Mental Health & Learning Disabilities Committee

Tue 17 June 2025, 13:30 - 15:45

MS Teams

Agenda

13:30 - 13:30
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Committee Chair*

1.2. Apologies for Absence

Oral *Committee Chair*

1.3. Declarations of Interest

Oral *Committee Chair*

13:30 - 13:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. Draft Minutes of 9th April 2025 Meeting

Attached *Director of Corporate Governance*

MHLD 20250617 2.1 Minutes 20250409.pdf (8 pages)

2.2. Committee Action Log

Attached *Director of Corporate Governance*

MHLD 20250617 2.2 Committee Action Log.pdf (4 pages)

2.3. Committee Forward Workplan 2025/26

Attached *Director of Corporate Givernance*

MHLDC 20250617 2.3 Cover Paper Mental Health and Learning Disability Committee - Forward Work Plan 2025-26.pdf (4 pages)

MHLD 202506217 2.3a FWP 2025-26 DRAFT (002) (002).pdf (6 pages)

13:30 - 13:30
0 min

3. ITEMS FOR DISCUSSION

3.1. ABUHB Mental Health Act Compliance Report

Attached *Chief Operating Officer*

MHLD 20250617 3.1 Mental Health Act Monitoring Report.pdf (4 pages)

3.2. HIW Mental Health Act Annual Report – ABUHB Response

Attached *Chief Operating Officer*

MHLD 20250617 3.2 HIW Mental Health Act Annual Report - ABUHB Response.pdf (5 pages)
MHLD 20250617 3.2a Appednix 1 HIW Mental Act Annual Report - ABUHB Response.pdf (6 pages)

3.3. Right Care Right Person

Attached *Chief Operating Officer*

MHLD 20250617 3.3 Right Care Right Person.pdf (5 pages)

3.4. Mental Health Services related Performance and Outcomes

Attached *Chief Operating Officer*

MHLD 20250617 3.4 Mental Health Services related Performance and Outcomes.pdf (16 pages)
MHLD 20250617 3.4a ABUHB Quarterly Performance slides March 25.pdf (10 pages)

3.5. 111 Press 2 Performance and Outcomes

Attached *Chief Operating Officer*

MHLD 20250617 3.5 111 Press 2 Performance and Outcomes.pdf (8 pages)

3.6. Assurance in respect of Mental Capacity Act and DOLS

Attached *Director of Nursing*

MHLD 20250617 3.6 Assurance in respect of Mental Capacity Act and DOLS.pdf (9 pages)

13:30 - 13:30
0 min

4. ITEMS FOR INFORMATION

4.1. Power of Discharge Sub-Committee

Oral *Chair/PoD Chair*

4.2. Mental Health & Learning Disabilities Final Internal Audit Report

Attached *Director of Corporate Governance*

MHLD 20250617 4.2 ABUHB 2425 Directorate Review MH&LD.pdf (13 pages)

13:30 - 13:30
0 min

5. OTHER MATTERS

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

Oral *Committee Chair*

5.2. Any Other Urgent Business

Oral *Committee Chair*

5.3. Date of the Next Meeting: 9th September 2025, 09.30-12.30

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

MINUTES OF THE MENTAL HEALTH AND LEARNING DISABILTIIES COMMITTEE

DATE OF MEETING	9th April 2025
VENUE	Microsoft Teams

PRESENT	Penny Jones, Chair
	Paul Deneen, Vice Chair
	Dafydd Vaughn, Independent Member
	Phillip Robson, Vice Chair
IN ATTENDANCE	Leanne Watkins, Chief Operating Officer
	Tracy Daszkiewicz, Director of Public Health
	James Calvert, Medical Director
	Rani Dash, Director of Corporate Governance
	Tracey Partridge-Wilson, Deputy Director of Nursing
	Louise Turner, Divisional Director of Mental Health and Learning Disabilities
	Rebecca Goode, Head of Operational Transformation
	Sarah Garland, General Manager, CAMHS
	Helen Dodoo, General Manager, Mental Health and Learning Disabilities
	Dr Mark Griffiths, CAMHS Consultant and Clinical Director
	Thomas Jaynes, Governance Support Officer
APOLOGIES	Jennifer Winslade, Director of Nursing

MHLD/0904/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
	Apologies for Absence Apologies for absence were noted.
	Declarations of Interest There were no Declarations of Interest raised relating to items on the agenda.
MHLD/0904/02	**Terms of Reference and Membership**

	a) Mental Health & Learning Disabilities Committee Rani Dash (RD), Director of Corporate Governance, introduced the report for information and noted the Committee's Terms of Reference had been updated to include to include Child and Adolescents Mental Health and Learning Disabilities as requested by the Board when the approved the ToR in November 2024. The Committee was assured the Terms of Reference would be reviewed on an annual basis. The Committee **NOTED** the Mental Health & Learning Disabilities Committee updated Terms of Reference. b) Power of Discharge Sub Committee Rani Dash (RD), Director of Corporate Governance, introduced the report for decision and noted a full review of the current Terms of Reference had been undertaken to ensure clarity on the role of the sub-Committee which was to provide assurance to the Board regarding the exercise of section 23 of the Mental Health Act. Paul Deneen (PD), Independent Member, acknowledged Rani Dash and the Corporate Governance team's work. The Committee **APPROVED** the revised Terms of Reference for the Power of Discharge Sub Committee.
MHLD/0904/03	**Overview of MH&LD Services and Improvement** Leanne Watkins (LW), Chief Operating Officer, introduced the presentation for discussion and acknowledged the work of the team and the improvement of the service. Louise Turner (LT), Divisional Director of Mental Health and Learning Disabilities, outlined the role and scope of in-patient and community Mental Health Services within the Health Board and the Committee was assured the service was dedicated to supporting the Welsh Government Strategy. The Committee noted the increased prevalence of Mental Health conditions across different age ranges in Gwent. The Committee noted the service worked in collaboration with engaged agencies; staff and service users had a long-term

vision for increasing community care and shared care models; the service was continuously raising public awareness across all services and there were community teams, primary mental health services and inpatient settings and specialist services.

The Committee acknowledged the journey of the service over the last 12 to 18 months and noted: the division had experience 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 the initial areas of concern. The Division had been reporting on the progress of quality, safety, and governance to various committees, including the Executive Committee, the Patient Quality Safety & Outcomes Committee, the Board and IQPD; the Health Board had contributed to the development of a paper for the Welsh Government Quality Delivery Board.

The Committee was assured that phase 2 of the Improvement Plan was underway which focussed on embedding and sustaining actions already taken and developing longer-term actions.

The Committee noted the division had undergone an end-of-year review on 6th June 2024 with the wider Executive Team and was assured progress had been made in a number of areas including, enhanced governance and visible leadership across the division; better processes for learning from deaths, and progress in delivering sustainable improvements in operational delivery. The Committee noted the improvement plan has been concluded, and was assured ongoing actions were being monitored through the Divisional Assurance process.

The Committee noted the division had integrated the Right Care Right Person with the new police and health alliance for mental health crisis management and was assured an improved discharge plan for acute inpatient care was in place. It was also noted that the Disengagement and DNA policy had been updated and was out for review.

The Committee acknowledged areas of progress.

and ongoing challenges of the division which included WCCIS challenges; recruitment and retention and estates.

Penny Jones (PJ), Independent Member, commented on the importance of the Committee understanding fully the Estate issues of the Division. PJ requested sites visits for Independent Members or for the Estates team to present to the Committee.

Action: Chief Operating Officer

Dafydd Vaughan (DV), Independent Member, commented on the WICCIS challenge and noted the importance of raising the issues, risks and staff experience of using the WICCIS system with the Board.

The Committee discussed and noted that Audit Wales would pick this up in their audit review of digital delivery, which would include speaking with staff.

Phillip Robson (PR), Vice Chair, welcomed the progress of the division and assurance on safety in a high-risk service. PR queried the role of Gwent Police and whether it would be appropriate for Gwent Police to attend the Committee for assurance and to build a relationship.

The Committee was assured that the relationship with Gwent Police was maintained through the Gwent Public Services Board. LT further assured the Committee that the Police and the Division had a positive strategic partnership.

Paul Deneen (PD), Independent Member, queried the safety of staff in the division and the incorporation of body cameras in the policies of the Health Board. The Committee noted a report had been submitted to the People and Culture Committee, which would be shared for the Committee's awareness and could form part of the Committee's workplan.

Action: Committee Secretariat/Director of Corporate Governance.

PD requested staff voices and views of the division to be part of the Committee's work plan.

Action: Director of Corporate Governance.

LT outlined the Improvement Journey to the Committee and noted in particular IMTP priorities that included: models of

care, digital transformation, workforce, partnerships, quality improvement and ministerial priorities.

The Committee discussed the assurance from the impact of special measures on the division and the Committee was assured on the improvement in organisational development and professional relationships.

The Committee received the infrastructure of the division and noted Mental Health, Older Adult Mental Health and Learning Disability Units, crisis services available in Gwent to prevent admission. The Committee was assured the Health Board worked in conjunction with Gwent Local Authorities on the Regional Partnership Board on housing services.

PD queried the outcomes on calls to the 111 option 2 facilities. The Committee requested a deep dive and further information to provide detail and outcomes.

Action: Chief Operating Officer

Helen Dodoo (HD), General Manager, presented the strategy of the division and the Committee was assured the service had undertaken substantial reviews into all four directorate areas, including engagement and feedback from individual patients, carers and Directorate staff members. The Committee noted the Directorate was developing a SMART CARE model that aligned to the strategic context and aims to ensure a high quality, safe, sustainable suite of services.

HD outlined the challenges for the PCMHSS Directorate which included: maintaining 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 Health Board area; A need to support care in communities and closer to home; The ability to recognise and predict workforce challenges across professions and the need to continue to review our model of service delivery by developing the more sustainable SMART CARE service model for the future.

HD outlined the division's Gwent Integrated Autism Service and Adult ADHD Service and the Committee discussed the significant increase in demand on both services.

The Committee noted the Learning Disabilities Directorate Strategy and an received an overview of the Older Adult Mental Health Service.

The Committee **NOTED** the presentation.

ABUHB Mental Health Act Monitoring Report and HIW Mental Health Act Monitoring Annual Report

The Committee **NOTED** the ABUHB Mental Health Act Monitoring Report had been received by the PQSOC Committee and **NOTED** the report for information.

The Committee noted the HIW Annual Report and noted the response from the Health Board would come to the next Committee meeting for consideration and approval.

Action: Director of Corporate Governance/Committee Secretariat

Overview of CAMHS Service

Leanne Watkins (LW), Chief Operating Officer, introduced the item for discussion and gave a presentation which set out improvements in the service and what the team has achieved and delivered.

Dr Mark Griffiths (MG), CAMHS Consultant & Clinical Director, noted the timeline of improvement of the service and core values and philosophy of the division.

MG outlined key achievements of the CAMHS service delivered in 2024-2025 which included: achievement of part 1B RTT waiting list target; achievement of ND RTT waiting list target alongside innovative and Wales leading transformation of assessment pathway; continued improvement to the country's most well developed single point of access system; UK wide benchmarking had shown that the division provided 26/27 elements of an idealised CAMHS offer and the only element missing was a specific BAME access which was being worked on; acknowledged Wales leads for a range of service areas and opening of Ty Fforest an innovative therapy space.

MG assured the Committee on improvement on performance indicators amidst increasing demand but conceded there were hidden internal waits. The Committee was assured these were

	being worked on and monitored by the division. MG noted the reach of the division had increased from 3% in 2013 to over 20% in 2024. The Committee was assured that there was a strong focus in all teams on preventative, early help/support and timely identification of problems and rapid initiation of interventions. The Committee was further assured by the successes and challenges of all the teams. The Committee was assured by the work of this specialist area of the division which was governed by two organising frameworks and the success and challenges of the teams and the positive impact of the team on prevention of admissions to paediatric beds and A&E attendances. The Committee noted future opportunities for the division which included a communication strategy and a CAMHS specific webpage; digital support for development of a dashboard, RPA and a patient journey tracker; staff training; accommodation solutions for more clinical spaces; pre and post diagnostic Neurodevelopment resources and the shift to a single point of access for support for neurodiversity. The Committee acknowledged the hard work, efforts and significant progress of the division. The Committee **NOTED** the presentation.
	Emerging Priority Areas for the Committee's Forward Work Plan The Committee had a discussion and noted priority areas that had emerged out of the meeting for forward planning.
MHLD/0904/04	**Power of Discharge Sub-Committee Minutes 19th November 2024** The Committee **NOTED** for information.
	Former Minutes and Action Log of the Mental health Act Monitoring Committee held on 4th June 2024 The Committee **NOTED** for information.

MHLD/0904/05	**Items to be Brought to the Attention of the Board and Other Committees** None raised.
	Any Other Urgent Business The Committee agreed for two in person meetings per annual cycle.
	Date of the Next Meeting: Tuesday 17th June 2025, 1.30pm to 4.30pm

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

Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
9th April 2025	MHLD/0904/03.1	**Overview of MH&LD Services and Improvement:** Mental Health and Learning Disability Site visits to be arranged for Independent Members, or the Estates Strategy for MH&LD to be presented to the Committee	Chief Operating Officer	17th June 2025	**Completed** Visit scheduled for Monday 1st June, to Anwylfan and Ty Cyfannol wards at YYF. Further visits to Mental Health & LD arears will be arranged later in the year.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
9th April 2025	MHLD/0904/03.1	**Overview of MH&LD Services and Improvement:** An update on the Right Care Right Policy to be provided to the Committee	Chief Operating Officer	17th June 2025	**Completed** 17th June 2025 Agenda Item
9th April 2025	MHLD/0904/03.1	**Overview of MH&LD Services and Improvement:** A report on Violence and Aggression against staff recently submitted to the People and Culture Committee to be shared with the Mental Health and Learning Disabilities Committee for awareness	Committee Secretariat	17th June 2025	**Completed** Scheduled on the Committee's Forward Work Plan
9th April 2025		**Overview of MH&LD Services and Improvement:** Staff's views and voices to be part of the Committee forward workplan especially in relation	Director of Corporate Governance	17th June 2025	**Completed** Scheduled on the Committee's Forward Work Plan

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		to performance and violence and aggression against staff			
9th April 2025	MHLD/0904/03.1	**Overview of MH&LD Services and Improvement:** A deep dive and further detail on the outcomes of calls to the Health Board's 111 Option 2 Mental Health Service to be presented to the Committee	Chief Operating Officer `	17th June 2025	**Completed** 17th June 2025 Agenda Item
9th April 2025	MHLD/0904/03.2	**ABUHB Mental Health Act Monitoring Report and HIW Mental Health Act Monitoring Annual Report** Health Board's response to the HIW Mental Health Act Monitoring Report to be included on the agenda for the next meeting	Chief Operating Officer	17th June 2025	**Completed** 17th June 2025 Agenda Item

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2025
CYFARFOD O: **MEETING OF:**	Mental Health & Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health & Learning Disabilities Committee - Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Mental Health and Learning Disabilities Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with reference to the Health Board's Standing Orders, the Health Board's Integrated Medium-Term Plan and the related Annual Delivery Plan.

The workplan is designed to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

The purpose of the Mental Health and Learning Disability Committee is to advise the Board and the Accountable Officer by critically monitoring and reviewing the way in

which the Health Board discharges its functions and responsibilities in respect of Mental Health and Learning Disabilities.

The Committee will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

As appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

In line with good governance practice, a committee forward work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business are a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. 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 Well Being of Future Generations Act – 5 ways of working	Not Applicable Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

Annual Programme of Business for 2025-26

Mental Health and Learning Disabilities Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2024/25
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Mental Health and Learning Disabilities 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. The Committee's purpose is to monitor the effectiveness and efficiency of service delivery for mental health, learning disabilities and CAMHS services and identify areas for improvement; and 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). In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurance regarding: • arrangements for discharging its functions and meeting its responsibilities regarding 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 • 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 • implementation of the National Dementia Standards within the health board.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings			
			QTR 1 Apr to June 17/06/25	QTR 2 July to Sept 09/09/25	QTR 3 Oct to Dec 09/12/25	QTR 4 Jan to Mar 24/03/26
Preliminary Matters						
Attendance and Apologies	Chair	**SI**	✓	✓	✓	✓
Declarations of Interest	Chair	**SI**	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	**SI**	✓	✓	✓	✓
Action Log and Matters Arising	Chair	**SI**	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2025/265	Chair DoCG	**AN**	✓			
Review of Committee Programme of Business 202526	Chair DoCG	**SI**	✓	✓	✓	✓
Annual Review of Committee Terms of Reference	DoCG	**AN**				✓
Annual Review of Committee Effectiveness 2025/26	Chair DOCG	**AN**				✓
Outcome of Annual Review of Committee Effectiveness 2025/26	Chair DoCG	**AN**				
Committee Annual Report 2025/26	Chair DoCG	**AN**				Q1, 2026/27
Committee Core Business						

Mental Health Act Compliance Report	COO	**SI**	✓	✓	✓	✓
Power of Discharge (PoD) sub-Committee Update	PoD Chair	**SI**	✓	✓	✓	✓
Annual Benchmarking Report	COO	**AN**				✓
Right Care Right Person Presentation Update	COO	**AN**	✓			
Mental Health Services related Performance and Outcomes, including Quality, Safety and Activity	COO	**SI**	✓	✓	✓	✓
111 Press 2 Performance and Outcomes	COO	**AN**	✓			
Assurance in respect of Mental Capacity Act and DOLS	DON	**Bi-Annual**	✓		✓	
Mental Health Estates Strategy	COO	**Bi-Annual**		✓		✓
MH&LD Division: Staff Wellbeing & Engagement	COO	**Annual**			✓	
Staff Security, including Violence and Aggression, specific to MH&LD Services staff	COO	**AN**			✓	
Assurance in respect of CAMHS Services	COO	**Bi-Annual**		✓		✓
Assurance in respect of Dementia Standards	DoN	**Bi-Annual**		✓		✓
MH&LD Divisional Risk Report	COO/ DoCG	**Bi-Annual**		✓		✓
MENTAL HEALTH & LD DIVISION: IMTP Priorities						

Models of Care	COO	**Annual**		✓		
Partnerships	COO	**Annual**				✓
Quality Improvement	COO	**Annual**		✓		
Workforce	COO	**Annual**			✓	
Digital Transformation	COO	**Annual**				✓

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
HoQI	Head of Quality Improvement for MHLD
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly

Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2025
CYFARFOD O: **MEETING OF:**	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health Act Update Report Q4 2024-25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Louise Turner, Divisional Director MH&LD

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

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 4, January – March 2025 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 higher than average, however this was in line with normal variation in activity between periods with no specific underlying reasons identified.

