee must be a member of the Mental Health and Learning Disabilities Committee and will for assurance purposes make regular reports to the Mental Health and Learning Disabilities Committee on the activity of the subcommittee.

## 2. Requirements of the Mental Health Act

2.1 The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who experience a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply for discharge to the Hospital Managers. Hospital Managers have a central role in operating the provisions of the Act and as detailed in these terms of reference ABUHB has made the decision to delegate this responsibility to the Hospital Managers Power of Discharge Sub Committee, and assurance will be provided to the Board through monitoring by the Mental Health and Learning Disabilities Committee.

## 3. Purpose

3.1 The purpose of the Hospital Managers Power of Discharge Sub-Committee is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 (the 1983 Act) and the Code of Practice are being exercised; and to provide assurance to the Mental Health and Learning Disabilities Committee (and ultimately to the Board) that the processes employed by the Sub-Committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.

2.2 A panel of three or more Members drawn from the Hospital Managers Power of Discharge Sub-Committee will hear individual cases where patients or their nearest relative have applied for discharge. The Members also sit on Renewal Hearings – they are collectively known as Hospital Managers Reviews.

## 4. Scope and Duties

4.1 The purpose of the Hospital Managers Power of Discharge Sub Committee is to:

- Monitor the exercise of Power under Section 23 of the Mental Health Act 1983 by Hospital Managers at Hearings involving 3 or more members of the Hospital Managers Power of Discharge Committee. These powers are formally delegated by the Health Board in its "Mental Health Act Managers Policy". This policy sets out the statutory functions of Hospital Managers
- Consider all relevant issues for Mental Health Act Hospital Managers to undertake their role in accordance with ABUHB and legislative requirements.
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully, this would include ensuring that during manager's hearings reasonable adjustments are made or support provided to ensure the patient's voice is heard. This could include responding to a request for a face to face hearing, provision of advocacy or translation services.
- Consider updates regarding recommendations made during panel hearings.
- Receive professional advice to support the discharge of the Mental Health Act Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services.
- Develop a rolling programme of training activities to ensure that its members are fully able to exercise their responsibilities. This will include a formal induction programme and regular training on the Mental Health Act 1983.
- Consider issues which are identified by Hospital Managers at Hospital Managers Hearings and which require action. This will be a standing agenda item for discussion by the group. The Chair will determine if the issue needs to be escalated and will liaise with the Director of Corporate Governance should legal advice need to be sought.

## 5. Membership

5.1 The Membership of the Hospital Managers Power of Discharge Sub Committee is as follows:

| | |
|---|---|
| Chair | Independent Member (who must be a member of the Mental Health and Learning Disabilities Committee) |
| Vice Chair | Hospital Manager Designated |
| Members | All of the Mental Health Act Hospital Managers appointed by ABUHB |
| In Attendance | Representatives from the Mental Health & Learning Disabilities Division - TBC |
| | |
| | |

5.2 By invitation, the Sub Committee Chair may invite any other officers from ABUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

5.3 Member Appointments - The membership of the Sub Committee shall be determined by the Mental Health and Learning Disabilities Committee, based on the recommendation of the Sub Committee Chair. The membership of the Hospital Managers Power of Discharge Sub Committee will be reviewed annually.

## 6. Quorum

6.1 A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the Sub-Committee.

## 7. Meeting Secretariat

7.1 The secretariat will be appointed via the Mental Health Act Managers.

## 8. Frequency of Meetings

8.1 The Hospital Managers Power of Discharge Sub Committee shall meet at least four times per annum and as otherwise directed by the Chair.

## 9. Withdrawal of Individuals in Attendance

9.1 The Sub 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.

## 10. Circulation of Papers

10.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

## 11. Delegated Powers, Authority & Access

11.1 The Hospital Managers Power of Discharge Sub Committee will comprise Mental Health Act (MHA) managers who have been independently appointed. The MHA managers sit as panels of three or more in order to exercise their power of discharge as detailed in chapter 27 of the MHA Code of Practice. The decisions made by the panels are binding and therefore are not required to be ratified by the Mental Health and Learning Disabilities Committee or by the Health Board. However, the procedures and behaviours adopted by the panel are subject to scrutiny and as such the MHA Managers are accountable to the Board via the Mental Health and Learning Disabilities Committee.

11.2 The Hospital Managers Power of Discharge Sub Committee will, in respect of its provision to the Mental Health and Learning Disabilities Committee, comment specifically upon:

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of Mental Health Act Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the Mental Health Act Manager role effectively.

11.3 To achieve this, the Mental Health and Learning Disabilities Committee shall support the group to provide assurance that:

- Mental Health Act Hospital Managers are effectively equipped and trained to undertake their role.

- ABUHB provides appropriate support to ensure the Discharge Panels operate effectively.
- ABUHB is aware of the impact of any legislative or service changes impacting on the Discharge panel's considerations and recommendations.

11.4 The Hospital Managers Power of Discharge Sub Committee is authorised to request legal advice via the Mental Health Act Team Leader (within their respective delegated limits) without recourse to the Mental Health Act Monitoring Committee.

11.5 The Chair of the Hospital Managers Power of Discharge Sub Committee shall have reasonable access to the Chair of the Mental Health and Learning Disabilities Committee, Executive Directors and other relevant senior staff.

## 12. Accountability & Responsibility

12.1 The Hospital Managers Power of Discharge Sub-Committee is directly accountable to the Mental Health and Learning Disabilities Committee, for its performance in exercising the functions set out in these terms of reference.

12.2 Due to the sensitivity of the patient information received, the Hospital Managers Power of Discharge Sub-Committee Members will at all times be aware of the importance of confidentiality, and ensure that they comply with the ABUHB's policies within this area of work.

12.3 The Sub-Committee shall embed ABUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

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

## 13. Reporting

13.1 The Hospital Managers Power of Discharge Sub-Committee, through its Chair and Members, shall work closely with the Mental Health and Learning Disabilities Committee, to provide advice and assurance through the:
- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

13.2 In doing so, the Hospital Managers Power of Discharge Sub-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.

13.3 The Hospital Managers Power of Discharge Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.

13.4 The Hospital Managers Power of Discharge Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:

- Report formally, regularly and on a timely basis to the Mental Health and Learning Disabilities Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
- Bring to the Mental Health and Learning Disabilities Committee's attention any significant matter under consideration by the Sub-Committee.

## 14. Applicability of Standing Orders to Committee Business

14.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Sub Committee, except in the following areas:

- Quorum

## 15. Chairs Action on Urgent Matters

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

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

## 16. Review

16.1 These Terms of Reference shall be approved by the Mental Health and Learning Disabilities Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.


# Overview of MH&LD Services and Improvement Journey

Aneurin Bevan University Health Board Meeting

**Mental Health and Learning Disabilities Committee**

9th April, 10:30-1:30pm

# Leanne Watkins
# Chief Operating Officer

# Mental Health & Learning Disability Services:-

- Mental Health Services within Aneurin Bevan University Health Board cover community and in-patient settings. Our focused service is dedicated to supporting the Welsh Government Strategy "Together for Mental Health".

- 1 in 4 people will experience some form of Mental Health condition in their lifetime.

- Mental Health disorders such as depression, anxiety, alcohol addiction and memory problems are very common in general hospitals. Research has shown that they are often not recognised or treated.

- 2 in 3 older adults admitted to a general hospital have, or may develop, Mental Health issues during their admission.

- Untreated Mental Health issues can lead to longer hospital admissions and poorer overall physical health in Hospital inpatients.

# What we do:-

- We have always worked in collaboration, co-creating services with many engaged agencies, such as our charity and local authority colleagues.
- Our staff and service users have a long-term vision for increasing community care and shared care models.
- We are continuously raising public awareness across all services regarding mental health issues, which affect 1 in 4 people.
- We have community teams, primary mental health services and inpatient settings. We manage specialist services such as addictions, plus many more.
- Mental Health services embrace the recovery philosophy.

.

- Reducing stigma is simply what it is all about.

# Journey last 12-18 months

- The Mental Health and Learning Disability Division has had significant leadership changes and was put under internal oversight to support areas such as incident management, safeguarding, quality, safety, and governance.
- A structured 30, 60, and 90-day improvement plan was implemented to address initial areas of concern and launch wider initiatives aimed at workforce modelling, leadership enhancement, performance, risk management, and transformative service changes.
- The Division has been reporting on the progress of quality, safety, and governance to various committees, including the Executive Committee, the Patient Quality Safety & Oversight Committee, the Board and IQPD.
- The Health Board has contributed to the development of a paper for the Welsh Government Quality Delivery Board, providing an update on the progress and actions taken by Aneurin Bevan University Health Board regarding performance, quality, and safety in adult mental health and learning disabilities services.
- Phase 2 of the Improvement Plan is underway, focusing on embedding and sustaining actions already taken and further developing longer-term actions.

# Contd ...

- The Division underwent an end-of-year review on 6th June 2024 with the wider Executive Team, acknowledging the difficulties faced during a period of heightened scrutiny and attention.

- Notable progress has been made in areas such as enhanced governance and visible leadership across the division, better processes for learning from deaths, and progress in delivering sustainable improvements in operational delivery.

- The improvement plan has been concluded, and ongoing actions are being monitored through the Divisional Assurance process.

- The Division has integrated the Right Care right person with the new police and health alliance for mental health crisis management.

- An improved discharge plan for acute inpatient care is in place, and the disengagement and DNA policy has recently been updated and is currently out for review.

# Areas of progress and focus ...

**Mental Health & Learning Disability Programme of Work around Patient Flow:**

- Digital solutions for ward data, pre-admission interventions, and alternatives to admission
- Minimise ward time, focus on least restrictive care
- Improve patient flow, address bed capacity

**Management of Variable Pay:**

- Increase in variable pay, especially nursing
- Impact on financial position and need for effective management and better workforce planning

**Enhanced Care Framework:**

- On track in older adults' directorate
- Training done, implementation April
- Expected care quality improvement

**Quality and Patient Safety:**

- Improved review process and timeliness of serious incident investigations (including concise review process)
- Effort to close open cases, identify themes and learning points

# Contd ...

**Workforce and Planning:**

- Ongoing efforts with workforce and planning
- LD well-being survey results and retention project for healthcare support workers
- Nursing & HCSW workforce strategy is in development draft to be shared April.

**Learning Forums:**

- Sharing and disseminating learning across the division.
- Participation in national strategic programme for leadership exchange.

**Continuous Improvement Plans:**

- Ongoing quality improvement work.
- Positive feedback from Llais Report in March.

**National MH & Wellbeing Strategy:**

- Engaged in all workstreams of National Programme through NSPB – National Board.

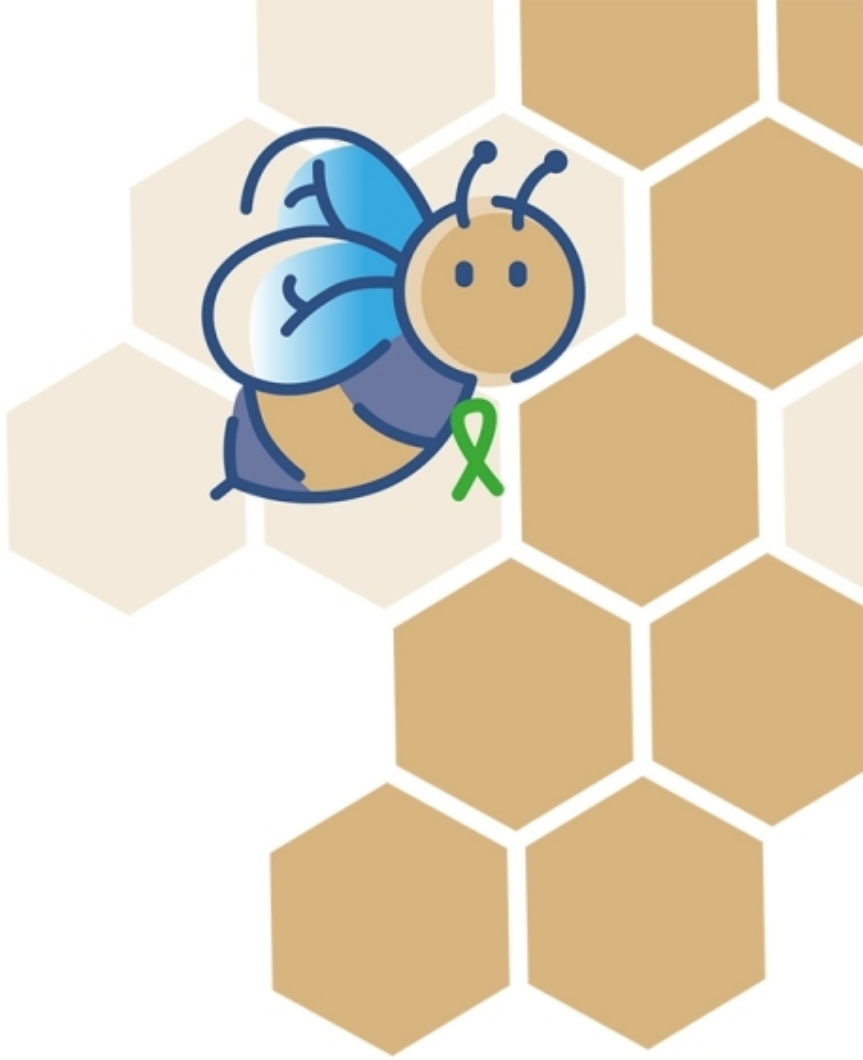
**Safeguarding Awareness and Training:**

- Bespoke training well-received, 91.6% compliance at Level 1.

# Challenges

- **WCCIS Challenges:** Ongoing issues with the patient information system and user interface necessitate ongoing workarounds to ensure validated data.
- **Recruitment and Retention:** Workforce and capacity challenges persist, but progress is evident with the arrival of the international nurse cohort and the initiation of formal workforce and organisation development programmes.
- **Estate:** Addressing the challenges of an aging estate and maintaining areas to ensure safe and therapeutic environments.

# Mental Health & Learning Disabilities Division



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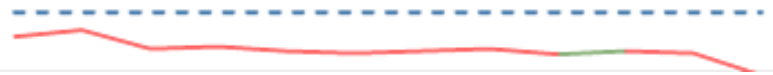
# IMTP PRIORITIES

# Performance Information

| Measure | Current February Submitted | Overall Change April - Current Date | Last Month Comparison | Actual VS Trajectory (Colour represents performance against trajectory/target) |
|---|---|---|---|---|
| Part 1a Compliance (Assessments completed within 28 days) | 89% | 371% | ↓ |  |
| Part 1a Waiting Lists | 494 | -63% | ↓ |  |
| Part 1b Compliance (Interventions completed within 28 days) | 94% | 727% | ↑ |  |
| Part 1b Waiting Lists | 270 | -88% | ↓ |  |
| Part 2 (Number of Individuals with a valid Care and Treatment Plan) | 72% | -12% | ↑ | |
| Psychological Therapies (Compliance) | 42% | -16% | ↓ |  |
| Psychologial Therapies (Number Waiting) | 1452 | 19% | ↑ |  |
| Memory Assessment Services (Referral to assessment within 28 days) | 45% | 3% | ↓ |  |
| Memory Assessment Services (Referral to Diagnosis 12 weeks) | 28% | -42% | ↓ |  |

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# Mental Health/Older Adult/ Learning Disability Inpatient Units

## Older Adult have 4 Inpatient Units

**3 Dementia Units**
Annwylfan
Sycamore
Cedar Parc

**1 Functional Older Adult Unit**
Hafan Deg

## LD have 2 Inpatient Units

Ty Lafant
Twyn Glas

## Adult have 3 Rehabilitation Units

Bellevue (Women), Ty Skirrid/Lindisfarne (Male) and Pillmawr (Male)

## Adult have 4 Acute Inpatient Units

Adferiad Ward, Talygarn Ward, Ty Cyfannol and Carn y Cefn

## 1 Psychiatric Intensive Care Unit managed by Adults

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# Crisis Services/Alternatives to Admission

- 111 press 2 24/7 Assessment service
- There are three Crisis Resolution Home Treatments Teams
- Gwent-wide Liaison service based at the Grange University Hospital (24/7)
- Ty Cynnal
- Shared Lives
- Intensive Community Service (ICS) for Learning Disability
- Older Adult Psychiatric Liaison for Older People

# Map of Housing Provisions in ABUHB

Kennard Court
**Blaenavon**

Skenfrith Court
**Abergavenny**

Acer House
**Brynmawr**

Shared Lives

Maple House
**Blaina**

Lions Court
**Blaenavon**

Coming Soon
**Fleur de Llys**

Ty Cynnal Support House **Newport**

Tyr Hen Ysgol
**Panteg**

Crouch Close
**Newport**

# Mental Health & Learning Disabilities

## Primary Care Mental Support Service Directorate

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# Overview of PCMHSS Directorate Strategy

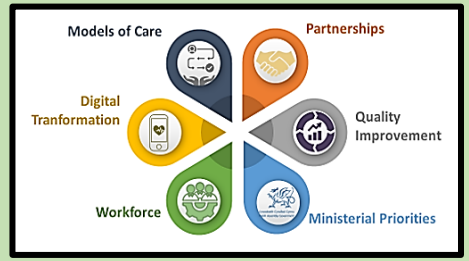
The PCMHSS has undertaken a substantial review of all four Directorate areas:

- Primary Care Mental Health Support Service
- Psychological Health Practitioner Service
- Integrated Autism Service
- ADHD Service

This has included engagement and feedback from individual patients and carers and Directorate staff members.

