DRAFT Mental Health Legislation Committee

Terms of Reference

Updated November 2019

1. INTRODUCTION

1.1 The Swansea Bay University Local Health Board (the health board) standing orders provide that "*The board may and, where directed by the Welsh Government must, appoint committees of the health board either to undertake specific functions on the board's behalf or to provide advice and assurance to the board in the exercise of its functions. The board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with standing orders (and the health board's scheme of delegation), the board shall nominate a committee to be known as the **Mental Health Legislation Committee**. The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3 The remit of this committee is to consider and monitor the use of the Mental Health Act 1983 (MHS), as amended, the Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the measure).

A summary of the definitions of legislation and a glossary of terms are presented at **appendix 1**.

2. PURPOSE

2.1 The purpose of the committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Mental Health Act 1983; and
- the provisions set out in the Mental Capacity Act 2005, and in the Mental Health Measure (Wales) 2010;

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales[1];
- the Mental Capacity Act 2005 Code of Practice[2];
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DOLS) Code of Practice;[3] and
- The Human Rights Act 1998
- The United Nations Convention on the Rights of People with Disabilities
- The associated regulations and local policies.

[1] http://www.wales.nhs.uk/sites3/documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
[3] https://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

The Committee will also advise the board of any areas of concern in relation to compliance with any of the mental health and capacity legislation.

3. SCOPE AND DUTIES

3.1 The committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of mental health and capacity legislation, including the Mental Health Measure, have the requisite skills and competencies to discharge the board's responsibilities;
- identify matters of risk relating to mental health and capacity legislation and seek assurance that such risks are being mitigated;
- consider and approve relevant policies and control documents in support of the operation of mental health and capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the hospital managers' power of discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to mental health and capacity legislation;
- consider matters arising from reports from Healthcare Inspectorate Wales (HIW), including visits, which relate to mental health and capacity legislation;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about mental health and capacity legislation;
- consider any other information or reports that the committee deems appropriate.

4. DELEGATED POWERS AND AUTHORITY

The Code of Practice requires that arrangements for who is authorised to take what decisions should be set out in a scheme of delegation, which is presented in the **'Powers of Discharge Policy'.**

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

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

- Review the Mental Health Legislation Risk Register bi-annually to ensure that risks relating to compliance with mental health legislation are being appropriately managed;

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

- Receive the Mental Health Legislation Committee Annual Report and consider issues in relation to the implementation of the Mental Health Strategy across the Swansea Bay area;

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

- Consider any reports made by the Public Services Ombudsman for Wales (PSOW) regarding complaints about Mental Health and Capacity legislation;

- Consider and approve on behalf of the Board any policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc.

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

- 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 Delivery Unit;
- 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 Delivery Unit structure;
- Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated;
- 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;
- Policies and procedures are developed and approved in line with the organisation's Written Control Document Policy;
- 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;
- Relevant legislative and regulatory frameworks, in particular, the Human Rights Act 1998, the Equality Act 2010, the Welsh Language Standards (No. 7) Regulations 2018 the Data Protection Act 1998, the General Data Protection Regulation (EU) 2016/679 ("GDPR"), and the Data Protection Act 2018 are adhered to.

4.3 The committee is authorised by the Board to:

- Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference.

- Seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the committee;

- 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, in accordance with the Health Board's procurement, budgetary and other requirements; and

- 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.

- *Note – HIW report recommendations are the remit of Quality Safety Committee (QSC) however any specific recommendations relating to Mental Health or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSC are appraised accordingly.

4.4 Sub Committees

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.

- Sub-Committee - In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Sub-Committee, terms of reference for which are attached as **Appendix 3.**

- Panel -Three members drawn from the pool of designated Associate Hospital Managers will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to a Community Treatment Order (CTO).

- The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Swansea Bay University Health Board, as well as the Power of Discharge Sub-Committee

5. MEMBERSHIP OF MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE

5.1 Members

A minimum of five members, comprising:

- Three independent members, to include one who is a Member of the Quality, Safety and Committee and one to be the Chair of Power of Discharge Committee;
- Director of Nursing and Patient Experience; and
- Chief Operating Officer (COO).