- There has been a significantly higher than average use of Section 4 in percentage terms, however in terms of patient numbers this was an increase from 4 in Q3 to 6 in Q4. This is monitored closely by both Health and the Local Authorities and is discussed regularly at the Mental Health Delivery Group Meeting. In most cases, use of section 4 has been directly related to the lack of availability of S12 approved doctors. As previously reported the agreement of remuneration for additional section 12 work during working hours has made some impact, with further work being led by the Assistant Divisional Director to reduce the number of detentions under section 4.

- There has been a slightly higher than average use of Section 136. No specific reason was identified for this increase. The number of repeat 136 detentions has reduced from 15 in Q3 to 9 patients in this quarter. The Adult Directorate continues to engage with multi agency partners to seek alternatives to the 136 processes for frequent attenders. Staff work with patients to promote use of core services eg via 111#2 to encourage access to services negating the need the need for S136.

- The Division has recruited 10 additional Associate Hospital Managers, and a Mental Health Act Manager Induction & Training Day was held on 18th March 2025. Hospital Managers hearings are now being held on a regular basis with 27 hearings held within the quarter. Whilst there is still a backlog of hearings with 29 currently outstanding, this has reduced from c60 cases in Q3. There are robust plans in place to conclude these by the end of July 2025.

Argymhelliad / Recommendation

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Mental Health Act (1983) Mental Health Act Code of Practice for Wales (Revised 2016)
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following
• **Workforce**	Not Applicable

• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. 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 **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2025
CYFARFOD O: **MEETING OF:**	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health and Learning Disability Division Self-Assessment against the finding of: Health Inspectorate Wales (HIW) - Mental Health, Learning Disability, Hospitals and Mental Health Act Monitoring - Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Nadine Gould, Divisional Nurse MHLD Amy Buckley, Interim Assistant Divisional Nurse

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board is now in receipt of HIW's Mental Health, Learning Disability, Hospitals, and Mental Health Act Monitoring – Annual Report 2023-24 which outlines the activity and findings from inspections conducted across Wales between April 2023 and March 2024 (Appendix 1).

The report provides insight into the challenges faced by mental health and learning disability services, including community-based care. In addition, it highlights many positive findings and acknowledges the dedication of the workforce, who continue to deliver care and treatment in an evolving landscape.

In response to the report, the Division has undertaken a self-assessment against each finding. The self- assessment has prompted several recommendations which will feed into the Divisional Improvement Plan in order to track and monitor progress against key areas identified as requiring focus and attention.

To note, a response to the CAMHs findings has not been included within this report as ABUHB does not have an in-patient provision. However, worthy of note, is Integrated CAMHS (ICAMHS) has benefited from a national focus on service improvements and additional funding. This expansion has allowed ICAMHS to create

a model with a far greater reach of CAMHS professionals than ever before. The offer now spans from upstream, preventative, early help and intervention work provided by the Part 1 teams, all the way to highly specialised and intense Part 2 functionally specific therapy teams.

Recent UK-wide benchmarking revealed that ABUHB ICAMHS provides 25 out of 27 elements of an idealised CAMHS offer, rivalling anything around the UK. It now encompasses 21 teams, which make up the whole integrated service model organised around the required Mental Health Measure framework

Cefndir / Background

In 2023-24, HIW conducted **26 onsite inspections** across a range of healthcare settings, including both NHS and independent hospitals. Two wards within ABUHB, Cedar and Talygarn, were included in the aforementioned inspections.

The wards inspected accommodated a range of patients, including:

- **Adults with mental health issues**
- **Older persons**
- **Individuals with learning disabilities**
- **Children and Adolescent Mental Health Services (CAMHS)**

The report concluded that, whilst areas of good practice were identified, there were issues identified as concern and that health boards and independent providers of healthcare need to improve upon their audit and governance processes to ensure that the areas identified within the report are addressed.

Asesiad / Assessment

As previously stated, the report sets out a number of key findings, by which the Division has undertaken a self-assessment against. Narrative has been provided to explain how the RAG rating was concluded (appendix 1).

The Self- Assessment indicated the following RAG rating:

Mental Health, including older and younger persons:

Least restrictive Care:	
Meaningful and Therapeutic Activities	
Medicines Management	
Risk Assessment and Care Planning.	
Environment of Care	
Staff and Patient Safety	
Privacy and Dignity of Patients	
Workforce	
Governance	

Learning Disabilities:

Patient and Staff Safety	
Training	

Care Plans and Risk Assessments	
Patient Information	
Use of seclusion	
Environment of Care	
Workforce	
Governance	

Monitoring the Mental Health Act 1983:

Mental Capacity	
Lawful Detention and Treatments	
Section 17(leave)	
Managers Hearings	
Ensuring Patients' Rights	
Statutory Consultees	
Audit and Governance Arrangements	

By way of governance and assurance the Divison will closely monitor and report progress against the findings via:

- Ward Managers Forum.
- Divisional QPS
- Integrated and managed via the Divisional Improvement Plan.
- Via the NHS Audit, Management and Tracking (AMAT) system.
- Patient Quality Safety Outcome Committee (PQSOC)

Patient Quality Safety Learning and Improvement Forum (PQSLI)

Argymhelliad / Recommendation

The Board/Committee is asked to:

1. Note the self-assessment, associated RAG rating.
2. Note that the recommendations and actions will be integrated within the Divisional Improvement Plan.
3. Note the governance and assurance mechanisms in place to monitor progress against the agreed recommendations and actions.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability All Health & Care Standards Apply Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Improve the access, experience and outcomes of those who require mental health and learning disability services

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	ECA – Extra Care Area DoLs- Deprivation of Liberty Safeguards MAR- Medication Administration Record MHA- Mental Health Act MCA- Mental Capacity Act ND- Neurodevelopmental PBS- Positive Behavioural Support PMVA- Prevention and Management of Violence and Aggression SMT- Senior Management Team ToR- Terms of Reference WARRN- Wales Applied Risk Research Network
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	**No does not meet requirements**

Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. 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 **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Divisional Response and RAG Rating Against the Findings of Mental Health, Learning Disability, Hospitals and Mental Health Act Monitoring - Annual Report 2023-24

Mental Health – Including Older and Younger Persons		
Finding Themes:	**RAG**	**ABUHB Response to Findings**
Least Restrictive Care:		

Use of Restraint		• The Division is engaged in National Patient Safety Workstreams for Reducing Restrictive Practice.
		• Restrictive Physical Intervention Policy is out of date and under review by Health and Safety. The existing Policy remains relevant and appropriate for use.
		• Prevention and Management of Violence and Aggression (PMVA) training is a mandatory requirement for the Division for staff working within inpatient settings. Training is provided and monitored through the Divisional Training and Development team.
		  ○ Adult Mental Health 87%
		  ○ Older Adult Mental Health 84%
		• Use of restraint is captured through DATIX. All incidents are reviewed daily for quality and monitoring purposes by the Senior Divisional Nursing Leaders. Actions are communicated back to the incident reporter and updates taken.

Use of Seclusion/ Segregation		• Designated ECA spaces to safely support those who require segregation and/or seclusion. • Management of Seclusion and Segregation Policy (including ECA) within date. • The use of Restrictive Practice Reduction plans including Positive Behavioural Support plans evident in LD. • Further audit is required for assurance that the seclusion and secretion policy is being implemented appropriately.
Meaningful and Therapeutic Activities		• There is variance in the availability of activities across all inpatient units, some with OT provision and activity programmes others without. • Petty Cash fund to purchase items support the purchasing of occupational activities and equipment. This can be utilised as and when required and is monitored by the Ward Manager. • Access to a Charitable funds account managed via the Senior Nurse

Medication Management		• All inpatient areas are audited through AMaT- which is monitored at Directorate and Divisional level. • Compliance with AMaT is a standard agenda item at Directorate/ Divisional QPS • MAR chart audit process in place across all in-patient wards. • Medics have been reminded to ensure all MAR charts are completed in full. • Health Board wide Policy has been extended to September 2025 • Weekly clinical room checks - including control drug and resus trolley audit, medication and stock check. • All registrants are expected to be compliant with Medication Management Training and attend 3 yearly update training. Compliance is monitored at ward level. • Signage is in place to remind all staff of the necessity to ensure the medication trolley is secured at all times.
Risk Assessment and Care Planning		• Care and Treatment Planning is mandated across all areas in line with Mental Health Measure and Clinical Practice - timeliness of completion of WARRN/CTP monitored. • Standardised admission pack used in AMH- to prompt completion of WARRN/CTP. • CTP and WARRN audit included in AMaT • Locally led audits of records are completed by Ward Manager and Team leaders and during line management supervision. • Annual CTP audit undertaken by Divisional audit lead. • WARRN risk assessment is mandatory for all registered staff. Compliance with WARRN training is monitored via Directorate and Divisional QPS meetings. Training dates are available and bookable throughout 2025. • Training compliance with WARRN and CTP now on ESR.
Environment of Care		• Across the Division, there is a variation in clinical environments. Challenges exist within areas that are located within older hospital sites however any issues are reported promptly • Risk assessments and environmental audits (HEB) are undertaken by the Directorate Team and Health and Safety through annual visits and bi-annual action plan reviews**.** • Risk registers are held by Directorate and Division and overseen by the Divisional Triumvirate

Staff and Patient Safety		• Personal Alarms Standard Operation Procedures in place (security person allocated on each shift which includes alarm testing) escalation of issues to directorate team. • Ligature risk assessments in place with 100% compliance across all inpatient wards within the Divison • Further exploration is underway into technological options to enhance the ligature program, such as door sensors and Oxehealth. • “Call Bell” signage is in place to enable the patient to identify more easily the location of the call bells. • Ligature cutters are available in all clinical areas adequate number of cutters are available in each clinical area and stored in accessible areas. • Ligature training is provided by the Divisional training department.
Privacy and Dignity of Patients		• Patients have free access to bedroom space • Vision panels are able to close during personal care. • Individual issues continue to be addressed via individualised risk assessments and care planning.
Workforce		• All Ward establishments have been reviewed during January 2025 and adjusted accordingly • Work programme in place to develop Neuro Developmental pathways across primary and secondary care mental health services. This includes capacity and demand modelling. A review of staffing resources across all teams will be included in this work. • Administrative support is available across areas. • Further work required to reduce reliance on temporary staffing arrangements.
Governance		• Divisional governance structure has been reviewed and implemented 2024/25 • Introduction of AMAT, Touchpoint and Escalation processes • Policy Group Divisionally led oversight reintroduced January 2025 • Dedicated and structured formal staff meetings in place - networks and forums introduced at Clinical, Directorate and Divisional level. • Evidence that staff are encouraged to complete HB and Divisional staff surveys and to actively participant in service developments and quality improvement initiatives. • SMT visits to clinical areas to improve communication between clinical staff and management. • Introduction of the Hive for staff to share improvement initiatives, gain support and learning.

		• Although there is evidence that formal feedback via CIVICA and PROMs is obtained the engagement with this is inconsistent across clinical areas.

Learning Disabilities		
Finding Themes	**RAG**	**ABUHB Response to Findings**
Patient and Staff Safety		• There are numerous patients in the community who require DOLS applications which are yet to be completed. • DoLs application is on the risk register. • DSM is collating information in relation to DoLs applications, with a plan to address these challenges
Training		• Mental Heath Act training dates available throughout 2025. • Mental Capacity Act training available via MCA team. • All registered staff have received Mental Health Act training.
Care Plans and Risk Assessments		• PBS plans continue to be updated as required following weekly MDT meetings and will be reviewed as part of weekly checks. • Where a patient has received IM medication in restraint on 2 occasions, a PBS plan will trigger a review. The PBS plan is updated to include the risk assessment to guide future practice, the threshold for further review if required outside of the weekly MDT meeting. • Risk assessment and PBS include the identification of triggers.
Patient Information		• A personalised timetable is completed weekly for each individual. • 'Mutual Help' are now established meetings & continue to be held every Monday where the week's activities are discussed and planned. • Language choice & preference is recorded in person's records. • 'Top Tip Tuesday' briefing poster circulated within the Division to remind staff of the importance of recording language & communication choices.
Use of Seclusion		• Audit of clinical record keeping to ensure use of seclusion and rationale documented. • Seclusion care plans in place • Incidents of seclusion discussed via touch point. • Further audit is required for assurance that the seclusion and secretion policy is being implemented appropriately
Environment of Care		• Environmental Weekly Check and Garden Risk Assessment in place

		• Estate issues are raised immediately which are triaged for urgency, appropriate staff attend to resolve the issue as soon as possible. Any delays are escalated via the Directorate/Divisional Management team.
Workforce		• The OT resource has been increased to support more time whereby they are ward-based. • SALT assessments are conducted in person. • Recent establishment review completed.
Governance		• Specialist equipment requests are managed through OT Lead- no delays noted in accessing necessary equipment. • Risks continue to be formulated in the WARRN and management plans reviewed at the weekly MDT meeting. • PBS plans continue to be updated as required following weekly MDT meetings, reviewed as part of weekly checks. • Assurance provided that PBS plans are being completed.

Monitoring the Mental Health Act 1983		
Finding Themes	**RAG**	**ABUHB Response To Findings**
Mental Capacity		• Mental Capacity Act training available via MCA team. • MCA to provide Divisional training compliance. • Further assurance needed on - Capacity to consent assessment during first 3 months of treatments
Lawful Detention and Treatments		• Mental Health Act training dates available throughout 2025. • Mental Health Act Administrator supporting mock HIW audits. • Mental Health monitoring committee TOR and agenda agreed. • Paperwork sent to Mental Health Act administration for scrutinization. • Responsible Clinician and Approved Clinician Policy updated and published on intranet Jan 2025. • Assurance provided that consent to treatment forms are stored with medication charts.
Section 17 (leave)		• Establishment reviews have recently been undertaken of inpatient areas to ensure safe and effective staffing levels- this allow section 17 to be facilitated to support recovery. • A checklist has been developed to identify whether patients have been offered a copy of the Section 17 form. • Assurance provided in respect of

		○ Full completion of section 17 paperwork ○ CTO considered after 7 days section 17 leave. ○ Section 17 in place for emergency leave
Managers Hearings		• 12 new recently appointed hospital managers • Significant progress has been made working through the back log and ensuring hearings are undertaken in a timely manner.
Ensuring Patients' Rights		• Evidence that patient rights are read on a weekly basis. • Verbal and written information shared with patients. • Offered advocacy and IMHA attend wards
Statutory Consultees		• Procedures on Second Opinion Approved Doctor visits (SOAD) updated and published on intranet Jan 2025 • The 2 statutory consultees are documented on the SOAD request form at the time of application.
Audit and Governance Arrangements		• Ongoing Mock HIW audits- Mental Health Act Administrator in attendance. • Mental Health Act paper is monitored and audited via Mental Health Act Administration department. • Mental Health Act Monitoring Committee TOR and agenda are currently being reviewed. • Further assurance is required to - Ensure that the auditing of MHA/MCA is routinely undertaken in clinical areas.

Right Care, Right Person - Gwent implementation overview

17 June 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Iechyd Meddwl ac Anableddau Dysgu Gwent
Mental Health & Learning Disabilities Gwent
Cyflwyno Gofal sy'n Canolbwyntio ar yr Unigolyn a Thosturiol
Delivering Person Centred & Compassionate Care

Bee-ddwch y Newid
Bee the Change
Iechyd Meddwl ac Anableddau Dysgu
Mental Health & Learning Disabilities

Our strategy has been to improve Health, Social care, and Police responses in Gwent via the RCRP phased roll out

- **Phase 1** focuses on Concern for welfare *(Autumn 2024).*
- **Phase 2** addresses AWOL and walk outs *(Winter 2024)*
- **Phase 3** deals with Transportation and Conveyance *(Summer 2025).*
- **Phase 4** covers Section 136 & voluntary mental health patients *(Spring 2025)*

Joint Collaborative Approaches

- There is ongoing collaboration with Gwent Police and Local Authorities, with monthly meetings supporting the phased RCRP rollout.
- This collaboration recognises the Police's role in high-risk incidents and mental health crises.
- Positive feedback has been received from multi-agency work on Phases 2 and 4, leading to growing confidence in RCRP roll out/handling complex scenarios.
- Key policies are being finalised post-RCRP launch, including an updated Missing & Absconder Policy ratified 15/05/25 by the – Clinical Standards & Policy Group.
- Section 135/136 protocols have been enhanced, and preparations are underway for the rollout of Phase 3 (Conveyance/Transport).
- The overall aim is to strengthen frontline response by aligning health, social care, and police in crisis response, and equipping wider teams with shared tools and approaches to manage incidents, supporting RCRP threshold changes.

Strengthening frontline response with training & skills development

- RCRP training and skills development aim for improved response coordination in real-time crisis situations and a shared definition of ‘immediate risk’.
- This will reduce ambiguity and support confident decision-making.
- Scenario-based incident sessions will be used to clarify roles and police thresholds.
- The training will also address gaps in information sharing and escalation and introduces joint de-escalation and communication training.

