Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2020-2021

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose
To check that people in Wales receive good quality healthcare.

Our values
We place patients at the heart of what we do.

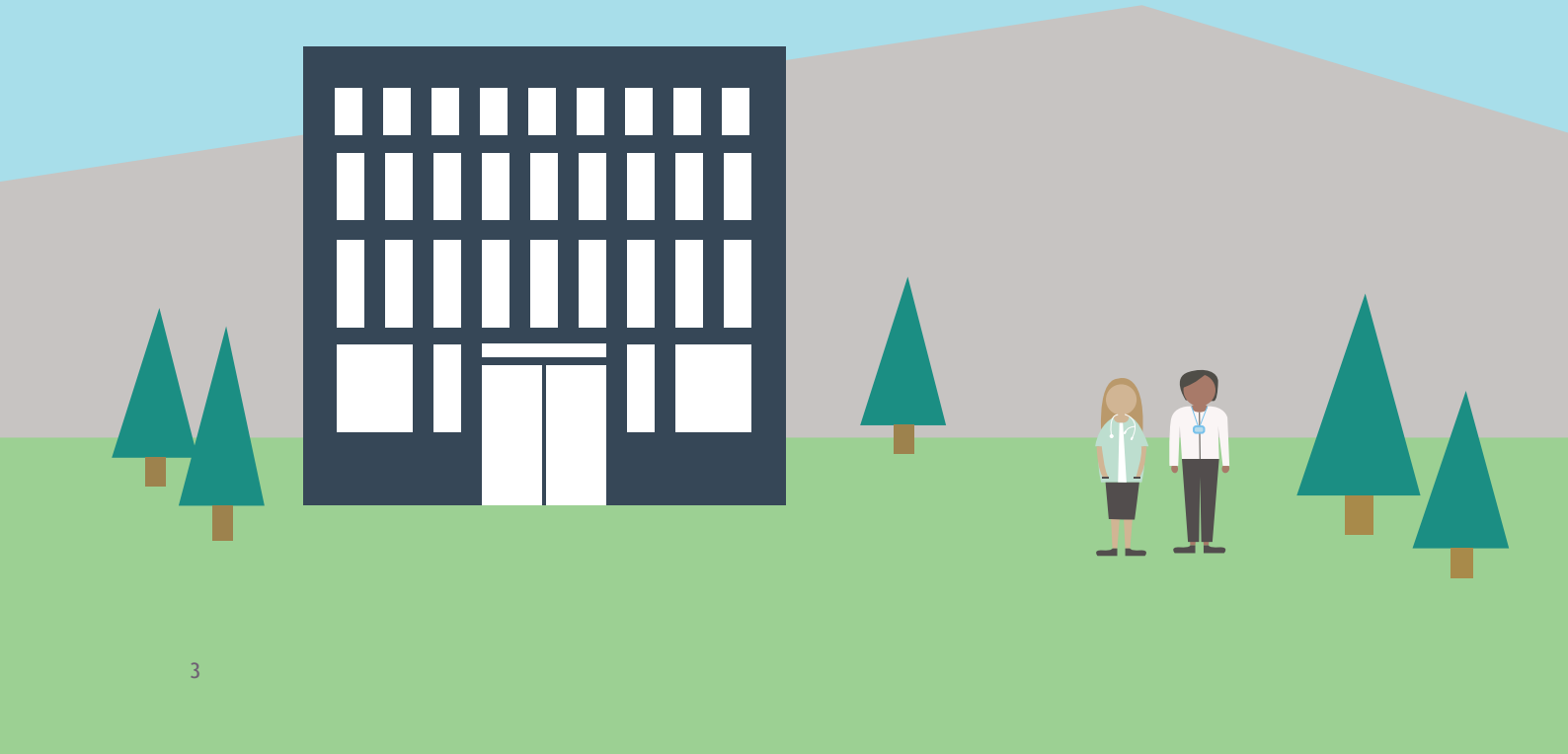
We are:
- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities
Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.



Executive Summary

Our role is to ensure people in Wales receive good quality, safe and effective healthcare. We regulate and inspect independent mental health and learning disability healthcare services, we inspect NHS mental health and learning disability healthcare services. We monitor how services discharge their powers and duties under the Mental Health Act 1983 in Wales.

Through our inspection and monitoring processes we identify areas of good practice and areas of concern. We encourage providers to take steps to improve the services they provide, and we take action if we identify people using services are at risk of harm. This report sets out our activity and findings during the period April 2020 to March 2021, and explores the extent to which mental health and learning disability healthcare services across Wales provided safe, dignified and least restrictive care during the pandemic.

Our findings are drawn from a combination of digitally enabled quality checks, onsite focussed review and inspection visits, analysis of information received through our concerns and notifications processes, and the work of our Review Service for Mental Health (RSMH). During the reporting period we:

- Carried out 8 on-site inspection visits:
    - 1 NHS
    - 7 independent healthcare providers

- Undertook 33 digitally enabled quality checks:
    - 18 NHS
    - 15 independent healthcare providers

- Reviewed and where necessary sought further assurance about:
    - 151 patient concerns
    - 553 Regulation 30 and 31 Notifications

- Completed 756 Second Opinion Appointed Doctor (SOAD) assessments.

We found that the pandemic required rapid and unprecedented change in the way that healthcare was delivered across Wales, and whilst many of the services we considered had coped well, we also heard that in some areas the pandemic had significantly impacted on patients and staff.

The services we checked had introduced infection prevention and control measures and had adapted the care environment to minimise the transmission risk of COVID-19. Most services had developed COVID-19 risk assessments, management plans and policies specifically to support and sustain the operational changes required to stop the spread of infection. Sadly, and despite changes being implemented to help reduce the spread of COVID-19, we were notified on a number of occasions throughout the pandemic, of incidents of COVID-19 affecting patients and staff in independent mental health and learning disability healthcare settings, and we were

aware of outbreaks of COVID-19 in NHS mental health and learning disability healthcare settings.

We learnt that maintaining a positive patient experience during the pandemic had been challenging for some care providers. National and local restrictions meant that patients were at times unable to have leave of absence (section 17 leave), or receive visits from family and friends. We heard that the requirement for social distancing and wearing of personal protective equipment (PPE) had also radically changed the way in which care was provided.

We found a clear focus on the need for regular and effective communication with patients about the latest guidance and restrictions, including local lockdowns and changes to leave arrangements. We were told that increased activities had been provided, and video calling could be used, at times when visitors and leave of absence were not permitted, to enable patients to maintain contact with family and friends. We learnt that arrangements had been introduced to enable patients to use telephone and video conferencing facilities to participate in consultations with members of the multi-disciplinary team, to access statutory advocacy and support services, and to participate in Mental Health Review Tribunals. We identified the potential for some patients, for a range of reasons, to experience difficulties with this approach and recommended that providers take steps to support and enable patients to engage with others via digital means.

