Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board

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

Our purpose

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

Our values

We place people at the heart of what we do. We are:

- **Independent** – we are impartial, deciding what work we do and where we do it.
- **Objective** – we are reasoned, fair and evidence driven.
- **Decisive** – we make clear judgements and take action to improve poor standards and highlight the good practice we find.
- **Inclusive** – we value and encourage equality and diversity through our work.
- **Proportionate** – we are agile, and we carry out our work where it matters most.

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use, and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety.
- We will work collaboratively to drive system and service improvement within healthcare.
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting and reviewing National Health Service (NHS) services and independent healthcare services throughout Wales against a range of standards, policies, guidance, and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS Health Boards and Trusts in Wales.

As part of HIWs annual reviews programme for 2021-22, we have undertaken a local review to consider the arrangements in place within Cwm Taf Morgannwg University Health Board (CTMUHB), when discharging adult patients (aged 18-65), from inpatient mental health services to the community.

The review set out to consider whether the processes in place within the health board support the safe, effective and timely discharge of patients to community mental health services, from its inpatient mental health units.

We explored whether the discharge planning process is robust, to ensure patients receive the required planned care and timely support once discharged from mental health units, and whether it is compliant with associated legislation where applicable. We also considered the governance arrangements in place for mental health services within the health board for the oversight of safe and effective discharge.

This report details our findings and 40 recommendations for improvement. The health board must consider all of these recommendations, and it is our expectation that these are taken forward in the context of broader improvement work.

We would like to express our thanks to all the staff working within the health board inpatient and the community teams, who helped inform our review by providing the requested information, participating in interviews and for completing our survey to share their views and experiences with us. We also convey our gratitude to the patients, families or carers who also helped inform our review by sharing their experiences with us by completing our survey.

Executive Summary

This report highlights the findings from our review of the quality and safety of discharge arrangements for adult patients being transferred from inpatient mental health units, within CTMUHB, back into the community. The key findings highlighted during our review are outlined below.

It was evident that efforts had been made by the health board to implement processes which set out to provide safe and effective care to patients as part of their admission and discharge from the inpatient unit. However, significant concerns were highlighted throughout our review which present risks to patient safety.

We found that overall, there was a very strong team working ethos amongst staff within the relevant community and inpatient teams. It was clear staff were striving to deliver services to patients in very challenging circumstances, often exacerbated by issues with workforce capacity and resource constraints.

Whilst assurances were provided by the health board regarding the efforts made to increase workforce capacity, it was clear that further work is required to strengthen the overall service's ability to meet the demand. Concerns regarding capacity were highlighted in inpatient and community areas, and it was clear that these issues and pressures being experienced were impacting on the ability of staff to undertake the full requirements of their roles and impacting on staff morale and well-being.

Arrangements have been introduced to help improve the communication between inpatient and community teams, in the form of weekly ward round meetings and complex patient discharge planning meetings. However, throughout our review, concerns were consistently highlighted around the effectiveness of communication and information sharing between inpatient and community teams. These issues had resulted in occasions where patients have been discharged with limited or no communication between teams, presenting a significant safety risk to patients.

When considering the necessary risk assessments undertaken for patients during admission to mental health inpatient units in both hospitals, we concluded there was an absence of a standardised systematic evidence-based approach for the management of patient risks, linked to risk assessments and risk management. The patient risk assessment process differed between each hospital, and we found two different approaches in place in some records within Royal Glamorgan Hospital. This demonstrates inconsistencies in the management of patient risks across the mental health services.

We found there were multiple patient clinical records management systems in place, which included paper records and several electronic systems. Taken as a whole, we found these to be collectively dysfunctional. These systems were not accessible to all staff involved in a patient's journey through inpatient and community mental health services. Throughout our review, concerns were repeatedly highlighted regarding the inability of staff to access essential information in a timely manner. Challenges around staff access to patient information and the communication of essential information between teams, significantly undermined the safe and effective discharge of patients.

In addition to issues of accessibility, further concerns were highlighted regarding the inconsistent use of the systems, which presented further risks and challenges in locating information when required.

It was highlighted that formal training and guidance for staff was not available for all of the clinical records systems in place.

We found that the demands experienced across the service were impacting on the availability of inpatient beds within the mental health units. As a result of the urgent need for beds, we were informed that on occasions, planned patient discharges were being expedited, to create space for new inpatients. These issues were again impacting on the effectiveness of safe discharge arrangements for patients, with examples provided of limited communication between teams, resulting in insufficient time to organise and implement required post discharge arrangements. This, in addition to the dysfunctional electronic record systems in place, exacerbated the risks to patient safety.

We saw evidence, when reviewing patient records, that good care and treatment was being provided to patients, with examples of coordinated working between inpatient and community teams. However, the quality and availability of information within the records that we reviewed was inconsistent. This meant that it was not always clear within patient records whether required actions, including completion of relevant assessments, had been undertaken as part of the patient's admission. Additionally, records reviewed did not always demonstrate that patients and their family or carer were being involved and appropriately communicated with during the discharge planning discussions.

We identified further concerns in relation to the inconsistencies found in the quality and detail of discharge planning information. It was not always clear within patient records that the required information was being shared with the relevant key staff and teams, or the patient. Whilst evidence was available to demonstrate that patient risk assessments were being updated prior to discharge, there was limited evidence of contingency or crisis plans or relapse indicators within the patient records we reviewed. On the occasions this information was available, it was not always evident that the information had been discussed and shared with the patient, their family, carer, or the relevant community teams.

During our review of patient records, we had significant concerns with the information documented for two patients, who were discharged from the inpatient mental health unit at Royal Glamorgan Hospital. Within both patient records, significant concerns had been highlighted relating to the safety of each patient. This included the risk of self-harm and suicide for both individuals, as well as risk of harm to others, for one of the patients. However, there were no robust management plans implemented for either individual, as part of their discharge planning process. This was pivotal to support them effectively and to maintain their safety once discharged to the community. In addition to these issues, there was evidence of poor communication and coordination of patient care between inpatient and community teams for both individuals.

Given the serious nature of several concerns highlighted during our review fieldwork, we issued the health board with an immediate assurance notification, and they were required to develop an immediate improvement plan and submit this to us, to provide assurances on the actions to be taken to mitigate against the relevant risks highlighted. Information regarding the immediate actions taken by the health board is detailed throughout our report and can be found in Appendix B.

Context

In its Operational Plan 2021-22, HIW committed to a programme of local reviews, which did not originally include the intention to review the discharge arrangements in place for adults from inpatient mental health services to the community, within Cwm Taf Morgannwg University Health Board (the health board). The decision to undertake this review was based on our concerns relating to the intelligence held within HIW and the result of numerous mental health inspections within Rhondda Cynon Taf (RCT) and Bridgend.

Over recent years, HIW has undertaken numerous onsite mental health inspections across RCT and Bridgend, and also several CMHT inspections jointly with Care Inspectorate Wales. We have on several occasions issued immediate assurance notifications to the health board in relation to some omissions in care, and also made comprehensive recommendations which have been published within inspection reports. These can be found on our website. We have also had cause for concern, where we found a repeat of issues in later inspections, demonstrating poor oversight and shared learning across the health board's mental health services.

We also hold a range of intelligence within HIW, which cumulatively, led us to become concerned about the quality of services provided to mental health patients within the health board. This includes Serious Incident notifications submitted to us via Welsh Government, concerns reported to HIW from patients or their carer's, and from staff whistleblowing disclosures.

Given the nature of the concerns highlighted above, HIW decided that a review of mental health services within the health board should be undertaken. The review focuses on the quality and safety arrangements within the discharge process for adult patients from inpatient mental health units to the community, within the health board's localities.

In April 2019, the health board boundaries changed, and the previous Cwm Taf University Health Board, became Cwm Taf Morgannwg University Health Board. This was following the transfer of Bridgend County Borough Council from the former Abertawe Bro Morgannwg University Health Board (which is now known as Swansea Bay University Health Board).

The health board now provides primary, community, hospital and mental health services to around 450,000 people living in the three boroughs of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

During our review, the health board's operational model included three Integrated Locality Groups (ILGs), each with their own strategic and operational focus. These were Merthyr Cynon, Rhondda and Taf Ely and Bridgend. Within each ILG there were Clinical Service Groups (CSGs), which manage the relevant services within each locality. Each CSG had its own senior and clinical management structure for the relevant services being provided.

At the time of our fieldwork the mental health service within the health board was provided across all three ILGs and was managed by three separate CSGs. They included six Community Mental Health Teams (CMHTs), three Crisis Resolution and Home Treatment Teams (CRHTs), and two adult mental health inpatient units.

Since our fieldwork, the health board has commenced an organisational change to endorse the onward development of a whole-organisation Care Group structure. This structure will move away from the geographical split of three integrated localities model as currently in place. The Care Group model aims to ensure a locality aspect is retained, to ensure an ongoing focus on quality and improvement, within a local authority area. It will also bring the health board together in its vision and ways of working, as opposed to being split into separate groups and endeavours to improve equality of access for patients.

Further details on the health board's Care Group structure can be found in the 'Governance Arrangements which Support Quality and Patient Safety' section of our report.

Adult mental health services within the health board at the time of our review:

Bridgend CSG

- Bridgend North CMHT
- Bridgend South CMHT
- Bridgend CRHT
- Princess of Wales Hospital Mental Health Unit
  - **Ward 14** – A 20 bed assessment and treatment ward (predominantly for Bridgend based patients).
  - **PICU** – An eight-bed unit, however, five of the beds are allocated to Swansea Bay University Health Board (SBUHB), due to no PICU facilities within SBUHB.

Merthyr Cynon CSG

- Merthyr CMHT
- Cynon CMHT
- Merthyr Cynon CRHT

Rhondda Taff CSG

- Rhondda CMHT
- Taff Ely CMHT
- Rhonda Taff CRHT
- Royal Glamorgan Hospital Mental Health Unit
  - **Assessment Unit** – A 14 bed ward – majority of patients admitted to the unit would initially be admitted to the assessment unit. On average this admission would be around seven to ten days, for initial assessment. The patient will then either be discharged or transferred to the relevant treatment ward if required.
  - **Ward 21** – A 14 bed treatment ward, predominantly for Merthyr Cynon based patients.
  - **Ward 22** – A 14 bed treatment ward, predominantly for Rhondda Taf based patients.
  - **Psychiatric Intensive Care Unit (PICU)** – A six bed unit, however, at the time of our fieldwork the unit was operating with only five beds, due to ongoing refurbishment work. We were informed that this work is scheduled for completion in February 2023.

What We Did

Focus of Review

The focus of our review was to explore the quality and safety of discharge arrangements for adult patients being transferred from inpatient mental health units within the health board, back into the community.

The review sought to address the following overall question:

Do the current arrangements for discharge of adults from inpatient mental health services into the community, support the delivery of safe, effective and timely care?

Throughout the review we explored:

- The quality and safety of the discharge process, including communication between inpatient and community-based services.
- The adequacy of patient assessment and risk management processes relating to discharge.
- How patients are supported in the discharge planning process, from the time of their admission through inpatient mental health services to the point of discharge, and the initial period post-discharge.
- The health board arrangements for monitoring and improving the quality, safety and effectiveness of its discharge arrangements.

Scope and methodology

We focused on the health board's processes for the discharge of adults from inpatient mental health units, and whether these arrangements were safe and effective.

To review the areas set out above, we:

- Requested relevant documentation from the health board, prior to and during our fieldwork, around its policies and procedures relating to discharge, as well as the local policies or guidelines across the mental health services.
- Held interviews with a range of health board staff.
- Undertook onsite fieldwork focusing on patient case studies.
- Conducted an online survey for staff working within the health board's mental health services and General Practitioners.
- Conducted an online and paper survey for patients, and their family or carers.

Staff Interviews

We held multiple interviews with staff from within the health board, including clinical staff, managers and directors working across mental health services. This included both adult inpatient mental health units at Royal Glamorgan Hospital (RGH) and Princess of Wales Hospital (POWH), and staff working within each of the CMHTs and CRHTs within the health board, including social workers.

We completed a total of 67 staff interviews and our findings will be highlighted throughout the report.

Patient Case Study

We asked the health board to provide us with an anonymised list of all adult patients who had been discharged from the inpatient mental health units at the RGH and POWH between 24 February 2021 to 24 February 2022. The list included 675 patients who had been discharged from the hospitals. From this list, we selected 100 patients to explore in more detail, with the aim of reducing the number further to 50. From the 50 patient records, we randomly selected between 25 and 30 to review during our onsite fieldwork. In choosing the patients, we aimed to consider a range of individuals, such as different ages, gender and race, and selected our records accordingly.

During our onsite patient case study, we reviewed 27 sets of clinical records to explore the discharge arrangements for the period detailed above. This included 18 patients who had been discharged from RGH and nine discharged from POWH. The patient records reviewed were both paper and electronic patient records.

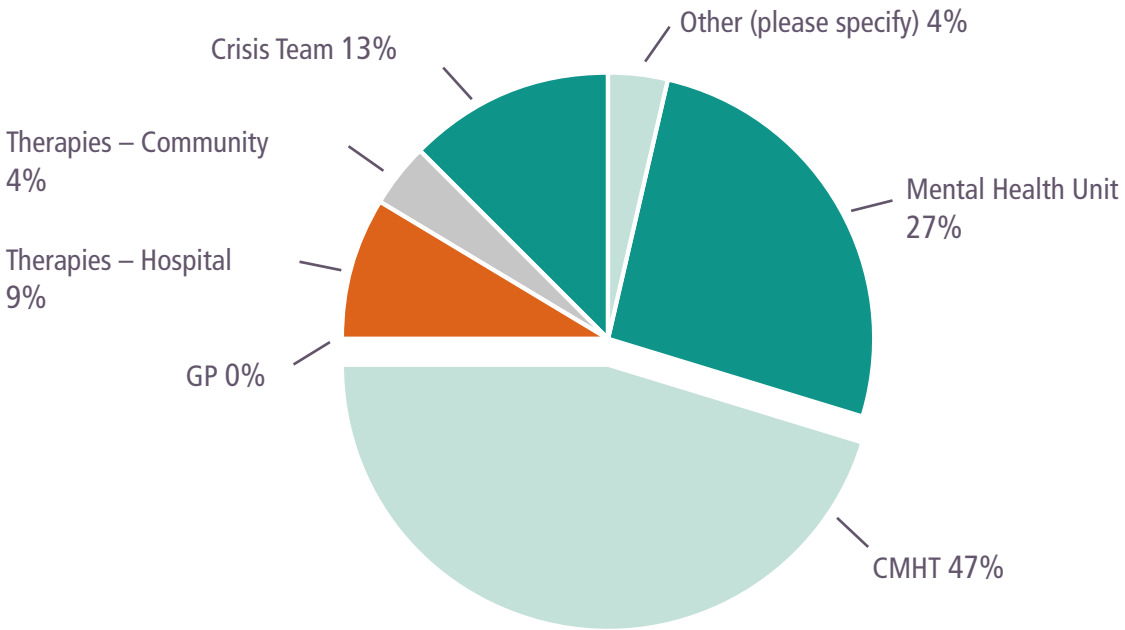
Our findings through our case study review are highlighted throughout the report.

Staff Survey

We developed and undertook a staff survey, to obtain the views of staff involved with the discharge process which included inpatient and community-based staff working within mental health services. The survey was shared with the health board to circulate to the relevant hospitals, community and primary care staff who deliver services to mental health patients. The survey was also promoted on the HIW website and via our social media channels and was available for completion between May 2022 to July 2022.

We received a total of 45 responses from a range of staff groups, these are detailed in the chart below.

It is disappointing to note that we did not receive any response from General Practitioners (GPs). Findings from our survey will be highlighted throughout the report.



Patient and family or carer survey

In addition to a staff survey, we also conducted a public survey to capture the views of people who have previously been discharged from inpatient mental health units within the health board. This was to gain an understanding of their experiences during the discharge process from the inpatient service to the community. The survey also included questions to allow family members and carers of patients to provide their views and experiences.

These surveys were available electronically and could be accessed via the HIW website and our social media channels. The posters promoting our surveys included QR codes to allow individuals to scan with their smart phones or tablets. The posters were sent to health board CMHTs to display, and staff were also asked to help promote completion of the survey.

In addition to the online survey, paper copies were also available, and we distributed these to each of the six CMHTs within the health board, alongside the posters. Individuals were able to complete the surveys anonymously.

It is disappointing to note that we received a very small number of responses, and subsequently we were unable to acquire quantitative data to help inform our review.

What We Found

Delivery of Safe and Effective Care

Do the current arrangements for the discharge of adults from inpatient mental health services into the community, support the delivery of safe, effective and timely care?