RCRP Next Steps

- Next steps for RCRP include further refining inter-agency working processes and ensuring timely, appropriate support access.
- The goal is to prevent duplication and enhance risk assessment.
- There will also be a streamlining of mental health referral pathways for Police, partners, and Primary Care.
- The exploration of community-based ‘Places of Safety’ and the design of a Single Point of Access (SPoA) are also underway to support therapeutic alternatives to custody, ED or admission.
- Phase 3, will focus on Conveyance and Transport, which has been deferred due to its complexity. It involves coordination with WAST and JCC, with regional teams ensuring best practice.

Mental Health Services related Performance and Plans

Mental Health & Learning Disabilities Committee

17th June 2025

Mental Health Services related Performance and Plans

Part 1: MH&LD Performance & Plans

Part 2: CAMHs

Part 1: MH&LD Performance & Plans

Progress of Divisional Priorities for 2024/25

Models of Care

- Workshops to develop models for Inpatient services with focus on models of recovery, rehab and maintenance. Where possible, directorates have identified that wards would be more effective and provide better patient safety if co-located.
- In line with the MH&WB Strategy, the division are developing the Single Point of Access.

Quality Improvement

- Inpatient (QPS) reviews completed for all wards.
- Baseline data capture for Enhanced Services
- Engagement in the National Patient Safety Programme
- Nursing Establishment Reviews completed
- Establishment of the QI-nnovation Hive in November.
- Divisional Strategy workshops completed, delayed until September due to release of Welsh Government Mental Health and Wellbeing Strategy

Ministerial Priorities

- Completion of Part 1a and 1b action plans to meet ministerial targets and transform ways of working.
- Review of Psychological Therapy waiting lists and commence action plan.
- Review Memory Assessment Services waiting lists.

Digital Transformation

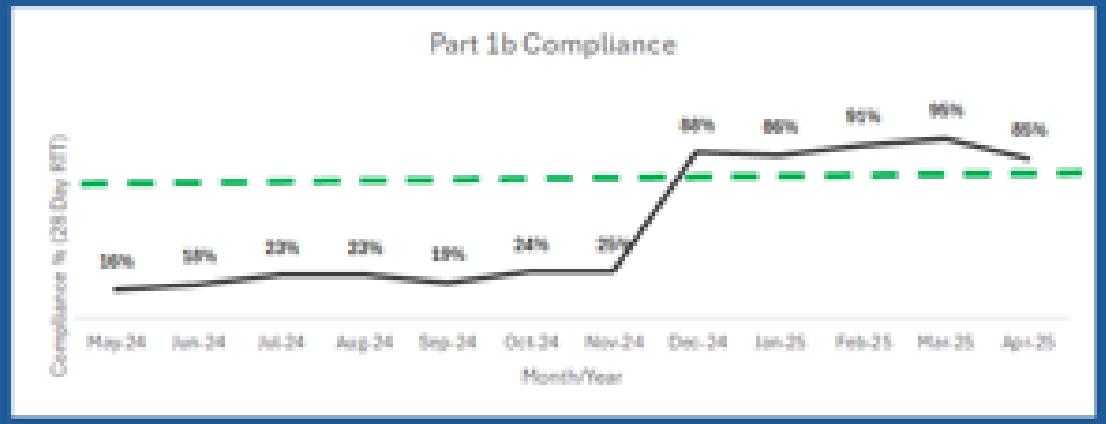
- Division fully engaged with new Electronic Patient Record.
- Implementation of RPA into PCMHSS, as a result average time between receiving referrals and processing has reduced from 35 days to 0.5 days.

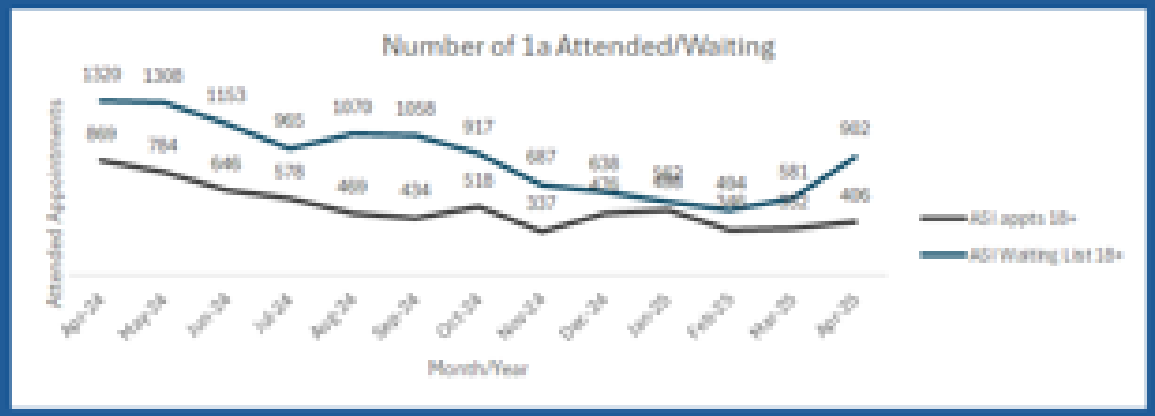
Neurodevelopmental Services

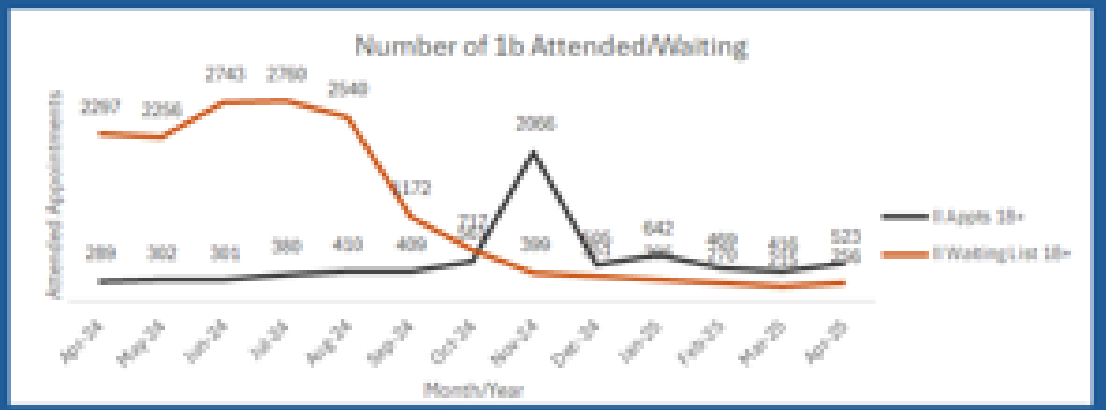
- Reviewed interface with CMHT services and Neurodevelopmental Services. Co-location of IAS and ADHD services.

