Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2017-2018

June 2019

Mae'r ddogfen yma hefyd ar gael yn Gymraeg. / This document is also available in Welsh.

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Contents

1 Executive summary

During 2017-18 we inspected a range of mental health and learning disabilities establishments in Health Boards (HB's) and independent healthcare providers in Wales. The range of inspections undertaken gives Healthcare Inspectorate Wales (HIW) an informed opinion on the services that are providing care and treatment to this vulnerable group of patients. During these inspections we have covered a number of key areas including;

- Monitoring how services use the Mental Health Act and the associated Code of Practice for Wales. HIW undertakes this function on behalf of Welsh Ministers and we consider how HB's and independent providers administer the Act and exercise their powers in relation to detained patients and those liable to be detained

- Monitoring how services comply with the Mental Health Measure (2010) by reviewing individual patient care and treatment plans to ensure that patients have a Care Co-ordinator appointed and patients have a comprehensive mental health and physical health assessment. In addition, Part 4 states that every in-patient must have access to an independent mental health advocate and this is another area that HIW monitors

- Monitoring the Mental Capacity Act 2005 and the use of Deprivation of Liberty Safeguards by individual Health Boards and Independent Providers.

- Ensuring that the independent providers of healthcare comply with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards for Independent Healthcare in Wales

- Monitoring how individual Health Boards meet the NHS Health and Care Standards 2015.

During this year we have also considered what specific issues have emerged in relation to elderly care wards and Child and Adolescent Services (CAMHS).

We have made some changes to this report. Specifically, we have not included an initial chapter setting out key published statistics: this information can be found on the Statistics Wales website at the following link: https://statswales.gov.wales/Catalogue/Health-and-Social-Care.

Our work

During 2017-18 HIW conducted a total of 34 Inspections, comprising of 24 in-depth inspections including 3 focused reviews and 1 Child and Adolescent CAMHS unit. We also visited 2 learning disability services and conducted 8 stand-alone Mental Health Act monitoring visits. In terms of the Mental Health Act we visited 50 wards to undertake monitoring visits, a number of these were undertaken as part of our in-depth mental health inspections and include the 8 stand-alone visits.

During the inspection year we also commenced a National Review of Adult Community Mental Health Services of the 7 Health Boards. These reviews were jointly undertaken with Care Inspectorate Wales (CIW) and we jointly reported our findings for each Health Board.

We also issued a number of immediate assurance letters requiring a quicker assurance to some of the more urgent findings from our visits for both the HB's and the independent providers of healthcare.

What we found

During our mental health and learning disability inspection visits we highlighted a number of areas of noteworthy practice, including:

- Patients were generally satisfied with staff interaction and the standards of care being delivered by staff
- Evidence of strong administrative governance and medical audit of the Mental Health Act records
- Evidence of detained patients being made aware of their rights under Section 132 of the Mental Health Act
- Some excellent examples of collaborative multi-disciplinary team working.
- An improvement in the range of therapeutic, social and recreational activities available to patients
- Committed staff teams who were working in services where there were significant challenges.

However, we also identified a number of concerning themes for the NHS and independent hospitals during our inspections including;

- Significant gaps in training of staff including; the Mental Health Act, the Mental Capacity Act and safeguarding
- Availability of sufficient staff with the right skills and knowledge to deliver effective care
- A lack of the physical healthcare needs of patients being adequately assessed
- Numerous issues with medicines management including Controlled Drugs
- A lack of appropriate patient information on display and available for patients
- Patient safety risks not appropriately identified and managed
- Inadequate cleaning of the environment of care
- A significant number of patient privacy and dignity issues
- A lack of maintenance, refurbishment and replacement programmes
- A lack of robust care and treatment planning
- A lack of sufficient in-patient beds

A significant number of these issues were previously identified during 2016-17. It is disappointing to note that Health Boards and independent providers have not developed sufficiently robust governance and audit processes to ensure on-going issues are addressed within reasonable timescales.

2 What we did

2.1 Strategic Framework

A number of key strategies provide the context for the work of HIW monitoring the delivery of mental health services for all healthcare providers both in the NHS and independent sector.

Together for Mental Health

This is the Welsh Government's 10 year strategy to improve mental health and well-being and is supported by a three year delivery plan (2016-19). It sets out the key actions for the Welsh Government and stakeholder agencies in the statutory and third sector. During our inspection programme HIW reviews some of the key actions of this strategy including; patient involvement, services delivered that are based on safety, dignity and respect and the pathway for CAMHS referrals and timely access for services. Our findings in relation to some of these areas are summarised in section 4 of this annual report.

Future Generations (Wales)

In addition the Well-being Future Generations (Wales) Act 2015 set out some key priorities to make public bodies such as the NHS and Social Services think about long term plans, work more closely with people and communities and work in a more joined up way. This area is considered within HIWs routine work and we also undertake joint inspections with a number of other key organisations where the working together of the NHS and Social Services is considered in detail. One example of this is our contribution to inspections of Youth Offending Teams (YOTs).

The Crisis Care Mental Health Concordat

The Concordat is a joint statement of commitment to improve the care and support for people experiencing or at risk of mental health crises and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983. The statement of commitment is supported by a number of agencies including; Welsh Government, NHS, the Police, Welsh Ambulance Service, Local Authorities and the third sector. HIW and Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) have a role in the scrutiny of the impact of the Concordat. HIW will be considering the effectiveness of the Concordat in 2018-19 and whether to undertake a specific thematic review of this area. This Concordat is also referred to within the Together for Mental Health Strategy and within our inspection programme when we consider

the effective use of the section 136 Suites within a hospital, the adherence to this Concordat is considered.

Dementia Action Plan for Wales

The above action plan sets out a vision for Wales for the period 2018 – 2022. Dementia affects a significant number of the population in Wales and it was estimated that in a joint report published in 2015 by Marie Curie and the Alzheimer's Society that there were 45,000 people affected by Dementia in Wales. A significant number of people with the illness will be supported in the community and it is only in the advanced stages of the illness that people may need longer term care in an hospital or care home. The action plan for Wales focuses on a number of key areas including: risk awareness and reduction, assessing individuals and a living well with dementia strategy. HIW will be assessing its methodology to ensure that it is able to have an informed opinion on the progress of the action plan.