The Directorate is currently developing it's SMART CARE model that aligns to the strategic context and aims to ensure a high quality, safe, sustainable suite of services.

# Meeting Patient Complexity Through Simplicity of Access: a SMART CARE Model




Peer Support

Individual Therapy

Higher Intensity Therapy

Supported Self Help

Assisted onward referral to Acute / Crisis / Specialist Services

Walk-in / Drop-in Info/Guidance/Adv

Group Therapy

Psycho Educative Course / Workshop

Proportionate Assessment of Need

Expert Assisted E-Support

Diagnosis?

Information And Self Help

A Back to Basics Approach

What is Called for Now?

# Aims of a PCMHSS SMART CARE Model

**To reduce**

- The need to be referred / access services
- Barriers to services
- Waiting time for Assessment
- Waiting time for Diagnosis
- Waiting time to 1st Therapeutic pathway session
- Waiting lists in services
- Costs
- Administrative burden

**To improve**

- Patient access (to different levels of expertise dependent on needs, e.g., PHP's do not 'assess')
- Patient feedback and outcome measures
- Compliance with Welsh Government Mental Health Measures (E.G., Parts 1a and 1b)
- Availability of self-help and waiting well information, guidance and advice
- Effective utilisation of technology
- Efficient use of service capacity through demand modelling
- Patient journey with services through audit of feedback and outcome data
- Staff wellbeing

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# Aims of the PCMHSS SMART CARE Model

**To ensure**

- Continuation of achievement of Part 1 of the Mental Health Measure (Wales)
- Patient need is matched to available resource (not necessarily into services)
- Person centred care
- Removal of barriers and provide ease of access into and between services
- Care is closer to home, for example the PHP service, and through emerging ‘virtual’ hub and ‘hybrid’ spoke model
- A focus on prevention, early assessment and intervention – by providing sufficient staffing with appropriate training and with consideration given to evidenced based therapeutic intervention training and development opportunities
- Patients have access to information, guidance and advice, as well as waiting well information / opportunities
- Patient assessment and intervention is proportional, prudent, appropriate and time limited with a clear pathway for discharge
- A focus on engagement, empowerment and co-production of services

# Aims of the SMART CARE Model

The PCMHSS Directorate will work with individuals and their carers who are 18 years or older.

The service will work with individuals who contact their GP and/or are identified by their GP/PHP or other Mental Health Practitioner as having the following needs:

*Mild to moderate mental health and wellbeing needs*

*Mental health needs that require further assessment by a Mental Health Professional*

*Are referred for consultation and associated recommendations for a psychotherapeutic course / group or therapy intervention*

*Neurodevelopmental condition*

*IAS / ADHD*

*Need further information guidance and advice*

*Professional who need information guidance and advice (e.g., GP's / PHP's)*

*Onward management of patients to secondary care and/or specialist services*

*Have an enduring mental health condition and are currently stable*

*The service also works alongside children's services where individuals are transitioning to adult care.*

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# Challenges for PCMHSS Directorate

- Maintain current performance against part 1 targets of the Mental Health Measure
- Maintain and improve efficiencies in flow
- Reduce variation in services across Boroughs, to ensure that equitable access is provided across the ABUHB – PCMHSS footprint
- A need to support care in communities and closer to home
- The ability to recognise and predict workforce challenges across professions
- The need to continue to review our model of service delivery by developing the more sustainable SMART CARE service model for the future.

# Gwent Integrated Autism Service (IAS)

The Gwent Integrated Autism Service (IAS) is a multi-agency specialist autism service within Gwent PCMHSS. The IAS provides a diagnostic pathway service for adults who life is being impacted by what could be Autism, that do not have a cooccurring condition such as  learning disability or a significant mental health presentations. The team have a support services who provide advice and support around Autism. The Gwent IAS is a collaborative agreement between Aneurin Bevan University Health Board together with the five local authorities of Gwent and provides services to the areas served by these organisations.  It is integrated with health and social care, hosted within ABUHB and Monmouthshire CC.

Success:

- Only IAS team with a peer mentor (lived experience)
- Team completed a research project in collaboration with Cardiff University, presented at the European Autism conference
- The IAS and ADHD team have undertaken pilot projects to provide a better experience to those accessing both services
- IAS and ADHD are working towards being collocated, with 'one front door'
- Services offered to people pre/pos diagnosis have increased, courses advice sessions etc
- Career progression growing within the team introduction of band 6 neurodevelopmental practitioner
- Collaboration with third sector agencies, Hope GB, Gwent wildlife trust

Challenges:

- To increase capacity in the team, short term funding applied, causes issues with retention and recruitment of staff
- Demand is outweighing capacity

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# Adult ADHD Service

ADHD service began its development in July 2023, taking over referrals in January 2024. The service is predominantly funded by NDIP, with 4 SIF funded practitioners. The small ADHD team covers the 5 boroughs of Gwent. The team accepts referrals for new diagnosis, handover of care, review of existing diagnosis private and NHS.

**Challenges**

- Recruitment and retention due to temporary posts (current establishment reached for first time 31/3/25)
- Demand out weighs capacity

**Strengths**

- ND steering group has been formed and a work programme devised to progress one pathway
- A number of individuals on waiting list have had clinician contact
- Awareness and education by team of staff, GP's and Gwent Police
- Networking with services around UK
- Development of consultant nurse post to ensure career progression and service sustainability
- Planned implementation of RPA
- Team constantly achieves 100% satisfaction on CIVICA
- Engagement with WAG, via national pathways group and professional advisory group for ADHD

# Strengthening Provision and Delivery of Welsh Government Legislation and Performance

- **Pre-Service Resourcing:** Chatbot, MELO, community engagement, Psychological Health Practitioners, single session therapy training, brief review of needs for information, guidance and advice via walk-in / drop-in, co-production, resourced at the front door.
- **In-service Capacity:** Prioritisation of resource to meet legislated targets
- **Employee Skills and Training:** Training plan that incorporate service needs AND individual skills development
- **Interface Commitments:** Cultivate relationships that support interfaces, that are multi-disciplinary and include GP Primary Care, PCMHSS, Secondary Care, Psychology, Mental Health Medical Consultation, Community and Social Care professionals.

# Mental Health & Learning Disabilities

## Learning Disabilities

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# Overview of Learning Disabilities Directorate Strategy

The Learning Disability Directorate have undergone a substantial review of the community and inpatient services. This has included engagement with individuals with a learning disability, carers and Directorate staff.

From this, the Directorate are currently developing the **Learning Disability Model of Care** that aligns to the strategic context and aims to ensure a high quality, safe and sustainable service for people with a learning disability living in Gwent.

**Statement of Purpose**

*'The Learning Disabilities Directorate is a multi-disciplinary, person centred, holistic service. We provide specific secondary healthcare to adults with a learning disability who cannot be supported by other services. We also support others to make reasonable adjustments to improve and maintain quality of life.'*

# Aims of the Learning Disability Model of Care

**To reduce**
•Health inequalities and avoidable deaths
•Restrictive practices including overmedication
•The need for hospitalisation in specialist units
•Long stays in hospitals
•Out of county / country placements

**To improve**
•Learning disability health checks and health action plans
•Education and reasonable adjustments across all services
•Access to mainstream health services incl mental health services
•Crisis prevention & response
•The quality of community placements
•The transition experience for young people as they move towards and into adulthood

**To ensure**
- Care is closer to home
- A focus on prevention, early intervention and crisis support – providing adequate staffing with appropriate skill mix with a broad range of therapeutic interventions
- Adults have access to effective community learning disability health teams (who work in synergy with the intensive support team and the crisis team to increase community capacity and reduce undue reliance on inpatient services)
- When it is necessary, that inpatient care is short term, focussed with a clear pathway for discharge
- A focus on engagement, empowerment and co-production of services

# Aims of the Learning Disability Model of Care

The Secondary Care Learning Disability service will work with individuals with a learning disability who are 18 years old or over and where the learning disability is impacting on the person's ability to access mainstream healthcare, despite the provision of reasonable adjustments. The service will work with individuals who have the following needs:

- *Mental health or emotional needs that has a significant impact on their quality of life*
- *Behaviours that challenge*
- *Neurodevelopmental condition*
- *Epilepsy*
- *Physical and multiple learning disabilities and complex health needs*
- *Dementia*
- *Have an enduring, long standing or acute, highly complex risk presentation*
- The service will also work alongside children's services where individuals are transitioning to adult secondary care services, this pathway is being developed.

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# Mental Health & Learning Disabilities

## Older Adult Mental Health Directorate

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# Overview of Older Adult Mental Health Service

We provide care for people with complex mental health issues (functional) and memory loss (Dementia).

The majority of older people receive community services, e.g. Memory Assessment Service, Community Mental Health Teams, local outpatient clinics and appointments in their place of residence: Across five LA areas in Gwent.

Specialist Inpatient Services for assessment and treatment dementia and functional care.

Joint working with other care providers e.g. Social Services, Third Sector, Primary Care, Frailty, COTE, District Nursing.

Comprehensive Older Adult Psychiatric Liaison service (OAPL) addressing the mental health needs of older people admitted to general hospital.

# Other Services Under Older Adult Mental Health Services

Older Adult Psychiatric Liaison (OAPL) have successfully adhered to their response times in 2024.

4 hours in urgent cases

24 hours in non-urgent cases

Reporting (via WCCIS) on response times has started in 2025.

There are currently 92 Care Homes in the ABUHB catchment area.

Care Home Liaison services (part of MAS) provide a response to Care Homes, they accept referrals as well as monitoring and supporting patients under the care of Memory Assessment Services.

ECT clinics operate across the MH&LD Division

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# Education and Training

ABUHB Dementia Awareness Training:

The Mapping, Education and Carer Service, provided by Older Adult Mental Health deliver the following training:

- Positive Approaches to Care (PAC)
- Carers Education Courses pan-Gwent and online (Dementia specific)
- Living Well with Dementia – Promoting Independence
- Therapeutic Observation and Engagement
- Dementia Care Mapping to Care Home and OAMH Inpatient Units

# Challenges for Older Adult Mental Health Service

The good news is people are living longer and are generally fitter, but the incidence of Dementia is increasing with the rise in age.

- ONS population projections state that there will be an increasing number of older people; over the next 15 years the size of the UK population aged 85 years and over is projected to increase from 1.6 million (2.5% of the total population) to 2.6 million (3.5%).
- Alzheimer's Disease (AD) affected 46,800 people in Wales in 2019, with numbers projected to increase to 55,700 by 2025 and 79,700 by 2040*.

A recognised need to improve the quality of care to Older Adult patients with mental health concerns.

A variation in services across our Boroughs, we need to ensure that equitable access to services are provided across the ABUHB footprint.

A need to support care in the community.

A need to address the inequalities of the provision of physical health care to Older Adult patients with mental health concerns.

The ability to recognise the predicted workforce challenges across professions, as well as strengthening AHP input into OAMH services.

The need to review our model of service delivery, to address the above, by developing a more sustainable service model for the future.

*Wittenberg R et al (2019) Projection of older people with dementia and costs of dementia care in the UK 2019 -2040, Care Policy and Evaluation Centre, the London School of Economics and Political Science

# Aims of the OAMH Models of Care

Our vision is to work with our communities for a healthier future, to care for patients when they need us and for our staff and services to aim for excellence in all that we do.

- Reduce health Inequalities
- Develop Inpatient Centres of Excellence
- Improve recruitment and retention
- Improve access to community services
- Ensure that Clinical Services are safe and sustainable for the future
- Provide value for money and long term affordability

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# Good News Stories

Joint working initiative between OAMH and Frailty has commenced in Torfaen. Close working with Frailty colleagues reviewing physical health issues on Hafan Deg Inpatient Unit

OAMH are looking to join an exciting research study SANDBOX (Scalable Assessment of Neurodegenerative Diagnosis via Biomarkers and Online Examination) This will enable speedier diagnosis of Dementia with reduced need for other Neurological testing.

# Good News Stories

Following a successful RPB bid, the ward garden on Annwylfan has had a complete refurb. This will hopefully help with outdoor therapeutic engagement and social activity.

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# Mental Health & Learning Disabilities

## Adult Mental Health Directorate

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# Overview of the Adult Directorate

The Adult Mental Health Directorate provide number services for patients with wide ranging mental health issues between **the ages of 18 and 65** across Gwent. This includes crisis and liaison support, inpatient services, community support and a range of specialist services pan Gwent.