ABUHB Part 1 and Waiting Lists

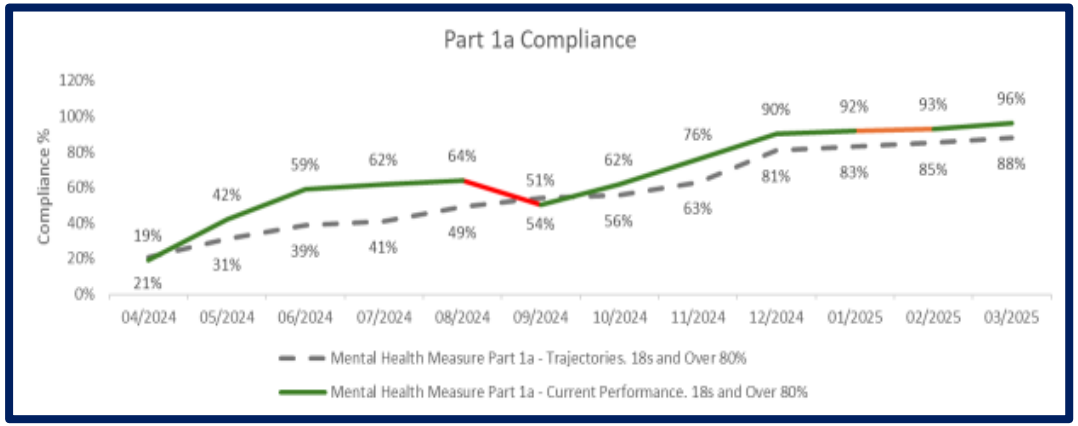
Adult

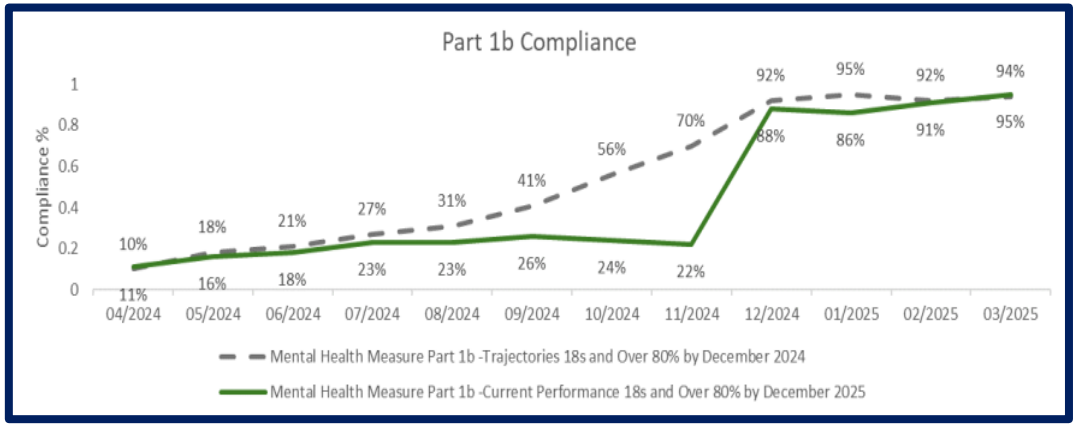


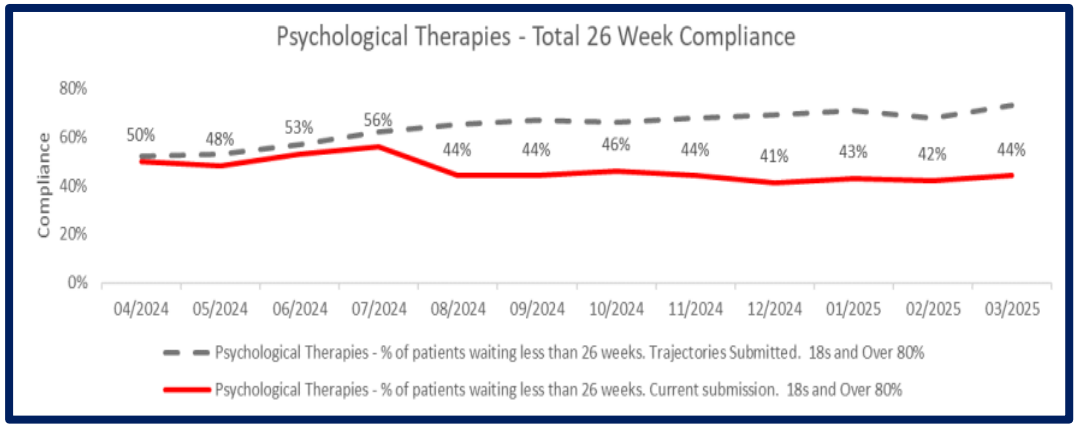


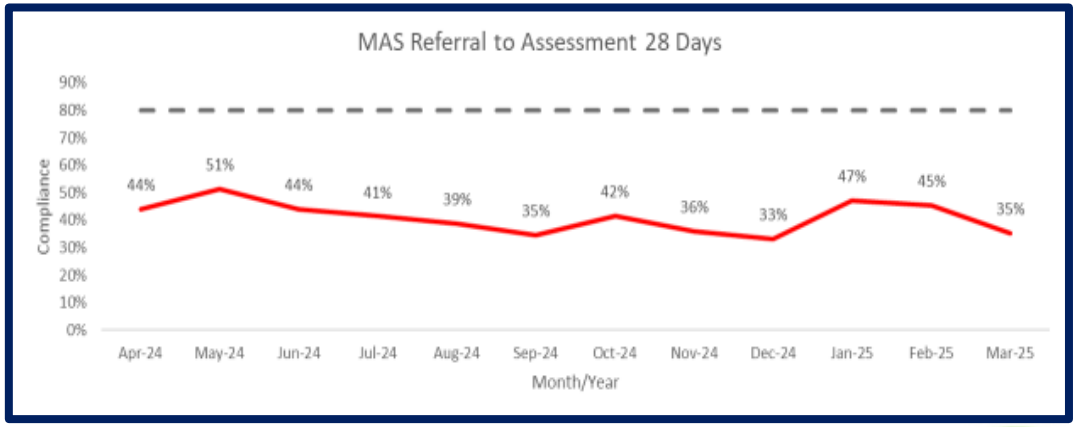


ABUHB Part 1 – Compliance

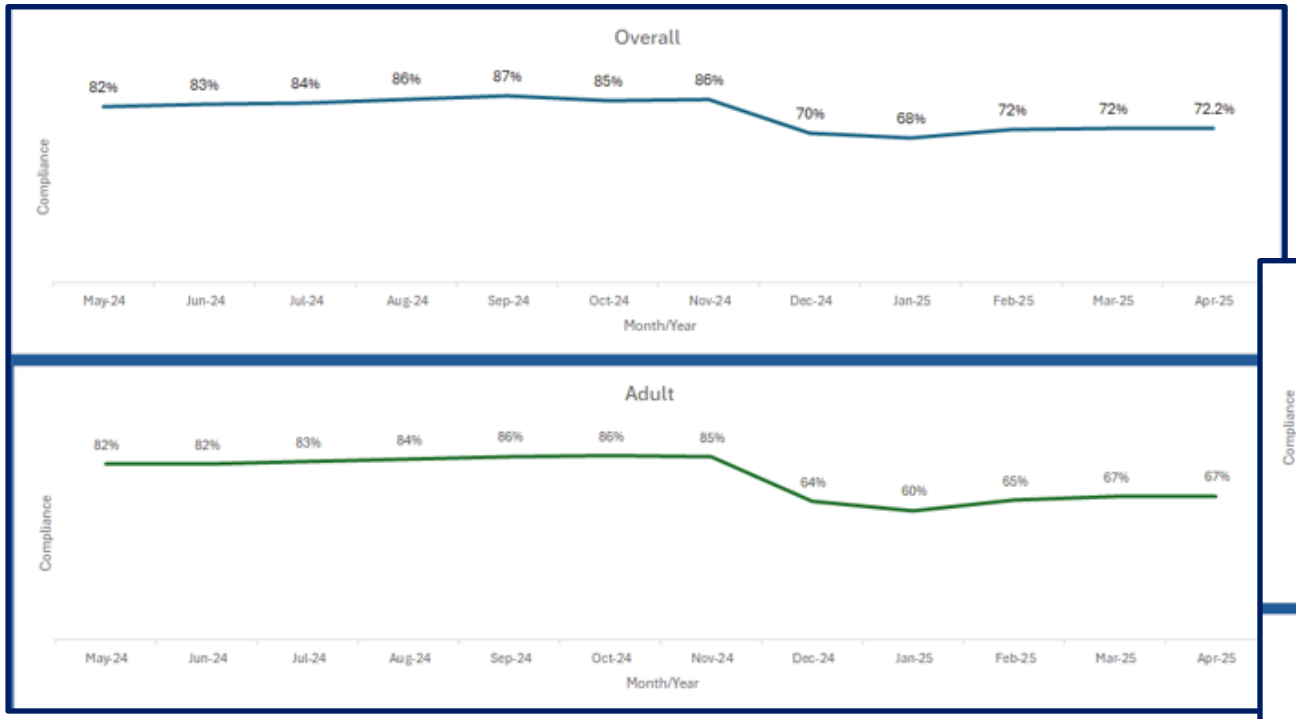


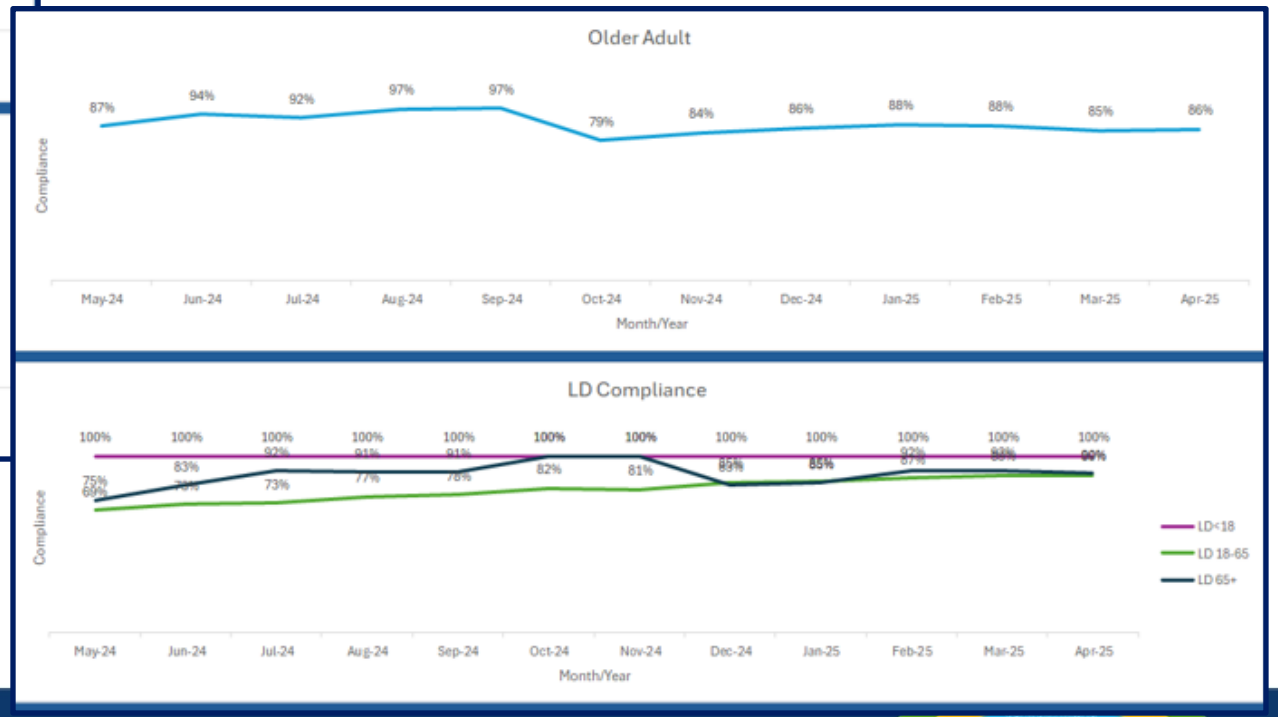




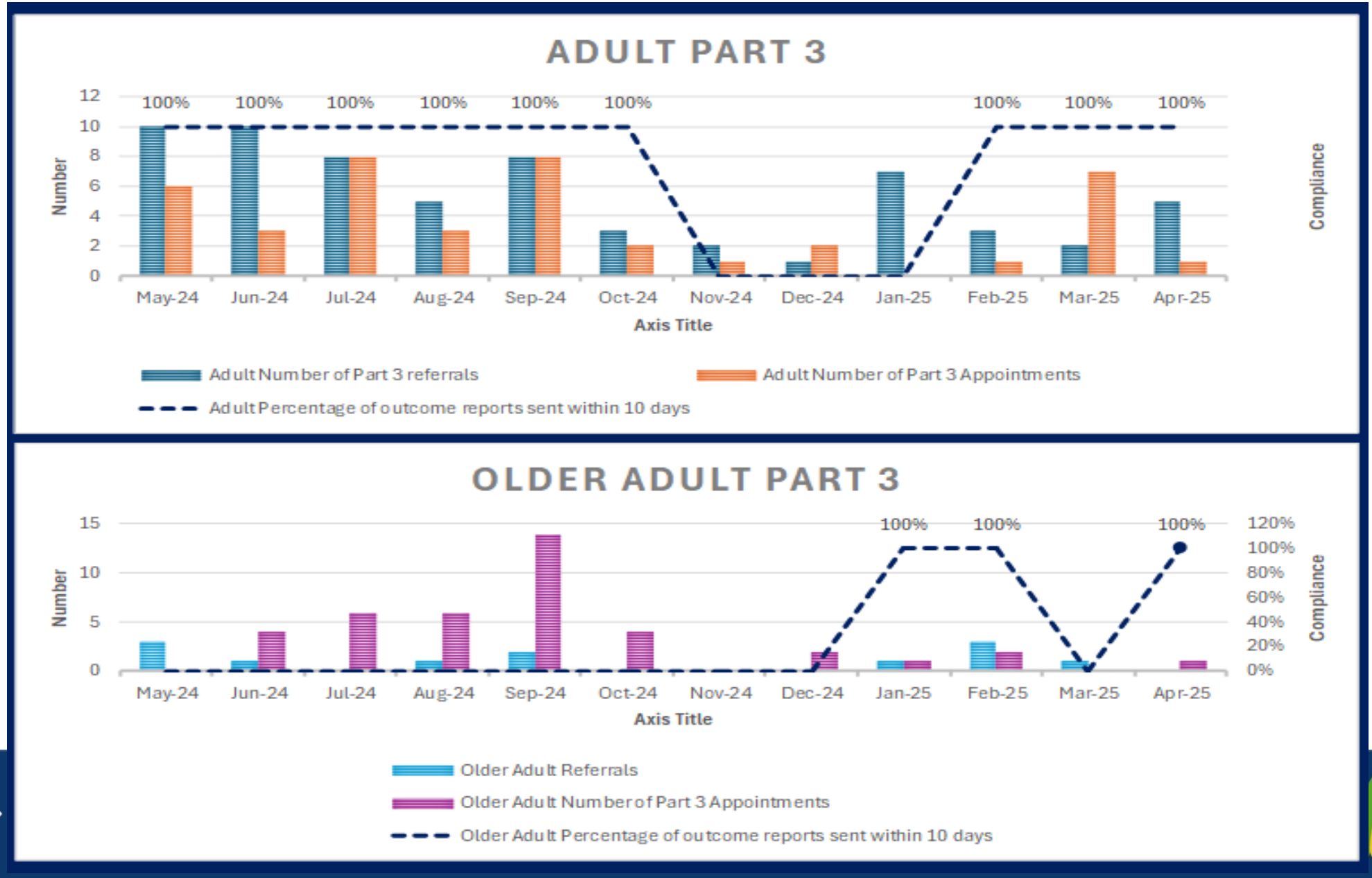


Mental Health Measure Part 2: CTP Submission Proforma





Mental Health Monitoring (Part 3)



Part 2: CAMHs

CAMHS performance descriptor

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

Performance Descriptor	Target	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
CAMHS Referrals Received		46	47	40	58	41	47	62	66	46	54	40	50	55
CHOICE CAMHS RTT %	80%	100.00 %	95.45%	92%	97.22%	86.36%	94.73%	100%	88.57%	100%	83.33%	94.28%	94.28%	95.00%
CTP %	90%	72%	75%	79.3%	80.1%	81.4%	98.00%	94%	100%	98%	98%	98%	98%	96.00%
CHOICE to NCP Conversion Rate	65%	77.35%	62.82%	79.54%	84.12%	73.84%	85.48%	76.92%	72.88%	71.21%	77.92%	79.68%	79.68%	68.96%
ND RTT %	80%	40.39%	40.34%	38.50%	43.29%	41.58%	47.71%	49.23%	53.15%	51.08%	61.36%	74.75	81.41%	81.38%
ND Referrals Received		243	263	253	281	81	189	218	268	237	284	359	388	258

PCAMHS	Target	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
1A Referrals Received		141	146	123	129	93	78	147	96	108	161	125	102	109
Part 1A MHM (appt attended within 28 days of referral)	80%	82.11%	86.17%	86%	94.26%	100%	94.73%	98.57%	91%	98.66%	81.43%	87.30%	81.25%	83.61%
Part 1B MHM 28 days following IA	80%	4.00%	0.00%	5.3%	4%	5.76%	2%	10%	25%	84.74%	84.21%	81.96%	84%	82.67%

Section 136 Data *(Obtained from MHA office)*	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
	0	3	4	2	4	1	2	5	2	1	2	3	2

Part 1 Compliance

- Since PCAMHS has aligned with ICAMHS, the service has increase the Initial assessment (IA) RTT compliance to meet/exceed the 80% target and has continued to sustain.

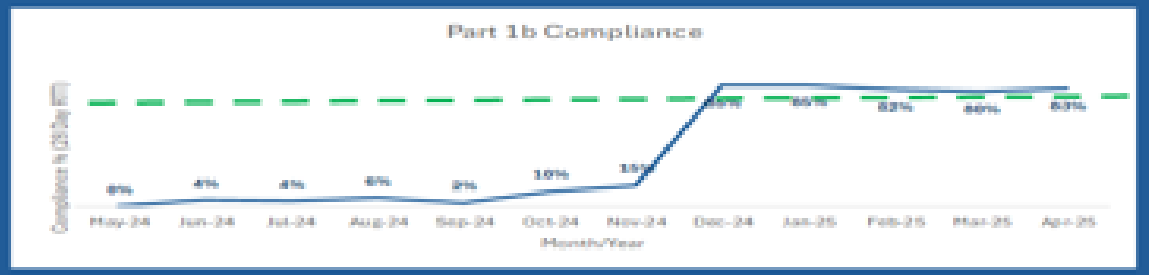
- Service-wide effort since Sept 2024 has significantly reduced the backlog intervention waiting list from approximately 600 to 24 patients currently waiting for their Initial Intervention (II) appointment.

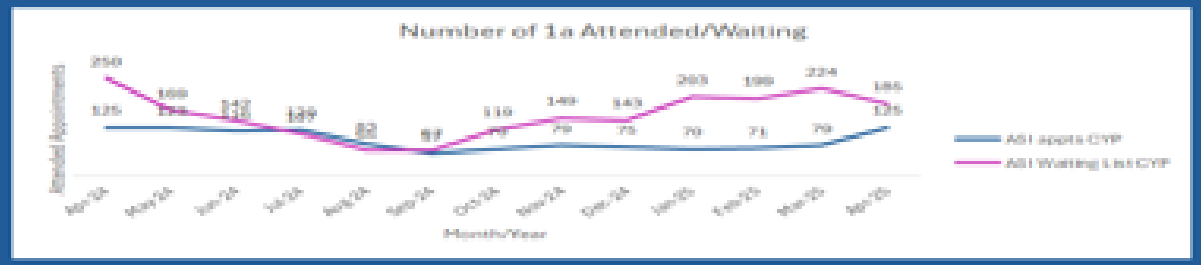
- The Launch of the 1+1 model effective from 4th September 2024. The initiative is to offer the +1 initial intervention within 28 days of the Initial Assessment. This has allowed PCAMHS to meet the 80% compliance target for 1b and sustain since December 2024. Wellbeing booklets introduced as part of the key intervention - one for younger and another for older young people.

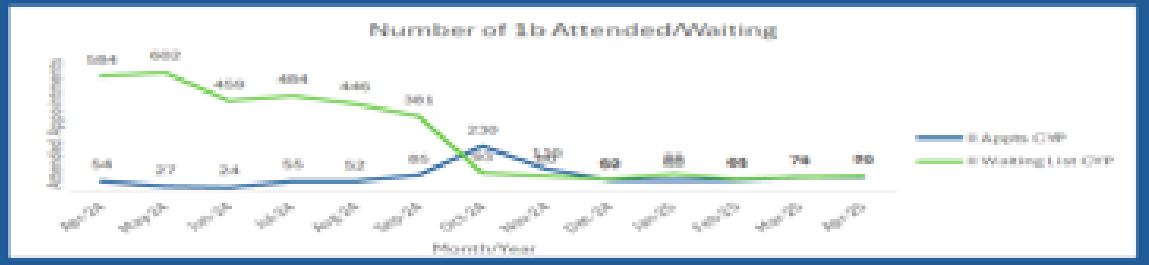
- There have been issues in terms of the recording of appointment/clock adjustments incorrectly which in March showed that the compliance for Initial Assessment (1A) hadn't been met (77%) - extensive communication and training of recording adjustments/appointments correctly which has mitigated the issue for April.

CAMHs Part 1 and Waiting Lists

CYP







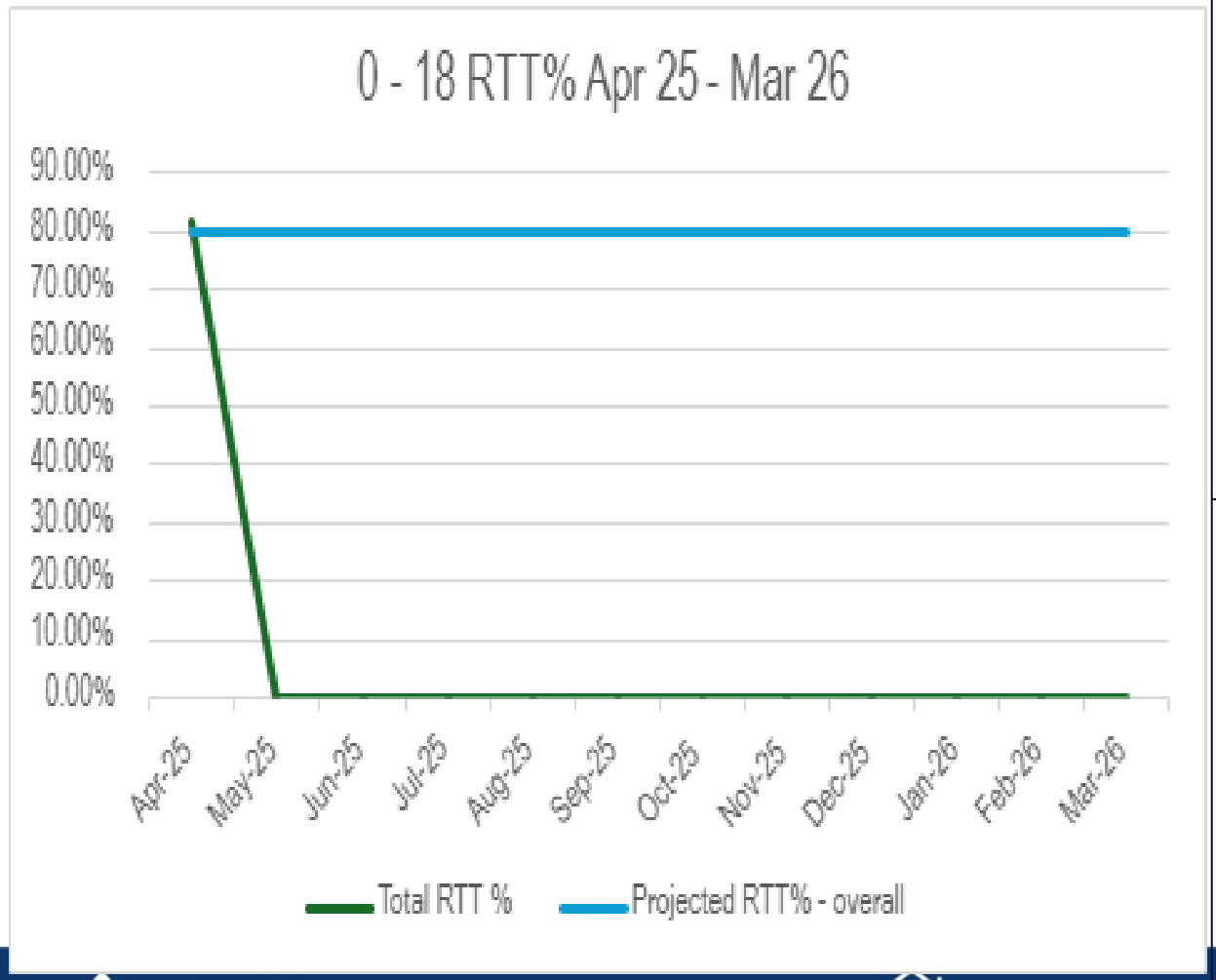
CAMHS Service Outcome Measures

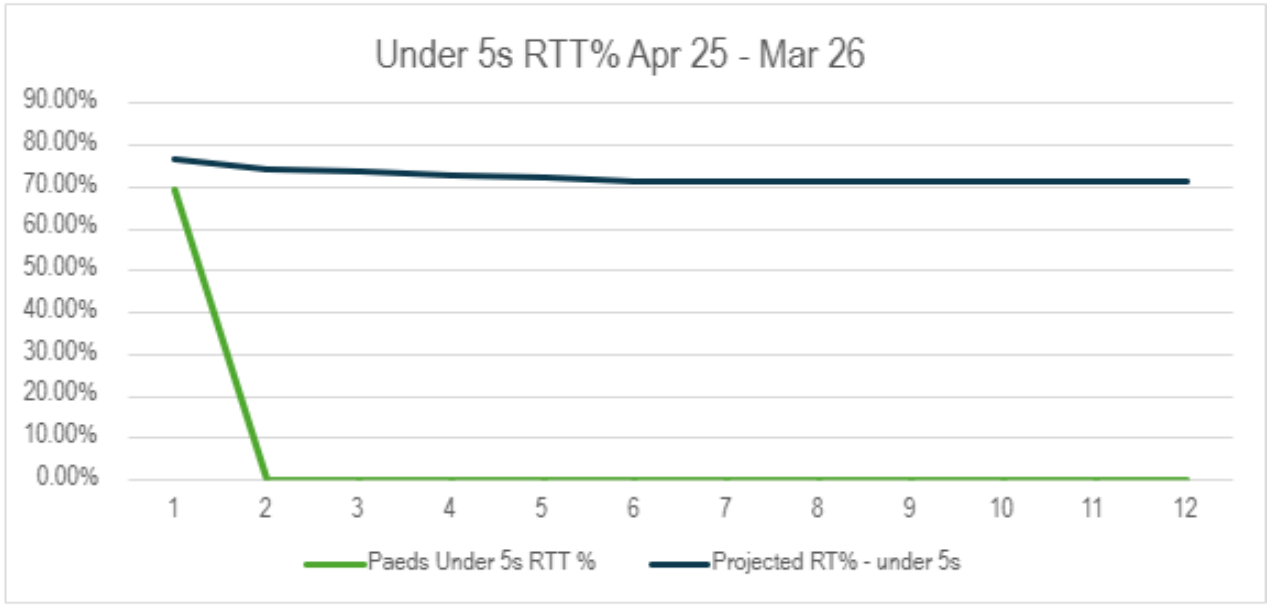
- Outcome Measures are used in the form of PREMs & PROMs – these are not being used consistently across the Service. Commitment to using a CYP-rated measures:
  - Global Based Outcome (GBO)
  - The Children's Global Assessment Scale (CGAS)
  - Strength and Difficulties Questionnaire

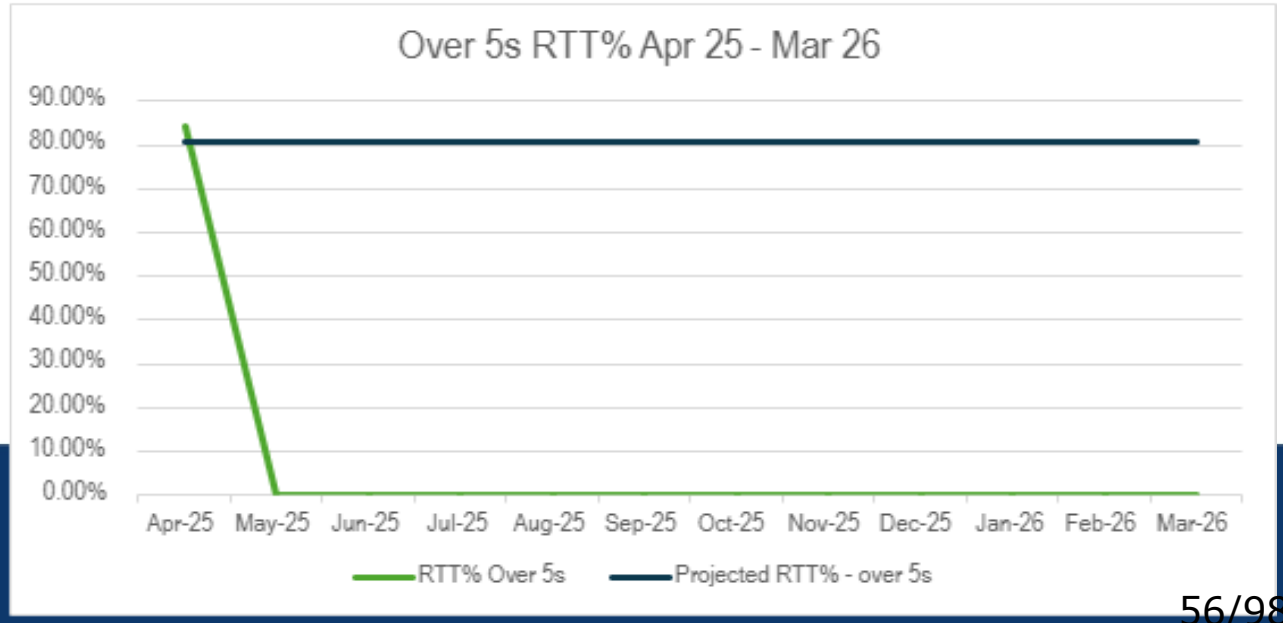
- An aim to have satisfaction measures complete using the Continuing Health Improvement Experience of Service Questionnaire (CHI-ESQ)

- The SIM and Team Leads are undertaking data recording/outcome work - quarterly audit/data gathering to be reported back to Teams and SMT to constructively inform our practise/service provision.

