

Mental Health, Learning Disability Services and Mental Health Act Monitoring

Annual Report 2024-2025



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 goal

To be a trusted voice which influences and drives improvement in healthcare.

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.



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1. Executive Summary

This report presents the findings of Healthcare Inspectorate Wales (HIW) from inspections of mental health and learning disability services across Wales between April 2024 and March 2025. During this period, HIW undertook 25 onsite inspections across NHS and independent hospitals, as well as community mental health teams (CMHTs), to assess the quality, safety, and effectiveness of care provided. Of the 25 inspections conducted, 14 were of NHS hospitals and 11 were of independent providers. This total includes two separate inspections of the same independent provider.

Mental health and learning disability services continued to face significant and, in many cases, long-standing challenges. Workforce shortages, environmental deterioration, and governance weaknesses remained key barriers to delivering safe, person-centred care. Persistent difficulties in recruiting and retaining skilled staff particularly in nursing, psychology, and occupational therapy continued to impact the quality and consistency of care. Inpatient services remained under pressure, with high bed occupancy and limited therapeutic engagement due to staffing constraints.

Many services demonstrated a clear commitment to delivering compassionate care, and HIW observed positive examples of multidisciplinary working and legal compliance with the Mental Health Act 1983. However, these strengths were often overshadowed by recurring and systemic issues.

Environment of care emerged as a particularly concerning area, with a large number of services both NHS and independent having concerns noted. Poor maintenance, damaged fixtures, and inadequate infection prevention and control were observed across both sectors. However, the concerns raised in NHS settings were generally more significant, with some hospitals experiencing deterioration since previous inspections and requiring urgent improvement plans.

Medication management also remained a persistent area of concern. Despite previous recommendations, HIW continued to find gaps in documentation, poor storage practices, and inconsistent oversight. These issues have been repeatedly highlighted in past inspection cycles, indicating a lack of sustained improvement and posing ongoing risks to patient safety.

Other recurring concerns included high reliance on bank and agency staff, alongside difficulty in filling specialist roles, and low morale in some settings. Audit processes were often inconsistent, policies outdated, and senior leadership lacked visibility. Patients' access to secure personal space was limited, with few gender-specific areas and inconsistent access to advocacy and information. Risk management practices were inadequate in several services, with inconsistent use of safety equipment and concerns around emergency preparedness.

HIW also continued to monitor the implementation of the Mental Health Act 1983 and the Mental Health (Wales) Measure 2010. While most services demonstrated compliance, areas for improvement were noted in documentation, consent to treatment, and discharge planning.

This year's findings reflect a continued pattern of systemic challenges, many of which have been highlighted in previous reports. While examples of good practice were evident, the persistence of these issues underscores the need for coordinated, strategic action across health boards, independent providers, and national stakeholders. HIW remains committed to working collaboratively to support improvement and ensure that mental health and learning disability services in Wales are safe, effective, and person-centred.

Throughout this report, HIW will note and explore the nuances between NHS and independent settings, ensuring that sector-specific challenges and strengths are clearly identified.

2. Context

Throughout 2024-2025, mental health and learning disability services in Wales continued to operate under significant pressure. Services faced persistent challenges in delivering safe, effective, and person-centred care, largely driven by workforce shortages, increasing demand, and the complexity of patient needs. In addition to these pressures, HIW observed a further decline in the quality of care environments across several settings. Many services reported issues such as poor maintenance, damaged fixtures, and inadequate infection prevention measures, with some environments showing deterioration since previous inspections. This highlights the growing need for sustained investment in the physical infrastructure of mental health services.

Recruitment and retention of skilled professionals particularly nurses, psychiatrists, psychologists, and occupational therapists remained a critical issue. These shortages impacted the ability of services to provide timely access to care, maintain therapeutic engagement, and ensure safe staffing levels across inpatient and community settings.

Inpatient services experienced high bed occupancy and limited capacity, placing additional strain on staff and reducing opportunities for meaningful interaction with patients. Community services also reported difficulties in maintaining continuity of care due to staffing gaps and fragmented service delivery.

HIW continued to monitor the implementation of key statutory frameworks, including the Mental Health Act 1983, Code of Practice for Wales (Revised 2016) and the Mental Health (Wales) Measure 2010. These documents remain central to ensuring that patients' rights are protected and that care is delivered in a legally compliant and evidence-based manner.

The Second Opinion Appointed Doctor (SOAD) service continued to operate as a hybrid model, combining face-to-face and remote assessments. While in-person contact remains the preferred approach, remote consultations were necessary in some cases. HIW emphasised the importance of timely and complete documentation to support the SOAD process.



3. Our Role in Mental Health and Learning Disability Care

HIW plays a vital role in ensuring the quality and safety of mental health and learning disability services across Wales. Our responsibilities include:

- Inspecting all NHS mental health and learning disability services to ensure they meet required standards of care.
- Regulating and inspecting independent mental health and learning disability healthcare services in Wales.
- Collaborating with key stakeholders across the health and care system to support improvement and share intelligence.
- Monitoring the use of the Mental Health Act 1983 (MHA) on behalf of the Welsh Ministers, ensuring legal safeguards are upheld.
- Providing the SOAD service, which offers independent medical opinions in specific cases under the Mental Health Act.
- Monitoring Parts 2 and 4 of the Mental Health (Wales) Measure 2010, which relate to care and treatment planning and primary mental health support services.
- Overseeing the implementation of the Deprivation of Liberty Safeguards (DoLS) to protect the rights of individuals who lack capacity and are deprived of their liberty in care settings.

Inspection and Regulation

HIW is the independent regulator of healthcare services in Wales, responsible for registering, inspecting, and taking enforcement action in relation to independent healthcare providers. This is carried out in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011, and the 25 National Minimum Standards for Independent Health Care Services in Wales.

On behalf of the Welsh Ministers, HIW also undertakes reviews and investigations into NHS healthcare services under Section 70 of the Health and Social Care (Community Health and Standards) Act 2003. In doing so, HIW considers the Health and Care Quality Standards to assess the quality, safety, and effectiveness of care provided by or for NHS bodies in Wales.

We made use of a combination of routine on-site and focused inspections during 2024-25. The findings from these inspections are summarised in section 5 of this report. In addition, a list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring the use of the Mental Health Act 1983

HIW is responsible for monitoring the use of the MHA on behalf of the Welsh Ministers. This statutory duty is carried out by a dedicated team of Mental Health Act (MHA) reviewers who form an integral part of HIW's inspection teams. Their role includes reviewing legal documentation, engaging with MHA administrators, and assessing how the Act is implemented across NHS and independent services.

Between April 2024 and March 2025, HIW inspections found that most services demonstrated a strong commitment to legal compliance and person-centred care under the Act. However, several areas for improvement were identified, which are summarised in Section 6 of this report.

Review Service for Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

- The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the MHA, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.
- A review of treatment under Section 61 of the MHA. When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.
- The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2024 and March 2025 is provided in section 7 of this report.

Monitoring the Mental Health (Wales) Measure

The Mental Health (Wales) Measure 2010 is structured into four key parts:

Part 1 – Primary mental health support services

Part 2 – Coordination and care planning for individuals receiving secondary mental health services

Part 3 – Assessment of individuals previously under secondary mental health services

Part 4 – Access to mental health advocacy

During our inspections, we routinely assess individual patients' Care and Treatment Plans (CTPs), focusing on the domains outlined in Section 18 of the Measure. These are:

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

We also evaluate the role of the Care Coordinator, particularly their level of engagement with the patient. Further detail on our findings related to risk assessment and care planning, as they relate to the Measure, can be found in Section 5 of this report. This includes our consideration of patients' access to advocacy services and the effectiveness of those arrangements.

Monitoring use of the Deprivation of Liberty Safeguards

Each year, we jointly publish, with Care Inspectorate Wales (CIW), an annual report on the use of the Deprivation of Liberty Safeguards (DoLS).

DoLS is an amendment to the Mental Capacity Act 2005 and was introduced to ensure that individuals who lack capacity, and are under continuous supervision and control in care homes or hospitals, are not unlawfully deprived of their liberty. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024, but this did not happen and there is no revised date for its implementation. DoLS can be used when detention under the MHA is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM includes organisations from the four nations that make up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), and His Majesty's Inspectorate of Constabulary in Scotland. Other member organisations that HIW undertakes joint work with include, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

The NPM held its annual conference on 24 and 25 April 2024 marking the NPM's 15th anniversary. The conference was held in Cardiff and HIW's Director of Strategy and Engagement shared insights on challenges and progress being made in Wales. HIW continues to have a membership on the steering committee.