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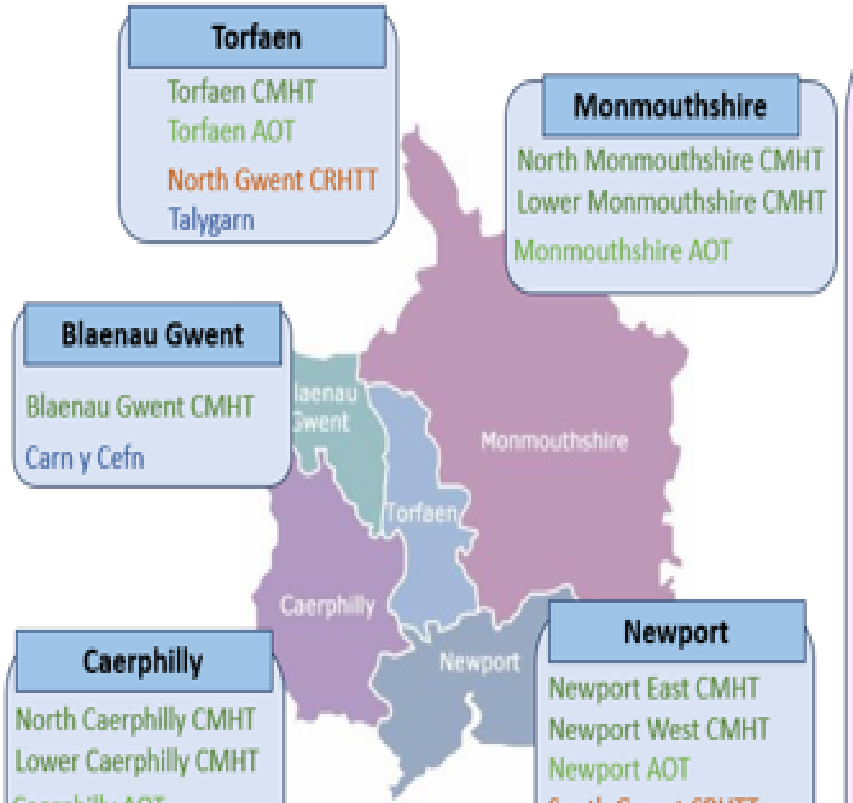
## Adult Mental Health Services

South Powys




### Pan Gwent Services

- Community Forensic Mental Health Team
- 136 Suite
- Ty Cynnal Support House
- Shared Lives
- Psychiatric Liaison Service
- Psychiatric Intensive Care Unit
- Ty Skirrid
- Bellevue
- Lindisfarne
- Pillmawr
- North Lodge
- South Lodge

**Psychological Services**

- Trauma Pathway
- Homelessness Service
- Hiraeth
- Part One Psychology Service

- Veterans Service
- Victims Hub
- ABSDAS North
- ABSDAS South
- Perinatal Service
- Specialist Eating Disorders
- Early Intervention for Psychosis
- Systemic Family Therapy
- Peer Mentor Development Team
- Conveyancing

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| | |
|---|---|
| **Veterans** | Veterans NHS Wales (VNHSW) in Aneurin Bevan University Health Board is a specialist priority service for military veterans with military service attributable mental health problems. |
| **Specialist Eating Disorders (SEDs)** | A multidisciplinary team that provides consultation, support and direct joint working to Tier 2 (CMHT), Tier 1 (Primary Care) and allied clinicians across Gwent. The service provides individual, group and family interventions and has an explicit 'gate keeping' role for any patients requiring referral to the Tier 4 Specialist Inpatient Unit or non-emergency access to an acute medical bed in the Grange University Hospital. |
| **Perinatal Mental Health** | The Perinatal Mental Health Service is a specialist community team that covers the whole of the Gwent area. Our multi-disciplinary team provides care and treatment to women who are pregnant or postnatal and are at risk of or are affected by mental illness. |
| **Early Intervention Service (EIS)** | EIS is focused on the early detection of, and recovery from, psychosis. We work alongside a 3rd sector charity based team called Adferiad Recovery. As a service we work with people aged between 14 and 35 living in the PAN Gwent area. If the person has either experienced a first episode of psychosis or those deemed 'suspected' of developing psychosis and meet the criteria then we support and offer a service for up to 3 years from the first appointment. |
| **Systemic Family Therapy** | The Systemic Family Therapy team cover the whole of Gwent and work with people in close relationships to better understand and support each other. They regularly see patients with their family members, partners and carers to enable family members to express and explore difficult thoughts and emotions in a therapeutic environment with qualified systemic family psychotherapists. |
| **Aneurin Bevan Specialist Drug and Alcohol Service (ABSDAS)** | Aneurin Bevan Specialist Drug & Alcohol Service (ABSDAS) is an NHS Specialist Addiction Service dedicated to helping people with addiction and/or dependency needs. ABSDAS works with a variety of health, local authority and third sector partners to help people achieve their goals of abstinence or harm reduction |

# Inpatient- Achievements and Challenges

## Achievements:

- Recently appointed 9 international qualified nurses who have settled in well
- Vacancy situation has improved (Nursing)
- We have advertised for 21 RMN nurses via the student streamlining process to cope with future demand
- 3 new Speciality Doctors appointed (moved from India)
- We have recently had a positive HIW inspection on Carn y Cefn ward in Ebbw Vale
- Directorates are carrying out their own mock HIW inspections and action plans are in situ

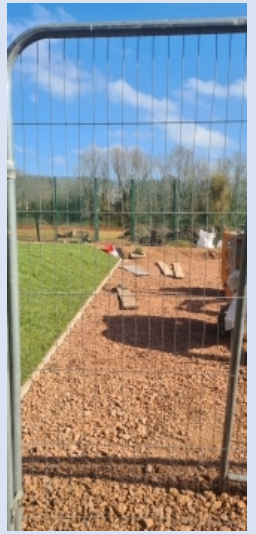
## Challenges:

- High Acuity
- Patient Flow challenges
- Increase admissions and bed occupancy
- Poor Estate in some areas (Talygarn, St Cadocs Hospital)

# Pillmawr Garden Development

£100k of capital funding is being used to add a usable recreation area for physical activities and ‘Recovery Through Sport’.  There will also be a new patio/seating area for BBQs and some bedding for gardening and therapeutic activities.

The purpose of the garden regeneration is to support recovery, physical activity and social inclusion for people with mental health and learning disability needs.



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# Specialist Services - Achievements and Challenges

## Achievements:

- ABSDAS – HCSW Event, 1 staff HCSW of the year, 1 staff won rising start and 1 received a commendation certificate
- Veterans Service are presenting at the '15 year' anniversary for VNHSW
- Perinatal service are part of an accreditation scheme
- EIS leading physical health monitoring and adventure therapy improvements in Wales. The Clinical Lead attended and presented at the 'All Wales' EIP physical health launch event
- ABSDAS working collaboratively with the Gastro Division
- There are Gastro Consultants in-reaching into our Eating Disorders

## Challenges:

- Funding challenges
- Funding is non-recurring

# Community - Achievements and Challenges

## Achievements:

- CMHT Torfaen have had a Patient Choice Recognition Award
- Upper Monmouthshire CMHT run an award-winning cooker and gardening group
- We are now appointing student streamliners into CMHT development posts
- Running a number of improvement projects (Text messaging/Duty Desk with LA)
- We have Physical Health monitoring in all boroughs and a generic SOP
- Positive feedback about Newport Duty Desk from patients
- Positive wellbeing feedback from students

## Challenges:

- Recruiting into community RMN posts remains a challenge
- High Care Co-ordinator caseloads
- Poor Estate
- Patients often required to tell their story more than once

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# Overview of Adult Directorate Strategy

The Adult Directorate are undergoing a substantial review of their community, inpatient services and secure services.

From this, the Directorate are currently developing the **Adult Mental Health Models of Care** that aligns to the strategic context and aims to ensure a high quality, safe and sustainable service for people living in Gwent our vision will be co-produced with people with lived experiences of mental health services.

We hope that through the changes we implement we will lead the way in developing excellence and promoting best practice in mental health services creating services that are inclusive, accessible, values people as they are and is responsive to their needs. Embracing Innovation and using the most up to date evidence-based approaches.

# Service Model Principles

| | | | |
|---|---|---|---|
| Equitable & Easy Access – One Front Door & Flexible Options | Skilled, well-resourced workforce and clinical leadership | Evidence-based Interventions | Close to home |
| Least Restrictive | Co-produced | Trauma-informed | Responsive, compassionate, person-centred care |

AI & Technologically advanced

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# Proposed Outcomes of the Models of Care Work

The Models of Care programme of work has been designed to systematically review all current services, assess current demand on services (including unmet demand), and use this information to design sustainable services for the future, in collaboration with staff, service users and their family carers.

The main outcomes of the work are to make improvements in the following areas:

## Efficiency

- Right-sizing
- Eliminating waste
- Utilising technology proficiently & proactively
- Diversifying the workforce to meet service needs

## Equity

- Removing unwarranted variation
- Standardising access across all services
- Focusing on areas for development

## Excellence

- Excel in innovation
- Progress Centres of Excellence

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**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**
**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 09 April 2025 |
| **CYFARFOD O:**<br>**MEETING OF:** | Mental Health and Learning Disabilities Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Mental Health Act Update Report Q3 2024-25 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Leanne Watkins, Chief Operating Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Louise Turner, Divisional Director MH&LD |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

The report provides activity information on the use of the Mental Health Act over Quarter 3, October – December 2024 and provides a comparison of activity over the previous quarter. Where available, other information sources will be used in order to highlight any trends, patterns or variation over time.

The report is presented to provide assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act.

**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 1983 (the Act) 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 Local Health Board's area is operating properly.

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

The health board requires that a quarterly report to be submitted that summarises the work of the Mental Health Act department and identifies how it has fulfilled the duties required of it.

## Asesiad / Assessment

This report is designed to provide information on trends and analysis of the use of the Mental Health Act and associated processes and to provide assurance to the Health Board that there are adequate governance arrangements in place to ensure the fair and lawful application of the act. The Mental Health and Learning Disabilities Division will continue to develop and refine the report as required.

The full quarterly report is attached, and identifies a number of themes for discussion, these are summarised below:

- General activity and detentions under the Act during this period were lower than average, however this is in line with normal variation in activity between periods with no specific underlying reasons identified.

- There has been a slightly higher than average use of Section 4 which in most cases, use of section 4 has been directly related to the lack of availability of S12 approved doctors.

  Mental Health Act work undertaken outside of their place of work (i.e. not where patients are in-patients) is classed as fee-paying services, which is not part of their contractual duties. Doctors are therefore under no obligation to undertake them and may decline to do so unless the fees offered are acceptable to them.
  Up until December 2024 Section 12 approved ABUHB doctors were not being paid for undertaking MHA assessment, whereas undertaking the assessment outside normal working hours will result in a fee paid to the individual doctor. This has resulted in difficulty in securing section 12 doctors during working hours.

  In December 2024 ABUHB approved remuneration for additional section 12 work during working hours for all section 12 approved doctors within the health board. We now have a list of section 12 doctors who are willing to undertake the additional MHA work so the use of emergency section 4 should only be used in an emergency situation and is likely to reduce the number of detentions under section 4 of the Mental Health Act due to lack of availability of section 12 doctors.

- Use of Section 136 has been higher in this quarter, although no specific was identified for the total increase, there were several repeat Section 136 detentions for 15 patients' during the quarter. The Adult Directorate have arranged multi agency meetings for several frequent attenders to explore alternatives to the 136 process. Staff in the 136 suite have close working relationships with Gwent Police MH managers and will devise proactive individual management plans for patients where appropriate. Staff also work with patients to promote use of core services eg via 111#2.

- There were no associate hospital managers hearings held during the quarter. This issue has been communicated previously and arose as a number of hospital managers left the Health Board and two managers took a leave of absence. This left 2 mangers in post, and as 3 managers are needed to form a panel, we were unable to schedule hearings. Since that time the position has significantly improved with recruitment of 12 hospital managers, enabling the restart of hearings from early February with over 30 hearings undertaken over the period. This improvement will be highlighted in the Q4 report.

**Argymhelliad / Recommendation**

The Committee is asked to receive the information provided on the use of the Mental Health Act.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 2. Safe Care<br>4. Dignified Care<br>6.2 Peoples Rights<br>7.1 Workforce |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Not applicable |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Choose an item. |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | The Mental Health Act (1983) Mental Health Act Code of Practice for Wales (Revised 2016) |
| Rhestr Termau:<br>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: | N/A |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk |
| **Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio<br>Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

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

## Annual Report 2023-24

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

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

In writing:

Healthcare Inspectorate Wales
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via:

Phone: 0300 062 8163

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

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

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

## Our purpose

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

## Our values

We place people at the heart of what we do.

We are:

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

**Objective** – we are reasoned, fair and evidence driven.

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

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

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

## Our goal

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

## Our priorities

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

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

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

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

# 1. Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

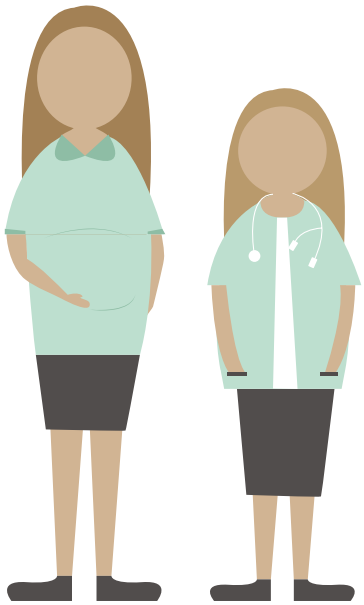
Overall, there were 199 complaints and concerns about mental health and learning disability healthcare services. This is an increase on the previous year from 164.

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

These figures can be broken down as follows:

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

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



# 2. Context

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

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

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

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

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

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

# 3. Our role in mental health and learning disability care

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

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

## Inspection and regulation

### NHS and Independent Healthcare

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

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

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

## Monitoring use of the Mental Health Act 1983

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

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

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

Consent to treatment forms are completed in a timely manner.

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

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

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

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

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

## Review Service for Mental Health

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

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

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

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

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

## Monitoring the Mental Health (Wales) Measure 2010

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

**Part 1** – Primary mental health support services

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

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

**Part 4** – Mental health advocacy.

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

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

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

## Monitoring use of the Deprivation of Liberty Safeguards

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

## UK National Preventive Mechanism

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

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

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

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

## Youth Justice Services

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

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

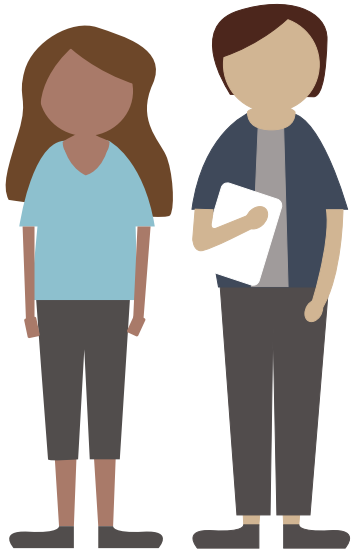
## Prison Healthcare

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

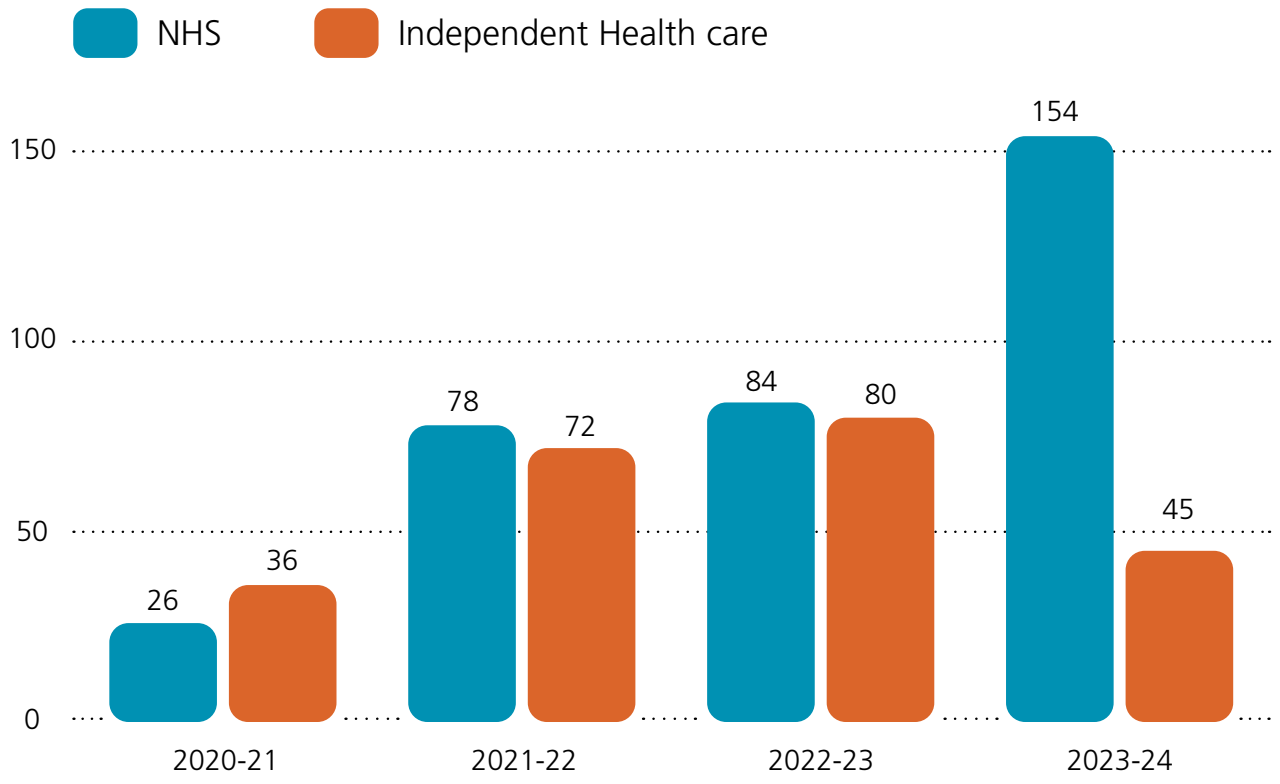
- There was inadequate oversight and planning of care for patients with long term conditions.
- Dental waits for urgent and emergency care were too long.
- Some pharmacy practices were not in line with good practice such as the management and use of stock medicines, secondary dispensing, and the lack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

## Dementia Partners National Steering Group.

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



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




# 4. Listening to concerns

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

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

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

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

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

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

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

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

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

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

## Staff concerns

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

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

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

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

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

## Regulation 30 and 31 Notifications

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

This is required by law and includes:

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

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

## Table of notification type for Regulation 30/31s

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

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

# 5. Inspecting mental health and learning disability healthcare services

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

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

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

During our onsite inspections we:

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

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

## Our findings

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

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

**Findings specific to Learning Disabilities.**

**Findings specific to CAMHS.**

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

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

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

### Least restrictive care

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

### Use of restraint

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

The guiding principles of the Code are:

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

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

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

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

This guidance is considered within our inspection process.