ND Performance







ND Performance

Improvements:

- The support of Welsh Government funding to increase ND Clinics to take place in evenings and weekends reducing waiting times and work towards meeting RTT target.
- Multi-disciplinary team to support children aged 5 years and younger on the waiting list: data indicates a reduction of 50% in the number of children aged under 5 years waiting as of April 2024 for an assessment. Longest weeks waiting = 40
- NESH (Neurodiversity Early Support Hub) in place as of 14th April 2025: early screening of referrals.

Opportunities:

- Changes to accepting for ND assessments i.e. only accepting children aged over 2.5 yrs
- Under 5s T&F group in place to look at pathway / referral form & questionnaires

Initiatives in Place: New Profiling Tools: ESSENCE D and QB Check

Initiatives to be explored:

- Robotic Process Automation (RPA): Automation of administrative tasks
- CONNECT Plus App: Real-time tracking of a child's appointments and updates on the process can enhance communication and transparency between families, clinicians, and education professionals.

Impact:

- Increasing Demand: Continuous rise in demand for assessments may outpace capacity improvements, leading to persistent backlogs.
- Resource Constraints: Limited resources and administrative support can hinder the implementation of new tools and processes.

Questions?

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Quarterly Performance Review
Mental Health & Learning Disabilities

Aneurin Bevan University Health Board
Adult and Older Adult

28th March 2025

Information reported as to January 2025
Information used for NHS management purposes only –
not to be disseminated

Mental Health– Adults & Older Adults (January 2025)

Healthboard	Part 1 Ref:		Part 1A (80%)		Part 1B (80%)		Part 2 (90%)		Part 3 (100%)		Psychological Therapies (80%)
	Adult	Older Adult	Adult	Older Adult	Adult	Older Adult	Adult	Older Adult	Adult	Older Adult	
Aneurin Bevan	1212	69	92.2%	96.1%	86.8%	80.8%	60.2%	88.4%	-	100.0%	42.5%
Betsi Cadwaladr	1002	103	69.5%	75.0%	66.8%	86.7%	82.6%	88.3%	75.0%	-	62.8%
Cardiff and Vale	1288	55	41.8%	23.1%	99.4%	100.0%	57.5%	75.2%	78.6%	-	70.8%
Cwm Taf Morgannwg	1045	52	89.9%	92.0%	99.7%	100.0%	85.5%	90.5%	-	-	56.4%
Hywel Dda	299	29	95.8%	100.0%	92.9%	87.5%	93.1%	97.4%	88.9%	100.0%	64.5%
Powys	64	13	56.7%	70.0%	77.9%	100.0%	82.7%	71.7%	-	-	66.4%
Swansea Bay	581	42	95.1%	100.0%	93.5%	100.0%	93.3%	97.8%	-	-	52.0%
All Wales	5491	363	73.8%	76.6%	86.7%	88.8%	74.7%	86.4%	81.5%	100.0%	56.3%

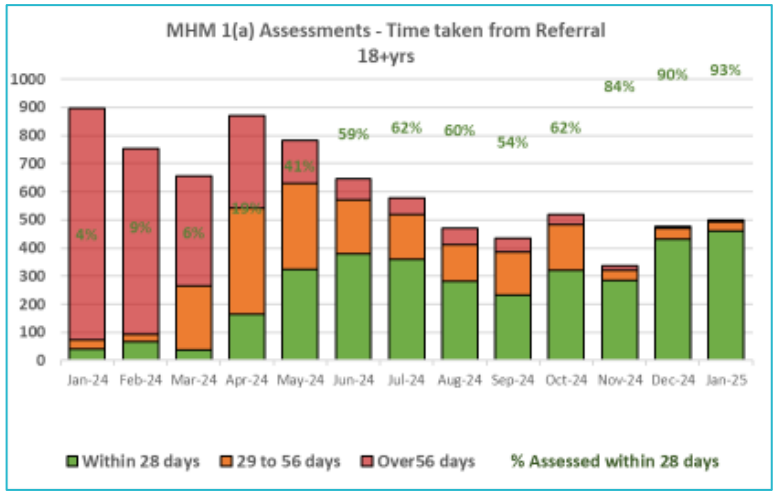
Assurance:

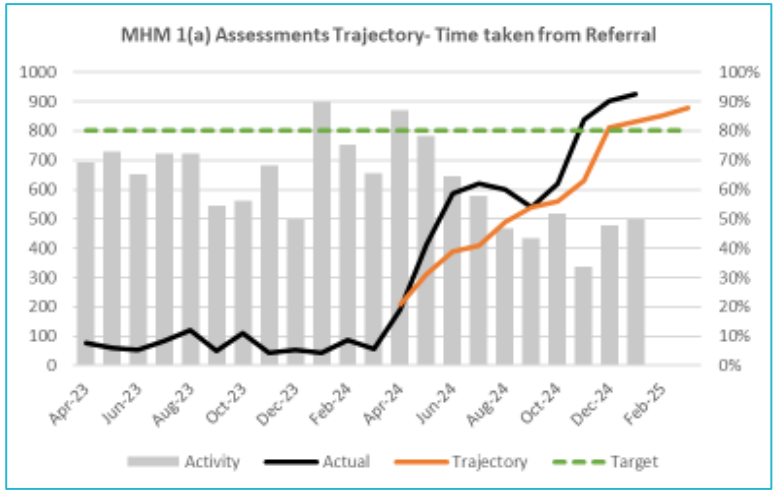
- Part 1 A and B sustained and improved performance.
- Part 2 adult drop in performance
- Psychological Therapies

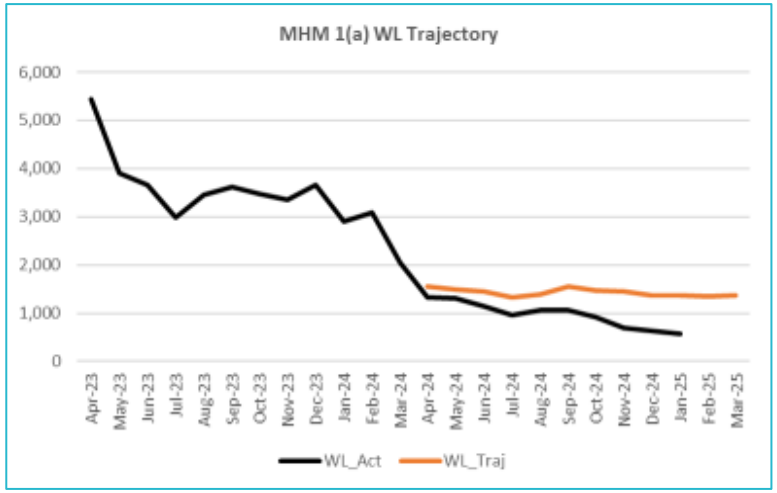
Mental Health - Part 1A

Assurance:

- Further improvement in Adult. Overall figure 93% meeting performance target
- Waiting list below trajectory







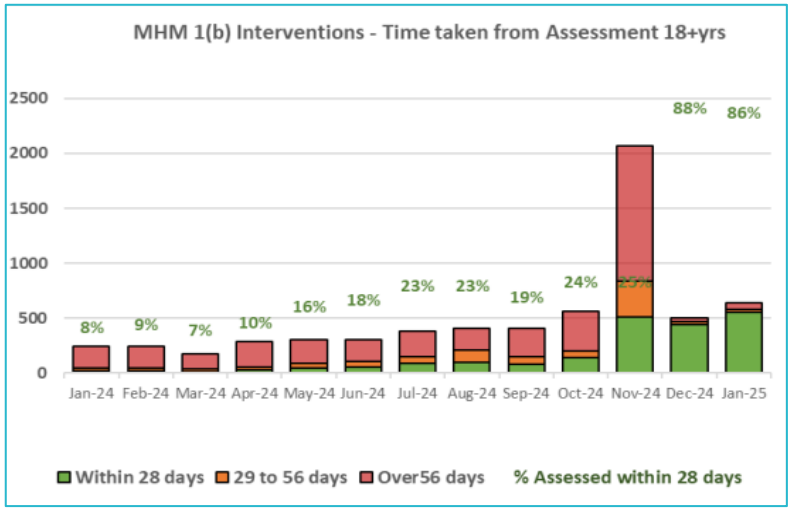
Mental Health- Part 1B

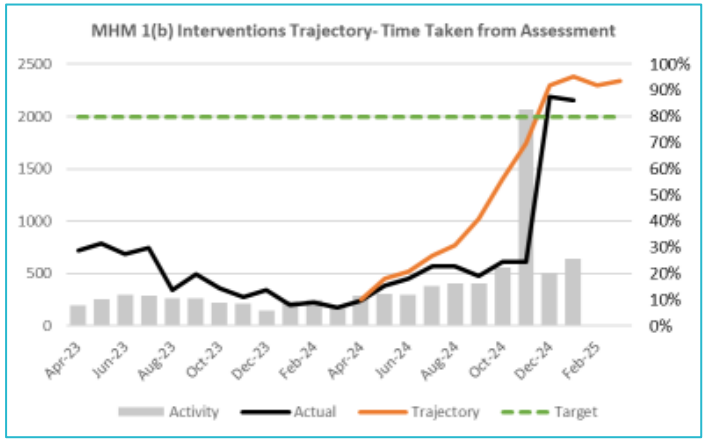
Assurance:

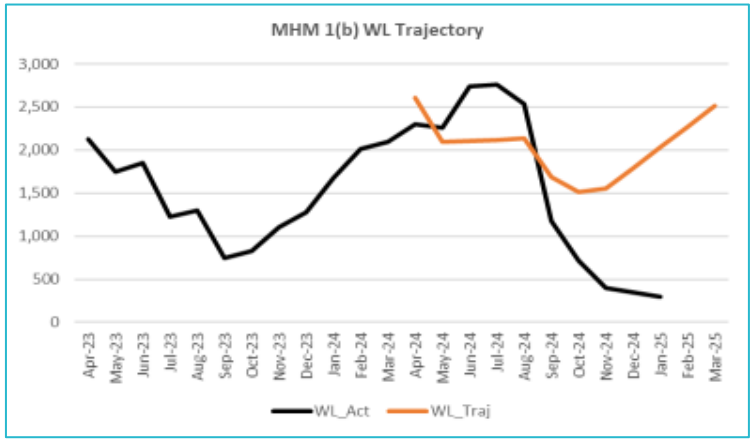
Sustained performance.

Questions:

- Update on ongoing intervention waiting list







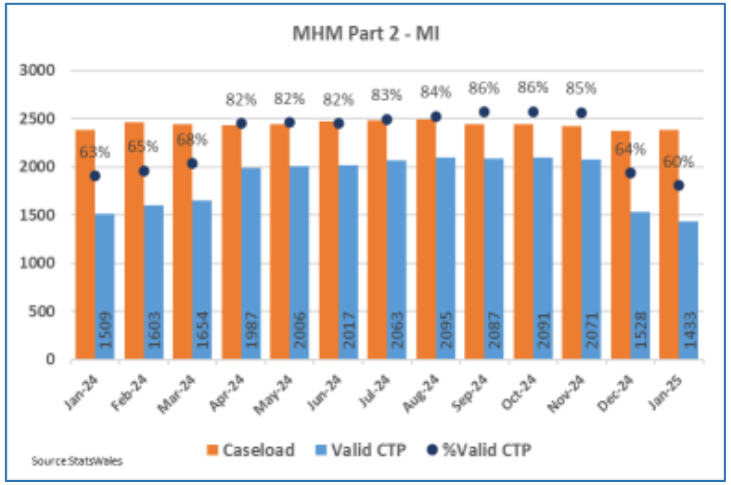
Mental Health- Part 2

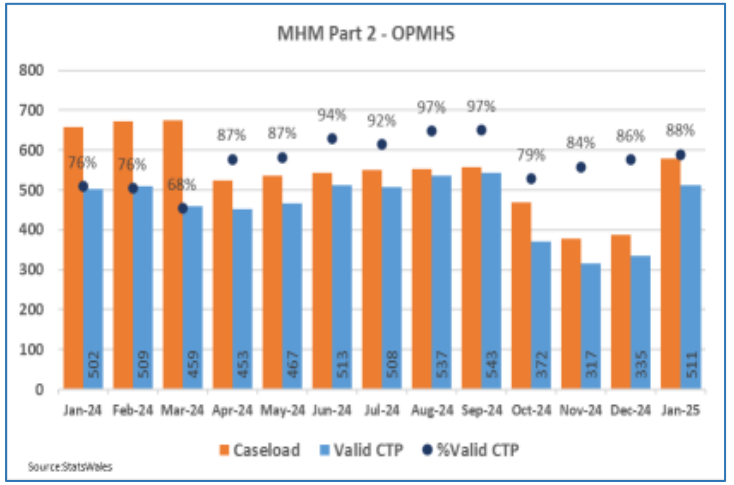
Assurance

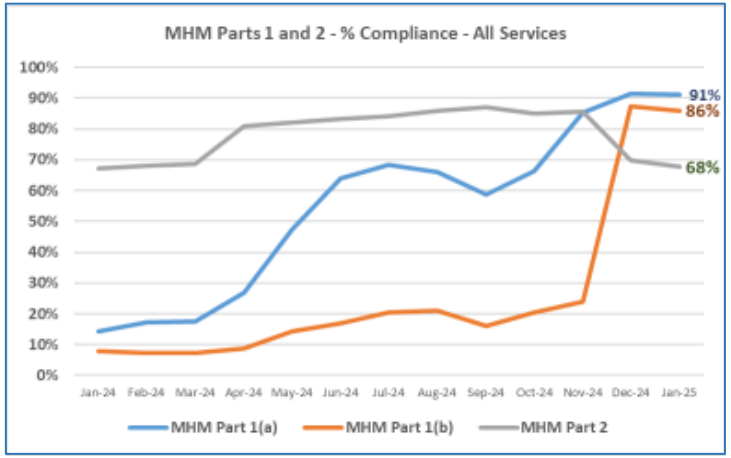
- Part 2 adult performance has dipped further to 60% 946 without a valid CTP