2.2 Our role in regard to mental health

HIW monitors the Health Boards in terms of their performance in meeting the Health and Care Standards and other key areas some of which are described above. For independent providers the primary legislation is the Care Standards Act 2000 and HIW considers compliance with the associated Independent Health Care (Wales) Regulations 2011 and how providers meet the National Minimum Standards for Wales.

HIW also has responsibility for monitoring how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983, on behalf of Welsh Ministers.

We discharge our responsibilities by a planned programme of inspections that cover a wide range of areas including;

- Whether there are adequate numbers of staff with the necessary skills, knowledge and training
- To what extent the environment of care enables staff to meet the patients' needs in a safe therapeutic way
- Whether care and treatment plans are evidence based and risks are well documented
- Processes for effective medicines management
- Quality of detention paperwork for patients who are detained

- Adequacy of governance and audit

HIW has a specific duty under the Mental Health Act to produce an annual monitoring report and for investigation of complaints relating to the application of the Act.

HIW also provides a registered medical practitioner to authorise and review proposed treatment in certain circumstances (the Second Opinion Appointed Doctor Service). This area is covered in further detail in section 4.4 of this report.

2.3 Using intelligence to focus our work

HIW uses a range of intelligence, gained from a number of sources as part of a risk-based approach to assist in determining our work programme. Further information on our risk strategy and our use of intelligence is published on our website https://hiw.org.uk/how-we-operate.

In the period of 2017-18 HIW received a total of 349 complaints and concerns for all its registered services, via letter, email or telephone either directly or via third party (compared with 329 complaints and concerns received in 2016-17), this is a 6% increase from the previous year. Of these, 58 (17%) were in relation to NHS mental health settings and a further 80 (23%) related to independent mental health settings. We have seen an overall increase of 28% in the number of concerns relating to mental health services compared to 2016-17. Table 1 shows what the concerns and complaints generally related to.

Table 1: Complaints and concerns received relating to mental health services, 2017-18 with a comparison of 2016-17

	NHS		**Independent**	
	2016-17	**2017-18**	**2016-17**	**2017-18**
Whistleblowing	3	5	9	12
Patient abuse	2	3	5	4
Infrastructure/staffing/facilities/ Environment	5	6	27	38
Consent/communication/confidentiality	1	0	0	0
Treatment/Procedure	26	35	21	19
Other	4	9	5	7

Total	**41**	**58**	**67**	**80**

The table above illustrates that there were two significant changes. The first being a 35% increase in the number of NHS concerns relating to treatment and procedure. The second being a 40% increase in the number of independent concerns relating to Infrastructure, staffing, facilities and environment.

Table 2 shows the source of the complaints and concerns.

Table 2: Source of complaints and concerns, 2016-17 & 2017-18

	NHS		**Independent**	
	2016-17	**2017-18**	**2016-17**	**2017-18**
Patient	14	21	18	32
Relative/Advocate/Other	24	32	27	36
Staff/Whistle-blower	3	5	22	12
Total	**41**	**58**	**67**	**80**

As Table 2 indicates, there has been an overall rise in the number of concerns brought to the attention of HIW. There may be a number of reasons for this increase including an increased awareness of HIW particularly in relation to staff, relatives and advocates but it is not clear what has led to this increase.

However, there has been a 45% decrease in the number of whistle-blower concerns in the independent sector. It is uncertain why this decrease has occurred. There are clear processes in the sector for individuals to use the whistle-blower process.

Another source of intelligence is the Regulation 30 and 31 notifications that we receive from independent establishments under the Independent Health Care (Wales) Regulations 2011. Specifically these events are:

- Death of a patient;
- Unauthorised absence;
- Serious injury;
- Outbreak of infectious disease;
- Allegation of misconduct; and
- Deprivation of liberty

During 2017-18, HIW received 171 notifications of patient safety incidents that occurred within independent mental health care settings. This is a significant reduction of 75 (30%) notifications from 2016-17. It is not clear whether there may be the under reporting of incidents by the independent sector or there may have genuinely been a reduction of incidents that met the threshold for reporting to HIW.

These were broken down into the following categories.

Table 3: Regulation 30/31 notifications, 2016-17 & 2017-18

	2016-17	2017-18
Serious injury	144	81
Unauthorised absence of a patient	47	46
Allegation of staff misconduct	39	32
Death of a patient	6	11
DOLS	8	0
Other	2	1
Total	**246**	**171**

The table above demonstrates that the figures have remained fairly similar to the previous years, apart from in two areas where there has been significant reduction in the number of regulatory notifications received. There has been a reduction of 43% in the number of serious injury notifications received and a reduction of 100% as there have been no DOLS notifications received. All concerns are assessed by a case manager and recorded as intelligence.

The case manager will coordinate as appropriate with relevant agencies including the police, safeguarding boards, coroner and will correspond with the setting to ensure that concerns and incidents are investigated and actions are implemented. Some concerns or incidents may trigger an HIW inspection. Where appropriate concerns at NHS settings can be escalated and action can be taken on regulatory breaches in independent settings in line with our enforcement and non-compliance processes.

2.4. Where we visited

During 2017-18 we conducted 24 in-depth inspections of NHS and independent mental health hospitals, 8 specific Mental Health Act monitoring visits and 2 learning disability hospitals inspections, so the total number was 34. The number of visits we conducted also included 3 specific focused

follow-up review visits that were undertaken in relation to specific concerns that HIW had. Within these visits we also considered how the HBs and individual registered providers addressed the following;

- Discharged their powers and duties in relation to patients detained under the Mental Health Act 1983.
- Complied with the Mental Health (Wales) Measure 2010
- Assessed how their responsibility in relation to the Mental Capacity Act 2005 was discharged including Deprivation of Liberty Safeguards

A full list of the health boards and independent registered providers visited is given in Appendix A.

2.5 How we inspect

We use a number of methodologies to ensure we consider a range of evidence to undertake our inspections and make evidence based conclusions. The methodologies used include; direct examination of a range of care documentation, observation of patient and staff interactions and the ward environments and the analysis of some key areas as listed below. We also consider the administration of the Mental Health Act and compliance with the associated Code of Practice for Wales. The areas covered during the inspection include;

- Examination of individual patient risk assessments to ensure that they address identified risks
- Ligature risk assessments including environmental risks
- Concerns, complaints and incidents logs and action taken
- A record of all restraints undertaken and time and position of restraint
- Appropriateness of intensive care facilities where used
- A selection of policies and procedures are considered and their implementation tested
- Is the environment of care adequate to meet the needs of the patient group and does it afford an appropriate level of privacy and dignity
- Medicines management including, ordering, storage and administration
- Availability of advocacy

- Nutrition and are patients receiving sufficient fluids
- Capacity and Consent to treatment issues.

