Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health Hospitals Learning Disability and Mental Health Act Inspections

Annual Report 2016-2017

March 2018

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

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1 Executive Summary

Introduction

During 2016-17 we inspected mental health establishments in Health Boards (HB's) and independent mental health and learning disability hospitals. These inspections give Healthcare Inspectorate Wales (HIW) an informed insight into how these services are meeting the needs of this vulnerable group of patients. During these inspections we have covered a number of key areas including;

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

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

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

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

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

In addition, to the above this year we have also undertaken some specific work on elderly care wards and Child and Adolescent Services (CAMHS). We have reported on these two distinct areas separately within this report. Following all our visits we formulate detailed reports and these can be found on our website along with the action plan that HBs and individual providers have submitted to reassure HIW how our findings will be addressed.

Our work

During 2016-17 HIW conducted a total of 29 Inspections (28 hospitals visited 1 visited twice) specifically we conducted 53 Mental Health Act Monitoring visits, a number of which were undertaken as part of our in-depth mental health inspections.

During this inspection year we have issued 19 immediate assurance letters requiring a quicker assurance to some of the more urgent findings from our visits for both the HB's and the independent providers of healthcare.

What we found

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

- Patients expressed satisfaction with the standards of care and caring approach displayed by staff
- Comprehensive and well maintained Mental Health Act records
- Comprehensive assessments of Capacity
- NHS hospitals continuing working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), and Safe wards, this is to be commended;
- The level of psychology and occupational therapy input across the independent sector is noteworthy.
- The openness of staff and patients to engage with the inspection process across both NHS and independent hospitals is generally very good.
- The positive rapport between patients and staff, despite staff dealing with very challenging patients;

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

- Concerns about the choice, quality of food and a lack of evidence that the nutritional needs of patients were being met
- The delivery of physical healthcare
- A lack of infection prevention and control
- A lack of robust processes for managing risk
- A lack of maintenance
- A lack of robust care and treatment planning including risk
- A lack of sufficient in-patient beds
- Availability of sufficient staff with the right skills and knowledge

Particularly disappointing was the number of significant issues that were identified during 2015-16 but continued to be an issue during 2016-17. Health Boards and Independent providers must develop long term strategies to sufficiently address the areas identified within this report and to ensure that the needs of this vulnerable patient group are sufficiently addressed.

2 Admission of patients to mental health facilities in Wales[1]

In 2016-17, the total number of admissions to mental health facilities in Wales was 8,723. This was a decrease of 574 (6 per cent) compared with 2015-16.

People who are compulsorily admitted to hospital are called 'formal' patients and people who are admitted to hospital when they are unwell without the use of compulsory powers are called 'informal' patients.

In 2016-17, 1,776 people were admitted formally to a mental health facility in Wales for assessment and/or treatment. This represents an increase of 44 (3 per cent) compared with 2015-16.

Table 1 shows a breakdown of patient admissions to mental health facilities from 2013-14 onwards. Please note that the official statistics were revised by Welsh Government in January 2018, following the discovery of a data issue in one of the health boards. As a result, some of the data for 2015-16 in the table below has been revised downwards and denoted (r).

Table 1: Number of patient admissions to mental health facilities, 2013-14 to 2016-17

Legal status	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Formal admissions	1,692	1,921	1,732 (r)	1,776
Informal admissions	8,582	7,841	7,565 (r)	6,947
All admissions	**10,274**	**9,762**	**9,297** (r)	**8,723**

Source: Welsh Government Statistics

In 2016-17, formal admissions accounted for 18 per cent of all admissions to NHS mental health services and 92 per cent of all admissions to independent mental health hospitals. One of the key reasons for this difference is that patients are generally admitted to independent mental health hospitals when they are already detained and require complex packages of care and treatment following a diagnosed mental illness. The NHS admits patients from the general public whereas the independent providers generally only admit

[1] The statistics in this chapter are taken from the official statistics published annually by Welsh Government. As they can be subject to revision, for the latest statistics please refer to the statistics on the Welsh Government's website. Healthcare Inspectorate Wales will not be revising this report, or previous versions of this annual report, if the official statistics are revised.

patients from NHS establishments. Within the NHS mental health services generally the length of stay is considerably less than in the independent sector and informal admissions for a short period of time are very common.

The total number of admissions has been reducing over the last few years, but it is difficult to observe a trend in the formal admissions due to the revision of the figures for 2015-16.

Figures for the total admissions to NHS mental health facilities by health board and independent settings are shown in Table 2.

Table 2: Number of patient admissions to mental health facilities by setting (NHS and Independent Mental Health Hospitals), 2016-17

Local Health Board/ Independent Hospital	Number	
	Informal	Formal
Betsi Cadwaladr UHB	887	375
Powys Teaching HB	271	48
Hywel Dda UHB	544	224
Abertawe Bro Morgannwg UHB	2,079	288
Cwm Taf UHB	1,037	108
Aneurin Bevan UHB	1,306	151
Cardiff and Vale UHB	803	354
Independent Hospitals	20	228
Wales	**6,947**	**1,776**

Source: Welsh Government Statistics

For NHS providers in Wales in 2016-17, Betsi Cadwaladr University Health Board had the highest number of formal admissions, (375) and accounted for almost one in four of all NHS formal admissions (24 per cent). Abertawe Bro Morgannwg University Health Board had the highest number of informal admissions (2,079), which accounted for almost a third (30 per cent) of all informal admissions).

2.1 Use of Section 135 and 136 powers – removal of an individual to a place of safety

Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear, to be mentally disordered. Police officers may use powers of entry under Section 135 of the Act to gain access to a mentally disordered individual who is not in a public place. If required, the police officer can remove that person to a place of safety. A place of safety may be a police cell, a hospital based facility or 'any other suitable place, the occupier of which is willing temporarily to receive the patient'

Section 136 of the Act allows police officers to detain an individual who they find in a public place who appears to be mentally disordered and is in immediate need of care or control.