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

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

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

## Use of seclusion

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

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

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

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

## Meaningful and therapeutic activities

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

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

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

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

## Medication Management

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

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

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

## Risk assessment and care planning

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

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

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

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

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

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

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

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

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

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

## Environment of care

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

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

## Staff and patient safety

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

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

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

## Privacy and dignity of patients

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

## Workforce

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

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

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

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

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

## Governance

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

- A lack of a robust system of governance oversight which ensures that the hospital's medications management processes support patient safety.
- During one inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.
- In one visit we identified that there was no formal process in place to obtain patient or family carer feedback.
- In another visit we did not see any evidence of changes that had been made as a result of formal patient feedback,
- There was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback,
- Policies were found to be out of date.
- Record keeping audits were generic health board audits, which were inappropriate for the mental health setting.
- A lack of ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement.
- A lack of quality governance and leadership to ensure effective communication between senior management and ward staff.
- In one visit we identified that the registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.
- The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.

The above issues were identified within our health boards and independent provider inspections and must be addressed as a matter of priority. Many of the issues above can be easily addressed with strengthened governance processes. In one of the most significant failures of governance, a health board did not ensure that robust processes were in place to correctly record restraint incidents within Datix to support effective investigation, supervision and governance oversight.

## Findings specific to Learning Disabilities

During 2023/24 we undertook three inspections of learning disability establishments and one assurance check to a CLDT jointly with CIW. Within these inspections, we noted some positive findings including, patients having access to advocacy services, and we observed staff interacting with patients in a proactive and engaging manner, and staff we spoke with demonstrated a genuine patient focus. Patients were also happy to engage with the inspection team and the views expressed to us were overall supportive of the care they receive.

In all four inspections no immediate assurances actions were requested, however, there were a number of areas for improvement identified.

### Patient and staff safety

Patient and staff safety is an important issue and central to any care and treatment delivered. If patients feel safe, they will respond much better to any treatment and will feel empowered to maximise their full potential. If staff feel safe, then they will be better equipped to care and empower patients in their care.

In our CLDT inspection we identified delays in allocating, assessing and authorisation of the Deprivation of Liberty Safeguards (DoLS) applications to both Rhondda Cynon Taf County Borough Council (RCT) and CTMUHB. This delay continues to result in many people being deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. Further work is required to ensure people rights are protected and care and support/treatment arrangements amounting to deprivation of liberty are appropriately authorised. Senior Managers must ensure there is sufficient capacity to meet statutory responsibilities.

In an inpatient hospital we found that the call bells in patient bedrooms were not easily accessible for patients.

### Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. It was pleasing to note that we only identified issues with the management of medication in one of our four inspections; this being in an independent hospital where the registered manager must ensure that medication stock reconciliation processes are always adhered to.

### Training

In terms of training, we identified one issue in the CLDT assurance review in relation to specific training related to the Mental Health Act. The training was not routinely delivered to all health board practitioners. We asked the health board to review and ensure that those practitioners delivering care to people subject to the Mental Health Act receive up to date knowledge of the act and its implications for the people supported. In another of our inspections we identified that the health board continues to utilise the expertise held within the Multidisciplinary Team (MDT) to provide person specific Positive Behavioural Support (PBS) training and supports staff to attend as required.

### Care plans and risk assessments

Care plans, in particular PBS plans, are an important component in delivering effective care and ensuring the patient is at the centre of all care and treatment delivered. In addition, any patient risks must be fully described with triggers identified and a range of strategies identified to mitigate against identified risks. We routinely examine care and risk documentation as part of the inspection process. In all four of our visits,

we identified issues with the care documentation including;

- a health board did not have an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board did not ensure that the latest behaviour support plan was available in the active file used by staff.
- We recommended additional information was documented relating to the reason(s) for why a particular intervention was implemented and what was done to justify that intervention as last resort.

## Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. In one of our inspections the patient information board was not up to date and therefore did not ensure that patients had access to appropriate information.

## Use of seclusion

The Mental Health Act and information position on seclusion is documented earlier in this section of the report. In one of our inspections the documentation relating to the use of seclusion was not completed accurately.

## Workforce

Workforce and the recruitment and retention of suitably qualified and experienced staff continues as an issue. In one of our inspections the health board did not ensure that staff were supported in any changes to their roles aligned with the service change from assessment and treatment to that of rehabilitation.

## Environment of care

In all three of our visits to in-patient settings we identified issues with the environment of care, environmental improvements were required in relation to the refurbishment, redecoration and repairs on wards and in one of our inspections the health board was required to ensure that the physical environment meets the needs of patients in receipt of rehabilitative care. Other specific environmental issues included heating problems and the lack of the development of a patient kitchen as part of a life skills programme of therapy. Lastly the registered manager needed to ensure that maintenance issues were resolved according to their level of priority and risk.

## Governance

A range of governance issues were identified in three of our four visits. These included:

- a health board needing to set up an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board needing to place emphasis on ensuring that issues relating to service change continue to be explored and acted upon in a timely and robust manner.
- The registered provider making sure that all policies are updated and reviewed.
- Health boards must establish and communicate timely and effective processes to ensure people who are supported by the CLDT, do not experience lengthy delays and bureaucracy in accessing medical equipment.

## Findings specific to CAMHS

During 2023-24 we inspected two of the three in-patient CAMHS units in Wales. Some positive findings were identified including, the environments of care was generally well maintained internally and care plans were generally of a good standard, but with some areas for improvement required. However, our inspections also identified a range of issues and following one of our inspections an immediate assurance letter was issued in relation to ensuring that the governance of restraints was appropriately reported and investigated including details on:

- triggers and build up to the restraint
- Accurate recording of the length of time of restraint.
- Subsequent analysis and investigation of the restraints to ensure lessons are learnt and that the restraints are analysed to identify any themes and whether the restraint could have been avoided and whether the type of restraint used was appropriate.

Other issues identified included, a number of vacant posts of educator, psychologist and occupational therapist that resulted in young people not having access to the education and therapies that they needed. In addition, we identified a range of issues with medicines management including:

- The medicines management policy was out of date.
- Gaps on the fridge temperature recording sheet in the clinic room.
- The temperature inside the clinic room was very hot and no room temperature checks were being undertaken to ensure that the temperature remained below the advised storage temperatures for the medication in the room.
- Staff we spoke with during the inspection were unclear about what to do in the event of an adverse drug reaction.

Lastly, on one of our visits we saw that a treatment pathway had not been put in place for a young person with a diagnosed condition on admission.

# 6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act (MHA) 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the MHA1983.

The MHA is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The MHA provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

## How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the MHA. Other individuals and organisations include, officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under The Act. This section of the annual report details how the MHA is being implemented and how the powers granted are being exercised and monitored in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2023-24 we focused on a number of key areas including:

- Are patients lawfully detained and is the detention under the Act the most appropriate.
- Under section 132 are patients informed about their rights, at the point of detention, and then at regular intervals. Is it recorded if patients have understood the detention or not.
- Is there a care and treatment plan in place that considers aftercare of the patient

We consider the detention of patients through a number of methodologies including interviews with patients and members of the multi-disciplinary team. We also use observation and we examine the detention paperwork to ensure patients are lawfully detained. In addition, we consult with the MHA administrators.

## Mental Health Act Reviewers

During our inspections we utilise the skills and knowledge of our MHA Reviewers whose purpose is to consider the detention of patients under the MHA. They make a judgement on the application of the MHA and whether it was being lawfully applied and the MHA 1983 Code of Practice was being adhered too. A number of key sections are scrutinised including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the

patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

## Our Findings

### Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity of each patient had been assessed and clearly documented.

However, on one of our visits, we identified that patient capacity and capacity to consent was not routinely assessed and recorded during the first three months of treatment and proformas were not routinely used in relation to patients that lacked capacity to make specific decisions about aspects of their care and treatment that were outside of the provisions of the act during their stay on the ward. In another of our visits we noted that mental capacity assessments were not fully completed and regularly reviewed and updated

In one case, the capacity to consent to treatment for patients was not regularly assessed using the framework set out in the Mental Capacity Act and guidance set out in the MHA Code of Practice for Wales (13.8) and recorded within their patient records.

### Lawful detention/treatment

HIW has a duty to monitor the MHA to ensure that the detention of patients is lawful and there are systems and processes in place to ensure audits and effective governance of the Act. A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. We found many examples of good practice including the MHA documentation was well organised, easy to navigate and securely stored and MHA administrators demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful.

However, during one of our visits, we identified that a review of the hospital's use of urgent treatment under Section 62 of the MHA was required, in order to ensure full compliance with the Act and full completion of relevant documentation.

In addition, we also identified in one of our visits that implementation of a robust system of audit and governance oversight in respect of the MHA was required.

In addition, Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness and the statutory certificate of consent forms must always state the correct type and dosage of medication that has been prescribed to patients.

### Section 17 (leave)

Section 17 leave is an important part of a patients journey to discharge from their section and back into the community. This process must be carefully managed with clear conditions of leave taking into account any risk factors and balances the needs of the patient with these risks. A number of areas of concern were identified during our inspections including:

- A review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in the decision-making process in relation to the leave process.
- Insufficient numbers of staff available to ensure patients are able to take their Section 17 leave.
- We saw examples where the patient Section 17 leave forms had been signed but not dated. The 'circulation list' tick boxes within the Section 17 leave forms were not fully completed to indicate who had been provided with a copy of the form.
- Incomplete Section 17 leave forms that did not include the date and details of all recipients, as a matter of good practice.
- We noted the conditions and outcomes of the section 17 leave for some patients could be strengthened to provide more clarity to staff on the expectations of the leave arrangements.
- We found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.
- The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the Community Treatment Order (CTO) might be more suitable option in accordance with paragraph 27.8-27.9 of the Code of Practice.

### Managers hearings

In terms of managers hearings, we identified two issues during our inspections, one was to ensure Hospital Managers Hearings are held in a timely manner as in one record we reviewed, we noted a delay of five months. Another area was that action must be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.

### Ensuring patients' rights

Section 132 and 132A of the MHA places a duty upon hospital manager to ensure detained patients understand how the MHA applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

On our inspections there was good evidence that patients were aware of their right and this was well recorded. Only on one of our inspections we did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.

### Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

In two of our visits we identified that that the views of the statutory consultees were not being routinely captured to support the medical treatment of patients authorised by the SOAD.

### Audit and governance arrangements

Throughout our visits we consider the audit and governance arrangements for the monitoring of the MHA by the health boards and independent providers of healthcare. During three of our monitoring visits we identified issues in the audit and governance oversight in respect of the

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

# 7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the Second Opinion Appointed Doctor SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH also undertake a review of section 61 and any deaths that occur of detained patients within the NHS. We can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

## Second Opinion Appointed Doctor Service

The SOAD is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

The SOAD service operates as a Hybrid service. Our methodology is set out in detail in our guidance to all SOADs and provided to all MHA Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021. One of the main changes we have implemented is that whilst all SOAD visits should occur in person for the purposes of interviewing the patient for most cases. However, in specific cases, namely Community Treatment Order (CTO cases), we have opted for a remote first methodology. All patients are to be consulted by their clinical team prior to the submission of requests if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right in all cases to specifically request an onsite visit from a SOAD. Our forms are being updated to

reflect these changes and will be published in the summer of 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the RSMH services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their certificate of consent CO forms.

**Full advice on our methodology is available on our website** and is currently being updated to reflect the changes we have made in 2023-24 this year.

## SOAD Recruitment

We have now recruited into the role of a Lead SOAD and plan to recruit to the role of Deputy Lead SOAD in early 2025. We continue to recruit additional SOADs to provide further resilience to the service.

### SOAD activity

During the period April 2023 to March 2024, the RSMH received 733 requests for a visit by a SOAD. This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

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

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

## Requests for visits by a SOAD, 2006-07 to 2023-24[1]

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

1 Source: SOAD requests to HIW

## Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

- Two working days for a referral in relation to ECT.
- Five working days for referrals about prescribed medication when the patient is in hospital.
- Ten working days when the referral is in relation to someone subject to a Community Treatment Order.

There are a number of reasons when on occasions we do not meet the above timescales including, the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

It must be reiterated that our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the MHA Administrators for all settings to try and ensure improvements in this process next year.

## Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the MHA administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW has produced guidance to MHA administrator in relation to this subject to minimise these instances.