All of our visits are unannounced and primarily commence during the evening followed by a number of days. This provides HIW with a view of care over a 24 hour period. The visits usually last between 2 and 3 days and the focus is upon the overall patient experience. The patients' views and opinions on all aspects of the service are crucial to the inspection process and the interviewing of patients is a key component of the inspection. The team also comprises an individual with expertise in the administration of the Mental Health Act in addition, to HIW staff and peer and lay reviewers.

2.6 Working with partner agencies

HIW works in partnership with a number of organisations in relation to mental health services.

HIW is a member of the UK's National Preventative Mechanism (NPM) that is made up of 21 bodies that have responsibility to visit and inspect places of detention. The United Nations' Optional Protocol to the Convention Against Torture (OPCAT) provides a framework for the NPM to focus on strengthening the work of monitoring places of detention.

In addition, HIW is a member of the steering group and the sub groups for children and young people and mental health.

HIW undertakes joint inspections with HMI Probation of Youth Offending teams throughout Wales. A number of other agencies also are involved with these joint inspections including Care Inspectorate Wales (CIW), Estyn and Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS). HIW's focus during these joint inspections is how the healthcare needs of the young offenders are being met, these include; physical and psychological needs, involvement of CAMHS, sexual health and drug and alcohol treatment strategies.

3 What we found

3.1 Inspections of mental health services

This section of the report summarises the finding from the 24 inspections undertaken in 2017-18.

Quality of patient experience

Quality of experience means different things to different people. That is why engagement of patients and significant others is paramount in assessing how effective a service is in providing a high quality experience throughout a patient's stay in hospital. During the inspection process we routinely engage with as many patients, visitors, relatives and staff as we can. Their views on the care and treatment they are receiving is an essential part in the judgement that HIW makes regarding the quality of the in-patient experience.

During our inspections we found that patients were not always given the information that they needed. This was of particular concern where patients were detained and not clearly informed of their rights under the Mental Health Act. Also of concern was the lack of information on how patients could complain if they had issues with the care and treatment that they had received.

HIW were also concerned that in 10 (42%) of our visits the privacy and dignity of patients had been compromised, this is an unacceptable way for some of the most vulnerable patients in our hospitals to be treated.

However, it was pleasing to note that the majority of patients were very positive about the attitude and approach by staff and the provision of meaningful and engaging activities.

Staff approach and attitude

Overall the feedback that we received from patients was very positive about the attitude and positive approach by staff and during the inspection process we frequently observed a good rapport between patients and staff.

However, on a very small number of occasions HIW reviewers observed inappropriate staff behaviour, as illustrated in the example below

Case Study

In one hospital HIW undertook an unannounced inspection visit. One of the significant issues identified was the observation of 2 inappropriate staff interactions with 2 separate patients. In the first incident a staff member was observed to be very close to a patient in a door way with the patient backed into a corner. There was no verbal or signed communication from the staff member to the patient. The appearance of this interaction was oppressive and intimidating and it restricted the patients movement with a non-approved form of restraint In the second incident we observed another member of staff using intimidating body language and speech with another patient.

The Registered provider responded to the issues raised above with an action plan

Access to information

Patients and their families need to have access to a range of information when admission to a mental health unit takes place. Information was not always provided in a suitable format for the patient group and in 15 inspections (62%) information on a number of key areas was lacking. This included;

- information on the Mental Health Act and patient rights
- up to date information on how to make a complaint including contact details for HIW
- information on the advocacy service.

Meals

Variety and choice of food in meals are important in mental health establishments where patients can be resident for longer periods of time.

In 6 inspections (25%) concerns were raised by patients about a number of issues including; the lack of availability of fresh fruit, the lack of variety of food, patient dietary preferences not being taken into consideration and the quality of food provided. This was less than last year where there were issues identified within 10 inspections (34%).

Privacy and dignity

We also identified issues impacting the privacy and dignity of patients in 42% (10) of our visits. These issues were more prevalent in the NHS settings which accounted for 9 out of the 10 relevant visits. Issues identified included

- Vision panels in patient bedroom doors routinely being left open
- Bedroom door blinds broken
- Information boards containing patient details not covered when not in use and could be observed by other patients
- Patient bedroom windows could be looked into by other patients and staff and there was a lack of curtains or curtains not hung appropriately.

Delivery of safe and effective care

Our inspections examine the environment in which care is being delivered and the degree to which this supports the delivery of safe and effective care. We also look at issues related to the planning and delivery of care to individuals within this environment.

One of the key findings was that many hospitals continued to not adequately assess and meet the physical healthcare needs of patients. This can have a significant effect on the well-being of individuals and the trend was continuing to increase since our last annual report. HIW also identified a range of issues with medicine management and some of these were very serious including issues around the storage and administration of Controlled Drugs. Of great concern to HIW was the area of patient safety including the management of patient risks including care and treatment plans, the absence of a nurse call system and the absence of up to date ligature risk assessments. These areas must be managed appropriately to mitigate the risk as much as possible for this vulnerable and unpredictable patient group.

Care and treatment planning

There continues to be an increase year on year of issues identified with the care and treatment plans for in-patient care. This year in 83% of our visits we identified issues compared with 59% in 2016-17 and 43% in 2015-16.

Patients' care and treatment plans are an essential element of delivering an holistic package of care. These plans need to clearly and accurately set out the required interventions and support that will empower and assist the patient in making progress along the care pathway.

The issues identified included:

- Lack of pre-admission assessments
- Lack of the formulation of admission care plans in a timely manner
- Lack of discharge plans
- Lack of focus on the "domains" within the Mental Health (Wales) Measure 2010
- Unmet needs not identified
- Lack of evidence of individual patient involvement

- Disorganised care records
- Some records did not contain the most up-to-date information
- Some care records were too brief and did not provide sufficient detail

In terms of risk management once again we identified numerous examples of a blanket approach to risk as opposed to an individual patient risk based approach. In addition we continued to find examples of where risks had been identified and no strategy to deal with those risks had been formulated. Given the well documented research around the numerous risks of self-harm, suicide and aggression for patients who are acutely mentally ill it was disappointing to note the lack of documented care strategies to address identified risks.