Both Section 135 and Section 136 allow for an individual to be detained in a place of safety for up to 72 hours. During this time period an assessment is undertaken to determine whether hospital admission, or any other help, is required. Section 136 is used significantly more often than Section 135. Table 3 shows the number of uses of Section 135 and 136 in Wales in 2016-17.

Table 3: Completed Mental Health Act assessments in hospital under Section 135 and 136, 2016-17

	Hospital is first and only Place of Safety Detention	Hospital is subsequent Place of Safety Detention after transfer from:			Unknown	Total Assessments
		Another Hospital	Police Station	Another Place		
Section 135	50	0	0	0	0	50
Section 136	1,722	18	33	3	3	1,779

Source: Welsh Government Statistics

For the majority of completed Mental Health Act assessments under both Section 135 and 136 in 2016-17, a hospital was the first and only place of safety. There were 33 completed Mental Health Act assessments under Section 136 that had been transferred from a police station, this is a 70 per cent reduction, compared with the 108 completed in 2015-16. The Mental Health Crises Care Concordat is a Welsh Government and partner agency strategy and commitment. A key objective of this is to stop using police custody suites as a place of safety expect in exceptional circumstances. Clearly this initiative has had a significant impact upon this area and great improvements have been made.

2.2 Community Treatment Orders

Community Treatment Orders (CTOs) were introduced in November 2008. 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.

Table 4 shows the health board breakdown of people discharged from hospital under a CTO in 2016-17 and Table 5 shows the outcome of those who are subject to a CTO in 2016-17 (numbers include discharged patients who had started their CTO in previous years). In 2016-17, there were 206 people discharged from hospital under CTOs in Wales. Of those patients still subject to a CTO in 2016-17, there were 128 recalls to hospital, 89 revocations and 132 discharges.

Table 4: Patients discharged from hospital under Community Treatment Order (CTO), 2016-17

Local Health Board	Legal status prior to CTO		Total
	Section 3	Other sections	
Betsi Cadwaladr UHB	26	*	*
Powys Teaching HB	7	0	7
Hywel Dda UHB	38	0	38
Abertawe Bro Morgannwg UHB	33	0	33
Cwm Taf UHB	33	*	*
Aneurin Bevan UHB	25	0	25
Cardiff and Vale UHB	25	0	25
Wales (a)	**202**	**4**	**206**
(a) Wales totals include patient discharged from independent hospitals under supervised			

community treatment.
* Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals. Further figures (5 or more) have also been suppressed to avoid secondary disclosure.

Source: Welsh Government Statistics

Table 5: Community Treatment Order (CTO) patient outcome, 2016-17

Local Health Board	CTO related activity				
	Recall	Revocation	Discharge	Assignment to the hospital of a CTO patient	Assignment from the hospital of a CTOI patient
Betsi Cadwaladr UHB	20	14	17	*	*
Powys Teaching HB	*	*	10	0	0
Hywel Dda UHB	21	16	23	*	*
Abertawe Bro Morgannwg UHB	35	19	5	0	0
Cwm Taf UHB	18	11	18	*	*
Aneurin Bevan UHB	17	16	18	*	*
Cardiff and Vale UHB	14	11	36	0	0
Wales (a)	**128**	**89**	**132**	**9**	**7**

(a) Wales totals include patient discharged from independent hospitals under supervised community treatment.
* Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals.

Source: Welsh Government Statistics

3 What we did

3.1 Strategic Framework

Together for Mental Health is the Welsh Government's 10 year strategy to improve mental health and well being. This is supported by a three year delivery plan (2016-19) which set out the key actions for the Welsh Government and stakeholder agencies in the statutory and third sector. In addition the Well-being Future Generations (Wales) Act 2015 set out some key priorities to make public bodies such as the NHS and Social services think about long term plans, work more closely with people and communities and work in a more joined up way .

This is particularly relevant for patients with mental health problems as most are cared for in the community with support from multiagency teams.

Our role in regard to mental health

The independent healthcare providers are regulated by HIW who has the responsibility for the registration and inspection of mental health and learning disability hospitals. All independent healthcare is regulated under the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards. HIW also has the responsibility for the inspection of NHS services, including mental health.

HIW discharges its responsibility by planning and undertaking a comprehensive programme of inspections to establish whether patients are receiving an appropriate level of care and treatment. The inspections also consider some of the wider issues including; staffing and training, the environment of care, patient care documentation. In addition, where appropriate, specific reviews of the care of detained patients and implementation of the mental health measure

Since 2009 HIW has also, on behalf of Welsh Ministers, been responsible for monitoring how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983. We do this by;

- Visiting detained patients in hospital settings and reviewing their care treatment and detention paperwork;

- Providing a registered medical practitioner to authorise and review proposed treatment in certain circumstances (the Second Opinion Appointed Doctor Service);

- Investigating complaints relating to the application of the Act; and

- Producing an annual monitoring report.

3.2 Using intelligence to focus our work

HIW uses intelligence as part of a risk-based approach to influence our work programme. Further information on our risk strategy and our use of intelligence is published on our website http://hiw.org.uk/about/plans/operating/?lang=en.

One key element of the intelligence that we use to focus our mental health work comprises concerns and complaints received from patients, carers or members of the public.