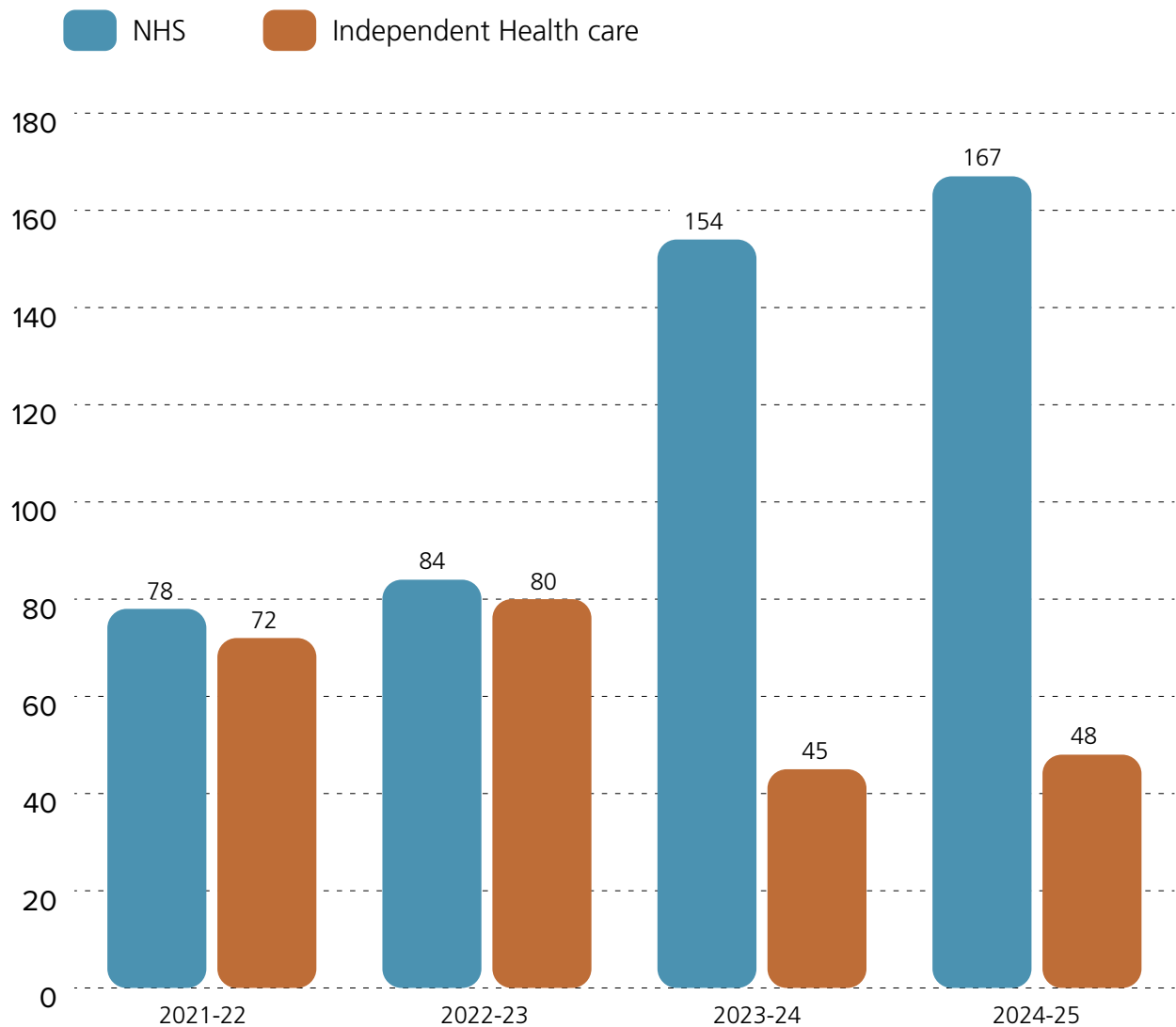
Youth Justice Services

HIW continues to work with His Majesty's Inspectorate of Probation (HMI Probation) on sharing intelligence for the inspections of Youth Justice Services (YJS) to consider the healthcare that young people are receiving. Other inspectorates that share intelligence and work with HMI Probation include CIW and Estyn. HIW is also represented at the Youth Justice Inspection Group, one of the key functions of which is to bring up-to-date knowledge to inform the effective sharing of intelligence and the co-ordination of inspection activity.

Dementia Partners National Steering Group

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIIG). A number of key stakeholders attend the meeting including representatives from NHS Wales Performance and Improvement, Improvement Cymru, the health boards and local authorities. Within this group, good practice initiatives are shared and published, new research is discussed, and the health boards provide regional updates. In addition, progress for the three workstreams of the Dementia Programme (2024-2025) are considered. The three areas are, Community & Connector, Hospital Charter and Memory Assessment which align with other work programmes is discussed.

4. Listening to Concerns



The chart above illustrates the number of patients who contacted HIW with concerns and complaints about mental health care, along with comparisons to previous years.

Over the past four years, the number of concerns and complaints received by HIW regarding mental health care has shown a notable increase for NHS services, while figures for independent providers have remained relatively stable:

- NHS Services: Reports rose steadily from 78 in 2021-22 to 167 in 2024-25, more than doubling over the period.
- Independent Services: Numbers fluctuated slightly, peaking at 80 in 2022-23, then declining to 48 in 2024-25.

This trend highlights growing engagement or concern among patients using NHS mental health services, while concerns related to independent providers have decreased in the most recent two years.

The table below for 2024-25 shows a breakdown of concerns and complaints by their subject

	Total	NHS	IND
Access, Admission, Transfer, Discharge (including missing patient)	28	24	4
Clinical Assessment (including Diagnosis, scans, tests, assessments)	14	14	0
Communication	6	6	0
Complaints Management	3	3	0
Consent & Confidentiality	2	2	0
Infection Control Incident	1	1	0
Infrastructure (including staff facilities, environment)	20	12	8
Medication Management	9	7	2
Mental Health Act	33	25	5
Other	6	4	2
Patient Accident	3	2	1
Records Management	20	20	0
Safeguarding	14	7	7
Self-harming Behaviour	9	8	1
Treatment/Procedure	7	6	1
Whistleblowing	40	21	19

During 2024-2025, HIW received a range of concerns from healthcare settings and members of the public regarding the delivery of mental health and learning disability services. These concerns reflect ongoing challenges in key areas of care.

For NHS services, the most frequently reported concerns were:

- MHA compliance
- Access, admission, transfer, and discharge
- Records management.

For independent providers, the highest number of concerns related to:

- Infrastructure
- Safeguarding
- MHA compliance.

The 'Infrastructure' category covers a broad range of issues, including the physical condition of buildings and any factors that disrupt or interfere with the delivery of services or operational processes.

The MHA Compliance category includes concerns about how the Act is applied in care settings. This may involve patients raising concerns about their detention or instances where the Act has been applied inaccurately or inconsistently.

These concerns closely mirror the themes identified during our inspections. We observed variation in how services applied the Mental Health Act, managed patient transitions, maintained care environments, and ensured accurate and timely record keeping. In some settings, safeguarding procedures and staff awareness required strengthening, and infrastructure limitations impacted the delivery of safe and therapeutic care.

Staff Concerns

Whistleblowing is distinct from raising a personal complaint or grievance. It involves reporting a serious concern in the public interest such as risks to patient safety, safeguarding failures, financial malpractice, or other forms of wrongdoing within a workplace or organisation.

HIW is a 'prescribed body' under UK whistleblowing legislation. This means that individuals can make a 'qualifying disclosure' directly to HIW and, in doing so, may be entitled to legal protection under the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA is designed to protect individuals who raise genuine concerns from being treated unfairly or suffering detriment as a result of speaking up. It ensures that whistleblowers are not penalised for acting in the public interest, even if their concern turns out to be unfounded, provided it was raised in good faith.

HIW takes all whistleblowing disclosures seriously. We assess each concern to determine whether it falls within our remit and whether further action is required. In some cases, this may lead to a focused inspection or engagement with the relevant health board or provider.

Further information about whistleblowing, including how to raise a concern with HIW, is available on our website: [Whistleblowing – Raising Concerns about Healthcare in Wales | Healthcare Inspectorate Wales](#).

In 2023-2024, Healthcare Inspectorate Wales (HIW) noted a significant decrease in the number of whistleblowing concerns received, with a total of 11 cases (6 from NHS mental health services and 5 from mental health independent providers). However, during 2024-2025, the number of whistleblowing concerns rose sharply to 40. This increase reflects a return to levels seen in earlier years, with 38 concerns reported in 2022-2023 and 28 in 2021-2022.

