

Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2018-2019

January 2020

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1 Executive Summary

Introduction

During 2018-19 Healthcare Inspectorate Wales (HIW) undertook 11 inspections of mental health hospitals in the NHS and 17 independent healthcare inspections. Four of these visits were made to the same independent provider due to ongoing concerns and two visits were undertaken to another independent provider.

Of these visits five were undertaken to CAMHS units and one specifically to an elderly care hospital ward for dementia patients. A summary of our findings in relation to CAMHS services was published in March 2019 as part of our report on healthcare services for young people and we have included that summary in this report. We also present the summary from our national review of community mental health services which was published in February 2019.

Our work

During our inspections we consider:

- how services use the Mental Health Act and the associated Code of Practice for Wales
- how HB's and independent providers administer the Act and exercise
- their powers in relation to detained patients and those liable to be detained
- how services comply with the Mental Health (Wales) Measure 2010 by reviewing individual patient care and treatment plans to ensure that patients have a Care Co-ordinator appointed, and have a comprehensive mental health and physical health assessment, and that in-patients have access to an independent mental health advocate
- application of the Mental Capacity Act 2005 and the use of Deprivation of Liberty Safeguards by individual health boards and Independent Providers
- compliance of independent providers of healthcare with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards for Independent Healthcare in Wales

- how individual health boards meet the NHS Health and Care Standards 2015.

What we found

One of the most positive aspects of our inspections continues to be the feedback that we get from patients regarding staff attitudes and their caring approach. We were pleased to see a clear improvement in the degree to which assessment and treatment of physical health needs was being considered alongside mental health needs. We have also seen a reduction in the number of complaints and concerns being raised with us by patients, relatives and staff.

However there a number of themes coming through that deserve further consideration by providers.

Environment of care

In a number of our inspections it was clear that the environment was compromising the privacy and dignity of patients, for example a lack of curtains for privacy between beds, and observation panels in bedroom doors defaulting to open.

In other inspections the environment was compromising the quality and safety of care through issues such as, inadequate and dirty showering facilities, a lack of available nurse call bells, or a lack of attention to patient and visitor health and safety.

Quality and safety of care

We continue to find issues across a number of fundamental matters that underpin high quality and safe care. For instance, we have observed issues with individual patients' care and treatment planning including:

- lack of detailed clinical entries
- unmet needs not fully documented
- lack of individual restraint reduction plans
- lack of documented patient and family involvement.

We have continued to identify medicines management issues such as:

- medicines administration records not fully completed

- errors identified by pharmacist audits not addressed
- medication cupboards and trolleys not locked when not in use
- no medication fridges
- single use items not disposed of after use
- controlled drugs not signed for by two staff.

Across our hospital and CMHT inspections we also identified concerns about patients' access to care including:

- questions about whether people are able to access care at the point of need
- a lack of clarity on how to access CMHTs
- long waiting times for psychology and therapeutic services
- concerns about whether NHS beds were sufficient to meet demand for potential inpatient admissions.

Management and leadership

Although there were fewer inspections this year during which we raised issues relating to staff resources and training, we continued to identify instances of:

- insufficient registered nurses including registered general nurses with the skills and expertise in managing patients' physical health needs
- staff being taken away from direct observations to perform other duties
- lack of staff availability to facilitate activities
- lack of administrative support impacting on nursing time
- lack of nursing staff impacting on management time.

Mental Health Act administration

During our reviews of the Mental Health Act we identified noteworthy practice in regard to governance and in areas such as section 17 leave authorisations. However, we have also continued to identify some specific issues in relation to documentation of decisions and actions in relation to the Act.

This year we have organised two workshops for Mental Health Act administrators in the health boards and independent healthcare providers. These meetings provide a forum for HIW to keep the administrators updated with HIW guidance produced for the Second Opinion Appointed Doctor (SOAD) service and the modernisation of this service.

It is important that providers of mental health services consider the issues and themes coming out of our work and use these to challenge the quality of their own services. In this year's report we have attempted to capture the extent to which we have continued to identify similar issues over the last three years. This appears to show that many issues that have been identified for a number of years are still present.

We will be taking steps to share our findings with providers and with the Welsh Government to explore what can be done to achieve sustained improvement in these areas.

2 Context

2.1 Strategic context

The key strategies informing the work of HIW and our role in monitoring the mental health provision are outlined below:

- **The Mental Health Crisis Care 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 Concordat is supported by, and has the involvement of, a number of agencies including the Welsh Government, the police, health boards, Welsh Ambulance Service, NHS Trust, local authorities and the third sector.

Since the publication of the original Concordat in 2015 a new 'Action Plan' has been developed and endorsed by the National Concordat Assurance Group and Welsh Government. This action plan sets out 20 actions to be implanted to support the following 6 core principles:

- people have effective access to support before a crisis point
- people have urgent and emergency access to crisis care when they need it
- people receive improved quality of treatment and gain therapeutic benefits of care when in crisis
- recovery, staying well, and receive effective support after crisis
- securing better quality and more meaningful data with effective
- analysis to better understand whether people's needs are being met in a timely and effective manner
- maintaining and improving communications and partnerships between all agencies/organisations encouraging ownership and ensuring people receive seamless and coordinated care, support and treatment.

HIW and Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) have a role in considering the effectiveness of the Concordat. In addition, a specific thematic review of crisis care in Wales is being undertaken by HIW in 2019-20.

Together for Mental Health

Together for Mental Health was published by Welsh Government in 2012. It is a 10-year strategy for improving mental health and wellbeing and improving the care and treatment of people using mental health services, their carers and their families.

The 2016-19 delivery plan is the second of three plans which sets out the actions to ensure that the strategy is implemented. The plan has eleven priority areas:

1. People in Wales are more resilient and better able to tackle poor mental well-being when it occurs.
2. The quality of life for people is improved, particularly through addressing loneliness and unwanted isolation.
3. Services meet the needs of the diverse population of Wales.
4. People with mental health problems, their families and carers are treated with dignity and respect.
5. All children have the best possible start in life which is enabled by giving parents/care givers the support needed.
6. All children and young people are more resilient and better able to tackle poor mental well-being when it occurs.
7. Children and young people experiencing mental health problems get better sooner.
8. People with a mental health problem have access to appropriate and timely services.
9. People of all ages experience sustained improvement to their mental health and well-being through access to positive life chances.
10. Wales is a 'Dementia Friendly Nation'.
11. The implementation of the strategy continues to be supported.

HIW continues to monitor the delivery plan for mental health in a number of ways. For example in regards to priority area 4, whether patients are treated with dignity and respect is reported upon within section 3.1 of this

report. In addition, priority area 7 is extensively reported upon in section 3.3.

Other strategic and legal frameworks that provide context to our work include the Well-being of Future Generations (Wales) Act 2015, and the Dementia Action Plan for Wales.

2.2 Our role in regard to mental health

HIW has an important role in holding the health boards to account in terms of their performance in meeting the Health and Care Standards and related standards. HIW is also the regulator for all independent healthcare providers for whom the primary legislation is the Care Standards Act 2000 supported by the associated Independent Health Care (Wales) Regulations 2011. HIW considers how independent providers meet the National Minimum Standards for Wales.

