Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health, Learning Disability Services and Mental Health Act Monitoring

Annual Report 2025-2026



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

About us

We are the independent regulator of healthcare and the inspectorate for NHS services in Wales. Our role is to check that healthcare is safe, effective, and meets the needs of people and communities.

Our purpose

We check the safety and quality of healthcare across Wales.

Our priorities

We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

We will collaborate with partners to share learning and drive lasting improvements.

We will ensure our people feel supported, valued, and empowered.

We will take action to improve the quality and safety of healthcare for the future of Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our values

Our values shape our work every day and ensure people remain at the heart of everything 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.

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1. Executive Summary

This report presents the findings from Healthcare Inspectorate Wales (HIW) monitoring, inspection and assurance activity relating to mental health and learning disability services in Wales between 1 April 2025 and 31 March 2026. During the reporting period, HIW undertook 31 onsite inspections across NHS and independent healthcare settings, including inpatient mental health services, learning disability services, community mental health teams, community learning disability teams and specialist services. This represents an increase from the previous reporting period, during which 25 onsite inspections were undertaken. HIW also continued to deliver its statutory responsibilities for monitoring the operation of the Mental Health Act 1983 (MHA), delivering the Second Opinion Appointed Doctor (SOAD) service, overseeing the Review Service for Mental Health (RSMH), and reviewing concerns and notifications received about services.

Across the 31 inspections undertaken during the reporting period, HIW made 477 recommendations for improvement, with 332 of these relating to NHS services and 145 within independent services. In response to identified risks, 10 inspections resulted in escalation through our service of concern process, seven of which related to NHS services and three which related to independent healthcare services. This reflects HIW's continued focus on supporting improvement and ensuring timely action where concerns relating to the quality and safety of care are identified.

Mental health and learning disability services continued to operate within a challenging environment, with services experiencing ongoing pressures relating to workforce capacity, increasing demand, environmental quality and access to care. Despite these challenges, HIW observed many examples of compassionate, person-centred care delivered by committed and skilled staff across Wales. Patients frequently described positive experiences of care and support, and inspections identified examples of effective multidisciplinary working, therapeutic engagement and positive ward-level leadership.

Key themes identified during 2025-2026:

- Compassionate, person-centred care continues to be delivered across many services.
- Workforce pressures remain a significant challenge across inpatient and community services.
- Environmental and estates issues continue to impact patient experience, safety and dignity.
- Access to services, continuity of care and discharge arrangements are a recurring concern.
- Effective multidisciplinary working and partnership approaches were evident across a number of services.
- Governance arrangements were often established but did not always result in timely action or sustained improvement.
- MHA safeguards were generally well implemented, although recurring issues relating to documentation, consent to treatment and patient understanding of their rights remained evident.

Concerns received by HIW highlighted recurring issues relating to access to services, continuity of care, discharge planning, MHA safeguards, patient safety, care planning, environmental quality and workforce pressures.

During the reporting period, HIW received 1,063 statutory notifications from independent mental health and learning disability services, compared with 1,032 during the previous year. Serious injury remained the most frequently reported notification type, whilst increases were also observed in notifications relating to deprivation of liberty. Notifications relating to patient deaths, unauthorised absences, allegations of staff misconduct and infectious disease outbreaks decreased compared with the previous reporting period.

HIW's monitoring of the MHA found that legal safeguards were generally being implemented appropriately. Positive findings included effective administration processes, access to advocacy services and examples of robust governance arrangements. However, recurring issues were identified in relation to consent to treatment documentation, statutory record keeping, staff understanding of legal processes and ensuring patients were supported to understand and exercise their rights.

During the latter part of the reporting period, the Welsh Government published its Mental Health and Wellbeing Strategy 2025-2035, setting out a long-term framework for improving mental health and wellbeing in Wales.
The reporting period also saw HIW continue to embed its revised NHS Wales Engagement Process and introduce guidance on the use of Closed-Circuit Television (CCTV) in regulated mental health and learning disability settings.
These developments support HIW's continuing commitment to intelligence-led regulation and providing independent assurance regarding the quality and safety of services across Wales.

Overall, the findings in this report demonstrate that many services continue to provide caring and compassionate support to people across Wales. However, workforce pressures, significant concerns regarding the suitability of some healthcare environments, access to services and ongoing governance issues continue to affect the consistency of service delivery. Addressing these challenges will be essential to ensuring that people receiving mental health and learning disability care have timely access to safe, effective and person-centred services. HIW will continue to use intelligence from inspections, MHA monitoring, concerns, notifications and engagement activity to support improvement and provide assurance to the public, Welsh Ministers and the Senedd.