In previous years we have commented on the variability in quality and robustness of risk assessment and care and treatment planning documentation. Through our on-site inspection and focussed review work we saw some examples of good practice, but overall improvement is still needed. During some of our visits our concerns about care plans required urgent remedial action and resulted in the issue of non-compliance notices.

We checked whether environmental risk assessments had been undertaken and acted upon. As in previous years we identified the need for routine maintenance, redecoration and replacement of fixtures, fittings and furniture in some settings. We were particularly concerned to find inconsistent practice around ligature risk assessment and examples where action had not been taken to reduce or remove identified ligature point risks. These issues were particularly concerning, and as a result we wrote to the Chief Executive of NHS Wales to raise our concerns and to ask that action be taken in this area.

Many staff working in mental health and learning disability healthcare settings across Wales have worked under significant pressure throughout the pandemic. We heard through our conversations with managers and others that they were very proud and complimentary about their staff, and the work that had been accomplished during a difficult and challenging time. We found that the pandemic had prevented opportunities for face to face training, and we learnt that at times staffing levels were only achieved through frequent and considerable use of temporary agency staff. Some settings were carrying a number of registered nurse and support worker vacancies, and in these settings staffing had been further compromised at times when permanent staff were absent from work because they had symptoms of coronavirus or were required to self-isolate. We identified that a number of NHS and

independent mental healthcare providers needed to take action to recruit permanent staff to ensure safe and effective care, and this is an area that needs urgent attention and focus in the coming months.

Context

The COVID-19 pandemic has had a significant impact on the citizens of Wales. Healthcare services had to adjust in unprecedented ways to respond to the challenges presented by the pandemic and also to comply with the measures implemented nationally and locally to reduce the spread of the virus. These measures were set out in the Coronavirus Act (2020), and at times included restricting the free movement of the public.

Mental health and learning disability hospital services continued to operate within the NHS and independent sector throughout this time, and were required to continue to comply with mental health legislation and requirements of the Mental Health Act Code of Practice for Wales (Revised 2016). As a consequence of national and local restrictions, visiting and leave arrangements were paused a number of times during the pandemic. This meant that patient relatives, friends and visiting professionals did not attend care settings during much of the period covered by this report, and patients who would ordinarily have been able to have leave of absence (section 17 leave) were confined to the hospital and its grounds for extended periods of time.

In March 2020 we took the decision to temporarily pause our routine inspection and review activity. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of undertaking digitally enabled quality checks. Through this approach we were able to seek assurance from services at a time when the risk threshold for conducting inspection visits was high because COVID-19 was spreading in the community.

Throughout the pandemic we continued to operate the Second Opinion Appointed Doctors (SOAD) through our Review Service for Mental Health (RSMH) to ensure the rights of patients detained under the Mental Health Act 1983 were safeguarded. We also continued to operate the Regulation 30 and 31 notification process to ensure we were notified of events that could impact on patient safety in independent mental health and learning disability healthcare settings. Throughout the pandemic we continued to listen and respond to patients, relatives and staff members who contacted us about their concerns.

Our role in mental health care

As the regulator and inspector of independent mental health and learning disability healthcare services, and inspector of NHS mental health and learning disability services we have a responsibility to monitor how services discharge their powers and duties under the Mental Health Act 1983. Our role is to provide the public with assurance about the quality, safety and effectiveness of mental healthcare services in Wales. We do this by:

Listening to concerns

We use information about healthcare services to gain assurance about the quality and safety of services provided to citizens in Wales. This includes:

- Listening to the concerns of patients, relatives and advocates
- Listening to staff concerns
- Monitoring and reviewing incidents, notifications and safeguarding concerns

By triangulating evidence from a number of sources we obtain a fuller picture about the quality of care and support provided by mental health and learning disability healthcare services in the NHS and independent sector. When issues are identified we may visit a hospital outside of our routine work programme to assess the level of compliance with legislation and the delivery of effective care. These inspections seek evidence and assurance on a range of matters that effect outcomes for patients.

Throughout the pandemic we continued to operate our concerns and notifications processes, and we also continued to respond to people in mental health and learning disability healthcare settings who contacted us. Information we received through concerns and notifications is summarised in section 4 of this report.

Inspection and regulation

We are the regulator for all independent healthcare providers in Wales and we monitor and regulate the sector in accordance with the Care Standards Act 2000 and Independent Health Care (Wales) Regulations 2011.

We inspect NHS healthcare settings in Wales to check that people receive good quality healthcare. We use the Health and Care Standards (2015) and other standards to inform our inspection approach.

We took the decision to temporarily pause our routine inspection and review visits during the pandemic to support healthcare providers to focus their resources on keeping patients and staff safe. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of digitally enabled quality checks during the pandemic. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the risk of COVID-19 spreading.

Our quality check process commenced in August 2020 and focused on the key areas of COVID-19 arrangements, environment, infection prevention and control, and governance.

Our findings from the quality checks, inspections and focussed reviews we undertook during the period April 2020 to March 2021 are summarised in section 5 of this report. A list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring use of the Mental Health Act 1983

We monitor how services discharge their powers and duties in relation to the Mental Health Act 1983. This is undertaken on behalf of Welsh Ministers and is to protect the interests of people whose rights are restricted under the Act. Our Review Service Mental Health (RSMH) can investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment. Information is reviewed to seek assurance that:

- Individuals are lawfully detained, well cared for, and informed of their rights under the Act
- The Mental Health Act Code of Practice for Wales (Revised 2016) is being followed
- Appropriate plans are made for patients before they are discharged from hospital.

When considering information about the use of the Mental Health Act we are attentive to potential patterns and themes emerging in mental health and learning disability healthcare services, and we use this information to formulate judgements about the effectiveness and quality of the care provided. Our findings for the period April 2020 to March 2021 are summarised in section 6 of this report.

Review Service Mental Health (RSMH)

Through the Review Service Mental Health (RSMH) we operate the Second Opinion Appointed Doctor (SOAD) service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the Mental Health Act, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.

When requested by the Responsible Clinician (RC) with overall responsibility for the patient's care, the RSMH appoints a Second Opinion Appointed Doctor. The role of the SOAD is to provide an independent opinion about the prescribed treatment, and to ensure that it is appropriate and in the patient's best interests.

A summary of work undertaken by SOADs between April 2020 and March 2021 is provided in section 7 of this report.

Monitoring use of the Deprivation of Liberty Safeguards (DOLS)

We monitor use of the Deprivation of Liberty Safeguards (DOLS). The DOLS were introduced in April 2009 as part of the implementation of the Mental Capacity Act 2005. The DOLS ensure legal and administrative protection for people who lack capacity to consent to how they are cared for on a day to day basis, and are used when detention under the Mental Health Act 1983 is not appropriate. The safeguards protect human rights by providing a framework to ensure that care is provided to people in the least restrictive way. We monitor use of the Deprivation of Liberty Safeguards in NHS settings through analysis of statistical information and examination of policy and procedure implementation. Our Deprivation of Liberty (DOLS) annual monitoring reports are available via the Healthcare Inspectorate Wales web site.