# 8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff, and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

## Feedback on this report

If you have any comments or queries regarding this publication, please contact us

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# Appendix A

## Relevant work 2022-23

| | Hospital | Date | Type |
|---|---|---|---|
| Health Boards | | | |
| 1 | Assessment and Treatment Unit, Swansea Bay University Health Board | 17 - 19 April 2023 | Inspection |
| 2 | Hergest Unit Betsi Cadwaladr University Health Board | 15 - 17 May 2023 | Inspection |
| 3 | Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board | 22 - 24 May 2023 | Inspection |
| 4 | Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board | 3 - 5 July 2023 | Inspection |
| 5 | Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board | 17 - 19 July 2023 | Inspection |
| 6 | Cedar Parc Ward, Ysbyty'r Tri Chwm, Aneurin Bevan University Health Board | 7 - 9 August 2023 | Inspection |
| 7 | Tŷ Llidiard Cwm Taf Morgannwg University Health Board | 11 - 13 September 2023 | Inspection |
| 8 | Caswell Clinic, Swansea University Health Board | 11 - 13 September 2023 | Inspection |
| 9 | Canolfan Bro Cerwyn, Withybush Hospital, Hywel Dda University Health Board | 16 - 18 October 2023 | Inspection |
| 10 | Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board | 13 - 15 November 2023 | Inspection |
| 11 | Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board | 20 - 22 November 2023 | Inspection |

| Hospital | | Date | Type |
|---|---|---|---|
| 12 | Community Mental Health Team Nant y Glyn Team, Betsi Cadwaladr University Health Board | 23 and 24 January 2024 | Inspection |
| 13 | Talygarn Ward, County Hospital, Aneurin Bevan University Health Board | 5 - 7 February 2024 | Inspection |
| 14 | Care Inspectorate Wales (CIW) & Healthcare Inspectorate Wales (HIW) – Inspection of Rhondda Cynon Taf County Borough Council/ Cwm Taf Morgannwg University Health Board/Swansea Bay University Health Board Community Learning Disability Team (CLDT) | 13-15 February 2024 | Inspection |
| Independent Healthcare Providers | | | |
| 15 | Ty Cwm Rhondda | 17 - 19 April 2023 | Inspection |
| 16 | Hillview Hospital | 9 and 10 May 2023 | Inspection |
| 17 | St David's Independent Hospital | 19 - 21 June 2023 | Inspection |
| 18 | Aberbeeg Hospital | 10 - 12 July 2023 | Inspection |
| 19 | Rushcliffe Mental Health Hospital Aberdare | 25 - 27 September 2023 | Inspection |
| 20 | Ty Gwyn Hall Hospital | 2 - 4 October 2023 | Inspection |
| 21 | New Hall Independent Hospital | 24 - 26 October 2023 | Inspection |
| 22 | Tŷ Grosvenor | 6 - 8 November 2023 | Inspection |
| 23 | Heatherwood Court Hospital Llantrisant Road, Pontypridd | 4 - 06 December 2023 | Inspection |
| 24 | Priory Hospital Cardiff | 8 - 10 January 2024 | Inspection |
| 25 | St Peter's Hospital | 26 - 28 February 2024 | Inspection |
| 26 | Coed Du Hall Hospital | 25 - 27 March 2024 | Inspection |

# Appendix B: Glossary

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|---|---|
| **Advocacy** | Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also independent mental health advocate. |
| **Approved Clinician** | A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician. |
| **Assessment** | Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made. |
| **Capacity** | The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005. |
| **Care Standards Act 2000** | An Act of Parliament that provides a legislative framework for independent care providers. |
| **CO2 form** | Certificate of consent to treatment (Section 58(3) (a)). |
| **CO3 form** | Certificate of second opinion (Section 58(3) (b)). |
| **CO7 form** | Certificate of appropriateness of treatment to be given to a community patient. |
| **CO8 form** | Certificate of consent to treatment for a community patient. |

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|---|---|
| **Community Treatment Order (CTO)** | Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention. |
| **Compulsory Treatment** | Medical treatment for mental disorder given under the Act. |
| **Consent** | Agreeing to allow someone else to do something to or for you, particularly consent to treatment. |
| **Deprivation of Liberty** | A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law. |
| **Deprivation of Liberty Safeguards** | The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves. |
| **Detained patient** | Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital. |
| **Detention/detained** | Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned". |
| **Discharge** | Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge.<br><br>Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient. |
| **Doctor** | A registered medical practitioner. |

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| **Electro-Convulsive Therapy (ECT)** | A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression. |
| **Guardianship** | The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian). |
| **HIW** | Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. |
| **Hospital managers** | The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board).<br><br>Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. |
| **Independent Mental Capacity Advocate (IMCA)** | Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service. |
| **Informal patient** | Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient. |
| **Learning disability** | In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act. |
| **Leave of absence (section 17 leave)** | Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as 'Section 17 leave'. |

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| **Liable to be detained** | This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time. |
| **Ligature** | A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety. |
| **Mental Health Review Tribunal** | The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order. |
| **Medical treatment** | In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care. |
| **Medical treatment for mental disorder** | Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations. |
| **Mental Capacity Act 2005** | An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth. |
| **Mental illness** | An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia. |
| **Multidisciplinary Team** | A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments. |
| **Patient** | A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar. It is simply a reflection of the terminology used in the Act itself. |

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| **Prescribed body** | The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure. |
| **Public Interest Disclosure Act** | The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013. |
| **Recall (and recalled)** | A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital. |
| **Regulations** | Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008. |
| **Revocation** | This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made. |
| **Responsible Clinician** | The approved clinician with overall responsibility for the patient's case. |
| **Restricted patient** | A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49.<br><br>The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement. |

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| **Second Opinion Appointed Doctor (SOAD)** | An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent. |
| **Section 3** | Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually. |
| **Section 12 doctor** | See doctor approved under Section 12. |
| **Section 17A** | This is a Community Treatment Order. |
| **Section 37** | This is a hospital order, which is an alternative to a prison sentence. |
| **Section 41** | This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public. |
| **Section 57 treatment** | Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function. |
| **Section 58 & 58A** | Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment. |
| **Section 61** | This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B. |
| **Section 132** | This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights. |
| **Section 135** | Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety. |

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| **Section 136** | Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control. |
| **SOAD certificate** | A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient. |
| **Statutory Consultees** | A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician. |
| **The Mental Health (Wales) Measure 2010** | Legislation that consists of 4 distinct parts:<br>Part 1 – Primary mental health support services.<br>Part 2 – Co-ordination of and care planning for secondary mental health service users.<br>Part 3 – Assessment of former users of secondary mental health services.<br>Part 4 – Mental health advocacy. |
| **Voluntary patient** | See informal patient. |
| **Welsh Ministers** | Ministers in the Welsh Government. |

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Aneurin Bevan
University Health Board

# Integrated Child and Adolescent Mental Health Service ( ICAMHS )

**Update for Executive Board 13th March 2025**

# You are never too far away from a CAMHS expert

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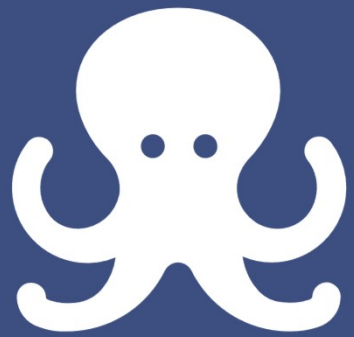
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

# Core Values/ Philosophy of Whole System



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**Reach:** Expertise being accessible both directly and indirectly to C&YP, their families and key universal practitioners.

**We've never had greater reach than now , and we aim to enhance it further**

**Connectivity:** Emphasis on co-production, collaboration, integration, within the whole Directorate System and outside with key partners.

**We've never had so many specialist teams and partnership connections**

**Transforming Risk into Opportunity:** The core and specialist teams within the Directorate whole-system offer the safety & containment of evidence-based therapeutic interventions delivered flexibly to enable C, YP & their families/carers to learn from the 'risk' and enable 'risk' to positively impact growth and development as they move forward with their lives.

**We've never had a more responsive and flexible whole system to meet the diverse needs of those struggling with the most complex and severe mental health difficulties**

## What ICAMHS has delivered in a year

- Achievement of Part 1B RTT waiting list target.
- Achievement of ND RTT waiting list target alongside innovative and Wales-leading transformation of the assessment pathway.
- Continued improvements to the country's most well-developed single point of access system – SPACE Wellbeing Panels.
- UK-Wide Benchmarking ( Annual ) reveals that ABUHB ICAMHS provides **25/27** elements of an idealised CAMHS offer.
- Acknowledged Wales-leads for various service areas: School In-Reach Team, Eating Disorders, ARFID, Forensic CAMHS, Drug & Alcohol Team, Trauma Therapy pathway, Child Psychotherapy pathway, Crisis outreach Team.
- Opening of innovative Sanctuary Space – Ty Fforest.

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# CAMHS performance descriptor

*Conversion rate data gathered from Teams (rest of data pulled from Qlik & validated)*

| Performance Descriptor | Target | Mar-24 | Apr-24 | May-24 | June-24 | July-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS Referrals Received | | 51 | 46 | 47 | 40 | 58 | 41 | 47 | 62 | 66 | 46 | 54 | 40 | 50 |
| CHOICE CAMHS RTT % | 80% | 100% | 100.00% | 95.45% | 92% | 97.22% | 86.36% | 94.73% | 100% | 88.57% | 100% | 83.33% | 94.28% | 94.32% |
| CTP % | 90% | 72% | 72% | 75% | 79.3% | 80.1% | 81.4% | 98.00% | 94% | 100% | 98% | 98% | 98% | 98% |
| CHOICE to NCP Conversion Rate | 65% | 88.00% | 77.35% | 62.82% | 79.54% | 84.12% | 73.84% | 85.48% | 76.92% | 72.88% | 71.21% | 77.92% | 71.00% | 77.9% |
| | | | | | | | | | | | | | | |
| ND RTT % | 80% | 33.50% | 40.39% | 40.34% | 38.50% | 43.29% | 41.58% | 47.71% | 49.23% | 53.15% | 51.08% | 61.36% | 73.85% | 80.27% |
| ND Referrals Received | | 295 | 243 | 263 | 253 | 281 | 81 | 189 | 218 | 268 | 237 | 284 | 311 | 245 |

| PCAMHS | Target | Mar-24 | Apr-24 | May-24 | June-24 | July-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1A Referrals Received | | 142 | 141 | 146 | 123 | 129 | 93 | 78 | 147 | 96 | 108 | 161 | 125 | 124 |
| Part 1A MHM (appt attended within 28 days of referral) | 80% | 78.12% | 82.11% | 86.17% | 86% | 94.26% | 100% | 94.73% | 98.57% | 91% | 98.66% | 81.43% | 80% | 80% |
| Part 1B MHM 28 days following IA | 80% | 9.00% | 4.00% | 0.00% | 5.3% | 4% | 5.76% | 2% | 10% | 25% | 84.74% | 84.21% | 80% | 80% |
| **Section 136 Data** *(Obtained from MHA office)* | | Mar-24 | Apr-24 | May-24 | June-24 | July-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
| | | 0 | 0 | 3 | 4 | 2 | 4 | 1 | 2 | 5 | 2 | 1 | 1 | 2 |

**Whilst we have a lot of green, there are hidden internal waits that are increasing**

- Things we do well

- **Innovation**
- **Integration**
- **Relentless pursuit of service improvement & transformational change**
- **Commitment to Quality of Services ( whilst maximising the quantity of what is on offer )**
- **Partnership Working**
- **Co-Production**

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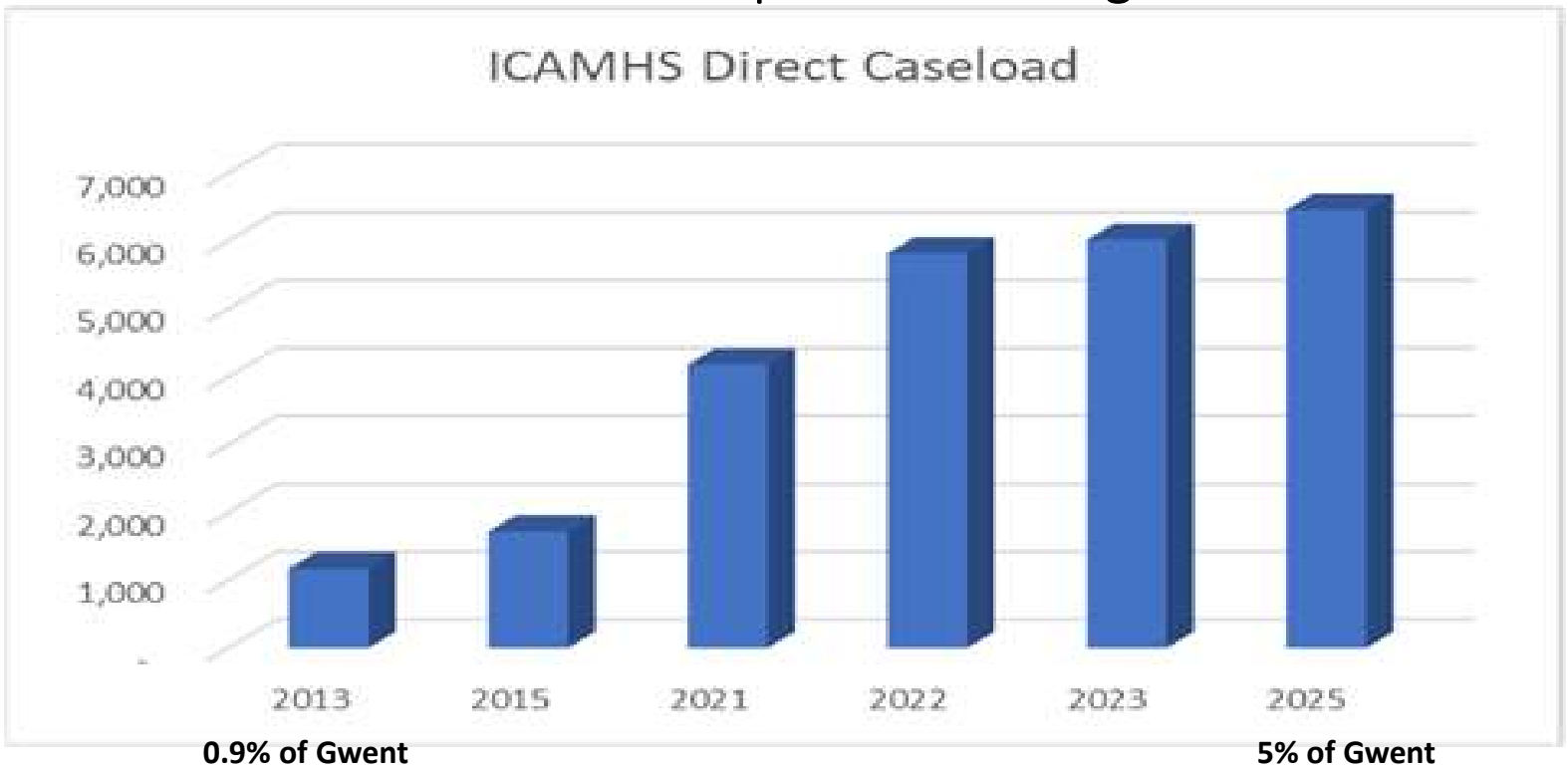
# The Demand on CAMHS is Rising