2. Context

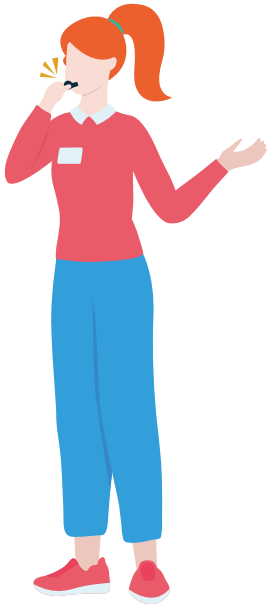
Mental health and learning disability services across Wales continued to operate within a challenging and evolving healthcare environment during 2025-2026. Services faced ongoing pressures relating to workforce capacity, increasing demand, service sustainability and the complexity of patient need. These pressures were experienced across both inpatient and community settings and continued to influence the delivery of care, access to services and patient experience.

At the same time, health boards, NHS trusts and independent providers continued to work towards improving the quality, safety and effectiveness of services. Throughout the reporting period, HIW observed examples of compassionate and person-centred care, alongside efforts to strengthen governance, improve multidisciplinary working and enhance patient involvement in care and treatment decisions. However, challenges relating to workforce availability, environmental quality, access to services and organisational responsiveness remained evident across a number of settings.

The wider policy landscape also evolved during the year. During the latter part of the reporting period, the Welsh Government published its *new Mental Health and Wellbeing Strategy 2025-2035*, replacing *Together for Mental Health* and setting out a long-term vision for improving mental health and wellbeing in Wales. While delivery of the strategy sits outside HIW's remit, its focus on prevention, early intervention, person-centred care and improved outcomes provides important context for the future development of mental health and learning disability services across Wales. HIW will continue to consider the changing policy landscape when planning its inspection, monitoring and assurance activity.

During 2025-2026, HIW continued to develop its intelligence-led approach to assurance and oversight, strengthening engagement with healthcare organisations and promoting consistent regulatory expectations across services. These developments reflect HIW's ongoing commitment to providing independent assurance about the quality, safety and effectiveness of care, while ensuring that the rights, dignity and wellbeing of individuals remain central to service delivery.

The findings presented within this report reflect evidence gathered through inspections, MHA monitoring activity, concerns and notifications received by HIW, engagement with healthcare organisations, and other sources of regulatory intelligence between 1 April 2025 and 31 March 2026. Together, these provide a picture of the opportunities, achievements and challenges facing mental health and learning disability services in Wales during the reporting period.



3. Our Role in Mental Health and Learning Disability Care

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. In relation to mental health and learning disability services, our role is to provide independent assurance to the Welsh Ministers, the Senedd and the public about the quality, safety and effectiveness of care delivered across both NHS and independent settings.

HIW undertakes inspection, regulation and monitoring activity in accordance with its statutory responsibilities. This includes inspecting NHS mental health and learning disability services, regulating and inspecting independent mental health and learning disability healthcare providers, and taking proportionate action where required to support improvement and address risks to patient safety.

A core element of HIW's role is the statutory monitoring of the MHA on behalf of the Welsh Ministers. This function is integral to our inspection programme and is carried out alongside our wider inspection and assurance activity. Through this work, HIW seeks assurance that individuals subject to the MHA are treated lawfully, proportionately and with dignity, and that the safeguards set out in legislation and statutory guidance are effectively applied in practice.

HIW also has responsibility for delivering the Second Opinion Appointed Doctor (SOAD) service in Wales, and for the oversight of the Review Service for Mental Health (RSMH). These functions provide additional legal safeguards for individuals whose rights are restricted under the MHA. In addition, HIW monitors compliance with Parts 2 and 4 of the Mental Health (Wales) Measure 2010, including the quality of care and treatment planning and access to independent mental health advocacy.

Our role also includes oversight of the use of the Deprivation of Liberty Safeguards (DoLS), undertaken jointly with Care Inspectorate Wales (CIW), and contributing to the UK National Preventive Mechanism in respect of places where individuals may be deprived of their liberty under mental health legislation.

During the reporting period, HIW continued to exercise its responsibilities through a combination of onsite inspections, focused review activity, monitoring of concerns and statutory notifications, and engagement with health boards, NHS trusts and independent providers. This approach enables HIW to triangulate intelligence from multiple sources, supporting a proportionate and risk based assurance programme.

The findings set out in this report reflect how mental health and learning disability services discharged their responsibilities within the legislative and regulatory framework in place during the reporting period. Further detail on our inspection activity, monitoring of the Mental Health Act, and operation of the SOAD and RSMH services is provided in the relevant sections of this report.

