Mental Health Act Monitoring Committee

Wednesday 26 August 2026, 14:00 - 16:00

Virtual Via Teams

Agenda

14:00 - 14:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Information *Kath Palmer, Committee Chair*

1.2. Apologies for Absence

Information *Kath Palmer, Committee Chair*

1.3. Declarations of Interest

Information *Kath Palmer, Committee Chair*

14:05 - 14:10
5 min

2. CONSENT AGENDA

Kath Palmer, Committee Chair

The Committee Chair will ask if there are any items from the Consent Agenda (Section 7) that Committee Members wish to bring forward to the main agenda for discussion

14:10 - 14:20
10 min

3. PRELIMINARY BOARD MATTERS

3.1. Action Log

Discussion *Kath Palmer, Committee Chair*

3.1. Action Log MHAMC 26th August 2026.pdf (6 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Kath Palmer, Committee Chair*

14:20 - 14:40
20 min

4. RISK MANAGEMENT / COMMITTEE BUSINESS GOVERNANCE ACTIVITY

4.1. Organisational Risk Register

Discussion *Louise Stait, Interim Assistant Director of Governance & Risk*

4.1a Organisational Risk Register MHAMC 26 August 2026.pdf (8 pages)
4.1.b Organisational Risk Register MHAMC 26 August 2026.pdf (2 pages)

4.2. Committee Annual Self Effectiveness Survey Outcome 2025-26 & Improvement Plan

Discussion *Louise Stait, Interim Assistant Director of Governance & Risk*

4.2 MHAMC Annual Self Effectiveness Survey Outcome 2025-26 and Improvement Plan.pdf (8 pages)

4.3. Review of the Committee Terms of Reference

Discussion *Louise Stait, Interim Assistant Director of Governance & Risk*

- 4.3a Review of the Terms of Reference MHAMC 26 August 2026.pdf (4 pages)
- 4.3b GC01 Standing Orders Schedule 3.3a MHAMC ToR - Reviewed by JD.pdf (12 pages)

14:40 - 15:35
55 min

5. STRATEGIC PILLAR: IMPROVING CARE

5.1. The Role of Independent Mental Health Advocacy (IMHA) and Quarter 1 Report

Information *Lois Danks, Advocacy Manager*

5.2. MHA Operational Group Report

Discussion *Robert Goodwin, Directorate Manager, CAMHs and Specialist Services*

- 5.2a MHA Operational Group Report MHAMC 26 August 2026.pdf (14 pages)

5.3. Deep Dive Spotlight: Section 136, Emergency Department Waiting Times including Places of Safety

Discussion *Robert Goodwin, Directorate Manager, CAMHs and Specialist Services*

- 5.3 Deep Dive Spotlight Section 136 ED Waiting Times including Places of Safety August 26.pdf (16 pages)

5.4. MHA Quarterly Activity Report / Analysis of Unlawful Detentions

Discussion *Robert Goodwin, Directorate Manager, CAMHs and Specialist Services*

- 5.4 MHA Quarterly Activity Report and Analysis of Unlawful Detentions Q1 26-27.pdf (32 pages)

5.5. Risks Relating to the Monitoring of the MHA

Discussion *Julie Denley, Deputy Chief Operating Officer (Mental Health, Primary Care and Community)*

- 5.5 Risks Related to Monitoring of the MHA Q1 MHAMC 26 Aug 2026.pdf (4 pages)

5.6. Highlight Report from the Power of Discharge Committee

Helen Lentle, Independent Member & Robert Goodwin Directorate Manager, CAMHs and Specialist Services

- 5.6 Highlight Report from the Power of Discharge Committee Q1 April-June 26-27.pdf (8 pages)

15:35 - 15:45
10 min

6. STRATEGIC PILLAR: CREATING HEALTH

6.1. Strategic Update from South Wales Police

There is no update on this occasion

6.2. Strategic Update from Local Authority Partners

Discussion *Local Authority Partners*

A verbal update will be provided on this occasion

15:45 - 15:50
5 min

7. CONSENT AGENDA

7.1. Items for Approval

7.1.1. Unconfirmed Minutes of the Meeting held on 27 May 2026

Decision *Kath Palmer, Committee Chair*

7.1.1 Unconfirmed Minutes 27.05.26 MHAMC 26 August 2026.pdf (10 pages)

7.2. Items for Noting

External Engagement Draft SWP Mental Health Policy 2026 - Deferred

7.3. Committee Annual Cycle of Business 2026

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

7.3a Annual Cycle of Business 2026 MHAMC 26 August 2026.pdf (4 pages)
7.3b MHAMC Cycle of Business 2026.pdf (5 pages)

7.4. Committee Forward Work Plan (non routine business)

Information *Kath Palmer, Committee Chair*

7.4 Forward Work Plan MHAMC 26 August 2026.pdf (3 pages)

15:50 - 15:55
5 min

8. CLOSE OUT BUSINESS

8.1. Committee Highlight Report to Board

Discussion *Kath Palmer, Committee Chair*

8.2. Any Other Urgent Business

Discussion *Kath Palmer, Committee Chair*

8.3. Meeting Feedback

Discussion *Kath Palmer, Committee Chair*

Is there anything we should do more or less of?

Have we managed our time and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM? Have we maintained a Strategic Focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our Strategic Goals?

15:55 - 16:00
5 min

9. DATE AND TIME OF NEXT MEETING

Information *Kath Palmer, Committee Chair*

25 November 2026 at 14:00 pm

Mental Health Act Monitoring Committee - Action Log (as at 03/06/2026)

Name of Meeting: Mental Health Act Monitoring Committee
Committee Chair: Kath Palmer

Date of meeting the action originated from	Minute Item ref no	Minute Ref Page No	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
MHAMC Dec 2025	5,2	3	Operational Group Report	To include a lived experience/patient story for future meetings. **ACTION:** Develop and agree a proportionate approach to the inclusion of lived experience within Committee meetings, including consideration of relevance to the Committee's remit, intended assurance objectives, practical arrangements, confidentiality considerations and the resource implications for operational teams.	Chair, MHA Operational Group	Chief Operating Officer	nov-26	Open	**Item has been deferred** The proposed patient story will be considered by the Operational Group to explore opportunities for incorporating lived experience into the work of the MHAMC, including consideration of Mental Health Act functions such as detentions, assessments and consent to treatment.
	4,1	3	Organisation Risk Register	To provide more information and follow up regarding risk 6232 in relation to the **Stability of the Legal Services Function**	Corporate Governance	Director of Corporate Governance/ Board Secretary	aug-26	Proposed to close	**Propose to close** Risk 6232 has subsequently been refreshed and refined through the risk review process, with the revised risk approved by N. Downes. The agreed action has been addressed through the risk review, and can be cross-referenced to the current risk report.
MHAMC May 2026	4,2	3	Draft Committee Annual Report 2025-2026	To include updates under Governance & Assurance: HIW Inspections and Outcomes report Updates to Mental Health Act	Corporate Governance	Director of Corporate Governance/ Board Secretary	aug-26	Proposed to close	**Propose to close** Narrative added into the Governance and Assurance section of the Annual Report. Confirmation received from Kath palmer and Julie Denley to say they are happy with the changes
MHAMC May 2026	5,1	4	Deep Dive Spotlight: Statutory Documentation audit for patients detained under the Mental Health Act (2025)	It was agreed to include routine reporting on the number of detained patients in the activity report	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Open	**Update as at August 26th 2026 - In Progress** It was noted that an annual WG census is submitted for detentions on the 31st March . There is also a KP90 report submitted with the total number of detentions during the year. This information will be included in the next Operational Group report
MHAMC May 2026	5,2	6	MHA Operational Group Update Report	To invite IHMA service to the next MHAMC to provide an overview of their Quarter 1 report as well as present the patient story	Corporate Governance	Director of Corporate Governance/ Board Secretary	aug-26	Propose to close	**Propose to close** Invite has been sent by R Goodwin and S Edwards to the meeting invite for August 2026 meeting
MHAMC May 2026	5,2	6	MHA Operational Group Update Report	To provide a high-level summary of key changes to the Mental Health Act	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Propose to close	**Propose to close** Updates will be included in the Operational Group reports.

MHAMC May 2026	5,2	6	MHA Operational Group Update Report	The upcoming Deep Dive into 12 hr waiting times within the ED should also include details of delays within places of safety.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Propose to close	**Propose to close** This will be included in the Deep Dive 5.3 ED and Places of Safety
MHAMC May 2026	5,2	6	MHA Operational Group Update Report	To provide training materials used for AMHP leads and arrange a dedicated training session for the members of the Committee.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Open	**In progress** Updates are regularly included in the Operational Group reports. Agreed a joint presentation from a Section 12 approved doctor and AMHP would be pursued.
MHAMC May 2026	5,3	8	MHA Quarterly Activity Report / Analysis of Unlawful Detentions	Details relating to deaths of detained patient numbers over a three year timescale to be provided going forward.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Propose to close	**Update to number of detained patients** There has been 2 deaths of detained patients in the previous two years.
MHAMC May 2026	5,5	8	Hospital Managers Power of Discharge Sub Committee	Extend invitations to Committee members for future Power of Discharge training sessions	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Propose to close	**Propose to close** The invite was extended to Committee Members for 23rd July 2026 training event.
MHAMC May 2026	6,1	08-jan	Strategic Update from South Wales Police	Confirm whether the Overarching Mental Health Policy should be presented to the Mental Health Act Monitoring Committee for information.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Open	**Update as at August 26th 2026 - In Progress** At the recent SWP engagement event on the draft section 136 policy held on Tuesday 21st July 2026, further changes were discussed and would be included within a revised draft document. First draft to be included in Operational Group report
MHAMC May 2026	6,1	8	Strategic Update from South Wales Police	To ensure the new Welsh Government standards come to MHAMC when available.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-26	Open	**Update as at August 26th 2026 - In Progress** Draft standards being considered by the Operational Group
MHAMC May 2026	6,2	9	Strategic Update from Local Authority Partners	To ensure that updates regarding local Authority policies would be presented to the Operational Group or other appropriate governance route for oversight.	Local authority	Local authority	aug-26	Open	**Update as at August 26th 2026 - In Progress** Policies being reviewed for presentation to the Operational Group

CLOSED ACTIONS: Mental Health Act Monitoring Committee 2026

Name of Meeting: Mental Health Act Monitoring Committee

Committee Chair: Kath Palmer

Date of meeting the action originated from	Minute Item reference	Minute Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
MHAMC Feb 2026	1,2	1	Apologies for absence	Amend meeting invite from Alyson Jones to Alexandra Beckham, Remove Dr Mary Self and check with Claire Williams if she would like people to come from the Care Group	Corporate Governance	Head of Corporate Governance and Board Business	mai-26	**CLOSED**	**Completed** Meeting invites have been updated.
MHAMC Feb 2026	5,2	5	MHA Operational Group Update Report	Healthcare Inspectorate Wales Annual Report to be circulated to Members. Add the risk relating to the prolonged use of emergency departments and paediatric wards as places of safety for young people to the Forward Work plan for future consideration, with particular focus on eating disorders and transition age young people	Chair, MHA Operational Group	Deputy Chief Operating Officer	mai-26	**CLOSED**	**Completed** HIW Annual Report circulated to Members sent out on 25/2/2026 The Risk has been added to the Forward plan
MHAMC Feb 2026	8,1	7	Committee Highlight Report	To escalate two positive reports, the power of discharge and the Deep Dive into Adult Detentions	Chair, MHA Operational Group	Deputy Chief Operating Officer	mar-26	**CLOSED**	**Completed** These matters were included in the Highlight Report submitted to the March 2026 Board.
MHAMC Feb 2026	8,3	7	Meeting Feedback	To review the attendance of the CBC's and to invite SWP to attend	Corporate Governance	Head of Corporate Governance and Board Business	mai-26	**CLOSED**	**Completed** - information provided to Julie Denley regarding CBC's and SWP
MHAMC May 2025	3,4	2	Committee Annual Self-Assessment	Corporate Governance Team to update Members on training and organise a face to face meeting for the future committee meetings along with a visit to a Place of Safety.	Corporate Governance	Director of Corporate Governance/ Board Secretary	mai-26	**CLOSED**	**Completed** A visit to Royal Glamorgan Hospital has been arranged for the 27 May 2026 meeting and a meeting room has been secured at the Snowdrop Centre for the Committee to hold a face to face meeting

MHAMC Sept 2024	6.2.1	4	Risks Related to the Monitoring of the MHA - Update on timescales of hospital place of safety	Operational Group to conduct a comprehensive review of the current room usage within hospital sites	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-25	**CLOSED**	**Completed** - The Adult Services Directorate has made some changes to the place of safety arrangements in September with the PCH facility temporarily transferring to RGH whilst refurbishment work is being undertaken. There are also plans being developed to improve the Bridgend place of safety Arrangements following comments during a recent HIW visit to POWh. The room utilisation work can progress when these changes have been worked through. A f**urther update on progress was provided to the Committee and included in the February 2026 Operational Group Update report**
MHAMC August 2025	5,2	6	Operational Group Report	The HIW unannounced visit to Ward 7 Ty Llidiard be highlighted to the Board as positive escalation.	Corporate Governance	Director of Corporate Governance/ Board Secretary	sep-25	**CLOSED**	Escalation provided within the Committee Highlight Report to the September 2025 Board Meeting
MHAMC August 2025	5,1	4	Deep Dive Spotlight - Section 135 (1) and 135 (2)	The actions / improvements identified following the deep dive audit to be captured in the Operational Group Report prepared for future meetings.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	des-25	**CLOSED**	Progress on the recommendations included within the deep dive will be closely monitored by the operational group. this includes the development of guidance to staff making an application to the court under section 135(2).
MHAMC August 2025	6.2.1	10	Forward Work Plan	To add updates family and carer feedback and updates from South Wales Police to the Forward Plan and Action Log.	Corporate Governance	Director of Corporate Governance/ Board Secretary	des-25	**CLOSED**	Added to Forward Work Plan for February 2026 meeting
MHAMC August 2025	4,1	3	Organisational Risk Register	To check whether the new escalation process would be relevant to share with Local Authority Partners	Service Director Mental Health and Learning Disabilities Care Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-25	**CLOSED**	This is an internal process to ensure documentation is completed in a timely fashion and does not require the input of the Local Authority
MHAMC August 2025	4,1	3	Organisational Risk Register	To escalate the risk in relation to clinical medical cover within the CTM Adult Mental Health Services to the Board via the Committee Highlight Report	Corporate Governance	Director of Corporate Governance/ Board Secretary	sep-25	**CLOSED**	Escalation provided within the Committee Highlight Report to the September 2025 Board Meeting
6.2.1	5	Deep dive into section 135 should be brought up at the next Committee Meeting	This item is on the forward work plan however wasn't captured in the May Committee meeting. It was suggested to move it to the August Committee meeting.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	aug-25	aug-25	**CLOSED**	This item was received at the August 2025 meeting.

MHAMC February 2025	5.4.	6	South Wales Police - Highlight Report	To request a written update from SWP and circulate to Committee Members outside of the meeting	Corporate Governance Team / South Wales Police		mai-25	**CLOSED**	The Corporate Governance Team has emailed South Wales Police in response to the action and sent chaser emails. Will update accordingly As of **April 2025**, it was agreed with the Executive Lead and Committee Chair that South Wales Police would present reports on an ad hoc basis due to their frequent attendance at Operational Group Meetings. If escalation is needed, it will be
MHAMC February 2025	5,6	6	Strategic Update from Local Authority Partners	Operational Management Board to discuss the issues raised in relation to transport.		Deputy COO/Director of Primary Community, Mental Health & LD	mai-25	**CLOSED**	The Service Director Mental Health and Learning Disabilities covered this off in her report to Operational Management Board and will escalate any actions needed as they arise. PROPOSE TO CLOSE
MHAMC September 2024	4,1	3	MHA Operational Group Report	Initiate an investigation to understand the recent increase in errors and explore solutions to address staff pressures and improve training programmes.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	nov-24	**CLOSED**	Going forward the operational group will identify the individual responsible for submitting a poorly checked scrutiny form. This will help identify any themes in terms of staff and service pressures. To help with learning.
MHAMC September 2024	5,2	3	MHA Quarterly Activity Report Breaches Analysis of Unlawful Detentions	Provide updates to the Committee on the progress of the electronic System in future meetings.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	feb-25	CLOSED	It was agreed to close this action at the February 2025 Committee meeting, However, with further updates to be received within the Risk Report and a separate progress report to be received at a future meeting.
MHAMC September 2024	5,6	6	Strategic Update from Local Authority Partners	Create a slide template for Local Authority representatives to facilitate ongoing review	LA Partners	Deputy COO/Director of Primary, Community, Mental Health & LD	des-24	CLOSED	A template was circulated for use in advance of the meeting.
MHAMC Dec 2025	5,2	3	Operational Group Report	Review Section 136 handover times from the Police focussing on the reason for a breach of the 1 hour target. This is particularly relevant for Emergency Department waits.	Chair, MHA Operational Group	Chief Operating Officer	feb-26	CLOSED	A new data collection has been developed to capture individual reasons for delay focusing on Emergency Department activity
MHAMC Dec 2025	5,2	3	Operational Group Report	Review Section 5(2) detentions against in patient admission rates and population size.	Chair, MHA Operational Group	Chief Operating Officer	feb-26	CLOSED	This is included in agenda item 5.1 Deep Dive Spotlight: Deep Dive into Adult Detentions
MHAMC Dec 2025	5,3	3	MHA Quarterly Activity Report/Analysis of Unlawful Detentions	To benchmark detention data against other Health Boards to determine if practice in our region was consistent with others.	Chair, MHA Operational Group	Chief Operating Officer	feb-26	CLOSED	This is included in agenda item 5.1 Deep Dive Spotlight: Deep Dive into Adult Detentions

MHAMC Dec 2025	5,3	3	MHA Quarterly Activity Report/Analysis of Unlawful Detentions	Complete a review of re-admission rates into the MH & LD Care Groups acute admission wards and benchmark these with other services.	Chair, MHA Operational Group	Chief Operating Officer	feb-26	CLOSED	This is included in agenda item 5.1 Deep Dive Spotlight: Deep Dive into Adult Detentions
MHAMC Dec 2025	5,4	4	Risks Relating to the Monitoring of the MHA	To keep the new Mental Health Act on the agenda for ongoing updates at future meetings.	Interim Nurse Director, MH & LD	Chief Operating Officer	feb-26	CLOSED	An update is included in agenda item 5.4 Risks Relating to Monitoring of MHA
MHAMC Dec 2025	5,6	6	Power of Discharge Sub Committee Highlight Report	To share the presentation on Trauma Focussed Care to the Committee.	Chair, MHA Operational Group	Chief Operating Officer	feb-26	CLOSED	Circulated to the Committee via email 22.12.25
MHAMC May 2025		5	Forward Work Plan	Corporate Governance Team to work with Mental Health Act Team in regards to topics of Deep dives for the next 12 months	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	feb-26	CLOSED	A programme of Deep Dives has been included in the Annual Cycle of Business for 2026 which is on the agenda for the February 2026 meeting
MHAMC Feb 2025	5.3.1	5	MHA Quarterly Activity Report – Breaches / Analysis of Unlawful Detentions	To undertake a deep dive into adult mental health detentions within the RCT area and present to the next meeting of the Committee for discussion.	Chair, MHA Operational Group	Deputy COO/Director of Primary Community, Mental Health & LD	01/05/2025 **Now February 2026**	CLOSED	This is included in agenda item 5.1 Deep Dive Spotlight: Deep Dive into Adult Detentions

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

CTMUHB Mental Health Act Monitoring Committee (MHAMC)

Organisational Risk Register – July 2026

Eitem yr Agenda / Agenda Item	**4.1**
Dyddiad y Cyfarfod / Date of Meeting:	Wednesday 26 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to: • **Review** the risks escalated to the Organisational Risk Register at Appendix 1. • **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Applies across all areas
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Supports delivery in general

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing: Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	This report presents the organisational risks assigned to the Mental Health Act Monitoring Committee for assurance and oversight. These are risks where the Committee is identified as an assuring committee. This report presents the July 2026 position of the Organisational Risk Register (ORR). The ORR has been substantially refreshed and rewritten in collaboration with risk handlers, with a focus on: • improving readability and clarity through plain language descriptions • presenting risks in a consistent format (current controls, gaps, and actions) The main report (Excel document) has also been redesigned to fit onto a single A4 page, responding to feedback from Independent Members for a more accessible, navigable view.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	From the July iteration: • While the risks have been reviewed, updated and rewritten for clarity, there is no movement in any of the risk scores overall. • There are no new risks for this committee, and no risks have been closed or deescalated since the previous meeting of this committee.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)*	• The next iteration of the ORR will be presented to the Executive Leadership Group (ELG) on 14 September 2026 and subsequently shared with the Board and its committees. • Work has been undertaken to review and refine the actions associated with each risk. The September iteration of the ORR will include clearer, time-bound

What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	actions and progress updates, supporting more effective monitoring of risk mitigation and delivery. • The Executive Leadership Group met on 13 July 2026 and carried out its routine review and moderation of the ORR, ahead of presentation to the Board and committees. As part of this discussion, the ELG noted a high number of risks with a current score of 20 and committed to review and moderate the risk scores for a future iteration of this report.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to: • **Review** the risks escalated to the Organisational Risk Register at Appendix 1. • **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks

1. Background / Context

1.1. The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

Risk Review

1.2. Care Groups and Central leads continue to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews.

1.3. The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.

1.4. The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.

1.5. All risks on the Organisational Risk Register have been substantially revised for quality, consistency and readability. Whilst amendments are normally highlighted in red text to aid visibility of changes, this has not been applied on this occasion due to the extent of the revisions, which would have significantly reduced the readability of the document.

1.6. In parallel, Executive review by the Chief Operating Officer has supported a comprehensive refresh of the Organisational Risk Register. This has included constructive challenge to risk scoring and escalation decisions, clarification of risk ownership and accountability, strengthening of controls and action plans, identification of opportunities to consolidate overlapping risks, and ensuring that risks are presented at an appropriate strategic level.

1.7. The review has also prompted further work with Care Groups to validate risk assessments, update mitigating actions and confirm the ongoing appropriateness of organisational escalation. This work remains ongoing and will continue to inform future iterations of the Organisational Risk Register.

Risk Training

1.8. Risk training, although not a core training requirement under the statutory and mandatory framework, is available via the Electronic Staff Record (ESR).

1.9. The sessions are run by the Interim Assistant Director of Governance & Risk, currently joined by the Business Manager for Chief Operating Office. The sessions are held virtually via Teams on a monthly basis for a duration of one hour.

1.10. Bespoke team sessions on Risk are also available by arrangement.

2. Strategic Insights

1.1 The July 2026 review suggests that the Health Board's overall risk profile remains broadly stable, with many of the principal organisational risks continuing to reflect longstanding challenges relating to workforce, capacity, service demand, infrastructure and regulatory compliance.

3. Risks and Opportunities

3 NEW RISKS AND NEW ESCALATIONS

Nil for this committee since May 2026

3 CHANGES TO RISKS

Risk Score Increased

Nil for this committee since May 2026

Risk Score Decreased

Nil for this committee since May 2026

Risk De-escalated from the ORR

Nil for this committee since May 2026

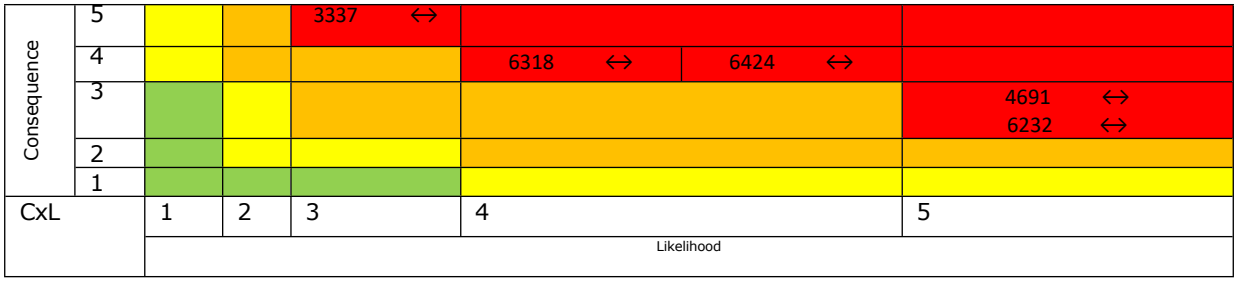
3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Nil for this committee since May 2026

3.4 HEAT MAP

The heat map provides a visual representation of the current Organisational Risk Register, showing the relative position of each risk based on its residual likelihood and consequence score, together with indicators of risk movement and escalation status since the previous report.

KEY:
↑ = score increased since previous report (May 2026)
↓ = score decreased since previous report
↔ = score unchanged since previous report
N = new risk identified and added to Datix since May 2026
~~XX~~ = risk closed



Emerging Risks Identified for possible future escalation

Nil for this committee since May 2026

4. Compliance and Governance

4.1 The Organisational Risk Register remains a key component of the Health Board's assurance framework.

4.2 It supports the identification, oversight and mitigation of significant organisational risks; strengthens executive accountability and committee assurance arrangements; and promotes transparency through structured reporting and publication where appropriate.

5. Benchmarks

5.1 Whilst there is no formal benchmarking mechanism for the Organisational Risk Register, the Health Board's approach is informed by internal and external audit recommendations, together with learning and good practice shared through NHS Wales governance and risk management networks. This provides an element of continuous comparative review and supports ongoing development of the organisation's risk management arrangements.

6. Conclusion

6.1 The July 2026 ORR reflects the outcomes of a comprehensive review of all risks with risk handlers and owners.

6.2 The July 2026 ORR is presented for information. Feedback from members on the content and presentation of the register is welcomed.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. The risks contained within the Organisational Risk Register collectively underpin all strategic risks within the Board Assurance Framework and support the delivery of the Health Board's strategic objectives.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A Resilient Wales The Organisational Risk Register supports long-term organisational resilience by identifying risks which may impact the sustainability of services, workforce, infrastructure and system working, and by supporting mitigation and continuous improvement.
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research The ORR strengthens organisational learning and continuous improvement by: • identifying areas of risk and vulnerability • supporting structured action planning

	• enabling oversight of risk management arrangements across the organisation

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Choose an item.
	The ORR itself has no direct environmental impact. However, it includes risks related to environmental sustainability (e.g. estates, infrastructure and wider environmental responsibilities), supporting organisational oversight and mitigation of environmental risks.

Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	**Outcome for Equality: NEUTRAL** The ORR is a governance and oversight document and does not directly impact on individuals or groups. Individual risks within the ORR may have equality implications, which are considered separately where relevant. **Outcome for Welsh Language: NEUTRAL** The ORR itself does not directly impact Welsh language provision. Any impacts relating to specific services or risks are considered within the relevant service or policy context.
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	**EWLIA not required for the ORR as a whole.** Individual risks may be subject to impact assessment where appropriate. **Quality Impact Assessment Outcome not required for the ORR as a whole.** The ORR does not introduce service change but provides oversight of risks which may affect quality. Individual risks may be subject to Quality Impact Assessment where relevant.
Cyfreithiol / Legal	**Yes (Include further detail below)** Legal implications are inherent within a number of risks included in the ORR (e.g. statutory compliance, regulatory requirements and duty of care). These are captured and managed at individual risk level.
Enw da / Reputational	**Yes (include further detail below)** Failure to manage identified risks may result in:

	• adverse patient outcomes • regulatory or audit findings • loss of stakeholder confidence The ORR supports mitigation of reputational risk through structured identification, monitoring and escalation of organisational risks.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**Yes (include further detail below)** The risks within the ORR reflect pressures and dependencies relating to: • workforce capacity and capability • financial sustainability • infrastructure and service delivery resources The ORR supports visibility and management of these resource impacts at organisational level.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Comprehensive review of risks at care group and directorate team meetings	June and July 2026	Changes captured in this report.
Executive Leadership Group (ELG)	13 July 2026	Review and moderation. Commitment to moderate risk scores for next iteration.

Acronyms / Glossary of Terms	

	A	F	G	H	I	K
1	**Datix ID and details**	**Risk Title / Risk Description**	**Current controls in place**	**Gaps in controls**	**Action Plan**	**Rating (current) and details**
6	**Mental Health and Learning Disabilities Care Group☐**					
7	**6318** **Risk Owner:** Chief Operating Officer **Risk Handler:** Directorate Manager - CAMHS and Specialist Services (Mental Health and Learning Disabilities) **Risk Domain:** Safety & Well-being - Patients / Staff / Public	**Tier 3 SHED (Severe and High Impact Eating Disorders) Team Service Capacity and Resilience** **IF** the Health Board and partner organisations are unable to provide sufficient workforce capacity and sustainable arrangements for the Tier 3 SHED service **THEN** the service may not be able to deliver safe, effective and consistent care **RESULTING IN** risks to patient safety and outcomes, reduced service effectiveness and increased operational and organisational pressure	• Regular joint working with Cardiff and Vale UHB, including established monthly oversight meetings • Improved governance, communication and escalation arrangements between organisations • Temporary service mitigations in place (e.g. nurse practitioner support, drop-in clinics, physical health monitoring) • Staff training and service development actions underway • Ongoing monitoring through Care Group and executive governance structures	• Workforce capacity challenges remain unresolved • Service sustainability remains dependent on partner organisation capacity • Temporary mitigations do not provide a long-term solution • Continued pressures on service delivery and effectiveness • Underlying structural issues not yet addressed	• Continue joint working with CAVUHB to develop sustainable service arrangements • Maintain regular oversight and monitoring through established governance routes • Progress workforce and service model improvements • Continue implementation of agreed actions arising from joint reviews and reports	**16** ↔ **C4 X L4** **Target Score: 6** **Opened: 29/08/2025** **01/07/2026**
8	**3337** **Risk Owner**: COO **and** Director of Digital **Risk Handler**: Service Director, Mental Health and Learning Disability **Risk Domain:** Safety & Well-being - Patients / Staff / Public	**Lack of a Single Electronic Patient Record in Mental Health Services inc CAMHS** **IF** Mental Health services do not have a single integrated electronic patient record system, **THEN** clinical staff may not have access to complete and consistent patient information, **RESULTING IN** risks to patient safety, including potential for clinical decisions to be made on incomplete information and avoidable harm.	• Dedicated programme in place to procure and implement a single electronic patient record system. • Procurement process underway, with supplier engagement and contract negotiation planned/ongoing. • Programme governance arrangements in place, including Programme Board oversight. • Key programme roles (e.g. project and programme management) recruited to support delivery. • Workshops undertaken to review current systems, processes and information requirements. • Interim measures in place to support information sharing across existing systems (e.g. defined access and recording arrangements).	• No single integrated electronic patient record currently in place across Mental Health services. • Dependence on multiple systems and interim arrangements to access patient information. • Programme remains in procurement/delivery phase, with full implementation not yet confirmed. • Continued reliance on manual or workaround processes to access and share information. • Benefits of a fully integrated digital record not yet realised.	• Progress procurement, contract award and mobilisation of the new electronic patient record system. • Undertake detailed implementation planning with the selected supplier. • Continue programme governance and oversight to support delivery to planned milestones. • Maintain and refine interim arrangements to support safe information sharing until implementation. • Keep the risk under review as the programme progresses through procurement and into delivery.	**15** ↔ **C5 X L3** **Target Score: 6** Opened: 07/11/2018 Last Updated: 01/07/2026
9	**4691** **Risk Owner**: COO **Risk Handler**: Service Director, Mental Health and Learning Disability **Risk Domain:** Safety & Well-being - Patients / Staff / Public	**Provision of safe and appropriate estate for Mental Health inpatient services** **IF** Mental Health inpatient environments do not meet required design, safety and quality standards, **THEN** care delivery may be constrained and the ability to provide safe, therapeutic and effective inpatient care may be compromised, **RESULTING IN** increased risks to patient and staff safety, reduced quality of care, and negative impact on patient experience and clinical outcomes.	• Inpatient Improvement Programme in place, including a workstream focused on safe and therapeutic environments. • Review and remodelling of adult inpatient services underway, with oversight through MHLD governance structures. • Feasibility work progressing to assess Mental Health inpatient estate requirements. • Engagement with Capital Team to support development of estate solutions. • Routine environmental and safety assessments undertaken, including ligature risk identification and mitigation. • Additional staffing measures implemented where environmental risks require enhanced observation or supervision. • Ongoing programme of service and workforce redesign supporting improvements in inpatient care delivery.	• Current inpatient estate does not fully meet required standards across all areas. • Long-term estate solution not yet agreed or implemented. • Reliance on interim mitigation (e.g. staffing adjustments) to manage environmental risks. • Feasibility and capital planning work not yet translated into a deliverable programme of change. • Environmental constraints continue to impact service delivery and patient experience.	• Progress feasibility work and develop options for improving Mental Health inpatient estate. • Work with Capital Team to develop and secure approval for estate solutions. • Continue inpatient service review and remodelling to align with future estate requirements. • Maintain environmental risk assessments and implement interim mitigations where required. • Keep the risk under review as estate planning and service redesign work progresses.	**15** ↔ **C3 X L5** **Target Rating: 6** Opened: 15/06/2021 Last Updated: 01/07/2026
17	***Director of Digital***					
18	**6424** **Risk Owner:** TBC (currently Director of Digital) **Risk Handler**: Head of IG **Risk Domain:** Statutory Duty, Regulation, Mandatory Requirements	**Mental Health Subject Access Requests (SARs) (IG/15)** IF... SARs in the Mental Health Team are not processed efficiently due to lack of staff and resources, THEN...we may not be compliant with the law, RESULTING IN... enforcement action from the regulator (ICO), plus increased complaints from requesters and affected parties, adverse press and loss of faith in the organisation to uphold data subjects' rights	• Mental Health Subject Access Request processes are established and in operation. • Executive leads and senior managers have been made aware of the backlog and staffing pressures affecting the service.	• Insufficient staffing and resources to process requests efficiently. • Backlogs have developed due to workforce capacity constraints. • Limited capacity to undertake the required review and redaction of records within statutory timescales.	• Escalate backlog and staffing pressures through appropriate management arrangements. • Support consideration of additional recruitment to increase capacity for request processing, redaction and review. • Monitor compliance with statutory timescales.	**16** ↔ **C4 X L4** **Target Score: 16** Opened: 20/11/2025 Last Updated: 01/07/2026

	A	F	G	H	I	K
1	**Datix ID and details**	**Risk Title / Risk Description**	**Current controls in place**	**Gaps in controls**	**Action Plan**	**Rating (current) and details**
19	***Executive Nurse Director***					
20	**6232** **Risk Handler:** Deputy Executive Director of Nursing **Risk Domain:** Safety & Well-being - Patients / Staff / Public	**Sustainability of the Legal Services function** **IF:** the Health Board does not sufficiently resource and support the Legal Services function **THEN:** it may not have the capacity, resilience or capability to meet its statutory and operational responsibilities **RESULTING IN:** increased staff turnover, reduced wellbeing and morale, and an increased risk of failing to meet legal obligations, with consequent reputational impact.	• Organisational Change Process (OCP) completed, and implemented on 5 May 2026 • Additional posts within the Legal Services Team approved, with recruitment underway to strengthen capacity and resilience, with the aim of achieving full recruitment to the revised establishment by 31 July 2026 • Recruitment of a new Lead for Legal Services • Plan to transition from recovery to a 'business as usual' model, from the Legal Services Recovery Plan, including implementation of the revised structure following delivery of the OCP, with full recruitment to the new establishment targeted for completion by July 2026. • Benchmarking undertaken with other organisations to inform structure and demand requirements	• There remains a gap in the full establishment of staff within the Legal Services Team, which is due to challenges with recruitment to the revised staffing structure, in line with the implementation of OCP. While full recruitment is targeted for 31 July 2026, this remains in progress and will extend beyond this timeframe. • Improvements from the OCP and recovery programme not yet fully embedded • Continued reliance on interim arrangements to maintain service delivery • Ongoing risk to staff wellbeing, retention and stability of the team	• Complete recruitment to the approved Legal Services Team structure and embed new staffing model • Continue implementation of OCP changes and associated service improvements • Deliver actions within the Legal Services Recovery Plan to strengthen capacity, processes and resilience • Continue to monitor demand and align workforce capacity accordingly	**15** ↔ **C3 X L5** **Target Rating: 6** Risk opened: 03/07/2025 Last updated: 01/07/2026

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Committee Annual Self Effectiveness Survey Outcome 2025-6 & Improvement Plan

Eitem yr Agenda / Agenda Item	**4.2**
Dyddiad y Cyfarfod / Date of Meeting:	26 August 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Kath Palmer (Health Board Vice Chair, and MHAMC Committee Chair)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Julie Denley, Deputy Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to **REVIEW** the outcome of the 2025-26 Committee Self-Effectiveness Survey and **APPROVE** the proposed proportionate improvement actions.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	This report supports the Health Board's overall governance and assurance arrangements by demonstrating that the Mental Health Act Monitoring Committee continues to review its own effectiveness, reflect on feedback from members and attendees, and identify any proportionate opportunities for improvement.
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	The report supports delivery of the Integrated Medium-Term Plan and Annual Delivery Plan by helping to ensure that the Mental Health Act Monitoring Committee remains effective in providing scrutiny, assurance and oversight in relation to matters within its remit.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The 2025-26 annual self-effectiveness survey for the Mental Health Act Monitoring Committee received six responses. Whilst this cannot be taken to represent the views of all attendees, the survey provides a useful opportunity to identify strengths and any proportionate opportunities for improvement. Feedback was positive across the majority of survey questions. All respondents gave positive responses in relation to the Committee's authority and resources, Annual Report, Cycle of Business, professional behaviours, meeting scheduling, closure of agenda items, virtual meetings, Committee boundaries, Chairing arrangements and Committee Highlight Reports. Five respondents confirmed that the Terms of Reference adequately define the Committee's role, whilst the remaining respondent noted that the Terms of Reference are currently being reviewed. Narrative feedback reflected positively on the Committee's willingness to reflect and continuously improve, including the use of themed deep dives to strengthen scrutiny and assurance. Respondents also identified a number of opportunities for further development.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	**Themes Arising from Feedback** The feedback received suggests that the Mental Health Act Monitoring Committee is operating effectively and is regarded positively by respondents. The comments received do not indicate any significant concerns regarding the Committee's governance arrangements or its ability to discharge its responsibilities. However, several proportionate opportunities for development were identified. Taken together, the feedback points towards a common theme: the importance of maintaining a clear focus on the Committee's specific role and remit. A shared understanding of the assurance the Committee is seeking to provide can help inform both the information presented to members and the development activities undertaken by the Committee, whilst ensuring that the operational resources required to support such activity remain proportionate. ***1. Committee Remit and Focus*** Whilst respondents generally considered Committee boundaries to be clear, several comments highlighted the importance of ensuring that the Committee remains focused on matters that sit within its Mental Health Act responsibilities and provides assurance in relation to its specific remit. One respondent also noted the risk that

discussion could stray into broader mental health issues outside the Committee's core responsibilities.

A clear and shared understanding of the Committee's remit also provides a helpful framework for considering the type of information, development activity and lived experience that is most likely to support effective scrutiny and assurance.
ACTION: Review whether any additional guidance or discussion would be helpful to support a shared understanding of the Committee's role, remit, assurance requirements and the matters that are within and outside the Committee's scope.
DUE DATE: Report to next MHAMC meeting: 25 November 2026.

2. Member Learning and Development

A number of respondents identified the value of ongoing development opportunities, particularly for newer Independent Members, reflecting the specialist and technical nature of the Committee's remit.

Suggestions included service visits, practical learning opportunities and regular development sessions to support understanding of Mental Health Act processes in practice. Respondents also highlighted the importance of presenting highly technical or clinical information in a way that supports meaningful engagement and scrutiny by all Committee members.

A number of relevant development opportunities have already been made available during 2026, including Approved Mental Health Professional (AMHP) training materials, invitations to attend a Power of Discharge training session and opportunities to visit mental health facilities. However, any future development activities should be proportionate and balanced against the operational resource required to arrange, prepare and support them.

ACTION: Consider whether any additional proportionate development opportunities should be incorporated into the Committee work programme, taking account of both member development needs and the operational capacity required to support such activity.
DUE DATE: Report to next MHAMC meeting: 25 November 2026.

3. Lived Experience

One respondent suggested that greater use of lived experience would further strengthen the Committee's work. Recent discussions regarding the use of patient stories have also highlighted the importance of being clear about the purpose of lived experience within Committee business and ensuring that any material

	presented supports the Committee in discharging its responsibilities. Consideration should also be given to the practical arrangements needed to identify, develop and support relevant contributions, and the resource implications of doing so on a routine basis. **ACTION:** Develop and agree a proportionate approach to the inclusion of lived experience within Committee meetings, including consideration of relevance to the Committee's remit, intended assurance objectives, practical arrangements, confidentiality considerations and the resource implications for operational teams. **DUE DATE:** Report to next MHAMC meeting: 25 November 2026. ***4. Welsh Language in Meetings*** One respondent indicated that they would welcome greater use of the Welsh language in Committee meetings. No further detail was provided regarding the type of usage they would find most helpful. Although this feedback came from just one attendee, similar feedback has been received through a number of other recent Committee self-effectiveness reviews. In response, the Governance Team has met with the Equality and Welsh Language Impact Team to explore practical and proportionate opportunities to increase the visibility and use of Welsh within Committee meetings. **ACTION (completed):** The Governance Team have met with the Equality and Welsh Language Impact Team to explore practical and proportionate opportunities to increase the visibility and use of Welsh within Committee meetings. **COMPLETION DATE:** 31 August 2026. **NEXT STEP:** Subject to agreement with the Committee Chair and Lead Officer, incorporate a small number of practical measures on a pilot basis for the Mental Health Act Monitoring Committee meeting on 25 November 2026.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Subject to agreement by the Committee, the actions listed above will be completed and reported back to the Committee.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to **REVIEW** the outcome of the 2025-26 Committee Self-Effectiveness Survey and **APPROVE** the proposed Committee Development action plan

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	This report does not directly affect the score or management of any individual strategic risk. However, it supports the Health Board's overall governance and assurance arrangements by helping to ensure that the Mental Health Act Monitoring Committee is operating effectively and is able to provide appropriate scrutiny, assurance and oversight in relation to matters within its remit. This contributes indirectly to the Board's wider assurance framework and the effective discharge of statutory and governance responsibilities.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	The report supports the Well-being Goals indirectly by strengthening the governance and assurance arrangements through which the Committee oversees matters within its remit. Effective committee scrutiny supports better decision-making, transparency, learning and accountability, which in turn contributes to more sustainable and integrated public services. The report does not propose any direct service, policy or operational change and therefore has no direct impact on any specific Well-being Goal.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership
	Culture & Valuing People
	Learning, Improvement & Research
	The report supports the Enablers of Quality by using feedback from Committee members and attendees to identify opportunities for improvement. The proposed actions are intended to support effective leadership, constructive committee culture, organisational learning and the continued development of governance and assurance arrangements.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable

Environmental Sustainability Impact (5Rs)	There are no direct environmental sustainability impacts arising from this report. The report relates to committee effectiveness and governance improvement, rather than a service, estates, procurement or operational change proposal.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: NEUTRAL Summary of impact: No direct equality impact has been identified. The report relates to the outcome of the Committee's annual self-effectiveness survey and proposed governance improvement actions. Outcome for Welsh Language: NEUTRAL Four respondents did not indicate that they would welcome greater use of the Welsh language at meetings. One respondent expressed support for greater use of the Welsh language, whilst another noted that bilingual greetings are routinely used. Given the limited and mixed feedback received, no specific improvement action is proposed at this stage. However, Welsh language visibility has emerged as a wider theme through other recent Committee self-effectiveness reviews. Any learning arising from that wider work will be considered across all Committees, including the Mental Health Act Monitoring Committee, where appropriate.	If no, please select a reason below. Choose an item. Not required at this stage – governance effectiveness report with no direct service, policy or operational change. Named Executive/Board member sign off for no EWLIA completion: Gareth Watts
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)*	A separate Quality Impact Assessment has not been undertaken, as the report does not propose a direct change to clinical services, patient pathways, staffing models or operational delivery.	

Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	The report is expected to have a positive governance impact by supporting the ongoing effectiveness of the Mental Health Act Monitoring Committee in providing scrutiny, assurance and oversight in relation to matters within its remit.
Cyfreithiol / Legal	There are no new legal implications arising directly from this report. The Mental Health Act Monitoring Committee operates within a statutory and regulatory context, and the annual self-effectiveness review supports good governance by helping the Committee reflect on its effectiveness in discharging its role. However, the report does not propose any change to statutory responsibilities, legal duties, policy or operational arrangements.
Enw da / Reputational	Choose an item. The report may have a positive reputational impact as it demonstrates that the Committee routinely reviews its own effectiveness, considers feedback from members and attendees, and identifies proportionate improvement actions. This supports transparency, accountability and continuous improvement within the Health Board's governance arrangements.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report** The proposed actions will be progressed through existing governance arrangements. Any future development activity, service visits or lived experience initiatives will need to be considered proportionately, balancing the potential benefits to Committee scrutiny and assurance against the operational capacity required to arrange, prepare and support such activity.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Mental Health Act Monitoring Committee members and attendees	July-August 2026	Six responses were received. Feedback was positive across the majority of survey questions and identified a small number of proportionate opportunities for further development relating to member development, practical learning opportunities, lived experience and future work planning.

Acronyms / Glossary of Terms	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Review of the Committee Terms of Reference

Eitem yr Agenda / Agenda Item	**4.3**
Dyddiad y Cyfarfod / Date of Meeting:	26th August 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Sharon Edwards, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter:	Louise Stait, Interim Assistant Director of Corporate Governance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Endorse the changes for Board Approval
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Not applicable If more than one applies, please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	N/A

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing:
Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Terms of Reference were approved by the Board on 26 March 2026. Since that time, a number of minor amendments have been made to reflect the current operating arrangements of the Committee. The principal amendments, highlighted through tracked changes, relate to quorum and attendance requirements that include the addition of the Chief Operating Officer or Deputy acting on their behalf along with two Care Group representatives. The remaining amendments are intended to provide greater clarity and consistency throughout the document. All proposed changes are shown as tracked changes for ease of review and consideration by the Committee.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The proposed amendments will ensure that the Committee's governance arrangements remain current, clear and aligned with organisational and operational priorities
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The Board will be asked to approve the minor changes on 24 September 2026

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to **review** the proposed amendments to the Terms of Reference and **endorse** them for approval by the Board.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Choose an item. If more than one applies, please list below: N/A

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable If more than one applies, please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not Applicable If more than one applies, please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable If more than one applies, please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome**	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below. Choose an item. Not required Named Executive/Board member sign off

(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Summary of impact:	for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Board	26/03/2026	Approved

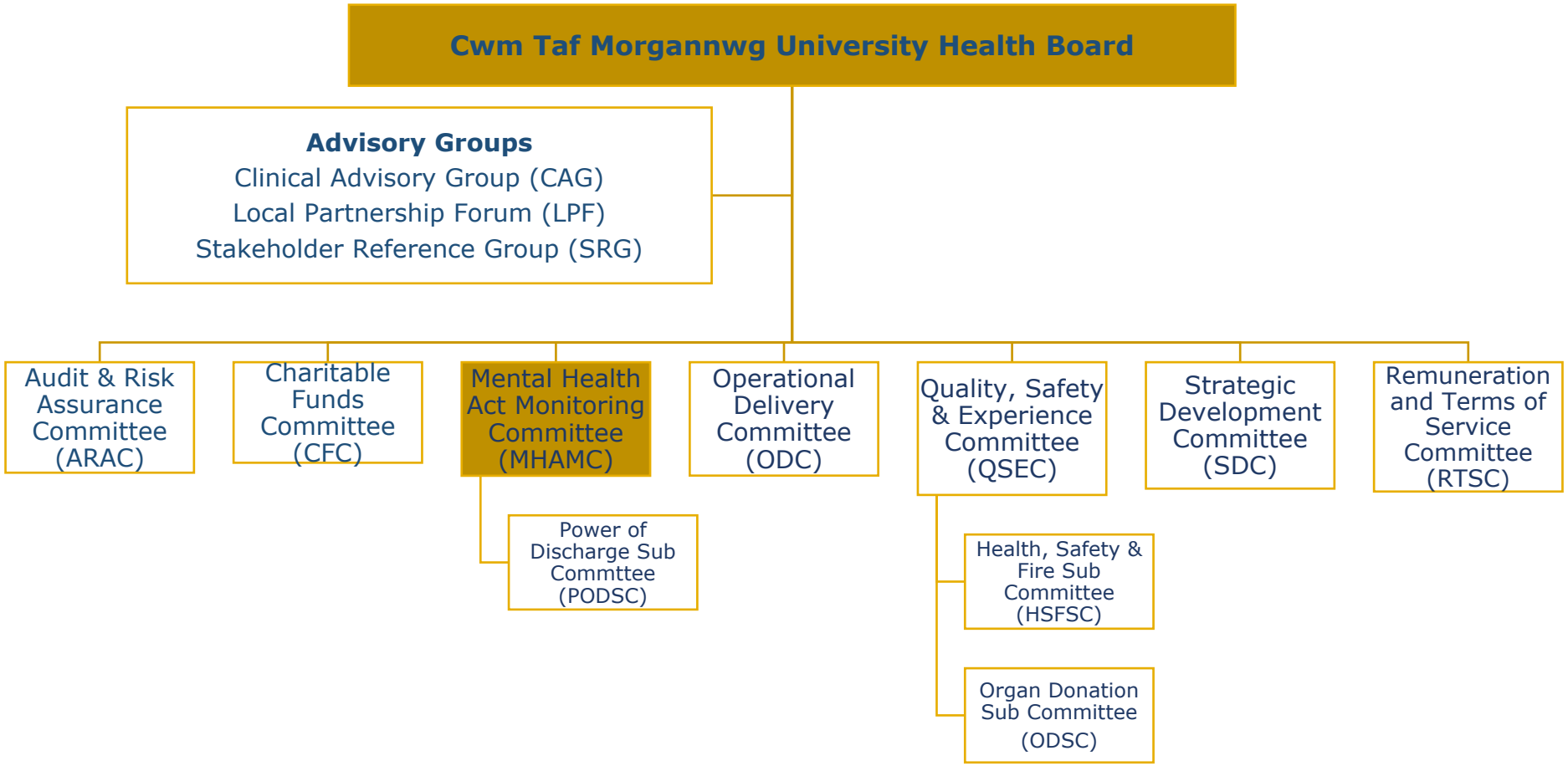
Acronyms / Glossary of Terms	

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

MENTAL HEALTH ACT MONITORING COMMITTEE (MHAMC)

Terms of Reference & Operating Arrangements
(Schedule 3.3a of the Standing Orders)

Last Approved: Health Board Meeting 26th March 2026
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)
Power of Discharge Sub Commttee (PODSC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)

Contents

Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26th September 2024	Approved	No later than the end of September 2025
Version 2	Health Board Meeting	26 March 2026	Approved	No later than end of March 2027
Version 3				

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Mental Health Act Monitoring Committee (MHAMC)**, the detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2. Purpose

2.1 To seek assurance that those functions of the Mental Health Act 1983, as amended, which have been delegated to officers and staff are being carried out correctly; and that the wider operation of the 1983 Act in relation to the CTMUB's area is operating properly;

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

2.3 CTMUHB's responsibilities as Hospital Managers are being discharged effectively and lawfully;

2.4 CTMUHB is compliant with Mental Health Act, 1983 Code of Practice for Wales;

2.5 CTMUHB works in partnership for example adhering to the South Wales Police Initiative: Right Care, Right Person.

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

3. Scope and Duties

In respect of its provision of advice to the Board, the MHAMC shall:

3.1 Review reports which have Mental Health Act related content from Healthcare Inspectorate Wales visits, the Delivery Unit and other external scrutiny bodies and approve the action plans for monitoring through its sub-

committee structure; the operational group will report on progress against these actions.

3.2 Review any areas of the Mental Health & Learning Disabilities Risk Register bi-annually where they explicitly relate to the MHA to ensure that the Mental Health Act Operating Group is appropriately managing risks relating to compliance with mental health legislation.

3.3 Receive Mental Health Act Monitoring Operating Group Update Report from previous meeting and the receive of Power of Discharge Sub-committee update report ensuring compliance with the Code of Practice.;

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

~~3.5 Receive Hospital Manager's Power of Discharge Committee Update Report. This report should ensure compliance with the Code of Practice.~~

In respect of its provision of assurance to the Board, the MHAMC will seek assurances that:

~~3.6~~3.5 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

~~3.7~~3.6 The wider operation of the 1983 Act (the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

~~3.8~~3.7 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated;

~~3.9~~3.8 Arrangements for the delegated authority of approval for Approved Clinicians and Section 12 Doctors in Wales are compliant with the Directions and Guidance from Welsh Government, and are monitored through the Mental Health Act Operations Group;

~~3.10~~3.9 Policies and procedures are developed and approved in line with the organisation's Written Control Document Policy, through the Mental Health Act Monitoring Operational Group;

~~3.11~~3.10 The training requirements of those staff who exercise the functions of mental health legislation have the requisite skills and competencies to discharge the Board's responsibilities, through the Mental Health Act Monitoring Operational Group;

~~3.12~~3.11 ~~Ensure that r~~Relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 2018, are adhered to.

~~3.13~~3.12 Cross-agency audit themes and sponsor appropriate cross-agency

audits take place through the Operational Group.

~~3.14~~3.13 Lessons learnt from difficulties in practice and the development of areas of good practice are presented~~.~~

~~3.15~~3.14 There is a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act.