## The Cases are more complex & take longer to treat



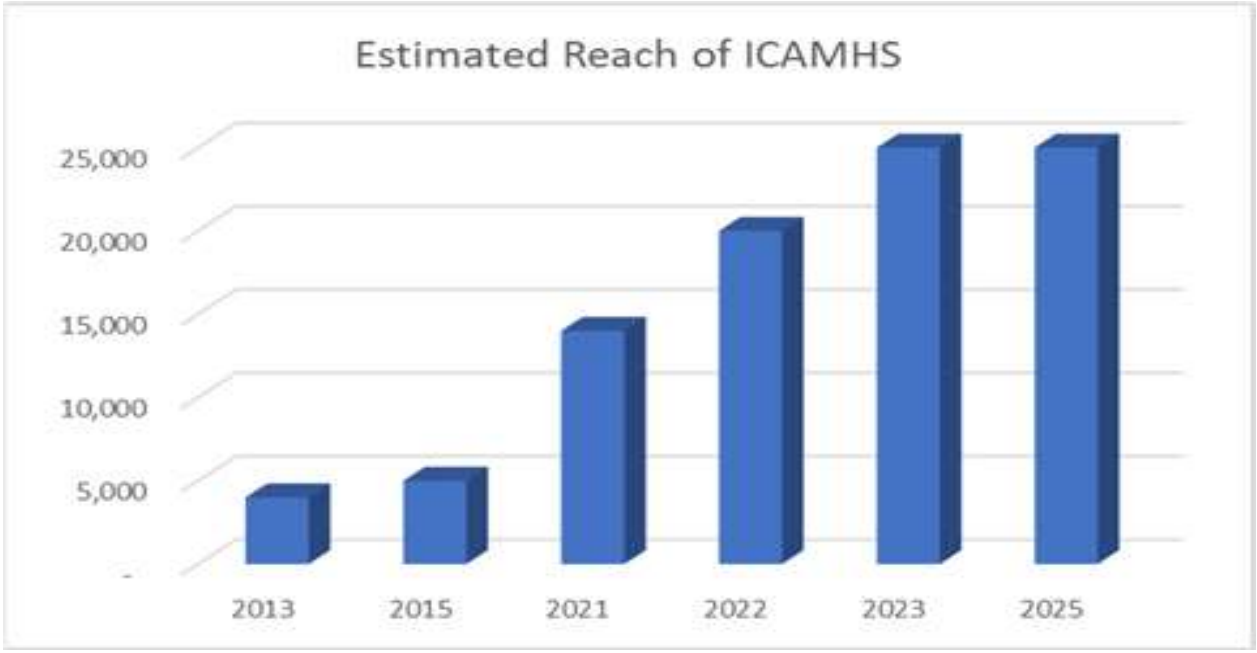

**0.9% of Gwent Population**

**5% of Gwent Population**

# ICAMHS Reach is Expanding

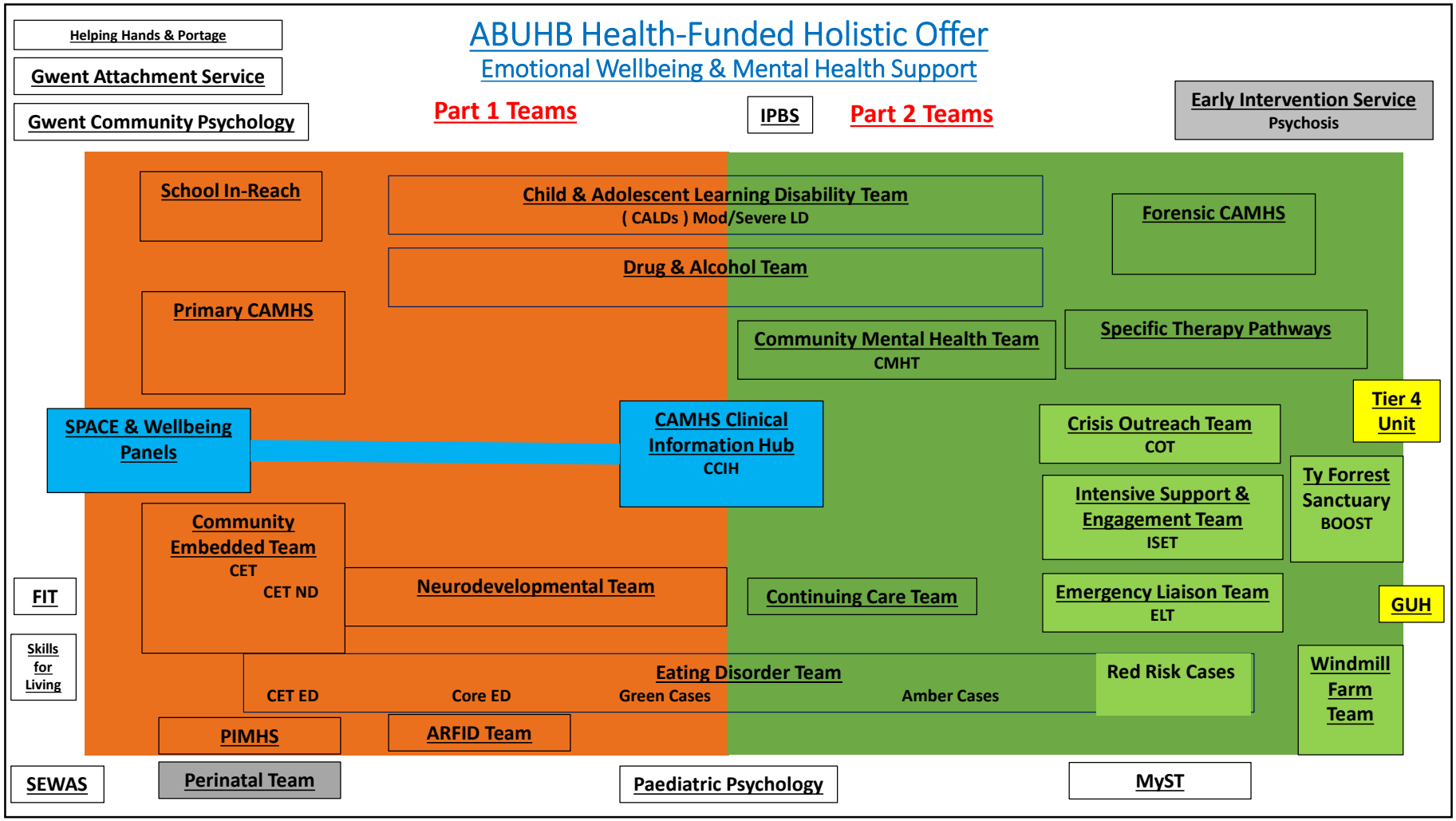
Our Offer Ranges from Upstream Prevention to Downstream Specialist Work

More Indirect Work as well as Direct F2F Therapy




**3% of Gwent Population**

**20% of Gwent Population**


ABUHB Health-Funded Holistic Offer
Emotional Wellbeing & Mental Health Support
Part 1 Teams
Part 2 Teams
Helping Hands & Portage
Gwent Attachment Service
Gwent Community Psychology
IPBS
Early Intervention Service
Psychosis
School In-Reach
Child & Adolescent Learning Disability Team
( CALDs ) Mod/Severe LD
Forensic CAMHS
Drug & Alcohol Team
Primary CAMHS
Community Mental Health Team
CMHT
Specific Therapy Pathways
Tier 4 Unit
SPACE & Wellbeing Panels
CAMHS Clinical Information Hub
CCIH
Crisis Outreach Team
COT
Ty Forrest Sanctuary
BOOST
Intensive Support & Engagement Team
ISET
Community Embedded Team
CET
CET ND
FIT
Neurodevelopmental Team
Continuing Care Team
Emergency Liaison Team
ELT
GUH
Skills for Living
Eating Disorder Team
CET ED
Core ED
Green Cases
Amber Cases
Red Risk Cases
Windmill Farm Team
PIMHS
ARFID Team
SEWAS
Perinatal Team
Paediatric Psychology
MyST

# Part 1 Teams

Providing assessment, intervention, and a range of indirect work for CYP with mild to moderate mental health difficulties.
7 Teams make up the Part 1 offer from ICAMHS

**Update:**

Strong focus on preventative, early help/support and timely identification of problems, and rapid initiation of interventions.

By working in partnership with other front-line agencies, we build their awareness and strengthen their responses – minimising the problems created by a 'hand-over' culture.

**Successes**

Our accessibility, both directly and indirectly, has increased considerably leading to lower numbers of CYP with unmet need

**Challenges**

The increased demand, in terms of numbers and complexity of case presentation, leads to capacity/demand mismatches across the Part 1 Teams

# Positive Impact of ICAMHS on other parts of ABUHB & Ext Agencies

**Preventative, Enhanced Support & Early Detection/Intervention Work provided by ICAMHS:**

- **In a Nutshell: We have reconfigured to contribute far more upstream expert work**
  **Integrated CAMHS has increasingly made a more preventative impact**

- **We are confident that we now detect those that need our services – fewer are missed**
- **Placing our CAMHS experts upstream reduces demand further down**
- **Our indirect work strengthens and empowers the networks to support CYP & their families**
- **We offer a flexible and accessible range of interventions for those with mild/mod difficulties**
- **We prevent significant numbers of cases going into care &/or needing Continuing Care**
- **We prevent mild difficulties becoming Mod/Severe leading to downstream benefits**
- **We enable more children with emotional difficulties to access education**

# SPACE Wellbeing Panels

The single point of access to ICAMHS.

Partners at the panels include Social Services, Third Sector and Education.

**Update:**

Guided by needs-led, holistic, person-centred principles and is aligned with NEST/NYTH model, Recovery-based approach, 'No Wrong Door' & 'No Bounce' initiatives.

**Successes**

Only service in Wales allowing self-referrals.
Rest of Wales keen to replicate our model.
Co-Production with CYP – 'Mind our Futures Gwent' representatives help us shape the processes and referral forms.
Efficient pre-allocation processes have been created to fast-track referrals that clearly meet thresholds for various ICAMHS teams.

**Challenges**

Increase in more complex cases.

Some unmet need scenarios – ongoing audit.

e.g. ASD/ADHD Post-Diagnostic support currently not commissioned.

School-Based Counselling only available during term time – Demand increases into PCAMHS during holidays.

# Schools In-Reach Team

An integral part of Gwent's 'Whole School Approach'.
Every primary and secondary school has a CAMHS professional providing consultation, joined up working, sign-posting, training and group work.
CYP needing ICAMHS interventions can be easily brought into the service.

**Update:**
Practitioners are playing a significant role in the transformed ND triage pathway.
Pilot of a new initiative to support children transitioning into High School.

**Successes**

ABUHB ICAMHS In-Reach model is acknowledged to be the most advanced and the best integrated with CAMHS ( National Review Nov 2024 ).

**Challenges**

Capacity shortfalls mean that we have struggled to offer an equitable service to all schools within Gwent.

# Primary CAMHS ( PCAMHS )

CAMHS therapists provide brief and focused assessments and interventions for CYP with mild & moderate mental health, emotional distress or behavioural difficulties.
The offer includes: 4-6 sessions of individual brief focused therapy; Advice to CYP/family; Consultation & support to partner practitioners also involved with CYP; A range of therapeutic groups; Signposting to more appropriate services.

**Update:**
In May 2024 **585** CYP waited **6-9 months** and **0%** were hitting RTT of starting 1B intervention < 4 weeks. By end December 2024 **80%** compliance with RTT achieved with all children starting 1B intervention within 4 weeks. Position continues to be sustained

**Successes**
Delivering a recovery plan to achieve the 1B RTT.
The whole service engaged with this plan.
New 1+1 intervention initiative has been piloted.
Wellbeing booklets have been successfully created & rolled out.

**Challenges**
To continue to meet 'steady state' sustainably.
ASD/ADHD Post-Diagnostic adjustment work is needed but not funded.

# Community Embedded Team ( CET )

Experienced CAMHS professionals provide accessible assessments, interventions, consultation and multiagency work for CYP with complex, but mild & moderate mental health difficulties. They work flexibly directly and indirectly to improve outcomes. The positioning of skilled multidisciplinary clinicians 'up-stream' enables collaboration with partner agencies to meet the needs of CYP. This results in a strengthening of the networks of support around CYP.

**Update:**
CET jointly represent ICAMHS, with PCAMHS colleagues at SPACE panels

**Successes**

In conjunction with Schools In-Reach & PCAMHS, CET successfully offers a range of interventions for CYP with Part 1 needs.

**Challenges**

The complexity of cases is increasing and the brief interventions making up the CET therapeutic model are increasing in length leading to increased waiting times.

# Neurodevelopmental Team

## Assessments for neurodiverse conditions such as ADHD & ASD are offered

**Update:**

In March 2024 **1066** CYP waiting for ND Assessment ( 35% met RTT ) & **691** > 1 year

By end of March 2025 80% will meet RTT & **0** are waiting > 1 year

New funding has enhanced our capacity in the under 5 pathway & allowed us to carry out an OOH w/l initiative.

Referrals have been streamlined & are now submitted via SPACE and involve Schools In-Reach – This was a Co-Production process.

New triage profiling tools, from Portsmouth & Glasgow, have been adapted to improve referral management.

Evidence-based assessment tools such as QB Testing & ADOS are used.

**Successes**

Improvements and transformation to both the Under 5 & Over 5 pathways.

The recovery plan has been successful in enabling us to meet RTT target.

Early Help Neurodiversity Hub set up.

Robotic Process Automation is planned to enhance admin efficiency.

A CONNECT Plus App will improve real-time tracking of referrals & appts.

**Challenges**

Poor referral quality & high admin workload – Innovations in place.

Increasing demand.

Resource constraints.

Variable stakeholder buy-in

# Parent Infant Mental Health Team ( PIMHS )

Highly specialised team who offer therapeutic interventions, consultations, training & reflective practice to strengthen the relationship between babies and their parents/carers in order to achieve developmental gain and other improved outcomes for high-risk children.
Part of the preventative and early intervention agenda of ICAMHS.
The offer ranges from direct interventions with the families to network support.

**Update:**

The team is small but multi-professional and highly skilled.

**Successes**

The team have created close partnership connections with perinatal services, Public Health Wales, Primary Care, Social Care, HV, Third Sector providers.

**Challenges**

Ensuring that the offer is equitable across Gwent.
Unstable funding arrangements.
Demand increases whilst capacity falls.

# Avoidant Restrictive Food Intake Disorder Team ( ARFID )

Consultations & assessments are offered for enduring and severe difficulties. For Mild/Moderate cases a post-diagnostic group with review is provided.
Assessments for neurodiverse conditions such as ADHD & ASD are also offered

**Update:**

The team is small ( 1.5 WTE ) but a combination of efficiency measures taken and innovation means the demand is equitably and well managed.

## Successes

Most developed response for these CYP in Wales

## Challenges

Currently not able to case hold because of capacity issues.

Sustainability is a major concern.

# Part 2 Teams

Providing assessment, intervention, and a range of indirect work for CYP with moderate to severe mental health difficulties.
14 Teams make up the Part 2 offer from ICAMHS

**Update:**
The specialist and intense part of ICAMHS
2 Important organizing frameworks: **The Mental Health Measure ( MHM ) & The Choice & Partnership Approach ( CAPA )**

**Successes**

Many of our specialist teams lead the way in Wales.

**Challenges**

Preventing a tendency to work in silo.

Managing the processes to ensure the system remains integrated

# Positive Impact of ICAMHS on other parts of ABUHB & Ext Agencies

**More Specialised & Intensive ICAMHS Work Provided:**

- **In a Nutshell:** **We have expanded the specialist therapy range we offer**
  **Our crisis response is far more flexible**

- **We prevent over 40 Tier 4 Admissions a Year**
- **We prevent over 250 Paediatric Bed-Days a year**
- **We divert hundreds of cases away from Emergency Department per year**
- **We prevent significant numbers of cases going into care &/or needing Continuing Care**
- **Estimated Cost Savings :** **Total = About £600K per Year**

# CAMHS Clinical Information Hub ( CCIH )

Consultation phone, triage of referrals and mapping/managing the processes for the whole integrated system. A senior CAMHS clinician is available Mon-Fri 9-5pm.
Admin are an integral part of the responses.
A centralised telephonic system is now in place which means there is only one number for professionals, families or CYP to call. The system works efficiently to direct the caller to admin queries, leave messages for clinicians, access the consultation phone or speak to the emergency duty practitioner.

**Update:**

CCIH oversees the threshold decisions made by each team in ICAMHS

**Successes**

The consultation phone has enhanced our accessibility to CYP & families at a time when there are internal waits to various teams around the system.

**Challenges**

There is a current shortfall of capacity to fully cover the consultation phone – Contingency plans are in place to mitigate the problems

# Community Mental Health Team ( CMHT )

Providing a comprehensive array of assessment, intervention, and a range of indirect work for CYP with moderate to severe mental health difficulties.
All cases will require over 10 sessions and often require multiple clinicians to work with them i.e. They are eligible for Part MHM & need a CTP.

**Update:**

Cases are seen on average for about a year before their problems have been resolved fully and can be discharged.

Capacity shortfalls & increasing demand from more complex cases means that current wait for intervention is **about a year** with over **200 CYP** waiting.

**Successes**

A comprehensive recovery plan and remodelling of the intervention model is ongoing.

Reflective peer practice within the team.

Recent awayday to enhance morale & improve MDT functioning.

We are close to full implementation of the lean CAPA model.

**Challenges**

Likely non-compliance with **2a RTT** and **CTP RTT** during this year, unless capacity enhancements can match demand.

Increasing complexity of caseloads have resulted in extended durations of care.

To improve the culture of universally using PREM & PROMs.

# Eating Disorder Team

Providing assessment, intervention, and a range of indirect work for CYP with eating disorders.
A wide range of Evidence-based interventions are offered including individual, group and family therapies.

**Update:**

ICAMHS have invested in Dietetic more than any other HB.