This section of the report incorporates the findings that help answer the question above, and to understand the current arrangements in place at the health board to facilitate a safe patient journey from admission to discharge, from adult mental health inpatient units to the community.

Assessment processes

Pre inpatient mental health assessment

Prior to any patient admission into a secondary care mental health unit, it is a requirement that a full and comprehensive mental health pre assessment is completed by the CRHT practitioners involved with the patient at that time.

The purpose of the assessment is to determine the severity of mental illness and to consider the needs of each individual. This is to establish the required actions and appropriate plan of care to support and manage their needs during their hospital stay and in planning for discharge. In addition, during the assessment, it is necessary to determine whether the criteria have been met for the formal detention of a person under the *Mental Health Act 1983*[1], and also to establish whether there are any alternative options of providing inpatient care and treatment to the patient, in line with their needs.

Each assessment is completed when concerns are identified regarding an individual's mental health and well-being, their personal safety and/or for the safety and/or protection of other people. The completed assessment must be submitted to the relevant mental health unit, as part of the admission process. Where it is deemed that an individual does not meet the criteria for a formal admission under the *Mental Health Act 1983*, alternative options for care and treatment are considered by the teams involved at that stage. This may include admission to hospital on an informal (voluntary) basis or identifying additional support for the patient in the mental health community services.

Assessments undertaken on admission to hospital

As part of the admission process, further assessments must be undertaken by inpatient healthcare staff to determine the mental health needs of the patient and to inform the individual's inpatient plan of care. This must include a comprehensive physical health assessment, to ensure any physical health issues, such as cardiovascular disease, diabetes or respiratory diseases are identified.

During our onsite patient case study review, we found that all nine records reviewed for patients admitted to POWH mental health unit, had evidence to demonstrate that a full comprehensive mental health assessment had been undertaken, as part of the admission process. However, only six of the nine case studies, evidenced adequate information regarding the physical health assessments of individuals.

1 www.legislation.gov.uk/ukpga/1983/20/contents

When reviewing the 18 patient records for our case study within the RGH, only half included evidence to demonstrate that full and comprehensive mental health assessments had been undertaken as part of the admissions process. Several of the assessments reviewed, did not include all the required details in line with the *Mental Health (Wales) Measure 2010*[2] under the *Mental Health Act 1983*, to evidence that all relevant areas had been assessed. This was despite the availability of a standard proforma which lists the required domains from the Measure.

We found evidence that a comprehensive physical health assessment had only been completed for 12 out of the 18 patients reviewed at RGH. Three records had no evidence to demonstrate a physical health assessment was completed, and whilst there was some evidence documented in the remaining three patient records, this was free text only, therefore highlighting that a systematic physical health assessment had not been completed. Consequently, we could not be assured a thorough assessment had been completed for nine of the 27 patient records reviewed during the case study.

Recommendation 1

The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the *Mental Health (Wales) Measure 2010* under the *Mental Health Act 1983*.

Patient safety risk assessments

During the admission process to an inpatient mental health unit, there must also be a full risk assessment completed, to help identify potential risk(s) to the patient's safety, and for the safety of other patients and staff members. Risk assessments and risk management are central to developing a patient care plan to meet the needs of the patient.

As part of the risk mitigation process, a patient should not only be assessed on admission, but also on an ongoing basis through routine reassessment throughout their hospital stay. Further reviews should be completed particularly after any patient escalation incidents, and when planning a patient's discharge back to community services. This is to ensure that any immediate or potential risks to the patient or others are identified promptly, and to implement mitigations as appropriate. Any risks identified within the assessment must then inform future care and treatment planning for the patient and must be considered when planning a discharge.

Risk assessments in RGH

During our case study review at RGH, we found evidence to demonstrate that comprehensive risk assessments had been completed in the majority of records reviewed. In addition, we found regular reviews and reassessments of risks were regularly being undertaken throughout the patient's admission. The assessments seen were well completed, evidence-based and reflected the *Wales Applied Risk Research Network (WARRN)*[3] principles.

2 www.legislation.gov.uk/mwa/2010/7/contents

3 Wales Applied Risk Research Network (WARRN) is a formulation-based technique for the assessment and management of service risk, for users of mental health services. It has been gradually adopted as the risk evaluation and safety planning technique for all seven health boards in Wales.

However, two patient records we reviewed highlighted that the, now discontinued, Care Programme Approach (CPA[4]) risk formulation had been completed. Whilst detailed assessments were available for both of these patients, the health board should ensure that in future, the risks assessments in use should accurately detail and reflect the *Mental Health (Wales) Measure 2010*.

We found that patient risk assessments were leading to the formulation of bespoke risk management plans. This is to mitigate against any risks identified for the patient and to inform care planning. However, in two of the patient records reviewed, whilst risk assessments had been completed for each patient, there was limited evidence to demonstrate that subsequent plans to mitigate against the highlighted risks had been implemented for both patients. This issue is detailed further within the 'Supporting the Discharge Process' section of the report.

Risk assessments in POWH

Our case study review at POWH, found evidence that comprehensive and detailed patient risk assessments had been completed, which had also been reflected in subsequent management and care plans for each patient reviewed. However, we found that the risk assessments reflected the relevant health board local policy, and did not entirely reflect national guidance, such as *WARRN* principles. Consequently, we concluded there was an absence of a standardised systematic evidence-based approach for the management of risks, linked to risk assessments and risk management. Our interviews with service managers confirmed this, and it was highlighted to us that the service was working towards introducing the *WARRN* principles within the mental health services at POWH.

Recommendation 2

The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.

Mental capacity assessments

Our case study identified a lack of evidence to demonstrate that patient mental capacity assessments were being completed at either hospital.

Whilst there were some records that referred to the relevant patient's mental capacity being assessed, there was limited or no evidence available to demonstrate how the assessor had reached their conclusion.

In view of our findings, we are not assured the mental health units had a formal standardised approach to mental capacity assessment, which reflects the criteria detailed within the *Mental Capacity Act, Mental Health Act 1983* or in line with *National Institute for Health and Care Excellence (NICE) Guideline 108*[5].

Recommendation 3

The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.

4 Up until 2012, the Care Programme Approach (CPA) was the main way of assessing and identifying the care needs of individuals with mental illness, receiving secondary mental health services. CPA continues to operate in England, but in June 2012, it was superseded in Wales by Part 2 of the Mental Health Measure (2010).

5 Overview | Decision-making and mental capacity | Guidance | NICE

Family or carer assessment

In line with *The Mental Health Act 1983 Code of Practice*[6], family or carers have a right to an assessment of their own needs, even if the person being cared for has refused an assessment for the provision of mental health support services.

Our case study found some evidence for the involvement of family or carers (in line with patient consent), regarding patient care, treatment and discharge planning arrangements. However, we did not find evidence that a carer's assessment had been completed within any of the patient records we reviewed.

Recommendation 4

The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals in line with *The Mental Health Act 1983 Code of Practice*.

Planning care and Treatment

Care and treatment plans

Part two of the *Mental Health (Wales) Measure 2010*, states that care and treatment plans must be developed for relevant patients of all ages, who have been assessed as requiring care and treatment within secondary care mental health services. The care and treatment plan must include the assessed needs of the patient, as well as the outcomes to be achieved, associated actions and specific services to be provided.

The *Mental Health (Wales) Measure Code of Practice*, states that it is the responsibility of the allocated patient care coordinator to develop a patient's care and treatment plan. It also recommends that in most cases, the care and treatment plan should be completed within six weeks of allocation to a care coordinator. The coordinator must consult other relevant mental health services, as well as the patient and their family or carer (in line with patients' wishes), with a view to agreeing the target outcomes for the individual.

The care and treatment plan should consider eight areas, which are:

- Medical and other forms of treatment, including psychological interventions.
- Accommodation.
- Finance and money.
- Personal care and physical well-being.
- Work and occupations.
- Parenting or caring relationships.
- Social, cultural or spiritual preferences.
- Education and training.

The health board's Care and Treatment Planning Policy sets out the requirements and responsibilities of mental health practitioners responsible for care and treatment planning, in line with the *Mental Health (Wales) Measure 2010*.

6 mental health act 1983 code of practice for wales.pdf – Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their families and carers.

The policy details the areas which need to be assessed and considered when developing the care and treatment plan. The policy also highlights that the performance target for the full assessment and development of a care and treatment plan should be within six weeks. In addition, that copies should be provided to the patient and other relevant services within 14 days of the plan being agreed.

Care and treatment plans at POWH

Our patient case study within POWH found that comprehensive care and treatment plans were in place, with clear actions and outcomes documented. However, we identified that some information included within the records continually referred to and reflected the Care Programme Approach, instead of the statutory Care and Treatment planning. This meant that it was not always evident that the principles had been embedded into practice, and therefore did not reflect the requirements of the *Mental Health (Wales) Measure 2010*.

We also identified that some patient care and treatment plans and other associated documents, were not signed and dated by the relevant staff members, when they were being reviewed and updated. Therefore, it was not clear who had reviewed and updated the plan, their role or designation.

We found evidence that weekly summaries, in line with care and treatments plans, were undertaken by relevant members of the inpatient nursing teams, for each patient being treated. These were comprehensive and informative, highlighting the patient's condition and progress and were informing future planning discussions.

Care and treatment plans at RGH

Our case study review within RGH, found that some patients had care and treatment plans in place, which had been developed in the community by their respective care coordinator. On admission to RGH, inpatient clinical staff should complete inpatient management plans to record relevant ongoing needs and highlight risks, to help inform the admission process.

Our interviews with staff identified that these management plans should be routinely reviewed and updated throughout the patient admission and should also inform the discharge planning process. On discharge, if the patient has an allocated care coordinator, they are responsible for developing and updating the patient's care and treatment plan, which should reflect the relevant inpatient documentation and agreed actions on admission, as part of the discharge process.

The records reviewed within RGH demonstrated that inpatient management plans were routinely being developed, reviewed and updated following any changes to the patients' condition. There was also evidence to demonstrate that the inpatient management plans were informing the discharge planning process.

The majority of patient records reviewed during the case study at RGH, evidenced recent care and treatment plans, which were detailed, and reflected the relevant requirements for each patient. However, as within POWH, we found that the documents were not being signed and dated consistently, to determine the contributing staff members' role and designation.

We identified that not all patients had a care and treatment plan readily available on admission within their hospital inpatient records. We found that several patients had previous admissions to the inpatient unit or were known to mental health services, and already had designated care coordinators.

This information was readily available via the electronic systems used within the relevant CMHT; however, the information was not available to us through the electronic system used within RGH, known as FACE, and would therefore not have been readily accessible to inpatient staff.

The issues relating to timely access to patient care and treatment plans is detailed further within our 'Patient Clinical Records Management Systems' section of the report.

Recommendation 5

The health board must ensure that patient care and treatment plans:

a) Reflect the requirements set out within the *Mental Health (Wales) Measure 2010.*

b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.

Discharge Planning Arrangements

Throughout our review, we explored the arrangements in place to manage effective, safe and timely discharge planning for inpatients within the mental health units.

Multidisciplinary team discharge meetings

Our case studies within both hospitals demonstrated that routine Multidisciplinary Team (MDT) patient case reviews and ward round meetings were being undertaken. Our interviews with staff identified that weekly ward round meetings were held within each hospital ward, and that relevant inpatient and community staff are invited to attend. This included CMHT and CRHT staff from the relevant areas. These meetings sometimes included other clinical staff from both the inpatient and community teams, such as pharmacists and therapies staff.

Our interviews with community staff, highlighted that a representative from their teams, usually the team manager, attends the ward round meetings for the respective wards. The aim is to ensure that the views of the team contribute to the planning discussions which take place and enables the community staff member to feed back to the wider community teams. The feedback would include, for example, a patient condition update whilst in hospital, and the sharing of information on any expected patient discharges who require CMHT or CRHT involvement following their discharge from the ward.

We were also informed that the ward staff circulate an agenda in advance of the ward round meetings, highlighting the patients who will be discussed. This provides notice and the opportunity for the relevant patient's CMHT care coordinator, to attend the meeting wherever possible. However, we were told that in most cases, it would be the CMHT manager who attends the meetings, and they would feed back to the relevant staff members.

We found that the weekly ward round meetings provide the opportunity to discuss patient progress, and to plan care and determine the level of support required to aid the patient in their recovery and rehabilitation for their progress towards discharge. The discussions also aim to consider and agree the level of support required for a patient, when they are discharged back into the community.

In addition to the weekly ward round meetings, we found that specific patient discharge meetings are also held when required. These meetings are convened when a more detailed discussion is required for patients with more complex needs. In addition, to discuss and agree the statutory post discharge arrangements that may be required, in line with the *Mental Health (Wales) Measure 2010*.

Ward round discharge planning process

During our staff interviews, some concerns were raised with us regarding the current structure of the ward rounds, and in particular, that on some occasions, there has been limited time to adequately discuss all of the patients listed on the agenda. Some staff felt this poses a potential risk to patients achieving a timely or a robust plan for discharge, and also shared their frustrations around the impact the overrunning of meetings can have on workload capacity.

Through our interviews with inpatient and community staff, we learned they could routinely contribute to the discharge planning process for their patients. It was also highlighted, that at times, there was not always a consensus between teams when planning the discharge of some patients, although staff said they felt able to raise any concerns they had as part of the discharge planning process.

To support the conflict between staff opinions around a patient's discharge, the health board has a Disagreement in Discharge Planning Process in place, to help manage the occasions where disagreements within teams are evident.

The process highlights that consideration should be given to postponing the patient discharge, and subsequently to plan an additional meeting, with involvement from more senior clinical management staff. This later meeting should allow for the disagreements to be addressed, and a suitable resolution to be determined before the patient is discharged. We consider this to be a positive approach to support the safe discharge of patient.

Recommendation 6

The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all mental health patients.

Community team attendance at discharge planning meetings

During our interviews with inpatient staff, it was highlighted that a representative from the community team had not always been present during weekly ward round meetings, where discharge plans are discussed. This was also raised with us as an issue by some community staff, who said it can sometimes be difficult to attend ward rounds or discharge planning meetings, due to the demands and complexity of their workload, and the logistical challenges in travelling to the wards.

This issue undoubtedly impacts on the effectiveness of the discharge planning arrangements in place, from inpatient to community care. Routine attendance at ward rounds would ensure robust discussions take place around discharge between the relevant teams in an efficient, effective and timely manner. This would help prevent the need for chasing key information following the meetings.
To help mitigate against this issue, we were informed that community staff can link into inpatient ward rounds and discharge planning meetings virtually. However, there have been occasional issues with the IT network, causing communication issues, impacting on staff ability to hear and contribute appropriately when attending a meeting remotely.

Our concerns regarding inadequate attendance at ward round and discharge planning meetings was escalated to the health board during our fieldwork. This issue is discussed further in the 'immediate assurance notification' section later in the report.

Coordinated working and communication between teams

We considered the arrangements in place to support communication and team coordination of planning for patient discharges, and whether these are effective.

Our staff interviews identified that improvements have been made in coordinated working between teams following the introduction of weekly ward rounds. When responding to our survey, 79% of staff responded positively and highlighted that a coordinated approach was in place between the inpatient and community teams, with some also feeling that arrangements were in place to support the timely discharge planning between inpatient and community teams.

In contrast to this, we found that issues around communication and effective sharing of information, were consistently highlighted as an ongoing issue. The majority of staff felt this was the biggest challenge for the service when coordinating care. Supporting this, around 45% of respondents to our staff survey felt that communication and information sharing between inpatient and community teams, regarding patient discharge, was ineffective.

Our interviews with inpatient staff highlighted the workload challenges and demands on their time, which has resulted in issues where key information has not been shared with community teams in a timely manner prior to discharge. This has subsequently impacted negatively on patient care and support in the community. In addition, staff also reported examples where patient discharges have been expedited due to system pressures and the demand for acute mental health beds. This has resulted in limited time for inpatient staff to communicate key information to the relevant community team. This issue is discussed further, later in the report.

Our interviews with community staff also highlighted concerns about inconsistencies in the timeliness of patient discharge plans being shared with them. This often impacts on their ability to undertake their roles effectively in supporting patients appropriately after discharge. This included examples where some patients known to CMHTs, had been discharged from inpatient units, with minimal or no notice provided to the CMHT, and the absence of information for their post discharge plan of care, thus impacting on patient care and support.

We also found that timely communication issues are exacerbated by the multiple patient record management systems in use across the health board's mental health services. These systems differed between inpatient and community teams, which means that some community staff do not have easy or timely access to key patient discharge information. This issue is discussed further in the 'Patient Clinical Records Management Systems' section of the report.