NHS Engagement Process: strengthening engagement, assurance and transparency

During the 2025-2026 reporting period, HIW continued to embed its new NHS Wales Engagement Process, designed to strengthen how we work with NHS organisations across Wales. The new model reflects a move away from a predominantly relationship manager approach towards a more structured, team based engagement framework, supporting clearer oversight, more consistent intelligence sharing, and earlier identification of risk.

Under this approach, HIW's clinical teams, including those responsible for mental health and learning disability services, now engage routinely with senior clinical and operational leads within each health board. These meetings are intelligence led and focus on understanding emerging risks, pressures within services, and areas requiring regulatory attention. They provide a structured forum for discussion ahead of, alongside, and following inspection activity, supporting a more proactive and coordinated assurance approach.

As part of this model, HIW's mental health and learning disability clinical team has also extended engagement to include Public Health Wales and the Welsh Ambulance Services University NHS Trust (WAST). This broader system engagement recognises the interdependencies between mental health services, population level intelligence, urgent and emergency care pathways, and crisis response arrangements. Involving these partners has strengthened HIW's understanding of how pressures elsewhere in the system may impact mental health and learning disability services, including access to crisis care, patient flow, and inter agency working.

The revised engagement process has supported clearer and more transparent communication between HIW and NHS organisations. Expectations around information sharing, governance arrangements and accountability are set out more explicitly, helping to ensure that intelligence is shared in a timely and consistent way. This has improved HIW's ability to triangulate information from multiple sources, including inspection findings, concerns, statutory notifications and engagement discussions, to inform regulatory decision making.

Importantly, the engagement process is not a substitute for inspection or regulatory action. Instead, it complements HIW's inspection programme by supporting ongoing dialogue, promoting openness, and enabling earlier conversations where risks are emerging. Through this approach, HIW aims to support continuous learning and improvement while maintaining its independent role in providing assurance about the quality and safety of mental health and learning disability services in Wales.

HIW guidance on the use of CCTV in regulated mental health and learning disability settings

During the year, HIW introduced a **Policy Statement on the use of Closed-Circuit Television (CCTV) in regulated mental health and learning disability settings**. This guidance sets out HIW's expectations for providers considering or using CCTV, recognising the sensitive balance between patient safety, privacy, dignity and legal rights.

The use of CCTV within mental health and learning disability services has been a longstanding area of debate. While CCTV may offer benefits in supporting incident review, safeguarding processes and accountability, it also presents significant ethical, legal and therapeutic considerations. The policy statement clarifies that CCTV should never be viewed as a replacement for appropriate staffing levels, effective leadership, or good quality care and supervision.

HIW's guidance emphasises that any decision to install or use CCTV must be clearly justified, proportionate and supported by robust governance arrangements. Providers are expected to demonstrate that less intrusive measures have been considered and that CCTV is only used where it is necessary to achieve a specific

and legitimate aim, such as enhancing safety or supporting learning following incidents. The guidance also highlights the importance of complying with relevant legislation, including data protection requirements, and ensuring that patients' rights are respected at all times.

A central principle of the policy is the need to consider the individual impact on patients. HIW recognises that constant surveillance may be distressing for some individuals, particularly those experiencing paranoia, trauma or heightened anxiety. Providers are therefore expected to undertake patient specific risk assessments and to give careful consideration to issues of consent, capacity and best interests where CCTV is proposed or in use.

The introduction of this guidance provides greater clarity and consistency for providers and supports a transparent regulatory position for HIW. Through inspections and ongoing engagement, HIW will consider how providers have applied the guidance in practice, including the quality of decision making, governance oversight and the extent to which patient dignity and therapeutic relationships are protected. This approach aims to ensure that where CCTV is used, it is done lawfully, ethically and in a way that supports safe, person centred care.



4. UK National Preventative Mechanism

Following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003, the UK's National Preventative Mechanism (NPM) was established in March 2009. HIW is one of 21 designated members and 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.

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.

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 holds an annual conference each year and this year the conference, held in Edinburgh, Scotland on the 30 April and 1 May, was attended by representatives of designated bodies of the NPM and a range of guest speakers. HIW continues to have a membership on the steering committee.



5. Listening to Concerns

Listening to and acting on concerns raised by patients, carers, family members, staff and members of the public remains an important component of HIW's approach to monitoring, regulation and assurance. Concerns provide valuable insight into how services are experienced and contribute to HIW's wider intelligence picture. Alongside inspection findings, engagement activity, whistleblowing disclosures and statutory notifications, concerns support the identification of emerging risks, recurring issues and areas which may require further scrutiny.