We run meal observation clinics; Multi-family therapy programmes; Family-Based Maudsley Model of recovery; Carer's skills groups; Body Image & Motivational groups

**Successes**

Our outcomes, even with serious EDs are very good.

Strong links to paediatrics when admissions are needed.

Excellent transition arrangement with adult services.

Comprehensive physical monitoring clinics allow us to work with severe cases whilst they remain at home – this reduces the use of GUH inpatient beds.

Partnership connections forged with diabetic team.

**Challenges**

Increased demand – an innovative RAG rating scheme helps us organise our capacity and help us meet therapeutic need appropriately.

Cases are more complex and a greater proportion are Part 2 meaning they need Care Coordination and CTP completion.

Current witing times for initial assessment ( CHOICE appointments ) is rising ( 14 weeks )

# Specific Therapy Teams

We offer an extensive menu of highly specialised evidence-based therapies

**Including:**

Trauma Pathway & Trauma Recovery Model: Most developed EMDR & CT-PTSD offer in Wales

Family Therapy:

Child Psychotherapy & Attachment-Based Therapies:

CBT, PBS & DBT:

Narrative & Solution-Focused Therapies

Group Therapies:

**Update:**

Centralised equitable pathways have been created for each therapy

**Successes**

We have created a Governance group made up of senior MDT therapists called **CQET** which oversees the quality of therapies we deliver, identifies supervision requirements, authorises development opportunities in-line with the whole system's training strategy & promotes q culture of providing outcome-focused therapy.

**Challenges**

There is insufficient capacity to meet the growing demand for specialist therapy.

Internal waiting lists for Trauma therapies, Attachment-based therapies, Family Therapy and Child Psychotherapy range from 3 months to over a year.

# Child & Adolescent Learning Difficulty Team ( CALDS )

Providing assessment, intervention, and a range of indirect work for CYP with moderate to severe learning difficulties accompanying significant emotional distress and behaviours of concern.
CALDs provides specialist multidisciplinary led work for children 4-18 years old

**Update:**

Current mismatch of capacity shortfalls struggling to meet increasing demand.

**Successes**

Excellent partnership working.

Now fully integrated with 'No wrong door' referral pathway of SPACE.

Introduction of regular webinars for carers & teachers.

Groups for families – 'Understanding behaviours of concern'.

Positive Behaviour Support ( PBS ) is now a central intervention used.

Highly valued multi-agency consultations across all of Gwent.

**Challenges**

Increase in crisis presentations.

The team are working hard to prevent the use of restrictive practices and inappropriate prescription of medication during crises.

The waiting lists for CALDs are going up.

# Continuing Care Team ( CC )

Provides support & oversight of the continuing care process for CYP who have complex health needs, above and beyond what statutory Health services can provide, and are open to ICAMHS/CALDs. Currently **21** cases open

**Update:**

New roles/initiatives have been developed to address identified gaps e.g. PBS practitioner, Clinical & Strategic Lead OT & Nurse assessor role

**Successes**

Development of a paper with DMT to consider CC position & ongoing collaboration with key stakeholders.

Cost savings identified through scrutiny of invoices.

Revised pathway of referrals to CC.

Digital animated CC training package

**Challenges**

Depleted CC workforce currently – leading to outstanding eligibility & placement reviews.

National Complex Care Database needs to be kept up to date.

Financial pressures.

Forecasted overspend 24/25 of **£144K** & 25/26 **£1.435m**

# Drug & Alcohol Team ( DAT )

Providing assessment, intervention, and a range of indirect work for CYP with both mental health and drug/alcohol difficulties

**Update:**

DAT funded through ring-fenced HB monies alongside Area Planning Board contributions – Recently a 10-yr contract has been agreed ( previously only for 3 years ).

Initiatives have been devised to provide screening and interventions for CYP presenting in A&E following recreational intoxication and offer tailored approaches for CYP who have been traumatized.

**Successes**

Excellent partnership working with Third Sector drug services.

We are central partners in a fully integrated Gwent-wide provision for under 18s

**Challenges**

Data collection is a problem as DAT are required to use a core data-set for Welsh Government and not WCCIS – which the rest of ICAMHS use.

Alcohol is currently the increasing demand.

There are no Detox beds for <18s

# Forensic CAMHS ( FCAMHS )

Providing Pan-Gwent assessments, consultations & interventions, and a range of indirect work for CYP presenting with offending behaviours with moderate to severe mental health difficulties.
Partnership agreements are in place with Youth Justice to provide input into YOS

**Update:**
FCAMHS have expanded to include nurses, Forensic psychiatrist time, psychologists.
There are clear links with the National Forensic Adolescent Consultation Service ( FACS ).

**Successes**

ABUHB FCAMHS are the Wales leads for service provision.

A 3-month pilot for Harmful Sexual Behaviour is now being rolled out.

Bespoke FCAMHS ND & Trauma pathways has been created.

A training matrix has been developed.

Liaison & Diversion services for courts is being developed

**Challenges**

Currently the 8B Forensic psychologist post is vacant with few candidates available.

Data management/recording remains a problem as YOS use a different system ( Child-View ) and not WCCIS.

There is a shortage of space for the team to use as a base.

# Intensive Support & Engagement Team ( ISET )

Providing longer-term therapeutic interventions for CYP who present in crisis. Often involve multiagency working for CYP in care placements.

**Update:**

ISET run a range of therapeutic groups to enhance resilience.

The use of integrated management plans, the trauma recovery model and structured clinical management have led to regular successful recovery outcomes.

**Successes**

The team have prevented breakdown of placements within Gwent and have , therefore, successfully reduced CC spend.

Close network working has enhanced collaborative relationships with partner agencies.

**Challenges**

Due to blockages in the ICAMHS system ISET often have to hold on to cases for longer than is needed.

ISET have had difficulties referring to Windmill Farm

Increase in cases needing complex integrated management plans.

# Crisis Outreach Team ( COT )

Offering a rapid intense package of therapeutic support as an alternative to admission for CYP in significant crisis. Resolving crises whilst CYP remain at home.

**BOOST –** Bolstering Our Outreach Scope & Therapy; 8 x B4 practitioners; Intensifying our crisis responses in a flexible way.

**Update:**

The crisis therapeutic package of support usually lasts 8-12 weeks.

The COT model has been refreshed & now involves consultation to other teams as well as direct work.

**Successes**

COT save about 40 admissions to Tier 4 a year, stabilising the crisis whilst CYP remain at home.

The process of admission to designated holding bed has been streamlined.

**Challenges**

Capacity shortfalls due to sickness and maternity leave have impacted on ability to prevent admissions.

# Emergency Liaison Team ( ELT )

Providing rapid assessments, and immediate responses, for CYP presenting in emergencies to A&E and Primary care.

ELT offer 7 days a week, 8am-6pm responses in the form of emergency duty phone calls, triage & consultation 'walk-abouts' in GUH early each morning & F2F assessments either in GUH, or diverting CYP to CAMHS base.

Detailed risk assessments form the basis of comprehensive safe discharge plans with ICAMHS follow-up.

**Update:**

The emergency duty phone is held at all times on shift and has meant that DSH/ODs can be prevented if concerned professionals contact us.

**Successes**

Paediatric & ED bed days are reduced significantly by rapid response and diversion of cases away from GUH.

Improved relationships with all wards and departments due to enhanced presence.

Close connections between ELT, Police MH control room team and 111 press2 have improved outcomes & reduced the need for s136 assessments.

Preventative Post-Vention responses are mediated by ELT.

**Challenges**

Increased emergency presentations at GUH can mean there are back logs for ELT assessments at times.

Backlogs elsewhere in the ICAMHS system ( e.g. CMHT ) mean that ELT clinicians are required to carry out numerous follow-ups and hold risky CYP until they can be taken on by a more appropriate therapeutic team.

# Sanctuary Team ( Ty Fforest )

Providing intense therapeutic work for CYP in emerging crisis within a newly opened sanctuary space. The team provide a diversion for CYP who are at risk of spending extended periods in GUH.

**Update**

The team receive internal referrals from ICAMHS teams.

**3 Pathways:**
Planned Sanctuary Work; Diversion from GUH Sanctuary work & Overnight Sanctuary Diversion work.

**Successes**

Planning has begun to create a partnership pilot with a Third Sector provider to offer overnight sanctuary

**Challenges**

We do not have the workforce capacity at present to staff the overnight sanctuary offer.

# ICAMHS Priorities

- **1. CMHT:** Average waiting times for intervention are **45 weeks.** Increased complexity and severity means longer duration of care. Throughput of cases affected. **196** CYP are waiting for intervention. All cases need Care Coordinators & CTPs to be completed. WG target of 80% compliance with CTPs is severely under threat.
- **2. Specific Therapy Pathways:** Particularly Child Psychotherapy and Trauma Pathway are struggling with capacity shortfalls.
- **3. CALDs:** Increasing waiting lists and higher numbers presenting in crisis. The team is under capacity in spite of model changes, innovations and efficiency gains have been put in place.
- **4. Eating Disorder Team:** The wiat for triage and initial CHOICE is going up ( currently 14 weeks ). Capacity is insufficient to meet increasing demand.
- **5. Sanctuary Team:** We do not currently have a staffing model to be able to action the overnight Sanctuary pathway.

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## Ongoing Challenges

- ND Recovery plan & Transformation of ND Pathway
- Maintaining compliance with PCAMHS 1B RTT
- Maintaining morale
- Continue to foster a culture of integration within the whole system

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- Opportunities – Discussion

- Communication strategy – CAMHS webpage, resources
- Digital support – dashboards, RPA, Patient journey tracker
- Staff training
- Accommodation solutions – clinic spaces
- Pre and Post diagnostic ND resources
- Shift to Single Point Access for support ( not diagnostic assessment) for Neurodiversity

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- Thankyou for your time, interest and ongoing support

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

**Power of Discharge Sub-Committee Meeting**

**Tuesday 19th November 2024 11:00 – 12:30**

**Virtually via Microsoft Teams**

**Present:**

Paul Deneen – Chair, Independent Board Member
Helen Moon – Integrated Mental Health Act Trainer and Clinical Lead Mental Health Act
Beverley Hopkins – Mental Health Act Team Lead
Carol Morgan – Associate Hospital Manager
Keith Dunn – Associate Hospital Manager
Peter Walters – Associate Hospital Manager
Amelia James – Mental Health Act Implementation Support Officer

**Apologies:**

Sarah Cadman – Head of Quality and Improvement

| Agenda Item | Key Discussion points /Updates | Action | Who |
|---|---|---|---|
| 1. Apologies and Welcome | Apologies received from Sarah Cadman.<br>Paul welcomed everybody to the meeting. | | |
| 2. Training Update and Discussion on Future Training | It was discussed that training had been put off due to the fact that we were going to wait until the new hospital managers were appointed.<br><br>Discussion took place about possible training.<br><br>It was finally agreed that the we will hold a briefing on teams before Christmas on Monday 16th December 10 - 12 and then hold the orientation day in the New Year.<br><br>The provisional schedule is as below:<br><br>1. Arrival and refreshments | **Helen, Bev and Amelia to look at the programme and include timings** | **HMoon / BHopkins / AJames** |

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| | 2. Welcome and introduction to the day<br>3. General overview<br>4. Hospital Managers review process<br>5. Roles and responsibilities of the Responsible Clinician (RC)<br>6. Recruitment of AHM's<br>7. Input from current AHM's<br>8. Questions<br>9. Close<br><br>All members will be invited to attend. | | |
| 3. Matters Arising and Minutes from previous Meeting | The minutes and action points from 10th September 2024 were reviewed and agreed and the follow up for the below were agreed as having been completed. | | |
| 4. Items for Decision | No items for Decision | | |
| 5. Items for Discussion | **<u>Feedback from AMH's</u>**<br><u>Capacity</u><br>It was discussed that there is currently a backlog of around 33 hearings and there are around 19 upcoming hearings that also need to be held.<br><br><u>Keith</u><br>Keith gave the group an update as he has been unwell for the past few months. He advised that he can gradually return to doing some hearings. Paul welcomed him back and expressed that he hopes Keith is feeling better.<br><br>**<u>Update on recruitment</u>**<br>Paul expressed his disappointment surrounding the hurdles and barriers that have been faced in the recruitment process. | | |

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| | Bev discussed that she had a significant update on the recruitment of the hospital managers. There are currently 8 people that have been sent an offer. Bev discussed that they are also looking at having a continual advert similar to other health boards and that she is linking in with the other health boards to find out how they do this through their recruitment.<br><br>Bev discussed that the final hurdle was the checks and that they had got these down to a minimum because they are managers working for other health boards. Paul suggested that we could possibly get a letter from the candidate's previous organisation or managers and look to appoint pending the outcome of the DBS. The individual would already have had the DBS for their own organisation.<br><br>Paul noted that it had been an extremely difficult and frustrating process and gave his thanks for Bev's efforts.<br><br>Carol raised the question of whether the 8 people who had received offers were only going to be participating in online hearings or if they would be prepared to come to St. Cadoc's. Bev noted that there is a mixture.<br><br>Pete asked the question of whether the 8 people who had received offers included the two people he had put forward. Bev confirmed that they did not as they have not received a conditional offer yet. Paul asked Bev to follow up on the names and has asked.<br><br>Following the meeting Bev has spoken with Trac and has emailed the candidate that is having problems.<br><br>**<u>Upcoming Changes</u>**<br><br>Paul advised that there will be some upcoming changes to the Mental Health Act Monitoring Committee. He will find out more at the meeting next week and will brief the group when he knows more. | **Bev to follow up on the two names Pete has submitted.** | **BHopkins** |

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| 6. Items for Information | **Mental Health Act Monitoring Committee Q1 Report**<br>The Mental Health Act Monitoring Committee Mental Update Report, Quarter 1, April – June 2024 was disseminated to the group.<br><br>Pete raised the fact that there had been an increase in the use of Section 5(2) holding powers within the last two quarters and asked the following question as a result:<br><br>"In what circumstances, if any, do AHMS have any involvement / responsibility in reviewing decisions to use Section 5(2) Holding Powers? Or have I just confused this with barring orders when nearest relatives unwisely discharge a patient"<br><br>*Following the meeting the response is as below. This information is taken from the Mental Health Act Administrators Manual.*<br><br>***Section 5(2) Holding Powers***<br>*AHM's have no involvement or responsibility to review Section 5(2) holding powers as the patients are not liable to be detained.*<br><br>***For your information***<br>*Regarding AHM's and the power of discharge please see below.*<br><br>*There are four occasions which result in the Manager's considering whether or not to exercise their power of discharge:*<br>• *The patient has appealed to them against the detention*<br>• *The Responsible Clinician has renewed the detention in hospital of a patient under section 20 or extended a community treatment order (CTO) under section 20A*<br>• *The nearest relative has given notice to discharge the patient but this has been 'barred' by the responsible clinician under section 25* | | |

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| | • *The hospital managers have decided to review the patient's case independently of any of the above three events* | | |
| 7. Any Other Business | Keith expressed that it was good to see everyone again and thanked the group for bearing with him during his recent illness.<br><br>Paul gave his grateful thanks to Sarah, Helen, Bev and Amelia for their help and support with the PODSC.<br><br>Paul also wished to thank Peter, Carol, Keith and Julie for their ongoing help and support as AHM'S. | | |

**Date of next meeting: Virtual meeting with training – Monday 16th December 2024 at 10:00**

**PODSC Meeting - Tuesday 25th February 2024 at 11:00**

**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**
**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 09 April 2025 |
| **CYFARFOD O:**<br>**MEETING OF:** | Mental Health and Learning Disabilities Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Final Report from the Mental Health Act Monitoring Committee** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Bryony Codd, Head of Corporate Governance |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board established a Mental Health Act Monitoring Committee. The purpose of this Committee was to advise and assure the Board and the Accountable Officer by critically monitoring and reviewing the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983.

