Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Annual Report 2021-2022

Contents

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 patients at the heart of what we do.

We are:

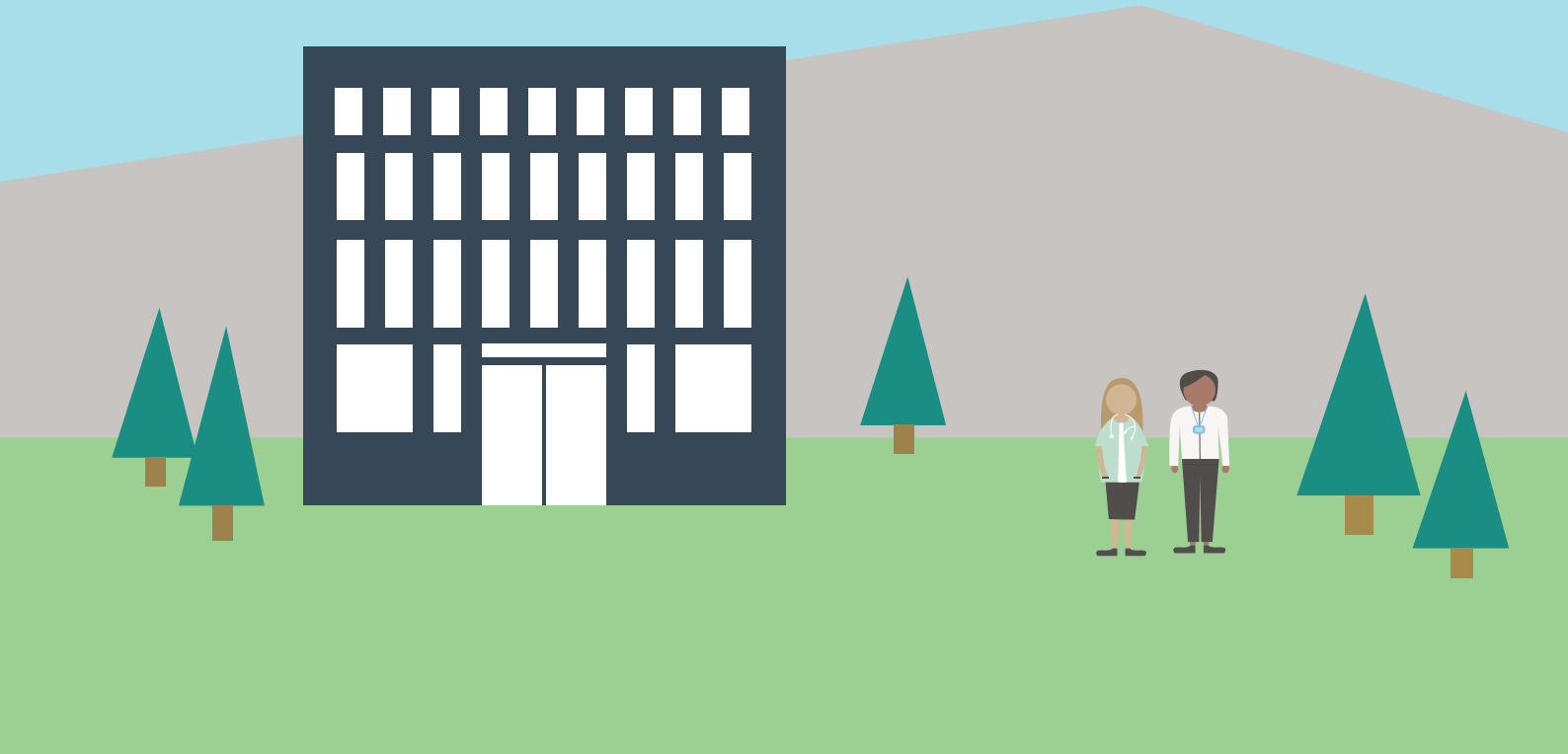
- Independent
- Objective
- Decisive
- Inclusive
- Proportionate

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 Healthcare Inspectorate Wales (HIW) activity and findings in relation to our mental health and learning disability services during the period April 2021 to March 2022. Our key role in this area is to monitor that patients receive safe and effective care. The areas we inspected against included:

- effective care and treatment plans
- appropriate levels of patient observations, based upon individual risks
- that least restrictive practices were in place.

This year continues to be a challenge for the in-patient mental health and learning disability services that we inspected and undertook focused reviews for. Mental health patients requiring in-patient care are vulnerable, and can be very challenging when in an acute episode of mental health crisis. These patients require care and treatment from a skilled, knowledgeable and experienced workforce and it is clear from our findings that this is posing a real challenge to the Health Boards (HBs) and independent providers throughout Wales. We found numerous examples of staffing challenges throughout our visits, and we were notified of examples of where enhanced observational levels had failed to safeguard vulnerable patients.

Other key areas in which we found the need for improvement were medicines management, use of restraint, patient observations, environments of care and risk assessment and care planning.

Chapter 6 of this report identifies the process and areas we focus upon gain assurance that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

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

- 26 on-site inspection and focussed reviews:
    - 12 NHS setting
    - 14 independent healthcare settings

- 12 Quality Checks:
    - 10 NHS settings
    - 2 independent healthcare providers.

We reviewed 738 notifications of incidents received that had occurred within independent mental health and learning disability healthcare settings. This was significantly higher than the number of notifications we received in 2020-2021.

In addition, we received 759 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This represents a slight increase from the April 2020 to March 2021 requests, however in general remains consistent with figures from previous years.

The SOAD requests can be broken down as follows:

- 657 requests related to the certification of medication
- 66 requests related to the certification of Electro-Convulsive Therapy (ECT)
- 36 requests related to medication and ECT.

We continued to consider Infection Prevention and Control (IPC) measures to minimise the risk of COVID-19. We found that there were good arrangements in place, across all mental health and learning disability healthcare settings, to ensure staff had appropriate access to the required levels of Personal Protective Equipment. At the end of this reporting period, it is pleasing to note that COVID -19 was having less of an impact on mental health and learning disability services. However, the impact that COVID-19 has had on people's mental health and feelings of isolation cannot be underestimated. In addition, COVID-19 has also had a very negative impact on detained patients' ability to take section 17 leave and this has impacted on their care pathways. The pandemic has also had a negative effect on staff throughout mental health and learning disability services. It is acknowledged that many staff working in these services across Wales have worked under significant pressure throughout the pandemic.

Within this report it is pleasing to note the good practice and feedback from patients in relation to staff engagement. Effective communication is essential to promote positive mental health and build a therapeutic relationship that can assist patients with recovery from an acute mental health crisis.

Although our on-site inspection and focussed review work allowed us to observe some examples of good practice across different aspects of service delivery, significant improvement was often required and there was a large degree of variability in the quality of care delivery.

2. Context

During this year, the COVID-19 pandemic continued to have an impact upon our inspection programme, but this impact was significantly reduced when compared to 2020-2021. Our on-site inspection activity has significantly increased from 2020-2021 and our remote quality checks significantly decreased. The clear advantage of our on-site inspection and on-site focused reviews is that we are able to facilitate face to face interviews with patients, relatives and a range of staff from across the disciplines.

Throughout 2021-2022 mental health and learning disability hospitals and community services continued to operate both within the NHS and independent sector. Numerous challenges for services continued throughout this inspection year and included inadequate staffing due to staff isolating after testing positive for COVID-19. This naturally had an impact upon patient therapeutic and recreational activities, and the ability of staff to facilitate section 17 leave for those patients detained under the Mental Health Act.

We continued to operate the SOAD service remotely through our RSMH to ensure the rights of patients detained under the Mental Health Act 1983 were safeguarded. As part of this process a range of documentation is required to be sent electronically to enable the SOAD to have access to key information in relation to the history and treatment for the patient. The SOAD, where possible, interviews the patient by telephone, or via a video call.