Key Insights from 2024-2025 Whistleblowing Data:

- The most frequently cited concern was cultural issues (including bullying, racism, discrimination, and poor management practices), accounting for 18 cases.
- Staffing levels, patient safety, and professional conduct each featured in 8 cases.
- Other recurring themes included clinical practice (6 cases), training and competence (3 cases), and whistleblower retaliation (4 cases).
- Less frequent but notable concerns related to environmental issues, record management, and food and nutrition (2 cases each).

These figures highlight that organisational culture remains the most significant area of concern, followed by workforce capacity and patient safety. Both NHS and independent providers face similar systemic challenges.

Of the 40 whistleblowing cases received in 2024-2025, 21 (52.5%) related to NHS services, while 19 (47.5%) concerned independent providers.

Regulation 30 and 31 Notifications

The table below shows the number of Regulation 30 and 31 notifications received by HIW between 1 April 2024 and 31 March 2025. In accordance with the Independent Health Care (Wales) Regulations 2011, registered persons of independent hospitals, clinics, and medical agencies are legally required to notify HIW of specific incidents relating to patient safety.

These notifications are a statutory requirement and help ensure transparency and accountability in the delivery of care.

The table also outlines the types of notifications HIW receives under these regulations. For the 2024-2025 reporting period, HIW received a total of 1,032 notifications from independent mental health and learning disability services. This represents a notable increase compared to 821 notifications received in 2023-2024.

One of the most significant changes was the rise in notifications relating to serious injuries, which increased from 462 in 2023-2024 to 649 in 2024-2025. This increase appears to be primarily due to improved relationships and communication with certain independent providers. These strengthened partnerships have fostered a more open and transparent reporting culture, resulting in more consistent and accurate reporting of incidents.

Notification Type	2023-2024	2024-2025
Death of a Patient	9	11
Unauthorised Absence	140	131
Serious Injury	462	649
Outbreak of an Infectious Disease	22	14
Allegations of Staff Misconduct	161	186
Deprivation of Liberty	27	41
Total	821	1032

5. Inspecting Mental Health and Learning Disabilities Healthcare Services

During 2024-2025, we undertook 25 onsite inspections across a range of healthcare settings, including both NHS and independent hospitals. The wards we visited provided care for adults with mental health needs, children and adolescents, individuals with eating disorders, people with learning disabilities, and older adults with mental health conditions. One independent provider required two separate onsite inspections within the year, reflecting the need for continued monitoring and follow-up. In addition to these hospital-based inspections, we also carried out two announced inspections of community mental health teams. These were conducted jointly with CIW, reflecting our continued commitment to collaborative oversight and a whole-system approach to mental health care.

During our onsite inspections, we:

- Engaged with a number of patients and visitors to gather their views on the quality of care and treatment being provided.
- Spoke with a range of staff from multi-disciplinary teams to understand their perspectives on the effectiveness of their roles and how they addressed any challenges.
- Reviewed a variety of care documentation, including risk assessments, and examined how Part 2 of the Mental Health (Wales) Measure 2010 was being implemented. We also considered the role of Care Coordinators and other members of the multi-disciplinary team in delivering coordinated care.
- Examined additional patient records, including observation notes, documentation of any restraints, and records of seclusion where applicable.
- Assessed whether effective discharge pathways were in place, including the arrangements for crisis management planning as part of the discharge process.

- Reviewed audit findings and governance processes to evaluate how services monitor and improve quality and safety.
- Considered the suitability of the care environments, ensuring that risks had been identified and that appropriate actions had been taken to mitigate them.
- Reviewed the administration of the MHA and assessed compliance with the Mental Health Code of Practice for Wales (2016).

A full list of the health boards and independent registered providers we inspected is included in Appendix A, along with links to the individual inspection reports.

Our Findings

This section presents our findings from inspections carried out between 2024 and 2025. The findings are organised into three distinct areas:

- Finding specific to older persons, younger adults and CMHTS
- Finding specific to Learning Disabilities
- Finding specific to CAMHS.

The detailed findings are drawn from our inspection reports following onsite visits conducted during the reporting period. Each section highlights key themes, examples of good practice, and areas where improvements are required.

Across the 25 inspections carried out during the reporting period, HIW made a total of 394 recommendations. Of the sites inspected, nine were required to enter the immediate assurance and non-compliance process. In three of these cases, immediate concerns were identified and resolved during the inspection itself.

The remaining six required the implementation of an Immediate Improvement Plan to address the non-compliance issues identified.

In addition, one independent provider remained designated as a Service of Concern while HIW continued to review evidence and allowed time for the required changes to become embedded. As part of this process, HIW undertook a second inspection at the hospital to assess progress and confirm that improvements were being sustained.

Findings specific to older persons, younger adults and CMHTS

Positive Findings

Across our inspections of older persons' wards, adult mental health services, and community mental health teams during 2024-2025, we found many examples of safe, effective, and compassionate care being delivered by dedicated staff teams. Patients frequently told us they felt safe, respected, and well cared for, and we observed staff interacting with patients in a kind, supportive, and dignified manner. These positive relationships contributed to calm and therapeutic ward environments, where patients were encouraged to engage in their care and recovery.

Staff demonstrated a strong understanding of individual patient needs and were committed to delivering person-centred care. In several settings, care planning was of a high standard, with detailed, individualised plans aligned with the domains of the Mental Health (Wales) Measure 2010. There was clear evidence of multidisciplinary team involvement and patient participation in care decisions. In one NHS older person setting, care plans had improved significantly since previous inspections, reflecting a commitment to learning and continuous improvement.

We also observed a variety of therapeutic activities being offered, including arts and crafts, cooking, board games, and physical activities such as walking and gym use. Staff were proactive in encouraging participation, and patients spoke positively about the opportunities available to them. In one setting, a patient-designed information booklet was being adopted across other wards, demonstrating a strong culture of co-production.

The use of restrictive practices was observed to be low in one independent mental health setting, where no restraints had been recorded over an extended period, demonstrating effective application of least restrictive, therapeutic approaches. In certain services, physical interventions were documented and followed by appropriate debriefs, and staff responded well to physical health needs through comprehensive assessments and ongoing input from physical health professionals. However, these examples were limited. Our inspections also identified recurring concerns about the consistent application, documentation, and oversight of restrictive practices, which are explored in detail later in this report.

A number of services demonstrated strong leadership and governance, with supportive management structures and positive team cultures. In several inspections, staff reported good compliance with mandatory training, regular staff and patient meetings, and a stable workforce with appropriate skill mix. Staff across a range of settings said they would recommend their service as a place to work.

Some care environments were found to be clean and well maintained, with features such as en-suite facilities and access to personal belongings. In certain settings, patients had access to mobile phones and tablets, and authorised leave was managed in a way that balanced individual preferences with safety. In one NHS older person setting, improvements were noted since previous inspections, particularly in audit processes, discharge planning, and Mental Health Act monitoring.

Overall, our inspections found that many patients were receiving timely, respectful, and individualised care in environments that supported their recovery and wellbeing. The commitment of staff, the quality of therapeutic engagement, and the presence of strong leadership in some settings were encouraging, but further work is needed to ensure these standards are met consistently across all services. While these positive examples are encouraging, they were not universal. A range of concerns were identified across the services inspected, which are explored in more detail later in this report.

Least Restrictive Care

This section outlines our findings on the use of restraint and seclusion across mental health services. While we observed positive examples of least restrictive approaches and therapeutic engagement in many settings, our inspections also highlighted recurring concerns about the consistent application, documentation, and oversight of restrictive practices.

Use of Restraint

The MHA – Code of Practice for Wales (2016) emphasises that any intervention, including restraint, should be guided by the principles of least restriction, patient involvement, and risk assessment. Restraint whether physical, chemical, environmental, or mechanical must always be a last resort, used only when other de-escalation strategies have failed. The Welsh

Government's 2022 framework for reducing restrictive practices further reinforces these expectations across health and social care settings.

Despite this, our inspections found that restraint incidents were not always being accurately recorded. In several services, staff failed to categorise incidents correctly within electronic reporting systems, making it difficult to extract reliable data and undermining governance and oversight. In one setting, the local restraint policy was found to be out of date, raising concerns about the currency of guidance available to staff.

Training compliance was another area of concern. In multiple settings, staff involved in restraint incidents were either out of compliance with mandatory physical intervention training or had not completed it at all. This included an incident involving an agency staff member who had not received the required training. In one NHS setting, only two out of twenty-nine staff were up to date with their physical intervention training at the time of inspection. In some cases, although staff claimed that only trained individuals were involved in restraints, the lack of documentation meant this could not be verified.