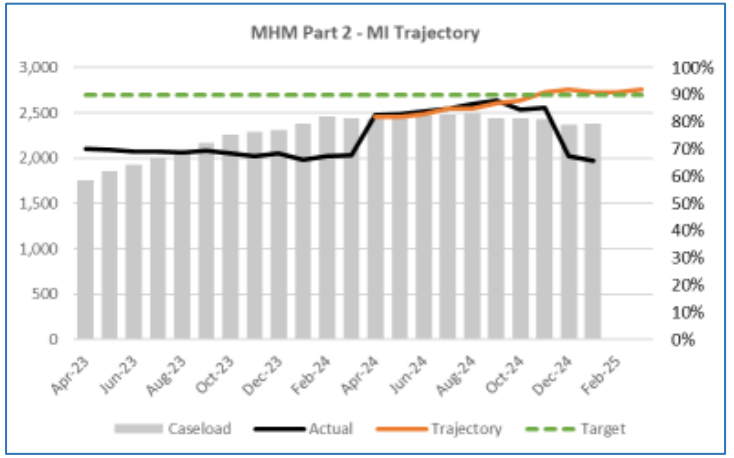
Questions

- Update on action plan to improve CTP compliance post cleansing exercise









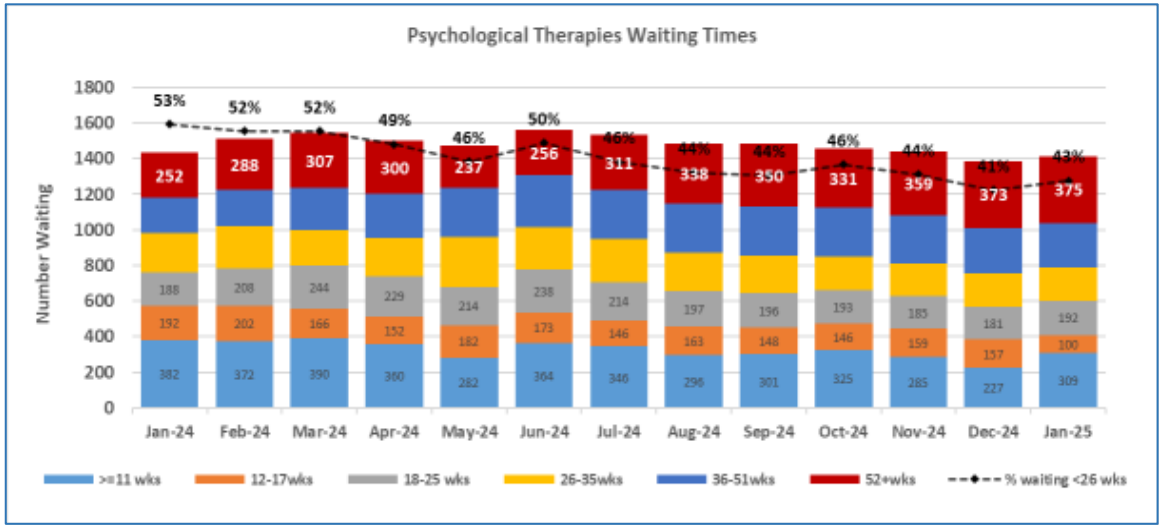
Mental Health- Psychological Therapies

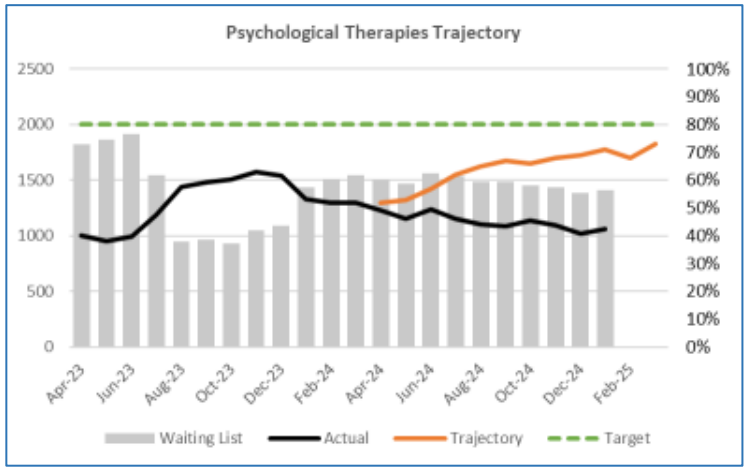
Assurance:

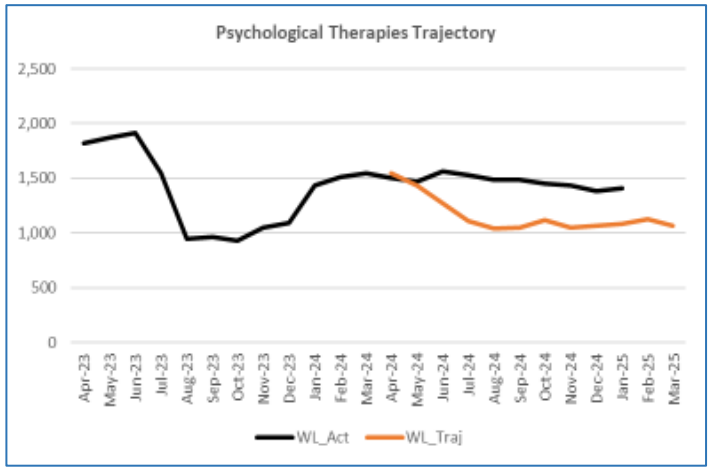
Performance slightly improved at 43% and remains under projected trajectory.

Questions

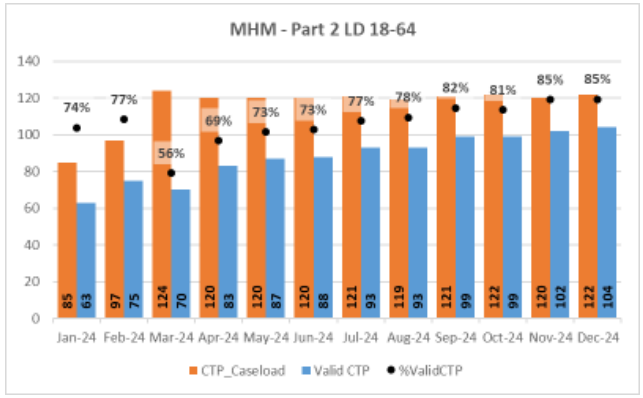
- How are intensive courses progressing? what impact is this having? Any feedback?
- Update on proposed 30,60, 90 day plan discussed at last meeting

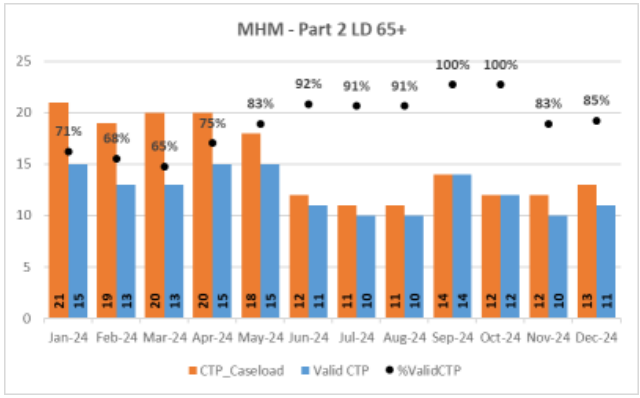






Learning Disability Adult January 2025



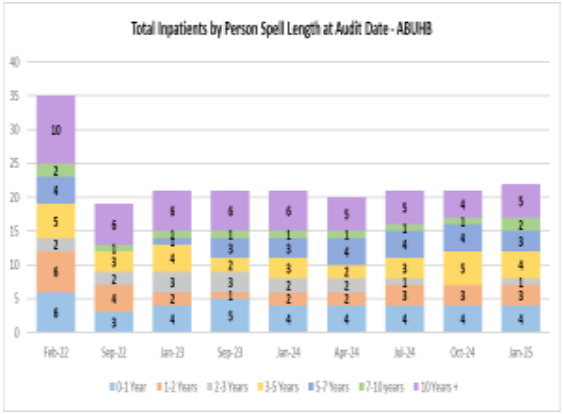


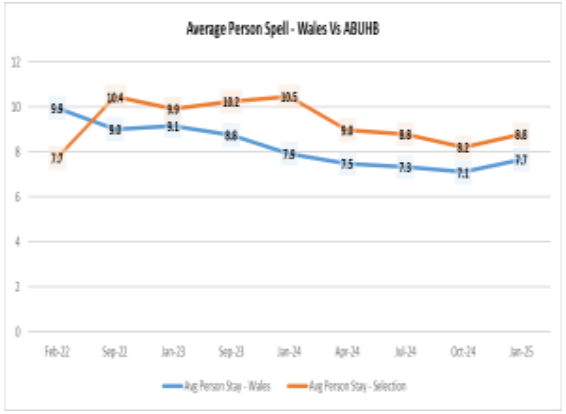
Performance and Quality Assurance

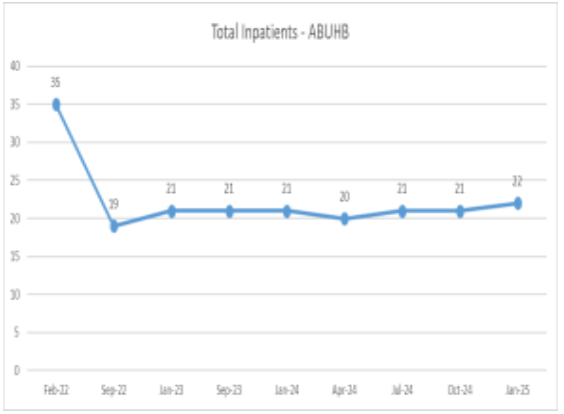
Part 2 small numbers
18-64 (85%). 18 with no valid CTP.
65+ (85%) in target. 2 with no valid CTP.

Specialist Inpatient Bed occupancy- (data as of 08/10/24)
22 patients in inpatient beds

Person Spell- (data as of Jan 25)
22.7% of patients in hospitals over 10 years.
Average person spell increased.







Pathway of Care Delays MH&LD February 2025

Mental Health		Learning Disabilities	
Delay Reason	No. of Patients	Delay Reason	No. of Patients
Awaiting completion of assessment by social care	1	Awaiting start of new home care package	1
Awaiting completion of arrangements prior to placement	2	Awaiting completion of arrangements prior to placement	1
Awaiting nursing/residential home self-funding	1		
Awaiting extra care/supported living availability	6	1Awaiting extra care/supported living availability	1
Awaiting Mental Health bed	1		
Homeless	3		

	Mental Health		Learning Disability	
Month	Jan 25	Feb 25	Jan 25	Feb 25
ABUHB	13	14	3	3
All Wales	124	131	17	18

Key
POCD figure remained the same
POCD figure increased
POCD figure decreased

Performance and Quality Assurance

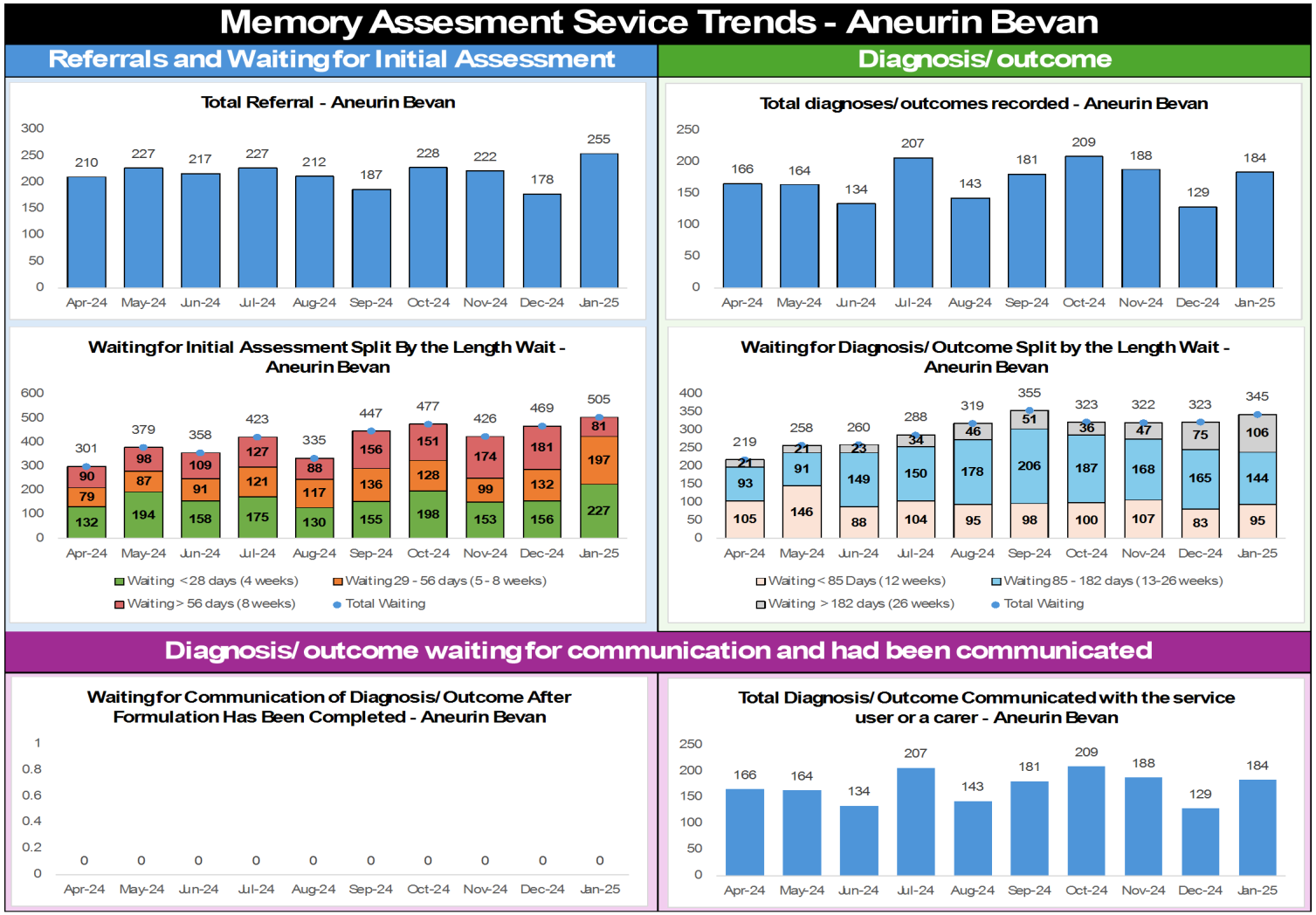
MH- Awaiting extra care/ supported living arrangements continues to be most reported reason for delay

LD – 3 delay reasons.

MAS

Assurance:

- Highest volume of referrals received through the year.
- Increased number of initial assessments completed <28 days. Reduction in those waiting >56 days.
- Those waiting for diagnosis has increased with 106 waiting over 26 > 26 weeks.



AOB

111p2 Performance and Outcomes 2024/25

MH&LD Committee - 17 June 2025

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2024/25 Key performance headlines

111p2 call flow efficiency and effectiveness
- 4% of well-being practitioner calls escalate to the professional/clinician line
- 96% of calls exit 111p2 at the well-being practitioner (Band 5) stage
- 17% of all professional/clinician line calls progress to urgent/crisis assessment
- 83% of all professional/clinician line calls exit without further escalation

Assessment Outcomes (from the professional/clinician line escalations):
- 44% receive an urgent assessment (within 72 hours)
- 56% receive a crisis assessment (within 4 hours)

Unanswered Calls (these are calls that were not picked up by the service)
- Representation is 2% of all calls received and this is due to a combination of high call volume/technical issues that is under review.

Abandoned Calls (these are calls where the caller hangs up before being connected to a practitioner)
- 2.9% left after 2 mins having gone through the introductory message, which indicates it is not as a result of long wait times.

Summary/overview of 111p2 service outcomes

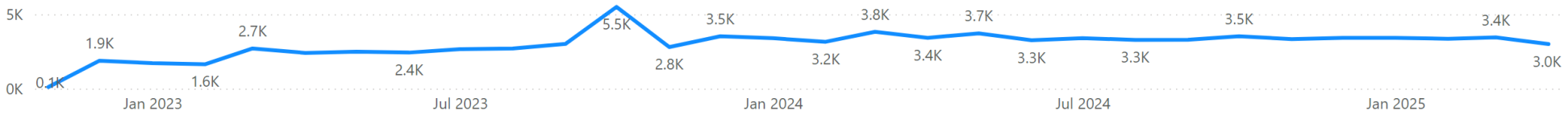
Collectively the outcomes continue to reflect a responsive 111p2 service that is delivering timely and appropriate care to our service users with:

- High Resolution at Initial Contact based on an impressive 96% of calls successfully managed at Well-being practitioner level, reducing pressure on other Pathways.
- Robust triage / effective early intervention / appropriate escalation with only 4% of calls escalated to the next stage (escalated to the clinician line); 83% are resolved without further escalation, showcasing efficient clinical decision-making and management.
- Timely Assessments as all individuals needing additional support received this promptly, within 4 hours (56%) and the remainder 44% all receiving an urgent assessment within 72 hours.
- Finally, we've observing low 'Unanswered and Abandonment' call rates. There is more work to do on call wait times management, however unanswered calls remain low at 2% and abandoned calls after 2 minutes are minimal at 2.9%, suggesting that

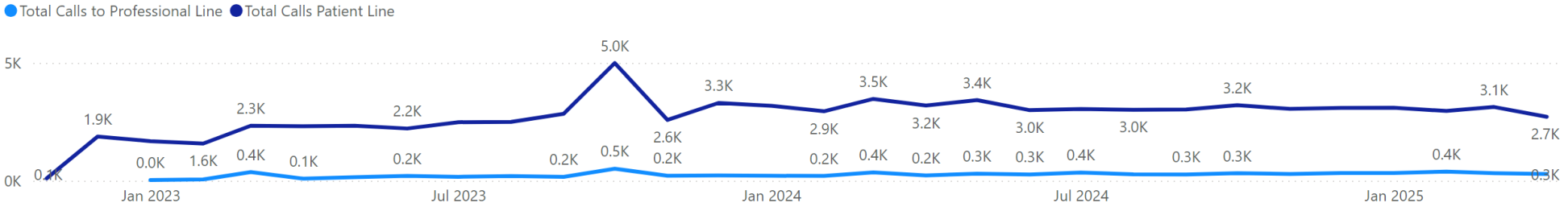
Calls Summary

Total Calls	Average Total Calls Per Month	Total Calls to Patient Line	Total Calls to Professional Line
89.71K	2.99K	83K	7K

Total Calls



Total Calls Patient/Professional Line



Total Calls Answered < 1 Minute	Patient Calls Answered < 1 Minute	Professional Calls Answered < 1 Minute
80%	79%	91%

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Abandoned Calls

34%

Total % Abandoned Calls

2.9%

TOTAL % Abandoned calls (WAST Definition)

*Abandoned calls are those calls where the patient or professional caller have abandoned the call during an announcement or whilst in a queue.

