Cwm Taf Morgannwg University Health Board (CTMUHB) – Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services

Terms of Reference

Why are we doing this work?

Healthcare Inspectorate Wales' (HIW) purpose is to check that people in Wales are receiving good quality healthcare, which is provided safely and effectively, in line with recognised standards.

As part of our annual reviews programme, we have committed to undertake a local review of the quality of discharge arrangements for adult patients (18-65) from inpatient mental health services in Cwm Taf Morgannwg University Health Board (CTMUHB).

A range of information sources considered by HIW have indicated concerns around mental health services within CTMUHB. These information sources include Serious Incident notifications submitted to Welsh Government, external concerns received by HIW relating to mental health services and previous HIW mental health inspections.

In response to the issues and concerns outlined above, HIW has decided to undertake a local review will aim to examine the quality of mental health services provided by CTMUHB

Scope and Methodology

This review will focus upon and assess the quality and safety of arrangements around the discharge of adult patients from inpatient mental health units, back into the community.

Our review will consider whether the relevant requirements relating to patient discharge, monitoring and contingency planning are being followed by the health board, including compliance with associated legislation. Additionally, we will assess the interface between inpatient mental health services and community services in

relation to discharge, including consideration of any oversight and quality governance arrangements in place at CTMUHB relating to the quality of discharge.

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system; in view of this, the review will also consider how service provision has been adapted in order to understand the impact the pandemic has had on monitoring and support for patients who have been discharged to the community.

The key question that this review will seek to answer is: *Do the current arrangements for the discharge of patients from inpatient mental health services into the community support the delivery of safe, effective and timely care?*

In answering this question we will consider:

- The quality of the discharge process, including communication between inpatient and community based services
- Adequacy of risk management processes relating to discharge
- How patients are supported at the point of discharge, and during the period post-discharge
- The health board arrangements for monitoring the quality and effectiveness of its discharge arrangements.

To assess the areas detailed above, the review will review individual records of formal and informal adult mental health patients who have been discharged from inpatient mental health units operated by the health board. To allow HIW to identify health board wide themes or alternatively issues specific to an area, the selection of patients will include individuals who have been discharged to each of the three local authority areas within CTMUHB.

To gather further evidence as part of our review, we will carry out the following additional fieldwork:

- Interviews with a range of health board staff
- Health board self-assessment
- Staff survey for relevant staff members involved in the patient discharge process to ensure views and experiences are captured
- We will seek to collate the views and experiences of patients, including individuals selected as part of our case study, as well as relatives/carers
- Document review and analysis of a range of corporate and operational information and data
- We will engage with other stakeholder organisations, where necessary, throughout our review.

Timescales

The table below includes estimated timescales for the review:

Activity	Timescales
Fieldwork planning and document review	January - March 2022
Fieldwork	April - May 2022
Report Publication	August 2022

Analysis and reporting

Throughout the review fieldwork phase, the review team will give immediate feedback if any issues arise which represent an immediate risk to patient safety.

The review will conclude with the publication of a report that will set out the key themes and recommendations identified from our work. Any information provided by staff during the fieldwork will not be directly attributed to them in the report.

The health board will be provided with a copy of the draft report to comment on factual accuracy and will receive a copy of the final report prior to its publication.

If areas for improvement are identified, the health board will be required to complete an improvement plan, which details how the services will address the findings set out in the report. Following review, any improvement plan will be published on HIW's website alongside the report.

If required, we will use our service of concern process to identify and escalate concerns, to support any necessary improvement or learning for the health board.

Personal data

This review forms part of HIW's work to provide independent assurance on the quality and safety of healthcare services in Wales. The Health and Social Care (Community Health and Standards) Act 2003 (Part II, Chapter 4) gives HIW the power to carry out inspections, reviews and investigations of the NHS or services provided for the NHS. This terms of reference sets out our intended approach to the review.

Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulations. Further information is set out in HIW's privacy notice which can be found on our website https://hiw.org.uk/privacy-policy.