~~3.16~~3.15 Consider trends and patterns of use of the Mental Health Act 1983.

~~3.17~~3.16 Consider issues arising from the operation of the hospital managers' power of discharge.

4. Membership

Members

4.1 The Membership of MHAMC is:

Chair	Independent Member (Vice Chair of CTMUHB) The Vice Chair of the Health Board shall Chair the Committee given their specific responsibility for overseeing the Health Board performance in relation to mental health service.
Vice Chair	Independent Member
Members	Four further Independent Members

4.2 The 1983 Act is operated by health and social care practitioners, in collaboration with a range of agencies including police and ambulance services, as well as third sector bodies such as advocacy providers. Membership of the Committee should reflect this, as different agencies and practitioners have differing responsibilities and duties under the Act.

4.3 The Independent Member Chair of the (Hospital Managers) Power of Discharge Committee should be a member of the MHAMC.

Support to Committee Members

4.2 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director for People.

4.3 The membership of MHAMC will be reviewed annually.

In Attendance

Chief Operating Officer
Deputy Chief Operating Officer - Primary Care, Community & Mental Health
Representative from South Wales Police (bi-annually)
Representative from Rhondda Cynon Taf County Borough Council
Representative from Merthyr Tydfil County Borough Council
Representative from Bridgend County Borough Council
Chair of the Mental Health Act Monitoring Operational Group
Head Administrator – Mental Health Act Administration Team
Representative from Welsh Ambulance Services Trust (Minimum of twice per annum)
Mental Health & Learning Disabilities Care Group Director representatives (Service Director, Medical Director and Nurse Director)

By Invitation:

4.4 Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

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

5 Quorum & Attendance

5.1 A quorum shall consist of no less than three of the membership and must include as a minimum the Chair or Vice Chair of the Committee and two other Independent Members, together with a third of the In Attendance Members. In addition the Chief Operaring Officer of Deputy acting on their behalf and two Care Group representatives must be present.

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

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

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

5.5 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

~~5.6~~

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

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

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet **at least four times per annum** and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

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

8 Withdrawal of Individuals in Attendance

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

9 Circulation of Papers

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

10 Access

10.1 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the MHAMC.

10.2 The Chair of the MHAMC shall have reasonable access to Executive Directors and other relevant senior staff.

11 Accountability, Responsibility & Authority

11.1 The MHAMC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

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

11.6 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:
    - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
    - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
- Approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

11.7 The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

11.8 At this stage, the Committee has established the following Sub Committee:

- (Hospital Managers) Powers of Discharge (POD) Sub Committee

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- ~~Together for Mental Health Partnership Board~~
- ~~Crisis Concordat Meeting Forum~~.

12 Reporting

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

- joint planning and co-ordination of Board and Committee business;
- sharing of information.

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

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

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

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

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

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

15 In Committee (Private Meeting)

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

16 Review

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Report from the Mental Health Act Operational Group meeting held 30th July 2026

Eitem yr Agenda / Agenda Item	**5.2**
Dyddiad y Cyfarfod / Date of Meeting:	26th August 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Robert Goodwin, Directorate Manager CAMHS and Specialised Services.
Cyflwynydd yr Adroddiad / Report Presenter:	Robert Goodwin, Directorate Manager CAMHS and Specialised Services.
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	None
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	MH&LD IMTP 2026-2029 Ensure strong relationships with key strategic partners to improve the efficiency and effectiveness of service delivery.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The MHA Operational Group is a partnership forum which reviews the implementation of the MHA in our region. The Group provides assurance and recommendations for development to ensure we improve the service we give to our patients and keep within the legal framework.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	This quarter's report includes, • a review of Q1 MHA activity April to June 2026 • information on the roll out of the Section 12 Approved Doctor app • progress on the development of the SWP Section 136 Policy • update on the new Mental Health Act. • Updates on Policy development and the Section 117 Aftercare Register together with a work plan for the Group.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Further work planned with the SWP and partners to • develop Section 136 Policy, • establishment of Project Team to implement the Section 12 Approved Doctor app and roll out of further awareness training • support for staff to avoid errors and breaches.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to note the work of the Operational Group.

1. Background / Context

The Operational Group has met on one occasion since the last meeting of the Mental Health Act Monitoring Committee which took place 27th May 2026. The meeting on 30th July 2026 was well attended with representatives from across Adult Mental Health Services, CAMHs, Mental Health Act Team, Social Services, the IMHA and Ambulance Service.

2. Strategic Insights

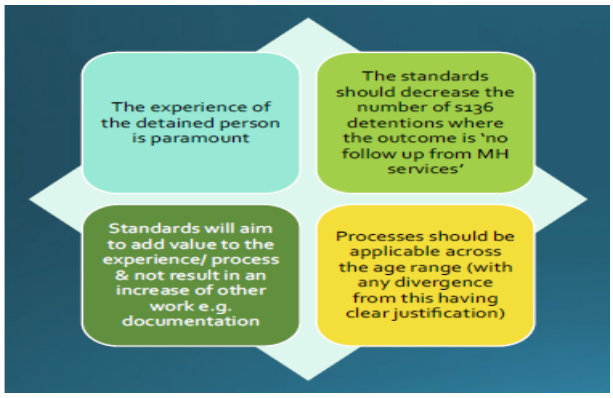
2.1 Development of Section 136 Best Practice Standards for Wales - NHS Wales Performance and Improvement.

A national task and finish group led by NHS Wales Performance and Improvement has begun to draft the attached Section 136 Best Practice Standards for Wales. (see Appendix 1 – 5.3b)

The paper sets out a set of All-Wales best-practice standards for the use of Section 136 of the Mental Health Act, aimed at reducing variation between areas and improving the experience and outcomes of people detained under s136. The four main areas are;

1. A consistent, person-centred approach across Wales
2. Faster access to the right place and assessment
3. Much stronger national standardisation and multi-agency working
4. Clear workforce competence, governance and accountability

These standards when finalised will support the development of the open access mental health support model for Wales. The guiding principles for all of the standards are shown in the diagram below.



It is acknowledged that some of the standards described in the document will be aspirational at this time but have been included to set the expected direction.

The Operational Group including Local Authority colleagues will review the draft standards and complete a self-assessment.

2.2 Draft South Wales Police Mental Health Policy 2026.

Following a period of partnership engagement the South Wales Police have developed the attached draft Mental Health Policy document which include arrangements for Section 135 and 136. (see appendix 2 – 5.3c)

At a further engagement event on 21st July 2026 the SWP requested information on the places of safety from each of the Health Boards in their area. It is proposed that in our region the Adult places of safety are confirmed as those located in;

- Coity Clinic at the Princess of Wales Hospital
- The Mental Health Unit at the Royal Glamorgan Hospital
- Emergency Department Suite at the Prince Charles Hospital.

For younger people there are segregated paediatric areas within each of the Emergency Departments. For adolescents between the age of 16 and 17 the Adult places of safety can be considered if there is capacity. If not the segregated paediatric areas within Emergency Departments would be the destination.

The Health Board has also been asked to confirm escalation arrangements in relation to handover delays which would follow normal operational routes in office hours and the on-call rotas out of hours. Escalation arrangements exceeding 1 hour would involve the local SWP Seargent and local Mental Health CRHT Manager, after 2 hours, escalation will be considered by the SWP local Inspector and through to the CRHT Senior Nurse or MH Bronze on call out of hours. After 3 hours, the SWP Silver Commander would contact the MH directorate Lead Nurse or MH Silver on call out of hours, further delays or escalation would be made between the SWP Gold Commander and the MH Care Group leadership team or the CTM Executive on call out of hours. Within our area we need to further develop the monthly Police Liaison meetings in order that they can be an effective venue to scrutinise Section 135 and 136 operational issues. Following receipt of the above information a revised draft document will be published by the SWP and further engagement event planned.

2.3 Section 12 Approved Doctors – Supporting the Crisis Care Pathway through digital innovation.

The MHA Operational group has been exploring the possibility of extending the current Welsh pilot scheme into our Health Board. The scheme will allow AMHPs to contact all Section 12 doctors through a digital app rather than individual communication. The app has been found to assist in the timely delivery of S.12 approved doctor assessments. There is strong support for this from our Local Authority partners. Support is being provided from Finance and Information Governance.

The Welsh Government Strategic Mental Health Workforce Plan Action 5 has the ambition to: Develop and implement plans to ensure that there is an appropriate supply of trained professionals to undertake new and existing legal roles.

This action will focus on increasing the number of mental health professionals who are able to participate in work often in relation to serious mental illness requiring a specific skill set. This will include Approved Mental Health Professionals (AMHP) and Section 12 Approved Doctors.

Engagement with AMHPs and NHS Doctors and managers carried out between 2021/2022 identified that availability and accessibility to S.12 Doctors was one of the top 3 barriers to AMHPs carrying out their duties. The other two barriers were noted as lack of acute mental health beds and a lack of availability of transport to convey detained patients. These challenges have reduced the attraction of the AMHP role and led to reducing numbers. In response to the feedback funding was agreed for additional S.12 Doctor training and a 12-month pilot of an existing app used extensively in England to help AMHPs make contact with S.12 Doctors and facilitate MHA assessments. The app is designed, developed and delivered by the company Vital Hub.

A commission to the value of £60,000 was placed by Social Care Wales and in January 2026 a pilot scheme began for 12 months in Aneurin Bevan UHB. A full evaluation will be produced on completion. Social Care Wales have secured the necessary £15k funding to extend the pilot into Cwm Taf Morgannwg UHB and have indicated their willingness to present the proposal to further stakeholders within area.

As a next step it is proposed that the pilot scheme be presented to the MH & LD Care Group Senior Medical Staff Committee.

2.4 Independent Mental Health Advocacy Quarterly Report April – June 2026.

It was noted that the South Wales Advocacy Service were presenting their Q1 report and a patient story at the MHAMC. The Group noted the receipt of 160 referrals this quarter. The key themes relating to discharge planning and application of the DoLS process were considered. It was noted that clinical teams were not automatically sent reminders when a DoLS was coming to an end. The chair of the Operational Group will raise this matter with the DoLs HB lead. The Group were assured that robust support was being provided to Mental Health patients with issues being escalated as required.

2.5 Mental Health Act Activity Report April – June 2026.

Whilst Adult detentions remained broadly stable a rise was noted in Section 2 and Section 3 detentions for the RCT area. The Group agreed to continue monitoring trends and further consider individual Community Mental Health Team (CMHT) activity within the locality. Section 135 and 136 detentions had remained stable for the previous four quarters. Just nine of the eighty-nine 136 detentions in the period were discharged without any follow up. There were no Section 135 detentions in the quarter.

The number of rectifiable errors had reduced to five compared to nine in the previous quarter. Three relating to the completion of Form HO2 and HO6 by the AMHP and two relating to the completion of Form HO14 by the nurse.

There were two fundamental breaches in Q1 compared with none recorded in the previous 3 quarters. The first related to an out of area assessment in London in which the Royal Glamorgan Hospital was wrongly identified as the admitting unit. In the second breach the Royal Glamorgan Hospital was wrongly identified by the AMHP as being the admitting unit rather than Ysbyty Cwm Cynon. The Group were advised that practitioner colleagues had been advised of their error and discussed the need for ongoing training. It was disappointing that the two breaches highlighted poor compliance with the scrutiny checklist. The group discussed the learning points which would be taken back to the regional AMHP forum in relation to the completion of HO2 and HO6 forms. The importance of applying the scrutiny checklist to avoid fundamental breaches was emphasised. Further work planned on awareness raising and support in relation to the scrutiny checklist (see Invalid Detention Poster as described below and attached in Appendix 3 – 5.3d)

There were two lapses in detention in Q1.

- In one case the Nearest Relative objected to the application of the Section 3 detention and the RC was not available to discharge the patient from Section 2.
- In the second case the patient was not found to meet the criteria for a Section 3 detention and the Section 2 detention was allowed to lapse rather than be formally discharged under Section 23.

The HO17 form should have been completed in good time before the expiry which occurred on the weekend. Staff informed and datix completed for both cases.

It was noted that there had been a single death in the quarter of a detained patient who had been receiving care on a general ward in Ysbyty Cwm Rhondda. The Group were advised of just two deaths of detained patients in the previous 2 years both as a result of natural causes. The operational group will continue to review all such deaths to determine if there are any themes.

2.6 Mental Health Act – Invalid Detentions Poster

The Mental Health Act have developed an invalid detentions poster for display in our Mental Health Units. The poster supports the existing scrutiny checklist which is designed to help prevent breaches to the Mental Health Act. (See appendix 3)

2.7 Health Inspectorate Wales SOAD Handbook.

SOAD Guidance - SOAD Handbook | Healthcare Inspectorate Wales (See Appendix 4 – 5.3e)

The Operational Group welcomed the new handbook which describes good practice in relation to the delivery of the Second Opinion Approved Doctor (SOAD)process. This forms part of the Consent to Treatment arrangements within the Mental Health Act.

The HIW SOAD Handbook (2026) contains four main messages;

- SOAD is fundamentally a patient safeguard, not simply a second clinical opinion.
- Patient voice, consent and capacity must be demonstrable.
- Treatment plans and CO3 certificates need to be precise.
- The quality of the clinical rationale is critical.

2.8 Health Inspectorate Wales Unannounced Visit to the Royal Glamorgan Hospital Adult Acute Mental Health Wards 13th – 15th April 2026.

The Mental Health Act (MHA) findings are notably positive in the HIW inspection of Wards 21, 22 and PICU at Royal Glamorgan Hospital (13–15 April 2026).

HIW reviewed five detained patients' records across the three wards. It found that all five detentions were lawful and compliant with the Mental Health Act and the Code of Practice for Wales.

The main MHA strengths were:

- Robust MHA auditing and monitoring arrangements.
- A dedicated and experienced MHA administration team supporting the hospital.
- A centralised database used to monitor statutory timescales, referrals and key due dates.
- MHA documentation was described as well organised, complete and easy to navigate, supporting effective oversight.
- Good processes were in place to ensure patients received information about their detention and rights.
- Patients' detention status was regularly reviewed.
- Patients had appropriate access to statutory safeguards and independent advocacy.
- Staff demonstrated a good understanding of their responsibilities in supporting patients to exercise their MHA rights.

There was also evidence of good medicines/MHA interface: consent-to-treatment certificates were appropriately completed and stored with MAR charts, and patients' current MHA legal status was clearly recorded.

HIW found that all patients had access to an Independent Mental Health Advocate (IMHA) and that advocacy involvement was clearly evidenced in the records reviewed. Staff demonstrated commitment to protecting patients' rights, and regular reviews were undertaken to minimise restrictions according to individual risk

2.9 Section 17 Leave Audit.

The Clinical Director for Adult Acute Inpatient Services presented an audit of compliance with Section 17 Leave Standards for the Princess of Wales Hospital and the Royal Glamorgan Hospital. Section 17 Leave has been a particular focus of HIW in recent visits. The audit considered the Standards contained within the Code of Practice which requires clear documentation, the setting of clear Section 17 Leave conditions and patient involvement in the process. The audit identified the need for improvements in the quality of documentation and the recording of outcomes. The clinical team was exploring options to improve communications with patients and their families. A process of re-audit has been agreed. The Operational Group will oversee the implementation of recommendations.

2.10 Update on the Mental Health Act 2025

The Operational Group were advised of some specific provisions under Commencement Order Number 1 which took effect on 6th April 2026. This extends the Human Rights Act 1998 to private providers who deliver NHS-funded mental health inpatient and after-care services. It closes an historical accountability gap. The new Mental Health Code of Practice will be developed over the next 1-2 years for England & Wales. The Operational Group look forward to being involved in the consultation.

The Welsh Government has newly structured its cabinet following the Senedd elections. They are heavily focused on their 10-year Mental Health and Wellbeing Strategy and have recently been advertising for a Senior Mental Health Policy Adviser to lead these operational changes across Wales.

2.11 Approved Clinicians Working without AC/RC Status in Wales.

The All Wales Approved Clinicians and Section 12 (2) Approval Panel in their letter to Health Boards on 29th July 2026 reconfirmed that the exercise of Approved Clinician functions in Wales without Welsh AC approval is not lawful under the Mental Health Act. Consultant Psychiatrists with Approved Clinician (AC) status in England are not able to undertake these functions in Wales without the necessary Welsh approval. Responsibility for verifying Approved Clinician status before a Clinician undertakes AC functions in Wales rests with the employing organisation as part of its recruitment, appointment and governance arrangements. The Operational Group were not aware of any particular concerns in relation to CTM UHB.

2.12 Section 117 Aftercare Register

The Section 117 Aftercare Register is subject to Partnership review. The currently recorded number of patients with entitlements under these arrangements is shown in the table.

Table 1 – Patients Subject to Section 117 Aftercare Arrangements

Locality	Adult	Older Persons	CAMHS	Learning Disabilities	ORT	Totals
Bridgend	140	14	5	0	0	159
Merthyr	109	13	3	1	13	139
RCT	448	74	7	0	31	560
TOTAL	697	101	15	1	44	858

The Mental Health Act Team are contacting Swansea Bay University Health Board for information on Learning Disabilities patients from our region who have been subject to Section 3 detention and therefore eligible for Section 117 Aftercare.

The Operational Group will audit compliance with the local policy when the above register is fully updated.

2.13 Operational Policy Review

The MHA team had made very good progress on the review of Operational Policies. The Health Board's Risk Assessment Tool had been applied to each of the approved policies. A list of ratified and policies subject to review is shown in Table 2 below.

Table 2. Schedule of Mental Health Act Operational Policies and their approval

REF NUMBER	TITLE	LEAD PERSON	PROGRESS
MH04	Community Treatment Policy	AT	Agreed In Operational meeting. 15/10/2021. Ratified in MHAMCM- 04/12/2023
MH06	Section 5(4)	AT	Agreed in the Operational Group 27/01/2023. Ratified in MHAMCM- 04/12/2023
MH07	Section 5(2)	JB	Agreed in the Operational Group meeting 28/04/2023. Ratified in MHAMCM- 04/12/2023
7MH08	Consent to Treatment Sec 58 and Sec 58a	AT	Agreed in the Operational Group meeting 28/04/2023. Ratified in MHAMCM- 04/12/2023
MHA117	Section 117 Policy	JB	Agreed in the Operational Group meeting on 28/07/2023. Ratified in MHAMCM - 04/12/2023
MH12	Section 17 leave policy	JB	Agreed in the Operational Group meeting 26/01/2024. Ratified in MHAMCM- 06/03/2024
MH28	Hospital Managers Scheme of Delegation	AT	Agreed in the Operational Group meeting 26/01/2024. Ratified in MHAMCM- 06/03/2024
MH17	Section 132&133 patients rights' procedure	JB	Agreed in the Operational Group meeting 26/01/2024. Ratified in MHAMCM- 06/03/2024
MH09	Hospital Managers Operational Procedure	JB	Agreed in the Operational Group meeting 26/01/24. Ratified in the MHAMCM- 05/06/2024.

New	Section 140 Policy	RG	Revision agreed in the operational group meeting 25/7/2025. For approval in Care Group Policy Committee and Executive Management Board.
New	Allocation of Responsible Clinician	AT	Agreed at the Operational Group meeting on 07/11/2024. Ratified in the MHAMCM on 19/02/2025.
New	Standard Operating Procedure for S117	AT	Agreed at the Operational Group meeting on 07/11/2024. Ratified in the Executive Management Board on 25/11/2024.
MH03	Section 136		South Wales Police to update policy with partners.
MH02	Section 135(1) Section 135(2)		South Wales Police to update policy with partners.

AGREED FOR REVIEW

2.14 Operational Group Work Plan

The group considered a proposed work plan including the following items:

Table 3. Operational Group Work Plan

Activity	Progress	Timescale
Service user feedback	Advocacy Support Cymru to circulate CTO Questionnaire involving the patients care coordinator.	November 2026
Policy Work	The South Wales Police have begun an engagement process in relation to the renewal of the Section 136 Policy.	November 2026
Review of the Section 135	Following the Deep Dive the Operational Group is coordinating the development of a Standard Operating Procedure to guide staff making a Section 135 application to the court.	November 2026
Draft Welsh Government Section 136 Standards	Complete a self-assessment of the draft Standards developed by the Welsh Government Performance and Improvement Team.	November 2026
Equality and Welsh Language	Impact assessment screening to be completed by the Operational Group.	November 2026
Quality Impact Assessment	Screening exercise to be completed by the Operational Group.	November 2026
Section 12 Approved Doctor Digital App	Develop the pilot scheme with Social Care Wales and the Service Provider Vital Hub.	February 2027
Review of Section 62	Completion of a deep dive into the use of Section 62 Emergency Treatment and the timing of SOAD applications.	November 2026
Review of Section 117	An audit tool will be developed to measure our Service against the standards within the Code of Practice and	February 2027

	our local policy. Prior to this the 117 register needs to be fully cleansed.	

3. Risks and Opportunities

3.1 Development of SWP Section 136 Policy and NHS Wales Standards

The SWP are finalising the draft Section 136 Policy with partners. This will include an escalation arrangement for delayed handovers of care. The NHS Performance and Improvement Team is also developing some supportive standards in this area.

3.2 Progress the implementation of the Section 12 Approved Doctor digital app

The aim is to improve access to Section 12 Approved Doctors by local AMHPs when they are organising a Mental Health Act assessment.

3.3 Further work to minimise the number of errors and breaches

A poster has been developed for circulation to support awareness raising on the errors and breaches checklist which has been developed for Practitioners.

3.4 Feedback from the HIW unannounced visit to the Royal Glamorgan Hospital Adult Acute Mental Health Wards, 13th – 15th April 2026

Very positive feedback in the HIW report following the unannounced HIWE inspection of the RGH Adult wards.

3.5 Update on the Mental Health Act

The key next step is the development of the Code of Practice for Wales. A consultation process is expected to start shortly.

3.6 Section 117 Aftercare Register

The current Aftercare Register is being reviewed. Current focus on Learning Disabilities patients who have this entitlement with Swansea Bay UHB being asked to confirm details.

4. Conclusion

The MHAMC is asked to **note** the work of the Operational Group described in this report.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2	
	If more than one applies please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales	
	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: **POSITIVE** Summary of impact: *The Group aims to ensure Equality of access to the Mental Health Act*. Outcome for Welsh Language: **POSITIVE** Summary of impact: *The Group aims to ensure Equality of access to the Mental Health Act*	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)*	**The Operational Group has placed the Quality Impact Assessment process on the agenda for its next meeting.**	

Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	
Cyfreithiol / Legal	**Yes (Include further detail below)**
	The Legal implications relating to the recent change in the Mental Health Act are being worked through and reported to the Mental Health Act Monitoring Committee.
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
MHA	Mental Health Act
AMHP	Approved Mental Health Practitioner
EDT	Emergency Team
SWP	South Wales Police
CAMH's	Child and Adolescent Mental Health Service
IMHA	Independent Mental Health Advocacy
AWOL	Absent Without Leave
SOAD	Second Opinion Appointed Doctor
RGH	Royal Glamorgan Hospital
HIW	Healthcare Inspectorate Wales
MHAMC	Mental Health Act Monitoring Committee
SWP	South Wales Police
CRHT	Crisis Resolution Home Treatment Teams

Appendices

Appendix 1- Section 136 Best Practice Standards (attached in supporting documents folder as 5.3b)

Appendix 2 - Draft South Wales Police Mental Health Policy 2026 (attached in supporting documents folder as 5.3c)

Appendix 3 – Mental Health Act – Invalid Detentions Poster (attached in supporting documents folder as 5.3d)

Appendix 4

SOAD Guidance - SOAD Handbook | Healthcare Inspectorate Wales

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Deep Dive Spotlight: Section 136, Emergency Department Waiting Times including Places of Safety

Eitem yr Agenda / Agenda Item	**5.3**
Dyddiad y Cyfarfod / Date of Meeting:	26th August 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Robert Goodwin, Directorate Manager CAMHS and Specialised Services.
Cyflwynydd yr Adroddiad / Report Presenter:	Robert Goodwin, Directorate Manager CAMHS and Specialised Services.
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	None
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	MH&LD IMTP 2026-2029 – ensure strong relationships with key strategic partners to improve the efficiency and effectiveness of service delivery.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	There has been a particular focus on Section 136 handover times from the South Wales Police since the introduction of the "Right Care Right Person" Policy initiative. The Police have been seeking to minimise Police waiting time at the point of handover in order to release their officers for other operational duties. A new Section 136 Policy is in development by the SWP which sets targets for the handover of patients and introduces escalation arrangements where there are particular delays.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The MHAMC has asked the Operational Group to undertake a "deep dive" into Section 136 waiting times particularly in our Emergency Departments which are a particular challenge across Wales. A number of meetings have been held with colleagues from the Mental Health Crisis Teams, local Emergency Departments, Local Authority AMHPs and South Wales Police to discuss the dataset below and identify next steps.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The document sets out the following further work to assist in reducing waiting times: • Improving Access to Section 12 Approved Doctors • Improving Access to AMHPs • Development of Parallel Assessments in the Emergency Department • Reduction in the number of 136 Detentions • Further development of local Police Liaison Committee arrangements • Mental Health Assessment of Children and Young People

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The MHAMC is asked to review and **note** the contents of this "deep dive" paper.

1. Background / Context

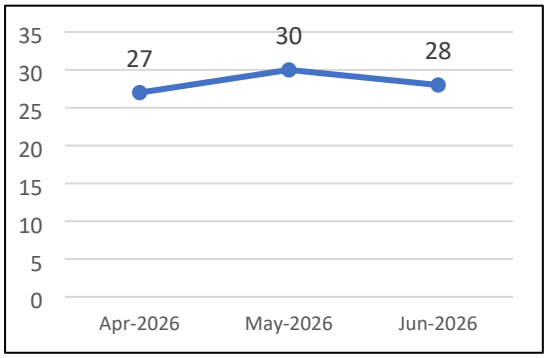
There has been a particular focus on Section 136 handover times from the South Wales Police since the introduction of the "Right Care Right Person" Policy initiative. The Police have been seeking to minimise Police waiting time at the point of handover in order to release their officers for other operational duties. A new Section 136 Policy is in development by the SWP which sets targets for the handover of patients and introduces escalation arrangements where there are particular delays.

The MHAMC has asked the Operational Group to undertake a "deep dive" into Section 136 waiting times particularly in our Emergency Departments which are a particular challenge across Wales. A number of meetings have been held with colleagues from the Mental Health Crisis Teams, local Emergency Departments, Local Authority AMHPs and South Wales Police to discuss the dataset below and identify next steps.

