Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Annual Report 2019-2020

Contents

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

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

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

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

Our priorities
Through our work we aim to:

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

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

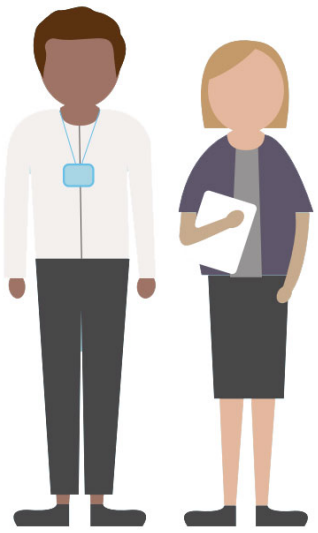
Influence policy and standards:
Use what we find to influence policy, standards and practice.

Executive Summary

This report sets out Healthcare Inspectorate Wales (HIW) activity and findings in relation to the care and treatment experience of people accessing mental health and learning disability services in Wales during 2019-2020.

During 2019-2020, Healthcare Inspectorate Wales (HIW) undertook 13 inspections to NHS hospitals, including to a Children and Adolescent Mental Health Service (CAMHS) unit, a medium secure unit, a learning disability service, a Psychiatric Intensive Care Unit (PICU) and services for older adults. We also undertook 15 visits to independent hospitals including to a learning disability hospital, medium secure units, and a CAMHS unit.

During our visits we assessed performance against the Health and Care Standards (2015), and as the regulator for all independent healthcare providers in Wales we monitored independent healthcare settings in accordance with the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011, and the National Minimum Standards for Wales. We monitored use of the Mental Health Act, the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS) and the Mental Health (Wales) Measure 2010 in NHS and independent healthcare settings.



Our Findings

We identified many positive aspects of healthcare provision during our visits. Staff interacted and engaged with patients respectfully and good team working was observed with dedicated and motivated staff. We found in many settings that patients were provided with a range of therapies and activities and we also saw good examples of care and treatment plans. In some instances it was clear that health boards and independent providers had made changes following our previous inspections and had implemented least restrictive models of care. We also found evidence of some effective governance arrangements which were having a positive impact on the care delivered.

However, we made a significant number of recommendations to individual health boards and requirements for improvement to registered independent providers of care. We observed a range of verbal interactions that varied considerably between staff, and between staff with patients, and some were not appropriate. In some settings we found poor morale amongst nursing and care staff, issues with physical health monitoring, and inadequate personal alarm systems for alerting staff.

We saw that the quality of care plans varied considerably. In some cases we could not find a care plan that addressed risks that had been identified; this was very concerning in relation to the safety of vulnerable patients. We identified that staff had not received training in a number of key areas including in relation to the Mental Health Act, the Mental Capacity Act, risk management, patient observations, eating disorders, and learning difficulties including autism and attention deficit hyperactivity disorder (ADHD). During our visits we continued to identify significant issues in relation to effective medicines management.

As part of our role in monitoring the use of the Mental Health Act we identified many examples of good practice with implementation and documentation of the Act, and it was apparent that there was a good level of governance and audit in place. In the vast majority of instances, legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation and there were comprehensive records for the administration of the Act.

Patient records stated that patients had been informed of their rights in line with Section 132 of the Act. Records evidenced that appeals against detentions were held within the required timescales and medication was provided to patients in line with Section 58 of the Act. In relation to Consent to Treatment, treatment certificates were kept with the corresponding Medicines Administration Record (MAR). This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

We did however identify some issues with the administration of the Act including in relation to incomplete or out of date documentation and the need for improvements to ensure that patients have their Mental Health Review Tribunals and manager's hearings in accordance with the timescales afforded by the Act.

Our role in mental health care

Using intelligence to inform our work

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

- Listening to concerns
- Monitoring incidents and notifications
- Examining safeguarding concerns and outcomes

By triangulating evidence from a number of sources we obtain a fuller picture about the quality of care and support provided by health care services in the NHS and independent sector. When issues are identified we may visit a hospital outside of our routine work programme to assess the level of compliance with legislation and the delivery of effective care. These inspections seek evidence and assurance on a range of matters and focus on positive outcomes for patients. Information we received through concerns about and notifications from mental health and learning disability providers during 2019-2020 is summarised in section 3 of this report.

Inspection and regulation

We inspect healthcare settings in Wales to check that people receive good quality healthcare. We use the Health and Care Standards (2015) and other standards to inform our inspection approach. We are the regulator for all independent healthcare providers in Wales and we monitor and regulate the sector in accordance with the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011, and the National Minimum Standards for Wales. Our findings from the inspections we have undertaken during 2019-2020 are summarised in section 4 of this report. Links to inspection reports for individual settings are included as Appendix A.