In the period 2016-17 HIW received a total of 329 complaints and concerns via letter, email or telephone either directly or via a third party (compared with 324 complaints received in 2015-16). Of these, 41 (12%) were in relation to NHS mental health settings and a further 67 (20%) related to independent mental health settings. We have seen an overall reduction of 28% in the number concerns received relating to mental health services compared to 2015-16. In this period, those concerns received related to:

Table 6: Complaints and concerns received relating to mental health services, 2016-17

	NHS		Independent	
	2015-16	**2016-17**	**2015-16**	**2016-17**
Whistleblowing	0	3	2	9
Patient abuse	4	2	11	5
Infrastructure/staffing/facilities/ environment	10	5	29	27
Consent/communication/confidentiality	3	1	3	0
Treatment/Procedure	22	26	44	21
Other	11	4	11	5
Total	**50**	**41**	**100**	**67**

The table above illustrates that there was a significant change of 52% in the number of independent sector complaints and concerns relating to treatment/procedure.

These concerns were received from a number of sources as set out below:

Table 7: Source of complaints and concerns, 2016-17

	NHS		Independent	
	2015-16	**2016-17**	**2015-16**	**2016-17**
Patient	18	14	28	18
Relative/Advocate/Other	24	24	35	27
Staff/Whistle-blower	8	3	37	22
Total	**50**	**41**	**100**	**67**

As Table 7 indicates, we have seen a 44% reduction in the number of staff/whistle-blower raising concerns with HIW, the reason for this may be linked to the reduction in complaints and concerns in the independent sector, but it is not clear what has lead to this reduction.

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

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

During 2016-17, HIW received 246 notifications of patient safety incidents that occurred within independent mental health care settings. This is a reduction of 23 notifications from 2015-16. These were broken down into the following categories:

Table 8: Regulation 30/31 notifications, 2016-17

	2015-16	**2016-17**
Serious injury	141	144
Unauthorised absence of a patient	63	47
Allegation of staff misconduct	38	39
Death of a patient	8	6
DOLS	15	8
Other	4	2
Total	**269**	**246**

The table above suggests that the prevalence of each type of incident has remained relatively static in comparison with 2015-16, with the largest reduction seen in the in the number of unauthorised absence of patients.

The information provided on the notifiable event forms enables HIW to assess a healthcare provider's ability to comply with the 2011 Regulations and ultimately that patients are being appropriately safeguarded.

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

3.3 Where we visited

During 2016-17 we conducted 29 inspections of NHS and independent mental health and learning disability hospitals. Within these visits we also considered how the HBs and individual registered providers addressed the following;

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

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

3.4 How we inspect

We use a range of methodologies to undertake our inspections and these include; naturalistic observations, analysis of data for trends and the analysis of documentation. During 2016-17 revised mental health audit tools were devised including the tools to monitor the Mental Health Act and compliance with the associated Code of Practice for Wales. These tools place the patient experience at the centre of the inspection process and cover a number of key areas including:

- Care planning and risk assessments
- Concerns, complaints and incidents
- Restraint and intensive care facilities where used
- Environment of care
- Privacy and dignity
- Medicines management including, ordering, storage and administration
- Availability of advocacy
- Nutrition
- Areas that have been externally accredited such as AIMS and safe wards
- Consent to treatment.

Visits are primarily commenced during the evening and are unannounced. Evening visits provide an invaluable insight into how an establishment functions during a 24 hour period. The visits to mental health units usually last between 2 and 3 days and the focus is upon the patient safety and experience. The team that visits comprises HIW staff and a peer and a lay reviewer. In addition, an individual with expertise in the administration of the Mental Health Act also makes up the inspection team.

4 What we found

4.1 Inspections of mental health services

4.1.1 Quality of patient experience

Engagement of patients and significant others is at the centre of all our inspections. A key priority of our visits is to engage with as many patients, visitors, relatives and staff as we possibly can. There are a range of tools that enable the inspectors to establish how patients feel about the care and treatment they are receiving.

Overall the feedback that we received from patients indicated that they were generally happy with the quality of their care .In addition, we received positive feedback about the caring approach displayed by staff. However, a number of issues were raised during inspections particularly with regard to meals and maintaining the privacy and dignity of patients.

Effective nutrition, variety and choice are particularly important in mental health establishments where patients may be resident for longer periods of time.

In 10 inspections (34%) concerns were raised about the quality of food. A range of issues were identified including:

- Lack of choice and variety at mealtimes;
- Lack of fresh fruit and vegetables;
- Lack of evidence that the nutritional needs of some patients were being met;
- Patients stated that concerns and feedback about meals were not acted upon.

We also found a reoccurring theme relating to preserving privacy and dignity in over half of the units visited. This occurred in both NHS and independent hospitals The issues identified included; shared bedroom facilities, vision panels in patient bedroom doors being left open routinely and patient information not protected from being seen by others. In addition, the availability of keys for bedroom doors was an issue and patients felt that it was demeaning to have to ask for access to their bedrooms if the doors were

locked. An inability to lock the doors was also an issue to preserve their privacy and dignity.

Last year patients told us that there was a lack of meaningful and engaging activities and although this was still an issue patients did report that this had improved during 2016-17. In a total of 28 hospitals visited in 6 patients stated that there were a lack of meaningful activities taking place and these appeared to be for a variety of reasons including a lack of therapists.

4.1.2 Delivery of safe and effective care

Physical health care

The physical health care that patients receive is an important contributory factor to their mental health. If a person is physically unwell then this can have a detrimental effect on their mental state.

Last year we identified that within 36% of the units visited physical health care was an area of concern .The physical healthcare of patients has improved from last year but still remains an issue. Out of a total of 28 hospitals visited within 6 (21%) of these we identified that patients were continuing to have difficulties in accessing appropriate physical healthcare.

Particular concerns included: the lack of a pain assessment tool; lack of a diabetic care plan; and a lack of detail with wound care including care planning If a patient is in pain due to an infected wound this can impact considerably on any efforts to treat a mental health problem. The issues identified were within both the NHS and the independent sector.

