Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2023-24

This report is also available in Welsh. If you would like a copy in an alternative language or format, please contact us.

Copies of all reports, when published, are available on our website or by contacting us:

In writing:

Healthcare Inspectorate Wales
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via:

Phone: 0300 062 8163

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

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

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people.

Our values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective – we are reasoned, fair and evidence driven.

Decisive – we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive – we value and encourage equality and diversity through our work.

Proportionate – we are agile and we carry out our work where it matters most.

Our goal

To be a trusted voice which influences and drives improvement in healthcare.

Our priorities

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.

We will adapt our approach to ensure we are responsive to emerging risks to patient safety.

We will work collaboratively to drive system and service improvement within healthcare.

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

1. Executive Summary

This report sets out the activity and findings for mental health and learning disability services during the period April 2023 to March 2024.

The report provides an insight into the challenges faced by mental health and learning disability services including community services. However, in spite of these challenges, there are many positive findings and it is clear that the workforce is appreciated by patients and others, in their endeavour to continue to deliver care and treatment in a changing landscape.

We continue, in the majority of our inspections, to receive feedback from patients who are complimentary about the care provided and about their interactions with staff. HIW staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many examples of good practice within the monitoring and implementation of the Mental Health Act (MHA) including documentation which was well organised, easy to navigate and securely stored, and MHA administrators demonstrating good governance and oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful. On our inspections, there was good evidence that patients were aware of their rights, and this was well recorded. There had also been improvements with patient observations, with very few issues being identified within our individual reports.

However, as mentioned above some areas continue to cause concern for us, particularly where there has been little or no improvement since our previous report. Workforce challenges in relation to recruitment and retention of staff was a finding in a significant number of inspections and there were vacancies across a wide range of disciplines. Medicines management also continues to be a theme, and the specific issues identified are discussed within section 5 of this report.

Risk assessments and care planning also continue to be a significant finding in our inspections and one very worrying example was of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan which had only been partially completed.

In two of our inspections this year, we identified issues with the seclusion of patients and the provision of meaningful and therapeutic activities. The environment of care provision was also concerning and in a number of our visits, we identified patient and staff safety issues. In one example, patient call bells were not easily accessible which meant that patients who required assistance were not easily able to summon staff.

We have also detailed, within this report, specific findings in relation to our learning disability and Children & Adolescent Mental Health Services (CAMHS) inspections.

We also identified, in some of our inspections, a lack of a robust system of audit and governance in our mental health and learning disability inspections. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider.

In seven of our visits, we identified very serious issues which led us to issue immediate assurance letters for health boards, or non-compliance notices for independent providers. The health board/independent provider responds to these letters or notices with an immediate improvement plan that HIW must agree. We made use of these processes following three health board inspections and four inspections of independent providers.

Chapter 6 of this report identifies the process and areas we focus on to be assured that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues
- Older persons
- Learning Disabilities
- CAMHS

Within the total of 26 we jointly visited one Community Learning Disability Team (CLDT) with Care Inspectorate Wales (CIW). We also undertook one visit to a Community Mental Health Team (CMHT). Our findings are drawn from these inspections.

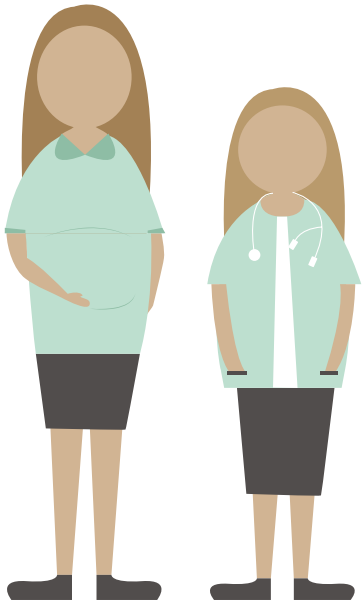
Overall, there were 199 complaints and concerns about mental health and learning disability healthcare services. This is an increase on the previous year from 164.

In addition, during the period April 2023 to March 2024, the Review Service for Mental Health (RSMH) received 733 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

665	requests related to the certification of medication
44	requests related to the certification of ECT
24	requests related to medication and ECT.

In conclusion, whilst we continue to identify areas of good practice the issues identified within this report are concerning and health boards and independent providers of healthcare need to improve upon their audit and governance processes to ensure that the areas identified are addressed.



2. Context

Throughout 2023-24 mental health and learning disability hospitals and community services faced many challenges in delivering services. Workforce challenges in the recruitment and retention of appropriately skilled, knowledgeable and trained staff in key disciplines continue to have a detrimental impact on the ability of health boards and independent providers to meet the needs of increasing numbers of patients who require care and treatment.

Patients continue to experience a lack of mental health support in a timely manner and when they are admitted to in-patient wards these are very busy places with extreme pressure on beds. Patients do not always have sufficient time with staff due to staffing pressures as outlined above.

In addition, in September 2023 we published the Improvement Plan – review of discharge arrangements for adult patients from inpatient health services in Cwm Taf Morgannwg University Health Board (CTMUHB). This followed the report itself which was published in March 2023 and contained a significant number of recommendations for the health board.

We continue to monitor the implementation of some key pieces of guidance and the Mental Health Act 1983 Code of Practice for Wales (revised 2016) and the Code of practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. The Mental Health Act 1983 Code of Practice for Wales is a key document to ensure patients' rights are promoted and protected. The Code provides a support framework that helps to ensure the delivery of care is evidenced-based and promotes effective care and treatment with the detained person at the centre of the decision-making process.

The SOAD service remains a hybrid model with a mixture of remote and face to face contact with patients who require a second medical opinion under the Act. However, our preference is for patients to be seen face to face but sometimes this is not possible. When a request for a SOAD is made there is still the requirement for health boards and independent providers to send key documentation to us to enable the SOAD to have access to key information in relation to the history and treatment for the patient.

We continue to work with a number of stakeholders for mental health and these stakeholders are listed within section 3 of this report. Following the end of Welsh Government's Together for Mental Health Delivery Plan in 2022, a new mental health strategy is expected from the Welsh Government to be in 2024.