Case Study

HIW undertook an unannounced inspection visit to a hospital in a health board. A number of issues in relation to the care and treatment plans of patients were identified including; a patient who had a chest infection and no care plan had been formulated. It was therefore difficult to assess what treatment was in place to deal with the issue and how effective it was. In addition, two care and treatment plans were out of date and did not reflect their current placement. The content of one of the plans was so generalist that it was difficult to see the relevance to the particular patient. We also found a lack of patient engagement with the care plan process and a lack of evidence that patients were aware of their care and treatment plans.

The Health Board has responded with an action plan to improve the provision and documentation of the care provided.

Physical health care

The physical health care that patients receive is an important factor in delivering care to meet all the needs of the patients. If patients are not physically well then this may have an impact on their mental health and may not let patients have the full benefit of treatment that they are receiving for their mental illness.

HIW are disappointed that there was a significant increase from 36% in 2016-17 to 50% (12 hospitals) in 2017-18 where issues were identified in relation to the physical healthcare being delivered on psychiatric wards.

Particular issues identified included:

- Physical healthcare records not adequately completed
- Physical observations not appropriately monitored and recorded following the use of rapid tranquilisation
- Lack of care plans for patients with physical healthcare issues
- A lack of recording when patients decline physical healthcare monitoring and/or treatment
- Physical healthcare documentation either absent or incomplete

Case Study

In one hospital, HIW undertook a focused review on registration compliance and governance. As part of the review process the care and treatment plans for a number of patients were examined. Issues identified included a Wales Applied Risk Research Network (WARRN) assessment that stated in January 2018 that suicidal behaviour was unlikely because of the hospital environment. However, the patient had attempted to commit suicide the previous year when an in-patient on a previous ward. This meant that the management plan to deal with the area of suicide did not take account of a significant issue.

In addition, for a patient there was no care plans in place relating to the medication regime and the side effects and discharge. Also the risk assessment for monitoring the side effects of medication was blank and this was of particular importance for the patient because they were on a high dose of medication.

Overall the issues identified during the visit were so significant that HIW made the decision to suspend the registration of the hospital with immediate effect.

Seclusion and associated records

The seclusion of a patient is a significant course of action and must only be used as a last resort and for the shortest period of time. When patients are secluded there must be a robust policy and procedure underpinning this and the seclusion facilities must be appropriate and safe for both patients and staff. Whilst not significant in numbers in 3(13%) of visits undertaken, HIW identified issues in relation to seclusion. These issues ranged from policies and procedures to effective communication facilities being available between the ward and the seclusion suite.

Infection prevention and control

During our inspections 8 of the visits (33%) identified that there were issues with the availability of hand gel and infection control issues. The infection control issues included; ripped fabric on patient chairs and the lack of individual hoist slings.

Medicines management

Again this year our inspections identified a wide range of issues in relation to the storage and administration of medication including controlled drugs. In 20 (83%) of the visits we identified issues with medicines management. This is an increase on 2016-17 where there were issues in 65% of the visits undertaken

These issues can be grouped in to three distinct areas:

- *The way in which medication for individual patients is being recorded:*

  - Medication Administration Charts (MAR) were not fully completed and did not specify how the medication should be taken or mental health legal status.
  - A lack of a system of auditing the medication charts to ensure any issues are dealt with properly
  - Reasons for “as required medication” were not recorded

- *The way in which medication generally is managed*

  - Medication not ordered in a timely manner
  - A lack of a system of auditing the medication charts to ensure any issues are dealt with properly
  - Unused and no longer required medication for ex patients was not disposed of promptly
  - A lack of recording of room temperatures to ensure that drugs were being stored at the correct temperature
  - No record of medication fridges, so the staff could not be assured that medication was being stored at the appropriate temperature
  - A lack of a system to facilitate collection of full “sharps containers”

- A lack of routine audits of clinical room to check on matters such as stock and cleanliness
- The date of opening was not present on liquid medication
- Pharmacy audits were not acted upon
- Some staff did not know the location of emergency drugs

- *Specific issues relating the management of controlled drugs*

- Checks not appropriately documented
- A lack of robust processes in place to dispense
- A lack of signatures for stock checking and disposal
- A lack of checking of Controlled Drugs
- Not stored securely

Patient safety risks

The management of the risks to patient safety is essential in delivering safe and effective care to this vulnerable group of patients. In 9 (38%) of visits undertaken HIW identified significant issues that did not demonstrate the effective management of risks by the HB and independent healthcare provider Some of these risks included; safety risks posed by furniture, fixtures and fittings were not identified and managed appropriately and another risk was due to a lack of timely maintenance and repair of damaged items. One of the most significant failings in terms of managing risk was a lack of effective patient observations and this is described in the case below

Case Study

In one independent hospital HIW undertook a focused review of the risk management arrangements. On one of the wards HIW observed unsafe practice regarding the observations of patients. These practices included; no attempt to obtain visual confirmation that patients were alright, the process observed consisted of staff knocking the bedroom doors and waiting for an answer. If the patient responded in some way then no further attempt was made to visually see the patient. Therefore the staff member had no idea what the patient was doing behind the closed door. In addition, gaps in recording were noted in observational records and members of staff

were signing 24 hour sleep charts retrospectively and when they were not the member of staff that actually carried out the check. In addition, the observational policy did not give staff sufficient guidance on how to undertake safe observation.

Following the visit HIW issued a Non-Compliance Notice to the Registered Provider and Registered Manager and a meeting was also arranged. In response to the findings the Registered Provider produced an action plan.

Maintenance

The area of adequate maintenance continues to be a major issue throughout the visits we undertook. In a total of 17 visits (70%) we identified a range of issues. These issues ranged from minor repairs and more significant issues such as a ward that was not fit for purpose. Some other issues included; inadequate lighting of external spaces, broken laundry facilities, a lack of audits for repairs and maintenance, unsafe garden areas and ripped and torn seating.

Lack of an available nurse call system

The lack of a nurse call system or patients unable to reach or activate appropriately remains a considerable concern for HIW. In 7 (29%) of hospitals visited there were very serious patient safety issues, including the complete lack of a nurse call system in patient bedrooms. This absence of a nurse call system in patient bedrooms, bathrooms and toilet areas was an issue that only occurred in hospitals within the HBs. All hospitals operated by independent healthcare providers had nurse call systems in patient bedrooms and bathroom areas. However, we identified that within one independent hospital that beds were not positioned appropriately to allow access to the nurse call system when patients were in bed. Health Boards need to devise appropriate action plans to deal with this failing.