Case Study

In February 2017, HIW undertook an inspection to Ysbyty Cefni part of Betsi Cadwaladr University Health Board (BCUHB). During the visit it was identified that an assessment for pain was only being utilised for patients when they were thought to be in pain. Therefore, patients who were unable to verbalise any discomfort were not being assessed for pain routinely. This was unsatisfactory and meant that there was an unacceptable risk that patients who had communication difficulties may not have been assessed for pain and could suffer harm as a result of this.

BCUHB responded positively to this and assured HIW that a recognised pain scale would be utilised more comprehensively and for every patient this would

be assessed on a daily basis.

Infection prevention and control

During our inspections 8 of the visits (28%) identified that there were issues with the inadequate cleaning of the ward environments including psychiatric intensive care facilities and a section 136 suite. In addition issues were identified in relation to a lack of hand gel at entrances to wards and soiled linen not appropriately dealt with.

Medicines management

This year our inspections identified a range of issues in relation to the storage and administration of medication including controlled drugs. In 19 of the visits (65%) we identified issues with medicines management.

This year our inspections identified the following issues;

- Insufficient observation when patients were taking medication
- Safe transportation of medicines to and from the ward clinics
- No record of medication fridges, so the staff could not be assured that medication was being stored at the appropriate temperature
- The date of opening medication was not routinely stated on containers and therefore the staff could not be assured that the medication was still in date
- Reasons for “as required medication” were not recorded
- A lack of robust medicines management audit procedures in relation to the prescribing, administration and recording of medication
- Controlled Drugs checks not appropriately documented
- Medication trolleys not appropriately secured

Managing risk

In the North of Wales and in the independent sector patients reported an issue in relation to having adequate access to GP services.

HIW are currently undertaking a review of the community mental health teams. Feedback from the community mental health teams have highlighted issues in relation to the quality of referral from GP practices together with at times poor communication between community teams and the GP practices. There is, at times, a lack of knowledge of the services available in the community which means that patients are not always referred to the most appropriate service initially. We are considering a review of these issues as part of the GP inspection programme in 2018-19.

Lack of an Available Nurse Call System

Of considerable concern to HIW was that during 6 inspections (21% of the hospitals visited) there were issues with the lack of the provision of a nurse call system for patients to use. In addition, during some visits beds were not positioned appropriately to enable patients to reach the call system when they were in bed. This is a significant issue for patients who may need assistance. These issues occurred in both NHS and independent settings.

Ligature risk assessments

In 5 of the hospitals visited there were issues with out of date ligature risk assessment. The area of self harm and suicidal behaviour for patients with a mental health issue is well researched and documented and therefore the fact that in a number of hospitals have failed to keep updated risk assessments around the risk of ligature is concerning.

Maintenance

There were improvements in the maintenance of facilities this year, however there are still high numbers of services where improvements to the environment are required. A total of 18 (64%) of hospitals visited (80% of those inspected in 2015-16) had maintenance, refurbishment and replacement of equipment and furniture issues and these were occurring across the NHS and the independent sector hospitals. Some issues were very concerning for example an unsatisfactory electrical safety report and the issues identified had not been addressed for over 6 months. This placed the safety of patients, staff and visitors at risk. An immediate assurance letter was sent to the provider within 2 days of the visit to identify the seriousness of

the situation. The provider gave adequate reassurance in relation to this area and ensured that the necessary remedial work was carried out.

Care and treatment planning

The number of inspections highlighting issues around inadequate care and treatment plans has increased to 59% (17 hospitals) from 43% last year and is an area of significant concern. Care and treatment plans are fundamental to ensuring that patients receive the individual care and treatment that they require and are an important tool for communication between patients, relatives and staff.

The issues identified included: poor documentation of physical healthcare; lack of patient and staff signatures; lack of family involvement without a documented reason why such involvement was not appropriate; and out-of-date care information. For example, in one instance a hospital inpatient still had a care and treatment plan which reflected their needs as a community patient. We were also concerned to find instances of a blanket approach to managing risk instead of an individualised one.

Case Study

In May 2016 HIW undertook an unannounced inspection visit to Cefn Coed hospital part of Abertawe Bro Morgannwg University Health Board. A number of issues were identified on Celyn (an older care ward) including; significant gaps in the "All Wales Food record charts", long gaps of between 3 and 12 days were recorded for when bowel movements were documented, this was of concern because some patients were on medication that had a side effect of causing constipation. Other issues included; no record of care for over 17 hours, a review of bed rails had not been undertaken with the required level of frequency, no review of waterlow scores (used to assess the risk of developing skin damage from pressure) and nutritional risk assessments not undertaken with an acceptable degree of frequency.

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

4.1.3 Quality of management and leadership

Governance, leadership and accountability

During the year of 2016-17 there were 8 hospitals (29%) where there were issues with governance processes. The figures represent 4 individual Health Boards and 4 individual registered independent providers. This was an increase on the figures for 2015-16.

In both NHS and independent hospitals there were distinct issues with a lack of sound governance and audit around issues such as: physical healthcare plans; risk assessment of patients; medicines management; maintenance; staff supervision and appraisal; and care planning and assessments.

Case Study

In November 2016 a visit to Phoenix House (operated by an independent provider) identified 29 regulatory requirements. Some of these related to significant issues such as: physical health monitoring; patient record-keeping, incomplete Mental Health Act papers relating to patients' detention, lack of staff annual appraisals and supervision, medicines management and the lack of a record of agency staff used. Registered providers should not rely on HIW to identify these significant issues and a robust audit and governance process would identify these issues at an early stage and enable the provider to put an action plan in place to identify and address the issues themselves,

Following the visit the provider was required to produce an improvement plan and provide evidence that improvements had been made.