3. Our role in mental health and learning disability care

HIW has a number of key roles within healthcare in Wales which are outlined below:

- we inspect all NHS mental health and learning disability services
- we are the regulator and inspectorate of all independent mental health and learning disability healthcare services
- we work with a number of key stakeholders
- we have a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers
- we provide a SOAD service
- we monitor parts 2 and 4 of the Mental Health (Wales) Measure 2010
- we monitor the implementation of the Deprivation of Liberty Safeguards (DoLS).

Inspection and regulation

NHS and Independent Healthcare

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduced a duty of quality. The Act places an overarching duty of quality on the Welsh Ministers regarding their health-related functions. The purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. Furthermore, HIW, on behalf of Welsh Ministers, considers the Health and Care Quality Standards when conducting reviews of, and investigation into, the provision of health care by and for NHS bodies under section 70 of the Health and Social Care (Community Health and Standards) Act 2003.

HIW is the registering body for all independent healthcare providers in Wales. We register, inspect, consider intelligence on complaints and concerns and enforce in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the 25 National Minimum Standards for Independent Health Care Services in Wales.

We made use of a combination of routine unannounced on-site hospital and focused inspections during 2023-24. The findings from these inspections are summarised in section 5 of this report. In addition, 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

The Welsh Ministers have a duty to monitor how services discharge their powers and duties in relation to the Mental Health Act (MHA) 1983. This duty is undertaken by HIW on their behalf. We have a number of knowledgeable and experienced MHA reviewers who form part of the on-site inspection team. These reviewers monitor how the health boards and independent providers discharge their duties under the Act. Our MHA reviewers examine detention paperwork to ensure legal compliance and consult with the MHA administrators employed by Health Boards and independent providers, to gain an insight into how the Act is administered and the governance processes in place. We also have a specific role in relation to the investigation of complaints, specifically in regard to legal detention and compliance with the MHA and the associated Code of Practice. During our inspections we routinely review a number of key areas as outlined below:

MHA detention paperwork ensures patients are lawfully detained and well cared for.

The legal status of patients is appropriately recorded on documentation including on individual drug administration records.

Consent to treatment forms are completed in a timely manner.

patients are given respect for their qualities, abilities, and diverse backgrounds as individuals, and that their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds are taken into account.

Section 17 leave documentation contains conditions and outcomes and is routinely utilised when appropriate and to assist patients in their care/rehabilitation pathway.

The MHA Code of Practice for Wales (Revised 2016), that has been prepared and issued under section 118 of the MHA 1983 is being followed.

Detailed plans are made for patients before they are discharged from hospital and consider key area such as relapse indicators.

In general, the findings from our inspections of the processes and application of the MHA were positive, however, we did find a number of areas for improvement. Our findings for the period April 2023 to March 2024 are summarised in section 6 of this report.

Review Service for Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the MHA, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.

A review of treatment under Section 61 of the MHA. 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.

The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2023 and March 2024 is provided in section 7 of this report.

Monitoring the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 consists of four 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.

During our inspections we routinely focus on individual patients' care and treatment plans and the areas as set out within section 18 of the Measure, namely:

- finance and money
- accommodation
- personal care and physical wellbeing
- education and training
- work and occupation
- parenting or caring relationships
- social, cultural or spiritual
- medical and other forms of treatment including psychological interventions ensure it for patients.

We also consider the role of the Care Coordinator and their level of engagement with the patients. Within section 5 of this report, we have detailed our findings on risk assessment and care planning where we consider various aspects of the Measure. We also consider the role and access for patients to advocacy services.

Monitoring use of the Deprivation of Liberty Safeguards

Each year, we jointly publish, with CIW, an annual report on the use of the Deprivation of Liberty Safeguards (DoLS). DoLS is a part of the Mental Capacity Act 2005. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024, but this did not happen and there is no revised date for its implementation. DoLS can be used when detention under the Mental Health Act 1983 is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM comprises of organisations from the four nations that make -up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), and His Majesty's Inspectorate of Constabulary in Scotland. Other members that HIW undertakes joint work with include, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

We attend NPM business meetings and HIW's representative is a member of the steering committee.

Youth Justice Services

In January and February 2024, HIW joined His Majesty's Inspectorate of Probation (HMI Probation) on the joint inspection of Conwy & Denbighshire Youth Justice Services (YJS). Key areas identified for improvement were for Betsi Cadwaladr University Health Board (BCUHB). Other inspectorates that participated in the joint inspection include, CIW, Estyn and HMICFRS. HIW's specific remit was to consider the services received by the YJS from a healthcare perspective. Key members of staff employed by the health board were interviewed as part of this process.

The improvements included for BCUHB to provide a designated number of hours of a CAMHS nurse and other CAMHS specialists available to the YJS. Clear delays were identified in young people having access to timely and an appropriate level of CAMHS support. In addition, there was lack of timely access to Speech and Language Therapy (SALT) services and the health board needed to undertake a governance and quality review of the support required for the YJS.

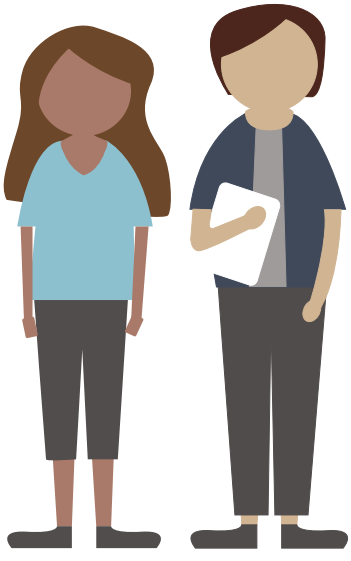
Prison Healthcare

In February 2024, HIW undertook a joint inspection of HMP Cardiff with HMI Prisons and other inspectorates including Estyn. The focus of these visits, from an HIW perspective, is to support the inspection of health services from a Welsh perspective. Generally, health services had improved since the last inspection, with 41% of prisoners telling the inspection team that the quality of the service was now good. In addition, services for prisoners with mental health problems had improved, with better access and a wider range of therapies than at the previous inspection. However, a number of key areas for improvement were identified as outlined below;