Recommendation 7

The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.

Recommendation 8

The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.

Staff-patient engagement when preparing for discharge

Our interviews with community staff identified that when preparing for discharge, they would routinely contact and visit patients on the relevant wards, to discuss with them and the inpatient staff, about the discharge plans. This would also allow the opportunity for community staff to review patient records to establish the patient's progress and post-discharge plans. Staff also informed us that discharge planning information is also routinely requested and shared with them via email.

We found evidence to demonstrate that decisions made during the ward visits were documented within the patients' notes. However, it was identified that there were no formal minutes being routinely recorded for all patient related meetings that were taking place. This meant it was difficult to ascertain which staff members were present at the meetings, and also there was limited or no information available on the discussions which led to specific decisions being made.

Ward administrative support

During our interviews with service managers from POWH, we were informed about the lack of ward clerk resource on one ward for a substantial period of time, which had been exacerbated by staff shortages through the COVID-19 pandemic. The absence of a ward clerk impacted on the unit's ability to undertake several administration tasks in a timely manner. This had an impact on timely discharge planning, and clinical staff were usually required to undertake these tasks, subsequently adding to their workload. However, we were informed that plans were in place to recruit additional administrative staff over the coming months to reduce the burden on clinical staff.

Recommendation 9

The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.

Recommendation 10

The health board must provide an update to HIW on the action taken and outcome, to address the administrative support issues within POWH mental health unit.

Out of area patient discharges

We found issues with the arrangements for coordinated discharges and poor communication for patients from Bridgend areas being admitted to RGH. The examples provided to us highlighted the communication issues between the RGH inpatient unit and the relevant Bridgend area CMHT. In some instances, staff have not been invited to contribute to the RGH ward rounds, to help inform discharge planning and have also been unable to access the key patient information. This again is the result of different patient record management systems. This has led to the patients being discharged from RGH, with no notice provided to the relevant CMHT in the Bridgend locality. The health board should consider this issue as part of its response to Recommendation 7, highlighted earlier in the report.

It is evident that a collaborative and effective multidisciplinary approach between inpatient and community teams is pivotal when planning the discharge of patients from inpatient care. Maintaining a collaborative approach to discharge planning, and one that is well communicated, will minimise risk to patient safety.

Potential risks identified during the assessment process and throughout a patient's in-hospital journey, should be identified early, in order to effectively plan for discharge. Plans of care can be implemented accordingly to help mitigate against any known risks to patient safety, in order to support the patient in their recovery. This approach should ensure that all relevant services and teams involved in the patient care process are fully involved in developing the discharge plans for each individual, and all teams should be aware of the patient needs before the patient is discharged from the ward. Patients requiring additional support within the community to manage their mental health, should not be discharged without the relevant teams being aware, and in agreement that the resource is available to manage the proposed discharge plans.

Immediate assurance notification

Our concerns highlighted above were identified during our onsite fieldwork, we addressed this issue through our immediate assurance process, by writing to the health board to seek timely assurance immediately after our fieldwork was complete.

The health board's written response to us, detailed that arrangements would be implemented to ensure the presence of dedicated community clinicians in all inpatient multidisciplinary discussions and discharge planning meetings. Additionally, the monitoring of attendance at the meetings would be undertaken by the relevant ward manager, with further monitoring to be undertaken by the area senior nurse. Where further escalation is required, this should be raised to the relevant area CSG Quality, Safety, Risk and Experience meeting, for discussion and to agree the action required.

Further details of our immediate assurance notification are included within the relevant sections of our report, and the health board's full response can be found in Appendix B.

Discharge Planning

Evidence was available in the majority of the patient records we reviewed, to demonstrate that inpatient management documents and MDT meetings were informing patient discharge planning. As detailed previously, evidence was available to confirm that MDT discharge discussions were taking place, in order to develop and agree the required care and treatment for the patient, as part of their discharge from the inpatient unit.

Within the records reviewed, we saw examples of coordinated working between inpatient and community teams, which demonstrated active involvement from relevant areas. However, information was not always available within the notes to confirm that relevant teams had been present and involved in the discharge planning process for the relevant patient.

As previously highlighted, within the patient records it was not always evident that the patient, and where appropriate, their family, carer or advocate were involved in or able to contribute to case review meetings, during the patient's admission to inform care and discharge planning. Although there was some evidence of discussions with family members throughout the discharge planning process, it was not always evident what their views were and how much they have been proactively involved in decision making, care planning and risk management.

The above concerns were included in our immediate assurance notification to the health board following the onsite fieldwork. The health boards' written response outlined that a template for inpatient MDT and discharge meetings would be developed.

This is to encourage and ensure that patient and family, carer and/or advocate are able to engage and provide their views, as well as to guide staff to appropriate recording of the meetings.

We were also informed that audit arrangements would be introduced to monitor compliance with these requirements. The health board's response detailed that these measures would be implemented by 31 July 2022. Subsequent discussions with senior managers, confirmed to us that these audit arrangements have now been implemented. Details of the health board's immediate assurance action plan are available in Appendix B.

Recommendation 11

The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.

Supporting the discharge process

We found evidence to demonstrate that patient risk assessments were being updated prior to their discharge from the inpatient units, with the purpose of informing planning arrangements. However, there was limited evidence of a contingency plan, crisis plans or relapse indicators within the records reviewed. On the occasions when this information was available, it was not always evident that the information had been discussed and shared with the patient, and where appropriate, their family or carers and the relevant community services. This, therefore, increases the risk to patient safety or mental well-being following discharge.

Discharge checklist

To support the discharge process, there was a standard discharge checklist available to staff, to prompt them and to record actions undertaken as part of the discharge process. This included the recording of what information had been shared with relevant teams and when, as part of the discharge process.

Through our case study review, we identified that the checklist was not being consistently used or completed in full by staff. It was, therefore, not always clear what actions had been completed as part of the patient's discharge, for example, what information had been provided to patients and key staff.

Discharge planning information

In support of our findings in relation to incomplete discharge checklists, when reviewing the patient records, we found it was not always clear that sufficient information had been provided to the patient, as part of the discharge process, which should include:

- The Patient's Rights under the *Mental Health Act (section 132)*.
- Accessible advocacy services.
- Entitlement to a self-referral process for assessment.
- Medication and side effects.
- Contact details for CMHT care coordinator, GP or any other relevant services.
- Contact details and information on benefits and entitlements.
- Reasons and rationale for their discharge, and a copy of the post discharge plan, including actions and outcomes.

Our concerns regarding inconsistencies with the quality and detail of discharge planning information were further substantiated during our case study review, where we had significant concerns regarding the information recorded for two patients discharged from the mental health unit within RGH. The documentation in both patients' records highlighted significant patient safety concerns, which included the risk of patient self-harm and/or suicide for both individuals, in addition to the risk of harm to others for one of the patients.

These concerns were highlighted before admission to hospital, during their inpatient stays and prior to their respective discharges. Despite the concerns documented within the patients' records, reiterated by the concerns of immediate family, there was no robust patient management plan implemented for either individual as part of the discharge planning process, to support them effectively and to maintain their safety and mental well-being in the community. In addition, there was evidence of poor communication and coordination of their discharges between inpatient and community teams, as well as issues with timely information sharing. Following their discharge, sadly both patients died within 10 months. The coroner's inquests for both patients have not yet taken place.

Given the serious nature of our concerns with this finding, we raised this at the time of our fieldwork with senior staff, and both incidents were included within our immediate assurance notification (in Appendix B) to the health board. We requested assurance from the health board that staff will be adequately trained in completing risk assessments and the formulation of risk management plans. This is to ensure consideration of the mitigations required for identified risks, to minimise self-harm or deterioration in condition for all patients being discharged from inpatient mental health units.

The health board was also asked to consider how essential communication between inpatient and community services could be immediately improved, with a view to ensuring that relevant information is routinely being shared, prior to, or immediately on discharge. Additionally, the health board was asked to ensure that prescribed plans of care after discharge, are communicated to the relevant community teams before the patient is discharged.

Recommendation 12

The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.

Recommendation 13

The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.

Admission to hospital

To understand the patient journey from the community, through hospital and planning for discharge, we explored the processes in place for the allocation of inpatient beds to patients.

Allocation of inpatient beds

The process for allocating inpatient mental health beds, begins with community teams contacting the relevant inpatient unit to establish bed availability. The community teams within Merthyr Cynon and Rhondda Taff, would aim to secure a bed at RGH, and with Bridgend community teams contacting POWH. If no beds are available within the patient's locality, attempts would be made to source a bed in the other locality of the health board. On the occasions where there are no beds available at both hospitals, authorisation is sought to broaden the search to other health boards in Wales, and occasionally across the border to England. Where NHS beds may not be available, the option around sourcing a private bed within independent healthcare services is also considered.

Demand on inpatient beds

Through our staff interviews, we learned that the process for locating an inpatient bed can be extremely time consuming and challenging for staff. This is exacerbated by logistical challenges when physically transferring a patient to the available mental health unit. Given these challenges and the risks presented by patients needing prompt admission to hospital, we were informed that at times, patients have been admitted to beds already allocated to other patients. This is when a patient is not currently occupying their bed, whilst they are on Section 17 leave[7] from the ward.

Staff concerns for bed availability and expedited discharges

Throughout our staff interviews, and from information received in our survey, staff consistently raised their concerns around the demand for inpatient beds. We were informed that it can be extremely challenging for community teams to secure a bed when needed. The impact of bed pressures has led to incidents where planned patient discharges are expedited, in order to create a bed space for other individuals needing acute inpatient mental health care from within the community.

We were informed by inpatient staff that only the patients assessed as being safe for discharge would be expedited. However, there was not always sufficient time for them to communicate all relevant information to the appropriate community teams, to manage the discharge in a coordinated and timely manner.

Concerns and frustrations were also relayed to us by community staff, where patient discharge plans had been amended without effective communication or agreement between all teams. Examples were provided to us about the amendments made to the agreed discharge plans and timescales. This presented challenges to community teams to manage the patient care effectively, therefore potentially increasing the risks to patient safety.

The 'demand for beds' challenges were understood and acknowledged by community staff. However, we were told during interview that for expedited patient discharges, the teams can be affected by insufficient time for staff to safely organise and implement the required post discharge arrangements, prior to the person leaving hospital. As previously highlighted, incidents had occurred where patients were discharged with limited or no notice provided to the community teams, posing significant risks to patient safety and mental well-being.

7 Patients detained under the Mental Health Act, may be entitled to leave hospital if authorised by Consultant (Responsible Clinician) in charge of care. This leave is referred to as "Section 17 leave", as it relates to Section 17 of the Mental Health Act.

Recommendation 14

The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.

Recommendation 15

The health board must provide an update to HIW on the actions taken or are outstanding, to mitigate the risks associated with the availability of inpatient beds.

Inpatient Unit Coordinator

Effective communication between inpatient and community teams is fundamental in mitigating the risks and challenges caused by bed pressures and any subsequent expedited discharges.

To help manage the issues and challenges with bed pressures within inpatient wards, we identified during interview with staff from RGH, that a Unit Coordinator role has been introduced to the unit. The role's responsibilities include collating the issues that occur with the demands on beds, and the pressure to discharge patients from the unit, and to coordinate a response and implement actions, to help resolve any admission or discharge issues. We were told that a staff rota is in place to rotate this role a week at a time between the Band 6 nurses, on a six-weekly basis. During their allocated week, the Unit Coordinator is the main contact for all ward staff, to collate information around admissions and discharges, including declaring bed status, as well as any other issues being experienced on the ward.

During interview, we learned that community staff endeavour to inform inpatient teams with sufficient notice of a potential admission. We were also told that during the COVID-19 pandemic, 'Huddle Meetings' were held several times a week, between community teams and ward leads within Merthyr Cynon and Rhonda Taf areas, to discuss ongoing workload challenges. This would include discussions around patients who require admission to hospital, the inpatient bed availability and any impending discharges. These discussions enabled teams to forecast future demand on their relevant areas, and also enabled the inpatient wards to plan for occasions where they may need to create bed space urgently and for near future demands. However, staff told us there were frustrated that these meetings no longer take place.

Recommendation 16

The health board should consider the benefits of reinstating the huddle meetings to help manage the issues with patient flow in and out of the inpatient units.

Minimising the need for inpatient admissions

During our staff interviews, it was highlighted that there is a need to increase the provision of services and support for patients within the community. This could help prevent patients being admitted to inpatient units, through other means within the community, such as alternative NHS provisions or by third sector services, and the use of mental health crisis beds. Staff felt this could help alleviate some of the bed pressures being experienced within inpatient units.

Some of the suggestions shared during our fieldwork, included increasing the capacity of CRHTs to allow for additional acute support to be available to manage patients in the community. This is highlighted further in our 'Workforce' section of the report.

Additional community mental health support

It is prudent to note that in March 2022, HIW published its report for the National Review of Mental Health Crisis Prevention in the Community. During this review, we explored the experiences of people with mental health needs, and the adequacy of services available to support their mental health and well-being at the earliest opportunity, including how this could help prevent admission to inpatient mental health services. Amongst many other findings, the review highlighted the 'gap' that can exist between primary or community care and secondary mental health services, with people falling between the criteria of different services that can provide support.

Similarly, there is a need to strengthen understanding of alternative services that provide support for individuals to prevent their mental health and well-being from deterioration. Organisations were required to submit an improvement plan to HIW in response to the review's recommendations. This is to ensure that the matters raised by the review are being addressed. HIW also has a reviews' follow-up process in place to assess progress made by healthcare providers in implementing actions. This is an ongoing process for up to two years following the publication of a review.

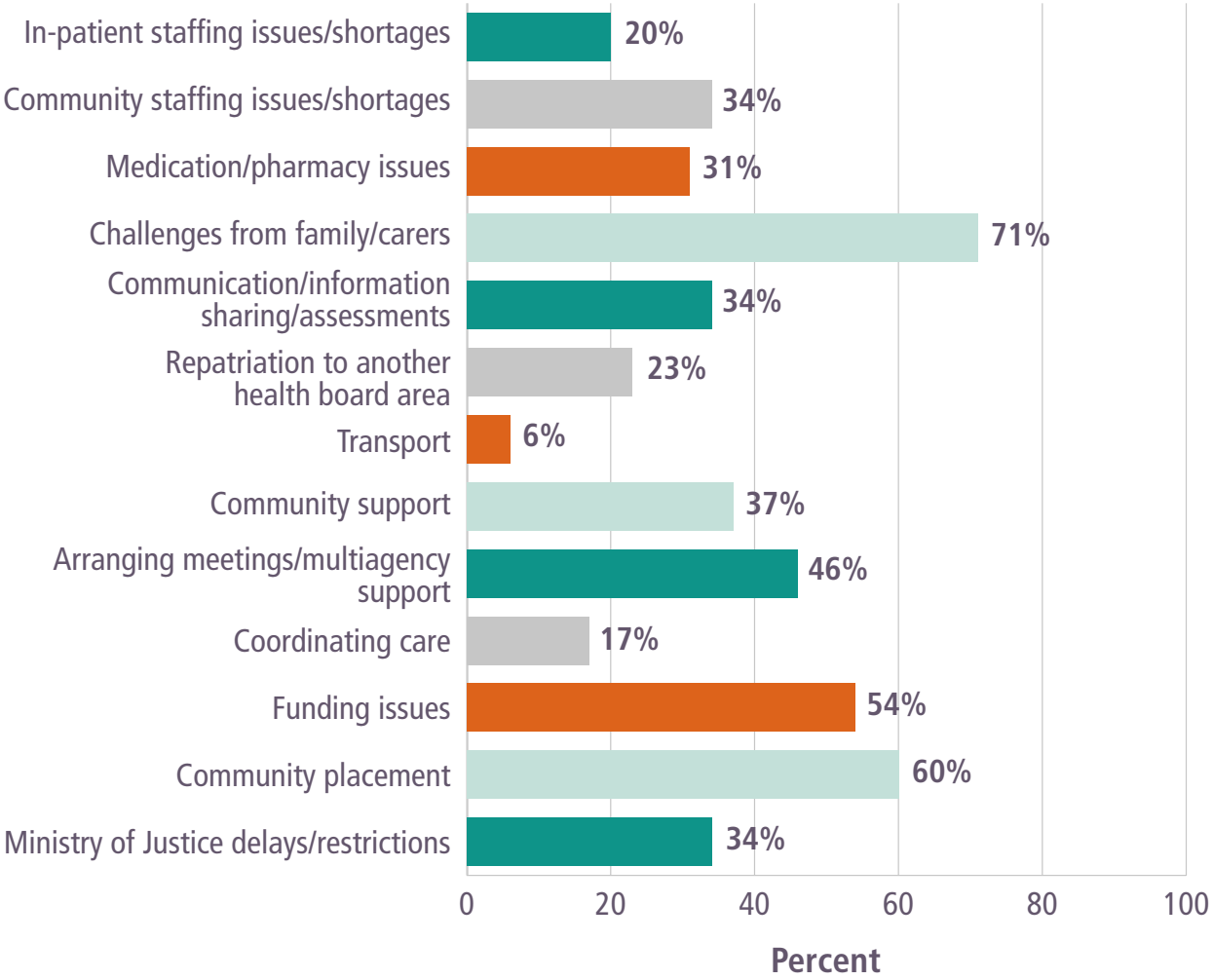
During this current review exploring the discharge processes in place, the concerns highlighted to us regarding bed pressures within the health board and the impact on admissions and discharges were discussed with senior managers. They acknowledged the significant challenges, and we were told during our fieldwork that options to increase bed capacity were already being discussed. For example, discussions around creating additional crisis beds within the community to relieve some of the pressures on inpatient beds.