Inadequate/lack of essential policies and procedures

In a number of our visits within both NHS and independent hospitals there was a lack of robust policies and procedures that were in line with best practice and NICE guidelines. In addition, some policies had not been reviewed for some time and had passed their proposed review date.

Case Study

In November 2016 HIW undertook an unannounced visit to Pinetree Court (operated by an independent provider) and identified a patient that had an

infectious disease and no care plan had been developed for the treatment of this. In addition, the NICE guidelines and the provider's policy stated that treatment should be provided to the "household". There was no documentary information to evidence what the provider considered a "household" within a hospital setting. Therefore in the absence of a clear policy and procedure staff did not have adequate guidance in relation to this area and therefore no consideration had been given to treating others at the hospital to prevent the spread of infectious diseases. Following the inspection the registered provider had confirmed that the appropriate improvement actions had been taken

Bed availability, admission and discharge

As with last year's inspections we found examples of a lack of in-patient beds in two Health Board areas (Aneurin Bevan and Hywel Dda) and this had resulted in some patients travelling many miles from home to receive care. In one example all newly admitted psychiatric patients were admitted onto one ward. This meant that existing patients, on that admissions ward, were transferred to other facilities across the HB at various times in the late night and early morning to enable other patients to be admitted to the admissions ward

Delayed discharges were also a theme on some of the wards that we visited. Health Boards had Delayed Transfers of Care (DToC) monitoring processes in place but it is essential these processes are used in a proactive way to manager the provision of beds Also Health Boards need to ensure that the care and treatment needs of these patients is effectively being met. These beds must be available in a timely manner for other patients who were awaiting admissions.

In three Health Board areas, Hywel Dda, Aneurin Bevan and Betsi Cadwaladr there remained a lack of strategic planning to address the lack of availability of a range of services. These included low secure services and the provision of a clear pathway for patients' rehabilitative care.

Resources and workload

Staffing levels

Although there had been an improvement when compared with last year providing adequate numbers of staff continued to be a significant challenge to all the healthcare providers. Out of 29 visits we undertook in 2016-17 there were 16 (57%) where we identified staffing shortfalls. In comparison for 2015-

16 out of 30 hospitals visited there were 19 (63%) where we identified shortfalls in the numbers and skill mix of staff.

Our inspections discovered a lack of sufficient numbers of staff for the required observational levels and challenging nature of patients being cared for. This shortage of staff covered a wide range of disciplines including, registered nurses, care support workers, medical, psychology and Occupational Therapy. The shortages were having a negative impact on a number of key areas including; the recreational and social therapeutic programmes for patients and the access to an appropriate level of psychological support.

In addition, the day to day care needs of patients were affected given the shortage of registered nurses working on the wards. Independent providers and the NHS were making efforts to minimise the effects of a lack of regular nursing staff by booking the same staff through the relevant nursing agencies and the internal "bank" nurse system.

Training

We continue to identify significant gaps in training with finding similar to last year.

Of the 29 visits we undertook in 13 of them (45%) where we identified training deficits. In 2015-16 training issues were identified in 14 (46%). The training deficits identified were in a number of key areas including;

- The Mental Health Act
- Fire safety
- The Mental Capacity Act 2005
- Deprivation of Liberty Safeguards
- The Mental Health (Wales) Measure 2010
- Infection control
- Managing violence and aggression including control and restraint

- Safeguarding
- Food hygiene
- Advocacy
- Wound care

In addition, to the above training deficits there was also a lack of training in the knowledge and specific skills required for caring for a range of patients including those with a personality disorder and older persons with a form of dementia. The knowledge and skills of staff are crucial in delivering effective patient care and the lack of in some instances a basic level of knowledge is extremely concerning.

This year a lack of compliance with mandatory training requirements was the same in the independent sector as the NHS. This is in stark contrast to 2015-16 were compliance with statutory training was much better in the independent sector.

Staff supervision

In 2015-16 we identified that this was an issue primarily with the NHS hospitals, however in direct contrast, during 2016-17 the issue of a lack of staff supervision was more prevalent in the independent sector. In 2016-17 out of the 28 hospitals HIW visited within 11 of them (39%) we identified issues with a lack of meaningful and documented staff supervision. This year the majority of these issues relate to the independent sector. It is difficult to explain why this area was identified more frequently within the independent sector. However, the HB's performance in relation to meaningful and structured supervision appeared to have improved considerably

4.1.4 Issues specific to the independent sector

Registered Managers

It is a requirement under the Independent Health Care (Wales) Regulations 2011 that where the Registered Provider is an organisation a manager must be appointed. All the independent hospitals in Wales belong to an organisation so therefore must have a Registered Manager.

During 2016-17 the situation in relation to a lack of registered managers at the independent hospitals had improved significantly since the 2015-16 report.

The vast majority of hospitals had a registered manager in place or had a proposed manager that was undertaking the registered manager process.