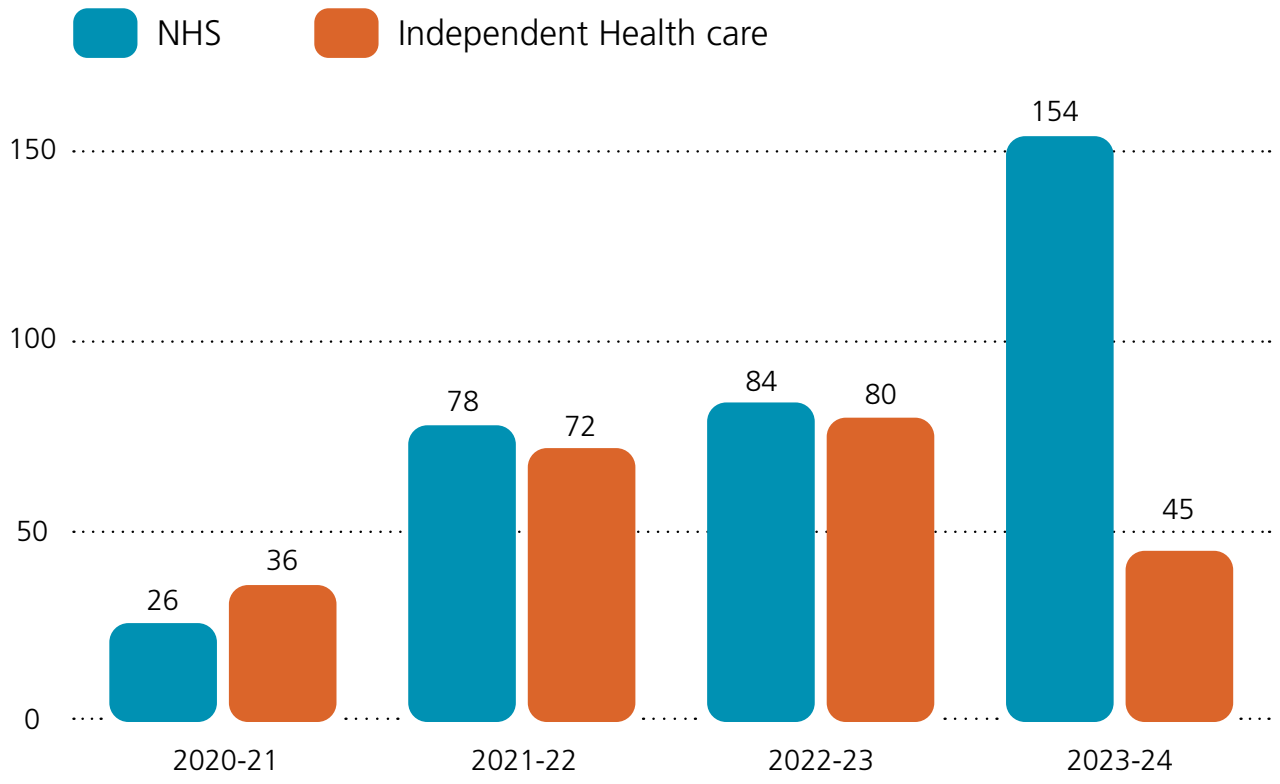
- There was inadequate oversight and planning of care for patients with long term conditions.
- Dental waits for urgent and emergency care were too long.
- Some pharmacy practices were not in line with good practice such as the management and use of stock medicines, secondary dispensing, and the lack of restrictions to drug storage areas.

Dementia Partners National Steering Group.

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). Within this group good practice initiatives are shared and the positive outcome for patients with a dementia and their significant others are identified. The health boards provide regional updates, within the group.



Number of patients contacting HIW with concerns and complaints about mental health care



4. Listening to concerns

During the period 1 April 2023 – 31 March 2024 we received:

614 complaints and concerns about healthcare providers in Wales, this is a reduction of 45

199 of these were about mental health and learning disability healthcare services. This is an increase on the previous year from 164

154 were in relation to NHS mental health and learning disability services and increase of 70

45 were in relation to independent mental health and learning disability services and this represents a decrease of 35.

The table below for 2023/24 shows a breakdown of concerns and complaints by their subject

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	12	2
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	15	3
Communication	9	2
Complaints Management	5	3
Consent & Confidentiality	5	0
Infrastructure (including staff facilities, environment)	19	11
Medication Management	16	4
Mental Health Act	12	4
Other	9	3
Records Management	13	0
Safeguarding	8	7
Self-harming Behaviour	5	3
Treatment/Procedure	16	2
Whistleblowing	6	5
Total	**150**	**49**

The highest number of concerns and complaints for the NHS was in relation to:

- Infrastructure (including staff facilities and the, environment). This concurs with our inspection findings in section 5 where infrastructure was identified in a considerable number of our on-site inspections.
- Medication management was also a key finding in our inspections and a range of issues were identified and these again can be located within section 5 of this report Treatment was also amongst the top concerns and again we have a considerable number of findings detailed within this report.
- The highest category of concerns and complaints for the Independent Healthcare providers was in relation to Infrastructure (including staff facilities and the environment). This demonstrates that both the NHS and independent providers of healthcare are having similar issues that can impact on patient care.

- Patients complain when there is a poor level of communication about their care and treatment pathway. Whilst it is acknowledged that there were only 11 concerns and complaints in relation to communication, elements of inadequate communication was also a theme in many of the other areas identified above.

Staff concerns

Whistleblowing is different to making a complaint or a grievance. A 'whistleblower' is somebody who makes a 'qualifying disclosure' about a concern at work. HIW is a 'prescribed body' under whistleblowing laws. This means that a whistleblower can make a 'qualifying disclosure' to us and will have certain employment protections under the Employment Rights Act 1996, which was amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA protects the public interest by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern, whether it is a concern about patient safety, safeguarding, financial malpractice, danger, illegality, or other wrongdoing.

Additional information in relation to whistleblowing can be found at **www.hiw.org.uk**.

This year we have seen a significant decrease (as outlined below) in the number of whistleblowers raising concerns with HIW compared to previous years It is difficult to explain this trend but maybe one explanation is that the health boards and independent providers have in place more effective whistleblowing procedures that has resulted in whistleblowers not contacting HIW because their whistleblowing concerns have adequately been addressed within the health boards and independent providers.

- 42 in 2020-21
- 15 in relation to NHS services
- 27 in relation to independent services
- 28 in 2021-22
- 10 in relation to NHS services
- 18 in relation to independent services
- 28 in 2022-23
- 18 in relation to NHS services
- 20 in relation to independent services
- 11 in 2023-24
- 6 in relation to NHS services
- 5 in relation to independent services.