Monitoring use of the Mental Health Act 1983

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

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

When considering information about the use of the Mental Health Act we are attentive to potential patterns and themes emerging in healthcare services, and we use this information to formulate judgments about the effectiveness and quality of the care provided. Our findings for 2019-2020 are summarised in section 5 of this report.

Second Opinion Appointed Doctor (SOAD) service

We operate the Second Opinion Appointed Doctor (SOAD) service for Wales. The SOAD service safeguards the rights of people who whilst detained under the Mental Health Act have refused prescribed treatment, or who have been assessed as unable to consent to the prescribed treatment. The role of the SOAD is to decide whether the prescribed treatment is clinically defensible, and in the patient's best interests. The SOAD can authorise and review proposed treatments in certain circumstances. A summary of the work of our SOADs in 2019-2020 is provided in section 5 of this report.

Monitoring use of the Deprivation of Liberty Safeguards (DoLS)

We monitor use of the Deprivation of Liberty Safeguards (DoLS), which were introduced in April 2009 as part of the implementation of the Mental Capacity Act 2005. The DoLS ensure better legal and administrative protection for people who lack capacity to consent to how they are cared for on a day to day basis, and are used when detention under the Mental Health Act 1983 is not appropriate. The Safeguards protect human rights by providing a framework to ensure that care is provided to people in the least restrictive way. We monitor use of the Deprivation of Liberty Safeguards in NHS settings through analysis of statistical information and examination of policy and procedure implementation. Our Deprivation of Liberty (DOLS) Annual Monitoring Report 2019-20 is available via the Healthcare Inspectorate Wales website.

Working with partner agencies

HM Inspectorate of Probation

We work in partnership with HM Inspectorate of Probation and a range of other partner agencies, including Estyn, Her Majesty Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Care Inspectorate Wales (CIW) to review Youth Offending Services (YOS). Our work focuses on the healthcare aspects of Youth Offending Services.

In February 2020 we participated in an inspection of the Cardiff Youth Offending Service (YOS). The inspection found that Cardiff YOS needed to improve in every aspect of its work and received the lowest category performance rating. We contributed to the HMI Probation led inspection report, which is available from the HMI Probation website.

UK National Preventive Mechanism (NPM)

The National Preventative Mechanism (NPM) was established in 2009 to comply with the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), ratified by the UK in 2003. The fundamental objective of the NPM is to prevent torture and ill-treatment of those deprived of their liberty.

We are one of 21 member bodies who undertake visits to monitor or inspect places of detention in the UK. The bodies consider implementation of the treaty and examine conditions of detention and treatment of detainees, and make recommendations to improve the treatment of individuals and conditions of detention. The UK's NPM liaises directly with the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) an international body established by OPCAT. We attend business meetings, and we are a member of the steering committee, the mental health and children and young people's sub groups. In April 2019 we hosted the NPM business and mental health sub group meetings.

Using intelligence to focus our work

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

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

Concerns and complaints

During 2019-2020 we received 366 complaints and concerns about health care providers in Wales via letter, email, web form or telephone, either directly or via a third party.

128 (35%) were in relation to mental health and learning disability services. Of these:

- 44 (12%) were in relation to NHS mental health and learning disability services.
- 84 (23%) were in relation to independent mental health and learning disabilityservices.

Table 1: Source of complaints and concerns, 2018-2019 & 2019-2020

Source of concerns and complaints	NHS Settings		Independent Healthcare Settings	
	2018-2019	2019-2020	2018-2019	2019-2020
Patient	19	16	22	35
Relative, Advocate, or Other	21	18	26	26
Staff member, Whistle-blower	2	10	29	23
Total	**42**	**44**	**77**	**84**

We received slightly more complaints in 2019-2020 than in 2018-2019. Table 2 shows the subject of concerns and complaints we have received in the last two years.

Table 2: Subject of the concerns and complaints

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

Across NHS and Independent providers of mental health and learning disability healthcare services there was a small variation in the number of concerns and complaints received overall when compared to 2018-2019. Notably we saw an increase in allegations of abuse and neglect this year, whereas complaints and concerns about infrastructure, staffing and facilities reduced. Each concern was assessed by a case manager who corresponded with the care setting and relevant agencies when appropriate to seek assurance that each was investigated and action taken when necessary.

Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011

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 topatient safety. This is a legal requirement, and includes notification of:

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

During 2019-2020, we received 570 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. Notifications were themed as shown in Table 3.

Table 3: Regulation 30/31 notifications, 2018-2019 & 2019-2020

Regulation 30/31 Notifications	2018-2019	2019-2020
Serious injury	85	309
Unauthorised absence of a patient	37	139
Allegation of staff misconduct	19	99
Death of a patient	5	11
Deprivation of Liberty	2	9
Outbreak of Infectious Disease	3	3
Total	**151**	**570**

During the year we worked with independent providers to ensure that we were correctly notified of all incidents in accordance with the Independent Health Care (Wales) Regulations 2011. We received more reports across all but one category. We received significantly more reports of serious injury in 2019-2020 compared to the previous year, this increase was expected as we had provided clarification on the definition of serious injury to independent mental health and learning disability service providers during this period.

Increased allegations of staff misconduct were also notable; this increase coincided with a change in ways of working within local safeguarding teams who started to provide us with information about safeguarding concerns and referrals. This enabled us to scrutinise the circumstances of the concern and to request further information and formal notification from independent mental health and learning disability healthcare providers when necessary.

Inspecting mental health and learning disability healthcare services

Where we visited

During 2019 -2020 we undertook:

- 13 inspections of NHS mental health and learning disability settings, including:
  - a medium secure unit
  - psychiatric intensive care unit (PICU)
  - services for older adults
  - services for children and adolescents (CAMHS)
  - services for people with learning disability and autism

- 15 inspections of independent hospitals, including:
  - learning disability setting
  - medium secure setting
  - child and adolescent mental health (CAMHS) setting

Our visits were all unannounced, often starting in the evening followed by subsequent days so that the inspection team could observe care and treatment provided at different times of the day. Two providers were visited more than once because of thenature of the concerns identified in those settings.

A list of the health boards and independent registered providers visited during the period is included as Appendix A, along with links to the full inspection reports.

What we did

We considered the quality of patient experience, delivery of safe and effective care, and the quality of leadership and management arrangements in the services we visited. We asked patients about all aspects of their experience, and we looked at:

- care and treatment plans, and checked that key areas were adequately addressed
- risk assessments, and considered whether they addressed identified needs and risks
- concern, complaint and incident records and reviewed actions taken
- records of restraints undertaken, and reviewed the time and position of the restraint, details of the staff involved, and looked for evidence that restraint wasused only as a last resort
- environmental audits of intensive care facilities, we checked that they were only used as a last resort, and we looked for evidence that time spent in such facilities was kept to a minimum

- policies and procedures, and examined how key policies and procedures wereimplemented
- the environment of care, and checked that it was appropriate for the needs ofthe patient group, and afforded appropriate levels of privacy and dignity
- medicines management, we looked at how medicines including ControlledDrugs were ordered, stored and administered
- access to advocacy
- whether patients received nutritious meals and sufficient fluids
- how capacity and consent to treatment were assessed and documented
- whether patients felt safe
- observed interactions between patients and members of the multi-disciplinaryteam

We reviewed administration of the Mental Health Act, and compliance with the Mental Health Code of Practice for Wales. We monitored use of the Mental Health (Wales) Measure 2010, and the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DOLS). Findings from our monitoring of the Mental Health Act are detailed in section 6 of this report. Our Deprivation of Liberty (DOLS) Annual Monitoring Report 2019-20 can be accessed via the Healthcare Inspectorate Wales web site.

Our findings

Patient Experience

A positive patient experience must be central to all aspects of care delivery, and we recognise that each patient will have a different expectation and opinion about the aspects of care that matter most to them as an individual. Staff who work in mental health and learning disability healthcare services must always strive to deliver a high quality of care in a complex care environment, and it was positive to note through our work in 2019-2020 that privacy and dignity related findings had improved overall although we continued to identify issues that needed to be addressed. One of the most positive aspects of our inspection findings continued to be the feedback we obtained from patients about staff attitude and caring approach.

Activities

Providing opportunity for people to engage in a range of meaningful and therapeutic activities can help provide structure to the day, and can positively impact on wellbeingand recovery by reducing stress, frustration and boredom.

We found in many settings that patients were provided with a range of therapies and activities. However, we found that there was a lack of meaningful activities in 10 of the 25 adult care settings (40%) we visited. This represented a poorer picture than in 2018-2019 when we noted this in 27% of our visits. We saw that there had been occasions when activities had been cancelled because of staff shortages or a lack of therapeutic space, and patients told us that there was a lack of opportunity to participate in activities. This was more prevalent in health board settings (24% of visits) than in the independent sector settings (16% of visits).