In previous reports, HIW presented concerns primarily by subject category. For the 2025-2026 reporting period, HIW adopted a more thematic approach to analysing concerns. Whilst concerns continue to be categorised for monitoring purposes, the analysis within this report focuses on identifying recurring themes, emerging risks and service-level issues. This approach enables concerns to be considered alongside other intelligence sources, providing a broader understanding of issues affecting mental health and learning disability services across Wales. Subsequent sections of this report outline how a number of these themes were also identified through HIW's inspection and assurance activity during the reporting period.

All concerns received by HIW are reviewed and contribute to our wider intelligence and assurance activity. This includes concerns relating to individual experiences of care, clinical decision-making and treatment. Some concerns received during the reporting period primarily related to individual disagreements regarding diagnoses, assessments undertaken under the Mental Health Act, detention decisions, or treatment recommendations.

The concerns received during 2025-2026 highlighted a number of recurring issues relating to the delivery of mental health and learning disability services across Wales. The most prominent themes related to access to services, continuity of care, discharge planning, application of MHA safeguards, environmental conditions within inpatient settings, workforce pressures, governance arrangements and patient safety. Subsequent sections of this report outline how many of these themes were also identified through HIW's inspection and assurance activity during the reporting period.

Access to Services and Continuity of Care

HIW received a number of concerns relating to access to mental health services and continuity of support. Concerns included access to community mental health services, crisis support arrangements, delays in specialist assessments, inpatient bed availability, discharge planning and follow-up care.

Concerns were also received regarding support available following discharge from inpatient services, including access to ongoing community support and Section 117 aftercare arrangements. These issues are explored further within later sections of this report relating to inspection and assurance findings.

Mental Health Act Safeguards

The application of MHA safeguards continued to feature within concerns raised to HIW. Concerns related to patients' understanding of their legal status, access to information regarding detention, entitlement to advocacy and arrangements supporting Section 117 aftercare.

Concerns were also received regarding processes associated with detention, review, and discharge under the Mental Health Act. These issues formed part of HIW's wider intelligence picture and informed ongoing monitoring activity during the reporting period.

Patient Safety and Risk Management

HIW received concerns relating to the management of risk, particularly where individuals were experiencing deterioration in their mental health or where concerns had been raised regarding discharge, crisis response arrangements or ongoing support.

A number of concerns related to the management of self-harm and suicide risk, communication of risk information and arrangements for supporting individuals requiring intensive care and treatment. These concerns contributed to HIW's ongoing assessment of patient safety within mental health services.

Care Planning and Communication

Concerns received by HIW highlighted issues relating to care planning, communication and involvement in care decisions. Themes included communication between services, communication with family members and carers, access to information regarding care and treatment, and the coordination of ongoing support.

HIW also received concerns regarding care planning arrangements, including concerns about the availability of care plans, involvement in care planning processes and coordination between different services involved in an individual's care.

Environment of Care

Environmental concerns remained a recurring theme during the reporting period. Concerns raised with HIW included the cleanliness and maintenance of inpatient environments, heating and ventilation, hygiene arrangements, laundry facilities and the condition of ward environments.

These concerns formed an important part of HIW's intelligence regarding patient experience, dignity and the suitability of care environments.

Workforce and Governance

HIW received a number of whistleblowing disclosures and concerns relating to staffing levels, workforce capacity, leadership and governance arrangements. These concerns included the impact of staffing pressures on service delivery, access to specialist professionals, organisational oversight and the management of risks within services.

Workforce and governance matters remained an important source of intelligence for HIW and informed engagement, monitoring and assurance activity throughout the year.



Conclusion

Whilst the approach to analysing concerns has evolved during 2025-2026, many of the themes identified remain consistent with those highlighted in previous years. Concerns relating to access to services, MHA safeguards, continuity of care, discharge arrangements, care environments, workforce pressures and governance continue to inform HIW's understanding of the challenges facing mental health and learning disability services across Wales.

During this reporting period, recurring concerns relating to crisis support arrangements, continuity of care following discharge, Section 117 aftercare and environmental conditions within inpatient settings formed a notable part of the intelligence received by HIW. Collectively, these concerns provided valuable insight into the experiences of people using services and contributed to HIW's intelligence-led approach to monitoring, inspection and assurance.

Alongside concerns and whistleblowing disclosures, HIW also receives statutory notifications from independent healthcare providers. These notifications provide a further source of regulatory intelligence and support the identification of emerging risks, patient safety issues and trends within services. The following section outlines the notifications received during the reporting period and the insight these provide into the operation of independent mental health and learning disability services.