This report covers the final year of the Together for Mental Health Delivery Plan: 2019-2022 which is the Welsh Government's strategy to improve mental health and well-being across all ages. The strategy was initially published in October 2012 and has been supported by a series of detailed delivery plans. The 2019-2022 is the third and final plan. In January 2020, the Welsh Government published a revised version of the final delivery plan in which the actions were updated. This was in direct response to the impact COVID-19 has had on the mental health and wellbeing of people in Wales.

Together for Mental Health sets out six high-level outcomes underpinning the 10-year strategy, these are:

- The mental health and well-being of the whole population is improved
- The impact of mental health problems and/or mental illness is better recognised and reduced
- Inequalities, stigma and discrimination are reduced
- Individuals have a better experience of the support and treatment they receive and feel in control of decisions
- Improved quality and access to preventative measures and early intervention to promote recovery
- Improved values, attitudes and skills of those supporting individuals of all ages with mental health problems.

HIW's inspection programme and other activities scrutinise a number of the above outcomes that are routinely assessed and reported upon within the individual inspection reports.

3. Our role in mental health and learning disability care

HIW is the regulator and inspector of independent mental health and learning disability healthcare services, and inspector of NHS mental health and learning disability services. HIW has a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers. In addition, we also have a specific responsibility in relation to listening to concerns, a brief overview of which is provided below, with more detail provided in section 4 of this report.

Listening to concerns

We have internal processes in place to analyse intelligence about mental health services in order give an overview of the quality, care and treatment given to patients. This intelligence may come from several sources including, concerns of patients, relatives, advocates and staff. In addition, we monitor and review incidents, notifications and safeguarding concerns.

In line with the Independent Health Care (Wales) Regulations 2011, independent registered providers have a duty to report a range of occurrences which act as a source of intelligence for HIW, these occurrences include:

- an unauthorised absence of a patient who is detained or liable to be detained under the Mental Health Act 1983
- death of a patient
- any serious injury to a patient
- outbreak of an infectious disease
- any allegation of misconduct resulting in actual or potential harm to a patient by the registered person or any person employed in the establishment or any medical practitioner with practising privileges
- any application made to a court in relation to depriving a patient of their liberty
- any request by a supervisory body by the registered person for a standard authorisation.

Information received from the above notifications feeds into our intelligence and evidence gathering to assist us in gaining an insight into the quality of care and treatment by mental health and learning disability healthcare services in the independent sector.

In relation to the NHS, we are routinely informed about the death of any detained patients, and this includes the cause and some other key information. We also gain intelligence from key stakeholders.

Issues identified in both the NHS and independent sector may result in a focussed on-site inspection being undertaken, outside of our routine work programme. The aim of the focussed on- site inspection is to assess whether an appropriate level of care and treatment is being delivered to patients considering any risk factors.

Inspection and regulation

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.

Within the NHS we use the Health and Care Standards (2015) and other standards to inform our inspection approach, to check that people receive good quality healthcare.

We made use of a combination of on-site and digitally enabled quality checks throughout the 2021-22 inspection year, the findings of which 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 1983. This duty is undertaken by HIW on their behalf. During our inspections the peer reviewers, for the Mental Health Act, undertake a system of case tracking for individual patients and interview the patients and relevant members of staff. In addition, our reviewers spend time with the Mental Health Act 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 role specifically in relation to the investigation of certain types of complaints. During our inspections we routinely review a number of key areas as outlined within the Mental Health Act 1983 – Code of Practice for Wales (revised 2016), namely:

- patients are lawfully detained and well cared for
- patients are informed about their rights under section 132 both orally and in writing and a record of this is maintained in the patients' file
- 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
- patients are entitled to lead as fulfilling a life as possible
- The Mental Health Act Code of Practice for Wales (Revised 2016) that has been prepared and issued under section 118 of the Mental Health Act 1983 is being followed
- the right plans are made for patients before they are discharged from hospital.

In general, the findings from our inspections of the processes and application of the Mental Health Act were positive, however, we did find a number of areas for improvement. Our findings for the period April 2021 to March 2022 are summarised in section 6 of this report.

Review Service Mental Health (RSMH)

HIW's Review Service for Mental Health (RSMH) administers 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 Mental Health Act, have refused prescribed treatment, or have been assessed as unable to consent to the treatment
- a review of treatment under Section 61 of the Mental Health Act, 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 2021 and March 2022 is provided in section 7 of this report.

Monitoring use of the Deprivation of Liberty Safeguards (DOLS)

HIW publishes a separate report, with Care Inspectorate Wales (CIW), on the use of the Deprivation of Liberty Safeguards (DOLS). DOLS is a part of the Mental Capacity Act 2005. There is legislation in place to replace DOLS with Liberty Protection Safeguards (LPS). HIW is a member of the LPS Implementation and Monitoring group with Welsh Government representatives and other key stakeholders. In addition, we are also members of the LPS Implementation Steering Group again with Welsh Government representatives and other key stakeholders. DOLS is 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) that was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. The other organisations that are part of the NPM include, CIW, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons). All of these inspectorates undertake visits to prisons, police and court custody and secure accommodation for children within Wales.

HIW is a designated body of the UK's NPM because of its distinct role in monitoring places of detention 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 we are a member of the NPM mental health subgroup.

Youth Justice Services

During this period, we continued to work with Her Majesty's Inspectorate of Probation (HMI Probation) on the inspection of Youth Justices Services (YJS). We undertake this work with a number of other inspectorates including, CIW, Estyn and HMICFRS. HIW's role is to consider the services received by the YJS from a healthcare perspective. Part of this process involves interviewing key members of staff, employed by the Health Boards, and considering the services on offer. We consider young people's access to Child and Adolescent Mental Health Services (CAMHS), Speech and Language Therapy, substance misuse and access to physical healthcare. The joint inspection of Cardiff YJS commenced in March 2022 by HMI Probation and the partner inspectorates, including HIW, were on -site in April 2022.

Dementia Partners National Steering Group

We attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). The group has three strategic priorities:

- Support health and care organisations to redesign and continuously improve the service they provide
- Support a focus on reduction in avoidable harm and safety within systems of care
- Sustainably build improvement capability within the health and care system.

The group has a number of key purposes including;

- to provide oversight and evaluate the readiness and implementation of the All-Wales Dementia Care Pathway of Standards across the Welsh regions and supporting workplans within the national programmes
- to support regional developments and achievement of the standards by sharing best practice, learning and innovations via agreed national and regional pathway structures
- oversight and support of regional and programme leads via peer network and national workstream structure
- oversight and promotion of national and regional workstream developments to support a once for Wales approach
- to provide advice, support and direction to the regional dementia boards and workstreams leads
- to provide support, advice and direction via update reports to the DOIIG

- to provide expert opinion from people who have lived experience and practitioners, clinical leads, academics, researchers and key partner organisations.

Attendance at the group provides a rich source of information that we can use to ensure services are implementing the All-Wales Dementia Care Pathway of Standards.

Mental Health Incident Group

Throughout the pandemic, HIW attended the Mental Health Incident Groups organised by Welsh Government. These meetings considered the resilience of services including Health Boards preparation and planning for dealing with the impact effect of the COVID-19 pandemic on mental health and learning disabilities services.

4. Listening to concerns

Concerns and complaints

During the reporting period we received:

- 514 complaints and concerns about healthcare providers in Wales
- 178 of these were about mental health and learning disability healthcare services:
  - 88 NHS mental health and learning disability services
  - 90 independent mental health and learning disability services.

Nature of concerns

During this reporting period we introduced a new Customer Relationship Management (CRM) system which has changed the way that we record concerns. Previously we would record the following categories:

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

After reviewing our previous categories, we decided to record information about the concerns and complaints we receive in a more granular way, using the following categories:

- Access, admission, transfer, discharge (including missing patient)
- Clinical assessment (Including diagnosis, scans, test, assessments)
- Communication
- Complaints Management
- Consent and Confidentiality
- Funding
- Infection Control Incident
- Infrastructure (including staff facilities, environment
- Medical Device/Equipment
- Medication Management
- Mental Health Act
- Other, to capture all concerns that fall outside of existing themes
- Patient Accident
- Records Management
- Safeguarding
- Self-harming Behaviour
- Treatment and Procedure
- Whistleblowing.