Regulation 30 and 31 Notifications

The table below reflects the number of Regulation 30 and 31 notifications received between 1 April 2023 – 31 March 2024.
The registered person of an independent hospital, independent clinic, or independent medical agency is required by Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 to notify us of specific patient safety-related events.

This is required by law and includes:

- Death of a patient.
- Unauthorised absence of a patient who is detained or liable to be detained under the Mental Health Act 1983.
- Serious injury.
- Outbreak of an infectious disease.
- Alleged staff misconduct.
- Any request to a supervisory body, by the registered person, for a standard authorisation of a Deprivation of Liberty.

During the reporting period, we received 821 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was 81 less than the notifications received in 2022-23. The classification of the notifications were themed as shown in chart below.

Table of notification type for Regulation 30/31s

Notification Type	Total
Death of a Patient	9
Unauthorised Absence	140
Serious Injury	462
Outbreak of an Infectious Disease	22
Allegation of Staff Misconduct	161
Deprivation of Liberty	27
Total	**821**

There was a decrease in the number of serious injuries reported to us from the previous year, however, there was an increase from 100 to 140 of unauthorised absence notifications, for patients detained under the MHA, when compared to the previous year. We continue to identify an increase in the numbers of patients self-harming and this illustrates the level of complexity and acuity of patients accommodated within the independent sector. The range of issues identified within this report, such as a lack of staff, poor risk management plans and care and treatment plans as well as issues with patient observation may be contributory factors in relation to serious injury. HIW has increased communication with the independent sector around the completion of these notifications and there has been increased engagement from providers.

5. Inspecting mental health and learning disability healthcare services

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- CAMHS.

Within the total of 26 we visited one CMHT and jointly visited one CLDT with CIW.

During our onsite inspections we:

- Spoke with a number of patients and visitors to ascertain their thoughts on the quality of care and treatment provided.
- Spoke with a range of staff from multi-disciplinary teams to ascertain their thoughts on the effectiveness of their roles and how any challenges were overcome.
- Examined a range of care documentation, including risk assessments and how part 2 of the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the role of the Care Coordinators and other members of the multi-disciplinary team.
- We also examined a range of other patient documentation including, observational records, any records of restraints, and records of any seclusion undertaken.
- Considered if there was an effective discharge pathway in place and the arrangements put in place to ensure there was a crises management plan considered as part of the discharge process.
- Examined audit findings and governance processes.
- Considered the appropriateness of the environments of care, and ensured that risks had been identified and appropriate action taken to mitigate against those risks.
- Reviewed administration of the Mental Health Act and compliance with the Mental Health Code of Practice for Wales (2016).

A list of the health boards and independent registered providers we inspected is included as Appendix A, along with links to the reports of findings.

Our findings

Within this section our findings are broken down into three specific areas:

Findings specific to mental health, including older and younger persons and the CMHTs.

Findings specific to Learning Disabilities.

Findings specific to CAMHS.

The detailed findings are drawn from our reports following our onsite inspections carried out in 2023-24. Where HIW identifies significant issues we send immediate assurance letters for health boards, and non-compliance notices for the independent providers. These letters or notices are sent within two days of the inspections being undertaken. The health board/ independent provider responds to these with an immediate improvement plan that HIW must agree. We issued a total of seven letters or notices between the period 1 April 2023 and the 31 March 2024. This comprised of three for health boards and four for the independent providers.

Findings specific to mental health, including older and younger persons and the CMHTs

A positive finding in the vast majority of our inspections was the feedback from patients who were complimentary about the care provided and about their interactions with staff. Our staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many areas of good practice with the monitoring and implementation of the Mental Health Act (MHA) and these will be further explored within section 6 of this report.

Least restrictive care

This part of the report covers three distinct areas, restraint, seclusion and segregation. During our inspections we were not assured that the least form of restrictive practice was always being utilised and our findings are identified within the sections below.

Use of restraint

The MHA 1983 - Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. Section 26.7 states that "when making decisions about any interventions undertaken during the management of a patient's care and treatment, the principles set out in Chapter 1 of the Code must be taken into consideration. Decisions about interventions should be discussed and agreed with the patient as far as possible. Interventions may include prevention, observation, restraint and/or seclusion".

The guiding principles of the Code are:

- Dignity and respect.
- Least restrictive option and maximising independence.
- Fairness, equality and equity.
- Empowerment and involvement.
- Keeping people safe.
- Effectiveness and efficiency.

Restraint covers a number of key areas including, whether it is physical, chemical, environmental, or mechanical. Any form of restraint should always be a last resort when all other interventions have failed, a risk assessment and a comprehensive care and treatment plan must be in place for all incidents of restraint. Risk assessments must consider all triggers and alternative strategies to a restraint being undertaken.

In terms of mechanical restraint, the Code stipulates that HIW must be consulted if this is being considered. The use of mechanical restraint in hospitals is very rare but in the event it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patients' extreme challenging behaviour, whether that is violence directed at others or self-injury. This form of restraint, as with all restraints, must be regularly reviewed and be in place for the shortest possible period of time.

Any restraints undertaken must follow national guidelines and local policies and procedures and this area is considered within our inspection process. The Welsh Government published **guidance** (October 2022) on a framework for reducing restrictive practices in childcare, education, health and social care settings is a key document that covers the use of physical, chemical, environmental and mechanical restraint.

This guidance is considered within our inspection process.

In six of our inspections, we found issues with restraint, these issues included staff undertaking restraint who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training. Staff who have not received training in restraint pose a significant risk to patients and fellow staff and they should not be used in restraint until they have received the necessary training.

In addition, 'Use of Restrictive Physical Intervention' policies had not been reviewed in two of our inspections and were out of date. Also, on two inspections, we found that restraint incidents were not correctly recorded or could not be filtered to produce specific restraint data. Therefore, as a result, accurate restraint data was not available. and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents. We were not, therefore, assured that patients and staff were being fully protected from harm within these hospitals.

One patient record reviewed contained no descriptive details on what positions the patient and staff were in when utilising a safehold. In addition, there was nothing recorded for post intervention observations after the patient had received intramuscular medication.