This provision would generate alternative options for community teams in relation to patients requiring additional monitoring and support, without the need to admit them to an inpatient unit. However, the location and availability of crisis beds within the community were yet to be determined by the health board. The initial proposals for this service are that it will be third sector operated, with the provision of CRHT support. We were told that the health board is in the process of developing these plans with a view to making this option feasible by approximately November 2023.

Delayed discharges

During our staff interviews, we heard about the concerns and reasons related to delayed discharges for patients, and how these impact on ward bed availability. These issues were also reflected in responses to our staff survey. Staff who responded felt that the most frequent reason for discharge delay was challenges from family or carers, followed closely by community placements and funding issues.

Further reasons for delayed discharges within our survey are highlighted in the chart below:



The health board should consider undertaking a review of the causal factors relating to delayed discharges in relation to the information above, with a view to identifying, addressing and mitigating against these issues. This could help reduce the number of delayed discharges being experienced, and subsequently alleviate bed pressures in the inpatient units to meet the demand for beds and to meet the acute patient needs.

Recommendation 17

The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.

Patient Clinical Records Management Systems

As part of our review, we explored the patient clinical records management systems in use. These were accessed by the inpatient and community mental health teams, to record and share essential information regarding patient care, discharge planning and ongoing patient needs.

The systems in place differed across the health board. With RGH and POWH using different systems, and different systems again being used within community teams.

Electronic records management system – FACE

In addition to paper-based records used on the wards at RGH, the main system used to record and share clinical information was the electronic records management system called FACE. All staff working within the mental health wards had access to this system, to record and view any information relating to patients in the unit. The FACE system is also accessible to Merthyr Cynon and Rhondda Taf CRHTs, who would also use the system to record patient information and access any previous clinical data available, for patients they were managing.

It was concerning to find that not all staff working within CMHTs have access to the FACE system, with none of the social workers managing within CMHTs having access. Our interviews with CMHT staff who did not have access to the system, found that when they needed to access patient information on the FACE system, they had to rely on a healthcare colleague to locate the relevant information and send them a copy of the required documents. This may result in information not always being available in a timely manner, therefore, potentially impacting on timely patient care.

Concerns were highlighted by inpatient and community staff on the difficulties experienced using the FACE system, particularly with locating the information needed for a patient. These concerns were reflected in our experience, when undertaking our onsite patient case study fieldwork at RGH. Whilst each patient had their own record, we identified a lack of standardised or consistent approach to uploading information onto the system, which meant it was unclear where documents would be saved.

It was also evident that there was no consistent approach to document naming conventions, meaning it was not always clear what information was contained within folders, unless they were opened individually. Additionally, despite there being specific folders within the system for individual patient records, entitled ‘Care Planning’ or ‘Risk Assessments’, such documents were being saved within the ‘Activity’ or ‘Contact’ folders instead.

The issues outlined above meant that trying to locate specific documents for a patient could be an extremely laborious and time-consuming process, particularly for patients who had a history of frequent contact with services and having several documents to navigate. This also presented the risk that the key information required is unable to be located. Not only was this issue consistently relayed to us by staff, but one we encountered ourselves on several occasions during our case study review.

Community staff informed us of their reliance on patient information being shared as part of the patient ward round discussions between teams, in the lead up to the patient discharge. This would later be followed up by an email prior to discharge with any necessary information.

Whilst this allows for the sharing of patient risks and plans of care for the patient, and knowledge that the necessary arrangements for the discharge have been made, we found this information was not always made available to community teams in a timely manner, therefore potentially increasing the risk to patient safety.

Electronic records management system – W-Drive

In addition to the FACE system, there was also a W-Drive in use which recorded patient information. Folders were set up within the W-Drive for each patient, with documents uploaded to allow staff from other areas, such as inpatient or community teams, to view information when required. However, not all staff had access to the W-Drive, and we were informed that access to folders within this drive could only be granted to inpatient and community staff following authorisation from their line manager.

During our staff interviews, an inconsistent understanding of the purpose of the W-Drive was highlighted to us. For example, what information should be saved on the drive, and whether information stored on this drive should also be available on FACE. However, during our case study, there were occasions where patient information that could not be located on FACE, was only available on the W-Drive.

Additional concerns were shared with us around the confidentiality and appropriateness of access to patient records stored on the W-Drive. Whilst we were informed that access had to be requested following authorisation from line managers, it was evident no process was in place to audit the identity of staff who had accessed and/or updated documents stored on the drive.

During discussions with ward and senior directorate staff, regarding the use of these systems, it was established that there was no formalised training provided to staff on the use of the electronic systems in place. In addition, there was no formal documented guidance available to staff to ensure appropriate use, and correct process for recording and appropriate storage of patient information. During our fieldwork, we were told that informal training was provided to new staff by their peers working within the same area, however, this undoubtedly is adding to the risk of inconsistent use, the risk of accessing all relevant data in a timely manner, and misplacement of some key data relating to patient records.

Electronic records management system – WCCIS

The electronic clinical records management system in place within CMHTs for Merthyr Cynon and Rhondda Taff areas is WCCIS (Welsh Community Care Information System). However, we were informed that there was a different WCCIS system for the Merthyr area, and Rhondda, Cynon and Taff Ely areas used the same system. The WCCIS system was predominantly only accessible to staff working within the relevant CMHTs and was not accessible to CRHT teams and the majority of inpatient staff.

We were informed that some ward-based Band 6 and 7 staff had 'read only' access to the system, however, not all staff had access, and discussions with some staff members revealed that they were unfamiliar with the WCCIS system and did not routinely access it for patient information. This is concerning, since inpatient and CRHT staff were reliant on CMHT staff to share relevant patient information with them from the WCCIS system, prior to any admissions or pre-admission involvement.

We were told that on occasions, essential information was not shared in a timely manner, such as up to date care plans and risk assessments prior to patient admission to hospital. As a result, teams are not always fully informed about the risk associated with the engagement of some patients, as well as understanding the known risks of patient self-harm.

Our staff interviews identified additional concerns regarding accessing patient information during out of hours periods, such as staff not having access to the relevant electronic systems to obtain patient data, and there being no colleagues available to provide the necessary information required. An example provided to us by staff, was a patient needing crisis support during weekends or outside normal working hours, and staff were unable to access the latest care and treatment plan and the risk assessment from the WCCIS system.

Complexities of multiple electronic records management system for patient data

Several community staff we interviewed, had access to both WCCIS and FACE. They explained that due to the risk of there being discrepancies and gaps between the two systems, they routinely record in both systems when updating patient records. This is to ensure that information is accessible to all staff teams outside of the CMHT who only have access to FACE.

This is duplication of information and is extremely time consuming. Due to the processes in place, the majority of staff told us that there is a reliance on information being emailed to relevant teams outside of the CMHT when required, to help mitigate the risk of staff not being able to access all relevant patient record systems.

Our staff interviews also informed us that the majority of medical staff working within the CMHTs in Merthyr Cynon and Rhondda Taf, as well as in the RGH inpatient wards, only routinely accessed and used the paper notes and the FACE system. This meant that they were unable to access any of the inpatient and CRHT information when required, and again this requires key information being requested from others or obtained via email from the WCCIS system, despite working within the same team.

Paper patient records

Within POWH mental health units, staff predominantly use paper records to record information regarding inpatient admissions and ongoing care. Each patient has a file which is updated and is transferred between teams for completion, whether they are an inpatient or managed in the community.

Overall, the content of patient paper records reviewed at POWH was good. They demonstrated effective and coordinated teamwork between members of the inpatient teams and the community services. However, the records were not well organised, which meant information relating to care and treatment planning was not always easy to locate, due to the structure and filing of the records. The health board should consider reviewing the paper records to ensure there is a standardised approach to record keeping, to allow for relevant care and treatment planning information to be accessed and used effectively by all staff.

When discussing paper records with staff in Bridgend, concerns were also highlighted to us about the condition and quality of the patient paper notes. We were told that some paper records were in poor condition due the volume of records stored within them. On occasions this has resulted in pages being accidentally ripped out or misplaced. This is a concern not only to staff but to HIW, as there is a risk of missing patient information which may impact on care, and the risks associated with unauthorised access to some patient details and the breach of patient confidentiality, in line with General Data Protection Regulation (GDPR)[8].

8 GDPR information

Recommendation 18

The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed:

a) to ensure a standardised approach to allow for more efficient access to patient information

b) to maintain the security of patient data and clinical information.

Electronic patient clinical information – ECAT

In addition to the paper-based records in the Bridgend locality, there was also an online drive accessible to staff to upload and share electronic patient clinical information, called ECAT. This system was initially established when POWH was part of the previous Abertawe Bro Morgannwg University Health Board (now Swansea Bay University Health Board), prior to merging into Cwm Taf Morgannwg University Health Board.

Whilst staff initially record information in paper patient records, the ECAT drive has specific folders for each patient, where staff upload documents. This allows staff working in other areas, such as community or inpatient teams, to access information. We were told that, with the exception of social workers working in both Bridgend CMHTs, all inpatient staff working at POWH, as well as the Bridgend community staff, had access and used the ECAT system for saving and sharing patient information.

We were advised that Bridgend CMHT social workers predominantly use WCCIS to record patient information, and whilst honorary contracts had been granted to social workers to allow them to access the ECAT drive, not all social workers routinely accessed and updated the system.

Conversely, we were also told some social workers were routinely updating both WCCIS and ECAT with relevant patient information, to ensure it is accessible to all. Again, as within other localities, staff highlighted the issues with duplicating information onto both systems, which was time consuming. The inconsistencies in the approach to different patient records may result in the risk of information being inconsistently recorded, or some patient information not being available to staff through the use of different systems.

We found that inpatient, CRHT and healthcare staff working within the same CMHTs, do not all have access to the WCCIS system used by the social workers in Bridgend. We were informed that there is a reliance on information being shared across teams when required, prior to admission or pre-admission involvement. Again, this presents the risk of complete information about patients, being readily available to relevant staff when required. We were informed by staff that this has occurred at times.

We also received concerns from staff that some team members did not always upload the relevant information to the ECAT drive. This resulted in staff from other teams not being aware of, or able to access information when required. In addition, similar concerns were raised to those regarding the W-Drive in the other localities; that the ECAT system does not audit which staff members had accessed or updated the documents stored on the drive.

Staff issues and frustration with patient clinical record systems

In addition to the concerns highlighted to us about staff access to all required information about patients within different localities, further risks were highlighted about the accessibility of information across the whole health board for mental health patients.

For example, if a patient is located in, and known to, mental health services within the Rhondda Cynon area and RGH and requires admission to POWH, staff there or within the community teams would not have any access to the FACE, W-Drive or relevant WCCIS systems from that locality. Staff would therefore need to request information from the relevant CMHT and/or inpatient wards, to gain information prior to or on assessment, including any risks associated with the patient. Similarly, the same issue would arise if a Bridgend patient was admitted to RGH, due to the unit and community staff having no access to ECAT. This in turn, poses a risk to patient safety.

Compounding this issue, our interviews with some medical consultants highlighted issues they have encountered during 'on-call' shifts. At times, patients from any area within the health board may require their input and support. The on-call consultant will not always have access to each of the patient record systems in use across the health board. As a result, they will not always have access to up-to-date patient information to help inform the most appropriate action required for a patient.

It is evident through our findings and our discussions with staff, that there are significant issues with the use of multiple patient clinical record systems in place across the health board. Clear frustrations are evident across staff groups about the lack of progress to date, in addressing this issue, with it not only affecting staff during the course of their work, but also impacting on patient safety.

During our fieldwork, several staff across the health board's mental health services told us that plans were in place to develop an NHS module of the WICCIS system, which could be used across the whole mental health service within the health board. However, we were informed that plans had been delayed on several occasions, and there were no proposed dates for implementation of the new system across teams at the time of our review.

Taken as a whole, we found the myriad of electronic patient record systems in place across the service to be collectively dysfunctional. Due to the extent of our concerns with the systems in place identified during our fieldwork, we included these issues in our immediate assurance notification to the health board on completion of our onsite fieldwork.

The health board responded to our concerns in writing, by outlining their immediate actions, some of which included:

- Developing a clinical team/staff matrix for all systems to determine which staff have access to which system and for what purpose; the health board has since confirmed this action is now complete.
- At least one staff member from each clinical team would be provided with support and resources to access information in line with agreed permissions; the health board has since confirmed this action is now complete.
- Agreed data entry standards and user guides for systems would be developed; the health board has since provided confirmation that the user guides are now in place, and the development of data entry standards are ongoing. The revised completion date for this action is 31 January 2023.
- Training needs analysis to be undertaken for systems in place and a training plan to be developed for all relevant staff; the health board has since confirmed that the revised completion date for this action is 31 January 2023.
- A health board wide MDT working group is to be developed, to establish a consistent approach to clinical record keeping; the health board has since informed us that the inaugural meeting is scheduled for January 2023.

Since our fieldwork, further discussions were held with senior managers within mental health services around our concerns about multiple patient record systems being in use. It was fully acknowledged that the use of multiple systems poses a significant risk to patients and staff, and consequently the risk has been listed on the health board's corporate risk register.

We were again informed that there are plans for the health board to implement a new electronic system for use across its mental health services, to enable all staff to access patient records appropriately and in a timely manner. It was again confirmed that plans to develop a health board wide WCCIS system across the mental health services had been developed. However, these plans had been paused, due to concerns around the suitability of this system across the whole service.

Since our fieldwork, the health board has appointed a Digital Director, who has undertaken a review, to determine the most suitable options available to progress and implement a new unified patient clinical records system to use across all teams. We were informed that the review considered the background to the issues within the health board and benefits of the single health and social care system. The options were recently discussed at executive board, and it was agreed to support the continuing rollout of WCCIS to mental health services within the health board. The business plan for the rollout of the system will be developed by the end of January 2023, which will outline the timescales for implementation.

Recommendation 19

The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.

Recommendation 20

The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.

Post discharge monitoring

The *National Institute for Health and Care Excellence (NICE) Guideline 53*[9], states that on patient discharge from an inpatient unit, there must be a discharge advice letter completed by the inpatient consultant psychiatrist and emailed to the patient's GP within 24 hours of their discharge.

A copy of the discharge letter must be provided not only to the GP, but also to the patient. Where appropriate, the letter should also be provided to their family or carer, the relevant community teams and other services that will be involved in the post discharge care and support arrangements. The letter should include details of the discharge plan, including the follow-up arrangements. In addition to the letter, a copy of the patient's up to date care plan must also be provided to the patient and the other services involved in their care, within 24 hours.

9 Recommendations | Transition between inpatient mental health settings and community or care home settings | Guidance | NICE

There was evidence available within most patient records we reviewed during our case study, to demonstrate that patient discharge letters had been sent, and included the key information regarding the discharge plan and follow up arrangements for patients. However, the letters we saw did not include all the details required. This included missing information relating to Part 3 of the Mental Health (Wales) Measure 2010, for the patients' rights to self-refer to the service. This information should be included to ensure that the patients and their family or carers are aware of what action can be taken, should there be any concerns or issues experienced with the patient's mental well-being, post discharge.

Our case study identified that some patient records had limited or no evidence to confirm that a discharge letter had been sent. Additionally, we found that five of the letters sent had taken between two to seven days post discharge, to be sent out and were not in the 24-hour timeframe.