This is an important issue for providers to address. All health boards and independent providers should ensure that patients have access to a range of meaningful social and recreational activities, and that they receive support to access and participate in activities when required.

Patient information

Patients must have access to clear and appropriate information in a suitable format to enable them to make informed choices about key matters and to express views and wishes.

We were concerned that in 21 of 25 visits (84%) we undertook to settings for adults, and also in each of the visits we made to settings for children and adolescents, we identified examples where information was not readily available, or was inaccurate, out of date, or not available in Welsh or other required language. We found that in many of the care settings we visited information was not readily available in relation to advocacy, the Mental Health Act, making a complaint, health promotion, and accessing drug and alcohol support. This represented a worsened position when compared to our 2018-2019 findings, when we identified this in 59% of our inspection visits.

Providers need to address this to ensure patients and when appropriate their relatives,are fully informed and able to exercise their rights.

Food and drink

The importance of a varied, well-presented and appealing choice of food and drinks cannot be underestimated for patients who may spend a significant amount of time inhospital as part of their care and treatment.

During our visits we actively discussed food and drink with patients, and in five (20%) of our visits to adult settings and in all of our visits to units for children and young people, this was identified as an issue. Issues and concerns raised with us included the availability of hot drinks throughout the day and a lack of menu choice to meet individual preferences. We also found that food and fluid charts were not always completed in full.

Privacy and dignity

We noted that privacy and dignity issues had improved when compared to our inspection findings of the previous year, however, in eight (32%) of our visits to healthboards we identified areas for improvement.

We found that staff did not always knock on a patient's bedroom door before entering, and in some settings we identified a lack of appropriate screening on some windows to maintain privacy and dignity. We commented on the need to ensure suitable facilitates were available for patients to discuss personal and confidential information, and to meet with visitors in private. In one setting we found that the facilities for childrento visit were bland, clinical and unwelcoming.

We made recommendations for some services to review bathroom facilities to ensure that privacy and dignity was not compromised, for example by replacing shower curtains, and to consider provision of single occupancy bedrooms instead of shared bedrooms wherever possible.

Safe and Effective Care

Seeking assurance that care is provided in a safe and effective way is central to our inspection approach. During our review of practices we consider how observations are carried out, and whether there is an outcome based approach to care and discharge planning. Our judgements are informed by talking to patients, staff and others,observing practices, and reviewing documentation.

Care and Treatment Planning

Patient care records including risk, care and treatment plans must be up-to-date, accurately reflect a patient's needs, and be appropriately and securely stored. Through our inspection work in 2019-2020 we saw examples of effective care and treatment planning, but again identified failings in care planning and risk assessment processes in many settings; we found a range of issues in 20 of the 25 (80%) settings for adults and each of the units caring for children and young people that we visited.

We found that some patient care records were overly full and difficult to navigate whilst others did not contain all of the relevant information. We saw records where aspects of the Mental Health Measure were not recorded clearly and consistently, and we were concerned to identify that not all patients had risk assessments and care plans in place.

We saw examples of care plans and risk assessments that were not sufficiently detailed, were not up to date, or had not been reviewed and therefore did not reflect changes in risk levels or provide up to date information about a patient's needs and care arrangements. Patient strengths, unmet needs, views, preferences and involvement in the care planning process were not always documented, and we werenot always assured that patients had received a copy of their care plan.

Effective Patient Observations

We saw effective arrangements for patient observation in many settings inspected, but in three of the 25 visits (12%) we made to settings for adults we identified concerns about the arrangements for patient observations. We found in one setting that one- to-one observations were not being continuously maintained, and in another that observational records were not fully completed. When patients are placed on one-to- one observation it is to mitigate a significant risk, such as self-harm and/or aggressive behaviour, and if one-to-one observations are not conducted appropriately the risk toindividual patients can be significant.

Physical Health Care

In five of our 25 visits (20%) we identified that there was inadequate documentation to assure us that assessment and monitoring of physical health needs was being addressed and recorded.

Serious health problems are common amongst people with severe mental illness, learning disabilities and autism, and physical health monitoring is an integral part of caring for this patient group. All providers must ensure that arrangements are in placeto identify and respond to the physical health care needs of patients.

Medicines Management

We continued to find significant and widespread issues with the storage, handling and administration of medicines during our inspection visits in 2019-2020. We found that there were issues of concern with overall medicines management arrangements in 80% of our inspections (20 out of 25 visits), and whilst this is a slight improvement on our findings in 2018-19 where we found issues in 86% of our visits this is still a significant finding and suggests that health boards and independent providers have not implemented robust governance and audit processes to address the continued areas of concern.