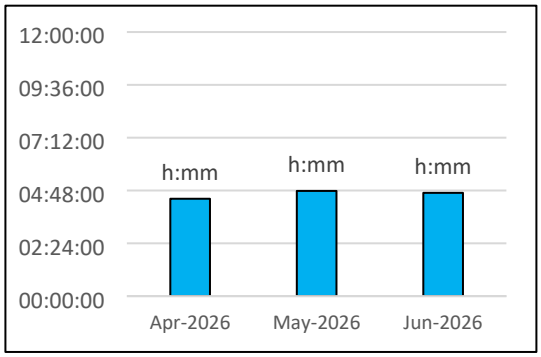
2. Strategic Insights

2.1 Total Section 136 Waiting Times

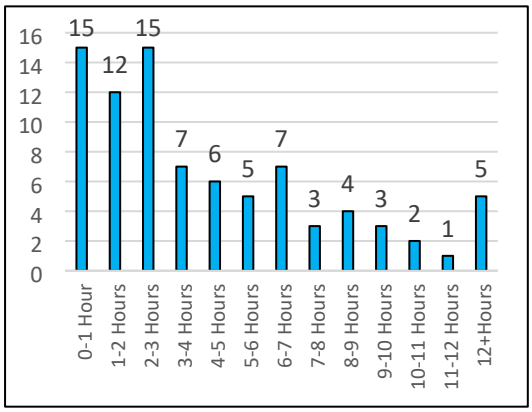
Graph 1: Number of Section 136 Detentions



Graph 2: Average of Total Officer Waiting Time 1st Place of Safety to Patient Handover



Graph 3: Total Officer Waiting Time 1st Place of Safety to Patient Handover

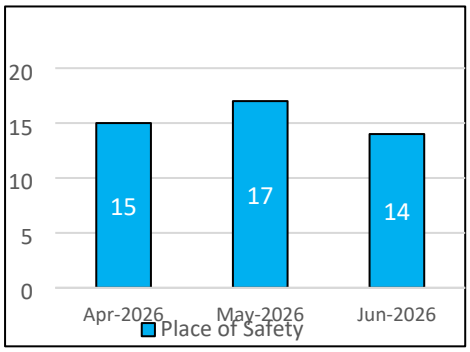


There were eighty-five Section 136 Detentions reviewed in the three-month reporting period April to June 2026. Forty-two (49%) of these detentions were handed over from the Police within 3 hours. Information was also presented on the number of repeat presentations. Thirty-seven of the Detentions were repeat presentations involving 11 individuals. Three of the individuals were responsible for eighteen of the Section 136 Detentions.

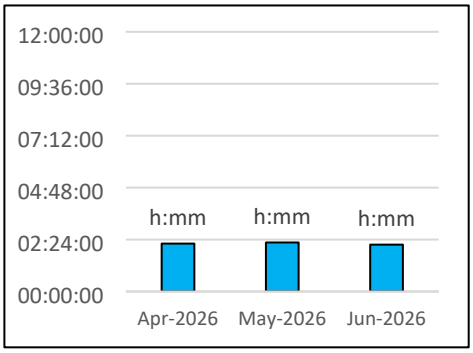
2.2 Mental Health Place of Safety Section 136 Waiting Times - April to June 2026

2.2.1: Total Waiting Times

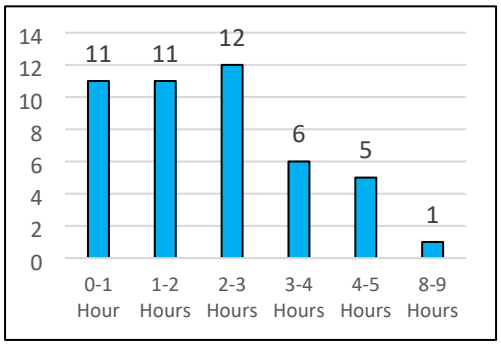
Graph 4: Number of Section 136 Detentions



Graph 5: Average of Total Officer Waiting Time



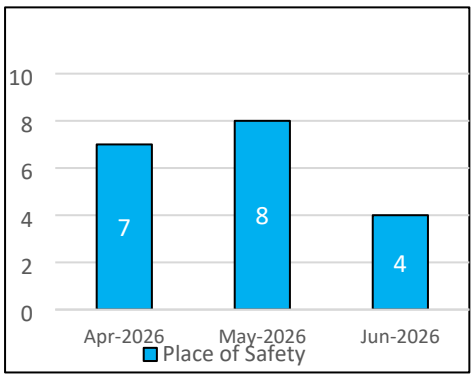
Graph 6: Total Officer Waiting Time Place of Safety to Patient Handover



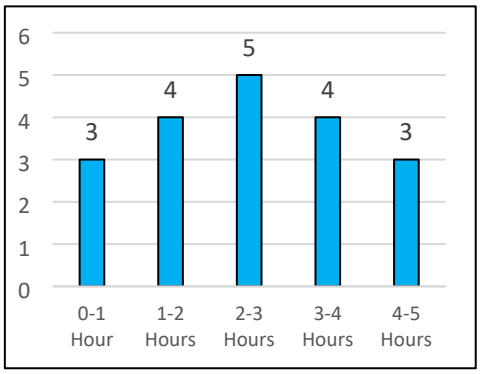
Forty-six of the Detentions had the Mental Health Place of Safety as their first point of contact. Of these thirty-four (74%) were handed over from the Police within 3 hours.

2.2.2: Royal Glamorgan Hospital Mental Health Place of Safety Waiting Times

Graph 7: Number of Section 136 Detentions



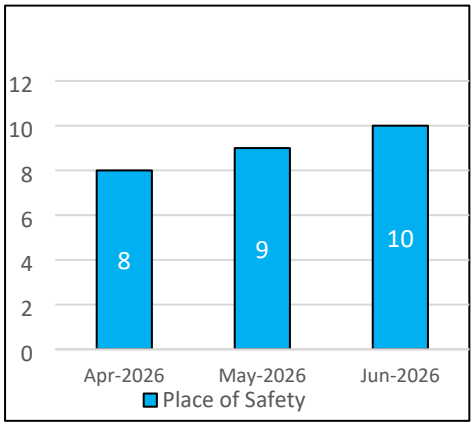
Graph 8: Total Officer Waiting Time Place Place of Safety to Patient Handover



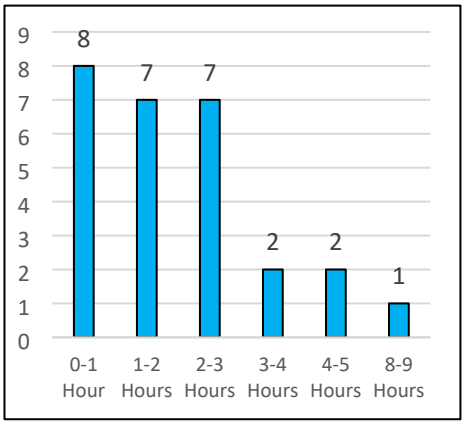
There were nineteen Detentions in the Royal Glamorgan Hospital Mental Health Place of Safety of which twelve (63%) were handed over from the Police within 3 hours.

2.2.3: Princess of Wales Hospital Mental Health Place of Safety Waiting Times

Graph 9: Number of Section 136 Detentions



Graph 10: Total Officer Waiting Time Place Place of Safety to Patient Handover

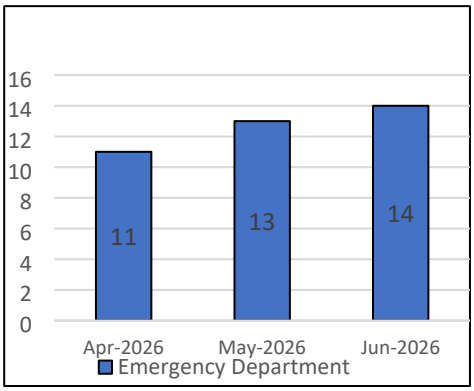


There were twenty-seven Detentions in the Princess of Wales Hospital Mental Health Place of Safety of which twenty-two (81%) were handed over from the Police within 3 hours.

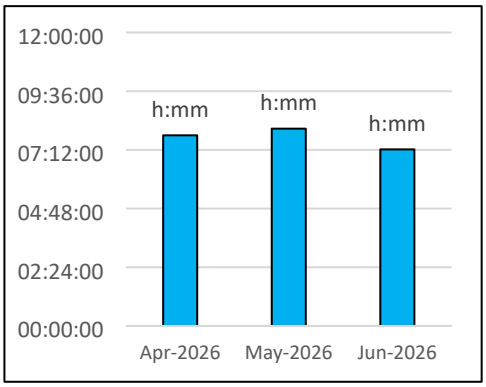
2.3 Emergency Department Section 136 Waiting Times - April to June 2026

2.3.1: Total Waiting Times

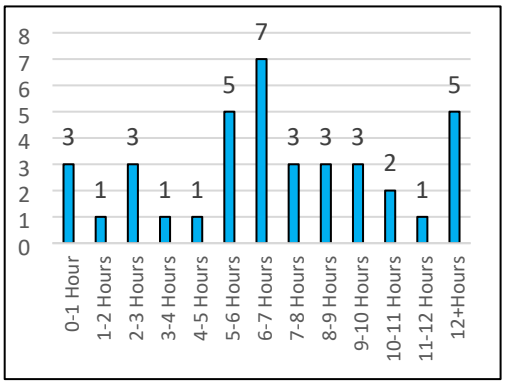
Graph 11: Number of Section 136 Detentions



Graph 12: Total Officer Waiting Time to Patient Handover



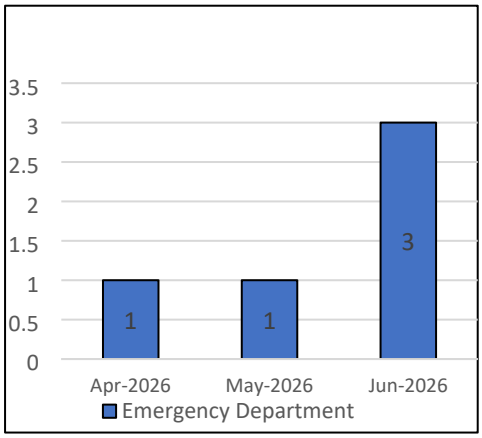
Graph 13: Total Officer Waiting Time to Patient Handover



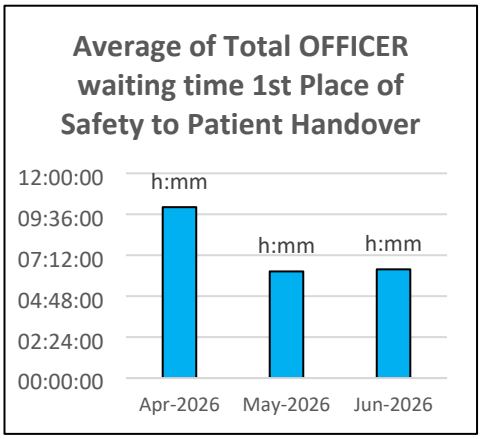
Average waiting times in Emergency Departments are considerably higher than those in the Mental Health Place of Safety. Of the thirty-eight Emergency Department presentations just seven (18%) were handed over from the Police within 3 hours.

2.3.2: Princess of Wales Hospital Emergency Department Waiting Times

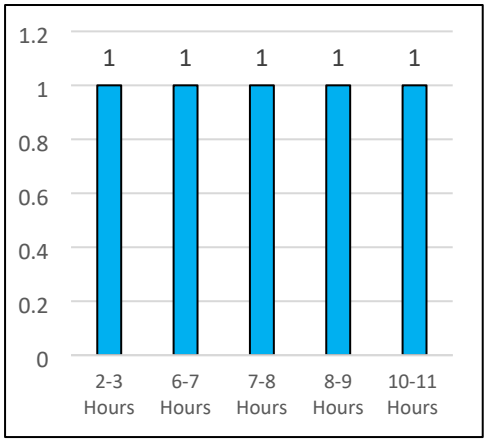
Graph 14: Number of Section 136 Detentions



Graph 15: Total Officer Waiting Time to Patient Handover



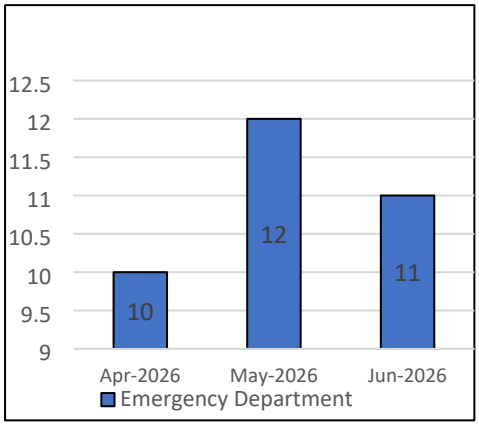
Graph 16: Total Officer Waiting Time to Patient Handover



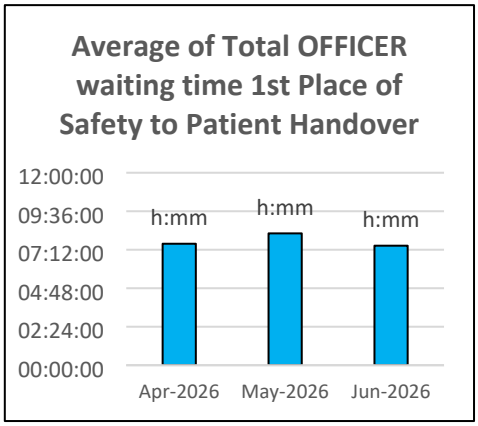
There were just five (16%) Emergency Department presentations in the 3-month period compared to twenty-seven to the Mental Health Place of Safety. Waiting times were much longer in this area.

2.3.3: Royal Glamorgan Hospital Emergency Department Waiting Times

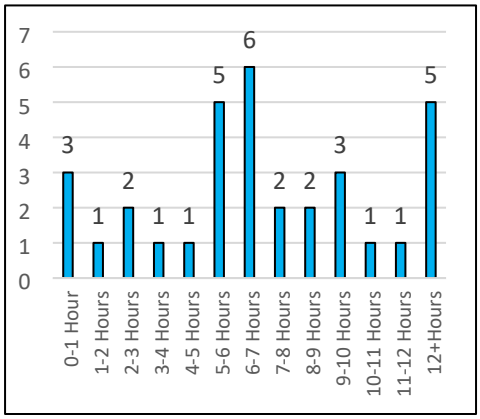
Graph 17: Number of Section 136 Detentions



Graph 18: Total Officer Waiting Time to Patient Handover



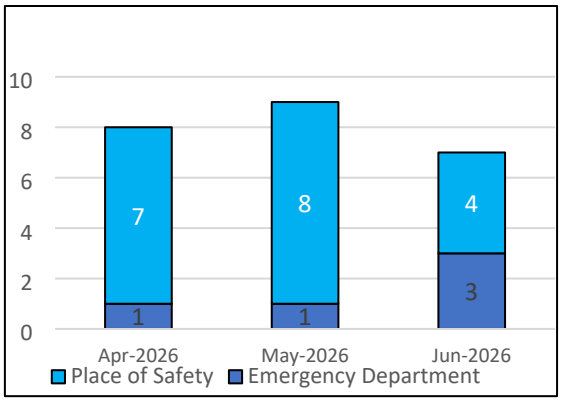
Graph 19: Total Officer Waiting Time to Patient Handover



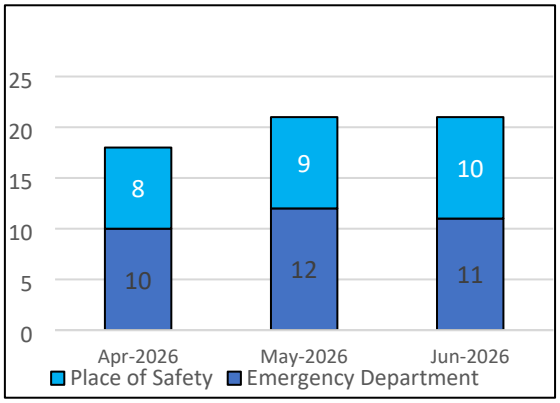
There were thirty-three (63%) Emergency Department presentations in the 3-month period compared to 19 to the Mental Health Place of Safety. This was a high proportion of Emergency Department attendances. The pattern of attendance for 2025 was reviewed across the Health Board of which 45% of attendances were in Emergency Departments. The average quarterly attendance in the Royal Glamorgan Hospital Emergency Department was 20 compared to 33 in the first quarter of 2026/2027. Waiting times were much longer in the Emergency Department than seen in the Mental Health Place of Safety.

2.4 Distribution of Section 136 Attendances - April to June 2026

Graph 20: Number of Section 136 Detentions - Princess of Wales Hospital



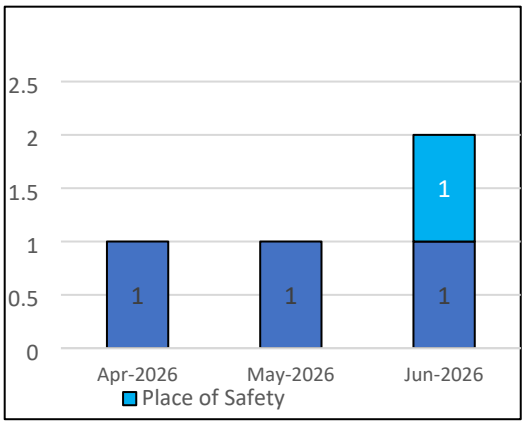
Graph 21 – Number of Section 136 Detentions - Royal Glamorgan Hospital



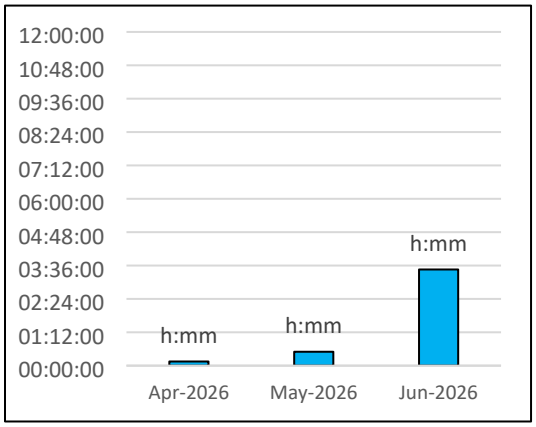
The increased volume of Section 136 Detentions in the Royal Glamorgan Hospital reflects the size of the area served and also the temporary transfer of Place of Safety arrangements from Prince Charles Hospital.

2.5 Total Younger Persons Section 136 Waiting Times – April to June 2026

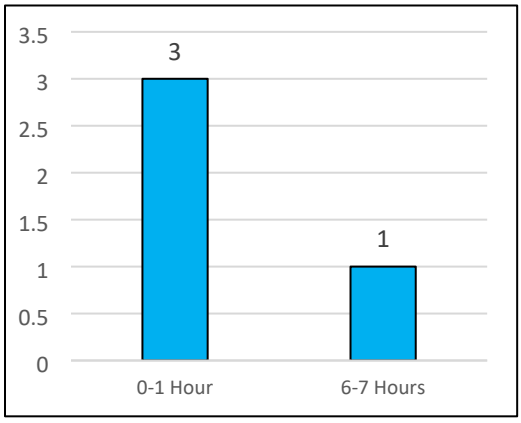
Graph 22: Number of Section 136 Detentions



Graph 23: Average Total Officer Waiting Time Place of Safety to Patient Handover



Graph 24: Total Officer Waiting Time Place of Safety to Patient Handover



There were 4 Section 136 Detentions involving younger people in the 3 month period. Of these 2 were 14 years of age and 2 were 16 years of age. 1 patient was taken to the Princess of Wales Hospital Mental Health Place of Safety. 3 patients were taken to the Royal Glamorgan Hospital Emergency Department.

2.6 Total Section 136 Reported Reasons for Delay – April to June 2026

Table 1: Patient Handover Reason for Delay

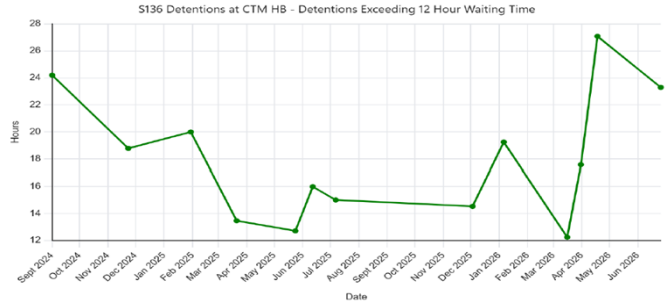
Reason for Delay	Count
Physical Health Concerns	**11**
Intoxicated	**3**
Admission to Mental Health Ward	**10**
Section 12 Doctor Availability	**2**
EDT AMHP Availability:	**15**
AMHP Availability	**1**
Total	**42**

Of the eighty-five Section 136 Detentions considered in this 3 month review the Crisis Team reported the above reason for delay for forty-two patients.

2.7 South Wales Police Waits in excess of 12 hours over a 2-year period.

On 21st July 2026 SWP held a further engagement event with Health Board Partners to discuss their draft Mental Health Policy which includes Section 135 and 136 arrangements. In the meeting the SWP circulated the graphs below. These 3 Health Board graphs identified the SWP record of 12+ hour Police waits over a 2 year period. The data gives some benchmarking information across the three Health Boards in the SWP area.

Graph 25: Section 136 Detentions – 12 hours or more – CTM UHB



Over the last 2 years there have been 13 detentions that have exceeded a 12-hour waiting time at a Place of Safety within Cwm Taf Morgannwg University Health Board. Ten of these were at the Emergency Department and three were at a Health Based Place of Safety.

The longest time spent at a POS1 was in April 2026 where officers spent 27 hours.

Of the 13 detentions within CTM, two cases subsequently required supervision and transfer to a second Place of Safety.

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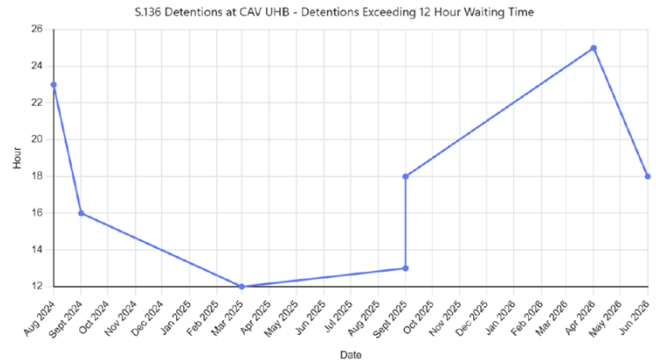
SOUTH WALES POLICE

Graph 26: Section 136 Detentions – 12 hours or more – CAV UHB



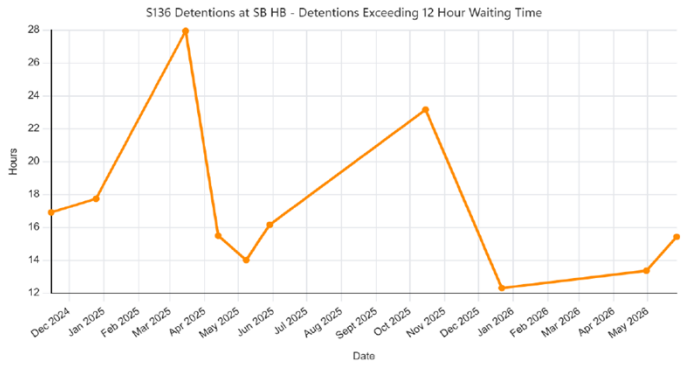
Over the past two years, seven detentions within Cardiff and Vale University Health Board (CAV UHB) exceeded the 12-hour waiting time threshold at a Place of Safety. These extended waits occurred within the Emergency Departments.

The longest time spent at the first Place of Safety was during April 2026 where officers spent 25 hours and 25 minutes.

Four of the seven detentions required transfer to a second Place of Safety, resulting in additional demands on police resources and necessitating further officer involvement.

HEDDLU DE CYMRU
SOUTH WALES POLICE

Graph 27: Section 136 Detentions – 12 hours or more – SB UHB



Over the last 2 years there have been Ten detentions that have exceeded a 12-hour waiting time at a Place of Safety within Swansea Bay University Health Board. Nine of these were in the Emergency Department and one was at a Health Based Place of Safety.

The longest time spent at a Place of Safety was in March 2025 where officers spent 27 hours and 57 minutes at the Place of Safety.

Within Swansea, four of the detentions resulted in a transfer to a second Place of Safety.

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SOUTH WALES POLICE

The graphs show that in the 2-year period there were the following 12 hour+ waits;

- CTM UHB – 13 with 10 in the Emergency Department and 3 in the Mental Health Place of Safety.
- CV UHB – 7 all in the Emergency Department
- SB UHB – 10 with 9 in the Emergency Department and 1 in the Mental Health Place of Safety.

All three Health Boards had a single longest wait in the 2-year period between 25-27 hours. The data was comparable between the three Health Boards.

3. Next Steps – Risks and Opportunities

3.1 Improving Access to Section 12 Approved Doctors

The Mental Health Act Operational Group is working with Social Care Wales to develop a digital pilot scheme which will help local AMHPs access Section 12 Approved Doctors. Funding has been agreed in principle by Social Care Wales to resource a 12-month pilot in our area by the digital provider Vital Hub.

There is also monitoring of two Doctor Mental Health Assessments to ensure these are only deployed when there is a significant likelihood of detention.

3.2 Improving Access to AMHPs

The reason for delay in handover of Section 136 patients from the Police has identified access to AMHPs particularly through the Emergency Duty Team. It is understood that there are often capacity issues out of hours and this would need to be explored further.

3.3 Development of Parallel Assessments in the Emergency Department

There is strong support within Mental Health and the Emergency Department to progress the introduction of a process to support parallel assessments in the Emergency Department. A draft Standard Operational Pathway Procedure has been developed for Adults by colleagues in the Royal Glamorgan Hospital Emergency Department. It is reported however that there is a reluctance by the Emergency Duty Team to deploy an AMHP for Mental Health Assessments before the patient is certified as medically optimised. Further discussion is needed to progress this proposal.

3.4 Reduction in the number of 136 Detentions

There is an acknowledgment that Police waiting times would be reduced if there was a reduction in the volume of Section 136 Detentions. There has been discussion around ensuring better communication between the local Police Officer and the 111#2 Mental Health line. The South Wales Police Section 136 app has a direct communication link to the professionals' line in 111#2 and better use needs

to be made of this facility. Partners have also discussed the value of ensuring diversion from Section 136 where appropriate through the use of community resources such as the Wellbeing Retreat in Bridgend.

3.5. Further development of local Police Liaison Committee arrangements

There is agreement on the need to further develop the work of the monthly Police Liaison Committee in order that they can effectively scrutinise the use of Section 136 and any escalation incidents triggered because of extended waits. The Group also needs to closely scrutinise repeat attendances to understand how these could be reduced and any variation in Emergency Department presentations.

3.6. Mental Health Assessment of Children and Young People

Whilst there were only four Section 136 Detentions involving younger people in the three-month timeframe under review there was acknowledgement of the need to further consider assessment arrangements not just those relating to Section 136. There are often challenges meeting the needs of younger people in Emergency and Paediatric facilities which need further consideration. Whilst the identification of dedicated Paediatric areas in each Emergency Department is a helpful step forward further work is required to ensure better integration of CAMHS Crisis Services and local Paediatric Teams.