Due to the change in categorisation of concerns, a direct comparison of figures with previous years may not be possible. Table 1 below shows the figures between 2019-2020 – 2020-2021.

Table 1: Subject of concerns and complaints 2019-2021

Subject of concerns and complaints	NHS Settings		Independent healthcare Settings	
	2019-2020	2020-2021	2019-2020	2020-2021
Alleged abuse and/or neglect	8	3	15	17
Infrastructure, including staffing, facilities and the care environment	12	7	28	20
Consent, /communication/confidentiality	1	2	1	2
Treatment/Procedure	7	15	12	9
Clinical Assessment	2	4	1	2
Mental Health Act	5	1	6	1
Other	6	33	21	35
Total	41	65	84	86

Table 2 shows the figures for this reporting year against the new categories.

Table 2: Subject of concerns and complaints 2021-2022

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	3	2
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	8	4
Communication	2	0
Infrastructure (including staff facilities, environment)	17	27
Medication Management	0	1
Mental Health Act	11	2
Other	9	14
Records Management	4	0
Safeguarding	7	9
Self-harming Behaviour	5	6
Treatment/Procedure	12	7
Whistleblowing	10	18
Total	88	90

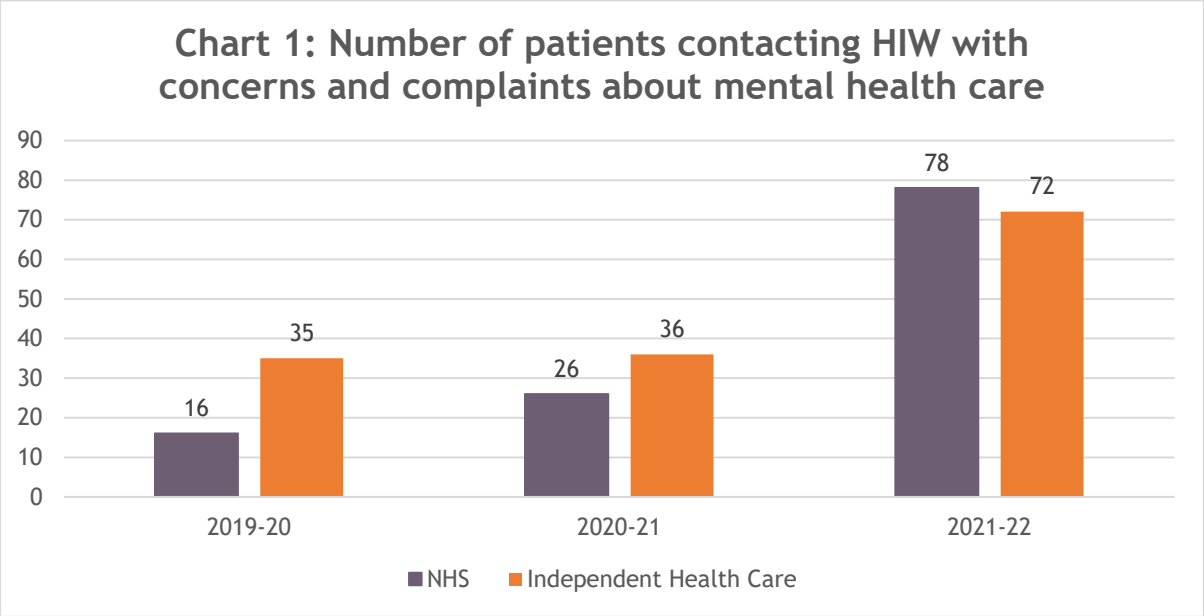
We have noted that the majority of concerns received in this reporting period have been in relation to Infrastructure (including staff, facilities, environment). This category covers complaints around staffing levels, staff training, staff supervision and support, etc. We are aware of the national shortage of staff across all sites within healthcare environments and we continue to monitor this area closely.

Concerns of patients, family members and advocates

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

- 95 in 2019-2020
- 109 in 2020-2021
- 150 in 2021-2022.

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



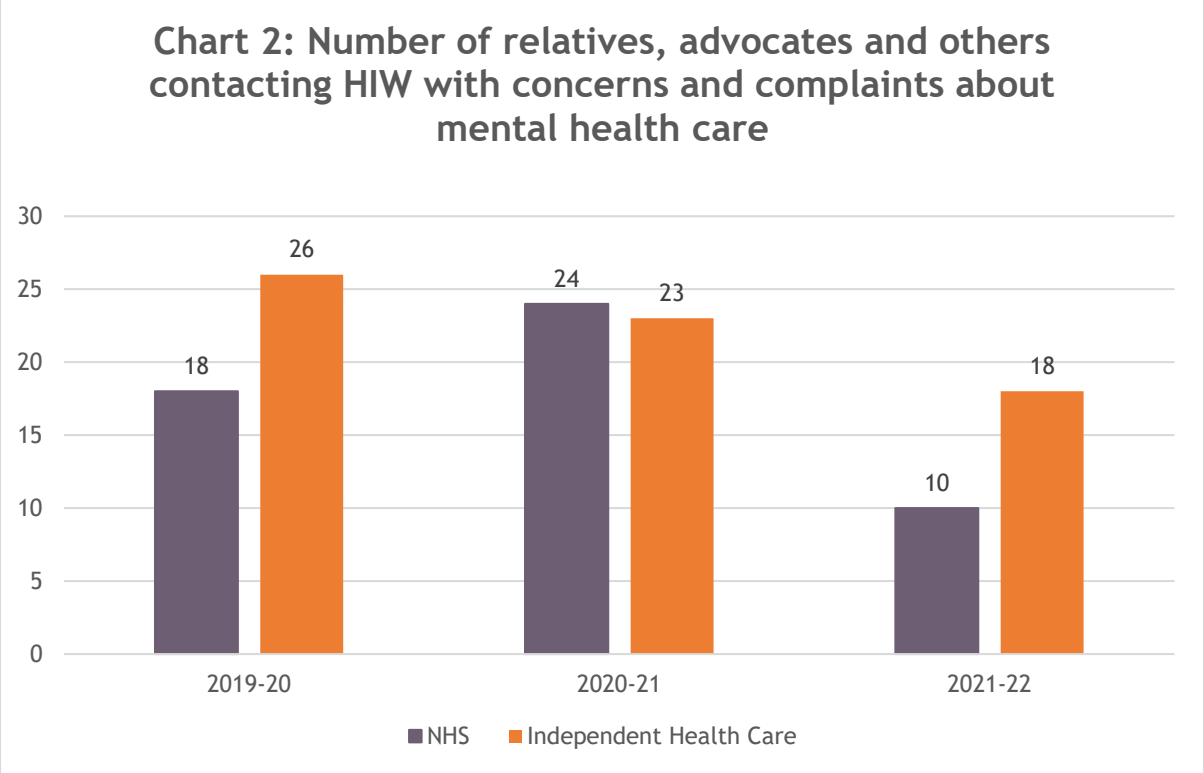


Chart 1 shows that over the past 3 years there has been an increase in the number of patients directly contacting HIW. In 2021-2022 we have seen over a 50% increase in the number of patients directly contacting HIW with concerns and complaints about mental health care.

Chart 2 shows a decrease in the number of concerns or complaints from relatives, advocated and other bodies directly contacting HIW.

Staff concerns

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

The figures below show that staff concerns are the lowest they have been in the past 3 years.