HIW also monitors how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983. This is undertaken on behalf of the Welsh Ministers

Welsh Ministers

We undertake a planned programme of inspections to assess the level of compliance with legislation and the delivery of effective care. These inspections seek evidence on a range of matters including:

- Staff with the necessary skills, knowledge and training and in sufficient numbers to deliver effective care
- Safe and well maintained wards that meet the patients' needs in a safe therapeutic ward
- Evidence of patient involvement in care and treatment plans and any risks are well documented
- Safe and effective discharge planning
- Effective medicines management including the handling, storage and administration of Controlled Drugs
- Scrutiny of the detention paperwork for patients who are detained
- Effective governance and audit processes.

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. We also provide a registered medical practitioner service to authorise and review proposed treatment in certain circumstances (the Second Opinion Appointed Doctor Service). This year HIW has organised 2 workshops for the Mental Health Act administrators in the health boards and independent healthcare providers. These meetings provide a forum for HIW to keep the administrators updated on the modernisation of the Second Opinion Appointed Doctor (SOAD) service and to present guidance that HIW has developed for the service. During 2018-19 HIW produced the following guidance:

- Guidance for the SOAD to codify and certify treatment plans
- Guidance for health boards/independent healthcare providers for the SOAD service.

Our specific work in relation to this area will be considered within section 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.

During the period 2018-19 HIW received a total of 334 complaints and concerns for all services, via letter, email or telephone either directly or via a third party. Of these, 42 (12.5%) were in relation to NHS mental health settings and 77 (23%) related to independent mental health settings. Although over a third of the concerns we receive relate to mental health we have seen an overall decrease of 13% in the number of mental health concerns compared to 2017-18.

Table 1 The subject of the concerns and complaints

	NHS		Independent	
	2017-18	2018-19	2017-18	2018-19
Patient abuse	3	3	4	1
Infrastructure/staffing/facilities/	6	16	38	54

Environment				
Consent/communication/confidentiality	0	0	0	0
Treatment/Procedure	35	7	19	17
Clinical Assessment	0	9	0	3
Mental Health Act	0	5	0	1
Other	9	2	7	1
Total	58	42	80	77

The table above illustrates that there have been changes in the types of concerns that have been raised with HIW. In NHS settings, we have begun to see a number of concerns around the Mental Health Act and the way patients are being detained under the Act. We have also seen a significant increase in complaints relating to staffing and environmental concerns. Meanwhile, complaints about patients' treatment and procedures within NHS settings have reduced significantly.

There was one notable change in figures for Independent Mental Health Setting. The number of concerns about infrastructure, staffing, facilities or the environment increased by 42%.

Table 2: Source of complaints and concerns, 2017-18 & 2018-19

	NHS		Independent	
	2017-18	2018-19	2017-18	2018-19
Patient	21	19	32	22
Relative/Advocate/Other	32	21	36	26
Staff/Whistle-blower	5	2	12	29
Total	58	42	80	77

As Table 2 indicates, there has been an increase in the number of whistleblowing concerns from Independent mental health settings.

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 staff misconduct; and
- Deprivation of liberty

During 2018-19, HIW received 151 notifications of patient safety incidents that occurred within independent mental health care settings. This is a reduction of 20 (12%) notifications from 2017-18. In some cases we have become aware of under reporting of incidents by the independent sector which has been addressed and actioned. However, this may also reflect a reduction in the number of incidents that met the threshold for reporting to HIW.

Notifications were broken down into the following categories.

Table 3: Regulation 30/31 notifications, 2017-18 & 2018-19

	2017-18	2018-19
Serious injury	81	85
Unauthorised absence of a patient	46	37
Allegation of staff misconduct	32	19
Death of a patient	11	5
Deprivation of Liberty	0	2
Outbreak of Infectious Disease	1	3
Total	171	151

In two areas there has been significant reduction in the number of regulatory notifications received: a reduction of 40% in the number of notifications regarding allegations of staff misconduct and a reduction of 55% in the number of death of patients in independent mental health settings. This reflects the reduction in similar categories of complaints and concerns.

All concerns and notifications 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 notifications 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 2018 -19 we undertook eleven inspections of mental health hospitals in the NHS and 17 independent healthcare inspections. Four of these visits were made to the same independent provider due to significant concerns and in addition two visits were undertaken to another independent provider. During these visits HIW monitored the use of the Mental Health Act, the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS) and the Mental Health (Wales) Measure 2010.

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

2.5 How we inspect

We consider a range of evidence during our inspections. 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 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 including time and position of the restraint
- appropriateness of intensive care facilities where used
- implementation of a selection of policies and procedures

- whether the environment of care is 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.

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 two and three 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 founder organisation of the UK's National Preventative Mechanism (NPM). In 2009 the UK government chose to designate multiple existing organisations rather than create a new single body called the NPM because many types of detention in the UK were already subject to monitoring by independent bodies.

HIW continues to work in partnership with Her Majesty's Inspectorate of Probation in the review of healthcare provided within Youth Offending Services. We also work with a range of other partner agencies including Estyn, Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and CIW. The outcome of this work will be explored within section 3.4 of the report.

3 What we found

3.1 Mental Health and Learning Disability Hospitals

During 2018-19 HIW undertook eleven inspections of mental health hospitals in the NHS and 17 independent healthcare inspections. Four of these visits were made to the same independent provider due to ongoing concerns and two visits were undertaken to another independent provider.

Of these visits, five were undertaken to CAMHS units and one specifically to an elderly care hospital ward for dementia patients. CAMHS will be summarised in a different section of the report. The findings described in this section specifically relate to the 22 inspections of adult mental health and learning disability services and include medium, low, locked and open rehabilitation services.

3.1.1. Quality of Patient Experience

All staff that work within mental health and learning disability services need to strive to ensure that the quality of the patient experience is at least good, and ideally is very good or excellent. One of the challenges for staff is that quality can mean different things to different people. One patient may be very happy with the experience, if for example, they had enjoyed the meals. Another patient may be satisfied with the experience if they had their medication on time. It is therefore important that staff get to know their patients in order to understand what matters to them.

Overall the number of inspections in which we raise issues regarding the quality of patient experience has reduced slightly. However, 59% of our inspections raised concerns that patients did not have access to the range of information that they needed, and 41% of our inspections raised issues relating to the privacy and dignity of patients. Neither of these issues seem to have diminished since our previous report.

It is important to recognize however that one of the most positive aspects of our inspections continues to be the feedback we obtain from patients regarding staff attitude and their caring approach.

Access to Information

Clear and appropriate information is critical for patients and their families to make informed decisions in a number of key areas. During 59% of our visits we identified that information was not readily available either on a notice board or as a patient leaflet. In some instances the information was available

but not in a suitable format for the patients to easily understand. Information that was not readily available included:

- advocacy
- the Mental Health Act
- how to raise a complaint
- information on HIW including contact details
- health promotion.