Ligature risk assessments

Whilst the area of out of date ligature risk assessments had improved since 2016-17 there continued to be issues with this area. Ligature risks had been identified through an assessment process but there was a lack of appropriate action identified to manage the ligature risks in 5 (21%) of visits undertaken in 2017-18. These risks must be effectively managed to ensure that patients who are at risk of self-harm and suicidal behaviour have an appropriate safe ward environment.

Quality of management and leadership

During our inspection programme HIW identified some key issues with the management and leadership of services. The availability of sufficient acute admission beds continues to be a significant challenge for Health Boards alongside the challenging complexity of some patients. Inadequate staffing numbers and a lack of training in some areas continue to be of concern because of the significant impact that this can have on effective patient care. In addition there remained a lack of robust governance processes in a number of the hospital wards that we visited.

Governance, leadership and accountability

During 2017-18 there were 4 (17%) of hospitals visited where HIW found a significant lack of governance and robust audit processes. However, given the numerous issues that HIW have identified within this report it could be argued that there are fundamental governance issues throughout the majority of mental health hospitals in Wales. One of the most concerning examples of governance issues was in an independent healthcare provider where the lack of effective governance and audit processes and other issues identified during the visit were so concerning, that HIW made the decision to suspend the registration of the hospital with immediate effect

The issue of effective governance must be addressed by both NHS and independent hospitals to ensure that this group of vulnerable patients have their care and treatment needs fully met.

Case Study

HIW visited a hospital that was part of a health board and identified a number of issues including policies and procedures that related back to the time that the service was managed by another health board a year and a half previously. Staff commented that policies and procedures were confusing and it was difficult to find the necessary information. Staff were not aware of any timescales and an action plan to ensure all the policies and procedures were provided by the relevant Health Board. This clearly demonstrated a lack of robust governance processes.

Following the visits the Health Board provided an improvement plan to address the issues.

Bed availability, admission and discharge

We found significant pressure on in-patient mental health beds throughout the Health Boards. This situation is compounded by the complexity, challenging and level of acuity of in-patients being accommodated. This can be resource intensive in terms of staff and also has significant implications for the other patients being treated on the ward. HIW continues to have concerns that the longer term planning of in-patient beds is not sufficiently robust in meeting the challenges of this complex group of patients'.

Case Study

In one Health Board hospital HIW undertook a visit and it was identified that when in-patient beds were not available the patient would be admitted on to wards and was accommodated overnight in communal areas. Whilst that area was made private for that person's sole use and had to be authorised by a senior manager it was not appropriate to accommodate those vulnerable patients within this temporary area. In addition, there were also occasions when a bed in another Health Board, NHS Trusts in England or the Independent sector would be utilised to accommodate a patient. Following the visit and the report the Health Board responded with an action plan of how it proposed to respond

We noted a lack of the provision of certain facilities such as low secure beds and this was clearly having an impact on delayed discharges. There remained in three Health Board areas, Hywel Dda, Aneurin Bevan and Betsi Cadwaladr a lack of strategic planning to address the lack of availability of a range of services. These included low secure services and the provision of a clear pathway for patients' rehabilitative care.

Resources and workload

Staffing was a significant issue in 17 (71%) of inspections. This was one of the highest scoring areas that was identified by HIW and was clearly impacting upon the services' ability to provide safe and effective care. The issue of staffing was prevalent in both the HBs and independent sector. Some of the key issues identified included:

- Insufficient Registered Nurses
- A freeze on the recruitment of staff
- Insufficient catering and domestic staff

- Locum consultants resulting in delayed patient discharges
- Insufficient capacity of MDT to promote timely care
- Inappropriate gender balance (only male staff on a ward when female patients were accommodated)
- Inadequate staffing numbers

The lack of staff in variety of disciplines was clearly having an impact on effective patient care. In one example the use of locum consultants was having a direct impact on the efficiency of patients being discharged and staff reported to HIW that the use of locum consultants was impacting negatively on patients having timely section 17 leave. In one of the most serious examples of inadequate staffing numbers there were only 2 members of staff to care for 7 patients in a low secure unit. This was woefully inadequate and did not allow for sufficient staff in the event that a restraint or other challenging behaviour was exhibited by the patient group.

Training

HIW continues to identify significant gaps in training and of the 24 visits undertaken in 2017-18, 58% (14 visits) identified a lack of adequate staff training. This compares to 45% in 2016-17 and 46% in 2015-16. The training deficits identified were in a number of key areas including;

- The Mental Health Act
- The Mental Capacity Act 2005
- Deprivation of Liberty Safeguards
- The Mental Health (Wales) Measure 2010
- Managing violence and aggression including control and restraint
- Safeguarding
- Appropriate communication skills
- Dignity and respect

In addition there was also a lack of training in a number of mandatory areas including; fire safety, general health and safety, moving and handling and infection control. We also identified that there were difficulties in HBs providing HIW with a sufficient level of assurance regarding staff attending training because of an ineffective system for monitoring.

HIW are disappointed to have identified a number of the same issues this year that were identified last year and the previous year. These include inadequate training in the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards, managing violence and aggression, and safeguarding. If patients complex needs are to be effectively met it is essential that the workforce are suitably skilled and trained. HIW are not convinced that the significance of effective training has been effectively recognised by the HBs and independent providers as the same issues keep being identified over a number of years.

Staff supervision

In 2017-18 visits 6 (25%) identified that supervision was not being undertaken on a regular basis. Although this is an improvement on the previous year it is a fundamental part of making sure that staff are appropriately knowledgeable and supported.

3.2 Issues specific to elderly care wards

In 2017-18 we continued our programme of visits to elderly care hospitals and we visited a total of 10. During the visits HIW observed some positive findings that included, dementia friendly fixtures and fittings, large faced clocks and in addition the date, month and the year was on display. We also observed many examples of a caring and positive rapport between patients and staff.