Documentation for Responsible Individual (RI) visits

In 2015-16 there was a significant issue with a lack of documented RI visits. All independent hospitals are registered with HIW and have to comply with the Independent Health Care (Wales) Regulations 2011. Regulation 28 places a requirement on the owners of an independent hospital to visit a hospital at least every 6 months and prepare a written report on the hospital. During our visits undertaken in 2016-17 this area had improved considerably with only one hospital where there was no documented reports to confirm that Responsible Individual visits had taken place,

4.1.5 Issues specific to elderly care wards

During our programme of hospital visits we carried out a number of specific visits to elderly care wards and identified the following issues;

- Dormitory style accommodation
- Unclear signage
- Lack of adaptive cutlery
- Insufficient provision of Occupational Therapy services
- A lack of a dementia friendly environment
- Inappropriate mix of patients
- A lack of the timely processing of DoLS referrals
- A lack of staff training in dementia awareness

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

There are three CAMHS units within Wales, one in the independent sector and the other two within local HB's. In 2016-17 HIW have inspected the

independent hospital and one of the HB units (Ty Llidiard) within Cwm Taf. The other HB unit will be inspected during 2018-19

A range of issues from the two visits undertaken in 2016-17 were identified including;

- Lack of routine maintenance
- Lack of cleanliness of the environment
- Lack of staff supervision and training (a particular issue identified with staff training in nasal gastric feeding)
- Issues with the care planning and risk assessment documentation
- Lack of progress from clinical audits
- Lack of sufficient information in relation to the recruitment and induction process of staff
- Listening and learning from feedback
- Some issues identified to a lesser extent within our programme of visits include;
- A lack of robust recruitment processes
- Fire doors wedged open
- A lack of child visiting facilities
- The lack of an effective system to capture staff training
- Inappropriate patient placement
- Patient observational forms not routinely audited

- Lack of staff personal alarms

- Restrictive practice and a blanket approach to risk

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

4.2.1 Purpose of the Mental Health Act

The majority of patients who access mental health and learning disability services in Wales are informal and this means that they will receive treatment on a voluntarily basis. However, some informal patients who are 'liable to be detained'[2] can be treated in hospital on a voluntary basis. A third group of patients who may require assessment or treatment can be detained against their will under the Act.

The primary purpose of the Mental Health Act is to protect an individual's rights because of the vulnerability created by their mental health issues. The Act ensures a number of protective elements including;

- protection to ensure that appropriate medical treatment is only administered to individuals who may not consent to it or have the capacity to consent under certain circumstances.

- some informal patients who are 'liable to be detained'[3] can be treated in hospital on a voluntary basis.

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

In addition to the Act there is the Code of Practice for Wales that gives guidance to a range of mental health professionals on how they should comply with their duties and functions under the Act. All mental health professionals are required to have regard to the Code of Practice that has

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

been written to support and promote good practice for those who are providing services under the Act

The Act gives a range of powers and responsibilities on a number of organisations and individuals including:

- Welsh Ministers;
- Officers and staff of Health Boards, independent hospitals and Social Services Departments, whether or not they work in mental health services;
- Police Officers;
- Courts;
- Advocates; and
- The relatives of individuals who maybe subject to the Act.

The Act is used in a number of diverse environments including:

- Mental health and learning disability wards;
- General medical wards for patients of all ages;
- Other hospitals;
- Accident and Emergency departments;
- Care homes;
- Patients' own homes;
- Courts; and

- Public places.

There are a number of legal processes that must be complied with when an individual is being considered for detention. These processes must also be followed when an individual has been detained with either a civil application for admission or a hospital order via the courts. The Act and Code of Practice give safeguards that intend to ensure patients are not inappropriately detained or treated.

5.2.2 How the Act is monitored in Wales

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

- Formulate an annual report

- Provide a registered medical practitioner to authorise and review proposed treatment of patients in certain circumstances

- Keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained

- Investigate complaints relating to the application of the Act.

HIW on behalf of the Welsh Ministers have a range of responsibilities to ensure that individual HB's and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales. Through its comprehensive inspection processes HIW monitors how services use the Act in a variety of areas including; patients within a hospital setting, patients that are subject to a Community Treatment Order (CTO) or guardianship.

HIW continues to develop comprehensive systems to ensure that its responsibilities for the Act are met. During 2016-17 HIW set up a working group to revise our tools to reflect the revised Code of Practice for Wales that came into force in October 2016. As part of this process we used reviewers with expertise in the administration of the Mental Health Act. These revised tools are used within our inspections when we interview detained patients in hospital and community settings. Within our reviews we also review the legal paperwork to ensure it complies with the Act and the revised Code of Practice. Another layer of safeguarding the interests of patients is that HIW

provides a second Opinion Appointed Doctor (SOAD) service. This area will be further considered later in this chapter.

Mental Health Act Reviewers

During 2017, we commenced a recruitment campaign to strengthen our pool of Mental Health Act reviewers. This campaign was very successful and induction and training will extend into the second quarter of 2017 and will significantly enhance our Reviewer capacity. All of our Reviewers have been recruited for their skills and knowledge of the operation of the Mental Health Act and their ability to consider how effectively Registered Providers and Health Boards discharge their powers and duties towards detained patients. Our reviewer role has many aspects and considers a number of key areas including;

- Are the many areas identified within the new Code of Practice revised in 2016 being met?

  Is the paperwork for the detention completed accurately and available at ward level as a source of reference for staff ?

- Is the patients' rights section 132 being upheld?

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

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

- Do patients have access to a multi disciplinary team that consists of a wide rang of disciplines including; medical, nursing, psychology, occupational therapy, social work and other specialist services as defined by individual patient need including physical healthcare?

In most cases our mental health act reviews are carried out as part of a general inspection and our MHA reviewers will be part of a larger inspection team. However, there will also be occasions when MHA visits are undertaken as stand-alone visit.

This year we have not undertaken any further specific Community Treatment Order (CTOs) inspections. However, a comprehensive thematic piece of work for community mental health teams throughout wales is planned for 2017-18. This piece of work will consider the area of CTO's

Findings from our visits

During 2016-17 we undertook visits to 28 hospitals that provided a range of mental health and learning disability care and treatment. Within these hospitals a total of 53 wards with detained patients were visited.