Use of seclusion

The MHA1983, Code of Practice for Wales 2016, has a section dedicated to the use of seclusion. Seclusion is described within the Code as "the supervised confinement of a patient in a room which may be locked". It is interesting to note that the Code uses the term "may be locked", implying that it is possible for a patient to be secluded within a room behind a door that is closed but not locked. The Code also sets out timeframes for when continued seclusion should be reviewed, these are, "every two hours by two nurses" and "every four hours by a doctor, or a suitably qualified approved clinician". The Code also states that seclusion is used as a last resort and for the shortest possible time. Policies and procedures must be in place for the use of seclusion and should reflect the National Institute for Health and Care Excellence (NICE) and other guidelines.

In two of our inspections, we identified issues with seclusion including, a patient being secluded in a separate area of the ward. We looked at the arrangements in place to manage this patient and identified a number of concerns:

- The area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area.
- The separate toilet facility being used by the patient had not been adapted for high risk patients.
- We were concerned that the patient was not having access to regular periods of fresh air.
- There was no seclusion care plan in place for the patient which contravened the health board policy.
- We were informed that there were not enough resources available for patients in seclusion to participate in activities.

In another inspection, the policy on seclusion had not been reviewed within the identified timescales and was out of date.

Meaningful and therapeutic activities

Activities play an important part in the treatment process, and during our inspections we routinely review this area to ensure a range of meaningful and therapeutic activities are available. There is an abundance of published research that confirms

the importance of meaningful therapeutic, social and recreational activity and the positive impact this has on patient wellbeing and their recovery pathway.

In many of our inspections we found examples of appropriate and meaningful therapeutic activities available for the patients. However, in six of our inspections we found a range of issues including no evidence of a dedicated therapeutic patient activity programmes on wards, and no dedicated staff available to support and supervise off-ward patient activities. In one inspection we found that the gym equipment and exercise machines in the activities room were cordoned off with signs forbidding their use. Other issues identified included little evidence that the activities on offer were being delivered in the hospital nor recorded prominently within patient records, and a lack of funding for patient occupational activities and equipment. There were also issues with the outside spaces and their utilisation to provide additional therapeutic activities for patients.

We continued to identify issues with section 17 leave under the Mental Health Act, but these will be addressed within section 6, Monitoring the Mental Health Act, of this report.

Medication Management

Again, this year we continued to identify issues with the safe and effective administration, storage and ordering of medication. This area continues to be a recurring theme in the majority of our inspections. Out of 19 hospitals and one CMHT we identified issues with medicines management in 16 hospitals and the one CMHT. This is a reoccurring theme in our inspections and it is increasingly disappointing to note that there has been no improvement on this area since our last annual report. Issues identified covered many different aspects of medicines management with the most significant being:

- The Mental Health Act legal status section of the Medicine Administration Record (MAR) was consistently left blank.
- A lack of Consent to Treatments forms attached to MAR charts and a lack of regular reviews.
- Limited pharmacy input and audit activity undertaken.
- A lack of governance of medicines management.
- Medication trolleys were not locked and secure when not in use.
- Unused medical equipment including wound care equipment and syringes had been removed from their original boxes/containers and placed in plastic baskets that prevented the expiry date of each item being viewed.
- Multiply missing signatures on the MAR charts.
- Out of date controlled drugs in the controlled drugs cabinet.
- Medication policies out of date and a lack of staff access to policies.

The issues listed above are only examples of the issues identified within our visits; many more were identified. The range of findings do not demonstrate effective oversight, audit and governance of medicines management for both health boards and independent providers.

Risk assessment and care planning

Out of 19 hospitals and one CMHT we identified issues in 16 of the 20. A robust risk management process and a clear and accurate care planning process is key to ensure patients' care and treatment needs are identified and any risks identified and a strategy in place to address these risks. In terms of care and treatment plans, HIW has a specific responsibility in monitoring part 2 of

the Mental Health (Wales) Measure 2010. Part 2 of the Measure requires all patients receiving secondary mental health care to have a care and treatment plan in place. Care and treatment plans) should be comprehensive, holistic, and patient focused.

The role of the Care Coordinator is outlined within the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

In chapter 3 of the Code of Practice the responsibilities of the care coordinator is set out for the following areas:

- working collaboratively with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
- ensuring that a care and treatment plan is developed and written;
- ensuring care and treatment plans are reviewed and revised;
- providing advice to service providers on the effective coordination of the care which is delivered;
- keeping in touch with the relevant patient. The are coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

As identified above, care coordinators are key individuals, and their input is central to assisting the patient with their journey through secondary mental health services. This is another area that is assessed within our inspections.

During our inspections we also interview patients and staff to get an understanding of the effectiveness of the care and treatment plans. It was good to note some good practice examples for the care and treatment plans and risk assessments we considered as part of the inspection process. Some examples of good practice identified included, seeing evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, helping to support hospitals in being able to deliver comprehensive care to the patients. In addition, we found examples of well-organised records completed, which were easy to navigate through clearly marked sections. Information was being captured comprehensively within the records and they were appropriately and securely stored. We also found examples of patients being involved in the planning and provision of their own care, as far as possible, and where patients were unable to make decisions for themselves, we saw evidence that relatives were consulted. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- We saw an example of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan and that had only been partially completed.
- We were not assured that appropriate arrangements were in place to meet the physical health care needs of patients.
- We were not assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010.
- We did not find evidence within patient records that patients were being supported to meet their individual dietary needs.
- In one of our inspections, we found incorrect information on the current care and treatment plans for two patients.
- Care and treatment plans had not always been signed by the staff member undertaking the review and were not always dated.

- The electronic system (WICCIS) had limited recorded entries for the patient.
- There was no evidence of a Wales Applied Risk Research Network (WARRN) risk assessment being updated to reflect the patient's admission.
- No evidence of current care planning to address the risks and needs of the individual.
- The patients' voice was not always reflected in all of the care and treatment plans viewed. There was also a tendency for plans to be risk and needs focused rather than strengths based.
- A lack of a review of patient care and treatment plans to ensure that all relevant information is included in accordance with guidance and legislation.
- START risk assessments were not fully completed to ensure the safety of patients, staff and visitors and to plan future care.

The issues identified above cover a wide range of patient documentation and risk assessments. HIW is not assured that the risk and care and treatment plans are always effective in mitigating the risks associated with acutely unwell patients who may display challenging behaviour. It is vital that the individual health boards and independent health providers develop effective audits and governance processes to ensure all care and treatment plans and risk assessments are robust and assist in an effective care pathway for all patients.