We also found that restraint incident reports often lacked sufficient detail. Descriptions of the events, including the actions of staff involved, were incomplete or missing, limiting the ability of managers to monitor trends, assess risks, and ensure accountability. As a result, some health boards were advised to conduct training needs analyses and consider whether additional conflict resolution or physical intervention training was required to ensure staff were adequately prepared to manage challenging behaviours safely.

These findings suggest that while restraint is generally used infrequently and with therapeutic intent, there is a clear need for improved training compliance, accurate incident reporting, and stronger governance to ensure that least restrictive practices are consistently applied and monitored.

Use of Seclusion

The MHA Code of Practice for Wales (2016) provides clear guidance on the use of seclusion, defining it as “the supervised confinement of a patient in a room which may be locked.” The Code emphasises that seclusion should only be used as a last resort, for the shortest possible time, and always in accordance with established policies and procedures. It also sets out specific review requirements: seclusion must be reviewed every two hours by two nurses and every four hours by a doctor or suitably qualified approved clinician. Local policies should align with national guidance, including that issued by the National Institute for Health and Care Excellence (NICE).

During one inspection, we identified a ward where the designated seclusion area did not meet best practice standards or comply with the health board’s own policy. Several environmental and safety concerns were noted. The room lacked a visible clock and did not have temperature controls accessible from outside. There were no en-suite toilet, shower, or handwashing facilities, meaning additional staff had to be arranged to escort patients to access these basic amenities. Staff also reported a known blind spot in the room, which required close monitoring. However, a blind spot mirror was not in place at the time of inspection, as it had previously been removed by patients and not replaced.

These issues raised concerns about the suitability of the environment and the adequacy of safeguards in place for patients subject to seclusion.

Meaningful and Therapeutic Activities

Therapeutic and meaningful activities are a vital component of mental health care, supporting recovery, wellbeing, and patient engagement. As part of our inspections, we routinely assess the availability, structure, and relevance of activity programmes across both inpatient and community services.

The importance of structured therapeutic engagement is well recognised. The Royal College of Psychiatrists states:

“A good ward offers a full and varied programme of therapeutic and leisure activities, available seven days a week, which are linked to patients’ care plans and recovery goals.”

Royal College of Psychiatrists, 2011. Do the right thing: How to judge a good ward – Ten standards for adult in-patient mental healthcare.

While this guidance is directed at inpatient settings, the underlying principle that meaningful activity should be embedded in care planning and recovery applies equally to community-based services.

Across several inspections, we observed examples of engaging and appropriate activities being offered to patients, such as arts and crafts, mindfulness sessions, gardening clubs, and access to social hubs. These activities contributed positively to the therapeutic environment and were often well received by patients.

However, a number of common challenges were identified. In many settings, there was no structured programme of activities tailored to individual needs. The absence of dedicated Occupational Therapists or activity coordinators limited the consistency and scope of what could be offered. In some services, staffing shortages further impacted the delivery of activities, with patients reporting that gym access, community leave, or social spaces were often unavailable due to a lack of staff.

Environmental factors also played a role. In certain settings, therapeutic spaces were under-utilised or not suitably adapted for example, sensory equipment was not positioned for easy use, and outdoor areas lacked features that could enhance their therapeutic value.

In addition, some services lacked formal mechanisms to gather feedback from patients and families about the activity provision, making it difficult to assess whether the activities met their needs or preferences. In one specialist setting, patients and families expressed a desire for more condition-specific therapeutic activities and greater availability over weekends.

Several services were advised to strengthen their approach to activity planning, ensuring that therapeutic engagement is not only available but also structured, inclusive, and aligned with recovery goals.

Overall, while positive examples were observed, our inspections highlighted the need for more consistent, well-resourced, and patient-centred activity provision across mental health services. Ensuring regular access to meaningful engagement remains a key area for improvement in supporting recovery and enhancing patient experience.

Medication Management

During our inspections, we observed examples of good practice in medication management, including comprehensive record-keeping, regular audits, and safe storage procedures. In some settings, staff demonstrated a clear understanding of medication protocols, and compliance with administration procedures was evident.

However, a number of recurring concerns were identified across services, highlighting inconsistencies in the safe handling, storage, and documentation of medicines.

In several settings, Medication Administration Records (MAR) charts were found to be incomplete or missing key information, such as patient allergies or legal status under the Mental Health Act. In some cases, photographs were not attached to MAR charts, increasing the risk of medication errors, particularly where patients shared similar names.

Storage and security of medication was another common issue. We found examples of medication being left unattended in clinical rooms, unlocked fridges, and emergency drugs stored inappropriately or without clear labelling. In one instance, a vial of controlled medication was unaccounted for, and in another, the emergency drug bag was stored on top of clutter, posing a risk in urgent situations.

Oxygen cylinder management was also inconsistent. Across multiple settings, cylinders were not secured properly, lacked appropriate signage, or were stored with tubing already attached. In some cases, staff were unfamiliar with how to operate portable oxygen equipment, and governance around oxygen use required strengthening.

Environmental and infection prevention concerns were noted in several clinical areas. These included damaged countertops, dusty or cluttered rooms, and gaps in cleaning schedules. In one service, the clinic room was not considered fit for purpose due to its layout and lack of secure sharps disposal.

Training and oversight also varied. Some settings lacked a dedicated mental health pharmacist, and in others, there was no clear process for routine checks of emergency medication or stock levels. In one community service, the absence of a Home Office licence for controlled drugs meant staff had to rely on external pharmacies for supply, creating logistical challenges.

Governance and audit processes were not always robust. In some cases, daily stock checks of controlled drugs were only carried out on certain wards, and post-incident documentation such as after rapid tranquilisation was incomplete or missing.

Many of the concerns identified this year mirror those reported in the previous inspection cycle. Issues such as incomplete MAR charts, missing consent documentation, out-of-date medication policies, unsecured medication trolleys, and poor storage practices were also highlighted last year. This suggests that while some improvements may have been made locally, systemic challenges in medication governance, training, and oversight remain across multiple services.

Risk Assessment and Care planning

A robust risk management process, alongside clear and accurate care planning, is essential to ensure that patients' care and treatment needs are identified, and that any associated risks are recognised and appropriately managed. Effective care planning not only supports patient safety but also promotes recovery by ensuring that interventions are tailored to individual needs.

HIW has a specific responsibility to monitor compliance with Part 2 of the Mental Health (Wales) Measure 2010, which requires that all individuals receiving secondary mental health services have a Care and Treatment Plan (CTP) in place. These plans should be comprehensive, holistic, and person-centred, reflecting the full range of a patient's needs, including their mental, physical, emotional, and social wellbeing.

A key element of this process is the role of the care coordinator, who is responsible for overseeing the development, implementation, and regular

review of the CTP. The care coordinator ensures that the plan is co-produced with the patient and relevant professionals, that it reflects current risks and goals, and that it is updated in response to any changes in the patient's condition or circumstances. The care coordinator also plays a vital role in ensuring continuity of care, facilitating communication between services, and supporting the patient's involvement in their own care planning.

This section summarises our findings on the quality and consistency of care planning and risk assessment across the services we inspected during 2024-2025.

Our inspections identified a range of issues relating to the quality, accuracy, and consistency of care planning and risk assessment across mental health services. While some services demonstrated elements of good practice, such as collaborative care planning and evidence of patient voice, a number of recurring concerns were noted.

In several settings, care plans and risk assessments lacked personalisation. We found examples where documentation was generic or identical across multiple patients, failing to reflect individual needs, goals, or current risk profiles. In some cases, observation care plans were not updated in line with reviews, and risk assessments focused heavily on historical behaviours without adequately describing current risks or appropriate interventions.

Errors in documentation were also identified. These included incorrect patient details, such as date of birth, and instances where entries were mistakenly recorded in the wrong patient's file. In a few cases, key plans, such as Positive Behaviour Support Plans or self-medication care plans, were missing altogether, despite clear evidence of need.

Access to psychological input was limited in a small number of services. Several wards had no dedicated psychologist, and in one case, the post had been vacant for an extended period. This raised concerns about the ability of teams to take a holistic, multidisciplinary approach to care planning and treatment decisions.

The quality of record keeping was variable. Some services had poor documentation standards, with missing discharge planning information, outdated care plans, or records that were difficult to navigate. In a few settings, care plans still contained outdated references to COVID-19, and updates following reviews were not consistently reflected in the documentation.

In community mental health teams, care and treatment plans did not always reflect a person-centred or empowering approach. Service users' views were not consistently recorded, and there were gaps in documenting capacity assessments, advocacy offers, and carer involvement. Delays in accessing psychiatry services and inconsistencies in recording the 'active offer' for Welsh language services were also noted.