We found that Medicines Administration Records (MAR) were not always completed accurately and in full, including all patient details, route of administration and record of administration. Some MARs did not contain signatures and the correct start date wasnot recorded for all prescribed medication.

We identified that the reasons for administering pro re nata (PRN) (as needed) medication, were not always documentedon MARs following each occasion of use.

On some visits we found that medication trolleys were not secured within the clinic. We also found medication trolleys, medication fridges and medication drawers that were left unlocked when not in use, and medication not being stored at the appropriatetemperature as the clinical rooms were excessively hot.

We saw examples of policies for medicines management that had not been reviewed and updated, and a lack of robust systems for managing and ordering out of stock and emergency medication. We again identified a number of issues with the management arrangements for Controlled Drugs (CDs), which included; designated CD storage cupboards being used to store items inappropriately, absence of CD schedules in clinic rooms, and the need to strengthen governance arrangements.

Safeguarding Procedures

During our visits we identified one adult setting where safeguarding incidents had not been managed promptly and effectively. This was an improvement on our findings in 2018-2019 when we identified a lack of robust safeguarding procedures in 14% of our visits.

Nurse Call System

Again this year we identified a lack of a nurse call system in seven (28%) of our inspection visits, five health board wards and two independent hospitals. The absence of a nurse call system was a particular issue in patient bedrooms and means that patients are unable to use this system to alert staff at times of need. Some providers considered that nurse call systems were not appropriate in adult mental health care settings, one of our inspection reports detailed:

> "There were nurse call points around the wards but not within patient bedrooms. During our previous inspection, we raised this as a concern with the health board. We were informed that the use of nurse calls bells for adult wards was considered, but the decision made was that it would not be appropriate for this group of patients. We were informed that all patients' whereabouts and well- being are checked regularly throughout the shifts. The health board's responsedoes not provide us with assurance"

Management, leadership and governance

Effective management, leadership, and governance are essential for ensuring safe and effective care delivery to patients cared for in mental health and learning disabilityhealthcare settings.

It was therefore concerning that in 10 (40%) of our visits to adult care settings and in our visits to settings for children and young people we identified inadequate audit and governance processes to ensure compliance with regulations and standards. We found that audit and governance arrangements were not fully embedded, and in 24% of our visits we found that policies and procedures were not up to date and did not reflect current good practice recommendations. On one inspection visit we found that the policies of a predecessor health board were still being used.

Staffing and workforce

We saw through our work in 2019-20 staff interacting and engaging with patients respectfully. Good team work was observed with dedicated and motivated staff. However, in 13 of 25 (52%) visits to adult mental health and learning disability settings we identified workforce deficits and challenges that health boards and independent hospitals need to address to ensure appropriate staffing levels and skill mix to providesafe and effective care.

Through our work we found examples of insufficient staff on duty to enable staff members to take statutory breaks, and to support patient activities. We identified occasions when there was a lack of designated nurse in charge at night/out of hours, and an over-reliance on bank and agency staff, which risks that staff will not have knowledge of the patient group. We also identified examples of insufficient housekeeping provision and the need to increase social worker input in one setting.

Training and development

Staff training and development is a core component of safe service delivery it was concerning therefore to find that some services did not have robust systems in place to monitor and record staff training.

In 10 of the 25 (40%) services for adults we visited during 2019-20 and in the services caring for children and young people we identified gaps in training compliance. We found deficits in a number of key areas including management of violence and aggression, safeguarding, dementia care, infection prevention and control, first aid, and specific training in relation to providing support to the patient group.

In six (24%) of our visits we found that there was no documentary evidence to provide assurance that staff supervision and appraisal had taken place, and we again identified that many providers did not share learning from inspections across their service to support organisational-wide learning.

Maintenance, Refurbishment, Replacement and Cleaning

A clean environment is an essential component of infection prevention and control. During 10 visits (40%) to settings for adults in 2019-2020, and in the visits we made to services for children and young people we identified inadequate cleaning arrangements in place, and identified areas including bedrooms, toilet and bathroom areas in need of deep cleaning.