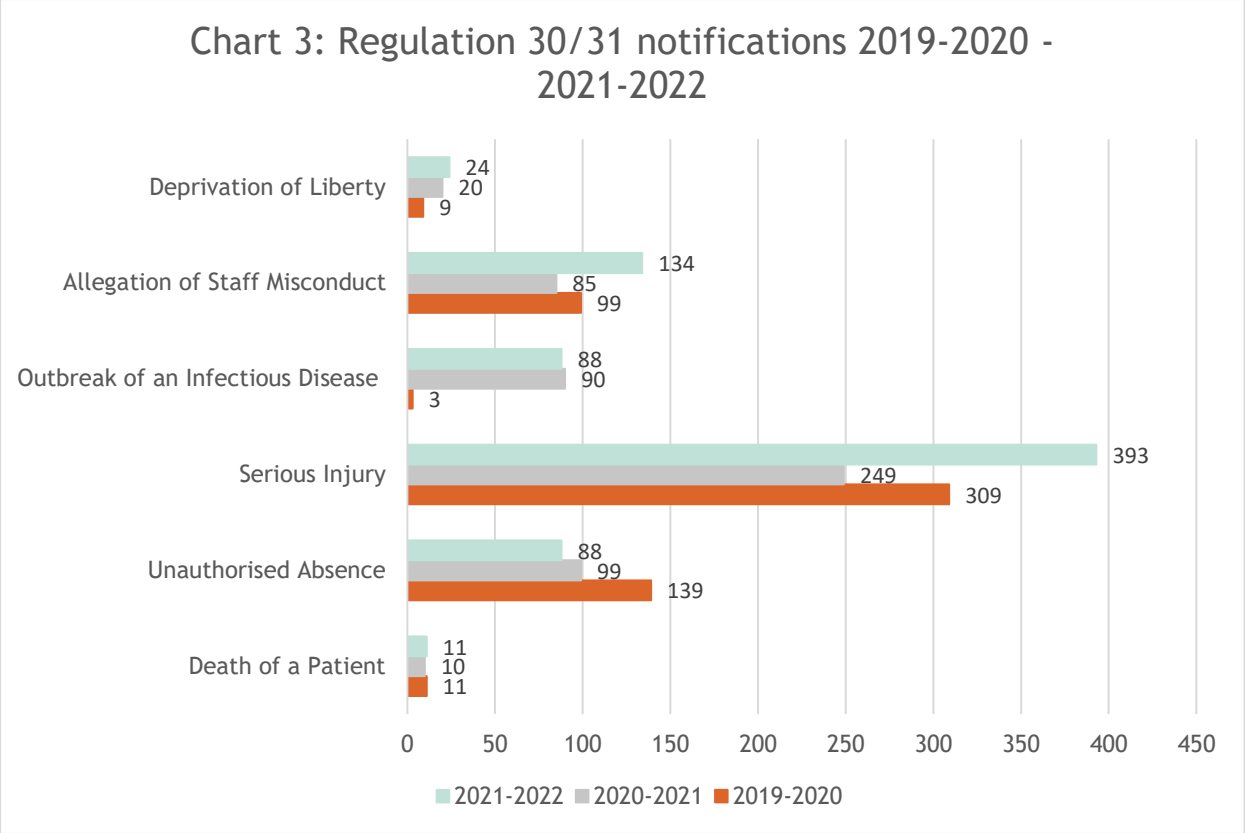
- 33 in 2019-2020
    - 10 in relation to NHS services
    - 23 in relation to independent services
- 42 in 2020-2021
    - 15 in relation to NHS services
    - 27 in relation to independent services
- 28 in 2021-2022
    - 10 in relation to NHS services
    - 18 in relation to independent services.

Reviewing Regulation 30 and 31 Notifications

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

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

During the reporting period, we received 738 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was significantly higher than the number of notifications we received in 2020-2021. Notifications were themed as shown in Chart 3.



During this reporting period we have noted a significant increase in the number of notifications received regarding serious injury of patients and allegations of staff misconduct being reported. We have also received a similar number of notifications regarding outbreaks of an infectious disease. This continues to show the impact that the Covid-19 Pandemic has had within independent mental health and learning disability settings in Wales. During this period, we have continued to see a reduction in the number of incidents relating to unauthorised absences, with the figures showing a reduction for the third consecutive reporting year.

We are continuing to work with independent providers of mental health and learning disability care, reminding them of their responsibilities to notify us of regulatory events. Additionally, we have strengthened our relationship with local safeguarding boards allowing us to triangulate information around notifiable events.

5. Inspecting mental health and learning disability healthcare services

In 2021-2022 we undertook a mixture of onsite inspections and remote quality checks to 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.

This year the number of onsite unannounced visits increased on the previous year of 2020-2021 but we retained a number of digitally enabled quality checks for some of our work in mental health and learning disability healthcare care settings. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the spread of COVID-19.

In 2021-2022, we undertook:

- 26 on-site inspection and focussed reviews:
  - 12 NHS settings
  - 14 independent healthcare settings
- 12 Quality Checks:
  - 10 NHS settings
  - 2 independent healthcare providers.

For comparison in 2020-2021, we undertook:

- 8 on-site inspection and focussed reviews:
  - 1 NHS setting
  - 7 independent healthcare settings
- 33 Quality Checks:
  - 18 NHS settings
  - 15 independent healthcare providers.

During 2021-2022 one independent healthcare provider was visited on three occasions because of the nature of the concerns identified.

During our onsite unannounced inspections and focussed reviews we:

- Interviewed a number of patients to ascertain their views on the quality of care and treatment provided
- Observed how a range of staff from multi-disciplinary teams interacted with patients and each other
- Examined how the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the effectiveness of the Care Coordinators Within this we also examined care and treatment plans, including records of restraints and any seclusion undertaken

- Reviewed policies, procedures, audit findings and governance processes
- Considered the diverse range of 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).

During our digital announced quality checks, we:

- Discussed and analysed the information submitted prior to the check taking place
- Used clinical expertise as necessary
- Examined audit and governance processes in relation to infection control and COVID-19, staffing numbers, training, and supervision to ensure staff had the knowledge and experience to support the patients
- Examined audits in relation to the application and monitoring of the Mental Health Act
- Examined records in relation to challenging behaviour and any use of restraint, segregation, and seclusion.

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

Our findings

Within this section our findings are broken down into three specific areas, mental health including older and younger persons, learning disabilities and CAMHS. The findings are drawn from a combination of the quality checks and the onsite focussed review and inspection visits we carried out during the year.

The COVID-19 pandemic was still having a significant impact on the delivery of services, but this was an improving picture by the end of March 2022.

Findings specific to mental health, including older and younger persons

Preventing and controlling the spread of COVID-19

We continued to focus upon IPC measures within mental health and learning disability healthcare services. In general, services continued to evolve their policies and procedures to take account of any outbreaks of COVID-19. Ward environments had evolved to provide separate areas in the event of any outbreaks, and on occasions entire wards had been designated to accommodate patients who had tested positive for COVID-19.

In terms of our inspection findings, training statistics for staff on infection control showed a high level of compliance and there was a general awareness of staff on the importance of this area to prevent the spread of COVID-19.

However, on occasions HIW was not assured that there were established IPC measures in place to manage and mitigate the risks posed by COVID-19. It is important that health boards and independent providers ensure all internal and national COVID-19 policies and measures are complied with to ensure the safety of patients, staff and visitors. In addition, sometimes we were not assured that all staff were aware of the positive cases of COVID-19 on the ward or that correct reporting mechanisms were in place.

We found that there were good arrangements in place, across all mental health and learning disability healthcare settings we checked, to ensure staff had appropriate access to the required levels of Personal Protective Equipment (PPE). During most of our inspection visits we observed the correct use of PPE, and that audits were being undertaken to monitor staff compliance with guidance and requirements. However, on some visits we found examples of staff going onto wards from another area of the hospital without complying with hand hygiene protocols and not wearing their masks correctly. On some occasions, staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues and it was unclear what procedures were in place to prevent any potential transmission of infection.

We also identified a lack of evidence that all areas of the hospital were thoroughly cleaned and decluttered and evidence of ongoing compliance with IPC standards. To prevent the spread of infection it is vital that there is a robust and comprehensive supervision and monitoring of IPC audits to ensure they are accurately completed.