It is important that patients and relatives have ready access to the information they need in these important areas.

Meals

Meals are an important part of a patient's experience and during our discussions with patients, meals are an important and frequently talked about area. Variety, taste and presentation along with the ability to cater for a range of dietary requirements are essential. In roughly a quarter of our visits a range of issues were identified including an inadequate choice of meals, and a lack of facilities for patients to eat meals when they wanted. Similarly in 2017-18, a quarter of our inspections identified issues with meals so there is very little change in this area.

Privacy and Dignity

HIW was concerned that in 41% of our visits privacy and dignity issues were identified as an area of concern. Privacy and dignity issues were more prevalent in the NHS with six out of the nine visits identifying concerns. Some of the issues are identified below:

- curtains for privacy between beds, within dormitory areas, were not able to be closed
- the default position for the vision panels in bedroom doors was open
- patients were unable to have a private telephone conversation
- there was visual access to areas of the ward from a public footpath outside the ward.

Each patient being treated has the right to have their privacy and dignity preserved and in the examples above this clearly was not happening. Such

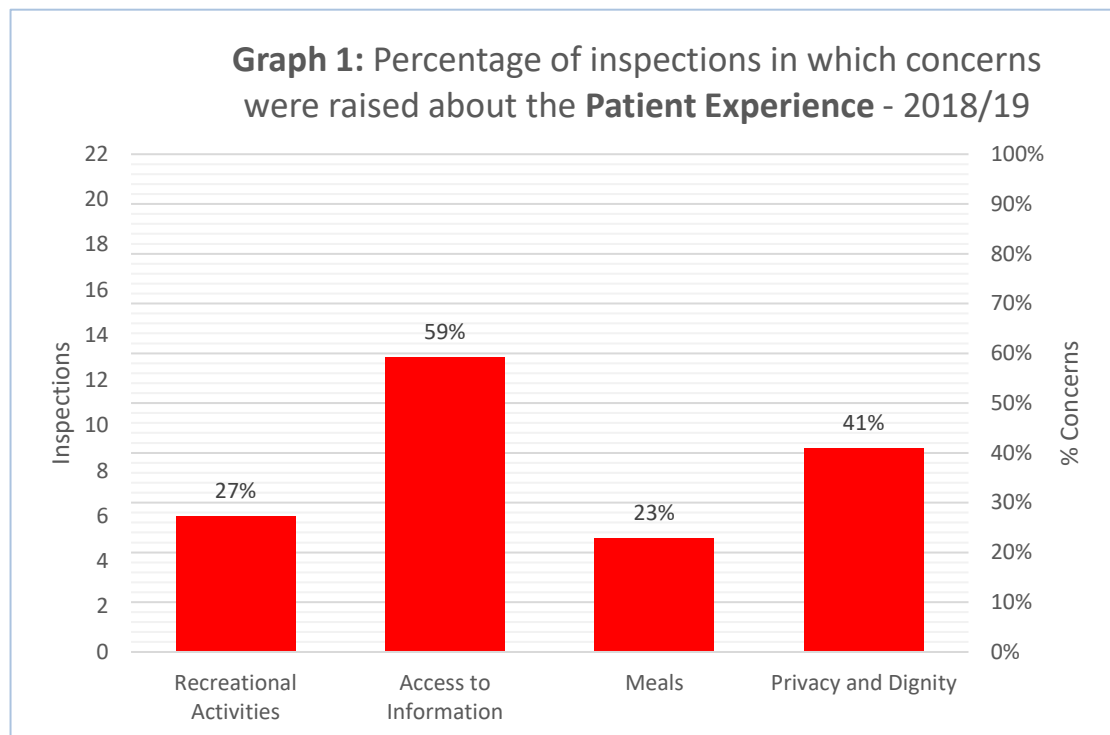
infringements upon a person’s privacy and dignity can have a detrimental effect upon recovery.

Meaningful Social and Recreational Activities

In 27% of our visits, patients complained of a lack of activities and these complaints ranged from section 17 leave being cancelled because of a lack of staff, unavailability of the hospital vehicle, and insufficient staff to supervise patients who wanted to use on site facilities such as the gym. One of our inspection reports stated: *“Most of the patients told us that the difficult part of their stay on the ward was boredom”*.

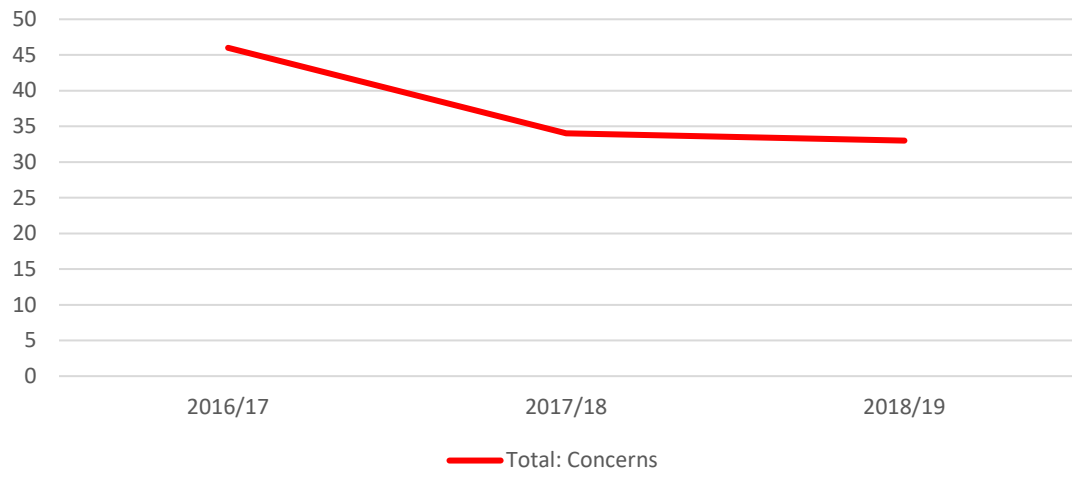
Overall incidence of patient experience issues

Graph 1 below shows that specific matters relating to the patient experience continue to be raised in between roughly a quarter and a half of our reports.



However, it is positive to note from graph 2 below that issues relating to patient experience were only raised in 33% of inspections in 2018/19 - a reduction from 46% in 2016/17.

Graph 2: Number of concerns raised about the Patient Experience - 3 year trend



3.1.2 Delivery of Safe and Effective Care

This area is core to our inspection framework and draws on a number of approaches including observation, interviews with patients, staff and others and the examination of documentation. Our findings in this area have been grouped into matters relating to the direct care and treatment of patients, and matters relating to the environment in which care is being provided.

We were pleased to see our inspections found that hospitals were becoming better at supporting the physical healthcare needs of patients alongside their mental healthcare needs.

However, care and treatment planning continued to be a significant concern and whilst this year the number of hospitals where we identified issues had reduced, the figure remains too high.

We continue to raise concerns regarding effective and safe practices within medicines management and this particular issue was raised as a concern across 86% of visits.