We also found that it was not always clear whether the discharge letter and updated care and treatment plan had been shared with the relevant teams involved in the post discharge arrangements for a patient. For example, one patient record detailed a plan, that post discharge treatment and support would include involvement from the Community Drug and Alcohol Team (CDAT). However, it was evident that the discharge letter had not been sent to the CDAT team, and consequently, the team was not aware of the patient's discharge from hospital until 14 days following discharge.

The NICE Guideline 53 also states that within a week of the discharge date, a discharge summary should be sent to the patient's GP and any other services involved with patient care. The summary should include information detailing the reason for patient admission to hospital and how their condition changed during their stay, leading to their discharge from the inpatient unit.

Most of the records reviewed included evidence of discharge summaries available. However, it was not always evident that the summaries had been shared with all the services involved in the patient's post discharge care and treatment. The health board should ensure that summaries are developed for all patients and shared with the relevant services, within a week of their discharge.

As previously highlighted, there was a standard discharge checklist document available to staff, to allow them to record actions completed as part of the patient's discharge. This would help ensure that the necessary discharge letters were completed and sent out to the relevant parties. However, it was highlighted to us that the checklist was not consistently being used by staff. This may have contributed to the completeness of information and delay in sending out key information to the patient and other services.

Recommendation 21

The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the *Mental Health (Wales) Measure 2010*.

Recommendation 22

The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.

Recommendation 23

The health board must ensure that discharge summaries are completed and sent out to the patients' GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.

Post discharge follow up planning

The health board's inpatient discharge procedure states that all patients, should be followed up within three days of their discharge from the mental health unit, in line with national guidance[10]. Our staff interviews identified that follow up arrangements are usually agreed between the relevant staff and the patient, prior to the patient being discharged from hospital. The three-day follow up should either be completed by inpatient staff, or by the relevant CMHT or CRHT staff. In most instances, the follow up would be face to face, however, we were informed that some initial follow up contact may be made via telephone, due to staff capacity.

We found that audit arrangements were in place to monitor compliance with the three day follow up process. We saw that recent discharge audits had been completed for both the health board's inpatient units. However, the audit found that not all patients had been followed up within the three-day timeframe. This finding was substantiated in our patient case study review, where evidence was not available in all records, to confirm that the patient had been followed up within three days post discharge.

Recommendation 24

The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.

Managing patients following discharge

During our interviews with community staff, we were told that if any issues or concerns regarding the mental well-being of a patient were identified following discharge, action would be taken in line with the patient's discharge plan. This included their crisis or contingency plans and their relapse indicators, which should be agreed as part of the patients discharge plan.

As part of the action to address the patient concerns, a visit would be made to the patient by the community team (or a patient may attend an appointment), for an assessment of their current condition. This is to determine the next steps in addressing the patient's needs. If the patient concerns or issues remain unresolved, further CMHT multidisciplinary discussions will take place, and may result in a consultant assessment being undertaken. However, we were informed that consultant assessments can be difficult to obtain, due to the resource available within the community. This issue is highlighted further within the 'Medical Staff Capacity' section of the report.

Following any assessment, options will be considered dependent on the level of risk to the patient's well-being. This may include an increase in the level of community support to the patient, with the assistance of CRHT if required. The aim is to stabilise the patient within the community to help prevent readmission to hospital. However, if the patient condition does not improve or deteriorates, the community services would work with the inpatient teams for readmission to hospital. As highlighted earlier, readmission can be very challenging and a time-consuming process due to bed availability within the inpatient units.

10 www.nspa.org.uk/wp-content/uploads/2022/04/NCISH-2022-report-bookmarked-FINAL.pdf

Workforce

As part of our review, we considered the workforce arrangements within the health board's inpatient and community mental health services. As already highlighted, we interviewed several staff and launched a staff survey to gain an understanding of their experiences.

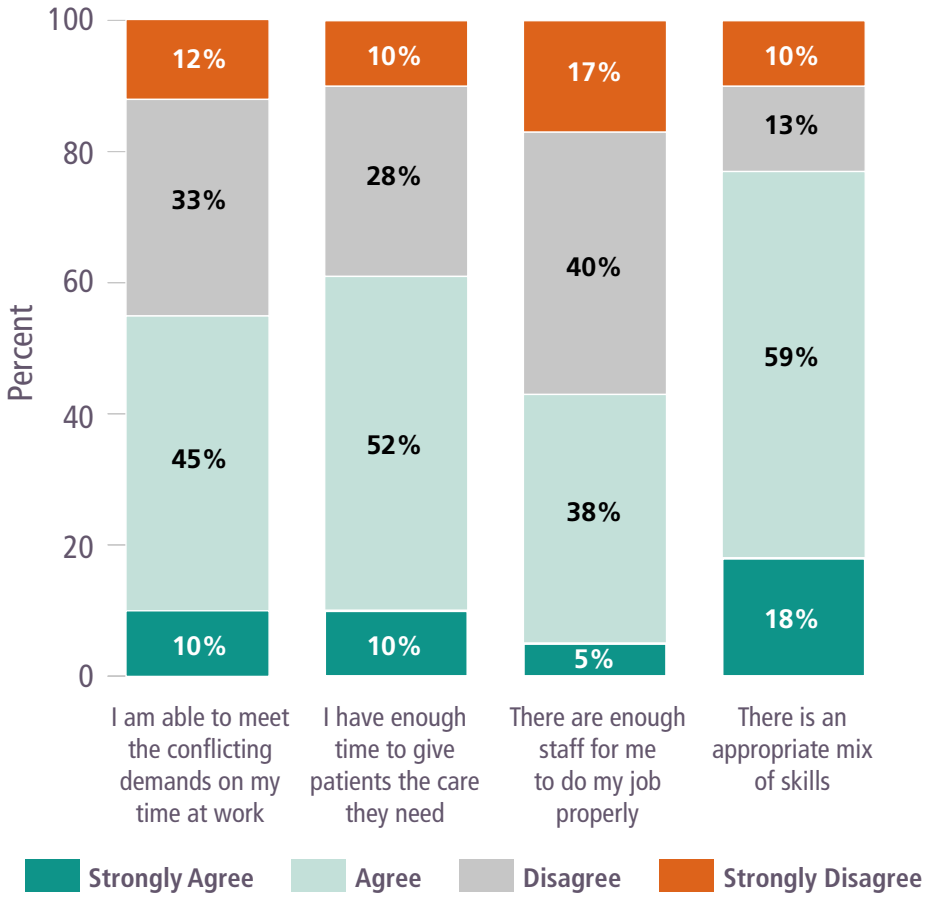
It was evident that both inpatient and community staff were striving to provide good care and treatment to patients, but in very challenging and pressured circumstances, exacerbated by issues relating to the numbers of available staff.

Our staff interviews identified concerns around staffing levels and the overall service capacity. In addition to the concerns highlighted during interviews, we received concerns through our survey, where 58% of respondents said they did not feel there were enough staff available to allow them to do their jobs properly.

The chart below highlights the staff responses around their workload, staffing and skill mix.

The chart demonstrates that more than half the respondents felt they can meet the conflicting demands on their work, although 46% disagreed with this. The majority also felt they have enough time to give patients the care they need, whilst 38% disagreed.

Whilst the majority of staff felt there was an appropriate skill mix in post, only 43% felt there are enough staff available for them to undertake their job properly.



Inpatient staffing levels

Our interviews with inpatient ward staff highlighted that adequate staffing levels have been an ongoing issue for the service. We heard about concerns related to the demands and pressures on staff workloads and the ability to deliver care and treatment to ward patients, in a timely manner. The required administrative needs and documentation for each patient, can also be extremely challenging, particularly when planning discharges.

As previously highlighted, workload demands and the increasing pressures on staff, have impacted on the discharge process, with some not always able to attend ward rounds or discharge meetings to contribute to decision making around patient care and the discharge plans. We were also told that the demands on staff can, and has, resulted in instances where relevant information is not shared with community teams in a timely manner. As detailed previously, the pressures on staff in undertaking their roles is increased further, with the administrative burden, exacerbated by the dysfunctional electronic records systems in place.

We found that issues relating to staff vacancies, staff absences and maternity leave have resulted in a reliance on temporary staffing and overtime to maintain safe staffing levels on each shift. Whilst there have been active attempts to recruit to vacant posts, not all have been successful. Data provided to us during our review demonstrated that vacancies in both inpatient units include eight Band 5 Staff Nurses in POWH, and seven Band 5 Staff Nurse in RGH.

The vacancies along with staff absences provides many challenges to the units to maintain safe staffing levels. Additional efforts were made by the health board to temporarily deploy community staff into inpatient wards, and on occasions, senior managers have undertaken ward shifts to help with staffing levels. This was for a limited period during the height of COVID-19 pandemic, when inpatient services were at risk of being compromised due to high levels of staff absences.

We also discussed the issues with inpatient staffing levels with senior managers. We were informed that significant work has been undertaken to review the staffing levels and skill mix on all inpatient mental health wards within the health board. This work has also involved benchmarking with other areas.

The report following the establishment review, outlines the current staffing levels, and the proposed required staffing levels for each ward. At the time of our fieldwork, the report had been submitted to health board Executive Team for review. We have since been informed by the health board that following the initial establishment review, a more comprehensive review is required, with underpinning principles and methodologies. This review will be taken forward as part of the newly developed nursing workforce meeting, which is scheduled for December 2022.

Given the concerns outlined by staff, the health board must ensure that there are appropriate and safe staffing levels on inpatient wards to maintain patient safety, and to allow staff to undertake the full requirements of their roles.

Recommendation 25

The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.

Staffing within CMHTs

We received consistent concerns by CMHT staff in relation to the capacity across the teams to respond to the demands on the service, and the ability to provide all the required care and support to patients. The referral numbers into CMHTs for the past three years, have shown an increased trajectory in referrals, with the number made in 2021-2022 more than double the number seen in 2019-2020:

- 2019-2020 – 1275
- 2020-2021 – 1446
- 2021-2022 – 2683.

This increase in referrals does, however, coincide with the pandemic and the significant impact with lockdown requirements being implemented and how this affected people's lives. In addition, the health board had to temporarily adapt its priorities and workforce to meet the challenges of the pandemic and the effect it had on the availability of the workforce.

Further staff concerns were highlighted to us, around the increasing complexity of patients they must manage. This has resulted in increasing workload challenges and pressures on staff. Staff told us that consequently, it can be extremely challenging to undertake the full requirements of their roles, which includes care coordination responsibilities for patients on their caseload, managing new discharges from inpatient services, as well as other tasks, such as holding weekly patient clinics. Staff also described their feelings as 'firefighting' to manage their workloads and maintain sufficient care and support for patients.

During our interviews, we were informed that due to the ongoing workload pressures within CMHT teams, an email was circulated from the senior management, advising them to prioritise their time to focus on the higher risk patients in their caseloads, and to reduce time spent with more stable patients. This was a short-term measure to re-establish service capacity. Whilst we did not request evidence around this decision making, it is concerning since minimising time with less complex patients, may in turn exacerbate their mental health condition.

As highlighted earlier in the report, workload demands impact on the ability of community staff to attend inpatient units to assess their patients, or to attend ward round and planning meetings in preparation for their discharge. In addition, workload demands also impact on staff ability to ensure that all key information is routinely shared with other teams in a timely manner.

We found that the impact on staff workload is heightened further by staff vacancies and absences, which subsequently have impacted on staff retention. It was disappointing to hear during our interviews, that some staff were also considering leaving their roles as a result of the impact it has had on their personal well-being. Staff informed us consistently that the CMHT capacity and staff remits should be reviewed, to help staff retention and to ensure that sufficient resources are available in all areas to meet the demand of patient needs.

Our interviews with senior managers found that establishment reviews or benchmarking in relation to CMHT establishments had not been completed. Therefore, the health board was not appropriately informed to determine the most appropriate levels of staffing in the community.

It was acknowledged by the health board that a review of available services and the demand in all areas should be completed, to help ensure that community teams are sufficiently resourced. It was also acknowledged that the health board must ensure that patients being referred to CMHTs were appropriate for the service or should instead be referred to other services.

Within HIWs report National Review of *Mental Health Crisis Prevention within the Community*, it was highlighted that mental health support provided by third sector organisations can be invaluable and can help ease the demand on NHS services. There are opportunities to strengthen links and collaboration with the third sector to benefit patient mental well-being. The health board should review and consider further what third sector services can support patients within the community to help minimise readmissions, and support people on discharge.

Recommendation 26

The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.

Crisis Resolution Home Treatment Teams

The CRHT teams support patients during the post discharge period, as well as supporting individuals with mental health needs in the community, to help prevent admissions or re-admissions to inpatient units. The CRHTs are also involved with sourcing inpatient beds when required.

As with CMHTs, concerns were consistently highlighted throughout our review, regarding the staff's capacity within CRHTs, to carry out the full requirements of their roles. Feedback from staff, outlined that issues including vacancies within the teams and staff sickness have led to occasions where CRHTs have struggled to cover shifts. Further concerns were highlighted regarding limited medical support and no psychology support available to patients managed within CRHTs.

As a result of the capacity issues, we were informed that the teams strive to ensure that clear justification and appropriate plans are made which demands CRHT intervention. This is undertaken during the inpatient discharge planning discussions, which contribute to discussions around community team capacity to ensure there is adequate resource to manage patients who require the team's support and intervention.

It was again acknowledged by senior managers that the role and capacity of CRHTs within the health board needed to be reviewed. We were informed that a health board working group has been established to determine the role and function of CRHTs, to understand how best to resource and structure the teams within the health board. Senior managers from each area have submitted their views to the working group, which will then be used to inform the group's decision regarding the required model for the CRHT service within the health board.

Given the concerns highlighted in regard to CRHTs resources, the health board must ensure that the review of CMHTs also incorporates the current functions of and the demand on the CRHTs. This is to determine the appropriate level of staffing for each team.

Merthyr CRHT work facility

During our interviews with Merthyr CRHT staff, we were informed that the team previously lost their work facility within Prince Charles Hospital (PCH), and subsequently the team was forced to split across two locations. The Crisis Team are now based at PCH, and the Home Treatment Team are based at Kier Hardy University Health Park. We were informed that this has impacted on the interface between both aspects of the team and can result in difficulties with staff being able to routinely support each other in relation to immediate advice and workloads.

As a result of the loss workspace at PCH, concerns were highlighted by staff regarding the lack of designated space available to enable the team to effectively undertake their roles. Staff we spoke with raised concerns around the available facilities to undertake patient assessments when required. Whilst we did not visit the room being used for undertaking patient assessments; we were told that it was not fit for purpose and did not meet the criteria for a mental health crisis consultation room due to the room layout.

The assessment room was also located in the middle of a busy corridor within the Emergency Department (ED) at PCH, which meant that patients arriving at the unit for assessment, have to wait in the main ED waiting area and subsequently would walk through the main corridor. This may include patients being brought to the unit escorted by the police when in crisis under Section 136 of the Mental Health Act[11], which could present risks to patient and staff safety, as well as impacting on the privacy and dignity of the individual.

Staff reported to us that the environment concerns had been raised with senior managers on a regular basis and was also listed on the relevant risk register. In our discussions with senior managers, this issue was acknowledged, and we were informed that communication had been ongoing in an attempt to resolve the issue in the interest of staff and patients. We were told that work was underway to create designated space within the hospital, adjacent to the ED, which would include an appropriate assessment room, and an adjacent room for the team's use. Since our fieldwork, we have been informed by the health board that this work is scheduled for completion by 31 January 2023.

Recommendation 27

The health board must provide HIW with an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.

Medical staff resource

The resource available within the medical staff teams was consistently highlighted as a key risk across all mental health services provided. This was highlighted to us through our staff interviews with inpatient and community teams. This issue is the result of both vacancies and sickness absence, which are impacting on medical staff capacity across all teams.

The significant demands on the service have resulted in some consultants undertaking additional roles, thus, increasing their workloads, and for significant periods of time. This has resulted in staff working under high pressure given the demands on the service and responsibilities of the role. It was disappointing to hear within our interviews, that some consultants were resigning from their posts imminently, due to the increased pressures of their role and demanding workloads.

11 Section 136, under The Mental Health Act, gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder to a place of safety for a mental health assessment and possible treatment.

Community medical staff resource

Within the community, we were told that at times, it is challenging for staff to access medical advice and input when required for any issues that arise during assessment, or when a patient requires further intervention, such as a medical review. We heard examples of where nursing staff undertake community mental health assessments for individuals, and a consultant is not always available for support or intervention, due to the conflicting demands on their role. This, at times, has resulted in the need to source *Section 12*[12] approved doctors, to undertake patient assessments, which can be very challenging. In addition, this presents issues, since these doctors may not be familiar with the patient, and/or the services available within the health board.