Across both inpatient and community settings, there was a need for improved governance and oversight to ensure care plans are regularly reviewed, accurately reflect current needs and risks, and are developed collaboratively with patients and carers. Several services were advised to strengthen their documentation processes and ensure that care planning aligns with the requirements of the Mental Health (Wales) Measure 2010.

Environment of Care

A safe, clean, and therapeutic environment is essential to support the wellbeing, dignity, and recovery of patients in mental health settings. During our 2024-2025 inspections, environmental concerns were identified in a large number of the mental health services visited, affecting the quality of care and posing risks to patient safety. These issues were observed across both inpatient and community-based settings.

Environmental concerns were raised or noted in 16 mental health settings. Of these, 9 were NHS services and 7 were independent services. While the distribution appears relatively balanced, the findings for NHS settings were notably more significant. Specifically, two NHS settings required immediate improvement plans due to environmental issues, and one NHS inpatient setting had significantly declined since the last HIW inspection.

Common themes included poor maintenance, such as damaged flooring, broken handrails, worn furniture, and unclean or cluttered clinical areas. In several services, garden and outdoor spaces were unkempt or lacked sheltered areas, limiting their therapeutic value and accessibility during adverse weather. Some wards had limited or outdated furnishings, with damaged seating, missing fixtures, or inadequate storage for patient belongings.

Infection prevention and control (IPC) risks were frequently noted. These included damaged surfaces, poor cleaning standards, and inappropriate storage of clinical waste or equipment. In some cases, kitchen and food storage areas were unhygienic, with unlabelled or expired food items and malodorous fridges.

A number of services lacked dementia-friendly design features, which are essential for supporting orientation, independence, and wellbeing in patients with cognitive impairments.

In several settings, the physical environment was not conducive to therapeutic engagement. For example, sensory boards were mounted too high for patients to use effectively, and ward areas were sparsely decorated with no dementia-friendly signage, colour schemes, or visual cues. A King's Fund "Enhancing the Healing Environment" dementia-friendly environmental assessment had not been conducted on one ward, despite clear need.

Outdoor spaces also presented challenges. Several garden and courtyard areas were poorly maintained, with broken fixtures, trip hazards, and unwelcoming layouts that did not support safe or meaningful use. In some cases, broken handrails, damaged greenhouse panels, and cluttered pathways posed safety risks, particularly for patients with mobility or cognitive impairments. These findings highlight the importance of embedding dementia-inclusive design principles into both new developments and ongoing maintenance programmes to ensure environments are safe, accessible, and supportive of quality of life.

As stated above, in two NHS settings, the environmental concerns were serious enough to trigger the Immediate Improvement Process. One service was required to temporarily close a ward to address the issues identified during inspection. In another, an Immediate Improvement Plan was implemented to resolve concerns including damaged fixtures, cluttered clinical areas, and infection prevention risks.

These findings reflect a continued pattern observed in previous years. In 2023-2024, environmental concerns were identified in 17 out of 19 hospital inspections and one CMHT, with issues such as mould, poor ventilation,

lack of handrails, and insufficient private spaces for clinical consultations. There were also concerns about the effectiveness of estates processes in identifying and resolving maintenance issues. Similarly, in 2022-2023, widespread problems were reported, including broken furniture, stained carpets, inaccessible gardens, and faulty fixtures, with many wards requiring redecoration and refurbishment.

This three year trend suggests that while some local improvements have been made, systemic issues remain unresolved. There is a clear need for sustained investment in the physical condition of mental health facilities, alongside robust estates management and regular environmental audits. Ensuring that care environments are safe, welcoming, and fit for purpose remains a key priority for improving patient experience and supporting recovery.

Staff and Patient Safety

Ensuring the safety of both patients and staff is fundamental to the delivery of high-quality mental health care. During our 2024-2025 inspections, we identified a range of safety-related concerns across inpatient and community settings. These included issues with emergency preparedness such as damaged fire doors that did not open properly, posing a risk during evacuation and inconsistent access to emergency equipment like defibrillators. Additional concerns included incomplete ligature risk assessments, staffing practices that did not always align with patient care plans, and unsecured clinical areas that compromised the physical security of the environment.

A recurring theme was the inconsistent use of personal safety alarms by staff, with some wards lacking clear policies or reliable sign-in/out systems. In several settings, ligature risk assessments were either incomplete or not effectively implemented, and in some cases,

staff were unfamiliar with the location or use of ligature cutters. Environmental safety risks such as unlocked storage rooms containing hazardous items, broken fire doors, and unsecured clinical areas were also observed.

Staffing practices were another area of concern. In one service, staff were not always allocated in line with patient care plans, including gender-specific observation requirements. There were also examples of staff undertaking prolonged periods of enhanced observation without adequate breaks, and of handovers being disorganised or lacking critical risk

information. In isolated or under-resourced wards, staff reported limited access to support services, such as crisis teams or specialist clinical input, which impacted their ability to manage escalating behaviours safely.

In community settings, concerns included limited access to emergency equipment, such as defibrillators, and a lack of clarity around out-of-hours crisis support for service users. Some staff were unaware of the location of emergency resources, and signage or information for patients was often lacking.

Case Study: Independent Hospital

At one hospital, serious concerns regarding staff and patient safety led to the implementation of the Immediate Improvement Process. During the initial inspection, we found that staff handovers were disorganised, observation practices were inconsistent, and staff were not always familiar with the patients they were assigned to. There were instances where patients were allocated staff of the incorrect gender for enhanced observations, contrary to their care plans. Documentation was generic and not reflective of individual patient needs, and some staff were observed not engaging therapeutically with patients.

Additionally, staff were undertaking extended periods of enhanced observation without appropriate breaks, and there were discrepancies between handover information and written care documentation. These issues raised significant concerns about the ability of the service to manage risk effectively and maintain a safe environment.

A follow-up inspection later in the year found that the service had taken meaningful action. Improvements in organisation, documentation, and risk management were evident, and staff were better supported to make informed decisions in the best interests of patients.

These findings highlight the need for robust safety protocols, effective communication, and appropriate staffing models to ensure that both patients and staff are protected from avoidable harm. Services must also ensure that safety equipment is accessible, emergency procedures are well understood, and that environments are regularly assessed for potential risks.

Privacy and Dignity of Patients

Respecting and upholding the privacy and dignity of patients is a fundamental aspect of mental health care. During our 2024-2025 inspections, we identified a range of issues that impacted patients’ experiences, including the physical environment, access to information, and the quality of staff interactions.

In several settings, patients did not have access to secure storage in their bedrooms, and in some cases, they were unable to lock their rooms or lacked keys altogether. Ensuite facilities were not always available, and in some wards, shower screens or curtains were missing, compromising privacy during personal care.

Environmental design also affected dignity. Some wards lacked gender-specific areas, and in others, patient bedrooms were sparsely decorated and not personalised, which can impact a sense of ownership and comfort. In a few services, staff observation panels were routinely left open, and emergency call points were not installed in all bedrooms, raising concerns about both privacy and safety.

Access to advocacy and information was inconsistent. In several settings, advocacy posters were outdated or missing, and information about HIW and patient rights was not displayed, despite this being a requirement under the MHA Code of Practice for Wales. In some cases, feedback mechanisms were either absent or not functioning, with suggestion boxes lacking forms or communal meetings not taking place regularly.

Communication and engagement were also areas of concern. Some patients reported that while they were asked for feedback, they did not feel listened to or involved in decisions about their care. In two settings, staff were observed not responding to patients' requests or engaging with them in a meaningful or therapeutic way. In one of these settings, patients reported feeling unsettled when staff spoke in a language they did not understand during periods of enhanced observation.

Catering and Food Provision

Catering and food provision was another recurring theme. Patients in multiple settings raised concerns about portion sizes, food quality, and lack of variety. In some cases, meal plans were not followed, or kitchen staff prepared incorrect meals, which was particularly concerning in specialist settings. While some services had made improvements in response to previous feedback, others still required action.

While some of these findings overlap with those discussed in the Environment of Care and Staff and Patient Safety sections, they are presented here to highlight their specific impact on patients' dignity, autonomy, and overall experience of care.

Welsh Language

Cultural and linguistic needs were not always met. In several settings, there was no evidence of bilingual information, and Welsh-speaking staff or patients were not clearly identified, limiting accessibility and inclusivity.

Workforce

Workforce capacity and stability remain a significant challenge across mental health services in Wales. Our 2024-2025 inspections identified a range of concerns relating to staffing levels, skill mix, recruitment and retention, and access to professional support. These issues were evident across both inpatient and community settings.

A consistent theme was staffing shortages, particularly in relation to registered nurses, occupational therapists, and psychologists. In several services, key roles such as dedicated OTs or psychologists were vacant, with some posts having remained unfilled for extended periods. This limited the ability of teams to provide holistic, multidisciplinary care and placed additional pressure on nursing and support staff.