We were also concerned about the issues we identified in regard to the environment of care which had the potential to impact on the emotional wellbeing of patients as well as their overall health and safety

Overall this area is characterised with issues across a range of recurring areas. It is important that mental health service providers focus on getting the basics right on a sustainable basis.

Care and Treatment

- **Care and Treatment Planning**

Our inspections continue to find numerous issues with individual patients' care and treatment planning and many of these issues were prevalent in previous years. Care planning is an essential component in delivering an effective treatment programme for patients that they feel part of. The range of issues identified within our inspection regime included:

- lack of timely updating to reflect changes
- plans not developed in accordance with the Measure
- unmet needs not documented
- lack of detailed clinical entries

- a lack of individual restraint reduction plans
- information not fully completed
- lack of documented patient and family involvement
- a lack of documentation in relation to medication and other treatment.

The issues above were equally prevalent across both the NHS and independent hospitals.

Less frequently we also identified a lack of evidence of staff adhering to the night time observation process, and observational paperwork being completed retrospectively which is clearly unacceptable practice.

- **Physical Health Care**

We were pleased to see, however, a clear improvement with the assessment and treatment of physical healthcare needs. We made recommendations in regard to this issue in only one hospital in comparison with twelve hospitals during 2017-2018.

- **Medicines Management**

Unfortunately we continue to identify medicines management failures across a range of areas. This was the fourth successive year of increase in the proportion of visits that identified problems with medicines management, and we raised these issues in 86% of our inspections. This demonstrates the health boards and independent providers have so far failed to implement robust governance and audit processes to address the areas of concern identified. This year we also continued to identify a number of issues with the management arrangements for Controlled Drugs.

Examples of the issues identified with regard to medicines management generally include:

- medicines administration records (MAR) were not fully completed with a number of omissions in the administration record, front pages not completed with patient details, PRN medication not always recorded as administered and the details and reasons were also not recorded
- prescribed medication not administered in accordance with written instructions from medical staff
- errors identified by pharmacist audits not addressed
- medication cupboards and trolleys were not locked when not in use

- no medication fridges
- medication not being stored at the appropriate temperature as the clinical rooms were excessively hot
- medicines management policies out of date and a lack of access to the most recent one
- single use items not disposed of after each use
- a lack of safe storage of used medical containers awaiting disposal.

Specific issues identified relating to the management of Controlled Drugs included:

- a lack of accurate recording
- drugs not signed by two members of staff
- drugs not accounted for.

Safeguarding Procedures

In 14% of our visits we identified a lack of robust safeguarding procedures. While the number is not significant, the consequences for the failure to have robust safeguarding procedure in place can have a serious impact on a patient. Some examples of the failures included a lack of documented safeguarding processes in place following a safeguarding incident, and feedback obtained on an inspection that patients and staff did not feel safe with allegations of intimidation and bullying.

Environment and safety

- **Maintenance, Refurbishment and Replacement**

In 2018-19 HIW continued to identify significant shortfalls in hospital maintenance, refurbishment and replacements. Although the figure was down from 17 visits (70%) in 2018-19 it still remained far too high at 13 visits (59%). There was a range of issues identified from routine maintenance to major works that was required.

For example, one of our inspection reports stated that:

“there remains only two showers for up to 22 patients this is too few for the number of patients. To compound this issue the designated male shower was running cool and therefore most patients were using the one shower designated for female patients.”

On a different inspection our report stated:

“the courtyard area was bleak and vermin were regularly seen in the area by staff and patients.”

The issues were spread fairly across NHS and independent healthcare providers. However, a specific issue in the health boards was the reported ability of the maintenance/estates department to respond in a timely manner.

- **Adequate Cleaning of the Environment**

In just over a third of our visits we observed inadequate cleaning of the environment. Issues ranged from dirty and stained toilets and showers, heavily stained floors and walls, dirty patient kitchen and dirty and stained patients drink dispenser area.

- **Lack of an Available Nurse Call System**

Again this year we continued to identify the lack of a nurse call system particularly in patient bedrooms. It is difficult for HIW to accept some of the reasons given to compensate for the lack of this provision.

For example, one of our inspection reports stated that

“On both wards we were told that call points in patients’ bedrooms had been deactivated. This was attributed to a number of false alarms. This meant, however, that staff in these areas (and not wearing personal alarms) may not be able to summon assistance without leaving the area. There was also no call system for patients to summon assistance whilst in their bedrooms”

This explanation did not assure HIW that patients could access assistance in a timely manner. Many patient bedrooms are geographically remote from the nurse’s office/station and in all three inspections where this was identified as a risk there were no nurse call systems in patient bedrooms.

- **General Patient and Visitor Safety Risks**

A range of issues were identified within the 2018-19 inspection programme. In around a third of our visits safety issues were apparent. These ranged from unauthorized access to areas that could be a risk to patients, an electrical socket that required repair in a patients’ bedroom, unsafe garden areas because of a lack of appropriate lighting and the lack of issuing to ward visitors and staff appropriate personal alarms. The areas identified pose a significant risk to patients staff and visitors, and demonstrates a lack of appropriate risk management.

For example one inspection report states:

“We saw that the garden area was untidy and did not have a bin. There was a significant amount of cigarette ends strewn on the floor. The small patio areas was also green with moss and very slippery. Staff told us that recently a patient had slipped on this decking and suffered a serious injury.”

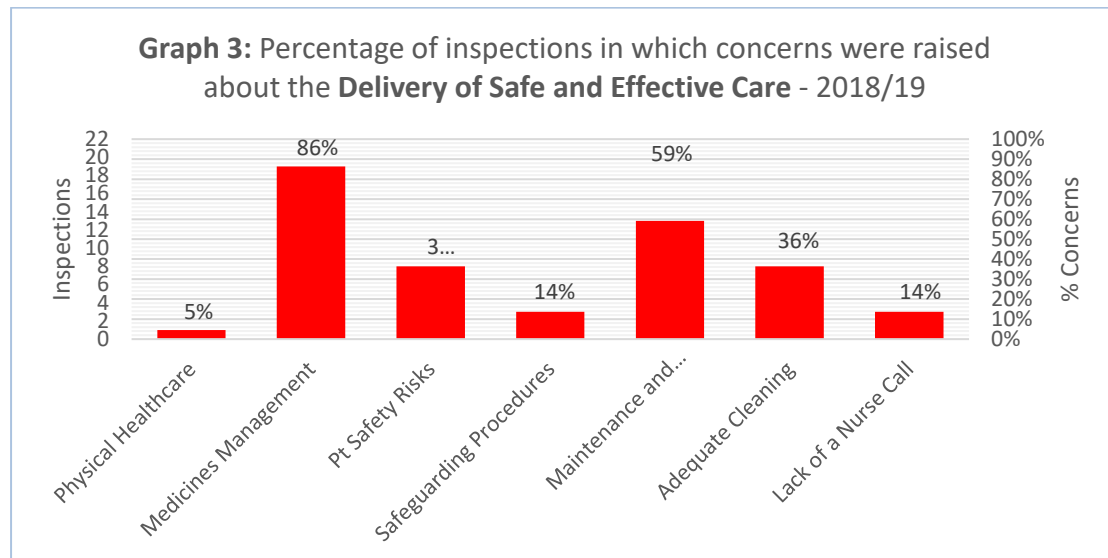
Other issues

On a less frequent basis we also identified a number of other issues relating the quality and safety of the environment of care:

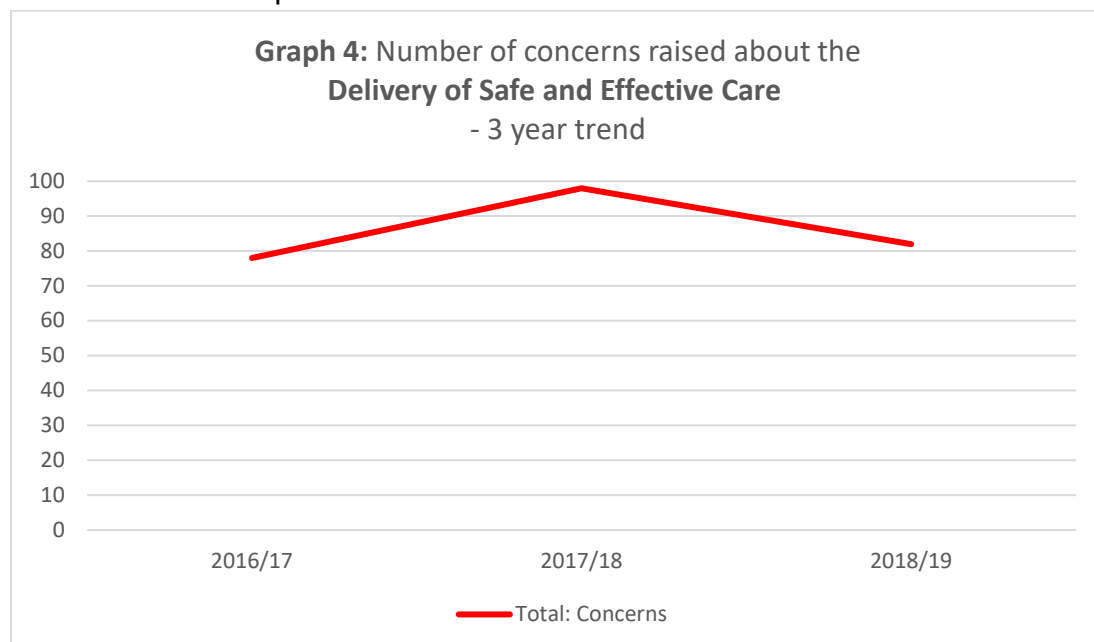
- lack of emergency trolley daily checks including discrepancies on the frequency of checks and the lack of an appropriate audit checklist
- staff were not familiar on how to operate oxygen cylinders
- no hand sanitizer
- clinical rooms that were not clean and well organized and clinic sinks not working
- clinical areas being used for storing of patient belongings and staff food.

Overall incidence of safety and effectiveness issues

Graph 3 below shows that specific matters relating to the safety and effectiveness of service continue to be raised in a significant proportion of our reports.



As for patient experience the proportion of reports highlighting issues relating to safety effectiveness has fallen slightly, but issues continue to be found in over half of our inspections.



3.1.3 Quality of Management and Leadership

Effective management and leadership are pivotal to ensuring the holistic needs of a diverse patient group are met. Effective governance

processes are essential in ensuring that hospitals are geared to meet the needs of the patients receiving care.

Although there were fewer inspections in which we raised issues relating to staff resources and training, we continued to identify examples of challenges in relationship to the management and support of services that need to be addressed. Specific issues arose in regard to the need for adequate staff of various disciplines. We also identified the need to strengthen training in some key areas, and to ensure that learning from external reviews and inspections is spread within service providers.

Bed availability, admission and discharge

It is clear that health boards can struggle to ensure that there are sufficient in-patient beds for all potential admissions. In two examples identified during our visits it was evident that meeting the needs of vulnerable patients would be difficult. In the first example, older persons with a diagnosis of dementia were admitted onto an adult acute mental health ward and in the second example some patients were required to sleep out from their ward. They had no place to store their belongings and the alternative ward was more restrictive. Such instances can be disorientating and have the potential to impede recovery.

Resources and Workload

In half of our visits there were deficits in the number of available staff across disciplines. While this was an improvement upon 2017-18 where we identified deficits in three quarters of visits, the numbers are still significant and we are regularly informed that recruiting the right discipline of staff remains a significant challenge for the mental health services. Some of the key issues identified included:

- insufficient Registered Nurses including Registered General Nurses with the skills and expertise in managing patients physical health care needs
- insufficient medical staff
- a lack of administration support at ward level that meant care staff spend long periods of time on general administration
- insufficient housekeeping provision
- adequate numbers of staffing to facilitate patient activities

- actual staffing lower than detailed in the Statement of Purpose (independent providers)
- insufficient management time for senior members of ward staff
- staff being taken away from direct patient observations and assigned other duties.

Training

In just over a third of our visits we found gaps in training. Whilst again this was a reduction compared to the 2017-18 findings, there clearly is more room for improvement. The training deficits identified were in a number of key areas including:

- managing violence and aggression including breakaway techniques
- basic life support
- infection control
- first aid
- conflict resolution.

It is also important that providers learn from our inspections and share that learning across the service. However, there are frequent examples in which we continue to highlight issues that have previously been raised. One report stated:

“It was also disappointing that the health board demonstrated a lack of shared learning from other inspections within its own health board as has resulted in repeat issues being identified”

Mental Health Act and Deprivation of Liberty Safeguards (DoLS) training had significantly improved since the previous year.

Staff Supervision and Appraisal

We identified a lack of documented supervision and appraisal in only a small amount of our visits this year. In only 14% (3 visits) was this an issue and this again was an improvement on the previous year.

Other Issues

Some less frequent issues identified within ‘Quality of Management and Leadership’ included:

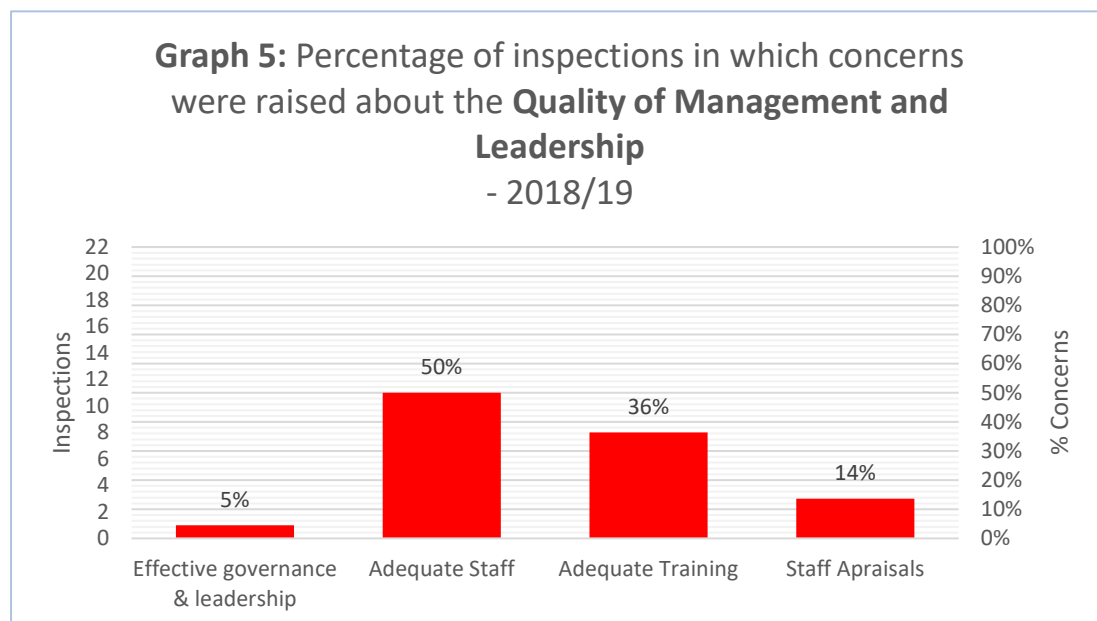
- a lack of effective communication between grades and discipline of staff that did not promote effective patient care
- policies and procedures not updated and some were not appropriate. Specific issues included, a policy for a challenging behaviour room had not been agreed, a blanket approach taken to patients having snacks, and a tranquilisation policy that wasn't up to date.

For example, one of our inspection reports stated that:

“There was a patient snack policy in place which limited the availability of snacks and drinks with high sugar content to certain amounts and during specific times of the day. This policy applied to all the patients accommodated regardless of individual abilities to make reasonable decisions and regardless of dietary intake and weight”

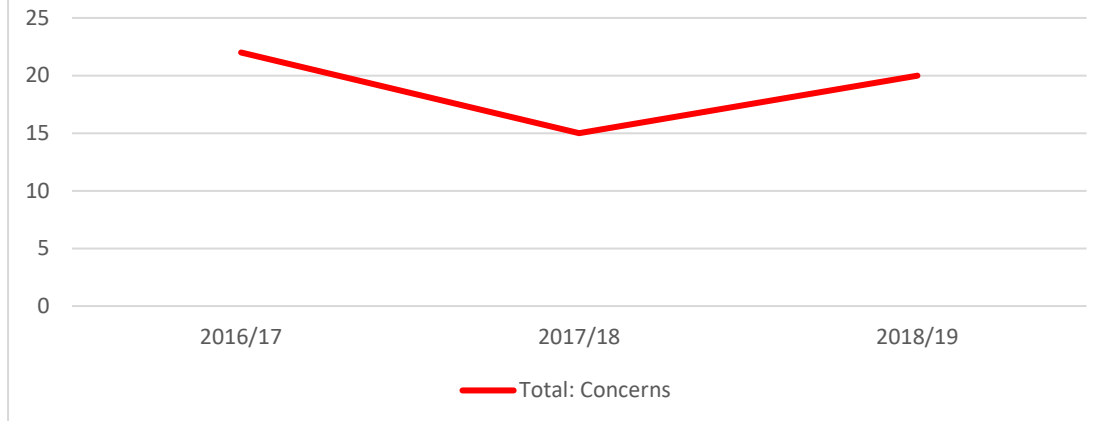
Overall incidence of management and leadership issues

Graph 5 below shows that specific matters relating to the safety and effectiveness of service continue to be raised in a significant proportion of our reports.



In terms of Graph 6 the quality of management and leadership over the last 3 years remains fairly consistent.

Graph 6: Number of concerns raised about the Quality of Management and Leadership - 3 year trend



Section 136 Suites

During 2018-19 HIW visited four Section 136 suites, two in Betsi Cadwaladr University Health Board (BCUHB), one in Hywel Dda University Health Board (H DUHB) and one in Aneurin Bevan University Health Board (ABUHB).

Findings included:

- the suite was inappropriately located and potentially very unwell patients from the suite had to walk through the main communal area of the ward to access the smoking area
- pilot working arrangements were in place for one health board and a police force area. These arrangements covered detained individuals, where for example aggressive behaviour was being displayed and when it was appropriate and safe for the police officers to leave. Staff stated that more effective communication between the police liaison officer and the crisis team could improve the care pathway for the patient
- there was an adverse impact upon the staff available to provide in-patient care as ward staff were being used to staff the suite
- the observational panel for one suite was not working
- there was a lack of privacy for patients using the section 136 suite. For example, an internal door leading from the section 136 suite to a staff area, had no privacy screen and this could impact upon the privacy of the person within the Section 136 Suite. In addition, there was no

screen to the toilet area, within the suite, therefore the patient had no privacy whilst using the toilet.

3.2 Community Mental Health Teams

In February 2019 HIW published a report on its 'Joint Thematic Review of Community Health Teams'¹ undertaken jointly with Care Inspectorate Wales (CIW).

The review looked at themes related to:

- access to services
- care planning
- delivery of safe and effective care
- governance.

It concluded that there was disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams (CMHT) across Wales. In particular:

- *A lack of clarity regarding how people access CMHTs, with links between General Practice (GPs) and CMHTs needing to be strengthened. In some areas there is a lack of knowledge of the range of services available for people to be referred to*
- *Concerns about the ability of people experiencing mental health crisis to access urgent support. Some service users have difficulty accessing services out of hours or have to attend A&E departments. A significant number of people did not know who to contact out of hours*
- *Service users or families not being fully involved in developing care and treatment plans*
- *Whilst CMHTs are meeting targets for the completion of assessments and/or care plans, we have found that this does not always mean that the quality of documentation is good*
- *There are significant challenges for people who need to access psychology or therapeutic services with long waiting times in Wales; up to 24 months in some areas*
- *In some areas there are problems in accessing some third sector or other support services, which means that the invaluable support those services can offer is not being used fully or effectively*

¹ See: <http://hiw.org.uk/docs/hiw/reports/190207joint-thematic-review-community-mental-health-en.pdf>

- *There is much work being undertaken on the transformation of services across Wales, which is positive. However, focus needs to be maintained on ensuring service users continue to receive appropriate care whilst wider changes are being made*
- *Information technology and universal access to patient/service user records is a considerable problem across CMHTs with health and social care service systems not working together properly*
- *The working environments of CMHTs need improvement with some clinical areas not fit for purpose.*

The report included 23 separate recommendations. All care providers should be familiar with the detailed evidence contained in this report and should ensure that they have fully addressed the recommendations relevant to their service.

We have continued to undertake reviews of CMHTs in Wales. We will be using our future inspections to assess progress against the issues identified in the thematic review.