However, we also identified a range of findings as listed below;

- Unsafe and inaccessible garden areas
- Numerous environmental issues with a lack of maintenance and an effective refurbishment and replacement programme, for example; broken sensors in bedrooms, ripped and broken chairs, bath that is suitable to meet patient needs and the provision of a nurse call system in key areas,
- A lack of information for patients on display in relation to a number of key areas including the contact details for HIW
- A lack of effective communication aids such as pictorial menus
- Lack of adaptive cutlery to enable patients with a weak grip or limited range of mobility to eat more effectively and independently
- Regular gaps in the fluid and food charts
- Patients' privacy and dignity being compromised by broken window blinds on patient bedroom doors
- Patients' information not adequately protected on an information board, within the office, that was also used for discussion with relatives
- Patient assessment documentation not fully completed with the names and designation of staff and the dates that the assessments were completed

3.3 Issues specific to Child and Adolescent Mental Health Services (CAMHS)

There are three CAMHS units within Wales, one in the independent sector and the other two within local HB's. In 2016-17 HIW inspected the independent hospital and one of the HB units (Tŷ Llidiard) within Cwm Taf. The other HB unit will be inspected during 2018-19. During all of our visits undertaken since 2016 some positive findings have been identified including;

- Comprehensive MDT plans of care
- A range of policies and procedures were available to instruct and guide staff on providing safe and effective care
- Patients treated with respect and kindness
- Good evidence of patients involved in the development of their Care and Treatment Plans
- Innovative use of technology to engage and encourage patients to provide feedback about their experience

During 2017-18 we specifically visited one of the three CAMHS units within Wales. Regis Healthcare in Ebbw Vale, an independent hospital was visited in March 2018. A range of significant issues were identified, during the visit, including;

- Inadequate staffing levels to maintain a safe environment
- Lack of an effective induction system for agency staff
- Insufficient staff trained in the use of the gym facilities outside core hours
- Excessive use of restraint both in terms of the number and length, some restraints lasted for an hour
- Lack of cleanliness of the environment
- Issues with the care planning and risk assessment documentation including a lack of relevant information in relation to physical healthcare
- Lack of robust clinical audits
- A blanket approach to allowing adequate time for the young people to prepare for meetings as opposed to an individual assessment

4.1 Monitoring the Mental Health Act, 1983 (the Act)

4.2 Purpose of the Mental Health Act, 1983

The primary purpose of the Mental Health Act is to protect vulnerable individual patients who access mental health and learning disability services in Wales. These patients are either informal and this means that they will receive treatment on a voluntarily basis or patients who may require assessment or treatment and can be detained against their will under the Act. However, some informal patients who are 'liable to be detained'[1] can be treated in hospital on a voluntary basis.

The Act ensures protection so that only appropriate medical treatment is administered to individuals who may not consent to it or have the capacity to consent under certain circumstances.

Where patients are detained, a thorough assessment of their mental health should be undertaken and the correct legal processes followed to protect the rights of detained patients who are held against their will under the Act. The key purpose of the Act is to provide a legal framework to protect the rights of both formal and informal patients and ensure that they receive an appropriate level of care and treatment in an environment that is conducive to their needs and promotes recovery. The key principle of the Act is based on treatment, not containment, and to balance the risks to the patient and those in society. The Mental Health Act allows for appropriate compulsory medical treatment to be given where it is necessary to assist the patient's treatment and rehabilitation.

A number of individuals and organisations are given powers and responsibilities under the Act and these include; officers and the staff of Health Boards, Social Services and independent hospitals, Welsh Ministers, Courts, Police Officers, relatives of those detained and advocates.

There are a number of areas where the Mental Health Act is used including:

- Mental health and learning disability wards;
- General medical wards for patients of all ages;
- Other hospitals;

[1] 'Liable to be detained' is a phrase which refers to individuals who could lawfully be detained but who, for some reason, are not at the present time, Such reason could include, for example, their current co-operation.

- Accident and Emergency departments;
- Care homes;
- Patients' own homes;
- Courts; and
- Public places.

There are legal processes associated with the implementation of the Act and these must be complied with if a patient is being considered for detention. These processes must also be followed when an individual has been detained with either a civil application for admission or a hospital order via the courts. The Mental Health Act and Code of Practice for Wales gives safeguards to ensure patients are not inappropriately detained or treated.

Code of Practice for Wales

The Mental Health Act 1983 Code of Practice was revised in 2016 and this provides guidance and the principles of how the Act should be applied in practice. The Code has been prepared and issued under section 118 of the Mental Health Act.

The Code of Practice for Wales gives guidance to mental health professionals on how they should comply with their duties and functions under the Act. All mental health professionals are required to have regard to the Code of Practice that has been written to support and promote good practice for those who are providing services under the Act.

4.3 How the Act is monitored in Wales

The Act is monitored in Wales by HIW on behalf of the Welsh Ministers who have specific duties that they are required to do in law. These duties include;

- To provide an annual report on how the Act is being implemented in Wales
- Provide a service under the Act where registered medical practitioner authorise and review proposed treatment of patients in certain circumstances
- Review the exercise of the powers of the Act in relation to detained patients and those liable to be detained

- Ensure individual HB's and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales

- Investigate complaints relating to the application of the Act.

HIW discharges its function through its comprehensive inspection processes where it monitors how services use the Act in a variety of areas including; patients within a hospital setting, patients that are subject to a Community Treatment Order (CTO) or guardianship.

Within our inspection process we also review the legal paperwork to ensure it complies with the Act and the revised Code of Practice. Another layer of safeguarding the interests of patients is that HIW provides a second Opinion Appointed Doctor (SOAD) service. This area will be further considered later in this chapter.

Mental Health Act Reviewers

HIW has a number of experienced and knowledgeable Mental Health Act reviewers to undertake our review of how the Mental Health Act is being implemented and administered throughout Wales. Our reviewers consider key areas including;

- Is of the Code of Practice revised in 2016 being implemented?

- Is the paperwork for the detention completed accurately and copies available at ward level?

- Are patients' rights under section 132 well documented and including a record as to whether or not they understand their rights?

- Are the necessary policies and procedures in place and do they reflect the Mental Health Act Code of Practice 2016?

- Is there an effective care and treatment plan that reflects their detained status and the Mental Health (Wales) Measure 2010?

- Is there a multi-disciplinary team with a range of disciplines that patients' have access too?

The review of the Mental Health Act maybe undertaken as part of a general larger inspection or there will also be occasions when MHA visits are undertaken as a stand-alone visit.