Least restrictive care

COVID-19 has had a significant impact upon restrictive patient care for a number of reasons. Patients were not always able to take section 17 leave because of a lack of staff, or because national and local restrictions meant that patients were at times unable to have leave of absence due to restrictions being put in place to prevent the spread of COVID-19. These restrictions have at times meant that patients were also not able to receive visits from relatives and friends. However, by the end of the reporting period of March 2022 this situation had dramatically improved.

The requirement for social distancing and wearing of PPE radically changed the way in which care was provided during the pandemic. Some patients found the wearing of masks by staff as a barrier to clearly understanding interactions with them but understood the rational for the wearing of these. In addition, social distancing made some therapeutic group work not viable because of the space required to facilitate these.

However, a positive area in most of our inspections was the quality of staff and patient interaction. Our staff observed many positive examples of effective communication and patients being treated with dignity and respect.

The use of digital technology continued to enable patients to maintain contact with family and friends at a time when person to person visits were not possible.

This technology also enabled patients to keep in contact with advocates, legal representatives and the wider care team.

Use of restraint

The Mental Health Act 1983 - Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. The Code is very clear that restraint must only be used as a last resort. Interventions that are used to restrain patients may take a number of forms including, physical restraint, confining patients to a limited space or closed room, locking doors to wards and chemical restraint. The Code also has a section on the use of mechanical restraint and in the event of any consideration of mechanical restraint being used, HIW must be consulted. 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 in place for the shortest possible period of time.

The Code also states that appropriate policies and procedures must be in place and appropriate guidance such as National Institute for Health and Care Excellence (NICE) is taken account of. All restraints must be thoroughly documented to ensure that the restraint is for the least possible time, is proportionate, and the issues/behaviour that led to the restraint are examined to determine whether other strategies could have been implemented to avoid a restraint taking place.

All patients should have an individualised risk assessment and associated care plan with a focus on reducing the need for a form of restraint. These plans should detail the "triggers" that lead to a restraint and comprehensively detail a plan for dealing with challenging behaviour that does not include restraint. During our inspections we found, some good examples of these plans.

During some of our inspections we identified issues with restraints including, the lack of a robust governance review of restraint data to ensure that the level and number of restraints was proportionate and always used as a last resort. In addition, there was a lack of evidence that demonstrated restraints were undertaken for the shortest possible time and staff had regularly evaluated, during the restraint, whether this could have ended earlier. We also identified, on some occasions, a lack of comprehensive analysis which documented and captured the descriptive detail and context around time of restraints and level of injuries sustained from the restraints. We also found on some occasions, a lack of environmental risk assessments to support staff in managing violence and aggression in small, confined areas and the lack of an embedded system to ensure the required risk control measures had been completed following a restraint.

Use of seclusion

The Mental Health Act 1983 - 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. On occasions we are informed that because a patient is confined to a room where the door is closed and not locked, it is not seclusion, this clearly is in direct contradiction to the Code of Practice. 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 NICE and other guidelines.

A number of Issues for seclusion were identified on our inspection visits. These included a lack of assurance that long term segregation or seclusion was appropriately managed within the confines of the Mental Health Act 1983 and the associated Code of Practice, in keeping with individual patient care plans, to ensure and allow opportunity for personal skills growth and development.

Section 136 Suites

Section 136 Suites are designated facilities that an individual is taken too by a police officer if they believe it is required in the interests of that person or for the protection of others. The removal of the person is only permitted in a place to which the public have access.

Within our inspections we visited one section 136 suite located within a hospital. Two issues were identified during the visit. These were that the health board ensures that the Section 136 suite remains open with sufficient staff available to cover admissions, and the health board ensures that there are appropriate privacy measures for the toilet located in the Section 136 Suite.

Patient Observations

Effective patient observation is the key to keeping the patient and others safe. Levels of patient observations used are:

- general observations
- 15-minute observations
- 30-minute observations
- hourly observations
- 1:1 observation
- 2:1 observation
- 3:1 observation.

In some exceptional circumstances 4:1 and 5:1 patient observation are also used.

During some of our inspections, we found that patient observational levels were routinely reviewed to ensure that they take account of any identified recent and historical risks and are regularly reviewed, by all members of the multi-disciplinary teams, and following any incidents. We identified a number of significant issues in relation to effective patient observations.

These included the review of how one-to-one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement, and a lack of accurately recording observations on the individual patient observational record sheets.

Meaningful and therapeutic activities

Providing a range of meaningful therapeutic, social and recreational activity can have a very positive impact on patient wellbeing and their recovery pathway. One of the greatest challenges, in the early part of the inspection year, was the provision of section 17 leave because of the continued effects of the pandemic. This was because of a lack of staff, due to their self-isolation because they had contracted COVID-19 and/or the imposition of local and/or national restrictions.

In terms of the provision of on-site recreational, social and therapeutic activities, a number of areas were identified for improvement on some of our inspections. These included a lack of assurance that patients were provided with appropriate activities that were targeted to improve their independence, development and growth. In addition, we identified the lack of monitoring of the number and reason why activities do not go ahead, or if they are postponed, to help identify any trends that could be resolved. We also identified the need for the review of the provision of therapeutic and social activities that are on offer, both within the hospital and in the community.

Whilst some of our inspections identified a good range of social and recreational activities that were available, we continued to identify a lack of meaningful therapeutic, social and recreational activity in some hospitals. This has been in a consistent theme in many of our mental health annual reports, the positive impact of these activities cannot be underestimated. Whilst it is acknowledged, as identified above, that COVID-19 has created many challenges in the provision of these activities, it is important that health boards and independent providers ensure the provision of these activities is a key priority in promoting patient wellbeing.

Medication Management

The safe and effective administration, storage and ordering of medication is an area that our inspection process routinely focuses upon. The majority of our inspections of mental health hospitals identified issues with medication management and this is the same as in previous years. Issues identified covered many different aspects of medicines management including:

- the room temperature of clinic rooms was not recorded, and arrangements were not in place to adequately manage the temperature of clinic rooms to enable medication to be stored within the temperature range advised by manufacturers
- a lack of an investigation and subsequent action in relation to the raised temperature in the clinical room
- Medication Administration Records (MAR) not completed correctly

- a lack of records for medication discussions with the patients recorded in patient notes
- medication not stored correctly
- temperatures on clinical fridges were not within the required temperature ranges and were not recorded on a daily basis
- a lack of recording of the opening date of liquid medications
- allergies were not clearly specified on drug charts
- staff were not aware of the location and content of the medication management policy
- standards for stock control for controlled drugs were not maintained in accordance with health boards own medications management policy
- medication fridges remaining locked when not being accessed by staff
- copies of consent to treatment certificates not found with the corresponding MAR chart
- registered nurses did not refer to the consent to treatment certificate when administering medication
- reason(s) were not documented for the administration of PRN medication on the MAR charts
- staff did not always fully complete the MAR charts and use the correct coding for why medication was not administered when this was applicable
- MAR charts did not always clearly identify which route of administration had been used when medication had been administered
- clinical rooms were not clean, organised, and clutter free
- all clinical policies were not reviewed and updated
- policies were not reviewed and updated regarding the use of non-registered nurses being used as secondary signature and provide training to staff
- a lack of clinical room audits completed at the required frequency
- regular audits on medication stock were not taking place
- medical devices were not cleaned and easily accessible
- sharps boxes were not removed and disposed of when full and were not stored appropriately, in addition, tracking labels were not completed correctly
- staff members were not consistently wearing the red tabard (designed so staff on medication rounds would not be disturbed) when delivering medication to patients on wards
- cupboards and trolleys were not locked when not being directly used. Regular checks should also be implemented to monitor and ensure ongoing compliance
- a lack of on-site external pharmacy audit visits to help improve governance arrangements regarding stock controls of controlled drugs and drugs liable to misuse
- an unsuitable location was being used to prepare and dispense medication to avoid any risk of potential medication errors.