Working as part of the UK National Preventive Mechanism

HIW is one of 21 member bodies of the UK's National Preventative Mechanism (NPM).

The UK ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. The National Preventative Mechanism (NPM) was established in 2009 to comply with the OPCAT.

We monitor and inspect healthcare settings where people may be detained in Wales as part of this arrangement. Our reviewers meet with patients, managers and others to talk about their experiences, and we make recommendations to improve the treatment of individuals and conditions of detention when necessary. During our inspection visits we check that patients are:

- Lawfully detained and well cared for
- Informed about their rights
- Treated with dignity and respect
- Enabled to lead as fulfilling a life as possible.

The UK's NPM liaises directly with the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, which is an international body established by OPCAT.

We attend NPM business meetings, and we are a member of the NPM steering committee, the mental health sub group, and children and young people's sub group.

Listening to concerns

We receive information in the form of concerns, complaints and notifications from people who use mental health and learning disability services, their relatives, visitors, service providers, staff, and visiting professionals. This information forms a key component of our approach to checking that people in Wales receive safe and good quality care and treatment.

Each concern, complaint or notification we receive is assessed by a case manager who engages with the care setting, and when appropriate, coordinates with relevant agencies to ensure that concerns are investigated and action is taken when required. We are particularly attentive to potential patterns and themes that may be apparent in mental health and learning disability healthcare services, and we use the information received to consider the safety and quality of care provided.

Some concerns and notifications may trigger us to have formal discussions with a care provider or to carry out inspection or other assurance activity. If necessary, concerns about 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.

Concerns and complaints

During the reporting period we received:

- 434 complaints and concerns about healthcare providers in Wales

- 151 of these were about mental health and learning disability healthcare services:
  - 65 NHS mental health and learning disability services
  - 86 independent mental health and learning disability services.

Nature of concerns

We record information about the concerns and complaints we receive in the following categories:

- Allegations of abuse and/or neglect
- Infrastructure, including concerns about staffing, facilities and the care environment
- Consent, confidentiality and communication
- Treatment and/or procedures
- Clinical Assessment
- Mental Health Act 1983
- Other, to capture all concerns that fall outside of our existing themes

Table 1: Subject of concerns and complaints

Subject of concerns and complaints	NHS Settings			Independent healthcare Settings		
	2018-19	2019-20	2020-21	2018-19	2019-20	2020-21
Alleged abuse and/or neglect	3	8	3	1	15	17
Infrastructure, including staffing, facilities and the care environment	16	12	7	54	28	20
Consent, /communication/confidentiality	0	1	2	0	1	2
Treatment/Procedure	7	7	15	17	12	9
Clinical Assessment	9	2	4	3	1	2
Mental Health Act	5	5	1	1	6	1
Other	2	6	33	1	21	35
Total	**42**	**44**	**65**	**77**	**84**	**86**

Notably in 2020-21 we received a greater number of concerns that did not fall into one of our existing categories. This included an increased number of concerns and complaints about infection prevention and control, specifically related to the Covid-19 pandemic. These concerns and complaints have been included in the 'other' category.

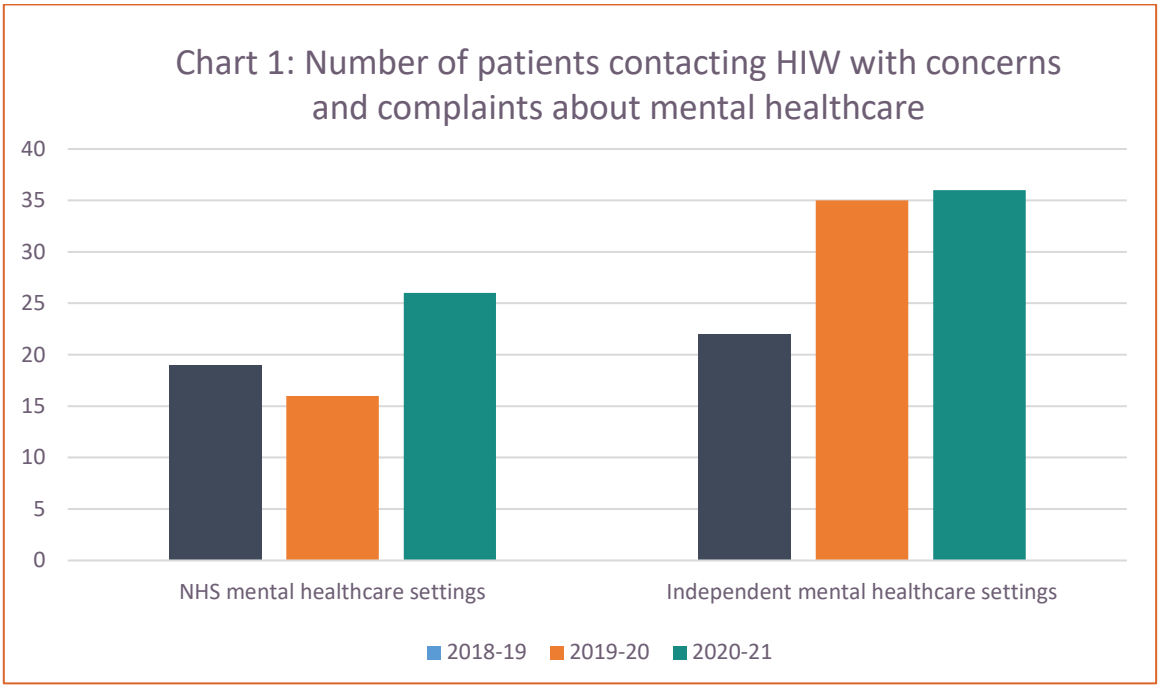
Concerns of patients, family members and advocates