We again identified that health boards and independent providers continued to have significant issues with effective maintenance programmes and systems of refurbishment and replacement. In visits to 10 NHS settings and 7 independent healthcare settings we identified a range of issues and failings, including;

- need for repairs to roof and ceiling
- damaged flooring, showers and bathrooms
- broken light fittings
- ward kitchen appliances that were not working
- ward environments that were in need of redecoration
- dining room chairs where fabric was ripped
- cracked mirrors

One of our inspection reports detailed:

> "The ward environments are below the environmental standard of other mental health wards within the health board. Therefore, patients who are admitted to these two wards are not receiving the same standard of care environments to those on other mental health wards within the health board".

It is not acceptable to have inadequately maintained and cleaned environments of care; some of the issues found posed a potential risk to the safety of patients. All health boards and independent providers need to ensure that they have adequate cleaning arrangements and systematic processes for responding in a timely way to estates and maintenance requests.

Monitoring the Mental Health Act, 1983 (the Act)

The Mental Health Act 1983 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 may be used in a number of settings, including:

- Mental health, learning disability hospitals
- Other hospitals
- Accident and Emergency departments
- Care homes
- Private residence
- Courts, and
- Public places.

The Act provides a legal framework to protect the rights of both formal and informal patients, and ensures that an appropriate level of care and effective treatment are provided in an environment that promotes recovery. The Act is underpinned by the principle of treatment rather than containment, and the need to balance the risks to the patient and to those in society.

People who access mental health and learning disability services do so either as informal patients, this means that they receive treatment on a voluntarily basis, or as detained patients, requiring assessment or treatment. Some informal patients who are 'liable to be detained'[1] can be treated in hospital on a voluntary basis. The Mental Health Act allows for appropriate compulsory medical treatment to be given when it is necessary to assist the patient's treatment and rehabilitation. The Mental Health Act ensures that safeguards are in place so that only appropriate medical treatment is administered to individuals who may not consent to the prescribed treatment, or may not have capacity to consent under certain circumstances.

How the Act is monitored in Wales

A number of individuals and organisations are given powers and responsibilities under the Act and these include officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, relatives of those detained and advocates.

Welsh Ministers have enshrined in law specific duties to monitor the Act. Healthcare Inspectorate Wales undertakes functions on behalf of the Welsh Ministers, including:

- Publishing an annual report detailing how the Act is being implemented in Wales.
- Reviewing how powers granted by the Act are exercised in relation to detainedpatients and those liable to be detained.
- Providing a service, known as the Second Opinion Appointed Doctor (SOAD) service, where in specific circumstances a registered medical practitioner will be required to authorise and review proposed treatments.
- Investigating complaints relating to the application of the Act.

In order to fulfil our role and responsibilities we took the opportunity when inspecting mental health and learning disability care settings, to talk to detained patients, hospital managers and other staff about matters that affect care and treatment provided to people detained under the Act, and we reviewed information and documentation to seek assurance that:

- People were lawfully detained, well cared for, and were informed of their rights.
- The Mental Health Act Code of Practice for Wales was being followed.
- Appropriate plans were made for people before they were discharged from hospital.

Mental Health Act Reviewers

We used Mental Health Act Reviewers to consider how the Mental Health Act was being implemented and administered throughout Wales during 2019-20. They considered key areas, including whether:

- The Code of Practice was available in English and Welsh, and was being implemented
- The legal papers for detention were completed accurately, and whether copieswere available at ward level
- Patients' rights under section 132 of the Act were well documented, in an appropriate format and included a record about whether the patient understoodtheir rights
- Key policies and procedures were in place and reflected the Mental Health Act Code of Practice 2016
- Effective care and treatment plans were in place that reflected the patients detained status, and the Mental Health (Wales) Measure 2010
- Patients had access to a multi-disciplinary team.

We monitored use of the Mental Health Act during our full inspection visits to mental health and learning disability healthcare settings, and also during focussed visits to specifically monitor use of the Mental Health Act as a standalone inspection activity.

Findings from our visits

During 2019-2020 we visited 47 hospital wards that accommodated detained patients. We focused on reviewing the way health boards and independent registered providers of services for detained patients, and those liable to be detained, used their powers and discharged their duties to provide assurance that the Act was lawfully and properlyadministered throughout Wales.

During our visits we identified areas of noteworthy practice including:

- Evidence of strong administrative governance and medical audit
- Good evidence that patients were provided with their rights under section 132and appropriate information was available
- Well maintained and easy to navigate records
- Improved staff resources and workforce structures
- Very knowledgeable and efficient Mental Health Act administrators.