We found that the health board has made attempts to recruit temporary doctors on locum contracts, to increase the medical resource available within the community. However, this is only temporary relief to cover the absences and vacancies until staff return to work or vacancies are recruited in to.

Inpatient medical staff resource

During our interviews, further concerns were highlighted to us regarding the consultant capacity within inpatient units. This again, was impacting on the accessibility of the required medical intervention. For example, at the time of our fieldwork there was only one consultant covering both wards within POWH mental health unit. We were informed that this was causing delays in the required medical input for patients across the unit. Whilst the issue was temporarily alleviated by the use of a locum consultant, this again was only a temporary measure, to help manage the medical workloads.

Functional inpatient model of care

As a result of the ongoing issues and risks relating to the medical capacity across the health board's mental health services, a 'Functional Inpatient Model of Care' was implemented. This related to the service provided by consultant medical staff across the adult mental health services within Merthyr Cynon, Rhondda Taf and RGH. The model was introduced in May 2022 across these areas; although, the model was already in place within Bridgend Community services and POWH, prior to the Bridgend locality becoming part of CTMUHB in 2019.

The new model means that community-based consultants are only responsible for patients whilst they are cared for in the community. Whilst the community-based consultant will continue their involvement with hospital admissions processes, following admission, the patient will be managed solely by the inpatient consultants. The community-based consultant will, therefore, no longer have oversight of the patients' care during their hospital stay. When planning for discharge the community teams remain part of the planning process, and once the patient is discharged from hospital, the responsibility for patient care is transferred back to the care of the community-based consultant.

12 Section 12 approved doctors are those approved to recommend compulsory admission for assessment or treatment under the Mental Health Act 1983.

Staff views of the functional inpatient model

When interviewing staff, we found conflicting views regarding the functional inpatient model.

We were told by inpatient staff that the new model had benefited the inpatient teams, as well as the patient, since there was now more frequent, timely and consistent access to consultants during the patients' stay on the wards.

The previous consultant model involved the relevant community-based consultants maintaining oversight of their patients throughout their hospital stay. This meant that inpatient staff were required to engage and liaise with several community-based consultants, regarding the care of different patients on the ward. We were told this was previously quite challenging as a result of the demands on consultants within the community, and therefore, was impacting on inpatient staff access to consultants in the community.

The new model allows for a consistent approach to inpatient care, where hospital-based consultants now manage patient care during the hospital stay, as opposed to several community-based consultants managing the care of different patients during their admission to hospital.

Whilst the view from inpatient staff were positive around the new patient management arrangements, concerns were highlighted to us by community staff regarding consistency and continuity of care for patients when they were in hospital. This was the result of changes in consultant-patient care management. For example, a patient known to CMHT services who is admitted to RGH, would have input from at least three different consultants as part of their care. This may include the community-based consultant responsible for the patient, an Admissions ward consultant, and the Treatment ward consultant, then on discharge, being transferred back to the care of the original community-based consultant.

Further concerns were expressed to us regarding the communication between inpatient and community teams in regard to plans for managing patient care. As highlighted earlier, staff gave examples of not being provided with sufficient information from inpatient teams prior to patient discharge from hospital. This issue was exacerbated when the pre-admission community treatment plans were being amended following admission, and the patient was later discharged without effective communication of the amended treatment plan to the community teams.

We were given the example of a complex patient with previous admissions to mental health units. The patient's community team admitted them to RGH, recommending formal detention under the Mental Health Act 1983 for a significant period of time. This was to stabilise their acute mental health episode, before being discharged back to community services. This was the usual prescribed treatment during the patient's previous relapses.

However, the patient was discharged in less than a week following admission, with little progress made in stabilising their condition. There was limited communication between inpatient and community teams during the admission and subsequent discharge. This resulted in the patient being readmitted shortly after discharge to stabilise their condition further. This example clearly demonstrates that effective communication is pivotal, particularly when a change to the previous model of care was implemented, in managing the best care to the patient.

During our interviews with some inpatient and community-based consultants, we heard of occasional discussions which may take place about patients between consultants. However, it was surmised that this may be dependent on particular relationships between the consultants involved rather than being it being planned or as a routine arrangement across all areas.

The rationale for the introduction of the functional model was to allow for more frequent and consistent inpatient consultant participation in patient care, and to help alleviate the workload pressures of the community-based consultants. However, given the concerns raised to us and the significant risks regarding the change of treatment plans for patient care, the health board must ensure that all relevant staff understand and accept the importance of routine discussions and collaborative working when planning care for patients, in a timely manner. This will help ensure all relevant teams are aware of and are in agreement with the proposed treatment plans in hospital and when discharged to the community.

In our interviews with senior managers, we discussed the concerns and risks with medical staff capacity across the mental health services, and the concerns were fully acknowledged. We were informed it has been extremely challenging for the service to maintain adequate medical cover across all community teams, however, they were optimistic that the workload pressures, and timely meeting of the demands on the service would be alleviated in the coming months. This will be the result of several community consultants returning to work from their periods of absence.

Given the demand and pressures on teams, and the impact on staff well-being, the health board must ensure it fully considers the required level of medical staff capacity required across all teams. This should be based on the number of patients managed under each caseload within each locality and take into consideration guidance published by Royal College of Psychiatrists[13], relating to reasonable workload expectations for consultant psychiatrists.

Since our fieldwork, we were informed that there are plans to recruit a new Medical Director, who will be responsible for developing a workforce plan, which will include medical establishments within mental health services at the health board.

Recommendation 28

The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.

Recommendation 29

The health board must take action to ensure there is sufficient medical capacity across all mental health teams.

13 college-report-cr207.pdf (rcpsych.ac.uk)

Allied health therapy services within RGH

To consider the holistic view of patient discharge, during our onsite fieldwork we also interviewed several therapy staff. Concerns were highlighted to us regarding the environments allocated to therapy services within RGH, and the range of facilities within it. Therapy resources are essential to enable staff to support patients during their recovery process, prior to discharge.

We found that the therapy service was previously allocated space adjacent to the mental health wards. This included office space, and a therapeutic Activities of Daily Living (ADL) kitchen, to allow patients to practice fundamental tasks, such as meal preparation and cooking to support themselves on discharge. In addition, a garden space, and a patient workshop, to stimulate patients and to teach them new skills ready for discharge. However, during the pandemic, the designated space was removed from the therapy service, and was redesignated as a new mental health ward, to care for patients on admission to hospital who were positive with the COVID-19 virus.

Whilst it was acknowledged that this environment was required as part of the service's response to the pandemic, the space continues to be used as a ward, impacting on the ability of therapies staff to undertake their roles effectively. This includes assessing patients for their suitability to care for themselves at home and supporting them through their recovery period in preparation for discharge.

Timely therapy assessments

The ability to ensure that patients undergo timely therapy assessments within the ADL kitchen on the mental health unit, has been compromised. Although, therapies staff can utilise the kitchen space on Ward 23 and the ADL kitchen within the St David's Older Person Ward, staff said that within the last 12 months, the kitchen on Ward 23 has not been available for around seven months. This has therefore, on occasions, affected full patient rehabilitation prior to discharge. In addition, staff also raised concerns around the insufficient workshop space and equipment available to support patients, which consequently limits the activities available to stimulate them and support them during their recovery.

In addition to limited space to carry out therapy services, concerns were also highlighted to us around the availability of desk and office space, to support staff in completing the required administrative tasks associated with their roles. Whilst we were informed that some desk space has been made available, it was highlighted that it is not sufficient for the number of therapies staff working within the service. This again impacts on the ability of staff to undertake the full requirements of their roles, to ensure patients receive the required level of therapeutic intervention, cognitive assessments and support. Consequently, we were told these issues impact on patient recovery for discharge from hospital.

Therapy staff morale

During our interviews, it was disappointing to learn that the issues experienced by the therapies staff, as set out above, have had a detrimental impact of staff morale and have led to some leaving the service. In addition, staff feel there is poor engagement and communication with therapies staff, and this has resulted in them not feeling valued within the mental health services. We were told this has been escalated to senior managers on a regular basis since June 2020, however, there has been limited progress in improving the required therapy facilities. Given the concerns highlighted by staff, and the impact and risks to patient rehabilitation, the health board must consider how the service has been affected, the impact this has had on patients and staff, and what needs to be implemented to help staff to undertake the full requirements of their roles and the benefits to patients.

Therapy staff capacity

Whilst interviewing therapies staff, concerns were raised with us regarding the capacity available within the service to meet the patient demand. We heard that the current capacity level presents significant challenges and increases workloads and pressure on staff. It is clear that staff are endeavouring to fulfil the relevant therapy requirements prescribed in patient care plans, to support and prepare them for discharge from hospital. However, we also heard of the potential impact of not fulfilling all therapy requirements for a patient in hospital, leading to long waits in the community for therapy treatment, hindering patient progress and resulting in readmission.

Our discussions with staff also identified that with the limited staff resource available, attendance at some ward rounds and discharge planning meetings is hindered, due to conflicting priorities. Therefore, the therapy needs of patients may not be sufficiently considered on all occasions when discussing patient progress and developing plans for discharge. The health board should consider the establishment in place for therapy services within mental health services, and whether intervention is required for improvement.

Recommendation 30

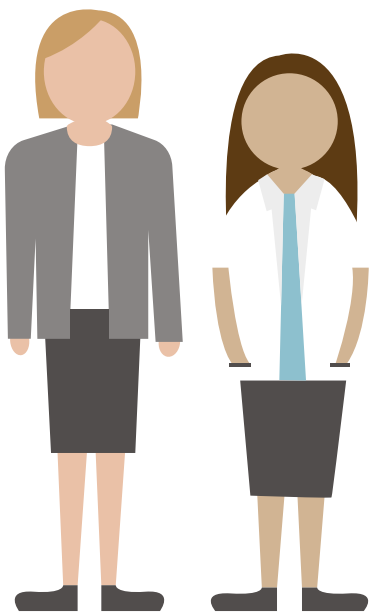
The health board must consider how it can work with therapies staff:

a) to act on the concerns raised

b) to enable them to undertake their role to adequately manage the needs of patients during their recovery phase prior to discharge.

Recommendation 31

The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.



Governance Arrangements to support Quality and Patient Safety

Health Board Operational Model

As highlighted earlier in the report, the health board's operational model at the time of our review included three Integrated Locality Groups (ILG), and each had its own strategic and operational focus. Mental health services are delivered through three Clinical Service Groups (CSGs), across primary and secondary care, and each CSG has its own senior and clinical management structure for the relevant services being provided.

During our fieldwork we were informed of the health board's plans to change the ILG operating model to a whole organisation 'Care Group' structure. The intention is that the Care Group structure will move away from the geographical split of three integrated localities model currently in place.

The health board's plan is for six Clinical Care Groups, which are:

- Planned Care
- Unscheduled Care
- Children and Families
- Diagnostics, Therapies and Specialties
- Primary and Community Care
- Mental Health and Learning Disabilities.

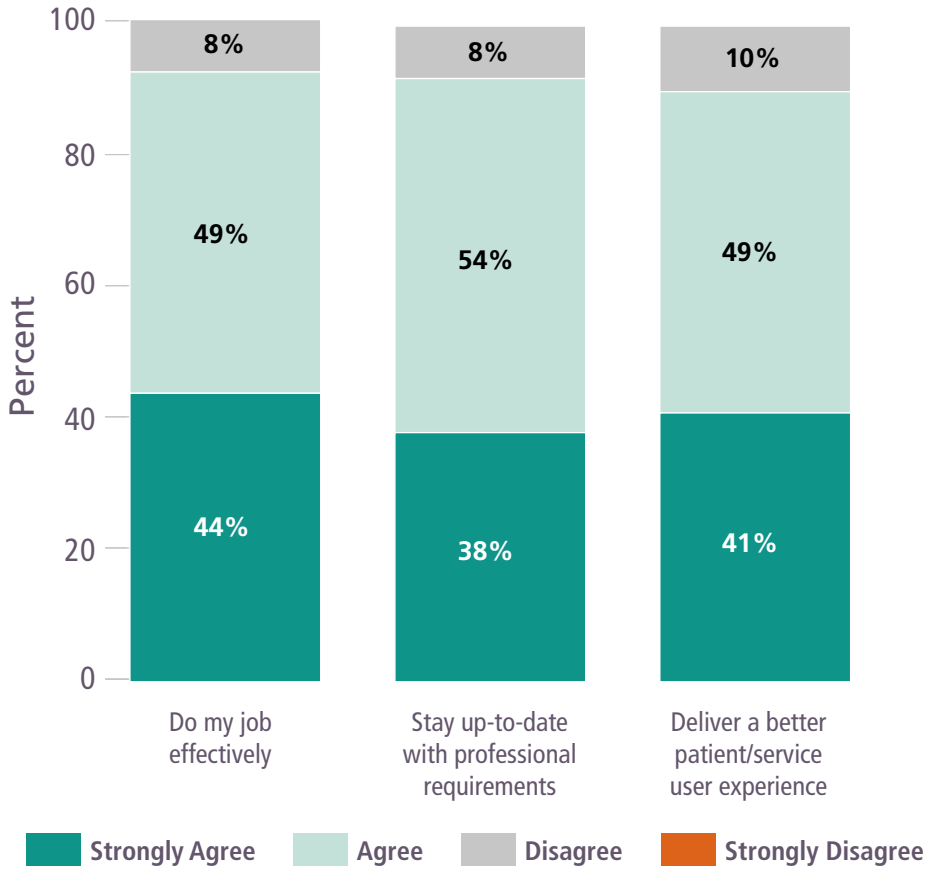
The move to the Care Group model will mean that responsibility for all adult mental health services within each ILG will move to the Mental Health and Learning Disabilities Care Group. The new model aims to ensure a locality aspect is retained, to ensure an ongoing focus on quality and improvement, within a local authority area. However, it will also bring the health board together in its vision and ways of working across the mental health service as a whole.

Our interviews with senior managers identified a positive response to the impending changes to the Care Group structure. We were told that the current model limits oversight across all mental health services of the three ILGs, due to the separate governance processes and management structures in place. It was highlighted to us that the new Care Group model would improve oversight and would allow for more consistent and robust reporting arrangements through the governance framework. Senior managers were optimistic that the new model would provide opportunities for a more consistent approach in the development and provision of mental health services and improving the arrangements in place for shared learning and common themes across the health board.

Staff Training

Overall, the feedback we received from staff throughout our fieldwork suggests that access to training was sufficient. However, as a result of the COVID-19 pandemic, over the past two years, this had predominantly been virtual training or e-learning. We heard that access to training has been difficult due to pressure on staff and the demands of patient care. However, the introduction of virtual training and the flexibility of access that it offers, has now made it easier for staff attend training that they may have not been able to attend previously.

In our staff survey, we asked staff about their training, learning and development. The response to some of our questions are highlighted in the chart below:



It is positive to find that almost all respondents to our survey felt their learning and training have enabled them to do their job more effectively, to stay up to date with their professional requirements and to deliver a better patient experience.

Whilst staff feedback on training was positive overall, issues were highlighted from some staff around the provision of formal training to assist them in undertaking their roles effectively in relation to the patient discharge process. In responses to our survey, 46% of staff said they had not undertaken training to support them in their roles with the discharge process, and 51% said they had only received informal 'on the job' training.

We received additional feedback from staff that further training was required, to support them in their role, and which reflects a number of the concerns highlighted throughout our review. This includes the following:

- Risk management around discharge, to enable staff to identify and formulate short-term and long-term risk reducing factors.
- *Mental Health Act* training.
- Requirements for an effective patient discharge.

In view of this feedback and the concerns highlighted throughout this report around discharge planning and post discharge arrangements, the health board should consider how it can undertake a training needs analysis for all staff within inpatient and community mental health services. This is to identify any training gaps and help address staff educational needs to ensure they are adequately supported in fulfilling their roles, particularly around the patient admission and discharge process of inpatient services.

Recommendation 32

The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.

Staff well-being and support

Our review highlighted several concerns around staff workload and the pressures staff face within their roles. This related to all staff disciplines across mental health services as a whole. However, within their immediate teams, we received feedback indicating that staff felt well supported by each other in their day-to-day tasks. We identified a good team working ethos within teams, which was highlighted through our staff interviews. Staff also told us they were able to access advice and support from their colleagues and managers within their relevant teams when required, in a variety of ways, such as informal or formal discussions and meetings.

We spoke with staff about the availability well-being support through the occupational health department. Staff were aware of how to access the support available to them, and that information was routinely circulated to staff. Staff told us they were also aware that well-being information was available via the health board intranet, which details the support available to them. This included how to access counselling services, third sector support and other well-being services. However, concerns were highlighted to us by some staff regarding the timeliness of access to appointments and well-being support through the occupational health department, due to the demands on the service.