4. Conclusion

The review of Section 136 waiting times found these to be particularly high in local Emergency Departments, a trend which was seen across Wales. There are a number of suggested next steps detailed above which would aim to reduce these waiting times in our Health Board improving the service for our patients and minimising the amount of Police time needed in the process.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A More Equal Wales

Link to Wellbeing of Future Generations Act – Wellbeing Goals	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality **NEUTRAL** Summary of impact: The purpose of the deep dive is to ensure and improve quality of access to Section 136 Mental Health Assessment. Outcome for Welsh Language **NEUTRAL** Summary of impact: The purpose of the deep dive is to ensure and improve quality of access to Section 136 Mental Health Assessment	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*		
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**	
Enw da / Reputational	**Yes (include further detail below)**	

	Waiting times for Section 136 Assessments are a challenge in Emergency Departments across Wales. The purpose of the report is to develop an action plan.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**Yes (include further detail below)**
	Potentially through the better resourcing of Place of Safety arrangements however this needs to be achieved within existing resources which is a challenge.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
MHA	Mental Health Act
AMHP	Approved Mental Health Practitioner
EDT	Emergency Duty Team
SWP	South Wales Police
CAMH's	Child and Adolescent Mental Health Service
MHAMC	Mental Health Act Monitoring Committee

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Mental Health Act Activity Report with Breaches and Errors / Analysis of Unlawful Detentions for Quarter 1 (April – June) 2026/27

Eitem yr Agenda / Agenda Item	**5.4**
Dyddiad y Cyfarfod / Date of Meeting:	26th August 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Alison Thomas – MHA Manager Jeremy Burgwyn – MHA Team Lead
Cyflwynydd yr Adroddiad / Report Presenter:	Robert Goodwin, Directorate Manager, CAMHS & Specialised Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Not Applicable
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Not applicable If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	Mental Health Act activity during Q1 2026/27 remained broadly stable, with detention levels, CTO usage and Section 135/136 activity largely within expected ranges and SPC limits. The MHA Office continued to provide effective statutory oversight and assurance across the Health Board. Whilst five minor documentation errors were rectified within statutory timescales, two unlawful detentions and two lapses of detention were identified, alongside ongoing challenges relating to documentation management, record keeping and delivery of MHA training.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Overall performance demonstrates effective statutory governance and supports CTMUHB's strategic objective of Improving Care. However, the breaches, lapses and ongoing documentation issues present legal, regulatory and patient safety risks, particularly in relation to lawful detention and patients' rights under the Mental Health Act and Article 5 ECHR. The findings reinforce the need for continued focus on staff compliance, training and improvements to record management processes.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being*	The MHA Team will continue to monitor activity, breaches, lapses and use of statutory powers through existing governance arrangements, while targeting areas of recurring risk through training, scrutiny and compliance monitoring. Work will also continue to support implementation of digital mental health records, improve accessibility of statutory documentation and strengthen assurance processes, with the aim of reducing legal risk, improving compliance and enhancing patient care.

made)	

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to note the report.

1. Background / Context

2.3 The purpose of this report is to present activity data including errors and breaches regarding the application of the Act within CTMUHB. The report presents the MHA activity to the MHA Monitoring Committee in respect of Q1 (Apr – Jun 2026/27). The report covers Adult, Older Persons Mental Health and CAMHS services managed by CTMUHB. A Glossary of Terms is attached for ease of reference (Appendix 2.)

2. Activity & Performance Overview

2.1 Adult Detentions

Graph 1:

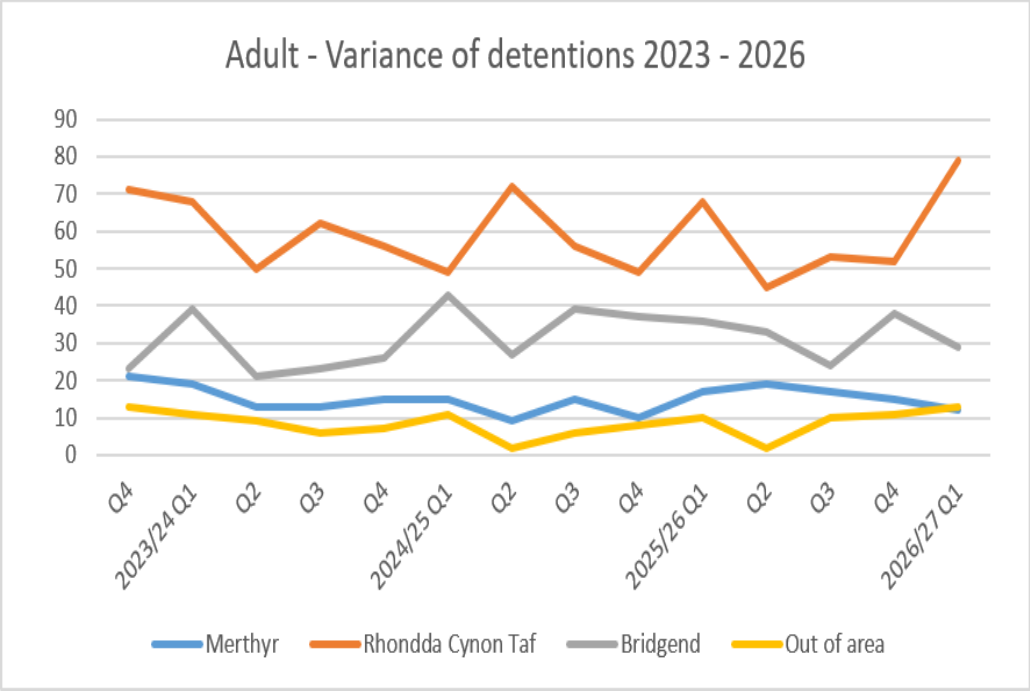
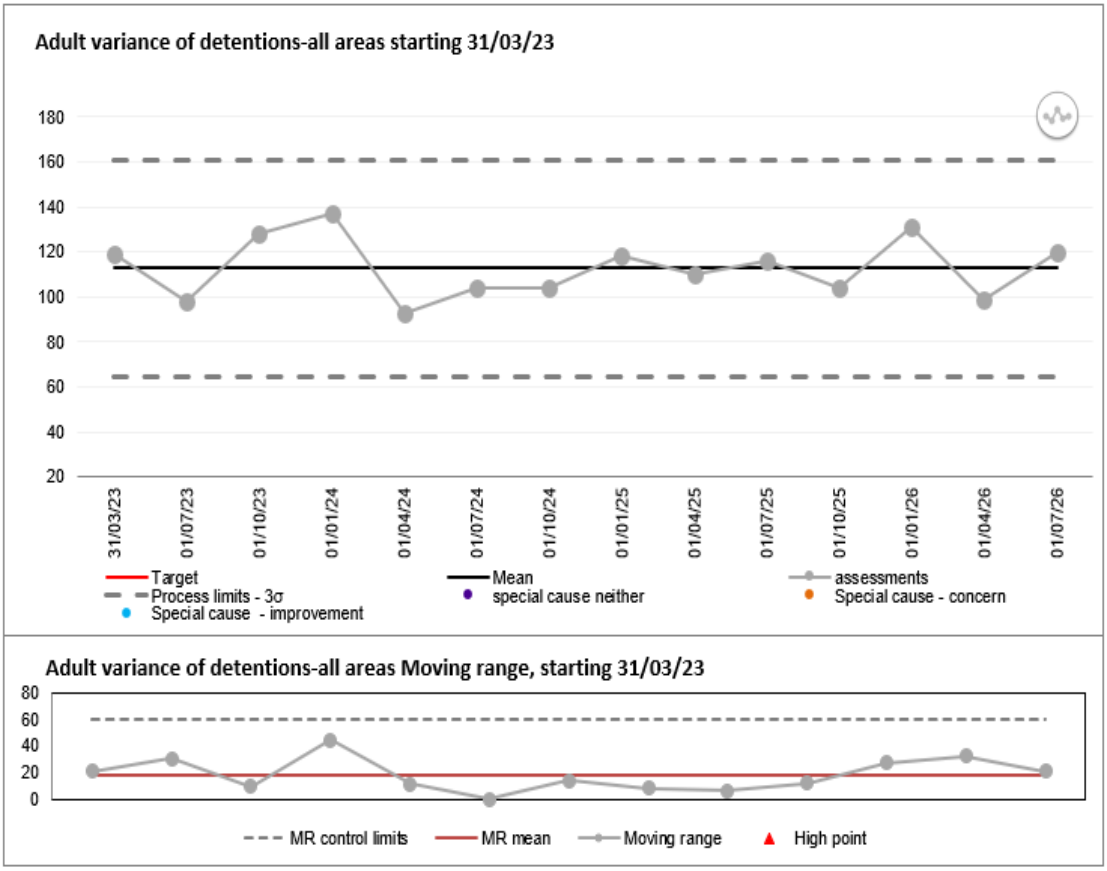


Chart 1:



Despite mostly slight variances from mean, Q1 figures are within a normal range and the SPC control limits for all areas. Further information on the utilisation of each section can be found here (Appendix 1).

Table 1

Locality	Mean 2022/26	Q1 2026/27
Merthyr	15	12
RCT	59	79
Bridgend	31	29
Out of area	9	13
Total	**114**	**133**

Locality analysis identified Rhondda and Cynon as the main contributors to the increase. However, the changes represent relatively small numbers and are considered consistent with the normal fluctuation seen in Mental Health Act activity.

2.2 Older Persons Detentions

Graph 2:

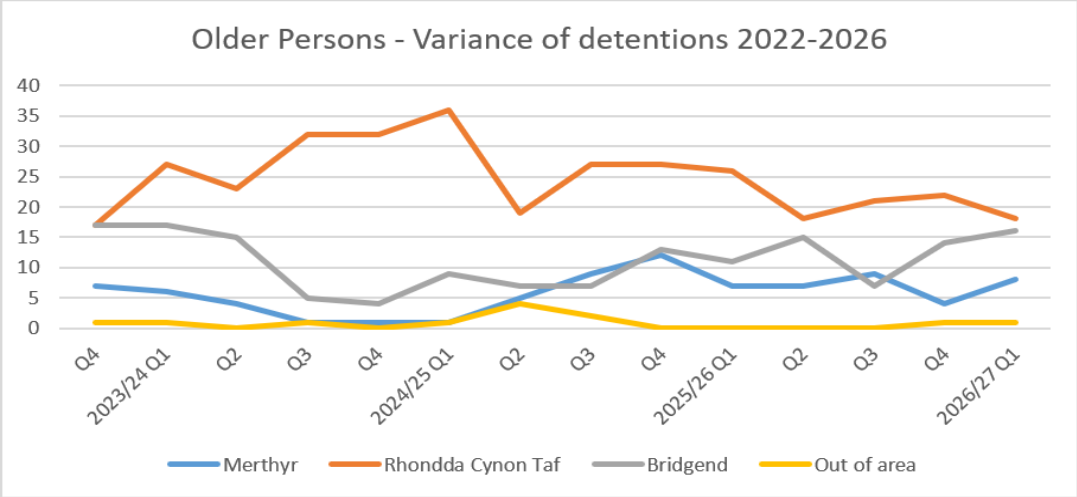
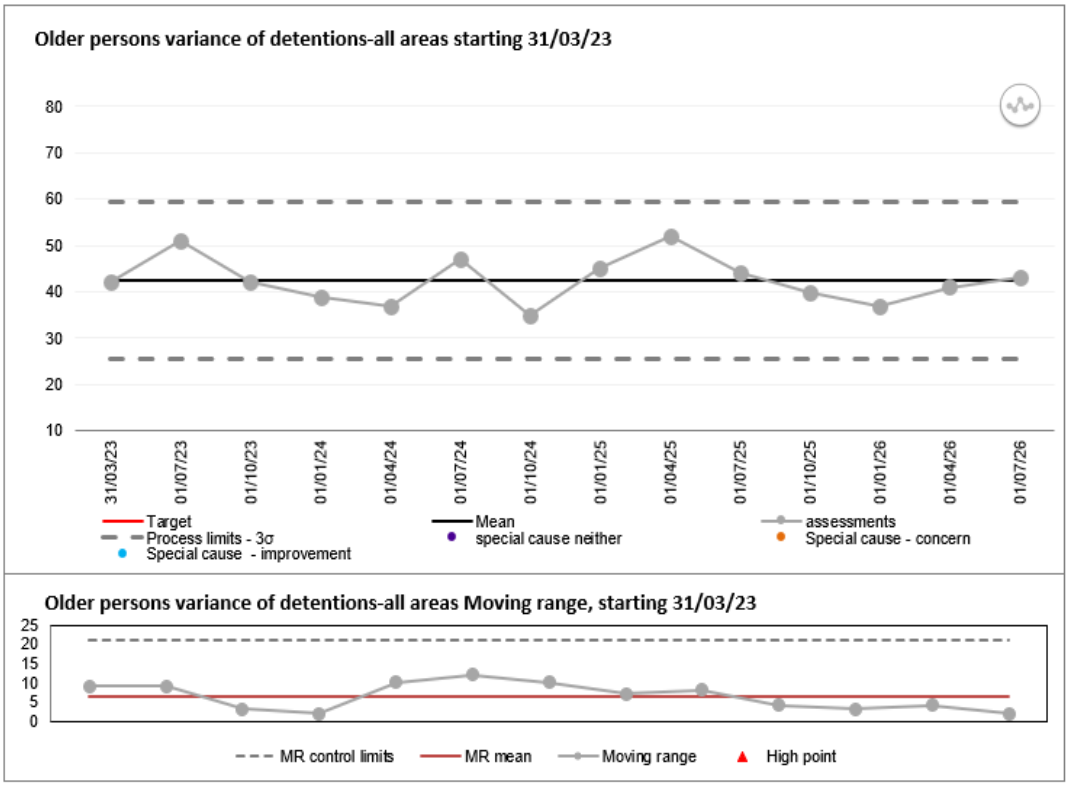


Chart 2:



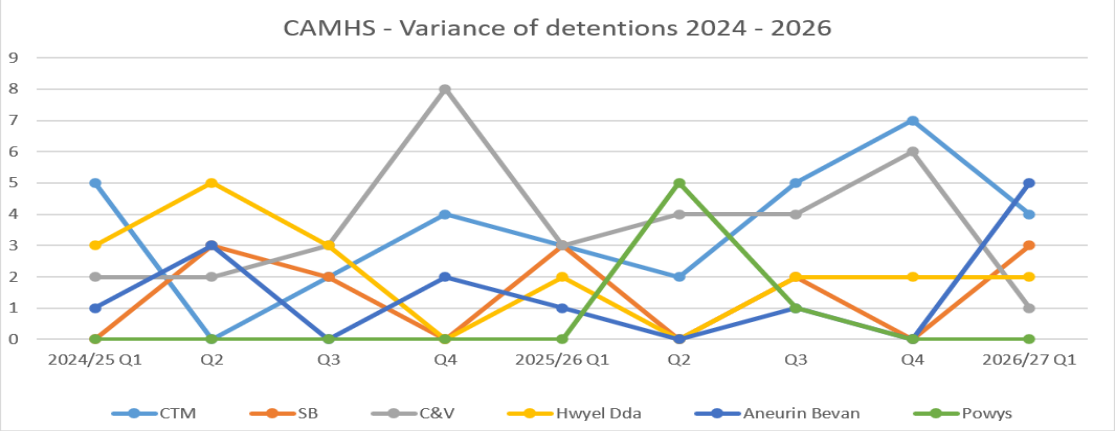
Despite slight variances in some areas, Q1 figures are aligned with the total mean, within a normal range and the SPC control limits for all areas. Further information on the utilisation of each section can be found here (Appendix 1).

Table 2:

Locality	Mean 2022/25	Q1 2026/27
Merthyr	6	8
RCT	25	18
Bridgend	11	16
Out of area	1	1
Total	**43**	**43**

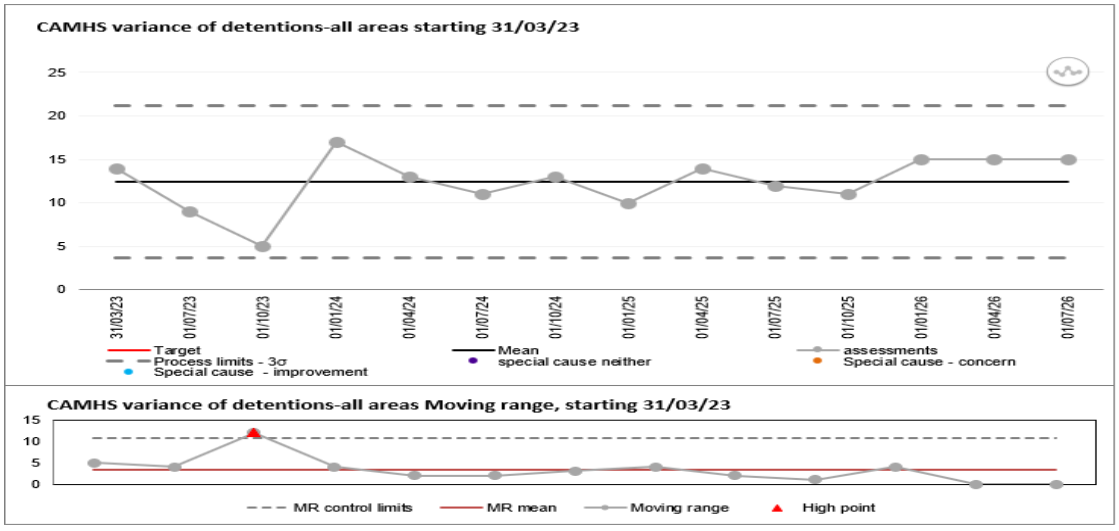
2.3 CAMHS Detentions

Graph 3:



As Ty Llidiard provides a regional CAMHS inpatient service for South Wales, detention activity includes patients from multiple Health Board areas.

Chart 3:



Despite slight variances from mean, Q1 figures are within a normal range and the SPC control limits for all areas. Further information on the utilisation of each section can be found here (Appendix 1).

Table 3:

Health Board	Mean 2024/26	Q1 2026/27
CTMUHB	4	4
SBUHB	2	3
C&VUHB	3	1
HDUHB	1	2
ABUHB	2	5
PTHB	1	0
Total	**13**	**15**

2.4 Community Treatment Orders (CTO)

The current CTOs in each area are shown below along with the table of mean figures for each area. There were 16 CTOs in place at the end of Q1.

Graph 4

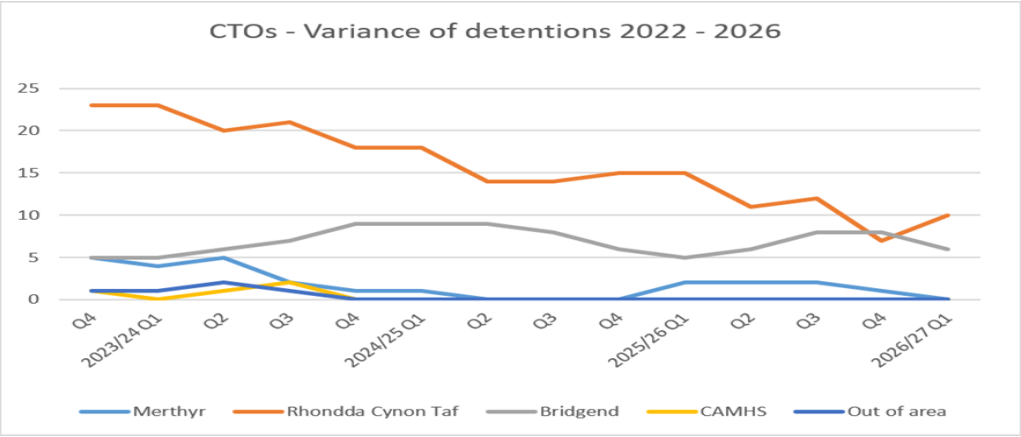


Chart 4:

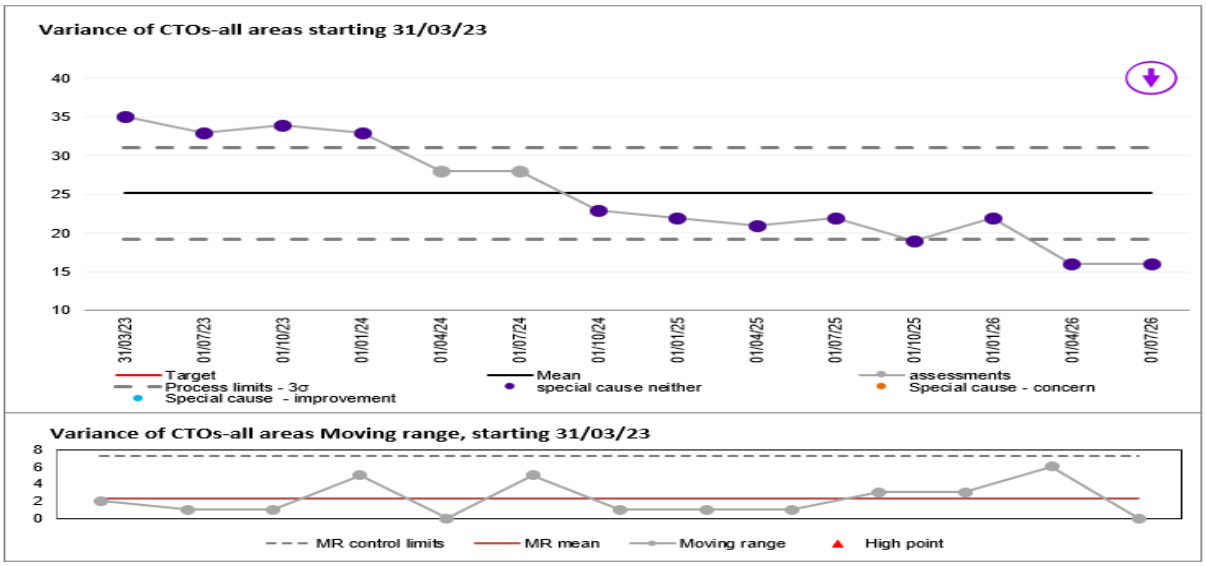


Table 4:

Locality	Mean 2023/26	Q1 2026/27
Merthyr	2	0
Rhondda Cynon Taf	16	10
Bridgend	7	6
CAMHS	0	0
Out of area	0	0
Total	**25**	**16**

The reduced use of CTOs is an established trend, which reflects the reduced use of CTOs across other Health Boards in Wales. Further information including breakdown of all CTO activity here (Appendix 1).

2.5 Use of Section 135/136 Police Powers

Graph 5:

This graph illustrates uses of Section 135/136 throughout the LSSAs from Q4 2022/23 to Q1 2026/27.

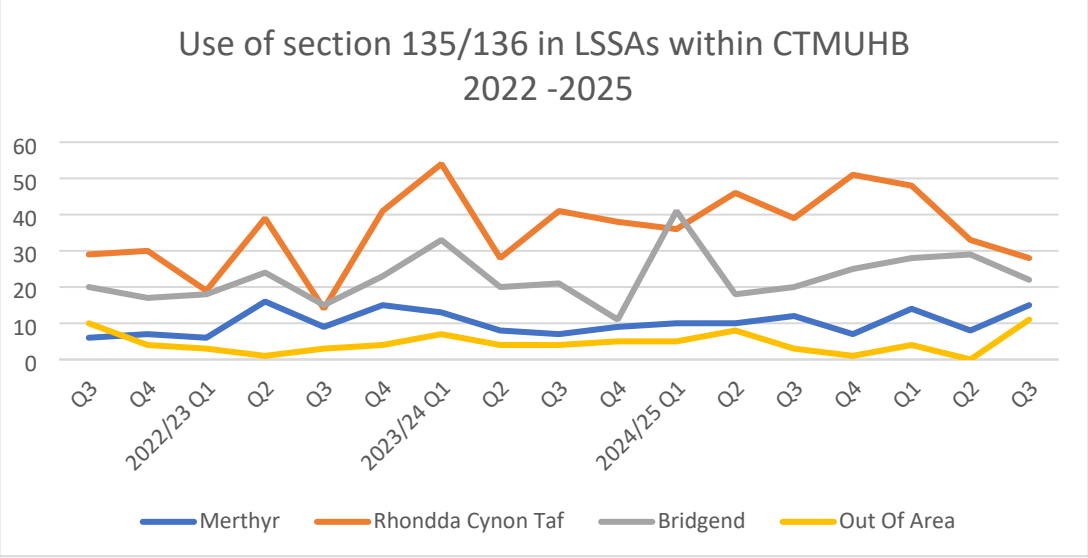


Chart 5:

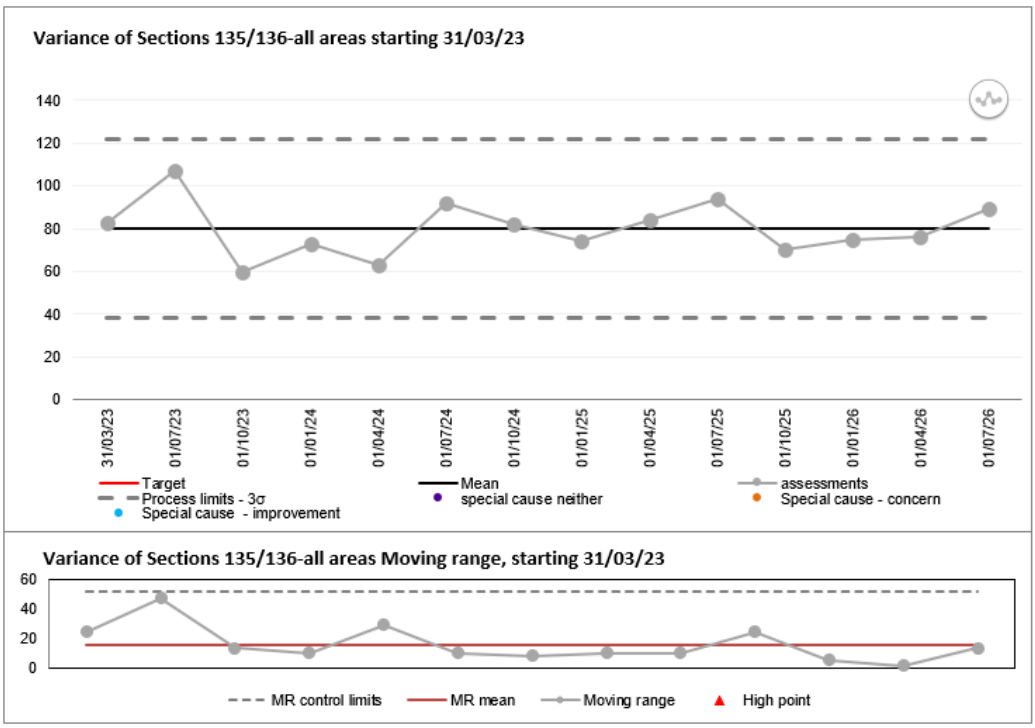


Table 5:

Use of Section 135 and 136 by area for Q1 2026/27, also with mean.