In November 2024, the Board approved revised Terms of Reference to enable a broader focus on all aspects of the Health Board's activities in relation to mental health, learning disabilities and child and adolescent mental health services. As a result, the Mental Health Act Monitoring Committee was stood down and a Mental Health and Learning Disabilities Committee established.

## Asesiad / Assessment

The Mental Health Act Monitoring Committee met once in 2024/25, on the 4th June 2024. The minutes of this meeting were approved by the Chair and an Assurance Report submitted to the Board in July 2024.

The minutes of this meeting, together with the Action Log, are provided as Attachment One, for information.

## Argymhelliad / Recommendation

The Committee is asked to **NOTE** the minutes of the final Mental Health Act Monitoring Committee held on 4th June 2025

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Enabler |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | None |

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| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | None |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk |
| **Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio<br>Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

# MENTAL HEALTH ACT MONITORING COMMITTEE ACTION LOG

| Outstanding | In Progress | Not Due | Completed | Transferred to another Committee |
|---|---|---|---|---|

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
|---|---|---|---|---|---|
| 04/06/2024 | **MHAMC 0406/3.1** | **Mental Health Act Compliance Report**<br><br>Data on use of Section 5(4) to be analysed to understand whether this was used with the same patients as repeat detentions | Deputy Head of QPS and Learning | September 2024 | **This will be included within future Mental Health Act Compliance reports to the MH&LD Committee** |
| 04/06/2024 | **MHAMC 0406/3.1** | **Mental Health Act Compliance Report**<br><br>Update on progress of obtaining data from local authorities and police regarding the result of the execution of warrants under Section 125 | Deputy Head of QPS and Learning | September 2024 | **This will be included within future Mental Health Act Compliance reports to the MH&LD Committee** |

# MENTAL HEALTH ACT MONITORING COMMITTEE ACTION LOG

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
|---|---|---|---|---|---|
| 04/06/2024 | **MHAMC 0406/3.2** | **Impact of Changes from the Right Care, Right Person Report**<br><br>Right Care Right Person to be placed on the agenda for the Committee's meeting scheduled for 16th September | Committee Secretariat | September 2024 | **To be included in FWP for MH&LD Committee** |
| 04/06/2024 | **MHAMC 0406/3.2** | **Power of Discharge Sub-Committee Update**<br><br>Update to be provided on the timing of PODSC meetings | Paul Deneen, Independent Member | September 2024 | **Revised Terms of Reference for the Power of Discharge Sub Committee included on the agenda** |

*All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.*

*Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.*

# CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

## MINUTES OF THE MENTAL HEALTH ACT MONITORING COMMITTEE MEETING

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| **DATE OF MEETING** | Thursday 4th June 2024 09:00-11:00 |
| **VENUE** | Microsoft Teams |

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| **PRESENT** | Pippa Britton- Vice Chair, Committee Chair<br>Paul Deneen- Independent Member, Vice Chair |
| **IN ATTENDANCE** | Leanne Watkins, Chief Operating Officer<br>Rani Dash, Director of Corporate Governance<br>Amy Buckley, Senior Nurse, Mental Health and Learning Disabilities<br>Sarah Cadman, Deputy Head of QPS and Learning<br>Kavitha Pasunuru, Assistant Divisional Director, Family and Therapies<br>Michelle Jones, Head of Board Business<br>Thomas Jaynes, Governance Support Officer |
| **APOLOGIES** | No apologies were received. |

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| **MHAMC 0406/1** | **PRELIMINARY MATTERS** |
| **MHAMC 0406/1.1** | **Welcome and Introductions**<br><br>The Chair welcomed everyone to the meeting. |
| **MHAMC 0406/1.2** | **Apologies for Absence**<br><br>There were no apologies for absence to record |
| **MHAMC 0406/1.3** | **Declarations of Interest**<br><br>There were no declarations of interest raised to record. |
| **MHAMC 0406/1.4** | **Minutes of the previous meeting**<br><br>The minutes of the meeting held on Wednesday 21st February 2024 were **AGREED** as a true and accurate record. |
| **MHAMC 0406/1.5** | **Committee Action Log- June 2024**<br><br>The Committee **RECEIVED** the action log and **NOTED** all actions were completed. |
| **MHAMC 0406/2** | **ITEMS FOR APPROVAL/RATIFICATION/DECISION** |
| **MHAMC 0406/2.1** | **Development of Committee Annual Programme of Business**<br><br>Rani Dash (RD), Director of Corporate Governance, introduced the Committee's annual programme of business. |

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| | RD advised that the annual programme had been developed to ensure statutory requirements for items of Committee business were scheduled across the year and would be utilised as a tool for informing and pre-empting committee business and to support the agenda setting process.<br><br>The Committee **RECEIVED** the report and **APPROVED** the proposed Committee Work Plan and **NOTED** that the Work Plan would be brought forward to each future Committee meeting for oversight. |
| **MHAMC 0406/3** | **ITEMS FOR DISCUSSION** |
| **MHAMC 0406/3.1** | **MENTAL HEALTH ACT COMPLIANCE REPORT**<br><br>Sarah Cadman (SD), Deputy Head of QPS and Learning, presented the report and provided assurance to the Committee on the Health Boards' compliance with the legislative requirements of the Mental Health Act.<br><br>SC noted the report provided activity information on the use of the Mental Health Act over Quarter 4, January – March 2024, and the report also provided a comparison of activity to the previous quarter.<br><br>SC presented the overall use of the Mental Health Act during quarter 4 and noted that, 51% had been used under Section 2; 20% under Section 3; 18% under Section 5(2) and 8% under Section 5(4). The use of Section 5 at 26% was higher than the previous quarter. SC noted the number of compulsory admissions by the borough of residence of each patient and noted that Newport and Torfaen had the highest number of detentions per population.<br><br>SC confirmed in comparison to the previous quarter, there had been a 22% increase in the overall<br>number of patients detained under the Act. Compared to the same quarter of last year (22/23) there had been a 5% increase and noted that the use of section 5(4) had increased substantially when compared to quarter 3, with a moderate increase in Section 4, Section 2 and Section 3.<br><br>SC commented on compulsory admissions to mental health wards of all adults under 65 years of age and noted that just under half (49%) of admissions were under Section 2 (Assessment) of the MHA and 17% of detentions under section 3 (Treatment). 30% of all adult detentions were under Section 5 of the Act which was a substantial increase when compared to the previous quarter.<br><br>The Committee was advised that when older adult patients had been admitted and detained, 84% were admitted under |

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| | Sections 2 or 3 and 13% were admitted under Section 5. There had been a 29% increase in the number of detentions compared to the previous quarter.<br><br>SC updated on the use of the Mental Health Act in the Learning Disabilities Service and noted 40% of patients were admitted under Sections 2 or 3 of the MHA with 60% of patients admitted under Section 5 provision. The number of detentions had stayed the same in comparison to the previous quarter. Whilst in respect of the use of the Mental Health Act in General Hospital Admissions, 75% of patients were admitted under Sections 2 or 3, with 25% admitted under Section 5, with an overall 33% decrease in the number of detentions when compared to the previous quarter.<br><br>The Committee was advised that during the period there had been one Under 18 Compulsory Detention under both Section 2 and 3 of the Act. This represented a 50% decrease in the number of under 18 detentions during the period and noted that performance was now within normal operating levels following the pandemic.<br><br>The Committee was advised that during the period there had been an increase in the use of Section 5(4) (powers conferred by the Act to detain whilst a patient). SC provided an overview as to when such occurrences occur. The Committee noted that over the past 6 months there had been a significant rise in use of Section 5(2) (power conferred by a doctor to detain whilst a patient) and noted that during the period 17 applications of this holding power had been utilised with 65% of these resulting in the patient being detained. The Committee was provided with an explanation of the data and was assured that the application of the Mental Health Act was appropriate and evidenced that staff were cognisant of the appropriate use of their powers.<br><br>Paul Deneen (PD), Independent Member, questioned whether there was a restriction on the number of times a nurse could issue a Section 5(4) and, in response, was advised that there was no restriction but advised that it would be a concern for a Section 5(4) to be repeatedly used as Section 5(2) would have been triggered.<br><br>Pippa Britton, Vice Chair, questioned the comparison in the use of the Section 5 with other Health Boards, and whether data could be extracted to show the use of Section 5 on repeat detentions for inclusion within a future report. The Committee discussed the complexities of this and noted that, during the period, the 17 patients that had been detained under Section 5(4) were also subsequently |

detained under Section 5(2), and 5 had lapsed and 1 had ended.

Amy Buckley (AB), Senior Nurse Mental Health and Learning Disabilities, noted that it would be useful to find out how many Sections 5(4) detentions then led onto Section (5)2 detention as this would then support the justification of the use of Section 5(4).

**Action**

- ***Deputy Head of QPS and Learning to analyse data on use of Section 5(4) to understand whether this was used with the same patients***

SC updated in further detail on the use of Section 5(2). The Committee was advised that use had slightly increased and resulted in 55% of patients who were then detained under section 2, 10% were subsequently detained under section 3 and 35% ended or lapsed without further detention. Outcomes of the 40 patients detained were noted and the Committee was informed that 26 converted to section 2 and 3 (detentions for assessment and treatment); and of those that did not convert: 1 was ended and 6 lapsed. The Committee was assured that work continued to reduce the lapse rate as it was not good practice.

SC provided an update on the use of Section 4 and clarified the use of Section 4 was used only in emergency situations where it was not possible to secure 2 doctors for a Section 2 assessment and was also felt necessary for a person's protection to detain.

SC noted Section 4 was used on 4 occasions in quarter 4 and use of Section 4 had increased by 100% in comparison to the previous quarter. Use of Section 4 represented the lack of availability of two doctors to undertake an assessment particularly in Monmouthshire. The Committee was assured work was ongoing to ensure Section 2 doctor support was avaliable and an internal rota was being developed for in-hours.

SC updated on the use of Community Treatment Orders (CTO) and advised that the number of orders had increased by 10%; from 21 at the end of quarter 3, 2023/24 to 29 at the end of quarter 4, 2023/24. 7 new CTOs had been made; 3 had been extended; 1 had been recalled to hospital but not admitted; 3 recalled to hospital and order revoked when readmitted.

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| | The Committee was advised that during the period there were no unlawful detentions and that one paper had failed the medical scrutiny process with 17 rectifiable errors recorded during the period. The Committee noted that these matters had been raised with the Senior Psychiatrists Committee for awareness, and noted that training around the scrutiny process was being conducted by the MHA Administration Department.<br><br>In response to a question SC advised that all case notes were digitalised and stored on WICCIS and confirmed that all other mental health documentation was paper based as it required "wet signatures" with the information stored by the Mental Health Administration Department and uploaded onto WICCIS for audit.<br><br>The Committee discussed the use of locum staff and their ability to complete paperwork and was assured that a plan was being developed to secure sustainable staffing levels which would mitigate this concern.<br><br>SC updated on use of Section 135 and noted that the MHA Administration Department had confirmed that the data was not complete for quarter 4. The Committee was assured that if a warrant was applied for by the Health Board the data would be easily attainable and SC confirmed that 3 warrants had been issued in quarter 3.<br><br>PD expressed concern of there being no full audit trail and that data was not being feedback by partners if a warrant had been executed after it had been issued. The Committee requested further information in relation to warrants executed under Section 135 by local authorities and the police.<br><br>**Action:**<br>• Deputy Head of QPS and Learning to update on progress of obtaining data from local authorities and police regarding the result of the execution of warrants under Section 135<br><br>SC updated on the use of section 136, noting a slight increase and confirmed that the usage was within normal parameters. SC advised that the numbers of under 18s detained under this section had substantially reduced when compared and advised that Newport and Caerphilly Local Authorities accounted for 59%.<br><br>The Committee was advised that during the period there had been a 23% reduction in the number of Mental Health |

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| | Act Managers' Hearings and that the number of Mental Health Tribunals were consistent over the past year with a 9% increase in quarter 4.<br><br>*The Committee **NOTED** the report and was **ASSURED** on compliance with the Mental Health Act.* |
| **MHAMC 0406/3.2** | **Impact of Changes from the Right Care, Right Person Report**<br><br>Sarah Cadman (SC), Deputy Head of QPS and Learning, provided an overview of the impact of the recent changes from the right care right person policy of Gwent Police and assured the Committee that the relationship between ABUHB and Gwent Police, especially the allocated Mental Health Lead was effective.<br><br>The Committee was informed that the current arrangements within the Health Board did not rely too heavily upon Gwent Police and to date since the implementation of the policy the Mental Health Division had not witnessed any impact of the change.<br><br>The Committee discussed the practicalities of the change and noted that the most impact predicted was use of the telephone 111 (2) service and the required response by police. SC noted that where police do not respond, cases were analysed at a joint agency meeting with the police to determine the appropriate response.<br><br>SC informed the Committee that the next phase of policy implementation was the management of "walk outs" from emergency departments and that it was anticipated that the impact of this upon the Division would be minimal and joint training with partners on expectations and behaviours during and after the policy implementation had taken place<br><br>Paul Deneen, (PD) Independent Member, expressed concerns over patients walking out of mental health facilities and advocated that the Health Board should continue to ensure good relationships with the police and for consistency of the service for vulnerable patients.<br><br>**Action**<br>• Committee secretariat to ensure Right Care Right Person is placed on the agenda for the Committee's meeting scheduled for 16th September |
| **MHAMC 0406/3.3** | **Power of Discharge Sub-Committee Update** |

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| | Paul Deneen (PD), Independent Member, provided an update to the Committee on the meeting held on 28th May 2024. The Committee was advised that a plan was being developed for members to undergo training. In regards to recruitment, two people had applied for Power of Discharge Committee membership and opportunities for recruitment were being explored with PODSC members from Cardiff and Vale University Health Board. The Committee discussed whether it was appropriate to recruit members from other Health Boards and concluded that it was appropriate but as part of this arrangement a reference and interview would be required.<br><br>PD advised that work was being undertaken to update the website, online hearings had commenced and that a monitoring report of the Committee had been produced.<br><br>In response to a question regarding the sharing of Power of Discharge Minutes with the Committee, Michelle Jones (MJ), Head of Board Business, confirmed that the timings of meetings scheduled presently did not enable the timely flow of information. PD agreed that it would be helpful if the Power of Discharge Committee met two weeks before the Mental Health Act Monitoring Committee.<br><br>PD expressed concerns regarding changes in the Mental Health & Learning Disabilities Division management team and the potential impact on the effectiveness of the Committee.<br><br>Leanne Watkins (LW), Chief Operating Officer, assured the Committee that support for the Committee's Business was embedded in the quality agenda and should there be any change, there would be a smooth and sufficient handover.<br><br>**Action:**<br>• Paul Deneen (PD), Independent Member, to arrange for changes to the scheduling of PODSC meetings to align with reporting to the Mental Health Act Monitoring Committee.<br><br>*The Committee **NOTED** the update.* |
| **MHAMC 0406/4** | **Other Matters** |
| **MHAMC 0406/4.1** | **Items to be Brought to the Attention of the Board and Other Committees**<br><br>There were no items identified to escalate to the Board or other Committees. |
| **MHAMC 0406/4.2** | **Any Other Urgent Business** |

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| | There was no other business raised for discussion. |
| **MHAMC 0406/4.3** | **Committee Reflections**<br><br>Paul Deneen (PD), Independent Member, reflected on a well-run meeting which was well chaired and thanked Sarah Cadman, Deputy Head of QPS and Learning, for her detailed input.<br><br>Rani Dash (RD), Director of Corporate Governance, reflected the inclusion of another Committee Member (Independent Member) would strengthen the Committee's effectiveness and this was being considered. |
| **MHAMC 0406/5.4** | **Date of the next meeting**<br>Monday 16th September 2024 |