Environment of care

We routinely undertake a tour of the wards to consider the appropriateness and safety of the areas that patients are accommodated within. We identified issues with the environment of care during seventeen of our nineteen hospital and one CMHT inspections. The issue of ligature risk assessments and availability of ligature cutters will be addressed within the staff and patient safety section below.

A range of other environmental issues were identified including, a lack of maintenance, redecoration and replacement of broken items. In addition, during one inspection, there were insufficient rooms available for Consultant Psychiatrists to hold confidential conversations with patients and in another inspection, there was mould and poor ventilation in shower rooms and toilets on all three wards. In another inspection there was a lack of handrails in the ward area and in bathrooms and in another inspection we were not assured there was an efficient process in place which ensured that outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.

Staff and patient safety

In all of our twenty inspections (nineteen hospitals and one CMHT) we identified a range of patient and staff safety issues. The issues identified covered a wide range of areas and some of the significant findings include:

- We noted throughout the inspection that staff were not wearing personal alarms or radios.
- No policy on the use of personal alarms was in place.
- Patient call bells were not easily accessible.
- We saw environmental examples of potential risks to patient safety as follows: glass damaged and boarded up and the electronic security of the door had been compromised.
- Ligature cutters were not available/easily accessible to all staff.
- Patient adverse reactions and venous thrombosis assessments were not being appropriately completed.

- Some ligature risks had been recommended for anti-ligature work in 2020 but still hadn't been completed.

Privacy and dignity of patients

Within this area we identified a number of issues including no privacy and dignity policy in place and patients could not freely access their bedrooms during the day. Significantly, during one inspection, we observed two instances compromising patient privacy: personal care given with bedroom doors open and a patient's room with a clear glass window and broken blinds. The window overlooked the nursing station of the ward and allowed light into the bedroom even with the blinds closed. This compromised patient privacy and dignity and posed a risk of potentially disturbing the patient.

Workforce

Significant workforce challenges persist across Wales. The picture is very mixed with some health boards and independent providers having more success than others with recruiting and retaining sufficient and well-trained staff. Staff shortages were affecting a range of disciplines including, medical staff, registered nurses, psychologists and occupational therapists. Staff shortages were having a detrimental effect on staff, and during one inspection, we were told that they felt that the current staffing template was not sufficient to support safe and effective care. In another inspection the comments from staff, and the difficulties we observed, raised doubts about whether the current staffing establishments were sufficient to provide safe and effective care to patients at all times.

In spite of extensive workforce challenges we continue to receive positive feedback from patients on staff attitudes and their willingness to assist patients on their care pathway. In addition, we continue to observe many positive interactions by a very busy workforce under pressure.

Workforce issues were identified in fourteen of the twenty inspections across a range of disciplines and some of these are outlined below:

- There were staffing vacancies for a range of disciplines including an activity coordinator. OT support worker, a dedicated consultant psychiatrist, a psychologist and a registered nurse.
- Staff told us that staffing levels had not been reviewed for some time and the environment, they were working in was becoming more challenging and complex. Some staff members felt that in general, their job was detrimental to their health.
- The Speech and Language Therapist (SALT) was completing telephone consultations with patients and had not visited the patients on the ward.
- We were told that staffing resources had not been reviewed to meet this increase in workload resulting from the number of service users diagnosed with ADHD being referred to the team and there was no workload management policy in place to support this.
- Staff told us that there was a lack of administrative support within the team to enable an effective service.

The above findings are only a sample of the range of issues that we identified during our inspection visits. The healthcare sector continues to experience significant challenges in the recruitment and retention of a sufficient number of knowledgeable and trained staff to deliver an effective service for some of the most vulnerable patients in mental health hospitals. It is therefore imperative that health boards and independent providers have a range of strategies to ensure the recruitment and retention of staff.

Governance

The issues identified within this report suggest that governance processes within health boards and independent providers of care are not effective. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider. Robust governance and audit processes are key to identifying, at an early stage, where the delivery of a service needs to improve to meet the needs of the patient group more effectively. In addition, lessons learnt do not appear to be embedded sufficiently to prevent issues reoccurring. Unfortunately, in nineteen out of twenty of our visits, we identified issues in relation to audit and governance, this is very worrying. Some of the areas include,

- A lack of a robust system of governance oversight which ensures that the hospital's medications management processes support patient safety.
- During one inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.
- In one visit we identified that there was no formal process in place to obtain patient or family carer feedback.
- In another visit we did not see any evidence of changes that had been made as a result of formal patient feedback,
- There was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback,
- Policies were found to be out of date.
- Record keeping audits were generic health board audits, which were inappropriate for the mental health setting.
- A lack of ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement.
- A lack of quality governance and leadership to ensure effective communication between senior management and ward staff.
- In one visit we identified that the registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.
- The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.

The above issues were identified within our health boards and independent provider inspections and must be addressed as a matter of priority. Many of the issues above can be easily addressed with strengthened governance processes. In one of the most significant failures of governance, a health board did not ensure that robust processes were in place to correctly record restraint incidents within Datix to support effective investigation, supervision and governance oversight.

Findings specific to Learning Disabilities

During 2023/24 we undertook three inspections of learning disability establishments and one assurance check to a CLDT jointly with CIW. Within these inspections, we noted some positive findings including, patients having access to advocacy services, and we observed staff interacting with patients in a proactive and engaging manner, and staff we spoke with demonstrated a genuine patient focus. Patients were also happy to engage with the inspection team and the views expressed to us were overall supportive of the care they receive.

In all four inspections no immediate assurances actions were requested, however, there were a number of areas for improvement identified.

Patient and staff safety

Patient and staff safety is an important issue and central to any care and treatment delivered. If patients feel safe, they will respond much better to any treatment and will feel empowered to maximise their full potential. If staff feel safe, then they will be better equipped to care and empower patients in their care.

In our CLDT inspection we identified delays in allocating, assessing and authorisation of the Deprivation of Liberty Safeguards (DoLS) applications to both Rhondda Cynon Taf County Borough Council (RCT) and CTMUHB. This delay continues to result in many people being deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. Further work is required to ensure people rights are protected and care and support/treatment arrangements amounting to deprivation of liberty are appropriately authorised. Senior Managers must ensure there is sufficient capacity to meet statutory responsibilities.

In an inpatient hospital we found that the call bells in patient bedrooms were not easily accessible for patients.

Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. It was pleasing to note that we only identified issues with the management of medication in one of our four inspections; this being in an independent hospital where the registered manager must ensure that medication stock reconciliation processes are always adhered to.

Training

In terms of training, we identified one issue in the CLDT assurance review in relation to specific training related to the Mental Health Act. The training was not routinely delivered to all health board practitioners. We asked the health board to review and ensure that those practitioners delivering care to people subject to the Mental Health Act receive up to date knowledge of the act and its implications for the people supported. In another of our inspections we identified that the health board continues to utilise the expertise held within the Multidisciplinary Team (MDT) to provide person specific Positive Behavioural Support (PBS) training and supports staff to attend as required.

Care plans and risk assessments

Care plans, in particular PBS plans, are an important component in delivering effective care and ensuring the patient is at the centre of all care and treatment delivered. In addition, any patient risks must be fully described with triggers identified and a range of strategies identified to mitigate against identified risks. We routinely examine care and risk documentation as part of the inspection process. In all four of our visits,

we identified issues with the care documentation including;

- a health board did not have an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board did not ensure that the latest behaviour support plan was available in the active file used by staff.
- We recommended additional information was documented relating to the reason(s) for why a particular intervention was implemented and what was done to justify that intervention as last resort.

Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. In one of our inspections the patient information board was not up to date and therefore did not ensure that patients had access to appropriate information.

Use of seclusion

The Mental Health Act and information position on seclusion is documented earlier in this section of the report. In one of our inspections the documentation relating to the use of seclusion was not completed accurately.

Workforce

Workforce and the recruitment and retention of suitably qualified and experienced staff continues as an issue. In one of our inspections the health board did not ensure that staff were supported in any changes to their roles aligned with the service change from assessment and treatment to that of rehabilitation.

Environment of care

In all three of our visits to in-patient settings we identified issues with the environment of care, environmental improvements were required in relation to the refurbishment, redecoration and repairs on wards and in one of our inspections the health board was required to ensure that the physical environment meets the needs of patients in receipt of rehabilitative care. Other specific environmental issues included heating problems and the lack of the development of a patient kitchen as part of a life skills programme of therapy. Lastly the registered manager needed to ensure that maintenance issues were resolved according to their level of priority and risk.

Governance

A range of governance issues were identified in three of our four visits. These included:

- a health board needing to set up an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board needing to place emphasis on ensuring that issues relating to service change continue to be explored and acted upon in a timely and robust manner.
- The registered provider making sure that all policies are updated and reviewed.
- Health boards must establish and communicate timely and effective processes to ensure people who are supported by the CLDT, do not experience lengthy delays and bureaucracy in accessing medical equipment.

Findings specific to CAMHS

During 2023-24 we inspected two of the three in-patient CAMHS units in Wales. Some positive findings were identified including, the environments of care was generally well maintained internally and care plans were generally of a good standard, but with some areas for improvement required. However, our inspections also identified a range of issues and following one of our inspections an immediate assurance letter was issued in relation to ensuring that the governance of restraints was appropriately reported and investigated including details on:

- triggers and build up to the restraint
- Accurate recording of the length of time of restraint.
- Subsequent analysis and investigation of the restraints to ensure lessons are learnt and that the restraints are analysed to identify any themes and whether the restraint could have been avoided and whether the type of restraint used was appropriate.

Other issues identified included, a number of vacant posts of educator, psychologist and occupational therapist that resulted in young people not having access to the education and therapies that they needed. In addition, we identified a range of issues with medicines management including:

- The medicines management policy was out of date.
- Gaps on the fridge temperature recording sheet in the clinic room.
- The temperature inside the clinic room was very hot and no room temperature checks were being undertaken to ensure that the temperature remained below the advised storage temperatures for the medication in the room.
- Staff we spoke with during the inspection were unclear about what to do in the event of an adverse drug reaction.

Lastly, on one of our visits we saw that a treatment pathway had not been put in place for a young person with a diagnosed condition on admission.

6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act (MHA) 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, 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 MHA1983.

The MHA 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 MHA 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.

How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the MHA. Other individuals and organisations 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. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under The Act. This section of the annual report details how the MHA is being implemented and how the powers granted are being exercised and monitored in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2023-24 we focused on a number of key areas including:

- Are patients lawfully detained and is the detention under the Act the most appropriate.
- Under section 132 are patients informed about their rights, at the point of detention, and then at regular intervals. Is it recorded if patients have understood the detention or not.
- Is there a care and treatment plan in place that considers aftercare of the patient

We consider the detention of patients through a number of methodologies including interviews with patients and members of the multi-disciplinary team. We also use observation and we examine the detention paperwork to ensure patients are lawfully detained. In addition, we consult with the MHA administrators.

Mental Health Act Reviewers

During our inspections we utilise the skills and knowledge of our MHA Reviewers whose purpose is to consider the detention of patients under the MHA. They make a judgement on the application of the MHA and whether it was being lawfully applied and the MHA 1983 Code of Practice was being adhered too. A number of key sections are scrutinised including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the

patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

Our Findings

Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity of each patient had been assessed and clearly documented.

However, on one of our visits, we identified that patient capacity and capacity to consent was not routinely assessed and recorded during the first three months of treatment and proformas were not routinely used in relation to patients that lacked capacity to make specific decisions about aspects of their care and treatment that were outside of the provisions of the act during their stay on the ward. In another of our visits we noted that mental capacity assessments were not fully completed and regularly reviewed and updated

In one case, the capacity to consent to treatment for patients was not regularly assessed using the framework set out in the Mental Capacity Act and guidance set out in the MHA Code of Practice for Wales (13.8) and recorded within their patient records.

Lawful detention/treatment

HIW has a duty to monitor the MHA to ensure that the detention of patients is lawful and there are systems and processes in place to ensure audits and effective governance of the Act. A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. We found many examples of good practice including the MHA documentation was well organised, easy to navigate and securely stored and MHA administrators demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful.

However, during one of our visits, we identified that a review of the hospital's use of urgent treatment under Section 62 of the MHA was required, in order to ensure full compliance with the Act and full completion of relevant documentation.

In addition, we also identified in one of our visits that implementation of a robust system of audit and governance oversight in respect of the MHA was required.

In addition, Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness and the statutory certificate of consent forms must always state the correct type and dosage of medication that has been prescribed to patients.