The visits identified some significant findings but also some areas of noteworthy practice including;

- Some comprehensive and well maintained detention records
- Good evidence of medical and administrative audit processes
- Some comprehensive assessments of capacity

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

- A lack of staff awareness of the revised Code of Practice.
- A lack of copies of the Code of Practice being available for reference for staff.
- A lack of statutory consultee forms being available.
- A lack of discussion documented in the patient records regarding the consultation by the statutory consultees.
- Section 17 leave poorly managed with copies of old forms not appropriately discontinued and a lack of evidence that patients had been given copies of these forms.

The Second Opinion Appointed Doctor Service (SOAD)

SOADs have a key role in safeguarding individuals who are detained under the Act. SOADs have a distinct responsibility to ensure proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

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

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

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

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

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

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

- Two working days for an ECT request;

- Five working days for an inpatient medication request; and

- Ten working days for a CTO request.

A continuing issue that our SOAD's find is that despite making arrangements to see a patient when they arrive the patient is not available. This has an impact for the patient and their treatment. In addition there continues to be occasions when the Responsible Clinician and Statutory Consultees are unavailable to discuss the treatment with the SOAD and to compound the

issue there is a lack of documentation in relation to the discussion about the patient that has taken place.

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

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

In Wales during 2016-17, there were 914 requests for a visit by a SOAD, an increase of 45 from 869 in 2015-16. Since 2013-14, the number of requests has risen each year.

Of these:

- 841 requests related to the certification of medication,
- 71 requests related to the certification of ECT,
- 2 requests related to medication and ECT.

The following table provides a breakdown of requests per year:

Table 9: Requests for visits by a SOAD, 2006-07 to 2016-17

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

2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914

Source: SOAD requests to HIW

Reviewer of Treatment (Section 61)

During 2016-17 for the first time HIW undertook an audit of section 61 forms for the review of patient treatment. When a treatment plan has been authorised by a medical practitioner (SOAD) appointed by HIW, a report on the treatment and the patient's condition must be given by the responsible clinician in charge of the patient's treatment and given to HIW. There is a designated form on our website for the responsible clinician to complete.

Our lead SOAD undertook a comprehensive review of these forms to ensure that adequate patient safeguards were in place. Overall the forms and supporting evidence was of a good standard but there were some issues identified and the HBs and independent providers of care were informed of the issues and responded with the required level of assurance. The following findings were identified;

- More medication listed under the treatment description than authorised on the CO3 form
- A lack of detailed progress on the form since the previous review
- Copies of CO2 and CO3 forms not attached to the review of treatment form
- A lack of particularising of medication
- Patients status of consent and capacity
- Issues with a lack of clarity of whether a patient was consenting to treatment
- Lack of copies of CO7 and CO8
- Dosage of medication not documented on the review forms

The audits of the review of treatment forms will be ongoing and further findings will be reported upon during our 2017-18 report.

6 Conclusion, Recommendations and Next Steps

The 2016-17 report continues to identify some key issues for Health Boards and independent providers. Of concern to HIW is that many of the areas identified were also apparent during our 2015-16 visits. These areas must be appropriately addressed to ensure that patients receive the care and treatment in an environment that is fit for purpose. Some significant issues have been identified in particular the inadequate care and treatment plans formulated for patients. HBs and independent providers should not rely on HIW to be a tool of quality assurance and must devise and implement robust audit and governance processes to identify and address the areas concerned.

For the first time this year we have also identified specific issues in relation to elderly care wards and Child and Adolescent Mental Health Services (CAMHS). Again HBs and independent providers need to consider these issues and how they can be effectively addressed.

HIW continues to work with partnership agencies, HBs and independent providers to improve the care and treatment delivered to this very vulnerable patient group.

Recommendations/requirements (requirements for Independent sector only)

Following our findings from our inspections during 2016-17 we have made the following recommendations and requirements (requirements under the regulations are for independent providers only) which the Health Boards and Independent Providers must address in order to deliver a safe and effective service to a vulnerable patient group within an appropriate environment of care. Such recommendations will have been included in the individual reports which have been issued to providers following each of our inspections.

Recommendation/requirement	**Regulation/standard**
Patient experience	
All Health Boards and Independent Providers must ensure that patients are provided with varied, nutritious meals and are given choice and are provided with fresh fruit and vegetables	Health and Social Care Standard 2.5 Regulation 15 (9) (a) & (b)
All Health Boards and Independent Providers must ensure that patients' privacy and dignity is maintained	Health and Social Care Standard 4.1 Regulation 18 (1) (a) & (b) & (2) (a) & (b)
All Health Boards and Independent Providers must ensure that patients have	Health and Care Standards 1.1, 6.1 and

access to a range of meaningful social and recreational activities and that they receive support to participate ion these	6.2 Regulation 15 (1) (a) & (b)
Delivery of safe and effective care	
All Health Boards and Independent Providers must ensure that all the physical health care needs of patients are fully assessed and addressed	Health and Care Standards 2.2 , 4.1 and 7.1 Regulation 15 (1) (a) (b) (c) & (d)
All Health Boards and Independent Providers must ensure that effective infection prevention and control measures are in place	Health and Care Standard 2.4 Regulation 15 (3) (7) (a) & (b) & 8 (a) (b) & (c)
All Health Boards and Independent Providers must ensure that effective medicine management systems are in place in relation to the storage, ordering, and administration of medicines	Health and Care Standard 2.6 Regulation 15 (5) (a) & (b)
All Health Boards and Independent Providers must ensure that effective risk management systems are in place	Health and Care Standard 2.1 Regulation 19 (1) (a) & (b)
The Health Boards must ensure that a comprehensive maintenance programme is in place for ALL its hospitals to ensure that the environments of care are and remain suitable to meet the needs of the patients	Health and Care Standard 2.1 Regulation 26 (!) & (2) (a) (b) & (c)
The Health Board and Independent Provider must ensure that each patient has a comprehensive risk assessment and care and treatment plan in place	Health and Care Standard 6.1 Regulation 15 (1) (a) (b) & (c)
Quality of management and leadership	
The Health Board and Independent Provider must have effective governance, leadership and accountability assurance systems in place to ensure compliance with the regulations and standards to ensure safe and effective treatment	Health and Care Standards 3.4, 3.5 and 7.1 Regulation 19 (1) (a) & (b) and (2) (a) (b) (c) (d) & (e)
The Health Boards and Independent Providers must ensure that polices and procedures are up to date and reflect current good practice recommendations	Health and Care Standards 2.1, 2.6 and 3.1 Regulation 9 (1)
The Health Boards must ensure that there are sufficient inpatient beds available for potential admissions	Health and Care Standard 2.1
All Health Boards and Independent Providers must ensure that all wards	Health and Care Standard 7.1