3.3 Mental health services for young people

On 29th March 2019 HIW published a report addressing the question ‘How are healthcare services meeting the needs of young people?’² The conclusions of this report are summarised below:

Why this issue is important

Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14. The Mental Health Act required that age-appropriate services be put in place and that patients aged under 18 with a mental health problem requiring admission to hospital are accommodated in an environment that is suitable for their age. For those young people with enduring mental illness the need for ongoing support and care from childhood into adulthood is vital. All children and young people should receive safe and effective care from mental health services which meet their needs.

What the evidence shows

When evaluating how young people with mental health needs are cared for, we have primarily considered the evidence from our inspections of the three CAMHS in-patient units in Wales which HIW inspected during 2018-19. This includes our inspections of Abergele unit within Betsi Cadwaladr University Health Board, Ty Lliard unit provided by Cwm Taf University Health Board and Regis Healthcare’s independent low-secure CAMHS unit where people with acute, long-term and complex needs are cared for. This unit was inspected on 4 separate occasions due to significant concerns regarding the way the service was being managed and young people were being cared for. In September 2018 a Notice of Proposal to cancel the registration was served on Regis Healthcare for numerous failings including the failure to formulate care plans to mitigate against significant patient risks. Extensive evidence and an action plan was submitted by the registered provider and progress assessed by HIW in subsequent visits a decision was made not to issue a Notice of Decision³. Throughout the year the service continued to be a service of concern under HIW’s enforcement process and remained under the highest level of scrutiny.

We have also considered the evidence from guidance, research and reviews around CAMHS services more widely.

² See: <http://hiw.org.uk/docs/hiw/reports/290319thematicyouthen.pdf>

³ A Notice of Decision is issued by HIW (the registration authority) under section 19 of the Care standards Act 2000. This Notice of decision is issued if HIW decides to adopt a Notice of Proposal issued under section 17 of the Care Standards Act. If HIW thinks sufficient progress has been made by a registered provider, in response to the issuing of a Notice of Proposal then it does not issue a Notice of Decision.

Conclusions

Within the three in-patient CAMHS units we inspected, it was positive to find that staff worked hard to provide compassionate, dignified and person-centred care. We also saw evidence of positive multi-disciplinary team working within the units.

However, across our inspections, we could not always be assured patients were receiving safe and effective care within CAMHS units. This is because we identified weaknesses around systems for ensuring safe care, including a system for locating emergency equipment. We also found improvements were needed to patient records, care planning and statutory mental health documentation. In the Regis Healthcare CAMHS unit, it was of particular concern to find excessive use of full physical restraint which compromised patients' safety, rights and dignity. We found there were ongoing challenges across CAMHS units to ensure there are sufficient numbers of staff with the right skills to meet the needs of young people.

Overall, HIW has significant concerns about the ability within CAMHS units to accommodate young people who are high risk due to challenges with staffing, environment and effective management and leadership.

The report included 10 separate recommendations for care providers to ensure that services were safe and effective in meeting the needs of young people.

All providers should be familiar with the detailed evidence contained in this report and should ensure that they have fully addressed the recommendations relevant to their service.

3.4 Working with partner agencies

HIW continues to work in partnership with a number of key agencies, including Her Majesty's Inspection of Probation (HMI Probation), the National Preventative Mechanism (NPM) and Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS).

HMI Probation

In March 2019 HIW participated in an inspection of the Western Bay Youth Offending Services and considered the healthcare that young people received. Several issues were identified with young people not receiving an adequate level of healthcare and we contributed to the final report produced by Her Majesty's Inspectorate of Probation.

National Preventative Mechanism

There are now 21 bodies designated to the NPM and HIW is one of them. HIW attends the business meetings, is a member of the steering committee, the mental health and children and young people's sub groups. HIW hosted the NPM business and mental health sub group in April 2019.

The Optional Protocol to the Convention against Torture and Other Cruel, Inhumane or Degrading treatment or Punishment (OPCAT) is an international human rights treaty designed to protect individuals deprived of their liberty. The treaty came into force in June 2006 and the 21 bodies that make up the NPM fulfil a key requirement of the treaty to ensure all places of detention are independently monitored. The bodies consider implementation of the treaty and examine conditions of detention, the treatment of detainees, make recommendations and requirements and comments on draft legislation and guidance to improve the treatment of individuals and conditions of detention. The UK's NPM liaises directly with the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) an international body established by OPCAT.

Each year along with the other designated bodies HIW conducts a self-assessment, that is peer reviewed, using methodology based on the SPT's "analytical self-assessment tools for NPMs. This tool allows the NPMs to examine individual organisational effectiveness and efficiency.

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

4.1 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. However, this piece of legislation remains largely unchanged since the Act was introduced in 1983 with only minor changes in 1995 and then 2007, this makes the piece of legislation some 35 years old.

Additionally in December 2017 there were changes to section 135 & 136 of the Mental Health Act introduced by the Police and Crime Act 2017. Professor Sir Simon Wessely chaired an independent review of the Act and an interim report was produced in May 2018⁴. A final report was published in December 2018.

In December 2018, the UK government stated that it will introduce a new Mental Health Bill to transform mental health care. Subsequently in 2019, the UK Government said that it would publish its formal response to the independent review in the form of a White Paper. The Welsh Government is awaiting the White Paper to consider the next steps for the operation of the Mental Health Act 1983 in Wales.

Patients that access mental health and learning disability services are either informal, 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'⁵ can be treated in hospital on a voluntary basis.

The Act puts safeguards in place to ensure only appropriate medical treatment is administered to individuals who may not consent to it or have the capacity to consent under certain circumstances.

When patients are detained under the Act, a comprehensive assessment of their mental health must 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 robust legal framework to protect the rights of both formal and informal patients and ensure that they receive an appropriate level of care and effective 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.

⁴ Professor Sir Simon Wessely undertook a full and independent review of the Mental Health Act and published a report on the findings and set out a list of recommendations.

⁵ '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 reasons could include, for example, their current co-operation.

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
- 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.

4.2 How the Act is monitored in Wales

Welsh Ministers have specific duties to monitor the Act that is enshrined in law. HIW undertakes this function on behalf of the Welsh Ministers. These duties include:

- to write an annual report on how the Act is being implemented in Wales
- keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained
- ensure each HB and independent registered provider discharge their duties so that the Act is lawfully and properly administered throughout Wales
- provide a service, known as the Second Opinion Appointed Doctor (SOAD) service, under the Act where registered medical practitioner authorise and review proposed treatment of patients in certain circumstances
- 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, and patients that are subject to a Community Treatment Order (CTO) or guardianship.

Within our inspection process we also review the paperwork in relation to the detention of patients to ensure it complies with the Act and the revised Code of Practice. Another important process of safeguarding the interests of patients is that HIW provides a SOAD service. This area will be further considered later in this chapter.

Mental Health Act Reviewers

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

- is of the Code of Practice available on the wards and being implemented?
- are the legal papers for the detention completed accurately and copies available at ward level?
- are patients' rights under section 132 well documented, in an appropriate format and include a record as to whether the patients understand their rights?

- are the key 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 may be undertaken as part of a general larger inspection or there will also be occasions when MHA visits are undertaken as a stand-alone visit.