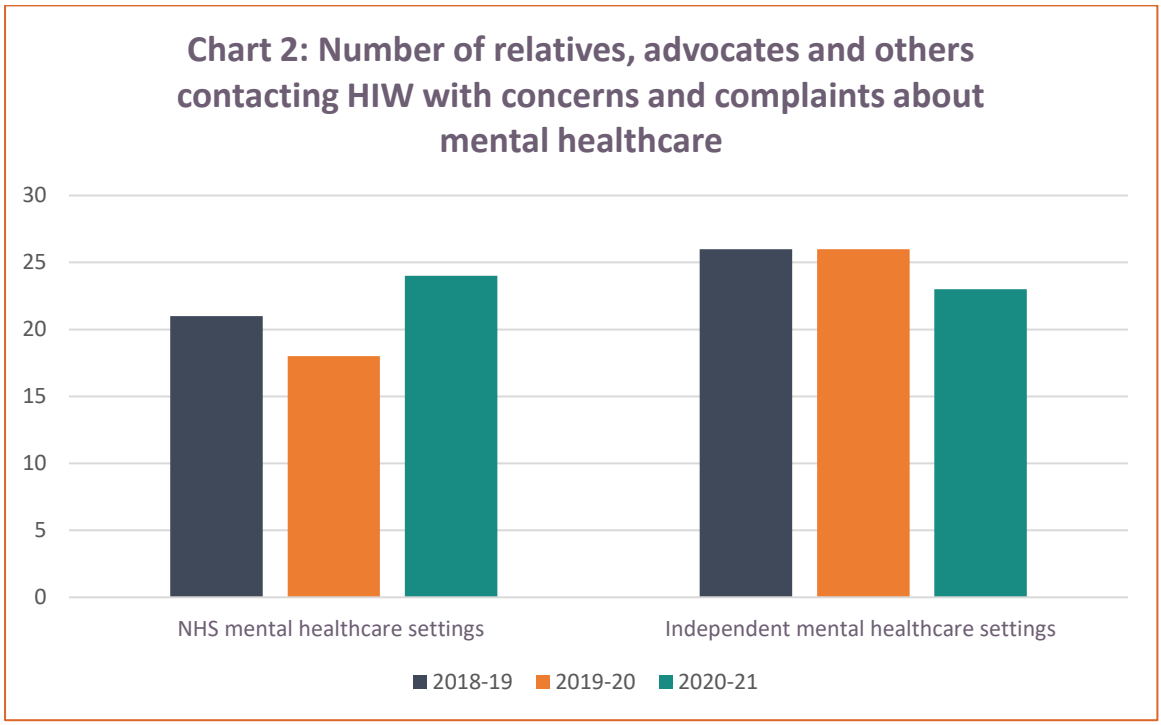
Over the last three years we have seen an increase in the total number of concerns and complaints that we have received from patients, relatives and advocates about mental health and learning disability services:

- 88 in 2018-19
- 95 in 2019-20
- 109 in 2020-21

A further breakdown is provided in charts 1 and 2, and further information about the theme of concerns is provided in Table 1.

Many of the complaints we received from patients were included in our 'other' category. We received concerns about section 17 leave, and detention under the Mental Health Act. Most of the concerns we received from patient relatives, advocates and others were in relation to their relative's treatment and/or procedures undertaken.





Staff concerns

As a Prescribed Body defined in the Public Interest Disclosure Act, we have a responsibility to consider 'whistleblowing' concerns reported in the public interest by workers or former workers in the mental health and learning disability healthcare services we regulate and inspect. Concerns may be about incidents occurring in the past, present, or could happen in the near future.

Over the last three years we have seen an increase in the total number of concerns and complaints that we have received from staff or former staff about mental health or learning disability healthcare services:

- 31 in 2018-19
  - 2 in relation to NHS services
  - 29 in relation to independent services
- 33 in 2019-20
  - 10 in relation to NHS services
  - 23 in relation to independent services
- 42 in 2020-21
  - 15 in relation to NHS services
  - 27 in relation to independent services

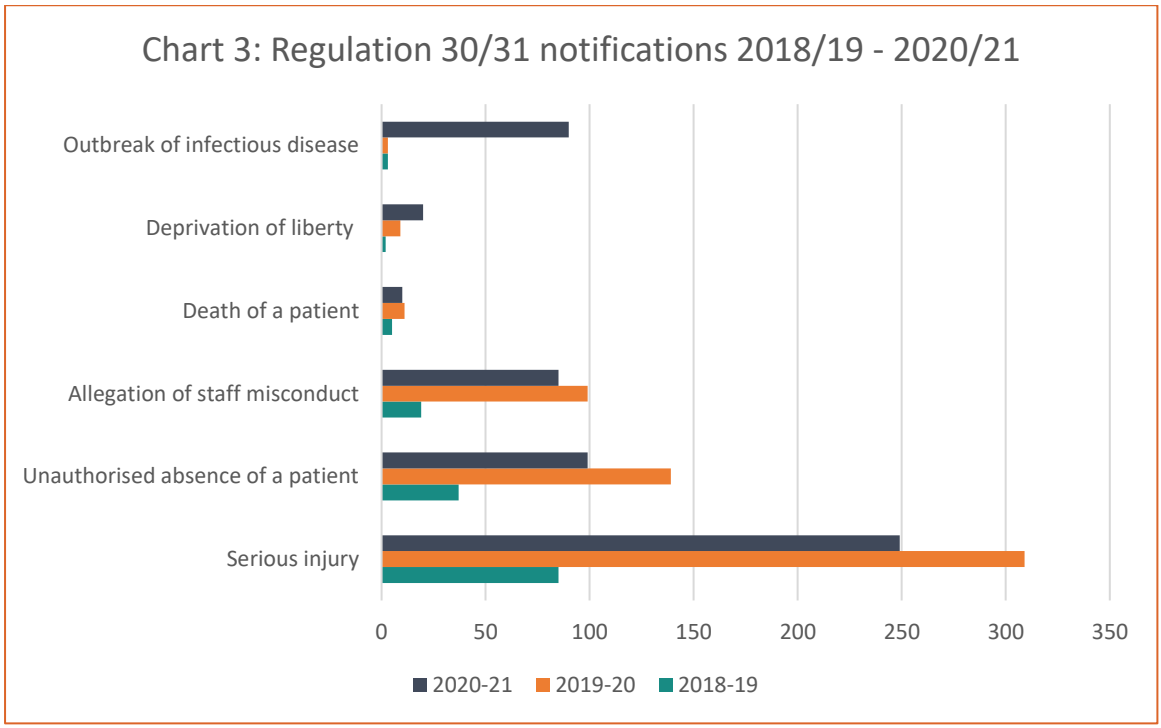
This year the majority of concerns received from existing or former staff were themed as being about infrastructure, facilities, the care environment, and staffing.

Reviewing Regulation 30 and 31 Notifications

Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person of an independent hospital, independent clinic, or independent medical agency to notify us about particular events that occur relating to patient safety. This is a legal requirement, and includes notification of:

- Death of a patient
- Unauthorised absence
- Serious injury
- Outbreak of infectious disease
- Alleged staff misconduct
- Deprivation of liberty

During the reporting period, we received 553 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was slightly less than the number of notifications we received in 2019-20. Notifications were themed as shown in Chart 3.



During 2020-21 we noted an increase in notifications about depravation of liberty, and a significant increase in notifications of an outbreak of an infectious disease. This was indicative of the Covid-19 pandemic impact within independent mental health and learning disability healthcare settings in Wales. We received fewer notifications about allegations of staff misconduct, unauthorised absence of a patient, and serious injury than in 2019-20.

In our report for last year we indicated that during that year we had worked with independent providers of mental health and learning disability care to ensure that we were correctly notified of all incidents in accordance with the Independent Health Care (Wales) Regulations 2011. As a result, significantly more reports of serious injury were received in 2019-20 than in the previous year and we commented that we had provided clarification on the definition of serious injury to ensure more accurate reporting. In 2020-21 we noted a slight reduction in the number of serious injury notifications when compared to 2019-20, and we will continue to monitor all such notifications throughout the course of the coming year.