Section 17 (leave)

Section 17 leave is an important part of a patients journey to discharge from their section and back into the community. This process must be carefully managed with clear conditions of leave taking into account any risk factors and balances the needs of the patient with these risks. A number of areas of concern were identified during our inspections including:

- A review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in the decision-making process in relation to the leave process.
- Insufficient numbers of staff available to ensure patients are able to take their Section 17 leave.
- We saw examples where the patient Section 17 leave forms had been signed but not dated. The 'circulation list' tick boxes within the Section 17 leave forms were not fully completed to indicate who had been provided with a copy of the form.
- Incomplete Section 17 leave forms that did not include the date and details of all recipients, as a matter of good practice.
- We noted the conditions and outcomes of the section 17 leave for some patients could be strengthened to provide more clarity to staff on the expectations of the leave arrangements.
- We found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.
- The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the Community Treatment Order (CTO) might be more suitable option in accordance with paragraph 27.8-27.9 of the Code of Practice.

Managers hearings

In terms of managers hearings, we identified two issues during our inspections, one was to ensure Hospital Managers Hearings are held in a timely manner as in one record we reviewed, we noted a delay of five months. Another area was that action must be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.

Ensuring patients' rights

Section 132 and 132A of the MHA places a duty upon hospital manager to ensure detained patients understand how the MHA applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

On our inspections there was good evidence that patients were aware of their right and this was well recorded. Only on one of our inspections we did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.

Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

In two of our visits we identified that that the views of the statutory consultees were not being routinely captured to support the medical treatment of patients authorised by the SOAD.

Audit and governance arrangements

Throughout our visits we consider the audit and governance arrangements for the monitoring of the MHA by the health boards and independent providers of healthcare. During three of our monitoring visits we identified issues in the audit and governance oversight in respect of the

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the Second Opinion Appointed Doctor SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH also undertake a review of section 61 and any deaths that occur of detained patients within the NHS. We can also 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 SOAD is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, 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, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a 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.

The SOAD service operates as a Hybrid service. Our methodology is set out in detail in our guidance to all SOADs and provided to all MHA Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021. One of the main changes we have implemented is that whilst all SOAD visits should occur in person for the purposes of interviewing the patient for most cases. However, in specific cases, namely Community Treatment Order (CTO cases), we have opted for a remote first methodology. All patients are to be consulted by their clinical team prior to the submission of requests if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right in all cases to specifically request an onsite visit from a SOAD. Our forms are being updated to

reflect these changes and will be published in the summer of 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the RSMH services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their certificate of consent CO forms.

Full advice on our methodology is available on our website and is currently being updated to reflect the changes we have made in 2023-24 this year.

SOAD Recruitment

We have now recruited into the role of a Lead SOAD and plan to recruit to the role of Deputy Lead SOAD in early 2025. We continue to recruit additional SOADs to provide further resilience to the service.

SOAD activity

During the period April 2023 to March 2024, the RSMH received 733 requests for a visit by a SOAD. This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

- 665 requests related to the certification of medication.
- 44 requests related to the certification of ECT.
- 24 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

Requests for visits by a SOAD, 2006-07 to 2023-24[1]

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
2021-22	657	66	36	759
2022-23	640	42	12	694
2023-24	665	44	24	733

1 Source: SOAD requests to HIW

Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

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

There are a number of reasons when on occasions we do not meet the above timescales including, the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

It must be reiterated that our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the MHA Administrators for all settings to try and ensure improvements in this process next year.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the MHA administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW has produced guidance to MHA administrator in relation to this subject to minimise these instances.

8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities 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

In writing:

Healthcare Inspectorate Wales
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via:

Phone: 0300 062 8163

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

Appendix A

Relevant work 2022-23

	Hospital	Date	Type
Health Boards			
1	Assessment and Treatment Unit, Swansea Bay University Health Board	17 - 19 April 2023	Inspection
2	Hergest Unit Betsi Cadwaladr University Health Board	15 - 17 May 2023	Inspection
3	Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board	22 - 24 May 2023	Inspection
4	Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board	3 - 5 July 2023	Inspection
5	Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board	17 - 19 July 2023	Inspection
6	Cedar Parc Ward, Ysbyty'r Tri Chwm, Aneurin Bevan University Health Board	7 - 9 August 2023	Inspection
7	Tŷ Llidiard Cwm Taf Morgannwg University Health Board	11 - 13 September 2023	Inspection
8	Caswell Clinic, Swansea University Health Board	11 - 13 September 2023	Inspection
9	Canolfan Bro Cerwyn, Withybush Hospital, Hywel Dda University Health Board	16 - 18 October 2023	Inspection
10	Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board	13 - 15 November 2023	Inspection
11	Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board	20 - 22 November 2023	Inspection

Hospital		Date	Type
12	Community Mental Health Team Nant y Glyn Team, Betsi Cadwaladr University Health Board	23 and 24 January 2024	Inspection
13	Talygarn Ward, County Hospital, Aneurin Bevan University Health Board	5 - 7 February 2024	Inspection
14	Care Inspectorate Wales (CIW) & Healthcare Inspectorate Wales (HIW) – Inspection of Rhondda Cynon Taf County Borough Council/ Cwm Taf Morgannwg University Health Board/Swansea Bay University Health Board Community Learning Disability Team (CLDT)	13-15 February 2024	Inspection
Independent Healthcare Providers			
15	Ty Cwm Rhondda	17 - 19 April 2023	Inspection
16	Hillview Hospital	9 and 10 May 2023	Inspection
17	St David's Independent Hospital	19 - 21 June 2023	Inspection
18	Aberbeeg Hospital	10 - 12 July 2023	Inspection
19	Rushcliffe Mental Health Hospital Aberdare	25 - 27 September 2023	Inspection
20	Ty Gwyn Hall Hospital	2 - 4 October 2023	Inspection
21	New Hall Independent Hospital	24 - 26 October 2023	Inspection
22	Tŷ Grosvenor	6 - 8 November 2023	Inspection
23	Heatherwood Court Hospital Llantrisant Road, Pontypridd	4 - 06 December 2023	Inspection
24	Priory Hospital Cardiff	8 - 10 January 2024	Inspection
25	St Peter's Hospital	26 - 28 February 2024	Inspection
26	Coed Du Hall Hospital	25 - 27 March 2024	Inspection

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.
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.
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.
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 – Co-ordination 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.