Given the issues highlighted throughout our report, regarding pressures on staff workloads, and the concerns for their personal well-being and the subsequent impact on this, the health board must consider how access to well-being support can be accessed in a timely manner, for all staff where required.

Recommendation 33

The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.

Audit Arrangements

We considered whether there were effective audit arrangements in place across the metal health services, and in particular whether any results from these audits were acted upon. During our staff interviews, we found that routine audits are undertaken to assess the quality of care and treatment being provided to patients, as part of their journey through the service. This includes discharge and care and treatment documentation audits.

We were provided with examples of the completed discharge audits, and those we reviewed highlighted similar issues to those found in our patient case study review. These included limited or no evidence of discharge information being shared with all required services involved in patient care, and examples of an absence of evidence that patients were followed up within three days following discharge, or that family members were involved in discharge planning decisions.

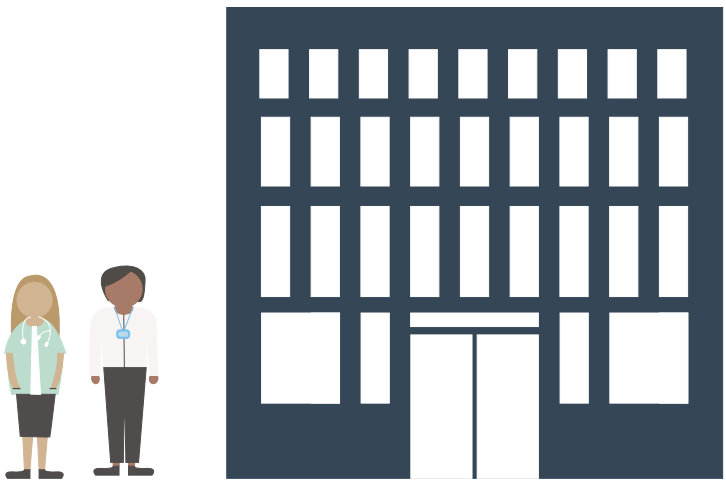
We were told that in most instances the ward manager or deputy ward manager was responsible for undertaking the audits, which are then collated and assessed by the relevant senior nurse. The data is then reported to the mental health Quality, Safety, Risk and Experience (QSRE) meeting.

Within each ILG, there are separate QSRE meetings held monthly, for which minutes were provided as evidence. These meetings are chaired by the Lead Nurse for the relevant CSG and are attended by staff including senior nurses and lead consultants. During the meetings, discussions include service updates for each area, ongoing serious incidents, Datix[14] analysis reports, and the outcome of routine audits. On the occasions where concerns require escalation, these are reported into the corporate QSRE meeting, which is chaired by the Executive Director of Nursing.

However, despite this governance process, it is disappointing to note that significant issues remain with the overall discharge process, which have been highlighted during the initial assessments on admission, throughout inpatient stays, and when planning for and following discharge.

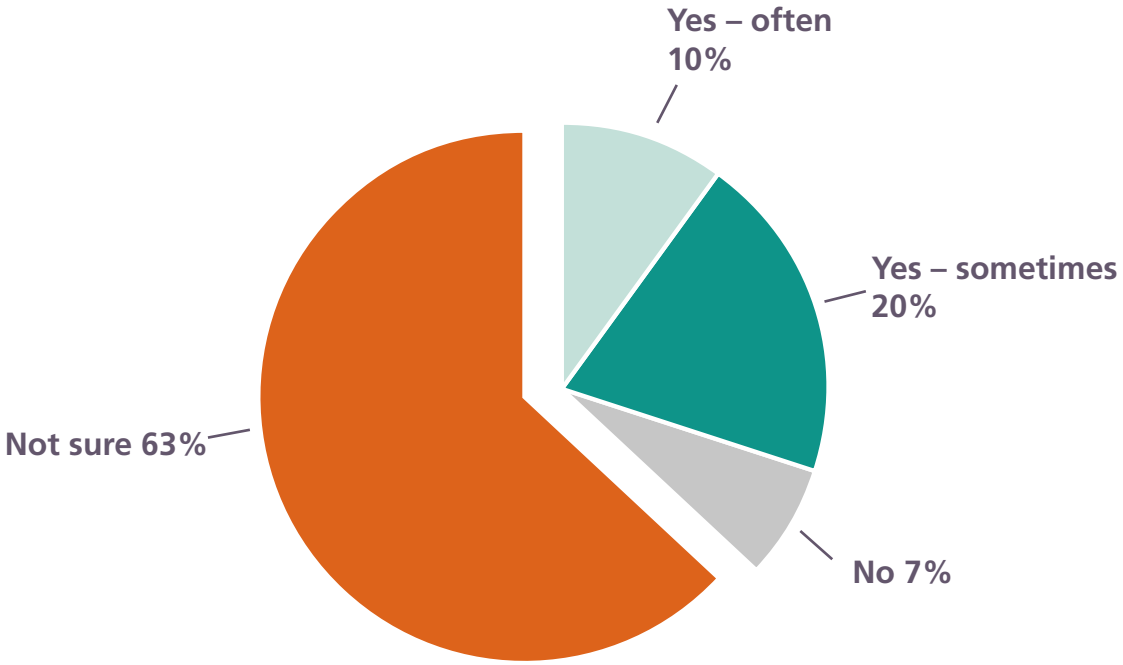
As part of the change to the new Care Group structure, the proposal is to introduce one QSRE meeting for the whole of the mental health services, as opposed to the current separate meetings for each ILG. In our interviews with senior managers, they were optimistic this model will allow for a more streamlined and consistent approach, as well as to improve the senior management oversight of the mental health services, which in turn will be reported corporately as appropriate.

Within our staff survey, 70% of respondents told us that they were either not sure, or that there were no regular audit arrangements in place to monitor the effectiveness of discharge arrangements. This is concerning since this number may suggest that audit results and subsequent learning is not routinely shared with staff. This was corroborated by the survey response where we asked staff whether lessons learned and findings from audits completed were shared with them, and 54% said no.



14 Datix is an electronic incident reporting system.

A breakdown of responses to our question to staff whether regular audits take place for the effectiveness of discharge arrangements, is highlighted in the chart below:



During our onsite fieldwork, we had significant concerns for the safety of some patients when being discharged from hospital. As highlighted earlier, we issued an immediate assurance notification to the health board (Appendix B), requesting immediate assurances that plans would be implemented to ensure safety is maintained.

The health board's immediate action plan highlighted that:

- All discharges from hospital would be audited within 24 hours by the ward manager.
- Audit reports would be routinely reviewed by the senior nurse, with any issues of non-compliance with the discharge process being addressed and reported to the QSRE for the relevant ILG.
- Any issues escalated would be reviewed, and any subsequent actions agreed, which would then be subject to ongoing monitoring through QSRE until resolved.

Given the issues highlighted during our fieldwork, and the health board's action plan response, it should consider the effectiveness and adequacy of the current audit arrangements in place. This includes consideration of our survey response where most staff were not sure or disagreed that audits were being routinely undertaken across the services. The health board must also consider a suitable ongoing plan of continuous and sustainable audits to both maintain patient safety and ensure shared learning across the mental health services, to highlight areas of concern to all staff, and that action for improvement is embedded in to practice.

Recommendation 34

The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.

Recommendation 35

The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.

Policies and procedures

As part of our review, we requested a number of documents from the health board, such as policies and standing operating procedures. The health board submitted all requested documents, and these were reviewed and used throughout the course of our review. It was concerning to find that several policies were still in draft format, and with a number of discrepancies noted. For example, the Bridgend CMHT Operational Policy still included references to the previous Abertawe Bro Morgannwg University Health Board. This was not appropriate since the units are now managed by Cwm Taf Morgannwg. In addition, the review dates of some policies had passed, and it was not always clear within the document if or when it had last been reviewed or updated, and when they were due for review again.

Our findings were discussed with senior managers, and they acknowledged that there were policies and procedures out of date, and that review dates of documents was an area which had been overlooked within the health board. However, we were informed that work was ongoing to address and rectify this issue. The health board has developed a risk assessment for the policies and procedures and has subsequently prioritised the list to review and update accordingly. There are also plans to implement health board wide policies and procedures for the mental health services, as it integrates into the new Care Group structure, so they are standardised, and practice does not differ across localities.

Through our interviews with senior managers, we were informed that the health board was confident that the policies and procedures which were 'out of date' did not include incorrect data, which could present any risks to patient safety. However, it was acknowledged that the policies needed a review and update as a matter of urgency. The target set by the health board is to ensure that every policy and procedure is updated to reflect the new operating model being implemented across the health board within 18 months of our review.

Recommendation 36

The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.

Risk Management

During our review, we considered the risk management process in place across the mental health services.

We identified that mental health risk and issue registers were in place for each of the three localities. The registers provided detailed information including the risk description, current risk level and rating, as well as the mitigations to minimise the risk and review dates. We were informed that any risks deemed very high, would be escalated to the health board corporate risk register, for oversight and monitoring. At the time of our fieldwork the only risk listed on the corporate risk register relating to adult mental health services was the multiple patient clinical records management systems in place.

On review of the risk registers, we noted that several of the key issues we identified throughout our review were not listed on the respective local risk registers. For example, the significant issues highlighted around community staff capacity to meet patient demand within CMHT and CRHTs. This was consistently highlighted as a risk as part of our discussions with staff, which is impacting on their ability to support patients within the community. This concern was acknowledged by some senior managers we interviewed, who said they were not assured that the community staff establishment currently in place was sufficient and safe. However, given this concern highlighted to us by staff across the three ILGs, the risk was not included on any of the risk registers we reviewed.

The health board has since informed us that it does not believe there is any question about the safety of staffing levels within mental health community services. Consequently, it should ensure that effective communication is made promptly with all staff across community teams, to manage their expectations and alleviate any concerns or anxieties that exist around the staff establishments, demonstrating how these are sufficient and safe.

Another example was the inpatient bed availability, which was consistently highlighted as a significant issue throughout our staff interviews. Again, this issue was acknowledged by senior managers, and we were informed that given the impact and risks that exist around the availability of beds, options to increase bed capacity were being discussed within the health board. However, this issue was not included on any of the risk registers we reviewed.

The examples above along with our overall review findings, pose a question as to whether there is sufficient visibility at executive and Board level regarding the significant risks and concerns identified and highlighted to us by clinical staff throughout the service, some of which are impacting on patient safety and staff pressure.

In view of the concerns highlighted throughout our review, the health board should reassess the current risk registers in place throughout its mental health services. The health board must ensure that all key risks are included on relevant registers, and in particular, that staff have training, or refresher training in risk management and risk management processes.

Recommendation 37

The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.

Clinical Incident management

We considered the process in place for reporting and managing incidents within the mental health services.

During our staff interviews, we were informed that following a clinical incident, most staff said they were aware of how to report incidents, errors or near misses, and this was completed through the electronic incident management system called Datix. This was substantiated by staff who responded to our survey, with 90% confirming they were aware of the reporting procedures.

We were informed that social workers who work within CMHTs, were not able to access the Datix system. Therefore, should they wish to report an incident, they must notify the CMHT manager to request that the incident be reported via the Datix system.

However, this process does not always allow for feedback to the relevant social worker, on any actions taken as a result of the reported incident, unless this was shared with them by the person who submitted the incident online via Datix. In addition, the social worker would be reliant on the CMHT manager to submit an accurate account of the incident that had taken place. The health board should consider how it can audit the process of 'second hand' reporting, to ensure it is in line with the original incident raised by the relevant social worker.

In the event of a serious patient safety incident, a serious case review is undertaken. These reviews are used to investigate and identify the root cause of the incident, to establish any learning from the incident, and in order to develop subsequent action plans and monitoring process for the actions. The aim is to implement actions to mitigate against any similar incidents occurring in the future. Staff informed us that information from the serious case reviews undertaken, including subsequent learning and actions, was routinely shared with them.

During our interviews with several staff, not all were aware of the arrangements in place to share learning following serious incident, incidents, errors or near misses. Several staff told us they had previously submitted incident forms via Datix; however, they had not received any feedback on the actions taken or any learning identified as a result. This was corroborated within our staff survey, where half of the respondents said that lessons learned following incidents reported were not routinely being shared with them.

Recommendation 38

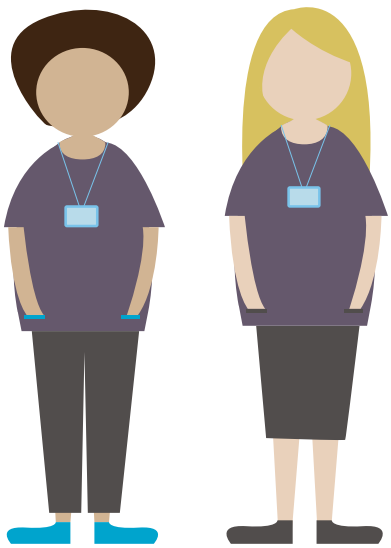
The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.

Recommendation 39

The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.

Recommendation 40

The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.



Conclusion

It is clear from our findings that those working within the health board's mental health services are committed to providing support and care to people with mental health needs.

The aim of our review was to explore the quality and safety arrangements in place around the discharge of adults from inpatient mental health units to the community. Our review has highlighted that many systems and processes are in place across the service which set out to provide safe and effective care to patients. However, we identified a number of significant issues that present clear risks to patient safety during the discharge process from inpatient units to community services.

Our review has not provided us with assurance that mental health services, in particular discharge processes, feature prominently on the health board's agenda. This requires attention and action, as we are not assured that issues and risks are being addressed appropriately at CSG level and being reported, escalated, and acted upon appropriately. This poses a potential risk to the safety of patients being discharged from inpatient services back to the community.

Whilst we are aware of the plan for the health board to fully implement the Care Group model, this will take time to embed. Therefore, the mental health services must do more to seek and engage the views of their staff and patients, their family or carers, to inform service design and improvement, particularly with the processes in place to manage a safe and effective discharge.

Action is required by the health board to make improvements and strengthen collaborative working between inpatient and community teams, in order to ensure the quality and safety of the discharge process is maintained and improved.

Overall, we consider the governance arrangements in place across the mental health services as a whole are not robust enough to ensure appropriate oversight of any risks or issues, in particular around the patient record management systems in place, and the impact this has on safe patient discharge from hospital. This includes a limited oversight of key risks across mental health services.

What Next?

We expect the health board to carefully consider the findings from this review and act upon the 40 recommendations set out within the report and listed within Appendix A.

The health board should use this review to improve the discharge processes in place and the mental health services as a whole. Furthermore, it should consider the process in place for staff documentation within patient records, and the communication processes between inpatient and community teams for other services throughout the organisation, to ensure it is safe and effective particularly with discharge processes.

The health board will be required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

It is our expectation that the health board will ensure that staff working within the mental health services have an opportunity to receive and understand the findings from our review.

We will publish the report and ensure it is shared directly with other health boards in Wales who have a responsibility to safely discharge patients from inpatient mental health services to the community. This is to ensure learning is shared, and to allow other health boards to consider the robustness of their discharge arrangements to maintain the safety and mental well-being of patient within the community.

Appendix A

Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

Recommendations	
1	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the *Mental Health (Wales) Measure 2010 under the Mental Health Act 1983*.
2	The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.
3	The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.
4	The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with *The Mental Health Act 1983 Code of Practice*.
5	The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the *Mental Health (Wales) Measure 2010*. b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.
6	The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.
7	The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.
8	The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.
9	The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.
10	The health board must provide an update to HIW on the action taken and outcome, to address the administrative support issues within POWH mental health unit.

Recommendations

11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.

12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.

13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.

14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.

15 The health board must provide an update to HIW on the actions taken or are outstanding, to mitigate the risks associated with the availability of inpatient beds.

16 The health board should consider the benefits of reinstating the huddle meetings to help manage the issues with patient flow in and out of the inpatient units.

17 The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.

18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed:

a) to ensure a standardised approach to allow for more efficient access to patient information;

b) to maintain the security of patient data and clinical information.

19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.

20 The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.

Recommendations

21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the *Mental Health (Wales) Measure 2010*.

22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.

23 The health board must ensure that discharge summaries are completed and sent out to the patients' GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.

24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.

25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.

26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.

27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.

28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.

29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.

30 The health board must consider how it can work with therapies staff:

a) to act on the concerns raised;

b) to enable them to undertake their role to adequately manage the needs of patients during their recovery phase prior to discharge.

31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.

Recommendations

32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.

33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.

34 The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.

35 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.

36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.

37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.