Some of the above issues that we identified are very significant, such as a lack of recording of patient allergies. Issues with medicines management have been a reoccurring theme for many mental health annual reports, the issues identified are very broad and not confined to one area.

Health boards and independent providers must improve upon this area and ensure processes for medicines administration and storage are significantly improved.

Risk assessment and care planning

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. These plans under the Measure cover a number of distinct domains including:

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

The care and treatment plans may also consider other needs identified during the assessment process. In addition to the Measure, there must also be a robust risk assessment process in place that takes account of historical and present risks. Risks identified need to have a plan of care to mitigate against identified risks and strategies in place to manage these. Patient observations are one example of a strategy that may be used in managing patient risks.

In addition, 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 identified some examples of good practice including care and treatment plans which evidenced multidisciplinary team input and there was evidence of patient input. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- physical health needs were not always identified and when they were monitoring, and assessment records were not always completed
- reviews were not undertaken, and dates were not recorded in care plans
- COVID-19 care plans were not fully completed
- care coordinators were not identified and named in patient records and a there was a lack of process for following up on requests for care and treatment plans from the relevant care coordinator
- a lack of a documented audit of the care and treatment plans on the unit
- care and treatment plans were not always accessible and communicated appropriately to patients (and relatives where applicable)
- staff did not have access to an overarching care plan for patients to enable unfamiliar staff to adequately provide safe care for patients

- Care and treatment plans were not always available in line with the Mental Health (Wales) Measure 2010
- agency staff were not familiar with patient care plans and risky behaviours
- care plans should have a better focus on recovery and rehabilitation goals to enable patients to work towards discharge back into the community
- the primary and secondary interventions did not have sufficient detail and focus in the 'important for" section regarding health and safety requirements needed to keep the person safe from harm
- a lack of individual patient nutritional needs being clearly incorporated in to care plans
- Positive Behavioural Support (PBS) plans were not consistently located on the electronic patient record.

The above issues encompass a lot of different areas in relation to the care and treatment plans and risk assessments. Health boards and independent providers should have a robust care plan audit process in place to identify and rectify the above issues in a timely manner. We are disappointed to have again this year identified so many issues that could easily be rectified with a robust audit and governance process.

Some of the above issues resulted in a non-compliance notice, or for the NHS an Immediate Assurance letter, being issued. This meant that we alerted the service to our concerns during our visit and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can be accessed on our website, or by following the relevant hyperlink in Appendix A.

Environment of care

In response to the pandemic, some clinical areas had been redesigned. This included the creation of facilities for isolation of new patients on admission, and for existing patients when displaying symptoms of COVID-19 or returning from periods of leave. This was easier to achieve in settings with single bedroom and ensuite facilities, and was more challenging to achieve in other settings, particularly those services provided within older buildings.

Cleaning regimes have improved as a result of the COVID-19 pandemic and services have generally responded well to ensuring enhanced cleaning and infection control measures were put into place. However, our inspections continued to identify a range of safety, maintenance, redecoration, and refurbishment issues.

We identified instances of a lack of environmental audits and where some of these audits had been undertaken there was no evidence that the issues identified were reviewed, given suitable timescales, and actioned appropriately. This meant that issues of patient safety were not addressed in a timely manner, a specific example of this was the need to review an environmental risk assessment to ensure that all risks have been identified and mitigated. In addition, there was a lack of evidence that ligature risk assessments had been reviewed to ensure the follow-up actions had been appropriately actioned and recorded.

Other issues identified included, the need for improvements to be made to the environment to ensure patients have a level of privacy in bedroom areas, showers, baths and toilets not working and some areas were in need of redecoration and routine maintenance. We also identified that environmental damages were not rectified in a timely manner and patients did not have the facility to obscure their bedroom window from external light and maintain their privacy.

One area that required immediate improvement was a cracked windowpane that posed a significant risk to patients. In addition, issues with patient kitchen areas and garden areas were identified.

The range of issues identified above do not demonstrate robust audit and governance processes for repairs, redecoration and environmental patient safety issues being identified and addressed in a timely manner.

Workforce

Access to sufficient, knowledgeable, and well-trained staff is critical for patients to receive safe and effective care. On a positive note, in many of our inspections we had a great deal of positive feedback from patients in relation to a positive staff attitude and their caring approach. In addition, this positive approach and a positive therapeutic relationship was observed during many of our visits.

However, whilst it is acknowledged that workforce availability is a national issue, we identified a range of issues with staffing in the majority of our inspections, these are outlined below:

- vacancies were not always filled, and future options were not sufficiently explored to encourage recruitment into the hospital
- we were not always assured there was sufficient staffing to provide appropriate clinical care to support and maintain the safety of some wards
- staff working excessive hours and regularly working beyond the end of their shift, staff informed us they were not always having meal breaks during 12-hour shifts and we were informed that staff had notified management of the situation, but it had not changed
- staff were being used from the Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long term leave. As a result, this had impacted upon the capacity of the Psychiatric Liaison Team to undertake their role
- staff rotas we reviewed highlighted a number of unfilled shifts
- staff rota records were not robustly managed and changes/amendments to staffing were not accurately recorded
- it was not evident that up-to-date ward acuity assessments had been completed to identify the required staffing levels. It is unclear if the current staffing levels were suitable for the current acuity and patient demands on the unit
- a lack of staffing to enable therapeutic and social activities to be undertaken as part of the hospital's rehabilitative focus
- a lack of staff to maintain a safe environment at all times including additional staff to cover observation times

- a review of the capacity of occupational therapy services to ensure that patient needs are fully met
- a lack of sufficient female staff to adequately cover the ward and provide dignified care to patients
- a lack of a stable workforce to reduce reliance on agency staff and provide HIW with assurances that systems are in place to ensure unfamiliar staff have a good knowledge on patients to provide safe and effective care
- a lack of workforce planning arrangements to ensure a consistent staff team is in place to provide support and rehabilitative care for patients and to monitor and prevent staff fatigue
- a lack of an appropriate level of long term cook provision
- a lack of staff to facilitate section 17 leave.

It is evident from the diverse range of findings on workforce that there are significant staffing challenges that continue to have a negative impact on patient safety, recreational and social activities, section 17 leave activities and care and treatment. Whilst it is recognised that there is a national shortage of a range of healthcare staff, planning and robust governance is key to mitigating against the potential risks of a lack of staff. It is unfair, and arguably unsafe, to expect an already stretched nursing staff to not have sufficient breaks and their concerns listened too.

When agency staff were used it was not always documented that they had the skills and knowledge to work with a specific patient group. In addition, when it is necessary to use agency staff, it is much more desirable to use the same agency staff as opposed to different individuals for each shift. Patients with a mental health and learning disability need to have continuity of care from staff that know them well to have an effective care and treatment approach in place.

Governance

It is evident from the range of findings within this report that robust governance and audit processes were not in place during many of our inspections. Specific issues identified included, a lack of monthly reviews of incidents and a lack of assurance from a health board that our findings were not indicative of wider systemic issues with the provision of safe and effective care. We also identified a lack of support from another health board for a unit to develop and implement a clear service model and ethos, and a lack of assurance from a registered provider did not provide assurances that robust systems and processes are in place for dealing with safeguarding matters and referrals.

In addition, we identified that a registered provider did not have a robust system of monitoring in place to ensure that staff appraisals and supervision was regularly taking place. The same registered provider was not ensuring that governance and audit arrangements were adequately embedded throughout the hospital and that information was being regularly assessed, monitored and documented, to ensure the quality of the service and to identify, assess and manage risks relating to safe patient care.

We also frequently identified a lack of a robust governance system in place to record, analyse and review restraint data. This is extremely concerning as restraint should always be used only as a last resort and implemented within a robust care plan process by appropriately trained staff. All restraints must be subject to a level of scrutiny to ensure that they are conducted appropriately and for the absolute minimum time period and a lesson learnt is routinely undertaken after each restraint. We also identified the lack of a clear governance and clarity of purpose for the de-escalation room.