Many NHS settings reported a high reliance on bank and agency staff to fill vacant shifts. While this helped maintain minimum staffing levels, it often led to concerns about continuity of care, staff familiarity with patients, and the therapeutic quality of interactions. In some cases, agency staff were not appropriately skilled or trained for the specific needs of the ward, and staff reported that they were unable to request familiar agency workers due to booking system limitations.

Staffing numbers were frequently unmet, and in some services, staff described the current establishment as insufficient to meet the acuity and complexity of the patient group. This was particularly evident in wards with high observation demands or where patients required enhanced support. In one setting, only one registered nurse was on duty overnight, raising concerns about the ability to respond to emergencies or provide safe care.

Workplace morale and wellbeing were also affected. Staff in multiple settings reported feeling undervalued, unsupported, or under pressure. Some described tensions within teams, unclear roles and responsibilities, and a lack of regular team meetings or clinical supervision. In a few services, staff feedback indicated concerns about fairness, equality, and the handling of incidents or professional conduct issues.

In community mental health teams, recruitment challenges were noted across both health board and local authority roles. Staff described difficulties in communication and coordination between disciplines, and some reported experiencing bullying or a breakdown in team relationships. There were also concerns about the geographical spread of services and the impact this had on workload and service delivery.

These findings are consistent with those reported in previous years. In 2023-2024, HIW noted that workforce challenges were widespread, with staff shortages affecting a range of disciplines and impacting the delivery of safe and effective care. Similarly, in 2022-2023, concerns were raised about the adequacy of staffing establishments and the effect of workforce pressures on patient care and staff wellbeing.

Despite some local efforts to improve recruitment and staffing models, the persistence of these issues suggests that systemic workforce challenges remain unresolved. Addressing these will require coordinated action across health boards and providers, including workforce planning, investment in staff development and retention, and ensuring that staffing levels and skill mix are aligned with patient needs.

Governance and Leadership

Effective governance is essential to ensuring that mental health services are safe, well-led, and responsive to the needs of both patients and staff. During inspections carried out in 2024-2025, some services demonstrated strong local leadership and well-established governance systems. These included clear organisational structures, effective ward-level management, and staff who felt confident raising concerns. In certain settings, policies were current and audit processes were actively used to support safe care delivery. However, these strengths were not consistently observed across all services.

Recurring concerns were identified in relation to leadership visibility, policy management audit reliability, and risk oversight. In several settings, staff reported limited visibility and communication from senior management. Questionnaire responses from NHS services indicated that many staff felt disconnected from leadership and unsupported in their roles, which may impact morale and service delivery.

Policy management was a common issue, with outdated or overdue policies identified in multiple services. These included policies relating to safeguarding, restraint, equality and diversity, and infection prevention. For example, three settings were found to have policies past their review dates, raising questions about their relevance and effectiveness in guiding practice.

Audit and risk management processes were often inconsistent. In two NHS inpatient hospitals, environmental and infection prevention control audits did not reflect the conditions observed during inspection, undermining confidence in internal monitoring systems. Ligature risk assessments were incomplete in some settings, and estates reporting systems were either faulty or lacked governance oversight, resulting in delays in addressing maintenance issues.

Fragmented governance structures were noted in some independent providers, where individual wards operated in isolation rather than as part of a cohesive service. This led to inconsistencies in staffing, documentation, and decision-making. At another inpatient independent provider, confusion over shift planning meant registered nurses were responsible for multiple wards simultaneously, potentially compromising patient safety.

Information governance issues were also identified. In one independent setting, patient-identifiable information was stored inappropriately, and one NHS service reported delays in uploading paper records to electronic systems. These issues could affect continuity of care and data security.

In community settings, governance arrangements were generally less developed than in inpatient services. At one Community Mental Health Team, gaps were identified in medication governance, transport policies, and partnership working with other agencies, including GPs. These shortcomings suggest a need for more robust systems to support safe and effective care in community-based services.

These findings are consistent with those reported in previous years. In 2023-2024, HIW noted that governance arrangements were not always strong enough to identify and address risks effectively. Similarly, in 2022-2023, concerns were raised about the accuracy of audit data, the timeliness of policy reviews, and the ability of services to respond to emerging risks.

Overall, while some services demonstrated effective governance and leadership, the persistence of these issues across multiple settings highlights the need for greater consistency, stronger oversight, and improved communication between frontline staff and senior management. Ensuring that governance processes are reliable, transparent, and responsive remains a key priority for improving the quality and safety of mental health care in Wales.

Section 136 Suites

Section 136 of the MHA allows a police officer to remove a person from a public place to a designated place of safety if they appear to be experiencing a mental health crisis and require immediate care and control. These places of safety are typically Section 136 suites within NHS Hospitals designed to support safe and effective assessments.

During 2024-2025, HIW inspected an NHS hospital where a consultation room was being used as a temporary place of safety for individuals detained under Section 136. The room was not compliant with the physical standards set out by the Royal College of Psychiatrists for Section 136 assessment facilities. Concerns were raised about its location, layout, and safety features. Staff reported incidents where individuals had locked themselves inside the room, and one incident involved an attempted ligature in nearby public toilets.

Staff also described the challenges of managing Section 136 assessments alongside their routine ward responsibilities. HIW raised these concerns with senior management, who confirmed that responsibility for Section 136 assessments would transfer to the Crisis Resolution Home Treatment Team (CRHT) later in the year. A review was also underway to explore the feasibility of establishing a centralised Section 136 suite for the locality.

While this transition is a positive step, HIW was not assured that the current environment was fit for purpose. The health board was asked to:

- Provide an update on staffing arrangements and the outcome of the centralised suite review.
- Outline interim measures to meet the required standards and ensure the safety of individuals detained under Section 136.

In response, the health board confirmed that a capital bid had been approved for a centralised Section 136 suite within the region. However, due to wider estate pressures, the designated ward had to be relocated, delaying implementation. In the meantime, Section 136 assessments are being conducted within existing mental health suites across the health board.

The CRHT now coordinates all Section 136 assessments, ensuring continuity of care through a dedicated crisis team. This approach is consistent across the health board, and the CRHT Operational Policy is currently under review to align practices across all teams.

Findings specific to Learning Disabilities

During 2024-2025, Healthcare Inspectorate Wales (HIW) carried out inspections at two independent hospitals in Wales that provide care and treatment for individuals with learning disabilities and

associated mental health needs. Both inspections were broadly positive, with evidence of safe, effective, and compassionate care being delivered by dedicated staff teams.

Across both settings, staff demonstrated a strong understanding of individual patient needs and consistently provided person-centred care. Interactions between staff and patients were warm, respectful, and supportive, and most patients told us they felt safe and well cared for. Staff at all levels including clinical, administrative, and senior management were observed engaging with patients in a dignified and compassionate manner.

Activities such as walking, fishing, and arts and crafts were available and generally well attended, contributing to a therapeutic environment. However, at one hospital, some patients expressed a desire for more variety in walking routes, noting that they were becoming bored with the same paths being used repeatedly. This feedback highlights the importance of ensuring activities remain engaging and responsive to patient preferences.

Leadership was a notable strength in both hospitals. Hospital managers provided clear and passionate direction, supported by committed multidisciplinary teams. Staff spoke positively about the support they received from colleagues and senior leaders, and a strong team-working ethos was evident throughout both services.

MHA compliance was also a positive feature. At one hospital, all statutory detention documents reviewed were found to be fully compliant with the Mental Health Act and Code of Practice for Wales. Records were well organised and easy to navigate, and the Mental Health Act administrator operated an efficient and effective system to support legal monitoring and review. Patients had access to advocacy services, and advocates were reported to visit the hospital regularly.

In one setting, the use of the seclusion room was rare, reflecting a therapeutic approach to care and a commitment to minimising restrictive practices.

Despite these strengths, HIW identified several areas requiring improvement, which varied between the two settings. At one hospital, patients had access to outdoor garden areas, but there were no sheltered spaces to allow continued use during poor weather. A sensory room was available but appeared cluttered and underutilised, suggesting it was not fulfilling its intended therapeutic purpose. At the other hospital, the main staircase had a missing rail, chipped paint, and visible dust. Flooring in bedroom areas was worn and required updating, while communal areas such as the coffee lounge and patient toilets needed maintenance and repair.

Documentation and record-keeping also required attention. In one hospital, Positive Behavioural Support Plans were overly detailed and written in formal language, potentially limiting their accessibility. In the other, some medication files lacked patient information sheets, and it was unclear from records whether care coordinators and carers had been invited to ward rounds and Care and Treatment Plan (CTP) reviews. On the first night of one inspection, patient-identifiable information was found in a locked treatment room; this was immediately addressed by the hospital manager.