However, our work monitoring the application of the Mental Health Act also identified areas of concern, including occasions when we noted that:

- Mental capacity assessments had not been completed, lacked the appropriatelevel of detail, or were not available in a patient's record
- Copies of Consent to Treatment Certificates were not kept with the corresponding Medication Administration Records ((MARs), and as a consequence staff were not always able to ensure that the medication was certified under the Act
- Patients detained under the Act were not always aware of their rights under section 132, or what the Act says about treatment of their mental disorder
- Medicine Administration Records (MARs) did not always document a patient'slegal status with regard to the Act
- Mental Health Act Administrators did not always have sufficient capacity and resources to safeguard patients as set out in the Code
- Arrangements for section 17 leave were not always managed appropriately; we noted occasions when patients were not provided with a copy of the section 17 authorisation form, leave forms had not been cancelled when no longer relevant, forms did not always contain details of restrictions, and were not always signed by the patient to evidence that they understood the agreed conditions of the leave.

These issues are of concern. Section 17 documents must be clear and contain the relevant conditions so that there can be no confusion about the current section 17 leave granted to the patient.

During 2018-2019 we did not investigate any complaints relating to the application of the Act, but were contacted by a number of people subject to detention who wished to make a complaint about their detention. We ensured that individuals were provided with information about how to access the Mental Health Act Review Tribunal appeal process, information about legal rights and how to access legal representatives and advocacy services.

Second Opinion Appointed Doctor Service (SOAD)

We continued to operate the Second Opinion Appointed Doctor (SOAD) service for Wales during 2019-2020. Our SOAD service comprised 19 suitably skilled and experienced registered medical practitioners, who worked under the professional supervision of a Lead SOAD. Independent assessment by a SOAD is required to safeguard the rights of:

- Liable to be detained patients on Community Treatment Orders (CTOs) (Section 17A) who lack the capacity to the proposed treatment or who did not consent for Part 4A patients;
- Patients for who serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57) areproposed;
- Detained patients of any age who do not consent or lack the capacity to consentto 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).

The SOAD service safeguards the rights of people detained under the Mental Health Act who refuse prescribed treatment, or who have been assessed as unable to consent to the prescribed treatment. The role of the SOAD is to decide whether the prescribed treatment is clinically defensible, and in the patient's best interests.

Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether or not the patient has capacity to consent to the prescribed treatment. The SOAD must be satisfied that the patient's views and rights have been taken into consideration. If satisfied the SOAD will issue a statutory certificate which provides the legal authority for the 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.

During 2019-2020 we received 954 requests for a visit by a SOAD. This is the highest number of requests that we have received since the establishment of the SOAD service within HIW (Table 4).

Of the 954 requests:

- 877 requests were related to the certification of medication
- 51 requests were related to the certification of ECT
- 26 requests were related to both medication and ECT.

Table 4: Requests for visits by a SOAD, 2006-2007 to 2019-2020

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
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

Source: SOAD requests to HIW

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

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

We have however identified occasions when the SOAD assessment has beendelayed. Analysis of the reasons for this has identified that this is most often because:

- The Responsible Clinician was not available for discussions with the SOAD
- The Statutory Consultees were not available to discuss the treatment with theSOAD
- An absence of documentation detailing the discussion about the patient, or
- Delays accessing patient records and detention papers that must be consideredby the SOAD.

To address these factors we have continued to work with the Mental Health Act Administrators in health boards and independent providers to ensure that processes are improved. Additionally, at the end of March 2020 the UK entered into national restrictions as a result of the coronavirus pandemic which resulted in the suspension of SAOD visits to hospital and other settings. A COVID-safe process was introduced to ensure certification could continue, full details of this change can be viewed on the HIW Review Service for Mental Health (RSMH) during COVID-19 website page.

Review of treatment (Section 61)

Once the 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 HIW for review by our Lead SOAD. This process is facilitated through the Mental Health Act Administrators office in NHS and independent hospitals.

For the fourth consecutive year we audited the reports to ensure that appropriate safeguards were in place. We noted fewer discrepancies overall, and improvement when compared to the previous year's audit findings. We found that there continued to be a small number of occasions when medication listed under the treatment description of the report was more than was authorised on the Certificate of second opinion (CO3 form), and copies of Consent to treatment form and Certificate of second opinion (if applicable) were always attached to the review of treatment report, which enabled timely an efficient review.

However, there continued to be occasions where reports contained incomplete information in relation to the patient's capacity to consent. We will continue to work with health boards and independent hospitals to reduce these occurrences.