have adequate numbers of staff (nursing, medical, psychology and Occupational Therapy) to ensure patients needs are fully met	Regulation 20 (1) (a)
All Health Boards and Independent Providers must ensure that ALL staff have the necessary training, knowledge and skills to effectively care and treat patients	Health and Care Standard 7.1 Regulation 20 (2) (a) & (b)
The Health Board and Independent Providers must ensure that ALL staff receive regular meaningful and documented supervision	Health and Care Standard 7.1 Regulation 20 (2) (a)
All Health Boards must ensure that elderly care and CAMHS provision meets the needs of the patient group and any treatment is timely	Health and Care Standard 3.1

Glossary

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

Approach (CPA)	determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers
CO1 form	Certificate of consent to treatment and second opinion (Section 57)
CO2 form	Certificate of consent to treatment (Section 58(3) (a))
CO3 form	Certificate of second opinion (Section 58(3) (b))
CO7 form	Certificate of appropriateness of treatment to be given to a community patient
CO8 form	Certificate of consent to treatment for a community patient
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory	Medical treatment for mental disorder given under the Act

treatment	
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	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if

	necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'Section 17 leave'.*
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other terms such as *'service user', 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under Section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on

	leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49 The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in an hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually
Section 12 doctor	See doctor approved under Section 12.

Section 17A	This is a Community Treatment Order
Section 37	This is an 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 rightss
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving

	treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; Part 1 – Primary mental health support services Part 2 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services Part 4 – Mental health advocacy
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Appendix A

Health boards and independent registered providers visited during 2016-17

Health Board	Hospital	Wards
Abertawe Bro Morgannwg University Health Board	Cefn Coed Hospital, Abertawe	Clyne, Fendrod, Gwelfor and Celyn wards,
Aneurin Bevan University Health Board	St Cadoc's Hospital	Adferiad, Beechwood, Belle Vue and Pillmawr
Betsi Cadwaldr University Health Board	Bryn y Neuadd	Ty Llywelyn Unit
Betsi Cadwaldr University Health Board	Ysbyty Cefni	The hospital comprises one ward that was visited
Cardiff and Vale University Health Board	Llandough University Hospital	East 4, East 1, East 10 and East 18
Cardiff and Vale University Health Board	Llandough University Hospital	Alder and Cedar
Cwm Taf University Health Board	Ty Llidiard Child and adolescent Unit	Enfys and Seren
Cwm Taf University Health Board	Royal Glamorgan	Seren and the Enhanced Care Unit
Cwm Taf University Health Board	Ty Llidiard	Enfys and Seren
Hywel Dda University Health Board	Withybush Hospital	Bro Ceryn Mental Health Centre - St Caradog Unit
Hywel Dda University Health Board	Hafan Derwen	Cwm Seren PICU and Low Secure Unit
Hywel Dda University Health Board	Prince Philip Hospital	Bryngolau ward

Independent provider	Hospital	Wards
CAIS Ltd	Hafan Wen	The hospital comprises one ward that was visited
Coed Du Hall Ltd	Coed Ddu Hall	Ash, Beech and Cedar

Craegmoor Hospitals Ltd	The Priory, Aberdare	The hospital comprises one ward that was visited
Elysium Healthcare (no.3) Ltd	Ty Gwyn Hall	Ty Gwyn, Skirrid View and Pentwyn House
Heatherwood Court Ltd	Heatherwood Court	Chepstow, Caerphilly, Caernavon and Cardigan
Acorn Care (Welshpool) Limited	Phoenix House	Phoenix House and Yr Hafan
Mental Health Care (St David's) Ltd	St David's	The hospital comprises one ward that was visited
Mental Health Care (New Hall) Ltd	New Hall	Adferiad, Clwyd and Glaslyn wards
Partnerships in Care Ltd	Aderyn	The hospital comprises one ward that was visited
Partnerships in Care Ltd	Llanarth Court	Awen, Deri, Osbern, Howell, Iddo, Treowen, Teilo and Woodlands Bungalow
Partnerships in Care (Rhondda) Ltd	Ty Cwm Rhondda	Cilliad and Clydwch
Pinetree Care Services Ltd	Pinetree Court	Juniper, Larch and Cedar Lodge
Priory Group Ltd	Cefn Carnau	Sylfaen, Bryntirion and Derwen
Regis Healthcare Ltd	Regis Healthcare Hospital	Brenin
Rushcliffe Independent Hospitals (Aberavon) Ltd	Rushcliffe Aberavon	The hospital comprises one ward that was visited
St Peter's Hospital Ltd	St Peter's	Brecon, Raglan and Upper raglan

NB – Hafan Wen is included within this report because the clinical treatment was led by a psychiatric consultant.

In addition, the Royal Glamorgan was visited twice during 2016-17.