Policy management varied between the two settings. At one hospital, the consent policy was overdue for review, having been due in April 2023. At the other, most policies were up to date, although the recruitment and equality and diversity policies were due for renewal in 2024. Additionally, health promotion materials such as smoking cessation information were limited in one setting. Notice boards intended to share updates and feedback such as “You said, we did” displays were present in another setting, but some contained outdated information, reducing their usefulness and relevance.

On one of the inspections, patients and carers were invited to complete questionnaires to inform HIW about their experience of the service. However, no completed questionnaires were returned, limiting the availability of direct feedback from those using and supporting the service.

Overall, both hospitals demonstrated a strong commitment to delivering high-quality care for people with learning disabilities and mental health difficulties. While the inspections highlighted areas for improvement, these were balanced by clear evidence of compassionate care, effective leadership, and a positive therapeutic culture.

Findings specific to CAMHS

In 2024-2025, we inspected one inpatient unit in Wales providing specialist mental health services for children and adolescents. During our visit, we observed staff engaging with young people in a respectful, kind, and compassionate manner, delivering care that upheld their dignity and emotional wellbeing. The ward environment was calm and therapeutic, with ensuite bedrooms and access to communal and secure garden areas that supported comfort and recovery.

We were assured that the health board is broadly meeting its responsibilities under the MHA. The records we reviewed were compliant with the MHA and the Code of Practice for Wales, with clear documentation supporting decisions around care and detention. Staff demonstrated a strong understanding of MHA processes, and compliance with mandatory training was high. The MHA files were well-organised and contained detailed, relevant information.

Despite these positive findings, we identified a number of areas requiring improvement. An immediate improvement plan was triggered due to concerns around medication management. These included the unsafe storage of oxygen cylinders, expired emergency and patient

medication, and a lack of evidence that essential equipment such as ECG machines had been calibrated. Medication records were poorly maintained, with some documents torn or incomplete, and inconsistencies were noted in recording legal status and attaching identifying photographs. These issues posed a potential risk to patient safety in the event of an emergency. The health board responded promptly, and actions were initiated during the inspection.

Further concerns were identified in relation to the application of the MHA including documentation errors in a tribunal report and the absence of routine mental capacity assessments to support young people in making informed decisions about their care. While the ward environment was generally positive, some areas required attention, such as garden maintenance, the lack of privacy glass in communal areas, and the limited provision of multi-faith resources in the therapy room.

Staff training and awareness also presented challenges. There was confusion about who the infection prevention and control (IPC) lead was and staff reported not receiving training on the Duty of Candour. Compliance with Restrictive Physical Intervention (RPI) training was low, and not all staff carried personal safety alarms, with no policy in place to guide their use. Staff support meetings were held regularly but were not formally recorded, limiting oversight of discussions and actions.

Record keeping and care planning required significant improvement. CTPs were not always person-centred or aligned with the Mental Health (Wales) Measure 2010. Delays in receiving external CTPs and disorganised paper records made it difficult to navigate care documentation. Weekly audits were not consistently completed, and some medication records were damaged or incomplete.

Governance and oversight mechanisms also needed strengthening. The ward's medicines policy was outdated, and several health board policies were past their review dates. Estates issues, including anti-ligature risks, had not been addressed in a timely manner, and there was no clear process to track and resolve these concerns. Staff noted that the introduction of an electronic health record system would improve their ability to deliver care effectively.

Finally, there was no evidence of a structured programme of individualised therapeutic activities for young people, and feedback from families indicated that communication with staff could be improved.



6. Monitoring the Mental Health Act (1983)

HIW is responsible for monitoring how health boards and independent providers in Wales exercise their powers and duties under the MHA. This statutory function is carried out on behalf of Welsh Ministers and forms a core part of HIW's role in providing assurance about the quality, safety, and effectiveness of mental health services.

The MHA provides the legal framework for the detention, care, and treatment of individuals with mental health needs who may require protection for their own safety or the safety of others. It ensures that care is delivered lawfully, proportionately, and with respect for patients' rights. People may access services voluntarily as informal patients or be detained under the Act, which includes specific legal safeguards.

HIW's monitoring work focuses on ensuring that individuals subject to the Act are treated with dignity and that care is delivered in a way that promotes recovery and legal compliance. This includes reviewing documentation, engaging with staff and patients, and assessing whether the systems and environments in place support safe and effective care.

How the Mental Health Act is Monitored

HIW is one of several bodies with responsibilities under the MHA, alongside health boards, social services, independent hospitals, Welsh Ministers, the courts, police, advocates, and relatives of detained individuals.

Our monitoring includes:

- On-site inspections to assess how providers apply their powers and responsibilities under the Act.
- Reviewing detention documentation to ensure individuals are lawfully detained.

- Speaking with patients and staff, observing care practices, and consulting with MHA administrators to understand how the Act is managed within healthcare settings.
- Operating the SOAD service, which provides independent medical opinions in specific cases.
- Reviewing complaints related to the MHA and, where necessary, conducting our own investigations if we are not satisfied with the provider's response.

This section of the report outlines how the MHA is being implemented across Wales and how the powers granted under the Act are being exercised and overseen.

Mental Health Act Reviewers

MHA Reviewers play a vital role in HIW's inspection team by evaluating how the MHA is applied across services. Their work focuses on ensuring that individuals detained under the Act are treated lawfully and that their rights are upheld throughout their care. Reviewers assess whether patients are informed of their rights at the point of detention and whether this continues throughout their stay. They examine the use of Section 17 leave, considering whether it is appropriately documented, risk-assessed, and reflective of the patient's preferences and safety needs.

In addition to reviewing documentation, Reviewers explore whether patients have access to legal representation and advocacy services, and whether they are aware of their right to apply to the Mental Health Review Tribunal for Wales. They also consider whether hospital managers are fulfilling their duty to refer cases to the Tribunal when required. Through interviews, observations, and detailed scrutiny of records, MHA Reviewers help ensure that the legal safeguards designed to protect detained individuals are being properly implemented and monitored.

Our Findings

Our inspections found that most services demonstrated a strong commitment to legal compliance and the delivery of person-centred care under the Mental Health Act. Across a wide range of settings, we observed numerous examples of good practice:

- Care plans were detailed and reflected active patient involvement.
- Statutory detention documentation was consistently compliant with the Act and Code of Practice.
- MHA records were well organised, securely stored, and easy to navigate.
- Patients' rights were regularly explained and documented, with access to advocacy services routinely available.
- MHA administrators ran efficient and effective systems to support the implementation, monitoring, and review of legal requirements.
- Capacity assessments had improved since previous inspections and were clearly documented.
- In one instance, the absence of the Code of Practice on a ward was addressed during the inspection, with copies made available immediately.
- Training and audit activity were evident in some services, with administrators delivering ward-based sessions and participating in national forums to share good practice.

These findings reflect a strong foundation of legal compliance and a clear focus on upholding the rights and dignity of individuals subject to the Mental Health Act.

Despite these positive findings, our inspections also identified recurring issues across both NHS and independent services:

1. Section 17 Leave

- Leave authorisation forms were not consistently shared with patients or family members.
- Risk assessments were not always included in Section 17 documentation.
- Some forms were incomplete, undated, or missing signatures.
- Outdated versions of forms were still in use.
- Leave forms were not always marked correctly as "no longer valid" in line with the Code of Practice.

2. Consent to Treatment and Capacity

- Delays in referring patients for SOAD reviews under Section 62.
- Lack of formal assessments documenting patients' capacity to consent to medication.
- CO₂ forms were not reviewed in a timely manner, with some not updated since 2021.
- No clear policy guidance on the timeliness of CO₂ form reviews.
- Inconsistent recording of rationale by statutory consultees following SOAD consultations.

3. Documentation and Record Keeping

- Legal status was not consistently recorded on Medication Administration Records (MAR charts).
- Expired or duplicated statutory documents were retained in MHA files.
- MHA records lacked clear organisation, with missing or outdated information.
- Patient ethnicity was not consistently recorded.
- Photographs were not stored alongside MHA records in some settings.

4. Patient Rights and Advocacy

- Patients were not always reliably informed of their rights, and this was not consistently documented.
- Informal patients were not always made aware of their right to leave the ward.
- Advocacy services were not consistently offered or recorded, and some patients were unaware of their availability.
- No hard copies of the MHA Code of Practice were available on some wards.