In our 2019-20 report we also commented that increased allegations of staff misconduct were notable. We set out that this had coincided with a change in ways of working that resulted in local safeguarding teams providing us with information about safeguarding concerns and referrals. In 2020-21 we noted a slight decrease in the number of notifications we had received alleging staff misconduct. We continue to scrutinise all notifications and safeguarding referrals we receive and will continue to use this information to inform our actions in the coming year.

Inspecting mental health and learning disability healthcare services

We took the decision to temporarily pause our routine inspection and review activity during the pandemic. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of undertaking digitally enabled quality checks for most of our work in mental health and learning disability healthcare care settings. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the spread of COVID-19.

We undertook:

- 8 on-site inspection and focussed reviews:
    - 1 NHS setting
    - 7 independent healthcare settings

- 33 Quality Checks:
    - 18 NHS settings
    - 15 independent healthcare providers

Our on-site inspection and focussed review visits were all unannounced, often starting in the evening so that the inspection team could observe care and treatment provided at different times of the day. Two independent healthcare providers were visited more than once because of the nature of the concerns identified in those settings.

During our on-site inspections and focussed reviews we:

- Observed how staff interacted with patients, and asked patients about all aspects of their experience
- Looked at assessment, care and treatment plans, including records of restraints undertaken
- Reviewed policies, procedures and audit findings, including those related to infection prevention and control
- Considered the environment of care, and checked that it was appropriate to meet the needs of patients
- Reviewed administration of the Mental Health Act, and compliance with the Mental Health Code of Practice for Wales.

Our quality checks were announced in advance. We wrote to providers to request documents and written evidence for our inspector and, when required, a clinical peer reviewer, to assess before interviewing staff as part of the quality check process.

Through our quality checks we:

- Considered how services designed and managed the environment of care to maintain safety for patients, staff and visitors during the pandemic
- Checked how services responded to the challenges presented by the pandemic, including how well they managed and controlled the risk of infection
- Explored whether management arrangements ensured sufficient numbers of appropriately trained and supported staff to provide safe and effective care.

Throughout the pandemic we also worked with the National Collaborative Commissioning Unit, the body that commissions specialist services on behalf of health boards in Wales, to ensure that enhanced arrangements were in place to monitor patient and staff safety within independent mental health and learning disability healthcare settings. This included seeking assurance about business continuity arrangements and obtaining regular updates on key issues, including staffing levels, potential infections, and instances where patients needed to isolate from others to prevent transmission of COVID-19.

A list of the health boards and independent registered providers we visited or were subject to a quality check is included as Appendix A, along with links to the reports of findings.

Our findings

Our findings are drawn from a combination of the quality checks and the on-site focussed review and inspection visits we carried out during the year.

We know that the Covid-19 pandemic required rapid and unprecedented change in the way that healthcare services were delivered across Wales, and whilst many of the services we considered had coped well, we also heard that in some settings the pandemic had significantly impacted on the health and wellbeing of patients and staff.

Preventing and controlling the spread of COVID-19

We found that mental health and learning disability healthcare services had introduced infection prevention and control measures and had adapted the care environment to minimise the transmission risk of COVID-19. It was positive to learn that arrangements had been put in place in many settings to ensure that patients were regularly provided with information about the pandemic, and the need for enhanced infection prevention and control arrangements and other restrictions.

We learnt that individual wards were considered as household bubbles in line with national guidance, and changes had been implemented to increase social distancing between patients within the ward bubble. These included decluttering patient areas

and the introduction of clear signage reminding patients and staff about the need for social distance. Some settings had introduced changes including staggered meal times so that less people were present at the same time in dining rooms and other communal areas. However, through our inspection activity we also saw areas such as offices where social distancing was not always complied with, and where we saw this we brought this to the immediate attention of the service providers.

We found that there were good arrangements in place across all mental health and learning disability healthcare settings we checked to ensure staff had appropriate access to the required levels of personal protective equipment (PPE). During most of our inspection visits we observed the correct use of PPE, and that audits were being undertaken to monitor staff compliance with guidance and requirements. We highlighted to some providers the need to ensure that staff correctly wore face masks in accordance with the current guidance and requirements, and to ensure information to support the correct donning and doffing of PPE and good hand hygiene practice was displayed.

We found that most services had developed COVID-19 risk assessments, management plans and policies specifically to support and sustain the operational changes required to stop the spread of infection. However, we observed through our quality checks and inspection visits that some services had not updated their plans and policies to reflect the latest government and public health guidelines, and we made recommendations for individual services when we found this.

Sadly, and despite changes being implemented to help reduce the spread of COVID-19 we were notified throughout the pandemic of incidents of COVID-19 affecting patients and staff in independent mental health and learning disability healthcare settings, and we were aware of outbreaks of COVID-19 in NHS mental health and learning disability healthcare settings. We found, through our quality checks, that independent mental health and learning disability healthcare services had been able to access advice and guidance from experts in Public Health Wales when needed, and NHS mental health and learning disability healthcare services had been supported though health board infection, prevention and control teams.

Dignified and least restrictive care

Maintaining a positive patient experience during the pandemic has been challenging for some mental health and learning disability healthcare services. National and local restrictions have meant that patients were at times unable to have leave of absence (section 17 leave), or receive visits from family and friends.

We learnt that throughout the pandemic, patients in some settings were considered to be one household for the purposes of the coronavirus regulations. This approach was adopted to ensure that care was provided in the least restrictive way. Expecting people who are detained under the Mental Health Act 1983 to be confined to their own bedroom would have be overly restrictive and could have negatively impacted on the mental wellbeing and recovery of some patients.

We heard that the requirement for social distancing and wearing of personal protective equipment (PPE) had radically changed the way in which care was

provided during the pandemic. We found that there was a clear focus on the need for regular and effective communication with patients about guidance and restrictions, including local lockdowns and changes to leave arrangements. We learnt that hospital managers and clinical staff approached this in a variety of ways, which included the introduction of daily patient briefings in some settings, along with one to one meetings when required. We heard positive comments from patients during our inspection visits about their relationship and interactions with staff. During our visits we also observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

We were told that video calling could be used to enable patients to maintain contact with family and friends at times when visitors and leave of absence were not permitted because of the pandemic. However, during some of our inspection visits we noted poor Wi-Fi access in some facilities, and poor access to ward mobile phones. In addition, as patient access to personal phones and other electronic devices might be dependent on risk assessment or level of independence, we were concerned that some patients may have experienced digital exclusion, and contact with family and friends might have been inhibited as a result. We encouraged care providers to take steps to maximise Wi-Fi coverage in patient areas, and to ensure arrangements were in place to provide assistance when necessary to support and enable patients to maintain contact with family and friends.

It was positive to learn that when restrictions eased, and visiting was permitted, significant efforts had been made to enable this in a safe and supportive way. Some settings had invested in additional garden furniture or had identified dedicated space for visiting. Enhanced cleaning regimes and 'track and trace' arrangements had been introduced. We found that this was generally well managed, and the necessary risk assessments were in place to ensure that the safety of patients, visitors and staff was maintained.