4.3 Findings from our visits

During 2018-19 we undertook visits to 52 wards that accommodated detained patients. The visits focused upon reviewing the exercise of the powers of the health boards and independent registered providers for detained patients and those liable to be detained. In addition HIW needs to ensure that each health board and independent registered provider discharge their duties so that the Act is lawfully and properly administered throughout Wales. HIW identified some areas of noteworthy practice including:

- well maintained records with evidence of strong administrative governance and medical audit
- section 17 leave authorisations demonstrated a flexible approach to meeting the specific needs of the patient
- very knowledgeable and efficient Mental Health Act administrators.

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
- 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 documentation to confirm that patients were made aware of their rights under section 132 of the MHA
- 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

- whilst there was some good practice in relation to section 17 (see above) there was still some issues identified. These included authorisation forms not cancelled when they were no longer relevant. This could lead to confusion about the patient's level of section 17 leave. In addition, there was a lack of evidence that patients were given copies of their section 17 authorisation leave forms.

During 2018-19 HIW did not investigate any complaints relating to the application of the Act, but took a number of calls from detained patients complaining about their detention. In these cases HIW gave patients information on accessing the Mental Health Act Review Tribunal in terms of the appeal process against their detention. In addition, HIW ensured that detained patients knew their legal rights and were able to access legal representatives and advocacy services.

4.4 The Second Opinion Appointed Doctor Service (SOAD)

The SOAD service is operated by HIW and we appoint registered medical practitioners to approve some forms of treatment. During 2018-19 HIW has recruited a further 6 SOADs and these have undertaken a comprehensive induction programme consisting of structured induction days. In addition, our lead SOAD has accompanied the SOADs on visits to detained patients. 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
- 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 that has occurred is the health board or independent provider not 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 as 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 patient's 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 2018-19, there were 910 requests for a visit by a SOAD (907 in 2017-18).

These were:

- 834 requests related to the certification of medication
- 51 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 2018-19

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
2018-19	834	51	25	910

Source: SOAD requests to HIW

4.5 Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has 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. The designated form is available on our website for the responsible clinician to complete. For the third consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place.

There continues to be an improvement in the quality of the information received on the forms and the supporting documentation was more comprehensive. Overall there had been improvement from 2017-18 in relation to the following areas:

- there were very few occasions where there was more medication listed under the treatment description than authorised on the CO3 form
- copies of CO2 and CO3 forms were always attached to the review of treatment form and this enabled a much more robust audit process
- the issue of a lack of particularising of medication had substantially improved since HIW had provided training to the Mental Health Act administrators who initially audit the forms before sending to ourselves. We are also planning to modify the existing section 61 forms to encourage the particularisation of medication
- there is no longer an issue of a lack of copies of CO7 and CO8 and all section 61 submissions were with the appropriate CO forms
- the medication not identified on the section 61 forms had again significantly improved.

The only area where there had not been a significant improvement following our review of section 61 forms was that a patients' status of consent and capacity was still unclear.

The audits of the review of treatment forms will be ongoing and further findings will be reported upon during our 2019-20 report.

5 Recommendations/requirements (requirements for Independent Healthcare Providers only)

Following our findings from our inspections during 2018-19 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 given access to appropriate information	Health and Social Care Standard 4.2 Regulation 9 (1) (g) & 19 (2) (b) (i)_
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)
All health boards and Independent Providers must ensure that patients' have a range of meaningful social and recreational activities	Health and Social Care Standard 1.1 Regulation 15 (1) (a)
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 CAMHS provision meets the needs of the patient group and any treatment is timely	Health and Care Standard 3.1

Appendix A

Relevant work undertaken in 2018-19

National Reviews

Title	Scope	Settings	Link to report
How are healthcare services meeting the needs of young people?	Included summary of CAMHS	All in-patient CAMHS	

Local Reviews

Health Board	Setting	Ward/ Team	Link to report
Abertawe Bro Morgannwg	Cefn Coed Hospital	The Tawe Clinic, Clyne and Fendrod	
Aneurin Bevan	County Hospital St Cadoc's Hospital	Taylgarn Adferiad, Beechwood (PICU) Belle Vue Pillmawr North Lodge South Lodge	
Betswi Cadwaldr	Abergele Hospital Ysbyty Glan Clwyd Ysbyty Gwynedd	Kestrel (CAMHS) Cynnydd Dinas Tegid Aneurin Cynan Taliesin (PICU)	
Cardiff and Vale	Hafan y Coed	Beech Oak Willow	
Cwm Taf	Royal Glamorgan Princess of Wales Ty Liidiard	Seren St David's Enfys (CAMHS) Seren (CAMHS)	

Hywel Dda	St David's Park Prince Philip	Cwm Seren (Low Secure unit) Cwm Seren (PICU) Bryngofal	
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Independent provider	Hospital	Wards	Link to report
	Coed Du Hall	Ash Beech Cedar	
Elysium Healthcare	Aderyn Cefn Carnau	Aderyn Bryntirion Derwen Sylfaen	
Ludlow Street Healthcare	Heatherwood Court Pinetree Court St Peter's	Caernarfon Caerphilly Cardigan Chepstow Cedar Lodge Juniper Larch Brecon Raglan Upper Raglan	
Mental Health Care	St David's	St David's	
Priory Group	Ty Catrin	Bute Heath Roath Sophia Trelai Victoria	
Priory Healthcare	Llanarth Court (2 separate visits) Ty Cwm Rhondda	Awen Howell Iddon Osbern Teilo Treowen Woodlands Bungalow Cilliad Clydach	
Regis Healthcare Limited	Regis Ebbw Vale	Brenin (CAMHS)	

	(3 separate visits)	Ebbw (CAMHS)	
Rushcliffe	Rushcliffe	Ruscliffe	

Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one’s own views, feelings and ideas. See also <i>independent mental health advocate</i> .
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	<p>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.</p> <p>Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.</p>
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	<p>Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge.</p> <p>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.</p>
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	<p>The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust or Health Board)</p> <p>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.</p>
Independent Mental Capacity Advocate (IMCA)	<p>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.</p>
Informal patient	<p>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.</p>
Learning disability	<p>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.</p>
Leave of absence (section 17 leave)	<p>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 '<i>Section 17 leave</i>'.</p>
Liable to be detained	<p>This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time</p>
Medical treatment	<p>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</p>

	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 ' <i>patient</i> ' should be used in practice in preference to other terms such as ' <i>service user</i> ', ' <i>client</i> ' 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 <i>Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008</i> .
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	<p>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</p> <p>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.</p>
Second Opinion Appointed Doctor (SOAD)	<p>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</p>
Section 3	<p>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</p>
Section 12 doctor	<p>See doctor approved under Section 12.</p>
Section 17A	<p>This is a Community Treatment Order</p>
Section 37	<p>This is a hospital order, which is an alternative to a prison sentence.</p>
Section 41	<p>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.</p>
Section 57 treatment	<p>Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function,</p>
Section 58 & 58A	<p>Section 58 treatments refer to medication for mental disorder and section 58A treatments</p>

	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 all 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 (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; 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.