6. Regulation 30 and 31 Notifications

Independent mental health and learning disability providers are legally required to notify HIW of certain incidents under Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011. These notifications provide an important source of intelligence regarding patient safety, provider governance and the operation of services.

The table below presents the number of Regulation 30 and 31 notifications received by HIW between 1 April 2025 and 31 March 2026. Registered persons of independent hospitals, clinics and medical agencies are legally required to notify HIW of specified incidents relating to patient safety. These notifications support transparency, accountability and regulatory oversight and are reviewed alongside concerns, whistleblowing disclosures, inspection findings and other intelligence sources to identify emerging risks and inform regulatory activity.

For the 2025-2026 reporting period, HIW received a total of 1,063 notifications from independent mental health and learning disability services, compared with 1,032 notifications in 2024-2025. Whilst the overall number of notifications remained broadly similar, there were notable changes within individual notification categories. Serious injury remained the most reported notification type and accounted for the majority of notifications received. Notifications relating to serious injury and deprivation of liberty increased during the year, whilst notifications relating to unauthorised absence, allegations of staff misconduct, outbreaks of infectious disease and deaths of patients decreased.

HIW considers that the increase in deprivation of liberty notifications may, in part, reflect greater awareness of regulatory notification requirements and more consistent reporting by providers following ongoing engagement with services. The intelligence obtained through these notifications contributes to HIW's understanding of patient safety risks and informs inspection, monitoring and engagement activity across independent mental health and learning disability services.

Notification Type	2024-2025	2025-2026
Death of a Patient	11	5
Unauthorised Absence	131	114
Serious Injury	649	704
Outbreak of an Infectious Disease	14	4
Allegations of Staff Misconduct	186	163
Deprivation of Liberty	41	73
Total	**1,032**	**1,063**

7. Key Findings from Inspection and Assurance Activity

This section brings together the key themes identified from inspection and assurance activity undertaken between 1 April 2025 and 31 March 2026.

During the reporting period, HIW undertook 31 onsite inspections across NHS and independent mental health and learning disability services in Wales, compared with 25 inspections during the previous reporting period. Of the 31 inspections undertaken in 2025-2026, 19 were in NHS settings and 12 were in independent healthcare settings.

The inspection programme also included three announced Community Mental Health teams (CMHT) inspections and three announced Community Learning Disability Teams (CLDT) inspections undertaken jointly with Care Inspectorate Wales (CIW), alongside inspections of learning disability inpatient services, child and adolescent mental health services (CAMHS), and other specialist settings. These inspections were carried out alongside HIW's wider programme of MHA monitoring, review activity and intelligence-led assurance work.

The findings presented in this section reflect evidence gathered through onsite inspections, engagement with patients and staff, review of care documentation, and wider assurance activity. They highlight both areas of effective practice and aspects of care where improvement is required, providing an overview of the quality, safety and delivery of mental health and learning disability services across Wales.

The findings are grouped into the following areas:

- Older persons and adult mental health services across NHS and independent settings
- Learning disability services
- Community mental health teams (CMHTs)
- Community learning disability teams (CLDTs)
- Child and adolescent mental health services (CAMHS)
- Eating disorder services.

Findings from Older Persons and Adult Mental Health Services NHS and Independent

Across the settings inspected, we observed many examples of compassionate, respectful and person-centred care. Patients frequently described staff as kind, supportive and responsive, and staff were often seen to demonstrate a good understanding of individual needs. In several settings, patients reported feeling safe and able to approach staff when they needed support. There was also evidence of strong multidisciplinary working, with care supported by regular reviews, coordinated discharge planning and involvement from a range of professionals.

In a number of services, care was supported by established governance arrangements, effective incident reporting systems and positive ward-level leadership. Patients also benefited from access to therapeutic activities, physical healthcare support and opportunities to engage in day-to-day routines that promoted recovery, wellbeing and independence.

Least Restrictive Care

There were positive examples of least restrictive practice across some settings, including evidence of de-escalation approaches, prevention-focused care and respectful management of incidents where restraint was required. In one setting, restrictive practice reduction was identified as a particular area of good practice, with a clear focus on prevention, early intervention and compassionate responses where restraint was used.

However, some findings indicate that restrictive practices and enhanced observation arrangements were not always supported by sufficiently clear care planning, monitoring or clinical oversight. In one setting, concerns were identified where enhanced observation levels were not clearly defined and staff were not always following prescribed observation requirements. In another setting, physical intervention incidents remained high, and environmental factors were noted as potentially contributing to escalation.