We found that arrangements had also been introduced to enable patients to use telephone and video conferencing facilities to enable participation in consultations with members of the multi-disciplinary team, and to enable continued access to statutory advocacy and support services. We found that all of the settings we checked could demonstrate that patients' rights to have their detention reviewed by the Mental Health Review Tribunal for Wales were maintained during the pandemic.

Use of restraint

Mental health and learning disability healthcare settings are required to have systems in place to ensure all incidents of restraint are recorded in sufficient detail, reviewed and monitored to ensure safe and lawful practice.

During our inspection and review visits we were told about strategies for managing challenging behaviour to promote the safety and well-being of patients. We heard about preventative and de-escalation techniques, and were advised that physical restraint of patients was used as a last resort to prevent harm to the patient or others. We saw good evidence in some settings that showed each patient had an

individualised restraint reduction plan in place which identified the least restrictive options for risk management.

We reviewed restraint data and identified a setting with a high number of restraints and instances of prolonged restraint taking place. The data included the use of 'soft' restraint of patients being fed through use of a nasogastric (NG) tube so we required the provider to review the data and to provide us with more information about whether restraint was only used as a last resort, and was proportionate to the circumstances. We revisited the setting and spoke with patients, staff, and looked at documentation, policies and procedures regarding the practice of restraint which resulted in a non-compliance notice in regards to the Independent Health Care (Wales) Regulations 2011 being issued.

We also identified, through our onsite work, a setting where patients detained under the Mental Health Act had been placed in handcuffs to go to a general hospital. Use of handcuffs must always be proportionate and necessary in the circumstances, and use must at all times be compliant with the Mental Health Act Code of Practice for Wales. On further scrutiny of this practice we required the provider to review and update their policy documentation to support safe and least restrictive practices.

Use of seclusion

The use of seclusion should always be the final option in response to a patient's risk behaviours, and should only be utilised when other behaviour management strategies have been unsuccessful. The rights of patients must at all times be safeguarded, and the potential for use of seclusion must be identified through robust assessment and care planning processes, and decision making informed by evidence based policies and procedures.

In 1 of the 8 inspection visits we undertook we identified significant deficiencies in the seclusion care plans provided to our inspection team. We identified that a patient was being cared for in a seclusion suite on an empty ward. Staffing requirements were unclear and the patient's care plan did not contain sufficient detail to assure us that staff were able to care for the patient safely and effectively. We were concerned about the use of CCTV cameras to monitor the patient when undertaking personal care, and the absence of a documented rationale to support this practice. We considered these to be serious matters resulting in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Meaningful and therapeutic activities

Through our Quality Check work we were told by some mental health and learning disability healthcare providers that the pandemic had significantly impacted on the wellbeing of patients, and had sometimes resulted in increased incidents of behaviours that challenge.

Providing opportunity and encouraging people to engage in meaningful and therapeutic activities can help provide a structured day and can positively impact on wellbeing and recovery by reducing stress, frustration and boredom. It was positive therefore to find through our quality check work that significant efforts had been made to develop additional activities and new initiatives to enable patients to be engaged with activities during the pandemic.

We learnt that patients were able to access a range of activities, and had opportunity to engage in therapies, educational and recreational activities. These included gardening and use of the hospital grounds for walking, yoga and outside gym activities, access to indoor exercise equipment, and indoor golf. We learnt that some mental healthcare settings had established a shop within the hospital to enable patients to buy items at times when they were unable to access local shops because leave of absence was not possible.

We have in previous reports stressed the importance of meaningful social and recreational activities for patients in mental health and learning disability healthcare settings and would strongly encourage service providers to maintain this additional provision when services return to usual ways of operating after the pandemic.

Risk assessment and care planning

Comprehensive risk assessments and care plans are necessary to ensure safe, effective and person centred care. In previous years we have commented on the variability in quality and robustness of risk assessment and care and treatment planning documentation.

It was pleasing to see during our inspection visits examples of good practice, including evidence of multidisciplinary team (MDT) input into care planning processes. We saw examples where individualised risk assessments and care plans relating to COVID-19 arrangements had been put in place to support patients, and to promote understanding about the importance of social distancing, good hand hygiene, and the use of face masks.

However, we also saw examples of inadequate risk assessment and care plan documentation. These were in relation to a variety of matters including, wound care, self-harming behaviours, observation levels, seclusion, the use of CCTVs, restraint, and a failure in some cases to evidence and document unmet needs. We again saw that documentation in relation to medicines management needed to be improved.

During some of our visits concerns about care plans resulted in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Whilst we saw evidence during some of our inspection visits that care documentation and risk assessments had improved following a previous inspection of the setting, overall improvement is still needed. Service providers must ensure appropriate systems and oversight arrangements, including clinical audit, are in place to ensure that care documentation is always completed to the required standard.

Environment of care

We heard that significant efforts had been made in response to the pandemic to redesign some clinical areas. This included the creation of facilities for isolation of new patients on admission, and for existing patients when displaying symptoms of COVID-19 or returning from periods of leave. This was easier to achieve in settings with single bedroom and en-suite facilities, and was more challenging to achieve in other settings, particularly those services provided from old estate.

We found that arrangements had been put in place in many settings to enhance cleaning arrangements to reduce the spread of COVID-19. We reviewed evidence, such as cleaning schedules and audits that highlighted frequent cleaning of higher traffic areas, including door handles, handrails and chairs. However, this was not the case in all settings and we highlighted the need for improved cleaning, decluttering and routine maintenance in patient and staff areas during some of our inspection visits, including the need for adequate numbers of cleaning staff during weekends to ensure this.

Through our quality checks and inspection visits we checked whether environmental risk assessments had been undertaken and acted upon. As in previous years we identified the need for routine maintenance, redecoration and replacement of fixtures, fittings and furniture in some settings. During some of our inspection visits we saw damaged or unsuitable furniture in patient areas and inadequate storage arrangements for patient belongings and ward equipment. In some cases we saw that this was having a detrimental effect on safety, privacy and dignity.

We checked the arrangements for ligature point risk assessments, and we were concerned to find inconsistent practice in six of the 12 quality checks we completed in NHS mental health settings. We found examples where action had not been taken to reduce or remove identified ligature point risks, and risk assessments that were over 12 months old. We were told by some staff that remedial work had been delayed due to cost and a backlog of work for estates and maintenance teams to address. These issues were particularly concerning, and as a result we wrote to the Chief Executive of NHS Wales in March 2021 to raise our concerns and to ask that action be taken in this area.

Workforce

Many staff working in mental health and learning disability healthcare settings across Wales have worked under significant pressure throughout the pandemic. We heard through our conversations with managers and others that they were very proud and complimentary about their staff, and the work that had been accomplished during a difficult and challenging time. We were told about a range of positive interventions to help support the well-being and mental health of staff, including access to

occupational health and psychological support. We also heard about the value of peer support in helping staff to feel supported.