Community mental health services

This year we have undertaken 7 joint reviews of adult community mental health services with CIW. One of the key areas considered within these visits were Care and Treatment Orders (CTOs). An all Wales Community Mental Health thematic report based upon our joint review work will be published in February 2019

Findings from our visits

During 2017-18 we undertook visits to 50 wards that accommodated detained patients. The visits identified some significant findings but also some areas of noteworthy practice including;

- Good documentary evidence of patients having their rights read and explained under section 132 of the Mental Health Act
- Good evidence of strong medical and administrative audit processes with the early identification of any issues

However, our monitoring of the application of the Act identified the following areas of concern;

- A lack of an appropriate level of detail for capacity assessments
- A lack of copies of consent to treatment certificates being kept with the corresponding medication administration records. It is essential that staff check that the medication is certified prior to administration.
- A lack of discussion documented in the patient records regarding the consultation by the statutory consultees.
- Patients not routinely being given copies of their detention papers
- Section 17 leave poorly managed and not accurately and fully completed. In addition copies of old forms not appropriately discontinued, a lack of documentary evidence that the leave has been appropriately risk assessed and a lack of evidence that patients had been given copies of these forms.

4.4 The Second Opinion Appointed Doctor Service (SOAD)

The SOAD service is operated by HIW who appoints registered medical practitioners to approve some forms of treatment. The SOADs have a responsibility to ensure proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

- Liable to be detained patients on CTOs (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients;

- Formal and informal patients who are being considered for various serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57);

- Detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58);

- Patients under 18 years of age, whether detained or informal, for whom ECT is proposed, when the patient is consenting having the competency to do so (Section 58A) ; and

- Detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

When a SOAD request has been received we aim to ensure that the visit takes place within the following timescales:

- Two working days for an ECT request;

- Five working days for an inpatient medication request; and

- Ten working days for a CTO request.

Occasionally our SOAD can be prevented from visiting the patient within the identified timescales if, when they arrive, the patient is not available. This has an impact for the patient and their treatment.

In addition, a number of issues can prevent our SOADs issuing a certificate once the visit had taken place including;

- Lack of availability of the Responsible Clinician

- Lack of availability of the Statutory Consultees to discuss the treatment with the SOAD

- Lack of documentation in relation to the discussion about the patient

- A lack of access to all the necessary patient records and detention papers

A further issue which has occurred is the lack of the HB or independent provider providing an independent translator where the patients' first language is not English.

We are working with Mental Health Act Administrators in health boards to ensure that the SOAD process is a smooth and timely as possible to ensure that the rights of patients are protected.

The role of the SOADs is to safeguard the rights of patients who are detained under the Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of individual patient's mental disorder and whether or not the patient has capacity to consent.

They must be satisfied that the patients' views and rights have been taken into consideration. If they are satisfied the SOAD will issue a statutory certificate which then provides the legal authority for treatment to be given. After careful consideration of the patient and approved clinician's views a SOAD has the right to change the proposed treatment. For example a SOAD may decide to authorise only part of the proposed treatment or limit the number of ECTs given.

In Wales during 2017-18, there were 907 requests for a visit by a SOAD (914 in 2016-17).

These were;

- 830 requests related to the certification of medication,
- 52 requests related to the certification of ECT,
- 25 requests related to medication and ECT.

The following table provides a breakdown of requests per year:

Table 9: Requests for visits by a SOAD, 2006-07 to 2017-18

Year	Medication	ECT	Both	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758

2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907

Source: SOAD requests to HIW

4.5 Review of treatment (Section 61)

When a treatment plan has been authorised by a medical practitioner (SOAD) appointed by HIW, a report on the treatment and the patient's condition must be given by the responsible clinician in charge of the patient's treatment and given to HIW. There is a designated form on our website for the responsible clinician to complete. HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place.

Overall the forms and supporting evidence were of a good standard but the following issues were identified;

- More medication listed under the treatment description than authorised on the CO3 form
- Copies of CO2 and CO3 forms not attached to the review of treatment form
- A lack of particularising of medication
- Patients status of consent and capacity
- Lack of copies of CO7 and CO8
- Medication not identified on the form

These issues were identified to the providers and were addressed promptly.

The audits of the review of treatment forms will be ongoing and further findings will be reported upon during our 2018-19 report.

5 Recommendations/requirements (requirements for Independent sector only)

Following our findings from our inspections during 2017-18 we have made the following recommendations and requirements (requirements under the regulations are for independent providers only) which the Health Boards and Independent Providers must address in order to deliver a safe and effective service to a vulnerable patient group within an appropriate environment of care. Such recommendations will have been included in the individual reports which have been issued to providers following each of our inspections.

Recommendation/requirement	Regulation/standard
Patient experience	
All Health Boards and Independent Providers must ensure that patients are provided with varied, nutritious meals and are given choice and are provided with fresh fruit and vegetables	Health and Social Care Standard 2.5 Regulation 15 (9) (a) & (b)
All Health Boards and Independent Providers must ensure that patients' privacy and dignity is maintained	Health and Social Care Standard 4.1 Regulation 18 (1) (a) & (b) & (2) (a) & (b)
Delivery of safe and effective care	
All Health Boards and Independent Providers must ensure that all the physical health care needs of patients are fully assessed and addressed	Health and Care Standards 2.2 , 4.1 and 7.1 Regulation 15 (1) (a) (b) (c) & (d)
All Health Boards and Independent Providers must ensure that effective infection prevention and control measures are in place	Health and Care Standard 2.4 Regulation 15 (3) (7) (a) & (b) & 8 (a) (b) & (c)
All Health Boards and Independent Providers must ensure that effective medicine management systems are in place in relation to the storage, ordering, and administration of medicines	Health and Care Standard 2.6 Regulation 15 (5) (a) & (b)
All Health Boards and Independent Providers must ensure that effective risk management systems are in place	Health and Care Standard 2.1 Regulation 19 (1) (a) & (b)
The Health Boards must ensure that a comprehensive maintenance programme is in place for ALL its hospitals to ensure that the environments of care are and remain suitable to meet the needs of the patients	Health and Care Standard 2.1 Regulation 26 (!) & (2) (a) (b) & (c)