5. Governance and Oversight

- Lack of administrative support for MHA functions in some community teams.
- Delays in reviewing Section 117 aftercare arrangements.
- Managers' hearings were not taking place regularly in some settings.
- MHA administrators lacked time and resources to deliver training or conduct quality audits.
- These findings highlight the need for strengthened governance, consistent documentation practices, and improved training to ensure that the rights of individuals subject to the MHA are upheld across all services.



7. Review Service for Mental Health

Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the MHA, and the administration of the SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH team also review any deaths of detained patients that occur within the NHS, and under section 61 of the MHA, we undertake a review of treatments that are administered without the patient's consent or under special legal provisions. The RSMH can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The SOAD service helps to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

Our methodology is set out in detail in our guidance to all SOADs and provided to all MHA Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

The SOAD service operates as a Hybrid service. The primary focus of the Service remains "in person first", which is to say that best practice and every effort is made to ensure SOAD visits should occur in person for the purposes of interviewing the patient for all cases except for Community Treatment Order (CTO cases), where we have opted for a remote first methodology. All patients are to be consulted by their clinical team prior to the submission of requests if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right in all cases to specifically request an onsite visit from a SOAD.

Current figures for remote vs onsite assessments in 2024-2025 show an approximate 50/50 split across all case categories. In response, we reviewed the fee structure and reimbursement levels for SOADs, introducing a targeted uplift specifically for the most vulnerable patients in ECT cases where a SOAD agrees to conduct an in-person visit.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their certificate of consent CO forms.

We continue to refresh our suite of guidance toolkits on all matters relating to the RSMH services, including the SOAD service. We have completed a draft of the SOAD Handbook guidance, which compiles various complex guidance into one easy to read document and are consulting on this publication with external stakeholders at our next annual MHA Administrator and SOAD training days, to be held in September and November of 2025 respectively.

Full advice on our methodology is available on our [website](#).

SOAD Recruitment

The 2024-25 recruitment campaign for the newly created Deputy Lead SOAD, designed to increase resilience and robustness in the service, aims to have the post filled by mid-summer 2025.

A new SOAD recruitment campaign was launched in 2024 with the aim of increasing the numbers of SOADs and bringing further resilience and robustness to the service in preparation for the forthcoming implications of the reform of the MHA, which may see a significant increase in demand for the service. This campaign will run until the summer of 2025.

SOAD activity

During the period 1 April 2024 to 31 March 2025, the RSMH received 782 requests for a visit by a SOAD. This figure is an increase from the 1 April 2023 to 31 March 2024 requests.

These figures can be broken down as follows:

- 695 requests related to the certification of medication
- 64 requests related to the certification of ECT
- 23 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

Requests for visits by a SOAD, 2006-07 to 2024-25

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694
2023-24	665	44	24	733
2024-25	695	64	23	782

Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Three key performance indicators, with precise timescales, are in operation to ensure the assessment is completed as soon as possible, and within:

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

There are a number of reasons why, on occasions, we do not meet the above timescales including, the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. However, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations has continued to support the improved timeliness of the assessment process. Sometimes delays may also occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient’s condition must be provided by the responsible clinician in charge of the patient’s treatment and given to HIW. The designated form is provided to the MHA administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the ninth consecutive

year HIW has undertaken an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales monthly. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the MHA. This process is designed to add an additional layer of patient safety to those being treated under the Act and complies with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There were 198 Section 61 cases reviewed in 2024-25 by our Lead SOAD, Dr Balarao Oruganti. A breakdown is provided below of issues and outcomes which have all subsequently been rectified.

Section 61 Review Year 2024-2025	Total
Cases reviewed:	198
Outcomes:	
No further action was required	183
New SOAD requested	6
Medication Issues	6
Capacity and Consent Issues	1
Certificate Duration Issues	1
Certificate Validity Issues	0
Miscellaneous Issues	1

Appendix A

Hospital	NHS Healthboard/ Independent	Date	Type
St Barruc's Ward, Barry Community Hospital	Cardiff and Vale University Healthboard	3-5 June 2024	Inspection
Hafan Y Coed, Llandough Hospital	Cardiff and Vale University Healthboard	1-7 July 2024	Inspection
Morlais Ward, Glangwili Hospital	Hywel Dda University Healthboard	1-3 July 2024	Inspection
Bryngolau Ward, Prince Philip Hospital	Hywel Dda University Healthboard	2-4 September 2024	Inspection
Suite 2, Tonna Hospital	Swansea Bay University Healthboard	30 September – 2 October 2024	Inspection
Newton Community Mental Health Team	Powys Teaching Healthboard	1-2 October 2024	Inspection
Carn Y Cefn Ward, Ysbyty Aneurin Bevan	Aneurin Bevan University Healthboard	15-17 October 2024	Inspection
Hydref and Gwanwyn Wards, Heddfan Psychiatric Unit	Betsi Cadwaladr University Healthboard	21-23 October 2024	Inspection
Ward 14 and PICU, Coity Clinic, Princess of Wales Hospital	Cwm Taf Morgannwg University Healthboard	13-15 November 2024	Inspection
Kestrel Ward, Abergele Hospital	Betsi Cadwaladr University Healthboard	13-15 January 2025	Inspection
Carreg Fawr Unit, Bryn Y Neuadd Hospital	Betsi Cadwaladr University Healthboard	21-23 January 2025	Inspection
Ward 7, Ysbyty Cwm Cynon	Cwm Taf Morgannwg University Healthboard	27-29 January 2025	Inspection
Clywedog Ward, Llandrindod Wells War Memorial Hospital	Powys Teaching Healthboard	10-12 February 2025	Inspection

Hospital	NHS Healthboard/ Independent	Date	Type
Hamadryad Community Mental Health Team	Cardiff and Vale University Healthboard	26-27 March 2025	Inspection
Meadow Ward, Ty Glyn Ebwy Hospital	Independent	15-17 April 2024	Inspection
All Wards, Llanarth Court Hospital	Independent	13-15 May 2024	Inspection
All Wards, Heatherwood Court Hospital	Independent	12-13 June 2024	Inspection
All Wards Heatherwood Court Hospital	Independent	23-24 September 2024	Inspection
Bryntirion and Dderwen Ward, Cefn Carnau Hospital	Independent	9-11 September 2024	Inspection
Delfryn House and Lodge	Independent	7-9 October 2024	Inspection
Juniper, Larch and Cedar, Pinetree Court Hospital	Independent	21-23 October 2024	Inspection
St Peters Hospital	Independent	18-20 November 2024	Inspection
Rushcliffe Independent Hospital	Independent	6-8 January 2025	Inspection
Aderyn Hospital	Independent	10-12 March 2025	Inspection
Bevan and Taliesin Ward, Abergeeg Hospital	Independent	31 March – 2 April 2025	Inspection

Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one’s own views, feelings and ideas. See also independent mental health advocate.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers.
CAMHS	Children and Adolescents Mental Health Service. A range of NHS services that assess and treat children and young people with emotional, behavioural, or mental health difficulties.
CO2 Form	Certificate of consent to treatment.
CO3 Form	Certificate of second opinion.
Community Mental Health Team	(CMHT) Teams of mental health professionals who support people with mental health needs in the community.
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment.

Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person’s freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained Patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention/Detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as “sectioning” or “sectioned”.
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Governance	The systems, processes, and practices through which an organization is directed, controlled, and held accountable. It ensures transparency, ethical conduct, and effective decision-making to achieve strategic objectives.

Hospital Managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers’ decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient.
Learning Disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time.
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.
Mental Health Act 1983 (amended 2007)	A law in England and Wales that allows people with serious mental health conditions to be detained, assessed, and treated in hospital or the community, sometimes without their consent, to protect their health or safety or that of others.
Mental Health Code of Practice for Wales (2016)	A statutory guidance document that supports professionals in applying the Mental Health Act 1983 in Wales. It sets out how legal duties should be carried out to ensure safe, lawful, and respectful care for individuals with mental health needs.
Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.

Medical Treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.
Medical Treatment for mental disorder	Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental Illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term ‘patient’ should be used in practice in preference to other terms such as ‘service user’, ‘client’ or similar. It is simply a reflection of the terminology used in the Act itself.
Prescribed Body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	(PIDA) The Public Interest Disclosure Act 1998 provides protection to “workers” making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.

Regulations	Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.
Responsible Clinician	The approved clinician with overall responsibility for the patient’s case.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient’s consent.
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually.
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control.
Section 17 Leave (Leave of Absence)	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as ‘Section 17 leave’.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient’s medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts: Part 1 – Primary mental health support services. Part 2 – Co-ordination of and care planning for secondary mental health service users. Part 3 – Assessment of former users of secondary mental health services. Part 4 – Mental health advocacy.

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

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