We found that the pandemic has prevented opportunities for face to face training. In addition, increased work pressures had led to reduced compliance with mandatory training in some settings, particularly during the early stages of the pandemic. Across Wales, we were told about an increased emphasis on e-learning, however, some essential training, such as safe de-escalation techniques, cannot be delivered as effectively remotely, and lack of training can pose significant risks to patients and staff. This will need urgent attention to address.

We learnt that, at times, staffing levels were only achieved through frequent and considerable use of temporary agency staff. We found that some settings were carrying a number of registered nurse and support worker vacancies, and in these settings staffing had been further compromised at times when permanent staff were absent from work because they had symptoms of coronavirus or were required to self-isolate. We identified that a number of NHS and independent service providers needed to take action to recruit permanent staff in order to maintain required staffing levels and skill mix to ensure safe and effective care. This is an area that needs urgent attention and focus in the coming months.

Monitoring the Mental Health Act, 1983 (the Act)

People who access mental health and learning disability services do so either as an informal patient or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the Mental Health Act 1983.

The Mental Health Act (hereafter referred to as 'the Act') is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The Act provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

As part of our statutory responsibilities we monitor how services discharge their powers and duties under the Act, and we provide the public with assurance about the quality, safety and effectiveness of mental healthcare services in Wales.

How the Act is monitored

HIW is one of a number of individuals and organisations with powers and responsibilities under the Act. These include officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained.

On behalf of Welsh Ministers, we:

- Publish an annual report detailing how the Act is being implemented in Wales
- Review how powers granted by the Act are exercised
- Operate the Second Opinion Appointed Doctor (SOAD) service
- Investigate complaints about application of the Act.

During 2020-21, and as part of the work we undertook to fulfil our role and responsibilities to monitor how mental healthcare services discharged their powers and duties under the Act, we:

- Talked to detained patients during our visits to mental healthcare settings
- Listened to the concerns of patients and family members who contacted us, and engaged with mental healthcare services to ensure concerns were investigated and action taken when required
- Spoke to hospital managers and other staff about matters that effected care and treatment provided to people detained under the Act
- Reviewed information and documentation to seek assurance that people were lawfully detained, well cared for, and were informed of their rights.

Mental Health Act Reviewers

During our visits to mental healthcare services we used Mental Health Act Reviewers to consider how the Act was being implemented and administered. They looked at relevant documents and checked if:

- The Mental Health Code of Practice 2016 was being implemented
- Legal papers for detention were appropriately completed and accessible
- All reasonable steps were taken to ensure that detained patients were given information about their rights in accordance with section 132 of the Act
- Policies and procedures reflected the requirements set out in the Mental Health Act Code of Practice 2016
- Effective care and treatment plans were in place, that reflected the patients detained status, and the requirements of the Mental Health (Wales) Measure 2010
- Patients had access to members of the multi-disciplinary team.

In each of our visits to mental healthcare settings we reviewed a sample of patient records and documentation relevant to a patient's detention.

Our Findings

Ensuring patient rights

Through our review of statutory detention documents we verified that the patients whose records we reviewed were legally detained. We saw evidence that detentions

had been renewed within the requirements of the Act, and that copies of legal detention papers were available.

We saw electronic documents on wards, and that paper records were stored securely in the Mental Health Act Administrator's office. The records we viewed were, in the main, well organised, easy to navigate and contained detailed and relevant information.

We saw entries in the patient records we reviewed which documented that the individual had been informed of their rights. We saw evidence of multidisciplinary team involvement in care plans, which reflected the domains of the Mental Health (Wales) Measure.

In most cases we saw evidence that appeals against detention were held within the required timescales. However, during one of our visits we were told that Hospital Manager Hearings had fallen behind during the COVID-19 pandemic, as the focus had been on ensuring that Mental Health Tribunals went ahead to review the patients appeal. We required the provider to address this.

During our inspection visits we checked that medication was provided to patients in accordance with section 58 of the Act, and that consent to treatment certificates were kept with the corresponding Medication Administration Record. We found that staff administering medication could refer to the certificate to ensure that the medication was prescribed in compliance with the consent to treatment provisions of the Act.

Generally we saw that section 17 leave forms were completed appropriately, risk assessed, and that there was evidence of patient involvement in this process. On the occasions when we identified that corrective action was necessary Mental Health Act Administrators agreed to do this. This included when we identified that a statutory consultee form was missing from the records being reviewed, a setting where we identified an error on the record of a patient no longer at the hospital, and the storage of section 17 and section 132 documentation.

Care and treatment planning

Generally we found that the patient records we reviewed were maintained to a good standard, were comprehensive and easy to navigate. We saw that recognised assessment tools were used to assess risk, and to monitor the mental and physical healthcare needs of the patient. We also saw evidence of multidisciplinary involvement in care plans which reflected the domains of the Mental Health (Wales) Measure 2010.

It was positive to see care documentation that was patient focussed and clearly demonstrated patient involvement in care discussions. However, we also saw care plans that lacked detail, did not adequately address identified risks, and did not include clear objectives and outcomes to support recovery. We noted in some instances that unmet needs were not always documented.

During some of our visits our concerns about care plans resulted in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Audit and governance arrangements

During our visits we reviewed the systems and processes that mental healthcare providers had in place to ensure oversight, monitoring and audit of their application of the Act.

In many settings we found there to be robust systems of audit in place for checking and managing statutory documentation. We found that some providers maintained oversight of the Act through clinical governance meetings. In some settings we noted that improvements had been made following our previous inspections. However, we were also advised that completion of improvement actions following audit process had been disrupted in some settings by the pandemic and the need for some staff to work from home. We recognised that the pandemic had presented new and varied challenges to mental healthcare services, however, service providers must take action to ensure improvements are completed in a timely manner.

Review Service Mental Health (RSMH)

We monitored how services discharged their powers and duties under the Mental Health Act 1983. We did this on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our Review Service Mental Health (RSMH) can investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The role of the Second Opinion Appointed Doctor (SOAD) is to safeguard the rights of patients who are detained under the Act and either do not consent, or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

The SOAD is an independent doctor, and assessment by a SOAD is always required to safeguard the rights of:

- Liable to be detained patients subject to Community Treatment Orders (CTOs) (section 17A) who either do not consent, or do not have capacity to consent to the proposed treatment

- Patients for whom serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (section 57) are proposed
- Detained patients of any age who do not consent or do not have capacity to consent to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder
- All patients under 18 years of age, including those who are not detained, for whom ECT is proposed

SOADs come to their own opinion about the degree and nature of an individual's mental disorder, and whether or not the patient has capacity to consent to the proposed treatment. The SOAD has responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

During the pandemic the SOAD service has continued to operate using an adapted 'COVID-19 safe' methodology. This meant that hospital visits were suspended, and a digitally enabled approach was put in place to ensure that SOADS were able to fulfil their statutory responsibilities, including having discussions with patients and staff. Full details of the temporary methodology can be viewed on the Review Service for Mental Health (RSMH) pages of the healthcare Inspectorate Wales website.