There was a lack of regular environmental audits to identify any unreported damaged areas and a lack of scrutiny that the multidisciplinary teams and Ward staff need to work collaboratively to optimise patient care. In addition, a registered provider needed to consider how the links between senior managers and ward staff at the hospital could be strengthened. In some of our inspections we also identified a lack of review and update of policies and the implementation of an audit of policies to ensure that ward staff had access to, and are referring to, the most recent version.

Findings specific to Learning Disabilities

During our inspection of learning disability services, we noted the positive therapeutic relationship between staff and patients. We also identified a range of patient information presented in an appropriate format for this patient group. However, many of the areas identified above were also identified within the learning disability services that we visited. In addition, to those findings, we have highlighted below some specific findings from our learning disability inspections:

- we required additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit
- we required details of how the health board would ensure that the environment was adjusted and maintained to ensure that environmental triggers to challenging behaviours were reduced and allowed access to suitable outdoor space
- we required assurances of how a health board would ensure that appropriate access to toilets, bathrooms and handwashing facilities would be provided for patients at the service
- we required assurance from the health board that, every effort was made to gather patient voice data on their views of the service provided and patients were able to provide feedback on their experiences of physical restraint
- we required assurance from a health board that patients were provided with appropriate activities that were targeted to improve their independence, development and growth
- the need to explore creative ways to enable patients to personalise their rooms during their stay at a Unit
- the need to review the capacity of occupational therapy service at a unit to ensure that patient needs are fully met
- a lack of a clear service model and ethos

- a registered provider needed to provide a detailed report and timeline on the events leading to a patient who was left sleeping on a mattress, awaiting a replacement bed
- reactive strategies must have more detail regarding specific responses and physical interventions employed
- a lack of information displayed in an accessible format for the patient group.

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

Findings specific to CAMHS

During 2021-2022 we inspected two of the three in-patient CAMHS units in Wales. We identified a number of positive findings that included, staff interacting with patients respectfully and evidence of good team working. In addition, staff had a good level of knowledge of the patients being cared for. During both inspections a range of educational, recreational and social activities were being provided.

However, our inspections also identified a range of issues that included:

- some clinical issues specifically reviewing the Nasogastric (NG) Insertion and Positional Confirmation for Adults, Children and Infants policy, or ensuring staff had access to the latest version
- care plans for patients requiring NG tubes did not outline the individual wishes of the patient to help best achieve successful feeding
- a lack of documentation to ensure that decisions to administer medication via NG feeding was justified
- a lack of documentation to ensure that details of the NG feeds were documented in patient care plans and minutes of meetings where this decision was made being available for staff to check
- the administration of medication via NG feed did not comply with medication guidelines
- a range of issues with the management of medicines including, medication medicine charts were not completed accurately and in full, medicine fridges were not cleaned and locked in clinical areas, out-of-date medication was not disposed of in a timely manner, incorrect auditing of out of-date medication and medication stock and a controlled drugs book was not accurately completed
- a lack of robust systems and processes in place for accurately recording all incidents and restraint data. These systems and processes are crucial to ensure all incidents are analysed for themes and trends and these must feed into individual patient risk assessments/management plans
- a lack of comprehensive risk assessments and care plans in place that provided specific and sufficient detail to enable and guide staff to provide safe and effective care

- insufficient governance and audit arrangements that were not adequately embedded to demonstrate that information was being regularly assessed, monitored, and documented, to ensure the quality of the service and to identify, assess and manage risks relating to safe patient care
- staffing did not always meet the needs of the patient group
- improvement was required in appointing to staff vacancies for the current recruitment process and retention of staff to maintain a stable staffing group for patients.

The Welsh Government published a reducing restrictive practices framework guidance on reducing restrictive practices in childcare, education, health and social care settings. This guidance covers a number of key areas including, positive behavioural support which is highlighted as an example of an approach that includes the key components required to support effective person-centred practice. The guidance document is also key in promoting a positive therapeutic approach for all the in-patient settings that we visit as part of our inspection programme and is part of our revised methodology that is to be introduced in April 2022.

6. Monitoring the Mental Health Act, 1983

Monitoring how services discharge their powers and duties under the Mental Health Act 1983 and amended in 2007, is a key responsibility of HIW, undertaken on behalf of Welsh Ministers. As part of our statutory responsibilities HIW provides 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 Mental Health Act 1983.

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

How the Mental Health Act, 1983 is monitored

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

On behalf of Welsh Ministers, we:

- Publish an annual report detailing how the Mental Health Act is being implemented in Wales
- Review how powers granted by the Mental Health Act are exercised.
- Operate the SOAD service
- Investigate complaints about application of the Mental Health Act.

During our inspection visits of 2021-2022 we checked that patients were:

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

We achieved the above by talking to detained patients and their relatives when we visited, including consideration of the audit and governance processes in place. We also spoke to staff including Mental Health Act administrators and other key individuals. In addition, we examined Mental Health Act detention papers to ensure patients were lawfully detained and the Mental Health Act 1983 Code of Practice for Wales 2016 was taken into consideration.

Mental Health Act Reviewers

During our visits to mental healthcare services, we were accompanied by experienced Mental Health Act Reviewers to assist us in determining whether the Mental Health Act was being lawfully applied and the Mental Health Act 1983 Code of Practice was being adhered too. A sample of patient records were examined, and a number of key areas were considered during our inspections including:

- detention papers were comprehensively completed and accessible to key individuals, including ward staff
- detained patients were informed of their rights, and this was recorded under section 132 of the Act
- section 17 leave documentation was appropriately documented
- policies and procedures reflected the requirements set out in the Mental Health Act Code of Practice 2016
- the detention of patients was routinely reviewed, and they had access to legal services and advocacy
- patient information on the Mental Health Act was routinely available and in a variety of formats and languages.

Our Findings

Mental Capacity

An assessment of a patient's capacity to consent is a key factor in determining whether the Mental Health Act or DoLS is appropriate. During our visits we identified a range of issues in relation to capacity to consent including:

- a lack of completed capacity assessments that were recorded in patient records
- a lack of evidence-based assessments for capacity to consent to treatment within the Mental Health Act Records
- a lack of reference to the consent to treatment certificates, by registered nurses, when administering medication
- copies of consent to treatment certificates were not maintained with the corresponding MAR Chart.

Lawful detention

A key component of our inspection process is the review of statutory detention documentation to ensure the patients, whose records we reviewed, were legally detained. We saw some evidence of good internal administrative audits and medical scrutiny. Detentions were commenced and had been renewed within the requirements of the Mental Health Act and the Code of practice had been taken into account.

We examined both paper and electronic documents that were held securely in the Mental Health Act Administrator's office and on the wards. During some of our visits we identified a lack of regular audits of the paperwork relating to the Mental Health Act and a lack of the results provided to the ward for them to carry out any required actions. Regular comprehensive audits are essential to ensure that the detention is lawful, managers hearings are undertaken in a timely manner and all detentions are undertaken within the requirements of the Mental Health Act.

Section 17 leave

Section 17 leave was one of the areas that we identified the most number of issues with during our visits. The issues identified included:

- a lack of the patient signing the section 17 leave form to evidence that the patient understood the agreed conditions of leave
- a lack of a clear record of patients receiving a copy of their leave form or the reason why this had not occurred
- no provision on Section 17 leave forms to indicate a patient's agreement or that they have been offered a copy of the form
- ensuring that where a patient lacks the capacity to consent, this is recorded on the leave form
- a lack of a record of the patient's involvement in decision around their leave

- the involvement of families, where appropriate, being documented on the section 17 leave form
- Section 17 leave forms were not always completed accurately and in full.

Ensuring patients' rights

The rights of patients are vitally important when they are detained under the Mental Health Act 1983. Section 132 and 132A of the Act places a duty upon the hospital managers to ensure detained patients understand how the Mental Health Act 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. Patients must also be given information in relation to legal advice and services, how to access advocacy services and how to make a complaint.