Members' terms of office will be reviewed annually by the committee and a member may resign or be removed. The committee chair may invite other executive directors or health board officials to attend all or part of a meeting to assist it with its discussions on any particular matter.

5.2 Member Appointments

- The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Health Board will be the Chair of this Committee and shall retain the role of Chair of this Committee throughout their tenure of appointment.

- Other appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by

the Board. Independent Members may be reappointed up to a maximum period of 8 years

5.3 Secretariat
The Director of Corporate Governance/Board Secretary shall ensure effective secretariat support is provided to the committee.

5.4 Support to Committee Members

5.4.1 The 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
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

6. COMMITTEE MEETINGS

6.1 Quorum
At least three members must be present to ensure the quorum of the Committee. Of these three, two must be independent members one of whom should be the Committee Chair or Vice-Chair.

6.2 Frequency of meetings
Meetings shall be held no less than quarterly and otherwise as the committee chair deems necessary and consistent with the health board's annual plan of board business.

6.3 Withdrawal of individuals in attendance
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.

7. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 Although the board has delegated authority to the committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.

7.2 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.3 The committee, through its chair and members, shall work closely with the board's other committees to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of information.

In doing so, it will 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.

7.4 The committee shall embed the health board values, corporate standards, priorities and

requirements through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The committee chair shall:

- report formally, regularly and on a timely basis to the board on the committee's activities, via the Chairs assurance report and through verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual committee report;
- ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The board may also require the committee chair to report upon the committee's activities at public meetings, for example the board's annual general meeting, or to community partners and other stakeholders, where this is considered appropriate, for example where the committee's assurance role relates to a joint or shared responsibility.

8.3 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 committee's performance and operation, including that of any sub-committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the health board's standing orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum;
- Notice of meetings;
- Notifying the public of meetings; and
- Admission of the public, the press and other observers.

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed annually by the committee with reference to the board.

Approval
MHLC – 25 November 2019
Board -

Annual review date: May 2020

Appendix 1

Mental Health and Capacity Legislation - Definitions

Mental Health Act

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

The MHA introduced the concept of "hospital managers" which for Hospitals managed by a local health board are the "board members"[4]. The term "hospital managers" does not occur in any other legislation.

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

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

With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of hospital managers have been set out in the health board's scheme of delegation.

Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 received royal assent in December 2010 and has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living.

The Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. It has four main Parts (Parts 5 and 6 are essentially about administrative issues), and each places new legal duties on Local Health Boards and Local Authorities to improve service delivery. The four Parts are as follows.

- **Part 1** seeks to ensure more mental health services are available within primary care.
- **Part 2** gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.
- **Part 3** gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.

[4] Chapter 11 – MHA 1983 Code of Practice for Wales, page 61

- **Part 4** offers every in-patient access to the help of an independent mental health advocate.

Guiding Principles

These Guiding Principles are set out in the Code of Practice for Parts 2 and 3 and are particularly important for these Parts, but they are also relevant for the whole Measure.

There are six in total and they are as follows.

- ***Patients and their cares should be involved in the planning, development and delivery of care and treatment to the fullest possible extent*** – so that professionals seek to involve a person as fully as possible in their care and treatment in a sensitive way, and one which promotes their confidence and recovery.

- ***Equality, dignity and diversity*** – so that professionals have due regard to a person's needs arising from their race, gender, religion, sexuality age or disability when delivering a service.

- ***Clear communication in terms of language and culture is essential to ensure patients and their carers are truly involved, and receive the best possible care and treatment*** – so that there is always an understanding that poor communication too often leads to inappropriate care and treatment, and that good communication is likely to lead to better outcomes. This principle also states that all possible steps should be taken to ensure that bilingual (Welsh and English) services are available.

- ***Care and treatment should be comprehensive holistic, and person-focussed*** – so that professionals are sensitive to the full range of a person's needs and that they plan care, treatment and support across whatever needs will help a person's recovery.

- ***Care and treatment planning should be proportionate to need and risk*** – so there is a recognition that, whilst on the one hand, some people with complex needs may need detailed care plans, on the other some people may need un-complicated help that will still significantly improve their situations.