38 The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.

39 The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.

40 The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.

Appendix B

Cwm Taf Morgannwg University Health board Immediate Assurance Notification updated/final response, submitted on 16 September 2022, with further updates received on 15 December 2022.

Immediate Improvement Plan

To maintain patient and staff confidentiality, some aspects within the action plan have been redacted in line with the General Data Protection Regulation (GDPR).

Delivery of safe and effective care
Immediate concern 1: **HIW is not assured the health board has robust governance processes in place for the safe discharge of patients from inpatient hospital services.** During our review's onsite fieldwork, we undertook case study reviews for numerous patients within the three localities of the health board. As a result, we identified two individuals who had been inpatients at the Mental Health Unit within RGH, who were later discharged, and sadly, both died following their discharge. The coroner's inquests for both patients have not yet been held. We identified clear documentation highlighting significant patient safety concerns for both individuals, and the risk of self-harm or suicide. For one of the patients, there was also a clear risk of harm to others as expressed by the patient. In both cases, the risks were highlighted before admission, during their inpatient stays and immediately prior to discharge. For one of the patients, this was highlighted on numerous occasions following discharge by the patient's family. Whilst there were clear risk assessments identifying the risks, it is concerning that there was no robust management plan in place for either individual, as part of the discharge planning process, to support them effectively and to maintain their safety in the community. In addition, there were examples of poor communication between secondary and community care, and with timely access to information sharing across community teams. For one of these individuals, there were also risks identified which related to the safety of any lone workers attending the home of the patient. As a result of the lack of evidence of action being taken or robust measures implemented in response to the risk level in these two cases, we are concerned that these issues pose a risk to the safety of current patients, and therefore requires immediate attention by the health board.

Immediate improvement required:
The Health Board must: i. Ensure that all staff are adequately trained in completing risk assessments and the formulation of risk management plans to mitigate against identified risks for patients being discharged or transferred to community or primary care teams. ii. Consider how essential communication between secondary and community or primary care teams can be improved immediately. iii. Ensure that appropriate and robust documentation of risks and management plans are shared with and received by community and primary care teams, prior to or immediately on discharge, and that any plans for care needed following discharge are considered and communicated to relevant teams involved in the patient journey. iv. Provide an update to HIW following the internal investigations of both cases highlighted above, including any issue or concerns identified, any lessons learned and the plans for sharing learning across the health board. This must include the actions required and subsequent action plan to mitigate against similar incidents occurring in the future. v. Ensure that processes are in place to routinely disseminate all learning to secondary care and community and primary care staff following any incidents which occur, and to put measures in place to assure itself that staff understand what is required of them to implement any improvements.

Health Board action plan:	Responsible person:	Action timescale:
i. Provide all registered nursing and Allied Health professionals and medical staff, and Local Authority clinical staff with training in Welsh Applied Risk Reduction Network (WAARN) training in formulation-based assessment and management. • A training needs analysis has been completed and training schedule in place to deliver training to UHB and Local Authority staff, present and new starters. A programme of training for 241 identified staff members commenced in May 2021 has been completed. Refresher training for 251 staff will be completed December 2022 with an ongoing biannual refreshers and new starter programme in progress. • MH service will develop business case for dedicated Risk management training resource to ensure sustainability of delivery of WAARN training programme. • Monitoring performance and supporting delivery will be undertaken by Risk Steering group (Monthly frequency). Steering Group will report by exception to Care Group.	Chair, Risk steering Group, MH Head of Nursing	31 December 2022

Health Board action plan:	Responsible person:	Action timescale:
ii. Ensure presence of dedicated community clinicians in all inpatient multidisciplinary discussions and discharge planning meetings. • On admissions ward: Daily MDT meeting will have Home Treatment Team (HTT) presence in person or via Teams. • On treatment wards: weekly ward rounds will have CMHT clinical presence and HTT when required. • Routine implementation of standards within Discharge Policy and "Discharge Checklist" will ensure named inpatient nursing staff are sharing information appropriately as agreed in MDT with community/primary care services. • Monitoring of attendance and process undertaken through audit of all discharges within 24 hours (ward manager) and biweekly document review (Senior Nurse). Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Head of Nursing	17 June 2022
iii. Ensure all discharge planning is multidisciplinary and Consultant led. All discharge documentation and planned communication will have senior clinical oversight. • Community presence in all MDT meetings as 1.II above. • Risk assessment, discharge plan, and Discharge Advice Letter (DAL) and agreed communication of the documents will be agreed and signed off by Consultant Psychiatrist or deputy. • Discharge Policy and responsibilities for all staff will be reintroduced to all inpatient/ Community teams. • Monitoring of process through audit of all discharges within 24 hours (ward manager) and biweekly document review (Senior Nurse). Report by exception to QSRE/Care Group.	MH Group Medical Director, MH Head of Nursing	31 July 2022
iv. Learning and any subsequent actions will be shared on completion of unexpected death reviews.	MH Head of Nursing	31 July 2022

Health Board action plan:	Responsible person:	Action timescale:
v. Learning for any serious incident/unexpected death is shared with a consideration of locality wide/Mental Health service wide/ Health Board wide mechanisms. • All serious incident reviews are presently signed off at CSG and Integrated Locality Group level and actions agreed. • Learning is shared in CSG QSRE with senior staff and disseminated within each CSG professional group. • Lessons are shared by Lead Nurses across CSG through quarterly pan CTM learning event, and at monthly HoN meeting and as required if urgent. • Key learning will be shared through monthly clinical team meetings; and with specific professional group through Senior Psychiatrists meeting (monthly), post grad meeting (weekly) and in daily inpatient safety briefings.	MH Head of Nursing	Complete

Delivery of safe and effective care

Immediate concern 2:

HIW is not assured that the health board has robust processes in place to communicate, across teams, essential patient information, in particular between inpatient services and community and primary care services.

During our review's onsite fieldwork, we identified various patient record management systems in place, which record essential information regarding patient care, discharge planning and ongoing patient needs within the community. The systems in place can differ between community services and inpatient mental health services across Merthyr Cynon and Rhondda Taf, and also within the Royal Glamorgan Hospital.

We found that some systems in use are not accessible to all key staff involved in the patient journey through mental health services, in particular, between inpatient care and community care, and for social care staff and healthcare staff within CMHTs. This presents a significant risk in communicating essential information to safely manage ongoing patient care, and to help prevent the risk of patient self-harm, or potential harm to others, following transfer of inpatient care to community services.

During our fieldwork, staff concerns have been consistently highlighted to us, regarding their inability to access some essential patient information when required. We were informed that this is a historic and ongoing issue, which is widely acknowledged across the mental health services, yet has not been resolved. This impacts on the effectiveness of safe discharge planning arrangements for patients, with some being discharged with limited or no information being available to the relevant community team members in a timely manner.

We were informed by staff that plans are in place to develop an NHS module of the WCCIS system, to provide access to all community and inpatient services within the health board, to share and communicate essential patient information. However, the development and implementation of WCCIS has been delayed on several occasions, with no planned date at present for roll out across all teams, and with the relevant training plan to support its implementation.

Staff Concerns were also highlighted to us around the use of inpatient records management systems, namely Face and W-drive. There is no standard or formal approach to recording information within these systems. Many entries were stored under 'contact record' or 'activity'. This therefore presents difficulties for staff to access and locate key information about patients in a timely manner. In addition, concerns were also highlighted to us regarding the W-drive. We were informed that any information on the W-drive should also be available on Face, however, this was not consistent for the records we reviewed. Furthermore, concerns were also highlighted around the confidentiality and appropriate access of patient records stored on W-drive, and there were no audit processes in place to monitor users, and users' documentation, and it was possible for users to make changes to or alter other staff entries on the system.

It was also highlighted to us that for staff already employed, there had been no formal training or guidance available to staff in relation to the use of Face or W-Drive. This prevents the consistency and quality of recorded information.

Immediate improvement required:
The Health Board must: i. Inform HIW of how it will urgently consider the ongoing issues with staff access to essential patient information across its mental health services. ii. Provide HIW with its action plan to maintain the immediate safe discharge of all patients, and safe ongoing care arrangements to address patient mental health needs, following their discharge to community and primary care services. iii. Inform HIW of immediate interim arrangements for record keeping and sharing patient information to maintain safety, prior to the implementation of the WCCIS system across its mental health services, and iv. Inform HIW of the training plan to support the above. v. Consider how it can develop and implement a consistent and standardised approach to the use of and documentation of electronic patient records within Face and W-drive. Staff must be trained consistently and appropriately for this.

Health Board action plan:	Responsible person:	Action timescale:
i. Undertake analysis of information access needs and agree standards for access: • Complete clinical team/staff access matrix ("who accesses what system for what purpose"). • Agree prudent minimal permissions for access to FACE/WCCIS/W Drive/T Drive. • Understand IT/cross agency (Health/Local Authority)/governance obstacles to access. • Initially provide each clinical team with at least one staff member with support and resources to access information in line with agreed permissions.	MH Group Operations Director	31 July 2022

Health Board action plan:	Responsible person:	Action timescale:
ii. Discharge Policy will be formalised and rolled out across all CTM Health units and responsibilities for all staff will be reintroduced to all inpatient/Community teams: • Ensure presence of dedicated community clinicians in all inpatient multidisciplinary discussions and discharge planning meetings. • On admissions ward: daily MDT will have Home Treatment Team (HTT) presence in person or via Teams. • On treatment wards: weekly ward rounds will have Community mental Health Team CMHT clinical presence and HTT when required. • Routine implementation of standards within Discharge Policy and "Discharge Checklist" will ensure named inpatient nursing staff are sharing information appropriately as agreed in MDT with community/primary care services. • Ensure all discharge planning is multidisciplinary and Consultant led. All discharge documentation and planned communication will have senior clinical oversight. • Community presence in all MDT meetings as 1.II above. • Risk assessment, discharge plan, and Discharge Advice letter (DAL) and agreed communication of same will be agreed and signed off by Consultant Psychiatrist or deputy. • Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Group Medical Director, MH Head of Nursing	30 September 2022

Health Board action plan:	Responsible person:	Action timescale:
iii. Complete clinical team/staff access matrix ("who accesses what system for what purpose") for all systems: • initially provide each clinical team with at least one staff member with support and resources to access information in line with agreed immediate permissions (2.II above). FACE • Agree data entry standards. • Consult with care partner (FACE provider) in relation to rationalising and simplifying process. • Formalise agreed standards and system adaptations into "user guides". W Drive/T drive • Identify all current users. • Agree access permissions and data owners. • Contents to be validated by data owner and purged if required. • Agree data entry standards. • Formalise agreed standards and system adaptations into "guidance".	MH Group Operations Director	30 September 2022
iv. • Undertake associated training needs analysis for adapted FACE/W drive/T drive system. • Map staff matrix/new starters/inductees against training analysis to understand training resource needed across CTMUHB. • Develop and share training plan.	MH Group Operations Director	30 September 2022
v. Develop a pan CTM MDT working group to develop consistent approach to clinical record keeping: Working Group will: • monitor progress of work stream in 2.III above • review record keeping arrangements across whole MH system (including paper records) and consider best practice across CTM to develop prudent governance and consistent process.	MH Head of Nursing	31 July 2022

Delivery of safe and effective care

Immediate concern 3:

HIW is not assured that patients and their relative or carer are being included in the planning process for discharge, when it is appropriate to do so.

When considering the process for discharge planning, during our review of patient records, there was limited evidence available to demonstrate that patients were always involved and appropriately communicated with during ward rounds, and their inclusion or contribution regarding their plans for discharge. This was evident in some records, we found that patients were discharged from some services without their knowledge of the plans. In other cases, they had not been discharged from service until a week or two following their actual discharge.

Similarly, there was limited evidence to demonstrate there was appropriate inclusion or involvement of a patient's family/carers or other advocate when it was appropriate to do so, when planning and preparing a patient for discharge. This was particularly evident in the case study records for one of the patients who was discharged and subsequently died following their discharge.

We also identified that no formal minutes were being routinely recorded for patient related meetings and weekly ward rounds, and also for MDT meetings and discharge planning meetings. This demonstrates a weakness in the governance processes in place, to maintaining patient safety, and in particular for the discharge process.

Immediate improvement required:

The Health Board must:

i. Ensure that all patients (where appropriate), are provided with the opportunity to contribute to their plan of care during ward rounds and when planning discharge. In addition, the patient contribution and their preferences and concerns should also be considered and recorded appropriately with their records.

ii. Ensure that patient families/carers or an advocate (where appropriate), are provided with the appropriate opportunity to contribute to discharge discussions and subsequent discharge plans. Their contribution should be clearly recorded within patient records.

Health Board action plan:	Responsible person:	Action timescale:
i. Formal inpatient meetings will have a patient focus with discharge planning coproduced with the person whenever possible: • Develop a template for inpatient MDT meetings and discharge meetings to encourage patient engagement, and guide clinicians to appropriate documentary recording of patient views. • Discharge Policy and responsibilities for all staff will be reintroduced to all inpatient/ Community teams. • Monitoring process through audit of all discharges within 24 hours (ward manager) and Biweekly document review (Senior Nurse) Report by exception to QSRE/Care Group.	MH Head of Nursing	31 July 2022
ii. Formal inpatient meetings will seek views of carers/families/advocates patient focus to aid discharge planning: • Develop a template for inpatient MDT meetings and discharge meetings to encourage carers/ families/advocates engagement, and guide clinicians to appropriate documentary recording. • Discharge Policy and responsibilities for all staff will be reintroduced to all inpatient/ Community teams. • Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Head of Nursing	31 July 2022

Delivery of safe and effective care

Immediate concern 4:

HIW is not assured that there are adequate arrangements in place to ensure all necessary processes and actions are in place, have been implemented or completed when preparing for a patient to be discharged.

The case study review identified that a discharge checklist was available to staff, however, it was not being used consistently, or completed in full by staff. It was therefore not always clear what actions had been completed as part of the patients' discharge. For example, what information had been provided to key staff and also the patient. In addition, staff highlighted that there was insufficient information included within some patient discharge letters, such as information regarding a patients' rights to self-refer under the Mental Health Measure following their discharge.

When we considered the relapse indicators in some discharge plans, we did see some areas of good practice. However, overall, there was limited evidence to demonstrate relapse indicators were being routinely used to inform and support relevant individuals, including the patient, family or carer, as part of the discharge process. This increased the risk of poor continuity of care or possible mental health crisis of a patient.

Immediate improvement required:

The Health Board must:

i. Ensure that discharge checklists are appropriately completed by staff as part of the patient discharge process, thus contributing to a safe discharge process.

ii. Review discharge letter templates, to ensure they provide sufficient information to patients and other key staff to support a patient following discharge and help maintain their safety and wellbeing.

iii. Ensure that patient relapse indicators are appropriately considered and agreed for each patient where appropriate, and that they are clearly recorded and promptly shared with key staff and the patient or relative/carer, as part of the discharge planning process.

iv. Ensure that arrangements are in place to maintain comprehensive records following formal MDT meetings, discharge planning meetings or others relating to patient care, and ensure these are shared and reviewed by relevant staff.

Health Board action plan:	Responsible person:	Action timescale:
i. • Discharge Policy and responsibilities for all staff will be reintroduced to all inpatient/Community teams. • Inpatient pathway (including discharge checklist) will be completed for all inpatients at point of discharge. • Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Head of Nursing	30 June 2022
ii. • Discharge information letter provided to family and person will be reviewed to include follow up arrangements under part 3 MH Measure (when appropriate). • Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Head of Nursing	30 June 2022
iii. • Discharge information letter provided to family and person will be reviewed to include preliminary relapse indicators. This will be further developed in the period following discharge by Community clinicians (when appropriate). • All care coordinated persons will have relapse triggers co-produced with care coordinator (and family when appropriate), documented in CTP plan and reviewed as necessary. • All inpatient and community staff will have training on person centred relapse planning. • Reports will be routinely reviewed by the Senior Nurse and where performance falls below complete compliance (100%) this will be reported to the Quality Safety Risk and Experience (QSRE) meeting/Care Group to understand reasons for lack of compliance and to agree actions. These actions will be monitored through QSRE until resolved.	MH Head of Nursing	30 September 2022

Health Board action plan:	Responsible person:	Action timescale:
iv. • Formal inpatient meetings will be clearly documented in an agreed format by a clinician with senior clinical sign off of all records. • Develop a template for inpatient MDT meetings and discharge meetings to guide clinicians to appropriate documentary recording. • Each inpatient unit clinical team will have access to appropriate IT infrastructure and admin support to enable audio recording and remote transcribing of formal meetings when required, i.e., professional's meeting/family meetings.	MH Head of Nursing	30 September 2022