The findings highlight the importance of ensuring restrictive interventions are supported by robust governance, clear documentation and post-incident review. This is particularly important where patients are subject to increased observation, seclusion, extra care or intensive support arrangements.

Meaningful and Therapeutic Activities

Access to meaningful and therapeutic activity varied across settings. In some services, patients had access to a broad range of structured activities, including occupational therapy, exercise, community engagement and recreational opportunities. These activities supported recovery, wellbeing, independence and social engagement.

However, in other settings, activity provision was limited, inconsistent or affected by workforce and environmental pressures. In one setting, there was an absence of structured therapeutic activity programmes across wards, despite this having been identified previously. In another, activity provision was affected by limited occupational therapy provision and patient acuity.

Some services demonstrated good access to activity spaces and outdoor areas, while others experienced restrictions due to safety concerns, staff availability or environmental limitations. This indicates that while activity provision can be a strength, it remains vulnerable to wider operational pressures and requires clear ownership, planning and review to ensure consistency.



Medication Management

Medication management was generally safe and well governed in a number of settings, with evidence of secure storage, regular stock checks, pharmacy input and audit arrangements. Some services demonstrated strong medicines governance, including regular pharmacy involvement, safe administration processes and patient involvement in medication decisions.

However, medication-related concerns were identified across several inspections. These included incomplete records, missing signatures, gaps in temperature monitoring, inconsistent recording of key information, and concerns about controlled drugs governance. In some settings, documentation linked to treatment and medication records was not consistently available, complete or accessible, reducing assurance that medication processes were always supported by accurate and up-to-date records.

In one independent setting, concerns were identified regarding controlled drug register completion, witnessing arrangements for controlled drugs administered at night, medication being administered by staff who were not registered nurses, and an unlocked medication fridge. These findings highlight the need for continued focus on medicines governance, staff competence, documentation and the reliability of audit processes.

Risk Assessment and Care Planning

Care and treatment planning was a strength in several settings. Records often reflected person-centred planning, multidisciplinary input, patient and family involvement, regular review, and alignment with the Mental Health (Wales) Measure 2010. In some settings, risk assessments were detailed and regularly reviewed, and discharge planning was actively pursued.

However, care planning was not consistently strong across all services. Issues included incomplete or missing care plans, care plans not being updated to reflect current needs, inconsistent recording of risk information, and unmet needs not being clearly identified. In some services, use of multiple documentation formats created inconsistency, while in another, staff were unable to locate a patient health record during inspection.

There were also examples where physical healthcare needs, enhanced observations or behavioural support plans were not fully reflected within care planning documentation. These findings indicate that, while many services had strong care planning frameworks in place, quality and consistency of records remained an area requiring continued focus.

Environment of Care

Findings relating to the environment of care reflected a mixed picture across services. In some settings, environments were clean, well maintained and supported the delivery of safe, therapeutic and person-centred care. Patients in these services had access to appropriate facilities, private space and well-managed ward environments that supported recovery and wellbeing.

However, environmental concerns remained one of the most consistent and significant themes identified across inspections. In several settings, issues such as ageing infrastructure, poor maintenance, damaged fixtures, cluttered environments and limitations in ward design impacted on patient safety, dignity and the overall therapeutic quality of care. These issues were often longstanding and, in a number of services, had been identified previously but had not been resolved within expected timescales.

The impact of these issues was particularly evident within older persons mental health services, where the physical environment plays an important role in supporting wellbeing and independence. Findings highlighted the importance of maintaining dementia-friendly environments, including orientation aids and therapeutic outdoor spaces, to support reassurance, dignity and independence. Where these features were poorly maintained, the environment did not consistently support the needs of people living with dementia.

The findings also highlighted wider challenges in ensuring improvements were delivered in a timely manner. In some services, delays in addressing known environmental risks, uncertainty regarding estates ownership and responsibility, and slow organisational responses reduced assurance that environments consistently supported safe and effective care.

There was a notable difference in the nature of environmental concerns across settings. In some NHS services, concerns were more frequently associated with ageing infrastructure, capacity pressures and challenges in delivering timely estates improvements. In contrast, independent settings generally demonstrated more consistently maintained environments, reflecting the requirement to meet regulatory standards as a condition of on-going registration. However, environmental issues were still identified in some independent services, typically relating to localised maintenance, cleanliness, accessibility or safety risks.

Overall, while many environments were suitable and supported the delivery of care, environmental quality remained one of the most consistent themes identified across inspection activity. Ageing infrastructure, maintenance issues and delays in addressing known environmental risks affected patient experience, dignity and the delivery of therapeutic care in a number of services. These findings highlight the importance of effective estates management, timely organisational response and sustained investment to ensure care environments consistently support safe, dignified and recovery-focused care.