Our Data

To prepare this report we analysed data from our work throughout 2019-2020 with patients and healthcare services, including our MHA activities and our inspections of mental health services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, staff and members of the public, and statutory notifications data submitted by independent providers of mental health 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 2019-2020

Provider	Setting	Ward	Date of inspection	Link to report
Aneurin Bevan HB	County Hospital	Talygarn	9 -11 September 2019	English
Aneurin Bevan HB	Maindiff Court Hospital	Ty Skirrid & Lindisfarne	20 – 22 May 2019	English
Betswi Cadwaldr HB	Ty Llywelyn	Branwen, Gwion& Pwyll	27 – 29 January 2020	English
Betswi Cadwaldr HB	Ysbyty Cefni	Cemlyn	16 – 18 September 2019	English
Cardiff andVale HB	Hafan y Coed	Elm & Maple	10 – 12 February 2020	English
Cwm Taf HB	Royal Glamorgan	Admission Psychiatric Intensive CareUnit, St David's, Seren, Ward 21 & Ward 22	8 – 11 July 2019	English
Cwm Taf HB	Ty Liidiard	Enfys (CAMHS) Seren (CAMHS)	7 – 9 May 2019	English

Cwm Taf HB	Ysbyty Cwm Cynon	Ward 7	13 – 15 January 2020	English
Hywel DdaHB	Bro Myrddin	Bro Myrddin	2 April 2019	English
Hywel DdaHB	Withybush	St Caradog &St Non	10 – 12 June 2019	English
Powys HB	Bronllys	Felindre	18 – 20 November 2019	English
Powys HB	Llandrindod Wells War Memorial	Clywedog	15, 16 and 17 July 2019	English
Swansea BayHB	Cefn Coed	Tawe Clinic - Clyne & Fendrod	19 and 21 August 2019	English
Coed Du HallHB	Coed Du Hall	Ash, Beech &Cedar	4 – 6 November 2019	English
Cygnet	Delfryn	Delfryn House, Delfryn Lodge & Rhyd Alyn	30 September & 1, 2 October 2019	English
Cygnet	St Teilo House	St Teilo House	7 - 9 October 2019	English
Elysium Healthcare	Phoenix House	Phoenix House	17 – 19 February 2020	English
Elysium Healthcare	Ty Gwyn Hall	Ty Gwyn Hall,Skirrid View &	27 – 29 January 2020	English

		Pentwyn House		
Elysium Healthcare	Ty Grosvenor	Alwen, Brenig,Flat 1 & 2	14 - 16 October 2019	English
Hafal	Gellinudd Recovery Centre	Autumn Suite, Meadow Suite, Spring Suite, Summer Suite & Winter Suite	22 - 24 July 2019	English
Ludlow Street Healthcare	Heatherwood Court	Caernarfon , Caerphilly, Cardigan & Chepstow	24 – 26 June 2019	English
Mental Health Care	New Hall	Glaslyn, Clwyd & Adferiad	9 – 11 March 2020	English
Mental Health Care	St David's	St David's	15, 16 & 17 December 2019	English
Priory Group	Ty Catrin	Bute, Roath, Victoria, Sophia, Trelai, & Heath	3, 4 & 5 June 2019	English

Priory Healthcare	Llanarth Court (two separate visits)	Awen, Howell, Iddon, Osbern, Teilo, Treowen & Woodlands Bungalow	6 – 9 January 2020	English
Regis Healthcare Limited	Regis Ebbw Vale (two separate visits)	Brenin (CAMHS) Ebbw (CAMHS)	2 – 4 December 2019 8, 9 & 10 April 2019	English

Appendix B: Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelingsand ideas. See also *independent mental health advocate*.
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriatetaking 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 healthboards 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 lackmental 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 MentalCapacity Act 2005.
Care StandardsAct 2000	An Act of Parliament that provides a legislative frameworkfor 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 dischargeof 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.
CompulsoryTreatment	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 ofLiberty	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 ofLiberty Safeguards	The framework of safeguards under the Mental Capacity Actfor 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 nolonger 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 lefthospital 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 brainof 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 protectother 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 operationof 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 bythe hospital managers to do so. This can include clinical staff.
Independent Mental CapacityAdvocate (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 inhospital 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 orincomplete 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 leaveand can be recalled to hospital if necessary in the interestsof their health or safety or for the protection of others. Sometimes referred to as *'Section 17 leave'*.

Liable to bedetained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the presenttime
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 treatmentfor 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 CapacityAct 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they losecapacity 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.
Recall (andrecalled)	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, itmeans 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 beforethe 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 theAct, 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 certaintypes 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 amental 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 theSection 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 apublic 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 fora 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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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

 WG42734 Digital ISBN 978-1-80195-760-1