- ***Care and treatment should be integrated and coordinated*** – so that when offering care and treatment, professionals recognise the range of services that may benefit a person, whether in the statutory or voluntary sectors, or whether specialist mental health services or more general services, and actively work together with other services to coordinate service delivery.

Mental Capacity Act

1.10 The Mental Capacity Act (MCA) came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

The MCA covers three main issues:

- the process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care);
- how people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions;

- the legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS).

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

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for a mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on Section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 24 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well-being of a person who is not liable to be detained under the Act so that he/she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135 (2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 24 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from a mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety for up to 24 hours so that he/she can be examined by a doctor and interviewed by an Approved Mental Health Professional in order that arrangements can be made for his/her treatment or care. The detailed person can be transferred to another place of safety as long as the 24 hour period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detailed or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act. As part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.

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

	within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under Section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the powers to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the County Court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. A Community Treatment Order (CTO) provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients. Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto CTO.
Section 17E (recall of	Provides that a Responsible Clinician (RC) may recall a

a community patient to hospital)	patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section17B (3)
Revocation	Is the rescinding of a CTO when a CTO patient needs further treatment in hospital under the Act. If a patient's CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be restricted, which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or Magistrates Court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the powers of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers the treatment is no longer required or beneficial, the person can be transferred back to

	prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State for Justice to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of un-sentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a S.47 or S.48
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41 • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for Community Treatment Order (CTO).
Administrative Scrutiny	To be confirmed
Section 58(3) (a)	Certificate of consent to treatment (RC)
Section 58 (3) (b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment) (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent Treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a

	danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician (RC), the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If an ay time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or a CTO is due to expire.
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.

DRAFT Hospital Managers Power of Discharge Committee

Terms of Reference

Updated November 2019

HOSPITAL MANAGERS POWER OF DISCHARGE COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The role of the Hospital Managers Power of Discharge Committee is to satisfy the Board that the processes employed by the Committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.

2. MEMBERSHIP

Chair	Non-Officer Member of the Board
Membership	Hospital Managers, to include all other Non-Officer Members of the Board and appointed Associate Members.
In Attendance	Nominated members of the Mental Health and Learning Disabilities Delivery Unit.
Member Appointments	The Hospital Managers shall retain their membership of the Power of Discharge Committee at the discretion of the Board, but only for as long as they remain Non-Officer Members or Associate Members of the Board. An annual appraisal system will be applied to support the annual renewal arrangements for Hospital Managers.
Appointment of Chairman	The chairing of the Committee should be undertaken by a Non-Officer Member of the Board

3. DUTIES

The Power of Discharge Committee shall:

- Monitor the exercise of Power under Section 23 of the Mental Health Act 1983 by Hospital Managers at Hearings involving 3 or more members of the *Hospital Managers Power of Discharge Committee.* These powers are formally delegated by the Health Board in its "Policy for Hospital Managers' Scheme of Delegation". This policy sets out the statutory functions of Hospital Managers

- Report annually to the Board

- Develop a rolling programme of training activities to ensure that its members are fully able to exercise their responsibilities. This will include a formal induction programme and regular training on the Mental Health Act 1983.

- Consider issues which are identified by Hospital Managers at Hospital Managers Hearings and which required action. This will be a standing agenda item for discussion by the group. The Chair will determine if the issue needs to be escalated and will be empowered to seek legal advice from the Health Board Solicitors.

4. MEETINGS

4.1 Quorum

The Power of Discharge Committee will require the following members to remain quorate:

1 Chairman of the Hospital Managers Power of Discharge Committee
1 Other Non-Officer Member of the Board
2 Associate Members

4.2 Frequency of Meetings

The Power of Discharge Committee shall meet at six monthly intervals. Additional meetings may be called by the Chairman at any time providing at least ten working days' notice is given.

5. REPORTING

The Chairman of the Committee will present an annual report to the Board.

6. REVIEW

The Terms of Reference will be reviewed annually or when changes in legislation dictate.