Staff and Patient Safety

Staff and patient safety was supported in many settings by respectful staff interactions, incident reporting systems, established risk assessment processes and visible ward-level leadership. Some services demonstrated strong incident management arrangements, including electronic reporting, debriefs and evidence of learning being shared through governance structures.

However, a range of safety concerns were identified. These included environmental hazards, infection risks, excessive heat in clinical areas, incomplete documentation, inconsistent use of personal alarms or radios, emergency equipment issues, and gaps in observation practice. In some settings, safety risks were linked to broader environmental or governance weaknesses rather than the actions of frontline staff.

Emergency preparedness was also identified as an area requiring improvement in one independent setting, where arrangements were not in place to ensure a safe and effective response to a medical emergency, and where basic life support training was not up to date for one registered nurse.

A useful theme emerging from the findings is the interface between safety, environment and governance. Several inspections showed that frontline care was often compassionate and responsive, but patient safety was undermined where estates, observation systems, emergency preparedness or governance processes did not provide reliable support. This reflects a wider pattern of good frontline care being affected by system pressures and inconsistent organisational follow-through.

Privacy and Dignity

Patients were generally treated with dignity and respect across the settings inspected, with staff observed knocking before entering rooms, maintaining confidentiality and supporting individualised care. In several services, patients had access to private bedrooms or private spaces, and staff interactions were described as kind, respectful and compassionate.

However, privacy and dignity were affected in some settings by environmental design, shared accommodation, observation arrangements and physical environment concerns. Shared bays and shared dormitories were identified as compromising privacy, dignity and infection prevention and control. In another setting, patients covering observation panels created a tension between privacy and safety, and no clear policy or consistent care planning link was in place to support decision-making.

There were also specific concerns in some settings relating to inappropriate CCTV monitoring, patient hygiene, access to adapted facilities, and restrictions that affected family contact. These findings highlight that dignity is not only about staff interaction, but also about environment, privacy, accessibility, communication and the way restrictions are applied.

Workforce

Many settings benefited from committed, skilled and compassionate staff teams. Staff were frequently described as patient-focused, supportive and knowledgeable, with positive ward-level leadership and strong team cultures. Some services had stable workforces, low reliance on agency staff and appropriate staffing levels to support continuity of care.

However, workforce pressures were evident in several settings. These included reliance on temporary or agency staff, gaps in specialist posts, limited psychology provision, reduced registered nurse cover at night, appraisal gaps and difficulties accessing mandatory or specialist training. Wider intelligence gathered through engagement activity also identified challenges relating to the availability of Section 12 approved doctors. Collectively, these issues affected therapeutic provision, consistency of care, staff development and assurance that all staff were equipped to meet patients' needs safely.

Training compliance was generally positive across both NHS and independent mental health inpatient services. However, inspections identified gaps in some settings relating to mandatory training, including MHA training, Basic Life Support, Immediate Life Support, safeguarding, infection prevention and control, and physical intervention training.



Governance

Governance arrangements were in place across many settings, including audit processes, incident reporting systems, ward meetings, safety huddles and quality review structures. Some services demonstrated robust oversight, with clear leadership, effective audit activity and evidence of learning from incidents.

However, governance did not always translate into effective action. Several inspections identified issues that had been previously known or escalated but remained unresolved, particularly in relation to estates, maintenance, documentation, training data and policy review. In some settings, audit processes had failed to identify concerns relating to medicines management, observation practices, emergency equipment or record keeping.

In some services, repeated inspection findings and differences between audit findings and conditions observed during inspection reduced assurance that governance systems were identifying and addressing risks effectively. This was particularly evident where concerns had been raised previously but improvement actions had not resulted in sustained change.

A key theme running through the findings is that systems were often present, but not always consistently effective. This was particularly evident where local staff were delivering compassionate care but wider organisational systems did not provide timely estates responses, reliable oversight or consistent implementation of policies and improvement actions.

Findings specific to Learning Disabilities Services

Findings from inspections of two learning disability inpatient services identified compassionate, respectful and person-centred care. Staff demonstrated a strong understanding of the needs of individuals, including communication preferences, and maintained positive relationships with patients and their families. Multidisciplinary working supported a holistic approach to care delivery and enabled timely access to wider health services. Physical healthcare needs were generally well managed, and safeguarding, medication management and governance arrangements were largely effective. A stable and experienced workforce supported continuity of care and overall service delivery.