Area	Mean 2023/26	Q1 2026/27
Merthyr	11	7
Rhondda Cynon Taf	38	55
Bridgend	22	22
Out of area	4	6
Total	**75**	**90**

Despite variances from mean, Q1 figures are within a normal range and the SPC control limits for all areas. Further information on the outcomes of assessments can be found here (Appendix 1).

The use of Sections 135/136 will continue to be monitored in the MHA Operational Group meeting and the Section 136 group meeting. Any trends will be discussed and reported back to the Committee.

2.6 Current Challenges

Problems with missing copies of statutory documentation in patient health records on paper-based wards remain as issue, as mentioned in previous reports. All services in Bridgend use paper-based records, as do Older Persons services in RGH. In other areas of the Health Board, this is confined to general wards.

The electronic patient system Care Partner is in operation on the acute mental health wards in RGH and within mental health rehabilitation services.

The MHA team are also experiencing issues with the timely scanning of statutory documentation from the off-site Mental Health wards. This has been proven to be more difficult due to the absence of their ward clerks and has been escalated to the senior nurses.

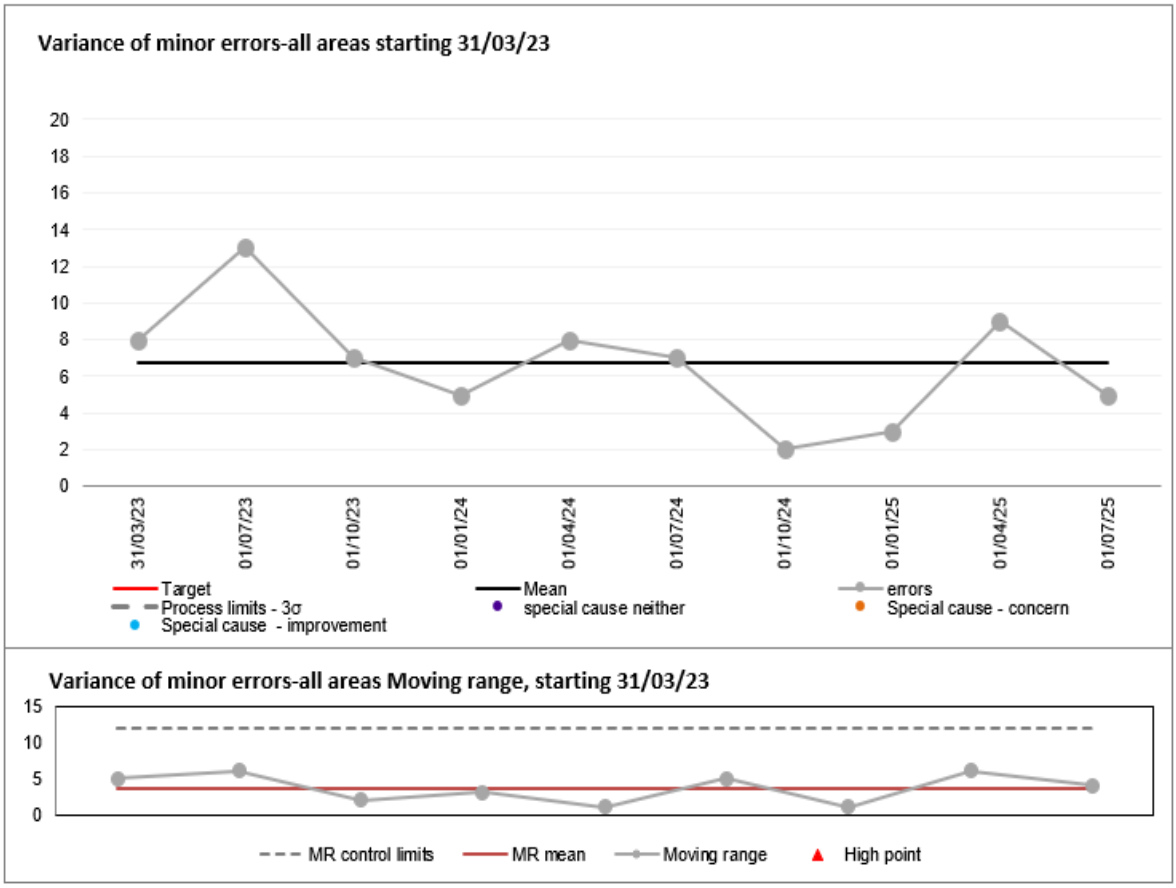
The rollout of Overview training on the Mental Health Act 1983 is proving extremely difficult for the MHA office to arrange. It is proving problematic for the ward managers to accommodate the most convenient time for staff to attend. The MHA manager has escalated this to the relevant senior nurses. Unfortunately, this has resulted in the team chasing completion of patients' rights proformas and statutory consultee entries in some areas.

2.7 Errors & Breaches

Administrative and medical scrutiny of section documentation is carried out by the MHA Office and medical staff approved under Section 12 of the Act to ensure compliance and to identify any amendments needed within the target time limit. Most of the errors recorded within this report are minor, relating to demographics.

Rectifiable Errors

Section 15 of the Act allows for the rectification of statutory detention documentation completed by Doctors and AMHPs within 14 days of admission to hospital. While the minor errors are defined by "principal de minimis" (meaning they are immaterial and too small to be of any consequence), the fundamental errors (breaches) are more serious and require further attention and scrutiny to ensure that lessons are learned and the breach does not reoccur.



The total number of minor errors across all services in Q1 was five, compared to nine found in Q4, all of which were rectified within the statutory timescales.

Table 6

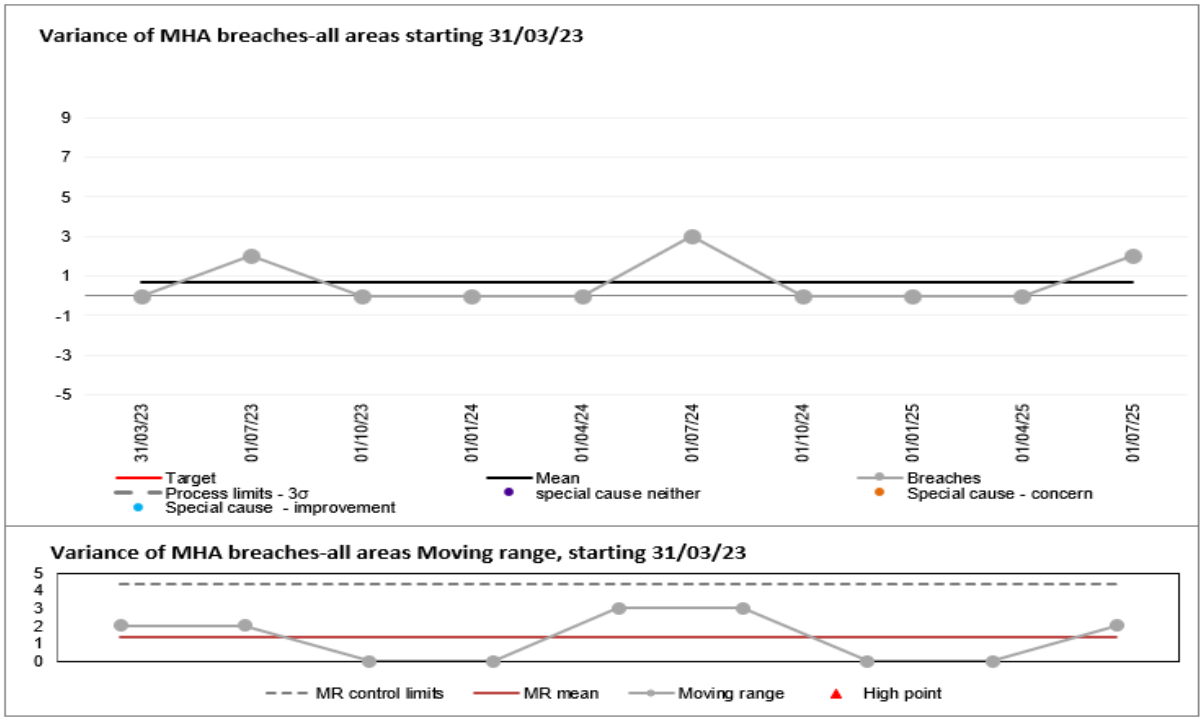
Rectifiable Errors		POW		RGH			
Responsible for Error	**Forms**	**PICU**	**14**	**Seren**	**Admissions**	**22**	**Total**
AMHP	HO2			1	1		2
AMHP	HO6		1				1
Doctor	HO3						0
Doctor	HO4						0
Doctor	HO8						0
Doctor or Nurse	HO12						0
Nurse	HO14	1				1	2
Other UHB	TC1						0
	Total	**1**	**1**	**1**	**1**	**1**	**5**

Fundamentally Defective

These are errors, which cannot be rectified under Section 15 and render the detention unlawful, therefore resulting in a breach of the Act.

Examples include unsigned section papers; incorrect hospital details or the wrong form being used. Medical recommendations and applications that are not signed cannot be remedied under Section 15 and therefore render the detention invalid.

All breaches are reported via DATIX to enable monitoring and for training to be put in place as necessary.



There were two breaches of the MHA in Q1 2026/27:

- The patient was assessed under the MHA 1983 in London.
  The application for Section 3 was made out to RGH but the patient was taken to POW. Ward staff asked the EDT AMHP to make a new application, which they did. Unfortunately, neither medical recommendation named either RGH or POW as a hospital where appropriate treatment was available. This means that the application was not based upon 2 valid medical recommendations, which rendered the detention unlawful. The CTM MHA Office advised the patient's Responsible Clinician to immediately discharge the patient from Section 3. The patient was further detained using the Doctor's holding powers of Section 5(2) until a new MHA assessment for Section 3 took place on 29/06/26

Action taken

Before applying for Section 3, it is the responsibility of the AMHP to ensure that the medical recommendations state the appropriate hospital, where treatment is available. The MHA team escalated this error to the EDT AMHP Manager. The MHA manager has contacted the AMHP team leads in all localities to emphasise the importance of using the receipt and scrutiny checklist with the ward staff to identify any errors at the point of detention.

- The patient was detained on an invalid Section 2 detention.
  The hospital named on the HO2 application completed by the AMHP was RGH instead of YCC, where the patient was admitted. This should have been picked up firstly by the AMHP and then by the nurse that completed Form HO14 receipt of detention whilst they were going through the receipt and scrutiny checklist. Unfortunately, the nurse did not fully complete the scrutiny checklist. The paperwork was not scanned through to the MHA Office as per agreed procedure, so the MHA office was not able to identify the issue. The AMHP contacted the MHA Office 2 days later to highlight the issue and of their plan to attend YCC to reassess and re-detain if necessary. The patient was re-detained on Section 2 on 22/06/26.

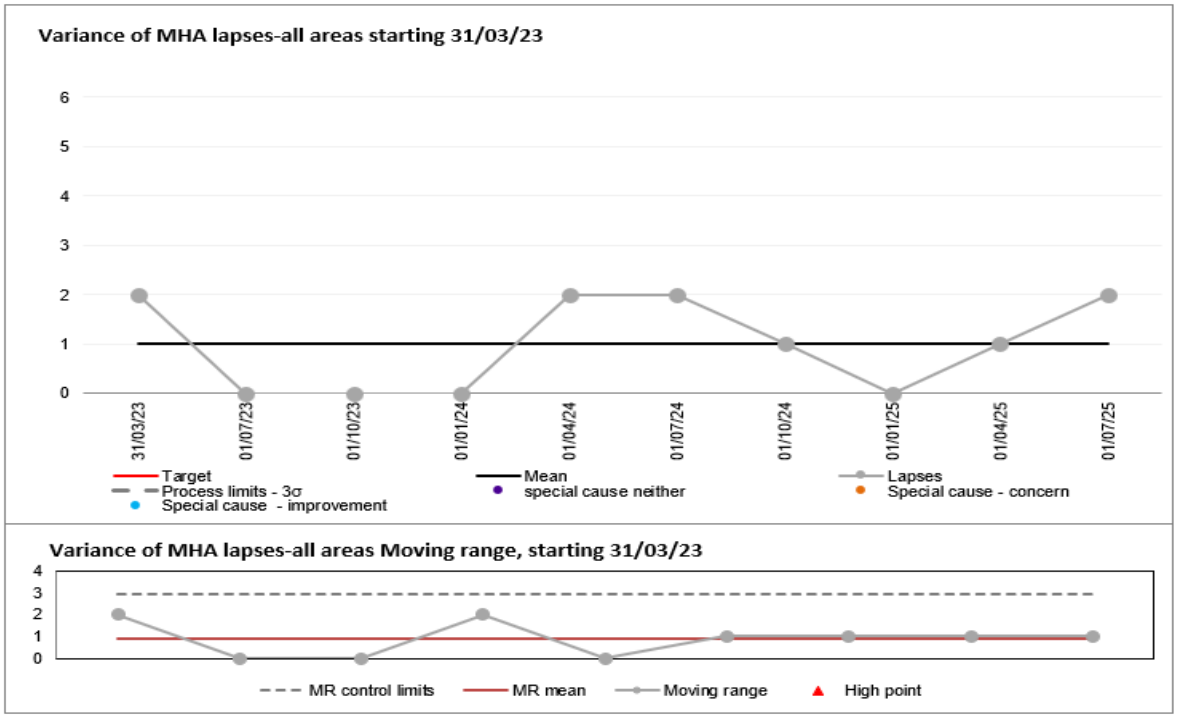
Action taken

It is the responsibility of the AMHP to state the name of the admitting hospital on their application. (In this case, the AMHP acknowledged their error) When the statutory paperwork is handed over to the nurse on the ward, the detention paperwork should be checked against the criteria on the receipt and scrutiny checklist and immediately scanned through to the MHA office. The MHA team highlighted to the ward manager that staff had not adhered to the agreed protocol. The MHA manager has further contacted senior nurses to suggest staff attend the training on the Overview of the MHA 1983.

2.8 Section Lapsing

Lapses in detention are not considered as breaches under the MHA. However, if the patient continues to be kept in circumstances which amount to a deprivation of liberty, this will be a breach of the person's rights under Article 5 of the European Court of Human Rights (ECHR). The Code of Practice regards lapses as a very serious matter, which must be urgently reviewed, reported to the Clinical Director and monitored to avoid re-occurrence.

Chart 8



There were two lapses of detention in Q1 2026/2027

Further information on the lapsed Section 2s can be found here (Appendix 1).

The breakdown of errors will assist the MHA team in identifying areas of concern, which will highlight the priority areas for MHA training.

2.9 Managers Hearings/Mental Health Review Tribunals

A detailed breakdown of these figures is available here (Appendix 1).

2.10 Other Activity

There was one death of a detained patient recorded during Q1.

The patient was detained under Section 2 of the Mental Health Act whilst receiving care on a general ward in Ysbyty Cwm Rhondda. Detention was implemented following a deterioration in the patient's mental state, including increased agitation and refusal of essential care and treatment. Due to physical health needs, the patient remained on the general hospital ward rather than being transferred to a mental health unit. The patient subsequently died due to their physical health issues whilst detained under Section 2 on 24/06/2026.

Consent to Treatment

In line with Chapter 25.38 of the Code of Practice for Wales, Hospital Managers should monitor the use of Urgent treatment under s62 (inpatients) and s64G for (CTO patients) to ensure that it is not used inappropriately or excessively.

Table 7:

Use of urgent treatment Forms	Jan	Feb	Mar	Apr	May	Jun
Section 62	1	5	5	3	3	7
Section 64						
Total	**1**	**5**	**5**	**3**	**3**	**7**

Further information on Consent to Treatment, including a detailed breakdown of the use of S62/S64 is available here (Appendix 1).

This will continue to be monitored in the Operational Group meetings and will form part of the yearly programme of deep dives.

3. Strategic Insights

3.1 Mental Health Act activity remains stable across CTMUHB, with demand and use of statutory powers continuing within expected levels despite a rise in overall detention activity. The report highlights the importance of strengthening compliance, documentation management and workforce knowledge to minimise legal and regulatory risks associated with unlawful detention and lapses. The continued transition towards a single electronic mental health record presents a significant opportunity to improve governance, reduce documentation-related risks, enhance assurance processes and support the Health Board's strategic objective of Improving Care through safer, more effective and legally compliant services.

4. Risks and Opportunities

4.1 Documentation errors, unlawful detentions and lapses of detention continue to present legal, regulatory and reputational risks, highlighting the need for ongoing compliance monitoring and staff awareness.

4.2 Digital transformation through the Mental Health Single Clinical Record Programme, alongside targeted training and assurance activity, provides an opportunity to strengthen compliance, improve governance and enhance patient care.

5. Compliance and Governance

5.1 The MHA Office continued to provide statutory oversight of Mental Health Act activity throughout Q1 2026/27. Five minor documentation errors were identified and rectified within statutory timescales. Two fundamentally defective detentions and two lapses of detention were reported, with learning identified and monitored through established governance arrangements. HIW also recognised the work of the MHA Team during its inspection activity.

6. Conclusion

6.1 Mental Health Act activity during Q1 2026/27 remained stable and within expected levels. While a small number of breaches and lapses were identified, appropriate action was taken and ongoing monitoring remains in place. The report demonstrates continued statutory oversight and supports the Committee's assurance regarding compliance with the Mental Health Act 1983.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2
	If more than one applies please list below: Strategic risk 3
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment

Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Confirmation received from Equality Team and Welsh Language Team that no QIA required for data reports.	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**	
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
MHA office staff MHA Operational Group	30/07/2026	

Acronyms / Glossary of Terms

MHA	Mental Health Act
MHAA	Mental Health Act Administrators
CTMUHB	Cwm Taf Morgannwg University Health Board
SBUHB	Swansea Bay University Health Board
C&VUHB	Cardiff & Vale University Health Board
ABUHB	Aneurin Bevan University Health Board
HDUHB	Hywel Dda University Health Board
PTHB	Powys Teaching Health Board
CAMHS	Child & Adolescent Mental Health Services
CTO	Community Treatment Order
RC	Responsible Clinician
AC	Approved Clinician
AMHP	Approved Mental Health Professional
CoPW	Code of Practice for Wales
ECHR	European Court of Human Rights
PICU	Psychiatric Intensive Care Unit
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RCT	Rhondda Cynon Taf
CMHT	Community Mental Health Team
LSSA	Local Social Services Authority

Appendix 1.

Graph 1

Quarter 1 MHA Adult Activity 2026/27

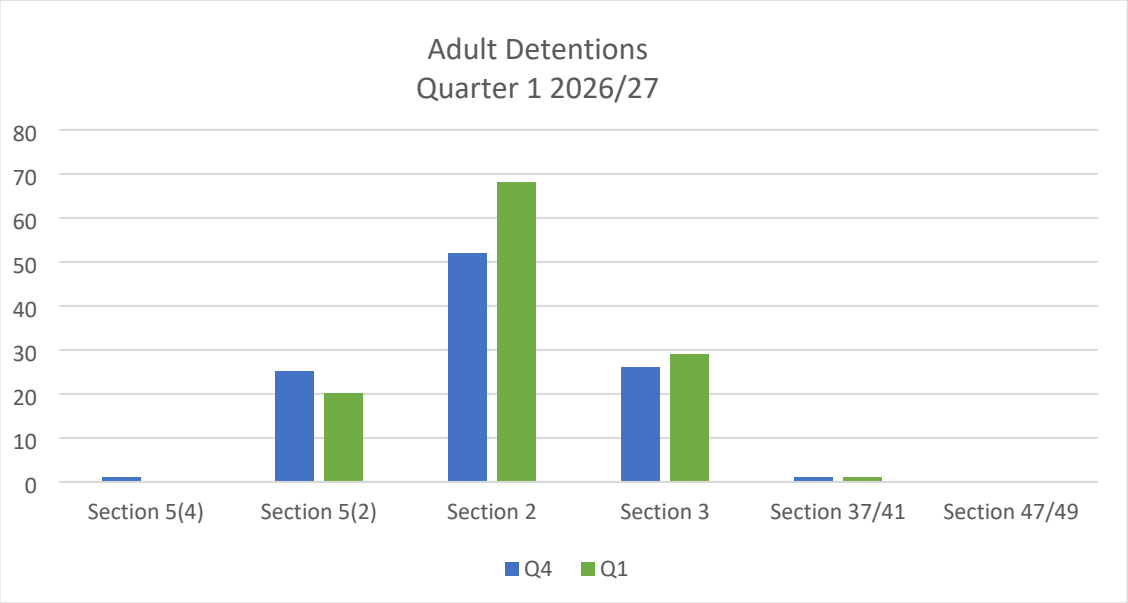


Table 1 Quarter 1 MHA Adult Activity 2026/27

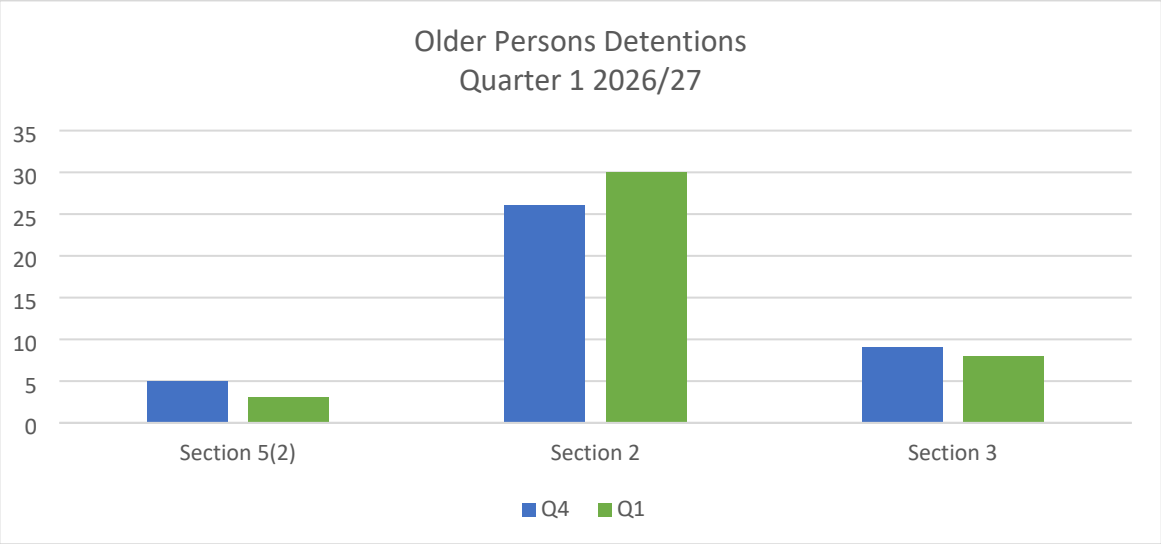
Section	Q4	% of total	Q1	% of total
Section 5(4)	1	0.95%	0	0.00%
Section 5(2)	25	23.81%	20	16.67%
Section 4	0	0.00%	2	1.67%
Section 2	52	49.52%	68	56.67%
Section 3	26	24.76%	29	24.17%
Section 37	0	0.00%	0	0.00%
Section 37/41	1	0.95%	1	0.83%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	0	0.00%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**105**	**100%**	**120**	**100%**

***There were 13 out of area detentions in Q1**

Table 2 Number of Adult MHA detentions per locality

Area	Q4	Q1
Merthyr	15	12
Rhondda Cynon Taf	52	79
Bridgend	37	29
Out of area	10	13

Graph 2 Quarter 1 MHA Older Persons Activity 2026/27



***There was one out of area detention in Q1**

Table 3 Quarter 1 MHA Older Persons Activity 2026/27

Section	Q4	% of total	Q1	% of total
Section 5(4)	0	0.00%	1	2.38%
Section 5(2)	5	12.50%	3	7.14%
Section 4	0	0.00%	0	0.00%
Section 2	26	65.00%	30	71.43%
Section 3	9	22.50%	8	19.05%
Total	**40**	**100.00%**	**42**	**100.00%**

Table 4 Number of Older Persons MHA detentions per locality

Area	Q4	Q1
Merthyr	4	8
Rhondda Cynon Taf	22	18
Bridgend	14	16
Out of area	1	1

Graph 3 Quarter 1 CAMHS Activity 2026/27

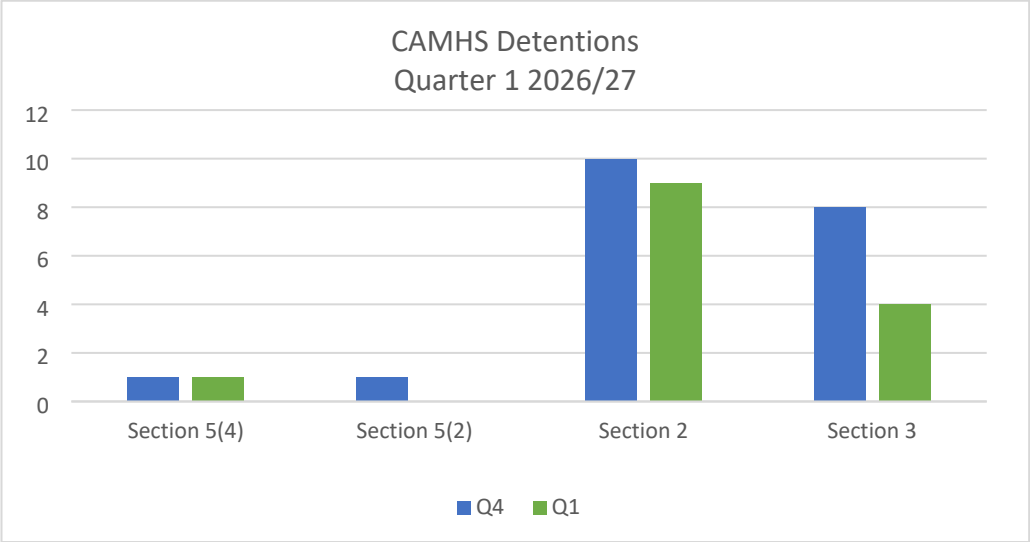


Table 5 Quarter 1 CAMHS Activity 2026/27

Section	Q4	% of total	Q1	% of total
Section 5(4)	1	5.00%	1	6.67%
Section 5(2)	1	5.00%	0	0.00%
Section 4	0	0.00%	1	6.67%
Section 2	10	50.00%	9	60.00%
Section 3	8	40.00%	4	26.67%
Total	**20**	**100.00%**	**15**	**100.00%**

Table 6 Number of CAMHS MHA detentions per locality

Health Board	Q4	Q1
Cwm Taf Morgannwg	8	4
Swansea Bay	0	3
Cardiff & Vale	6	1
Hywel Dda	5	2
Aneurin Bevan	0	5
Powys Teaching	1	0

USE OF SECTIONS AND OUTCOMES for Q4 2025/26

Section 5(2) of the Mental Health Act 1983

A 'holding power' can be used by doctors to detain an inpatient in hospital for up to 72hrs for assessment under the Act. This section cannot be used in A&E because the patient is not an inpatient. A non-psychiatric doctor on a general medical ward can use this section.