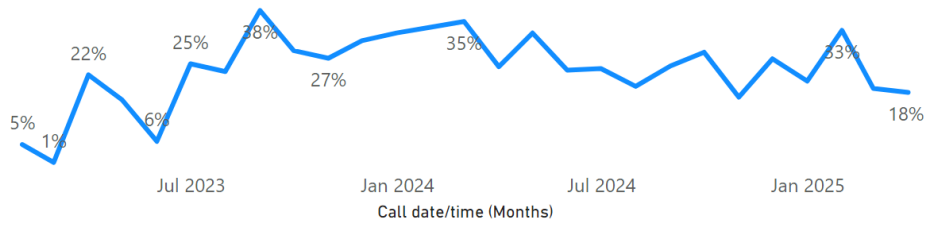
% Of Abandoned Calls < 1 Minute

90.2%

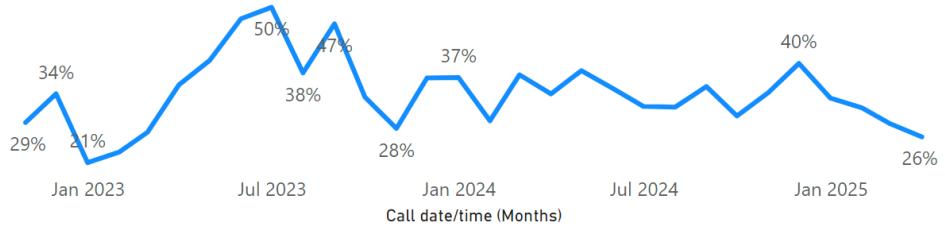
% Of Abandoned Calls < 2 Minutes

91.3%

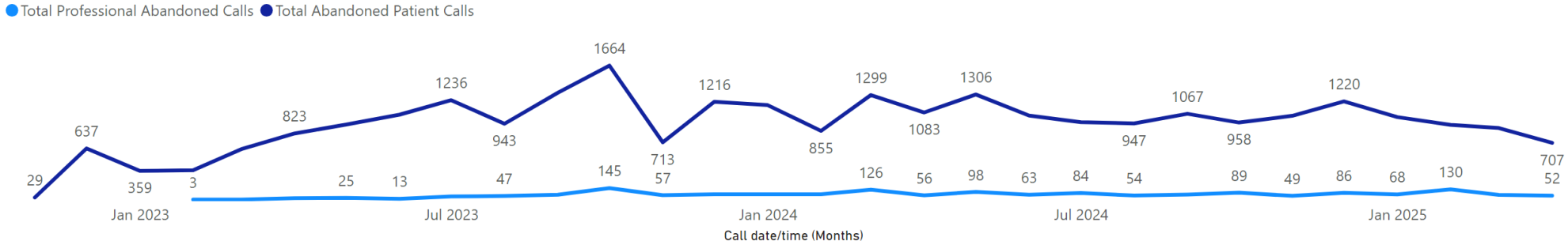
Calls Abandoned By Professionals Ringing Professional Line



Calls Abandoned by Patient



Total Abandoned Calls Patient/Professional



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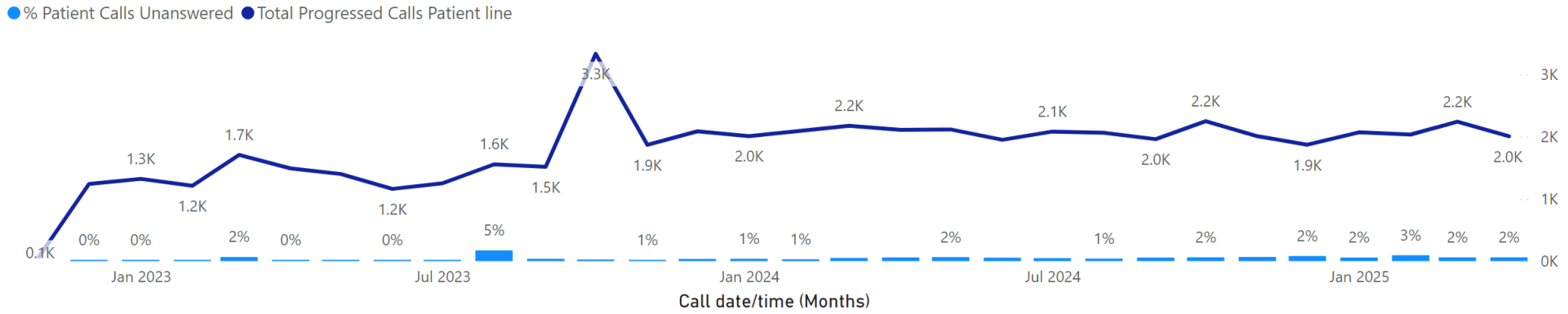
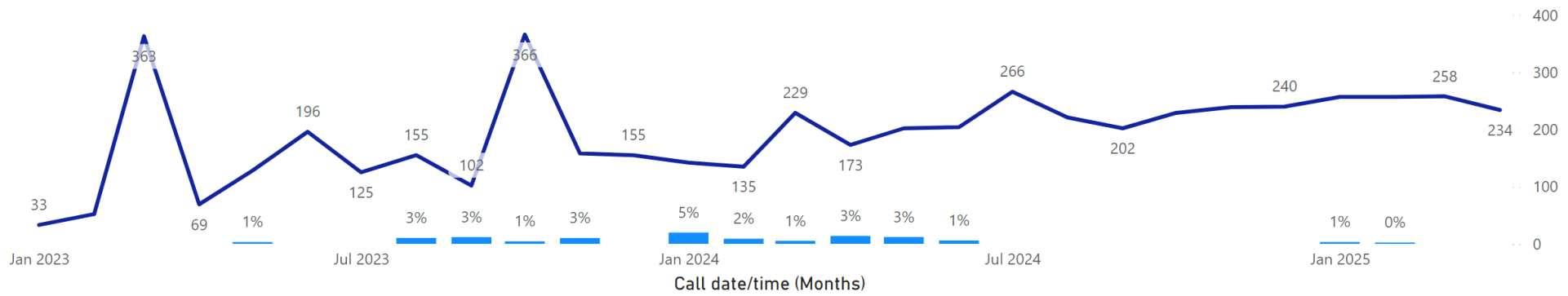
Unanswered Calls

*Unanswered calls are calls that have connected to a phone line but have either gone through to an 'engaged' tone (consideration of professional line only having one line) or have rung and not been answered.

Patient Calls Progressed and Unanswered



Professional Line Calls Progressed and Unanswered



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Emerging/New service model based on the Wales 10yr Mental Health & Wellbeing Strategy

2025/26, we are transforming our services by focusing on enhancing accessibility and integration of service pathways:

1. **Open Access Services** – we aim to remove traditional thresholds/barriers, allowing direct and timely access to support without lengthy referral processes, promoting early intervention and crisis prevention.
2. **24/7 Integrated Crisis Care Offer** - we plan to establish a comprehensive, 24/7 crisis response through various channels like 111p2, New Open Access SPoA, CRHT, RCRP; aiming for seamless care response/transitions and reduced reliance on ED or Secondary provisions or Admissions.
3. **Community-Based Alternatives to Secondary/Inpatient Care,** by expanding options such intensive home treatment offer, offering therapeutic environments in the community in conjunction with our LA partners and promoting recovery closer to home, we will reduce hospital admissions.

Transforming our services…

1. **Optimising Digital capability** – we aim to develop a cohesive digital infrastructure that will support Open Access/Integrated care pathways, remote consultations and efficient communication with service users.
2. **Enhanced Peer Support/Voluntary Support** - we will be prioritising integrating individuals with lived experience into the service model to provide empathy, understanding, and guidance, fostering hope and empowering recovery. And 3rd sector input community groups, person-centred innovative approaches and accessible support

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2025
CYFARFOD O: **MEETING OF:**	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on the Mental Capacity Act and Deprivation of Liberty Safeguards
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tom Grace and Tanya Strange

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides an overview of the Health Board's responsibilities under the Mental Capacity Act (MCA) 2005, with a specific focus on the Deprivation of Liberty Safeguards (DoLS). It aims to provide assurance regarding the Health Board's implementation of the MCA in clinical practice and outlines the governance structures supporting compliance and training.

In addition, the paper highlights key risks associated with current DoLS processes, including delays in authorisation, increasing demand, Consortium challenges and legal exposure due to capacity and resource constraints. These risks may impact the Health Board's ability to ensure that deprivations of liberty are lawfully authorised and in line with statutory duties.

Cefndir / Background

The Mental Capacity Act (MCA) provides the legal framework for supporting people who may lack capacity to make specific decisions. The Deprivation of Liberty

Safeguards (DoLS), introduced as an amendment to the MCA, are a legal mechanism to protect individuals who lack capacity and are deprived of their liberty in hospitals or care homes.

Within Aneurin Bevan University Health Board, MCA and DoLS responsibilities are shared across services. The Health Board hosts the Gwent DoLS Consortium, which coordinates DoLS assessments in hospital and across five local authorities. However, longstanding issues, such as delayed assessments, inadequate documentation, and increasing training demand, have been further compounded by the cancellation of Liberty Protection Safeguards (LPS) implementation. A briefing paper if being prepared for a future Executive Team meeting.

A recent audit highlighted significant gaps in MCA compliance, particularly around capacity assessments, best interest decisions, and documentation. In parallel, a significant backlog of DoLS referrals, particularly in hospital settings, raises concerns about legal compliance, human rights protections, and reputational risk.

Efforts are underway to improve governance, training, data quality, and assessment capacity. However, assurance is required that statutory duties are being met and that risks are being actively monitored and escalated.

Asesiad / Assessment

MCA Compliance: Health Board Responsibilities

To demonstrate compliance with the Mental Capacity Act (MCA), the Health Board must:

- **Ensure staff understand and apply the five statutory principles** of the MCA in day-to-day practice.
- **Assess and record mental capacity** for specific decisions when there is reason to doubt it.
- **Involve the person as fully as possible** in all decisions and consult family or others close to them where appropriate.
- **Make best interest decisions** using a structured, transparent process when someone lacks capacity.
- **Consider the least restrictive option** that meets the person's needs.
- **Provide role-specific MCA training** and ensure it is up to date, accessible, and mandatory.
- **Maintain clear records** of assessments and decisions, including rationale and evidence of consultation.
- **Apply the Deprivation of Liberty Safeguards (DoLS)** when individuals are deprived of liberty in care settings, ensuring timely applications and renewals.
- **Monitor compliance through audit and reporting** and take action where gaps are identified.

These duties are both legal requirements and critical safeguards for individuals' rights and freedoms.

MCA Specialist Team

The Health Board has employed a team of MCA Specialist Practitioners. The Team supports clinicians by providing expert guidance, training, and direct case-based support to ensure legal and person-centred practice. In essence, the MCA team acts as both a safeguarding function and a capacity-building resource,

helping clinicians deliver safe, lawful, and person-centred care. Specifically, they:

- **Case Support and Consultation**

Advise on complex cases, including capacity assessments and best interest decisions.

Support clinicians in decision-specific capacity assessments, ensuring they are legally compliant and well-documented.

Help navigate difficult ethical or legal scenarios, including use of restraint, refusal of treatment, or disagreement among professionals/family.

- **Training and Education**

Deliver tiered MCA/DoLS training tailored to staff roles (e.g., Level 1 awareness to Level 3 specialist decision-makers).

Facilitate bespoke ward-based sessions and reflective practice to embed learning in real-world contexts.

- **Quality Assurance**

Review documentation (e.g., consent forms, capacity assessments, best interest records) and provide feedback to improve practice.

Audit compliance and contribute to assurance reporting.

- **Improving Practice and Systems**

Develop tools, templates, and resources to support clinicians (e.g., decision-making flowcharts, best interest checklists).

Promote cross-team learning and share examples of positive and poor practice to build confidence and consistency.

- **Legal and Policy Alignment**

Ensure clinical teams are aware of and working within current legislation, guidance (e.g., Code of Practice), and local policy.

Escalate legal risks (e.g., unlawful deprivation of liberty) and support action planning to reduce them.

MCA Regional Forum

The Health Board MCA Forum has been established to drive best practice and training across the organisation. It brings together health boards, local authorities, and cross-sector practitioners to support the implementation of Liberty Protection Safeguards (LPS) and ensure consistent MCA practice. The Forum reports into regional governance structures and meets 3 monthly.

Membership includes divisional representation. Quarterly reporting is available electronically for staff to view.

Reporting

DoLS monitoring and reporting is through the Regional DoLS Consortium which in turn reports to the Regional Partnership Board. The Primary and Community Care Division are represented on the Consortium. The MCA/DoLS Strategic Lead is not part of this Division so is not able to directly contribute.

Regular updates and exception reports are provided to the Health Board Safeguarding Group, Quality Learning Forum and relevant committees. Additionally, the MCA Strategic Lead co-chairs the DoLS/MCA Network and reports updates and challenges within this forum.

There are also national reporting mechanisms to HIW and CIW.

Training and Workforce Development

The Health Board has introduced mandatory MCA/DoLS training using a tiered model tailored to roles. While uptake is increasing, particularly for in-person workshops, challenges persist due to resource pressures, variable staff attendance, and gaps in existing training programmes. Bespoke, interactive delivery has received positive feedback and is supported by the MCA team across programmes.

Audit and Assurance

A recent audit highlighted significant gaps in MCA compliance, including missing capacity assessments, poor documentation, and limited involvement of patients or families in best interest decisions. In some cases, this resulted in potentially unlawful deprivation of liberty. These findings indicate ongoing risks and reinforce the need for targeted improvement efforts. The MCA Specialist Teams are therefore proactively supporting clinical teams.

Challenges

Persistent barriers include:

- Logistical and resource constraints for training.
- Variable engagement, especially among medical staff.
- Concerns about increased workload post-training.

Despite this, staff feedback confirms the value of face-to-face and ward-based MCA support.

Advocacy and Good Practice (Feedback from IMCAs)

Positive examples of best interest practice have been noted, particularly where staff delayed decisions to enable proper family involvement. The Learning Disability Team provided critical advocacy in complex cases. However, IMCAs raised concerns about delays, inconsistent assessments, and decision-making without appropriate consultation or documentation.

National and Regional Developments

The following summarises national and regional developments, aimed at improving MCA practice.

- All-Wales MCA/DoLS eLearning modules and a national competency framework (Levels 1–3) are in final stages.
- A national MCA implementation heat map is under development.
- DoLS forms and LPS guidance are under review by Welsh Government.
- In England, ICBs are developing heat maps, and SCIE is leading hospital access improvements for vulnerable groups.

Promotion and Engagement

The MCA team continues active involvement in:

- Future Care Planning and Bereavement initiatives.
- Awareness events and resource development (e.g. consent videos, family DoLS leaflets).

Risks: Backlog delays, incomplete or poor-quality assessments, insufficient training coverage, and inconsistent application of MCA principles pose risks to patient safety, legal compliance, and quality assurance.

Opportunities: Strengthened regional coordination, enhanced training programmes, improved data reporting, and cost-saving measures present opportunities to improve timely assessment, compliance, and resource use.

Assurance: Regular reporting, audit activities, positive staff engagement in training, and governance via the Gwent MCA Regional Forum provide assurance of ongoing efforts to address challenges and improve statutory compliance and patient outcomes. The Consortium actively contributes to these initiatives and wider strategic forums, ensuring continual alignment with best practice.

Deprivation of Liberty Safeguards (DoLS): Current Position, Risks, Opportunities, and Challenges

The Gwent DoLS Consortium, established in 2009 with a team hosted by Aneurin Bevan University Health Board is responsible for coordinating Best Interest Assessments and supporting Supervisory Bodies in discharging their statutory duties under the Deprivation of Liberty Safeguards framework. Despite efforts to prioritise high-risk individuals through a nationally endorsed risk tool, the Consortium faces significant operational and structural pressures that impact the timely protection of individuals' rights.

Key Risks

- Significant delays in assessing potential deprivations of liberty mean individuals may be unlawfully deprived of their liberty without proper

authorisation or safeguards. This includes a notable lack of hospital-based assessments.

- The Health Board and partners may be vulnerable to legal challenge for failing to meet statutory DoLS obligations, risking reputational damage and potential judicial scrutiny.
- The absence of timely assessments increases the likelihood of care decisions being made without legal or ethical justification, undermining the protection and voice of individuals lacking capacity.
- The current funding model places a disproportionate financial burden on the Health Board. The Health Board covers 47.42% of the Consortium's overspend, despite only 14% of Section 12 assessment activity relating to Health Board patients.
- Split accountability between Health Board divisions and Local Authority partners creates confusion over roles, delays in sign-off processes, and lack of clear operational leadership.
- The growing complexity of statutory data submissions places pressure on a small central team. Only the Health Board has contributed resources (a dedicated data clerk on a fixed term contract) to meet daily and monthly reporting demands.

Key Challenges

- Over 1,200 referrals are waiting for assessment across risk levels. Long delays persist, particularly in renewing expiring authorisations and responding to new referrals. This is experienced across Wales.
- A critical gap exists in the number of hospital-based assessments compared to care homes. This results in people potentially being deprived of liberty on hospital wards without the required legal authorisation.
- Current management arrangements lack clarity. Operational and budgetary responsibilities are spread across teams, contributing to inefficiencies and delayed decision-making.
- DoLS signatories often report lack of confidence, experience or clarity in their role, when acting as signatories.
- High specialist assessment costs continue to create financial strain. Efforts are underway to reduce reliance on Section 12 assessments through the use of equivalent clinical evidence.

Opportunities for Improvement

- A proposed review of the Consortium arrangements offers an opportunity to clarify roles, improve accountability, and streamline decision-making. An Executive Briefing is being prepared for further consideration.
- Briefing papers submitted to Welsh Government outline strategies to reduce Section 12 costs, including smarter use of existing evidence to reduce the need for external assessments.
- Short-term investment in dedicated data support has improved reporting compliance. Expanding this across all Consortium partners could strengthen the existing overall system resilience.
- The cancellation of LPS provides an opportunity to refocus on improving existing DoLS processes while ensuring future flexibility for any forthcoming legislative changes.

- Detailed analysis of delays and missed assessments, particularly in hospitals, can be used to inform targeted interventions and improve frontline awareness.

Conclusion

The Health Board continues to strengthen Mental Capacity Act (MCA) compliance through a tiered training programme, positive staff engagement, and the ongoing support of a dedicated MCA team. This team provides expert advice, case-specific guidance, and quality assurance, helping to embed consistent, lawful, and person-centred decision-making across services. Assurance is further supported through regular audits, staff feedback, and ongoing review of education and practice to ensure the Health Board meets its legal duties and safeguards individuals' rights.