SOAD activity

During the period April 2020 to March 2021, our Review Service Mental Health (RSMH) received:

- 756 requests for an assessment by a SOAD:
  - 693 were related to the certification of medication
  - 43 were related to the certification of ECT
  - 20 were related to both medication and ECT

Fewer requests were received in 2020-21 than in the previous 6 years. The reasons for this are unclear. Information about the number of requests per year since establishment of the SOAD service within HIW in 2006 is provided in Table 2.

Table 2: Requests for visits by a SOAD, 2006-07 to 2020-21

Year	Medication	ECT	Medication & ECT	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
2019-20	877	51	26	954
2020-21	693	43	20	756

Source: SOAD requests to HIW

Timely SOAD assessment

It is important that the SOAD assessment is completed in a timely way, and once a request has been received the RSMH aim to ensure that the SOAD undertakes the assessment as soon as possible, and within:

- 2 working days for a referral in relation to ECT
- 5 working days for referrals about prescribed medication when the patient is in hospital
- 10 working days when the referral is in relation to someone subject to a Community Treatment Order.

In our report last year we indicated that when SOAD assessments took longer to complete this was most often linked to the need to request further information or for consultations or interviews to be arranged, and included:

- The availability of the Responsible Clinician or Statutory Consultees to be consulted by the SOAD
- Absence of documentation detailing interview with the patient
- The availability of the patient, or it was not clear whether the patient wished to be interviewed by the SOAD

We have found that implementation of the COVID-19 safe methodology has enabled the SOAD easier access to consult with the Responsible Clinician and Statutory Consultees. This, in combination with the requirement for all relevant

documentation to be provided to the SOAD in advance of the consultations, has resulted in an improvement in the time taken to complete the assessment process.

Throughout the pandemic we have continued to work with the Mental Health Act Administrators in local health boards and independent mental healthcare settings to ensure that the SOAD referral and assessment process was completed in a timely way. We intend to keep elements of the COVID-19 safe methodology to maintain the improvements in the referral and assessment timescales seen during the reporting period. This will include:

- Offering the option of telephone or video conference consultations with the Responsible Clinician and Statutory Consultees, and Maintaining the requirement for health boards and independent mental health hospitals to provide information for the SOAD in advance.

Review of treatment (Section 61)

When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.

Our lead SOAD audited the reports on a monthly basis to ensure that appropriate safeguards were in place to protect the patient's rights. Although we have continued to identify areas for improvement, overall we have noted continued improvement in the quality of the documentation. We will continue with our audit programme in the coming year and will continue to work with mental healthcare service providers to make improvements.

Our Data

To prepare this report we analysed data from our work between April 2020 and March 2021, including our Mental Health Act monitoring activities, quality checks, and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Feedback on this report

If you have any comments or queries regarding this publication please contact us

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Appendix A: Relevant work 2020-2021

	Hospital	Link	Date	Type
1	Ty Grosvenor, Wrexham	English	29/06/2020	Focussed review
2	Heddfan Unit, Wrexham Maelor Hospital	English	07/07/2020	Focussed review
3	Delfryn House and Lodge, Mold	English	10/08/2020	Quality check
4	Gellinudd Recovery Centre, Pontadawe	English	11/08/2020	Quality check
5	Ty Gwyn Hall, Abergavenny	English	12/08/2020	Quality check
6	Cefn Carnau Uchaf, Caerphilly	English	12/08/2020	Quality check
7	Coed Du Hall, Mold	English	12/08/2020	Quality check
8	St Teilo house, Rhymney	English	13/08/2020	Quality check
9	St David's Independent Hospital, Corwen	English	13/08/2020	Quality check
10	Newton Ward, Caswell Clinic, Glanrhyd hospital	English	25/08/2020	Quality check
11	Angelton Clinic, Glanrhyd Hospital	English	03/09/2020	Quality check

12	Heatherwood Court, Pontypridd	English	08/09/2020	Quality check
13	Ty Llidiard, Bridgend	English	09/09/2020	Quality check
14	Careg fawr Unit, Bryn Y Neuadd Hospital	English	29/09/2020	Quality check
15	Tawe Ward, Ystradgynlais hospital	English	30/09/2020	Quality check
16	Ty Grosvenor, Wrexham	English	04/10/2020	Focussed review
17	Bryngolau Ward, Prince Phillip Hospital	English	06/10/2020	Quality check
18	Adferiad Ward, St Cadoc's hospital	English	07/10/2020	Quality check
19	New Hall hospital, Wrexham	English	21/10/2020	Quality check
20	Priory Church Village, Pontypridd	English	10/11/2020	Quality check
21	Aderyn, Pontypool	English	16/11/2020	Quality check
22	Cefn Yr Afon, Bridgend	English	18/11/2020	Quality check
23	Ablett Unit, Ysbyty Glan Clwyd	English	20/11/2020	Quality check

24	Aberbeeg Hospital, Abertillery,	English	25/11/2020	Quality check
25	Ty Skirrid Ward, Maindiff Court Hospital	English	25/11/2020	Quality check
26	Rushcliffe Independent Hospital, Port Talbot	English	27/11/2020	Quality check
27	Ty Catrin Cardiff	English	30/11/2020	Inspection
28	Ty Lafant Assessment and Treatment Unit, Llanfrechfa Grange Hospital	English	01/12/2020	Quality check
29	Hillview Regis Ebbw Vale	English	17/01/2021	Focussed review
30	Pinetree Court, Cardiff	English	18/01/2021	Quality check
31	Llanarth Court, Abergavenny,	English	25/01/2021	Inspection
32	Ty Cwm Rhondda, Ystrad, Pentre	English	27/01/2021	Quality check
33	Hillview Regis, Ebbw Vale	English	23/02/2021	Focussed review
34	Enlli Ward, Bronglais Hospital	English	02/03/2021	Quality check
35	Morlais Ward, Glangwili Hospital	English	04/03/2021	Quality check

36	East 12, University Hospital Llandough,	English	10/03/2021	Quality check
37	Coed Celyn Hospital, Wrexham	English	17/03/2021	Quality check
38	Hazel Ward, Hafan y Coed	English	18/03/2021	Quality check
39	Delfryn Lodge, Mold	English	22/03/2021	Inspection
40	Clywedog ward, Llandrindod Wells Hospital	English	23/03/2021	Quality check
41	Hergest Unit, Ysbyty Gwynedd	English	30/03/2021	Quality check

Appendix B: 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
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety

Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
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.
Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
National Collaborative Commissioning Unit	The National Collaborative Commissioning Unit (NCCU), hosted by Cwm Taf Morgannwg University Local Health Board is the collaborative commissioning service of NHS Wales.
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.
Prescribed body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
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 a 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 (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.

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To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

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