Table 7

S5(2) OUTCOMES	Jan	Feb	Mar	Apr	May	Jun
Section 2	7	3	3	4	2	5
Section 3	4	0	2	1	3	4
Informal	5	2	4	2	2	1
Discharged	0	1	0	0	0	0
Lapsed	1	0	0	0	0	0
Invalid	1	0	0	0	0	0

Section 2 of the Mental Health Act 1983

The power to detain someone believed to be suffering mental disorder for assessment (and treatment). The order lasts for up to 28 days and cannot be renewed. The patient has a right to appeal against detention to a Mental Health Review Tribunal.

Table 8

S2 OUTCOMES	Jan	Feb	Mar	Apr	May	Jun
Section 3	10	8	6	6	10	11
Informal	13	15	21	11	9	24
Discharged	9	6	7	6	6	13
Lapsed	0	0	0	2	0	0
Invalid	0	0	0	0	0	1
Transfer	1	1	1	1	2	1

- ***One recorded death of a detained patient in June***

Section 3 of the Mental Health Act 1983

The power to detain someone for treatment of mental disorder. This section lasts for up to 6 months and can be renewed for another six months and then annually. Patients have the right to appeal against detention to a Mental Health Review Tribunal.

Table 9

S 3 OUTCOMES	Jan	Feb	Mar	Apr	May	Jun
Section 3 renewed	3	1	3	2	1	3
Informal	2	4	4	7	8	7
Discharged	6	2	6	3	4	4
Lapsed	0	0	0	0	0	0
Invalid	0	0	0	0	0	1
Transfer	2	0	1	3	1	2
CTO	0	0	0	0	0	2

Number of compulsory admissions under the Mental Health Act 1983 (Section 2, 3, 4 and 37 only)

Table 10

	Q4 2025/26	Q1 2026/27
Adult Detentions	85	109
Older Persons detentions	36	39
CAMHS detentions	14	13
TOTAL	**135**	**161**

SECTION LAPSING

Detentions under the Mental Health Act can lapse for the following reasons:

- A section expires without the RC exercising their power to discharge under Section 23 MHA or the patient is not further detained under Section 3 of the MHA.
- The AMHP and RC have a difference of opinion on the appropriateness of further detention under Section 3 of the MHA.
- No further assessment by an AMHP and/or RC has taken place in respect of the next steps in relation to the patient's detention status.

Allowing a section to expire through passage of time would not be considered good practice. Any detention should end as soon as the legal criteria no longer applies to the patient.

When no further detention is required, it is good practice for the RC to complete a discharge form.

There were 2 lapses of detention in Q1.

- A patient was detained under section 2 which was due to expire at midnight on 26/04/26. The patient was assessed by a section 12 doctor and AMHP and further detention under section 3 was felt appropriate, but the Nearest Relative was objecting to this and so no application could be made. The RC was not available or agreeable to discharge the patient from the section 2. Ward staff and patient were advised that the section 2 would lapse at midnight and the patient would then become informal.
- The patient was detained under Section 2 of the Mental Health Act, with the detention due to expire at midnight on 11/04/2026. The patient was assessed prior to the expiry of the Section 2; however, it was determined that the criteria for detention under Section 3 were not met. Consequently, the Section 2 detention was allowed to lapse on 11/04/2026. As the Mental Health Act Office is not operational at weekends, the ward did not contact the duty Responsible Clinician to formally discharge the patient under Section 23. Upon identifying the issue, Mental Health Act Office staff immediately notified the Responsible Clinician, the ward team, and the patient.

TRANSFER BETWEEN HOSPITALS

Section 19 of The Mental Health Act allows for the transfer of Part 2 (Section 2, 3 and CTO Patients) and some Part 3 (Section 37, 37/41, 47, 47/49 and 48/49) detained patients from a hospital under one set of managers to a hospital under a different set of managers. For restricted patients transfers are subject to the prior agreement of the Secretary of State.

Table 11

SECTION	Q4	Q1
Part 2 Patients to CTUHB	7	10
Part 3 patients to CTUHB	1	0
Part 2 patients from CTUHB	6	13
Part 3 patients from CTUHB	1	0
TOTAL	**15**	**23**

COMMUNITY TREATMENT ORDER, Section 17A (CTO)
Q1 CTO Activity 2026/27

Table 12

SECTION	Power	Q4	Q1
17A	Community Treatment Order made	2	5
	Community Treatment order extended	7	3
	Recalled to hospital and not revoked	0	0
	Recalled to hospital and revoked	3	1
	Discharged from CTO	5	2
	Transferred	0	1
	Other (Deceased)	0	0

Current CTO by area

Table 13

Area	Q4	Q1
Merthyr	1	0
Rhondda Cynon Taf	7	10
Bridgend	8	6
CAMHS	0	0
Out of area	0	0
Total	**16**	**16**

USE OF SECTION 135 AND SECTION 136

Police powers under the MHA to authorise removal to a Place of Safety.

Section 135

Warrants under the Act for (1) assessments on private premises and (2) recovering patients who are absent without leave. It lasts 24 hours but can be extended, if necessary, by 12 hours up to a maximum of 36 hours.

Table 14

Section 135 of the Mental Health Act	Q4	Q1
Assessed and admitted informally	0	0
Assessed and discharged	0	0
Assessed and detained under Section 2	3	0
Assessed and detained under Section 4	0	0
Assessed and detained under Section 3	1	0
Recalled from Community Treatment Order	0	0
TOTAL	**4**	**0**

Section 136

Power to detain someone in immediate need of care or control and remove him or her to a place of safety. Power to detain lasts for up to 24hrs but can be extended, if necessary, by 12 hours up to a maximum of 36 hours.

Table 15

Section 136 of the Mental Health Act	Q4	Q1
Assessed and admitted informally	10	10
Assessed and detained under Section 2	10	18
Assessed and detained under Section 4	0	1
Assessed and detained under Section 3	0	0
Discharged with no follow up required	13	9
Discharged referred to community services	38	49
Section 136 lapsed	1	2
Other /(Recall from CTO)/ or transfer	0	0
TOTAL	**72**	**89**

HOSPITAL MANAGERS HEARINGS

Under the provisions of the Mental Health Act 1983, detained patients have a right to have their detention reviewed by the Hospital Managers. The Hospital Managers responsibilities are as follows:

- Undertake a review of detention at any time
- Must review a patient's detention when Responsible Clinician (RC) submit a report under Section 20/20A renewing detention and extending CTOs
- Must consider holding a review when a patient requests it
- Must consider holding a review when the RC makes a report under Section 25 (1) barring a nearest relative application for the patient's discharge

Table 16

Hospital Managers Hearings	Q4	Q1
Number of Hearings held	20	21
Number of Referrals by Hospital Managers	19	25
Number of Appeals to Hospital Managers	0	1
Number of Detentions upheld by Hospital Managers	19	21
Number of Hearings Adjourned	0	0
Number of Hearings postponed	7	12
Number of detentions discharged by Hospital Managers	0	0
Number of patients discharged by RC prior to Hearing	2	0

Q1:

- 1 hearing cancelled as patient discharged by MHRT
- 12 hearings postponed for following reasons:
  - ❖ 6 occasions unable to secure a full panel
  - ❖ 2 occasions no RC available due to MHRT attendance
  - ❖ 1 occasion RC attending training
  - ❖ 1 occasion patient requested postponement
  - ❖ 1 occasion solicitor not available
  - ❖ 1 occasion patient went AWOL

TRIBUNAL HEARINGS

The Mental Health Review Tribunal for Wales (MHRT) is a statutory body that works independently of the Health Board to review appeals made by detained patients for discharge from their detention and community orders under the Mental Health Act 1983. Patients are also automatically referred by the Hospital Managers in certain circumstances.

Table 17

MHRT Hearings	Q4	Q1
Number of Hearings held	25	27
Number of Referrals by Hospital Managers	12	12
Number of referrals by Ministry of Justice	1	1
Number of referrals by Welsh Ministers	1	0
Number of Appeals to MHRT	37	43
Number of Detentions upheld by MHRT	17	23
Number of detentions discharged by MHRT	4	2
Number of Hearings adjourned/postponed	10	6
Number of Hearings cancelled by patient	2	7
Number of patients transferred to another Health Board prior to Hearing	1	1
Number of patients discharged by RC prior to Hearing	10	8

Consent to Treatment

Medication after three months

The MHA team send reminder emails to the Clinicians in charge of treatment of detained patients at least four weeks before the expiry of the three-month period. This includes if a patient becomes a CTO patient, and if they have their CTO revoked during the three -month period. A patient's move between detention and a CTO does not change the date on which the three-month period ends.

Before the three-month period ends, the approved clinician should personally seek the patient's consent to the administration of medication.

If the patient lacks capacity to consent to the proposed medication or refuses, the RC completes a SOAD request form, which is submitted to HIW to arrange.

If the SOAD has not issued the certificate to authorise the treatment prior to the deadline date of the 3 -month rule, the RC has no alternative than to complete a certificate of urgent treatment under either S62 or 64G.

Table 18

Breakdown in the use of Section 62 -Urgent Treatment in hospital settings

Section 64- Urgent Treatment in the Community

Hospital	Ward	Jan	Feb	Mar	Apr	May	Jun	6 month ward/area totals
POW	PICU			2		1	1	4
	14		2				1	3
RGH	St David's							0
	22							0
	21	1	1					2
	PICU		1				3	4
	Admissions				1			1
	Seren		1					1
YGT	SRU					1		1
YCC	Ward 7				1			1
Angelton	Ward 2							0
Pinewood				2		1	1	4
Ty Llidiard	Enfys			1	1		1	3
Community								0
Monthly Totals		1	5	5	3	3	7	24

EXAMPLES OF GOOD PRACTICE

The Mental Health Single Clinical Record Programme has reached a key milestone with the successful completion of procurement and selection of the Access Group's Rio system. This marks a significant step towards a unified digital mental health record and provides opportunities to benefit from shared learning with other Welsh Health Boards already using the system.

Despite increasing levels of detention activity during Quarter 1, the Mental Health Act Office continued to provide effective statutory support and assurance across the Health Board. The team facilitated 21 Hospital Managers Hearings and 27 Mental Health Review Tribunal hearings, ensuring patients were able to exercise their legal rights.

Appendix 2

MENTAL HEALTH ACT (1983)

GLOSSARY OF TERMS

SUMMARY OF COMMON SECTIONS OF THE MENTAL HEALTH ACT 1983

Section 5(4) Nurse holding power.	This means that if a Nurse feels that a patient suffers from a mental disorder and should not leave hospital s/he can complete this form allowing detention for 6 hours pending being seen by doctor or Approved Clinician (*1 holding power form required*)
Section 5(2) Doctor's or Approved Clinician's Holding power	This means that an inpatient is being detained for up to 72 hours by a doctor or Approved Clinician if appears to suffer from mental disorder and patient wishes to leave hospital. (*1 holding power form required*)
Section 4 Admission for assessment in cases of emergency	Individual is detained for up to 72 hours if Doctor believes person is suffering from mental disorder and seeking another Doctor will delay admission in an emergency. *(1 Medical Recommendation and AMHP assessment required)*
Section 2 Admission for assessment	Individual is detained in hospital for up to 28 days for assessment of mental health. **Criteria:** • Suffering from mental disorder of a nature or degree that warrants the detention of the patient in hospital for assessment for at least a limited period. • And it is necessary that patient ought to be detained in the interests of own health, own safety, protection of other persons *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*
Section 3 Admission for Treatment	Individual is detained in hospital for up to 6 months for treatment of mental disorder. **Criteria:** • Suffering from mental disorder of a nature or degree which makes it appropriate for patient to receive medical treatment in hospital • Moreover, it is necessary for the patient's own health, safety, protection of other persons that patient receive treatment in hospital.

	• In addition, such treatment cannot be provided unless the patient is detained under Section 3 of the Mental Health Act. *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*
Section 7 Guardianship	Individual who suffers from mental disorder can be given a guardian to help them in the community. Guardianship runs for six months and can be renewable. **Criteria:** • Live in a particular place • Attend for medical treatment, occupational; education or training at set places and at set times. • Allow a doctor, an approved mental health professional or other named person to see patient *(2 Medical recommendations (or one joint recommendation) and AMHP assessment required)*
Section 37 Guardianship by Court Order	Court can make an order (6 months) that patient be given a guardian if needed because of mental disorder. The guardian is someone from social services. **Criteria:** • Live in particular place • Attend for medical treatment, occupational education or training at set places and times • Allow a doctor or an approved mental health professional or other named person to see you • *(Court Order required)*
Section 37/41 Admission to hospital by a Court Order with restrictions	Individual admitted to hospital on the order of the Court. This means that the Court on the advice of two doctors thinks that patient has mental disorder and need to be in hospital for treatment. The Court makes restrictions and as such, patient cannot leave hospital or be transferred without the Secretary of state for Justice agreement. *(Court Order with restrictions required)*
Section 135 Admission of patients removed by Police under a Court Warrant	Individual brought to hospital by a Police Officer on a warrant from Justice Of Peace, which means that an AMHP feels that individual is suffering from mental disorder for which s/he must be in hospital. Warrant last for 24 hours (but can be extended up to 36 hours). *(Section 135 (1){**non-detained patient**} warrant required or Section 135 (2){ **sections and CTO patients**} required)*
Section 136 Admission of mentally disordered persons found in a public place	Individual brought to hospital by Police Officer if found in public place and appears to suffer from mental disorder. Assessment by Section 12 Approved Doctor and Approved Mental Health Professional. Section 136 last for 24 hours (but can be extended up to 36 hours). *(Police Service Section 136 monitoring form required)*

Section 17 A Community Treatment Order (CTO)	CTO allows patients to be treated in the community rather than detention in hospital. Order last 6 months and is renewable. There are conditions attached which are: • Be available to be examined by Responsible Clinician for review of CTO and whether should be extended. • Be available to meet with Second Opinion Doctor or Responsible Clinician for the purpose of certificate authorising treatment to be issued. The Responsible Clinician may also set other conditions if relevant to individuals, carers and/or family. (*CP1 Form to be completed by Responsible Clinician and AMHP)*
Section 17 leave	Allows Responsible Clinician (RC) to grant day and/or overnight leave of absence from hospital to patient liable to be detained under the Mental Health Act 1983.Leave can have set of conditions attached for the patient's protection as well as protection of others. Leave can be limited to specific occasions or longer-term. There is a requirement for RC to consider CTO if overnight leave will be over 7 days. Patients can be recalled to hospital if they do not comply with the requirement of their leave. *(Section 17 leave non-statutory form required)*
Section 117 aftercare	This section applies to persons who are detained under Section 3, 37, 45 A, transferred direction under section 47 or 48 and who cease to be detained after leaving hospital. It is the duty of the Health Board and Local Authorities to provide aftercare under Section 117 free of charge to patients subject to the above sections. Patients can be discharged from Section 117 aftercare if they no longer receiving services.
MHAM Hearings (Mental Health Act Managers)	Patients detained under sections of the Mental Health Act are entitled to appeal against their detention to the Hospital Managers several times during their period of detention. Patients are also referred to the Hospital Managers by the Mental Health Act Administrators when the Responsible Clinician (RC) submits a report renewing the section.
MHRT Hearings (Mental Health Review Tribunal)	Patients detained under Sections of the Mental Health Act are entitled to appeal against their detention to the Mental Health Review Tribunal for Wales once in each period of detention. If a patient decides to withdraw their appeal, they can appeal again at a later date and do not lose the right of appeal. Patients are also automatically referred to the Mental Health Review Tribunal by the Mental Health Act Administrators if they have not exercised their right of appeal after a set period. Mental Health Act Administrators also automatically refer patient subject to a CTO, which has been revoked by the Responsible Clinician, to MHRT.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Version 2 August 2026

Mental Health Act Monitoring Committee

Risks related to the Monitoring of the Mental Health Act

Eitem yr Agenda / Agenda Item	**5.5**
Dyddiad y Cyfarfod / Date of Meeting:	26/08/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Choose an item..
Adroddiad wedi'i baratoi gan / Report Prepared by:	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter:	Julie Denley Deputy Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	

1. Situation /Background

1.1 The purpose of this report is to present risks related to the monitoring of the Mental Health Act (MHA) evident in Q1 (April – June 2026) and for discussion and scrutiny related to actions and key milestones related to mitigating these risks.

2. Specific Matters for Consideration

2.1 It is noted that the overall use of the MHA in quarter was slightly above the 4 year quarterly mean, driven by an increase in adult detentions.

2.2 RCT detentions were above the mean but within control limits.

2.3 Despite variances from mean in the number of S135/136, Q1 figures are within the SPC control limits for all areas.

2.4 The number of minor errors this quarter was 5, down from 9 in Q4 (4 year mean is 6), pleasingly all were rectified within the time limit.

2.5 There were 2 fundamental breaches in quarter, the first since Q1 2025/26. Both were reported via Datix, and appropriate remedial action was taken in a timely manner.

2.6

3. Risks / Matters for Escalation

3.1 The HIW feedback from RGH provides good assurance regarding statutory MHA compliance. HIW found lawful detention, strong documentation, effective statutory monitoring, good MHA administration and appropriate protection of patients' rights.

3.2 The development of a S136 policy by SWP is welcomed.

3.3 The drive to improve the number of errors and breaches through the poster shows the focus on continuous improvement.

3.4 The Operation Group will continue to scrutinise all minor errors and fundamental errors.

4. Recommendation

4.1 The Committee is asked to **note** the contents of this report

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 4 Community & Partner Engagement If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd		

(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen) **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
AC	Approved Clinician
CTMUHB	Cwm Taf Morgannwg University Health Board
IMHA	Independent Mental Health Advocate
LA	Local Authority
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
Q	Quarter
RC	Responsible Clinician
RCRP	Right Care Right Person
S	Section (of the MHA)
SPC	Statistical Process Control charts
SWP	South Wales Police

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee

Highlight Report from the Power of Discharge Committee

Eitem yr Agenda / Agenda Item	**5.6**
Dyddiad y Cyfarfod / Date of Meeting:	26th August 2026.
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Alison Thomas- MHA Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Helen Lentle- Chair of the Hospital Managers Power of Discharge Sub Committee and Independent Board Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Not Applicable
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* ***Strategic Context:*** *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* **Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan** *(Reference relevant priority)*	MH&LD IMTP 2026/29 - Workforce enablers to include: maintain focus on retention, wellbeing and inclusion and patient outcomes including: improved access, outcomes and experience for all.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy **grynhoi'r wybodaeth bwysicaf yn fyr**. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: **Executive Summary of what the report is describing:** Start by **summarising briefly** the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* **What** *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Health Board Power of Discharge Committee is a quarterly opportunity for the Associate Hospital Managers to meet as a Group with senior colleagues to discuss the delivery of Hospital Managers Hearings within the Health Board. These Hearings are a prescribed safeguard for detained Mental Health patients under the terms of the Mental Health Act 2025.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB* *ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* **So, what** *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks* *etc and any options for addressing these)*	Overall performance demonstrates effective statutory governance and supports CTMUHB's strategic objective of Improving Care. However, the breaches, lapses and ongoing documentation issues present legal, regulatory and patient safety risks, particularly in relation to lawful detention and patients' rights under the Mental Health Act and Article 5 ECHR. The findings reinforce the need for continued focus on staff compliance, training and improvements to record management processes.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The MHA Team will continue to monitor activity, breaches, lapses and use of statutory powers through existing governance arrangements, while targeting areas of recurring risk through training, scrutiny and compliance monitoring. Work will also continue to support implementation of digital mental health records, improve accessibility of statutory documentation and strengthen assurance processes, with the aim of reducing legal risk, improving compliance and enhancing patient care.
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* **Recommendation** (Linked to the "What Next" section above).	The Committee is asked to **note** the report.

1. Background / Context

The purpose of this report is to provide an update to the Mental Health Act Monitoring Committee on the work of the Hospital Managers Power of Discharge Sub Committee which met on 23/07/2026. The meeting was attended by 10 Associate Hospital Managers together with an Executive Director from the Health Board, representation from the MHA team and the Mental Health & Learning Disabilities Care Group.

2. Performance & Activity

2.1 The Role of the Hospital Managers

The role of an Associate Hospital Manager is a statutory position as defined in the Mental Health Act 1983. They provide a safeguard for those patients who are detained under the Act or subject to a Community Treatment Order, to ensure that patients, nearest relatives and carers are aware of their rights to request discharge by the hospital managers. Under the provisions of the MHA 1983, detained patients have a right to have their detention reviewed by the Hospital Managers

2.2 Hospital Managers activity Q4 (January – March 2026 and Q1(April – June 2026)

Table 1: Hospital Managers Activity

Hospital Managers Hearings	Q4	Q1
Number of Hearings held	20	21
Number of Referrals by Hospital Managers	19	25
Number of Appeals to Hospital Managers	0	1
Number of Detentions upheld by Hospital Managers	19	21
Number of Hearings Adjourned	0	0
Number of Hearings postponed	7	12
Number of detentions discharged by Hospital Managers	0	0
Number of patients discharged by RC prior to Hearing	2	0

Q1 witnessed 12 postponed hearings for the following reasons:

Six were postponed because of the difficulty in convening full hospital manager panels, which highlighted the requirement to increase the number of individuals

who would be able to act in the capacity of Chair. The quarter had also coincided with annual leave arrangements which further reduced the number of available

hospital managers. On three occasions, due to medical staff changes, the covering RC had prior commitments, attendance at MHRTs and a training event.

One of the Hearings was postponed at the patient's request and another as no legal representation was available to support the patient.

In addition, a patient went AWOL from one of the acute adult wards.

2.3 Experiences arising from Hospital Managers hearings.

One of the Hospital Managers discussed a hearing with another provider, in relation to the renewal of Section 3 for an Older Person, who was suffering from dementia. Within the content of the reports, it stated that the patient was due to undergo a DoLS assessment. When the RC asked the nurse present if this had been completed, which was an affirmative, the RC stated that he was discharging the patient from detention and that the hearing did not need to go ahead. As there had been no official confirmation that the patient was subject to the provision of DoLS, the hearing continued. The RC was requested to explain to the family the difference between a Section 3 and DoLS.

A discussion took place about a hearing with a different provider. The barring hearing was held following a request by the nearest relative to discharge their relative from detention under section 2. At the start of the hearing, the Chair explained the criteria for detention but also the need to consider the element of dangerousness. The discussion highlighted the complexity of barring hearings and the need for more training on this topic.

Another Associate Member shared their experience of chairing a hearing in CTMUHB. This emphasized to new panel Members the importance of questioning and evidence gathering, in helping to satisfy their decision that criteria for continued detention is met. The discussion further emphasized the responsibility of the panel members was to protect the liberty of the individual and of the significance of the entire professional team working together for the patient.

One of the newly appointed Hospital Managers reflected on how grateful they were to their fellow panel members and the MHA team for all their support in making this a positive learning experience.

2.4 Hospital Managers Annual Appraisals

Participation in an annual appraisal process forms part of the Health Board role profile for the Associate Hospital Manager. These appraisals have been conducted by the chair of the Power of Discharge Committee supported by the chair of the Mental Health Act Operational Committee. The purpose of the appraisal is to give the Hospital Manager the opportunity to provide direct feedback on their role and to suggest any areas for improvement. These annual reviews are a necessary step before re-appointment into the role.

All 9 of the Associate Hospital Managers who were currently active in the first quarter of 2026/27 received an appraisal and all are to be re-appointed into the role. During the appraisals there was a very helpful exchange of ideas and suggestions.

A summary document identifying key themes was shared with the Group. These included strong teamwork, positive patient focused ethic, positive support for the Mental Health Act Team, and the importance of diversity in the group. The following areas were also discussed together with next steps.

- Timeliness of Clinical Reports
- Training and Education
- Welsh Government annual Associate Hospital Manager Conference
- Remuneration Ongoing commitment to increasing the Welsh Language offer within our service
- Reception and Hosting Arrangements for Hospital Managers Hearings
- Provision of information to support Associate Hospital Managers in their role

2.5 Mental Health Training Programme.

At the start of the meeting a very informative presentation was delivered on Psychosis in adults. Members of the Mental Health Act Monitoring Committee had been invited to attend the training event. The slides to the event would be circulated by the Mental Health Act Manager. The Group discussed future training events which could include;

- Barring orders
- Psychologically informed services
- Substance use.

2.6 MHA activity report- Q1 (April – June 2026).

The Group were provided with a summary of the Mental Health Act activity report for Q1, which highlighted that the detention activity remained within expected levels.

Two fundamental breaches of the Act had occurred, whereby the AMHP had named the incorrect hospital in their applications.

Concerns regarding the use of Section 62 will continue to be monitored.

2.7 The Mental Health Act 2025

A brief update was shared with the Associate Members on commencement orders, development of the Code of Practice and Welsh Government work relating to the 10-year Mental Health Strategy.

3. Conclusion

The Mental Health Act Monitoring Committee are asked to note the contents of the report.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* **Link to Strategic Risk(s) on the Board Assurance Framework** (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* **Equality & Welsh Language Impact Assessment Outcome** *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd		

(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen) **Quality Impact Assessment Outcome** *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	
Cyfreithiol / Legal	**There are no specific legal implications related to the activity outlined in this report**
Enw da / Reputational	**There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report**
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	**There is no direct impact on resources as a result of the activity outlined in this report**

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
PODSC	23/07/2026	

Acronyms / Glossary of Terms	
MHA	Mental Health Act
AMHP	Approved Mental Health Professional
EDT	Emergency Duty Team
SWP	South Wales Police
CAMHS	Child and Adolescent Mental Health Service
IMHA	Independent Mental Health Advocacy
AWOL	Absent Without Leave
SOAD	Second Opinion Appointed Doctor
RC	Responsible Clinician
DoLS	Deprivation of Liberty Safeguards

Agenda Item	7.1.1

Unapproved Minutes of the Mental Health Act Monitoring Committee

Date and Time of Meeting	Wednesday 27th May 2026 at 14:00p.m
Venue	In-Person at CTM Gwaun Elai Breast Diagnostic Seminar Room, RGH (Snowdrop Centre)

Members Present	Kath Palmer	Committee Chair
	Hayley Proctor	Independent Member (Vice chair)
	Rachel Rowlands	Independent Member (via MS Teams)
	Rhys Goode	Independent Member
In Attendance	Robert Goodwin	Directorate Manager, CAMHs and Specialist Services
	Sarah Argent	Consultant Child & Adolescent Forensic Psychiatrist
	Lloyd Griffiths	Interim Nurse Director, Mental Health & Learning Disabilities
	Louise Stait	Assistant Director of Governance and Risk (Interim)
	Julie Denley	Deputy Chief Operating Officer (via Teams)
	Gemma Moeller	South Wales Police Representative
	Kate Riley	Rhondda Cynon Taff County Borough Council Representative
	Sharon Edwards	Corporate Governance Officer (Minutes)

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	The Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing, and colleagues joining for specific agenda items. A special welcome was given to Sarah Argent who is a Consultant Child and Adolescent Forensic Psychiatrist attending in Clare William's absence and Gemma Moeller who was attending on behalf of Gareth Prosser, the new South Wales Police representative.