Despite ongoing efforts to improve awareness and training, significant delays in DoLS assessments, particularly in hospital settings, pose legal, financial, and safeguarding risks. Current governance and funding arrangements are no longer fit for purpose.

To improve this, we are reviewing management structures, reducing reliance on costly commissioned assessments, strengthening training for signatories, and enhancing data reporting capacity. All identified risks will continue to be actively monitored and escalated through appropriate governance channels, including ongoing updated to the Safeguarding Committee to ensure transparency and accountability.

A detailed report (SBAR) summarising current risks, gaps, and improvement options will be submitted to the Health Board Executive Team in the very near future. This will include proposals for assurance and sustainable delivery.

Argymhelliad / Recommendation

The Mental Health and Learning Disabilities Committee is asked to:

1. **NOTE** the positive actions being taken to embed MCA into clinical practice
2. **NOTE the significant delays** in DoLS assessments, particularly in hospital settings, and the associated legal and human rights risks.
3. **NOTE** the intent to present an SBAR to the Executive Team on the current DoLS arrangements and options for improvement.
4. **Endorse actions** to mitigate financial risk, including efforts to reduce reliance on costly Section 12 assessments through appropriate use of equivalent evidence.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. 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 **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

Mental Health & Learning Disabilities

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board

Reasonable Assurance

Contents

Review Reference	ABUHB-2425-09
Fieldwork	October – November 2024
Executive Sign Off	March 2025
Audit Committee	April 2025
Executive Lead	Leanne Watkins, Chief Operating Officer
Head of Internal Audit	Stephen Chaney, Head of Internal Audit
	Rhian Gard, Audit Manager

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

We reviewed the arrangements from the 90-day Plan (the 'Plan') for the Mental Health and Learning Disabilities division (the 'Division'), to ensure that these have been embedded.

Overview

We have concluded reasonable assurance on this area. The 90-day Plan (the 'Plan') was implemented alongside 30-day and 60-day actions as part of an Improvement Plan to address concerns raised in July 2023, following HIW inspections and other concerns relating to assurance of safety and quality of services within the Division. The Improvement Plan targeted the initial areas of concern, but helped launch wider initiatives which focused on workforce, leadership, performance and governance, to help drive continuous improvement across the Division. The Division has encountered different challenges since the Improvement Plan was put in place, one being the change in the whole triumvirate team. Whilst recently, progress has been made in implementing the actions (three of the four actions) from the Plan not all of actions have been fully implemented and subsequently, not embedded.

The significant matters requiring management attention include:

- A governance structure is in place within the Division but is still being developed. Whilst progress has been made there is a benefit in defining the governance structure more clearly.
- Progress discussion is taking place at multiple forums across operational, divisional and executive levels, however there was a lack of detailed focus and challenge when actions are not implemented on time.
- The Plan lacks specific timelines to ensure accountability and transparency.
- The Plan is not fully complete, so it is not yet possible to observe the embedding of the outcomes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	To ensure appropriate governance and monitoring / communicating arrangements are in place to support the implementation if the 90-day plan.	1, 2	**Reasonable**
2	To determine if there is a clear accountability for actions, with defined timescales for implementation and there is clear management of them.	3	**Reasonable**
3	To ensure the outcomes of the 90-day plan are delivering the intended outcomes	4	**Reasonable**

Management Actions

0
High Priority

4
Medium Priority

Themes

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Governance, monitoring and communicating arrangements	**Reasonable**

Prior to the development of the Improvement / 90-day Plan (the 'Plan'), there were few governance arrangements in place. However, the interim leadership team are implementing a longer-term governance structure, with ongoing adaptations still being completed to suit the needs of the Division. The new governance arrangements were introduced in February 2024 and focus on four pillars: Assurance; Quality Patient Safety (QPS); Strategic change (the Annual Plan); and Sustainability (workforce). We found numerous meetings taking place at operational, divisional and executive levels regarding the Plan's actions. Some of the initial meetings focussed on the Plan but have now been stepped down and these have become part of business-as-usual discussions, within the operational and divisional forums.

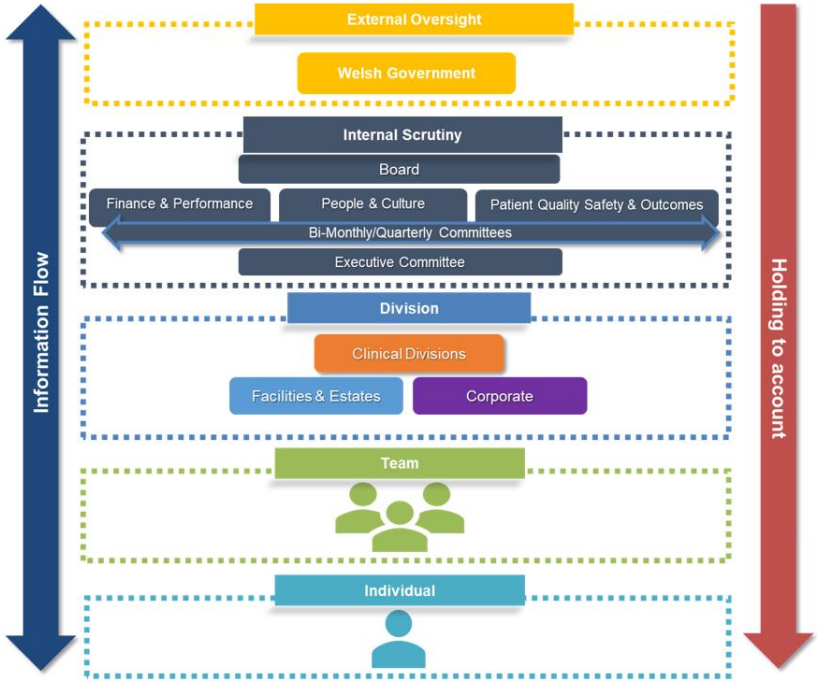
Although there is evidence of discussions and updates provided, the meetings observed and the minutes from other forums sampled, did not focus on the management of actions within these sessions. Furthermore, some of the discussions focus on steps being taken rather than defined actions being monitored until completion.

Regular executive involvement is evident, but it has not been possible to observe challenge over the progress and delivery of the Plan. We reviewed Committee and Board papers over the last 12 months and confirmed regular discussion is underway and reported to the Patient, Quality and Safety Outcomes Committee (PQSOC) and Board. However, we did not identify extensive formal discussion within the Mental Health Act Monitoring Committee. Overall, actions completed, progress underway and implementation of the Plan is discussed within formal settings, but there is no accountability against pre-determined delivery milestones. Consequently, there is a risk that actions are not implemented in a timely manner.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance arrangements** The Division is in the process of undertaking a review of its governance structure to ensure it is fit for purpose, recognising that the existing structure is slightly complicated with many different meetings taking place. During our review, we identified discussion taking place, across multiple forums, however, there was no clearly defined pathway for the monitoring and reporting on the actions outlined in the 90-day plan.	Potential risk of: The Plan not being implemented fully.	**Agreed Action:** • Continuous reporting through daily, fortnightly, and monthly meetings, and the reinstated MH&LD Committee. • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. • Improvement plan aligns with Health Board's Quality Strategy and new accountability framework. **Expected Evidence of Implementation:** • Monitor against the Performance Management and Accountability Framework (PMF) at Divisional Assurance (DA) meetings, quarterly and mid-year reviews with the wider execs.

- Agreed workplan for the MH&LD Committee and plan for the year – starts April 2025.
- Triangulate inspection and audit data, linking it with the wider QPS team identifying any trends or areas of concerns.
- Continue monthly IQPD reporting.
- Continue reporting to JET twice yearly.
- Bespoke Board Development sessions as required.

Evidence of working to the framework below:



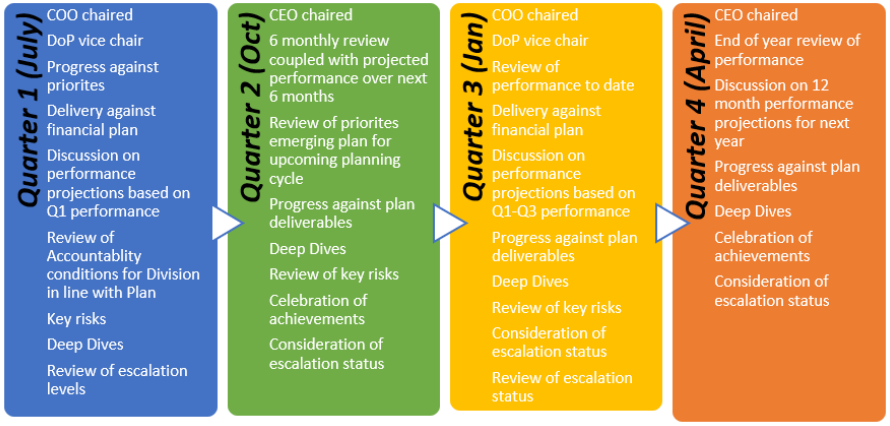
By the end of Q1, we plan to showcase our reporting through the outlined structure, including minutes, action plans, and presentations.

		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th June 2025**
	Theme: Governance	Control Design	

2	**Monitoring and communicating arrangements**
	Whilst discussion and updates are provided at numerous committees, in addition to the Board. However, there is no detailed specific monitoring / challenge over the delivery (or non-delivery) of actions within the Plan against agreed timeframes and the intended outcomes. In addition, where actions are not delivered on time there is no formal escalation or subsequent tracking over any remediation.
		Potential risk of:
		The Plan not being implemented fully.
			Agreed Action:
			• We will continue discussions and updates at various committees and the Board, emphasising the need for detailed monitoring and challenge over long-term actions and outcomes – using the performance and accountability framework.
			• The 90-day improvement plan has evolved into a broader, long-term improvement program, focusing on culture change and workforce development, requiring sustained effort and commitment. These measures will enhance accountability and ensure timely delivery of initiatives.
			Expected Evidence of Implementation:
			• Monthly Divisional Assurance Review Meetings.
			• Quarterly Divisional Performance Review Meetings.
			• Corporate teams – 6 monthly assurance review meetings.
			• Internal Divisional and corporate team arrangements
			  • Performance meeting including key metrics and delivery against agreed trajectories and forecast.
			  • Quality and safety which risk, clinical governance, patient experience, health & safety etc. is discussed.

- Monthly financial position review (key drivers of the financial position to be discussed in detail; this will vary by Division and Directorate).
- Monthly savings review to assure in-year plans and build a pipeline of future savings opportunities.

- Agreed workplan for the MH&LD Committee and plan for the year **– starts April 2025.**
- Triangulate inspection and audit data, linking it with the wider QPS team.
- Continue monthly IQPD reporting.
- Continue reporting to JET twice yearly.
- Bespoke Board Development sessions as required.



Specifics

- Alignment of ward standards with HB procedures is currently underway.
- Regular briefings and improved BAU escalation methods have been implemented.
- Continuous Patient Safety Incident reviews are conducted with the Executive Director of Nursing and COO, focusing on safeguarding, incident reporting, and disciplinary actions.

			• Integration of the Right Care Right Person initiative with the new police and health alliance for mental health crisis management. • All registered staff undergo training in clinical risk assessment (WARRN), delivered internally by dedicated trainers and supported by clinical staff. • WARRN risk formulations are completed where risks are identified, reviewed annually or when circumstances change, including transitions between outpatient or inpatient care and crisis services. • Specialist risk assessments are available, coordinated via the forensic service, highlighting risks in suicide, violence, and fire setting. • An improved discharge plan for acute inpatient care is in place. • The Disengagement and DNA policy has been recently updated and is currently out for review, outlining actions for teams and directorates. • Ongoing work on patient search, observation policy and practice, safeguarding reporting, and escalation. We will show evidence and progress through the established monitoring framework. We recommend a 6-month period to ensure processes are fully embedded and sustained.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Communication & Engagement	Control Operation	

Objective 2: Implementation	**Reasonable**

The 30, 60 and 90-day action Improvement Plan was put in place during July 2023 and agreed by the previous triumvirate team, alongside Executive input.

Within the 90-day Plan (the 'Plan'), as of November 2024 we found that not all the actions had been fully implemented. Initially, actions were detailed in two Excel spreadsheets, one for an Executive update and one for internal use, with responsible owners, timescales, and RAG ratings. This was later changed to a PowerPoint version without RAG ratings, timescales and responsible officers. The current format outlines actions required, expected outcomes, current position and next steps. Discussion with key members of the Division demonstrates a focus on improvement and ensuring the actions in the plan are implemented. However, as described within objective one, we have not regular evidence of clear accountability when actions are incomplete. We found that two out of the four actions sampled in detail were complete (Missing Persons Policy in Commissioning Services and Patient experience engagement), whereas the two remaining (NCCU in commissioning services and WCCIS functionality) are still work in progress with no deadline in place. We recognise that some actions may involve other stakeholders, but delivery is not clearly defined.

In January 2025 we received updated evidence and a revised Improvement Plan, following a review within the Division. The updated Improvement Plan is the amalgamation of the live documents mentioned above. We have reviewed this evidence and found further progress has been made but the WCCIS functionality is partially complete. As the tendering process for the new system is not yet complete, it will not be in place until September 2025.

Key Findings		Risk & Impact	Agreed Management Action
3	**Implementation** The 90-day action plan was originally scheduled for completion by December 2023. However, as of January 2025, we confirmed three out of the four actions have been fully completed with one action partially complete. Whilst we confirmed that progress has been made against each of the actions, with considerable work completed / underway, the Plan has still not been fully delivered. Overall, we found that the Plan lacked specific delivery milestones and we found multiple live records in use to record status updates. Upon implementation of the Plan, there is value in reviewing the process adopted for the delivery and monitoring of actions to inform future plans. In particular, how accountability for the delivery of actions is maintained.	Potential risk of: • A lack of management resulting in delayed deliverables and benefits	**Agreed Action:** • From September 2024, MH&LD transitioned into Phase 2 of the Improvement Plan, focusing on sustaining actions and developing long-term initiatives. • The Triumvirate and senior leadership team are now permanent, with ongoing efforts in culture change and workforce development. • A robust monitoring framework is being implemented, including detailed tracking, regular progress reviews, and formal escalation procedures. This will have oversight by the COO and the QPS Team. • Staff training and development are prioritised to enhance accountability and ensure timely delivery of actions.

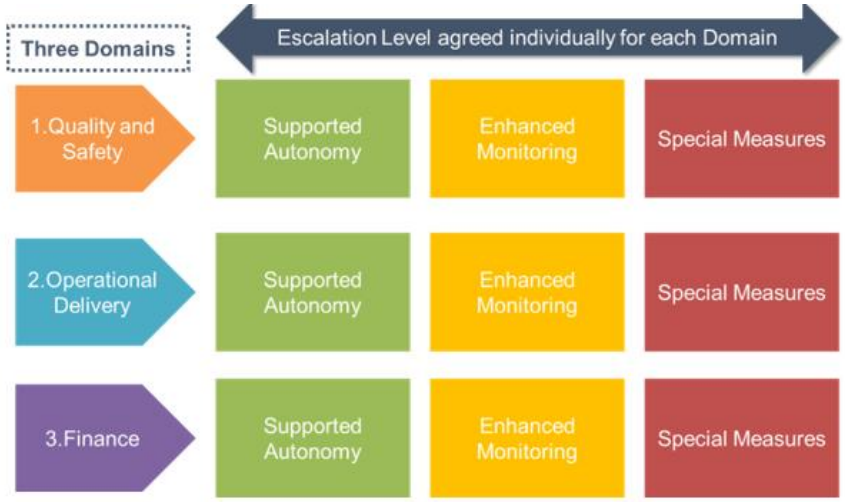
			Expected Evidence of Implementation: • Staff engagement events scheduled. • Participate in National events. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk process. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking it with the wider QPS team. • Continue IQPD reports. • Continue JET twice yearly reporting. • Bespoke Board Development sessions as required. We will provide evidence through DA minutes and documentation, thoroughly reviewing action logs to demonstrate decision-making processes and accountability at all levels.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Objective 3: Intended Outcomes	**Reasonable**

As previously described, we have observed progress towards implementing the 90-day actions, as three of the four actions have been fully completed, and one is partially complete. Whilst we recognise that a period of time has lapsed, since the Improvement Plan was first launched and the initial focus on the actions have now been integrated into a divisional focus of improvement, we have been unable to observe clear outcomes or deliverables linked to the completed actions.

There is evidence of regular updates at the PQSOC and Board and some scrutiny in Divisional assurance meetings. However, there is a lack of analysis to demonstrate outcomes of the fully completed actions and whether they have delivered their intended outcome. Furthermore, at this stage there has been no post implementation review completed, to highlight any gaps in the actions and to ensure actions are embedded once fully implemented. Consequently, we have been unable to fully test against this objective.

Key Findings		Risk & Impact	Agreed Management Action
4	**Intended outcomes** We found progress is being made in implementing the 90-day actions; however, not all actions have been fully implemented, preventing us from determining if the Division is achieving the intended outcomes. Completing a post-plan analysis would be beneficial in outlining the necessary steps to embed these actions once they are all fully implemented.	Potential risk of: Intended outcomes from the 90-day action plan not being delivered resulting in-patient harm and reputational risk.	**Agreed Action:** • Tight oversight on Disability Division for serious incidents and governance. • Improvement plan sustained. • Initiatives in workforce, leadership, performance, risk, and service changes progress. • Reporting to key committees and meetings. • NHS Executive Colleagues' advisory role continues. **Expected Evidence of Implementation:** • Staff engagement events / staff survey results. • Staff retention. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk processes/plans in place. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking it with the wider QPS team and escalate when needed. • Continue monthly IQPD reporting. • Continue reporting to JET twice yearly. • Bespoke Board Development sessions, as required.

			• Evidence of adhering to the principles of escalation as outlined in the PMF.  Evidence this progress with documentation and reporting to the DA meeting each month. Demonstrate how issues or concerns are escalated and responded to.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Planning, Delivery & Deadline Management	Control Design	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]