During our inspections we identified, on occasions, that there were no clear records of patients being informed of their rights and the outcome of the discussion, or the reason why this had not occurred. Where this was the case, we made recommendations to healthcare providers to improve in this area.

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.

Statutory consultees must know the patient well enough to undertake the role and during the discussion with the SOAD they should consider commenting on the proposed treatment and the patient's ability to consent to that treatment, the views and wishes of the patient, any other possible treatment options and the facts of the case.

During our inspections we found that statutory consultees were not always documenting their views, in the patient's record, on the medical treatment authorised by the second opinion appointed doctor.

Audit and governance arrangements

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

The findings detailed above illustrate where we identified gaps in robust audit and checking arrangements. Section 17 was a particular issue where the documentation fell short of what was expected. It is essential that health boards and independent providers improve on the governance arrangements in this area.

In addition, an assessment of a patient's capacity to consent is a key factor in determining whether the Mental Health Act is appropriate, and this area must be routinely audited, with any issues identified addressed as a matter of priority.

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 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 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 Second Opinion Appointed Doctor (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, 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.

Since the beginning of the COVID-19 pandemic, the SOAD service has operated using an adapted 'COVID-19 safe' methodology. This meant that hospital visits were suspended, and a digitally enabled approach was put in place to ensure that SOADS were able to fulfil their statutory responsibilities, including having discussions with patients and staff. Full details of the temporary methodology can be viewed on the RSMH pages of the HIW website.

However, it is envisaged that onsite SOAD visits to meet patients face to face will recommence during 2022-2023.

SOAD training

A regular programme of training is provided to all our SOADs to encourage best practice and improved knowledge. In the year 2021-2022 one training event was held, focussing on the topic of Depression Treatment and Medications. The next training session is scheduled for early 2022 focussing on legal updates to the Mental Health Act 1983.

SOAD activity

During the period April 2021 to March 2022, the RSMH received 759 requests for a visit by a SOAD. This figure is a very slight increase from the April 2020 to March 2021 requests.

These figures can be broken down as follows:

- 657 requests related to the certification of medication
- 66 requests related to the certification of ECT
- 36 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 2019-2020.

Requests for visits by a SOAD, 2006-2007 to 2021-2022[1]

Year	Medication	ECT	Medication & ECT	Total
2006-2007	428	106	3	537
2007-2008	427	79	5	511
2008-2009	545	60	2	607
2009-2010	743	57	11	811
2010-2011	823	61	17	901
2011-2012	880	63	1	944
2012-2013	691	59	8	758
2013-2014	625	60	5	690
2014-2015	739	68	5	812

[1] Source: SOAD requests to HIW

2015-2016	793	60	16	869
2016-2017	841	71	2	914
2017-2018	830	52	25	907
2018-2019	834	51	25	910
2019-2020	877	51	26	954
2020-2021	693	43	20	756
2021-2022	657	66	36	759

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:

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

Whilst we strive to meet the above timescales, there are a number of reasons why sometimes the timescales are not met. Some of these reasons include the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. However, this has significantly improved since the introduction of telephone consultations with the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has also resulted in an improvement in the time taken to complete 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.

Throughout the pandemic we have continued to work with the Mental Health Act Administrators in local health boards and independent mental healthcare settings to ensure that the SOAD referral and assessment process was completed in a timely way. We intend to keep elements of the COVID-19 safe methodology to maintain the improvements in the referral and assessment timescales seen during the reporting period. This will include, offering the option of telephone or video conference consultations with the Responsible Clinician and Statutory Consultees, and maintaining the requirement for health boards and independent mental health hospitals to provide information for the SOAD in advance.

Review of treatment (Section 61)

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 Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the sixth consecutive year, HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed on a monthly basis by our lead SOAD for Wales.

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 few occasions where more medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

We stated last year it is our intention to improve these forms. HIW has implemented a new CRM system which will enable more thorough reporting on these figures in future mental health and learning disabilities annual reports. To this end, the audits of the review of treatment forms will be ongoing and further findings will be reported upon during our 2022-2023 report, where figures will be provided, including totals and outcomes.

8. Our Data

To prepare this report we analysed data from our work between April 2021 and March 2022, including our Mental Health Act monitoring activities, quality checks, and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Feedback on this report

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

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Appendix A: Relevant work 2021-2022

Hospital		Date	Type
1	Learning Disabilities Residential Service, Hywel Dda University Health Board	7/04/2021	Quality check
2	Learning Disabilities Residential Service, Cwm Taf Morgannwg University Health Board	13/04/2021	Inspection
3	Cefn Carnau Uchaf, Thornhill, Caerphilly	13/04/2021	Inspection
4	Royal Glamorgan, Pontyclun	20/04/2021	Quality check
5	Aneurin Bevan University Health Board	20/04/2021	Quality check
6	Cefn Carnau Uchaf, Thornhill, Caerphilly	06/05/2021	Inspection
7	Ysbyty Cwm Cynon, Mountain Ash	12/05/2021	Quality check
8	Llwyneryr Unit, Morriston, Swansea	19/05/2021	Quality check
9	Aberbeeg, Pendarren, Abertillery	24/05/2021	Inspection
10	Mesen Fach, Bryn y Neuadd	27/05/2021	Quality check
11	Bronllys, Brecon	15/06/2021	Inspection

12	Hafan Derwen, St David's Carmarthenshire	16/06/2021	Quality check
13	Pinewood House, High Street, Treorchy	20/07/2021	Quality check
14	Withybush Hospital, Fishguard Road, Haverfordwest	12/08/2021	Quality check
15	Hergest Unit, Ysbyty Gwynedd	06/09/2021	Inspection
16	St Cadocs, Lodge Road, Caerleon, Newport	13/09/2021	Inspection
17	Hergest Unit, Ysbyty Gwynedd	20/9/2021	Inspection
18	Ty Gwyn Hall, Llantillio Pertholey, Abergavenny	5/10/2021	Inspection
19	St Peter's, Chepstow Road, Langstone, Newport	11/10/2021	Inspection
20	Tan y Coed, Bryn y Neuadd, Llanfairfechan	19/10/2021	Inspection
21	Hywel Dda University Health Board, Parc Dewi Sant, Carmarthenshire	1/11/2021	Quality check
22	Llanarth Court, Raglan	1/11/2021	Inspection
23	Tŷ Llidiard, Coity Road, Bridgend	08/11/2021	Inspection
24	Priory Church Village, Tonteg, Pontypridd	15/11/2021	Inspection

25	Hillview, Ebbw Vale	15/11/2021	Inspection
26	Heatherwood Court, Llantrisant Road, Pontypridd	29/11/2021	Inspection
27	Rushcliffe, Scarlet Avenue, Aberavon, Port Talbot	30/11/2021	Inspection
28	Cefn Carnau Uchaf, Thornhill, Caerphilly	06/12/2021	Inspection
29	Brecon and District Community and Mental Health Centre, Bridge Street, Brecon	14/12/2021	Inspection
30	Tŷ Cwm Rhondda, Tyntyla, Ystrad, Pentre	10/01/2022	Inspection
31	Aderyn, Usk Road, Penperlleni, Pontypool	31/01/2022	Inspection
32	Hafan y Coed, Penlan Road, Penarth	14/02/2022	Inspection
33	Coed Du Hall, Nantalyn Road, Mold	28/02/2022	Inspection
34	Learning Disabilities Residential Service Betsi Cadwaladr University Health	28/02/2022	Quality check
35	Cefn Coed, Cockett, Sketty, Swansea	14/03/2022	Inspection
36	Swansea Bay University Health Board, Learning Disability Service	15/03/2022	Inspection

37	St Teilo House, Rhymney, Tredegar	28/03/2022	Inspection
38	Pinetree Court, Newport Road, Cardiff	29/03/2022	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
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 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services Part 4 – Mental health advocacy
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

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