1.2	**Apologies for Absence**
	Apologies were received from: • Helen Lentle, Independent Member • Dily Jouvenat, Independent Member • Gethin Hughes, Chief Operating Officer • Clare Williams, Service Director • Gareth Prosser, South Wales Police • Alex Beckham, Merthyr Tydfil County Borough Councill • Kelvin Barlow, Bridgend County Borough Council
1.3	**Declarations of Interest**
	There were no declarations identified
2.	**CONSENT AGENDA BUSINESS**
2.1	The Chair reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda and queried whether there were any items from the Consent Agenda (Item 6) that the Committee Members wished to bring forward to the main agenda for discussion. There were none.
3.	**MAIN AGENDA**
3.1	**Action Log**
	Members agreed to close the proposed actions and noted that one action is still in progress, with the patient story to be presented at the next Committee.
Resolution:	The Action Log was **NOTED.**
3.2	**Matters Arising Not Captured on the Action Log**
	There were no matters raised.
4.	**RISK MANAGEMENT ACTIVITY**
4.1	**Organisational Risk Register**
	L Stait presented the Organisational Risk Register. The report noted that one risk was removed from the organisational risk register during the reporting period following a reduction in its score to 12. No new risks were identified, and no existing risks were formally closed. L Stait asked members to consider whether the risks presented were those expected and whether they were content with the associated scoring. H Proctor queried risk 6232, relating to the stability of the legal services function, noting the prolonged Organisational Change Process. It was agreed that N Downes would be contacted to provide an update. K Palmer raised a query regarding risk 4973 whether adequate senior medical cover is now in place, specifically whether permanent Clinical Directors are in post. S Argent confirmed that Interim Clinical Directors are currently in place on a six-month basis, with the intention that these roles will subsequently move to substantive three-year appointments. She went on to say that medical staffing pressures have eased significantly, and this improvement is reflected in more stable application of the Mental Health Act.

	K Palmer raised a query regarding the progress of the Mental Health IT system, specifically whether Welsh Government approval had been secured. L Griffiths confirmed that Welsh Government approval and funding have been secured in writing. However, the programme is currently in the procurement appeals stage, meaning the system cannot yet be progressed further until this process is concluded. It was noted that the appeals process is expected to be time-limited, after which implementation can proceed.
Resolution:	The Committee **REVIEWED** and **NOTED** the Organisational Risk Register.
Action:	To provide more information and follow up regarding risk 6232
4.2	**Draft Committee Annual Report 2025-2026**
	K Palmer presented the Draft Annual Report 2025-2026 which detailed the topics that had been covered during the year, along with attendance at these meetings R Goodwin suggested that Healthcare Inspectorate Wales inspections and outcomes report, along with updates to changes to the Mental Health Act should be included within section 5, Governance and Assurance.
Resolution:	The report was **ENDORSED** for approval at Board subject to the amendments
Action:	Draft Annual Report to be updated with suggested comments
5.	**GOVERNANCE ASSURANCE**
5.1	**Deep Dive Spotlight: Statutory documentation audit for patients detained under the Mental Health Act (2025)**
	R Goodwin presented the report which provides the results of a Health Board-wide audit of Mental Health Act statutory documentation across 14 wards during 2025/26. Overall compliance remained consistently high (around 95–98%), with several standards achieving full compliance. Areas of lower compliance were mainly linked to paper-based records, delays in documentation processes, and medical staffing challenges. Key improvement actions include strengthening documentation practices, reinforcing staff responsibilities, increasing training, and progressing the move to electronic records. Quarterly audits were continuing to support ongoing assurance and improvement. H Proctor queried how the Second Opinion Appointed Doctor (SOAD) consultee process works in practice and why consultees are required to record discussions, questioning accountability for documentation. R Goodwin explained that the SOAD must consult with clinicians involved in the patient's care and while the SOAD produces a report, consultees are also required to record the discussion in the health record as part of the process. H Proctor raised concern about instances where staff were unable to recall conversations, querying reasons for this and whether there is follow-up or learning. R Goodwin acknowledged the concern and confirmed this is an area of focus for improvement as the likely causes are staff awareness and operational pressures rather than systemic failure.

	H Proctor asked whether learning and expectations around documentation are being reinforced with staff (for example through team meetings) to which R Goodwin confirmed this forms part of the improvement approach, with emphasis on increasing awareness and reinforcing requirements across teams. K Palmer queried the overall number of detained patients, noting that whilst the number of wards was provided, there was no clear sense of total volume or trends. R Goodwin and L Griffiths confirmed that quarterly detention volumes are recorded and that oversight data is available. It was noted that Mental Health Status is one of the reportable measures to Welsh Government. It was suggested that additional reporting, including aggregate figures and Mental Health Status data, could be incorporated to provide improved oversight for the Committee. It was also noted that the roll-out of electronic whiteboards is expected to support real-time visibility of detention data. J Denley queried what value a daily number of detentions would provide to the Committee, noting the importance of understanding "so what" this information would demonstrate. In response, K Palmer advised that such data would be useful in providing an overall view and context of detention levels, supporting improved Committee oversight. K Palmer congratulated the team on their positive report, noting that it provided a high level of assurance to the Committee. K Riley of RCT County Borough Council and G Moeller of South Wales Police also expressed their thanks, highlighting the strong support provided by the MH Act Team, and the excellent working relationship.
Resolution:	The Committee **NOTED** the report
Action:	It was agreed that additional reporting on daily detained patients would be provided to future meetings to improve Committee oversight.
5.2	**MHA Operational Group Update Report**
	R. Goodwin presented an update and highlighted the key matters for Members' attention. The report provides an update on the work of the Operational Group, noting positive inspection outcomes, stable MHA activity, and continued strong compliance. It highlighted ongoing work to reduce Section 136 waiting times and progress key policy, being part of a pilot scheme, workforce, and service improvement initiatives. R Goodwin presented the report, noting activity levels remained relatively stable, with detentions and Section 135/136 activity broadly in line with the established mean. No fundamental breaches were reported in Q4, marking a continued positive trend. Members noted performance data regarding places of safety and Emergency Departments (ED). It was reported that 80% of individuals held under section

	136 in places of safety were assessed within two hours, compared to 56% within ED, with 44% waiting over two hours. It was agreed that ED waiting times would be the subject of a future deep dive to better understand the underlying causes and patient experience. Members were also advised of ongoing work to develop appropriate places of safety for younger people and adolescents, recognising this as an important area for future service development. K Palmer queried the Independent Mental Health Advocacy (IMHA) service and the associated tender process. R Goodwin confirmed that NHS Wales Shared Services Partnership (NWSSP) is supporting the re-procurement of the contract. It was noted that it is a statutory duty to provide IMHA services, however, responsibility sits with individual Health Boards. It was clarified that a lived experience and patient case study will be presented at a future meeting, subject to consent. K Palmer enquired if the IMHA reports would identify key themes and experiences to which R Goodwin responded that the IMHA service provides quarterly reports, which detail how IMHAs support patients and demonstrate the development of positive relationships with multidisciplinary teams. It was agreed that, when the IMHA representative attends to present the patient story, they will also be asked to provide an overview of their Quarter 1 report. K Palmer and R Goode queried the Section 136 data, noting that whilst a deep dive was planned on 12-hour waits within ED, it was unclear whether similar analysis would be undertaken for 12-hour waits within places of safety. R Goodwin confirmed that this was a reasonable request, noting the need to understand the reasons for patients waiting over 12 hours. K Riley suggested that, as part of the deep dive, specific questions should be developed for auditors to ensure appropriate prompts are in place. This should include consideration of whether any patients are reaching the upper limit of 24 hours, noting that whilst extensions are possible, these must be formally authorised by a doctor. It was further noted that the analysis should align with the Code of Practice, with a focus on understanding the reasons for extended waiting times, supported by a narrative to explain the circumstances. R Goode queried whether there is a particular spike in activity at weekends or out of hours. In response, K Riley confirmed that Section 136 activity is proportionately higher out of hours, with the majority of assessments undertaken by the out-of-hours teams. Discussion also covered places of safety, including the need to better understand the different types, associated activity levels, and the potential for patient transfers between locations.

	J Denley noted that occurrences of extended waits are very low, typically 1–2 cases per year, and that reporting on location has been included in previous reports. K Palmer mentioned the remit of Section 12 and the potential for a training session for Committee members to support understanding. H Proctor noted that there have been recent changes to the Mental Health Act and wondered if there was a summary of these changes. K Riley advised that, whilst some changes have been introduced, implementation timescales for others remain unclear, with certain elements expected to be phased in over a longer period. It was suggested that a high-level summary of key changes could be shared to provide clarity. R Goode confirmed that the Committee would benefit from an overview of what has been implemented and what is forthcoming, to support understanding of current and future legislative changes. It was agreed that K Riley would provide a summary of training materials used for AMHP leads, and S Argent would share notes from a recent training session. Members also agreed that a dedicated training session for the Committee would be arranged. K Riley further advised that details of a supporting application/tool would be shared for Members' reference.
Resolution:	The Committee **NOTED** the report.
Action:	To invite IHMA service to the next MHAMC
Action:	To provide a high-level summary of key changes to the Mental Health Act
Action:	The upcoming Deep Dive into 12 hr waiting times within the ED should also include details of delays within places of safety.
Action:	To provide training materials used for AMHP leads and arrange a dedicated training session for the members of the Committee.
5.3	**MHA Quarterly Activity Report / Analysis of Unlawful Detentions**
	R. Goodwin presented the report and highlighted the key matters for Members' attention. The Committee received the Quarter 4 Activity Report, noting as above that Mental Health Act activity remains stable, with detention levels and Section 135/136 activity in line with expected averages. It was reported that no fundamental breaches were identified, continuing a positive trend. A small number of minor errors were recorded, primarily relating to documentation, all of which were rectified within required timescales. The report highlighted a small number of Section 5(2) lapses, attributed to timing and recording issues rather than inappropriate use, with appropriate follow-up and learning in place

H Proctor queried whether the reduction in Community Treatment Orders (CTOs) should be interpreted positively or as an area of concern, particularly in the context of the shift towards community-based care.

R Goodwin and L Griffiths advised that the reduction reflects a national trend and is not unique to the Health Board. It was noted that clinicians are increasingly utilising Section 17 leave as part of discharge planning, enabling patients to test their resilience outside of a hospital setting. They further explained that CTOs carry a high threshold and specific clinical purpose, and that current evidence does not demonstrate significantly improved outcomes when compared to less restrictive alternatives.

K Riley noted that CTOs have a specific and limited role, requiring defined criteria to be met, including the ability to recall patients to hospital where necessary. It was highlighted that where patients are not engaged in the process, CTOs may be less effective. S Argent further advised that the evidence base has not demonstrated significantly improved outcomes compared to other approaches, noting that alternative discharge pathways are increasingly being utilised, but that additional data would be helpful.

J Denley noted that the powers a clinician has under a CTO have historically been limited, which has previously been reported over the years.

K Palmer referred to the report where there were no deaths of detained patients in Quarter 4, and queried the position over a longer timeframe, noting a lack of visibility of data over the past, for example five years. She asked whether this information is routinely recorded and whether it is something the Committee should consider, including whether the lack of oversight presents a potential issue for the Health Board.

In response, R Goodwin and L Griffiths confirmed that there is a formal process, and that data is available retrospectively, with three years of accessible data on unexpected deaths.

Members discussed the need for data to include both hospital and community settings, covering all patients subject to the Mental Health Act.

J Denley suggested incorporating a three-year position within the routine data report, rather than reporting by individual quarters, to establish a consistent Mental Health Act data table. This would include all patients subject to the Act, whether on a ward or on leave.

K Palmer queried what action is taken in relation to a Section 5 lapse.
R Goodwin confirmed that the matter is followed up with the clinician involved, and it was further noted that any learning is shared with the wider team to support improved compliance.

Resolution:	The Committee **DISCUSSED** and **NOTED** the report.
Action:	Details relating to deaths of detained patient numbers over a three-year timescale to be provided going forward.
5.4	**Risks Relating to Monitoring of Mental Health Act**
	L Griffiths presented the report, which highlighted stable MHA activity with no fundamental breaches, a small increase in minor errors (all rectified), and ongoing monitoring of key risks including Section 136 waiting times and system pressures, alongside positive assurance from Healthcare Inspectorate Wales (HIW) inspection feedback.
Resolution:	The Committee **NOTED** the report.
Action:	None identified
5.5	**Hospital Managers Power of Discharge Sub Committee**
	An overview was provided by R Goodwin which provided an update on the Sub Committee's activity A small number of hearings had been postponed, primarily due to patient requests, medical staffing challenges, and difficulties convening panels. It was noted that recruitment of additional Hospital Managers is progressing, which is expected to improve panel availability. Ongoing work includes improving arrangements for face-to-face hearings, capturing themes from Hospital Manager appraisals, and supporting training and development opportunities. Key themes will be reported at the next meeting. K Palmer raised a concern regarding Hospital Managers chairing panels, noting that this may present a challenge going forward where individuals may have limited experience or confidence in undertaking the Chair role. She also suggested that Power of Discharge training sessions could be opened up to members of this Committee to support increased knowledge and understanding. Members agreed that widening access to training would be beneficial.
Resolution	The Committee **NOTED** the report
Action	Extend invitations to Committee members for future Power of Discharge training sessions
6	**CREATING HEALTH**
6.1	**Strategic Update from South Wales Police**
	A verbal update was provided by G Moeller who highlighted that the Section 135 / 136 Overarching Policy Review has undergone partner consultation and is nearing finalisation with the legal department. K Palmer queried whether the policy should be brought to the Committee to which R Goodwin noted that the policy aligns with emerging Welsh Government Section 136 standards, with draft standards recently issued for consultation. Members were advised that feedback is required by 12th June, and the policy will progress through the Operational Group before being brought back to Committee. Regarding the Right Care, Right Person approach, G Moeller noted that all phases are implemented and early indications are of positive partnership

	working and outcomes across the region. Members were informed of a pilot scheme involving St John Ambulance, commencing in June, to support the safe transportation of individuals, subject to consent, as part of wider work towards a national transport solution. She also indicated that the new Chief Inspector would attend a future meeting to provide a further update, and that a partner portal is being introduced to support improved communication and coordination.
Resolution	N/A
Action	Confirm whether the Overarching Section 135 /136 Mental Health Policy should be presented to the Mental Health Act Monitoring Committee for information.
Action	To ensure the new Welsh Government standards come to MHAMC when available.
6.2	**Strategic Update from Local Authority Partners**
	K Riley outlined ongoing regional work to standardise Approved Mental Health Professionals (AMHP) policies, including aligning AMHP warranting processes and updating guardianship policies across the region. It was reported that workforce pressures within the AMHP role remain a key focus, with actions underway to support recruitment, retention, and service sustainability. K Riley noted positive progress against the inspection improvement plans, with evidence submitted on time and to a high standard. However, staff raised concerns regarding the availability of and access to Section 12 approved doctors, as well as the link between crisis and community services. It was noted that the Local Health Board and Local Authority are currently meeting monthly to share feedback. It was also noted that staff had raised concerns about a reduction in AMHP numbers, resulting in increased pressure on resources. Matters relating to job descriptions, roles, out-of-hours arrangements, and remuneration were discussed. The AMHP Lead is currently reviewing these issues. K Palmer queried whether the policies would be presented to the Committee; however, K Riley advised that updates could be provided via the Operational Group or through future reports to the Committee. L Griffiths acknowledged the scale of the work and commended the quality and timeliness of submissions, noting the positive impact on organisational assurance and external reputation.
Resolution:	N/A
Action:	To ensure that updates regarding local authority policies are presented to the Operational Group for oversight, or other appropriate governance route.
7	**CONSENT AGENDA**
7.1	**Items for Approval**
7.1.1	**Unconfirmed Minutes of the Meeting held on 25th February 2026**
	The minutes were **approved**
7.2	**Items for Noting**

7.2.1	**Forward Work Programme**
	The Forward Work Plan was **NOTED**.
8	**CLOSE OUT BUSINESS**
8.1	**Committee Highlight Report**
8.2	**Any Other Urgent Business**
8.3	**Meeting Feedback**
	The Chair invited Members to comment and reminded them that they could also relay feedback outside of the meeting.
8.	**DATE AND TIME OF NEXT MEETING**
	Wednesday 26thth August 2026 at 14.00 pm

Agenda Item
7.3

Mental Health Act Monitoring Committee

Committee Annual Cycle of Business 2026

Dyddiad y Cyfarfod / Date of Meeting	26/08/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Sharon Edwards, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Louise Stait, Interim Assistant Director of Corporate Governance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Board Development Session	26/02/2026	Approved

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Mental Health Act Monitoring Committee should, on an annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2026 to 31 December 2026.

1.3 The Cycle of Business was Approved by the Health Board at its Board Development Session held on 26 February 2026.

2. Specific Matters for Consideration

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

3. Key Risks / Matters for Escalation

3.1 Please refer to **Appendix 1** – Mental Health Act Monitoring Committee Cycle of Business for further detail.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies, please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe	
	If more than one applies, please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Mental Health Act Monitoring Committee are asked to **NOTE** the Annual Cycle of Business.

6. Next Steps

6.1 The Committee will continue to review the Annual Cycle of Business at each of its meetings.

Mental Health Act Monitoring Committee (MHAMC) – Annual Cycle of Committee Business

(1st January 2026 to the 31st December 2026)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Mental Health Act Monitoring Committee (MHAMC) meets at **least 4 times per annum**.

Committee Chair:	**Committee Vice Chair**	**Executive Leads for Agenda Planning**
• Kath Palmer, Vice Chair of the Health Board	• Hayley Proctor, IM Trade Unions	• Gethin Hughes, Chief Operating Officer (supported by the Deputy COO for PCC and MHLD)

Link to the Board Assurance Framework Dashboard

CTMUHB Committee Business:

Improving Care Strategic Goal aligned to Committee Business
- Delivering Safe and Compassionate Care
- Developing new models of care
- Digital Transformation for patients and staff
- Ensuring timely access to care

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Organisational Risk Register	Director of Corporate Governance / Board Secretary	All Regular Meetings		✓		✓	✓	✓		✓			✓		X	✓	EMB	Received by Board for Information in Admincontrol	Risks aligned from the Organisational Risk Register to the BAF
Shared Listening and Learning Story	Deputy Chief Operating Officer (Mental Health,	Twice Per Annum					✓ Not being shared at this meeting						✓		X	✓	N/A	N/A	Topic dependent to whether it aligns to a Strategic Risk.
Report from the Mental Health Act Operational Group	Deputy Chief Operating Officer (Mental Health,	All Regular Meetings		✓		✓	✓	✓		✓			✓		X	✓	No	No	Topic dependent to whether it aligns to a Strategic Risk.
Deep Dive Spotlight report to include: • Completion of statutory MHA documentation • Section 136 Emergency	Deputy Chief Operating Officer (Mental Health, Primary Care and Community)	All Regular Meetings (as required)		✓		✓	✓ Completion of statutory MHA documentation	✓		✓ Section 136 Emergency department waiting times.			✓ Use of Emergency treatment Section 62 and timely requests for SOAD assessments.		X	✓	There may be occasions where matters highlighted during a deep dive would need to be escalated to OMB/EMB	N/A	Topic dependent to whether it aligns to a Strategic Risk.

department waiting times. • Use of Emergency treatment Section 62 and timely requests for SOAD assessments. • Review of section 117 Aftercare register and compliance with policy (to be scheduled for 2027)																			
Mental Health Act Quarterly Activity Report / Breaches/Analysis of Unlawful Detentions – Mental Health Act	Deputy Chief Operating Officer (Mental Health, Primary Care and Community)	All Regular Meetings		↵		↵	↵	↵			↵			↵		X	↵	No	No	Topic dependent to whether it aligns to a Strategic Risk.

Improving Care Strategic Goal aligned to Committee Business CONTD • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																			
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**	**Alignment to Strategic Risks on the BAF**
Highlight Report from the Provision of Discharge Sub Committee	Deputy Chief Operating Officer (Mental Health, Primary Care and Community)	All Regular Meetings (where applicable)		↵		↵	↵	↵		↵			↵		X	↵	N/A	N/A	Topic dependent to whether it aligns to a Strategic Risk

Creating Health Strategic Goal aligned to Committee Business

- Reducing Health Inequalities
- Equal focus on Mental Health and Physical Health
- Supporting our communities
- Being a Healthy Organisation

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board	Alignment to Strategic Risks on the BAF
Strategic Update from South Wales Police *(Based on the identification of key challenges / strategic areas in relation to Mental Health.)*	South Wales Police	All Regular Meetings - As and when required		✓			✓			✓			✓		X	✓	N/A	N/A	Topic dependent to whether it aligns to a Strategic Risk.
Strategic Update from Local Authority Partners *(Based on the identification of the key challenges / strategic areas in relation to Mental Health)*	Local Authority Partner's	All Regular Meetings		✓			✓			✓			✓		X	✓	N/A	N/A	Topic dependent to whether it aligns to a Strategic Risk.
Mental Health Act Legislation	Deputy Chief Operating Officer (Mental Health, Primary Care and Community) / Clinical Service Group Manager MH Care Group	Annually											✓		X	✓	Would be reported into SDC for escalation purposes only when required	Would be reported to Board for escalation purposes only when required	Topic dependent to whether it aligns to a Strategic Risk.

Governance / Committee Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability																		
Items of Business	**Executive Lead / Or External Representative**	**Reporting Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Consent Agenda**	**Main Agenda**	**Prior Reporting Requirements e.g. EMB/OMB**	**Onward Reporting into Board**
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings													If all actions are complete	If there are actions in progress / overdue actions	N/A	N/A
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X	N/A	N/A
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X	N/A	N/A
Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings		Annual Review											Except for the annual review in November	Annual Review only	N/A	N/A
Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually													X		N/A	Yes
Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					Deferred To August								X		N/A	N/A
Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					Deferred To August								X		N/A	Yes

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	**a) Enough capacity to meet elective demand** **b) Enough capacity to meet emergency demand**	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
2.	Improving Care, Sustaining our Future  Click Here for Risk 2	**Ability to deliver improvements which transform care and enhance outcomes**	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	**Enough workforce to deliver the activity and quality ambitions of the organisation** *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	**Effective Community and Partner Engagement in service changes and developments**	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	**Delivery of a digital and information infrastructure to support organisational transformation**	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	**Ability to maintain a safe and fit for purpose estate infrastructure**	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	**Fulfilling our Environmental and Social Duties and ambitions**	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	**Prevention and early Intervention to support Healthy Life Expectancy**	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	**Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)**	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	**Ability to develop a fit for the future estate to reflect our future clinical service model**	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	**Delivery of an Integrated Care Model**	Chief Operating Officer	Strategic Development Committee

Mental Health Act Monitoring Committee – Non-Routine Committee Business Forward Plan

(1st January 2026 to the 31st December 2026)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
August 2025	Mental Health Act Monitoring Committee	Committee	Family and Carer Feedback	Chair requested that this item be added to the Forward Work Plan for a future meeting	Corporate Governance Team	Deputy Chief Operating Officer (Primary Care & Community & Mental Health and Learning Disabilities)	August 2026	To be confirmed, under discussion as part of the annual self-assessment AGREED ACTION Develop and agree a proportionate approach to the inclusion of lived experience within Committee meetings, including consideration of relevance to the Committee's remit, intended assurance objectives, practical arrangements, confidentiality considerations and the resource implications for operational teams.
February 2026	Mental Health Act Monitoring Committee	Committee	MHA Operational Group Update Report	Risk relating to the prolonged use of the emergency departments and paediatrics wards as places of safety for young people to be added to the Forward Plan for future consideration with particular focus on eating disorders and transition age young people	MHA Operational Group	Deputy Chief Operating Officer (Primary Care & Community & Mental Health and Learning Disabilities)	August 2026	Now Proposed for November 2026

COMPLETED ITEMS:

May 2025	Mental Health Act Monitoring Committee	Committee	5.6. Strategic Developments in Wales	Defer to August Committee Meeting	*Nurse Director Mental Health and Learning Disabilities*	Gethin Hughes, Chief Operating Officer	August 2025	**Completed** This item was received at the August 2025 meeting.
June 2024	Mental Health Act Monitoring Committee	Committee	Deep Dive - Section 135 – Use and Code of Practice Compliance in CTM	Deferred from February Meeting	Chair MHA Operational Group	Gethin Hughes, Chief Operating Officer	August 2025	**Completed** This item was received at the August 2025 meeting.
February 2025	Mental Health Team	Operational Group	Allocation of Responsible Clinician Procedure	Approved by Operational Group and awaiting endorsement by Executive Management Board	Chair, MHA Operational Group	Gethin Hughes, Chief Operating Officer	May 2025 – Deferred to August 2025	**Completed** This was approved at the February 2025 meeting
February 2025	Email request	Deputy COO / Director of Primary, Community, Mental Health and LD	Section 136 conveyance to Emergency – review of standards against code of practice and local policy	Email request following review of forward work plan	Chair MHA Operational Group	Gethin Hughes, Chief Operating Officer	May 2025	This item is on the agenda for the May 2025 meeting
February 2025	Mental Health Act Monitoring Committee	Committee	Deep Dive – Mental Health Detentions within RCT	To undertake a deep dive into adult mental health detentions within the RCT area and present to the next meeting of the Committee for discussion.	Chair MHA Operational Group	Gethin Hughes, Chief Operating Officer	May 2025	This item is on the agenda for the May 2025 meeting
August 2025	Mental Health Act Monitoring Committee	Committee	Fee Review Update Report for Hospital Managers	Verbal update provided at August 2025 meeting with a report to be provided to the December 2025 meeting for the Committee to Note.	Deputy Chief Operating Officer (Primary Care & Community & Mental Health and Learning Disabilities)	Deputy Chief Operating Officer (Primary Care & Community & Mental Health and Learning Disabilities)	December 2025	**Completed** Received at the December 2025 meeting
August 2025	Mental Health Act Monitoring Committee	Committee	Deep Dive into adult detentions (including a review of the UK benchmarking information, a look at section 136 cases who are also care coordinated,	Chair, MHA Operational Group requested via the Chair that this item be included as an update within the MHA Operational Group Report	Chair, MHA Operational Group	Deputy Chief Operating Officer (Primary Care & Community & Mental Health and Learning Disabilities)	Deferred from December 2025 with a brief update contained within the Operational Group Report for December meeting.	**Completed** Received at the February 2026 meeting

			section 5(2) and variation in detention rates between RGH and POWH)					