The Health Board and Independent Provider must ensure that each patient has a comprehensive risk assessment and care and treatment plan in place	Health and Care Standard 6.1 Regulation 15 (1) (a) (b) & (c)
Quality of management and leadership	
The Health Board and Independent Provider must have effective governance, leadership and accountability assurance systems in place to ensure compliance with the regulations and standards to ensure safe and effective treatment	Health and Care Standards 3.4, 3.5 and 7.1 Regulation 19 (1) (a) & (b) and (2) (a) (b) (c) (d) & (e)
The Health Boards and Independent Providers must ensure that policies and procedures are up to date and reflect current good practice recommendations	Health and Care Standards 2.1, 2.6 and 3.1 Regulation 9 (1)
The Health Boards must ensure that there are sufficient inpatient beds available for potential admissions	Health and Care Standard 2.1
All Health Boards and Independent Providers must ensure that all wards have adequate numbers of staff (nursing, medical, psychology and Occupational Therapy) to ensure patients' needs are fully met	Health and Care Standard 7.1 Regulation 20 (1) (a)
All Health Boards and Independent Providers must ensure that ALL staff have the necessary training, knowledge and skills to effectively care and treat patients	Health and Care Standard 7.1 Regulation 20 (2) (a) & (b)
The Health Board and Independent Providers must ensure that ALL staff receive regular meaningful and documented supervision	Health and Care Standard 7.1 Regulation 20 (2) (a)
All Health Boards must ensure that elderly care and CAMHS provision meets the needs of the patient group and any treatment is timely	Health and Care Standard 3.1

Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also *independent mental health advocate.*
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers

CO1 form	Certificate of consent to treatment and second opinion (Section 57)
CO2 form	Certificate of consent to treatment (Section 58(3) (a))
CO3 form	Certificate of second opinion (Section 58(3) (b))
CO7 form	Certificate of appropriateness of treatment to be given to a community patient
CO8 form	Certificate of consent to treatment for a community patient
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory Treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you: Particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.

Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as “sectioning” or “sectioned”
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.

Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust or Health Board) Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Independent Mental Capacity Advocate **(IMCA)**	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence **(section 17 leave)**	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'Section 17 leave'.*
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological

	therapies, and specialist mental health intervention, rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other terms such as *'service user', 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.

Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49 The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in an hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually
Section 12 doctor	See doctor approved under Section 12.
Section 17A	This is a Community Treatment Order
Section 37	This is a hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function,
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments

	electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 61	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; Part 1 – Primary mental health support services Part 2 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services

	Part 4 – Mental health advocacy
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Appendix B

Health Boards, elderly wards and independent registered providers visited during 2017-18

Health Board	Hospital	Wards
Abertawe Bro Morgannwg University Health Board	Caswell Clinic	Tenby, Cardigan, Ogmore, Penarth and Newton
Abertawe Bro Morgannwg University Health Board	Cefn Coed Hospital, Abertawe	Celyn and Derwen
Abertawe Bro Morgannwg University Health Board	Neath Port Talbot	Calon Lan
Abertawe Bro Morgannwg University Health Board	Neath Port Talbot	Ward F
Abertawe Bro Morgannwg University Health Board	Glan Rhyd	Taith Newydd – Cedar and Rowan wards
Abertawe Bro Morgannwg University Health Board	Glan Rhyd	Wards 2 and 3 within Angelton Clinic
Abertawe Bro Morgannwg University Health Board	Princess of Wales	Ward 14 and the Psychiatric Intensive Care Unit
Aneurin Bevan University Health Board	Llanfrecha Grange	Assessment and Treatment Unit
Aneurin Bevan University Health Board	Ysbyty Aneurin Bevan	Carn-Y-Cefn
Aneurin Bevan University Health Board	Ysbyty Ystrad Fawr	Tŷ Cyfannol and Tŷ Glas
Betsi Cadwaldr University Health Board	Ablett Unit	Cynnydd and Dinas
Betsi Cadwaldr University Health Board	Bryn Hesketh	One older persons ward

Betsi Cadwaldr University Health Board	Heddfan	Clywedog, Dyfrdwy and Tryweryn
Cardiff and Vale University Health Board	Llandough University Hospital	Hafan y Coed – Beech
Cardiff and Vale University Health Board	Llandough University Hospital	Daffodil
Cwm Taf University Health Board	Royal Glamorgan	Admission, ward 21, ward 22 and PICU
Hywel Dda University Health Board	Two Learning Disability residential establishments Hospital	Two establishments
Hywel Dda University Health Board	Hafan Derwen	Cwm Seren PICU and Low Secure Unit
Elderly Care wards	**Hospital**	**Wards**
Abertawe Bro Morgannwg University Health Board	Neath Port Talbot	Ward G
Abertawe Bro Morgannwg University Health Board	Tonna	Suite 2
Aneurin Bevan University Health Board	Ysbyty'r Tri Chwm	Cedar Parc
Aneurin Bevan University Health Board	Ysbyty Ystrad Fawr	Annwylfan
Betsi Cadwaldr University Health Board	Bryn Hesketh	One older persons ward
Betsi Cadwaldr University Health Board	Heddfan	Gwanwyn and Hydref
Cardiff and Vale University Health Board	Llandough University Hospital	Daffodil
Powys Teaching Health Board	Llandrindod Wells War Memorial	Clywedog
Powys Teaching Health Board	Ystradgynlais	Tawe

Independent provider	**Hospital**	**Wards**
CAS Behavioural Health Ltd	Delfryn House and Lodge	Delfryn House, Delfryn Lodge and Rhyd Alyn

Cambian Healthcare Limited	St Teilo House	The hospital comprises one ward that was visited
Elysium Healthcare (no.3) Ltd	Cefn Carnau	Bryntirion, Derwen and Sylfaen Units
Hafal	Gellinudd Recovery Centre	Meadow, Spring, Summer, Autumn and Winter Suites,
Heatherwood Court Ltd	Heatherwood Court	Chepstow, Caerphilly, Caernavon and Cardigan
IMeUs Limited	Pendarren Court	Cwm Nant
Mental Health Care (New Hall) Ltd	New Hall	Adferiad, Clwyd and Glaslyn wards
Parkcare Homes (No 2) Ltd	Priory Hospital, Church Village	The Main Building and Garth View
Partnerships in Care Ltd	Llanarth Court	Awen, Deri, Osbern, Howell, Iddo, Treowen, and Teilo
Priory Healthcare	Priory Aberdare	One Ward
Regis Healthcare Ltd	Regis Healthcare Hospital	Brenin and Ebbw

NB – In addition, Heatherwood Court, was visited twice during 2017-18.