Least Restrictive Care

Across both services, the use of restrictive practices was low, and care was delivered in line with least restrictive principles. Staff demonstrated appropriate management of behaviours of concern, supported by positive behavioural approaches. However, in some cases, the absence of fully individualised restraint reduction plans limited assurance that restrictive practices were being consistently minimised through proactive planning.

Meaningful and Therapeutic Activities

Both services provided opportunities for engagement in activities; however, provision was not consistently structured. Activity programmes were often limited or delivered on an ad hoc basis, with a lack of consistent planning to support therapeutic engagement, skill development and independence. In addition, delays in discharge and prolonged admissions within one service impacted the ability of individuals to access meaningful and varied daily activities.

Medication Management

Medication management arrangements were generally safe and well governed across both services, with appropriate systems in place for prescribing, storage and audit. However, improvements were required to ensure that patients were consistently provided with accessible information about their medication, including easy-read or pictorial formats. In one service, further development of assessment tools, such as those used to support pain identification in individuals with communication difficulties, was also required.

Risk Assessment and Care Planning

Care and treatment planning was in place across both services and reflected multidisciplinary input, with evidence of regular review. However, improvements were required to strengthen the quality and consistency of documentation. Across both services, issues included the use of repetitive or copied text and inaccuracies within records. Care plans were not always sufficiently individualised or strengths-based, and did not consistently reflect the full range of individuals' needs across all domains, reducing assurance that care was fully person-centred.

Environment of Care

Environmental concerns were identified across both services and represented a key area for improvement. While infection prevention and control processes were generally in place, the overall condition of the environment did not consistently support therapeutic care. Issues included poor maintenance, damaged or missing fixtures, environmental cleanliness concerns, and delays in estates responses. These factors impacted on patient experience, dignity and, in some cases, safety.

Staff and Patient Safety

Concerns relating to safety were primarily associated with environmental risks within both services. Maintenance issues, ligature risks and environmental deficiencies reduced assurance that settings were fully safe for patients, staff and visitors. In one service, risks relating to hazardous substances and security arrangements were identified as requiring immediate action.

Privacy and Dignity

Across both services, staff interactions promoted dignity and respect, and patients were supported to maintain privacy. However, environmental issues, including poor maintenance and limited personalisation, detracted from the overall patient experience. In addition, concerns were identified in one service regarding the secure storage of records, reducing assurance that confidentiality was consistently maintained.

Workforce

Both services benefited from an established and experienced workforce, with positive staff engagement and an appropriate skill mix. Staffing levels were generally sufficient to meet patient needs, supported by supervision and development opportunities. However, there was a need for continued oversight of workforce pressures and safe staffing arrangements at an organisational level. In addition, some gaps were identified in appraisal completion and specialist training development.

Governance

Governance arrangements were in place across both services, with evidence of audit activity, incident reporting processes and oversight mechanisms. However, inconsistencies were identified in areas including audit completeness, capture of informal feedback, and oversight of environmental and estates-related risks. Improvements were also required to strengthen aspects of record management and ensure governance processes provided comprehensive assurance across all areas of service delivery.

Overall, findings across both services indicate that, while compassionate and person-centred care is being delivered by committed staff, there are consistent areas requiring improvement. Environmental quality, the consistency and person-centredness of care planning, and access to meaningful therapeutic activity were identified as key themes. Addressing these issues will be important to ensure that care is not only safe, but also supports dignity, independence and improved outcomes for individuals receiving care within learning disability inpatient services.



Findings from Joint Inspections of Community Mental Health Teams (CMHT)

HIW worked jointly with CIW to undertake announced inspections of 3 CMHTs across Wales. These inspections reflected the integrated delivery of health and social care, with contributions from both organisations to support a whole-system assessment of service provision.

Across the CMHTs inspected, we observed committed and dedicated staff providing care within often challenging circumstances. In more than one service, service users reported that they felt listened to and involved in decisions about their care. Multidisciplinary and partnership working were areas of strength, particularly where teams were co-located, supporting more effective communication and coordination.

However, our inspections identified variability in the quality and consistency of care delivered across community services.

Across more than one CMHT, care and treatment planning did not always reflect a fully person-centred approach. While plans were generally in place and aligned with the Mental Health (Wales) Measure 2010, they did not consistently capture service users' views, priorities, or outcomes. In some services, care plans lacked sufficient detail to demonstrate review, progress, or multidisciplinary decision-making.

MHA processes were generally understood, and documentation relating to Community Treatment Orders was largely compliant. However, issues were identified in more than one service relating to incomplete documentation and delays in accessing MHA assessments due to workforce and administrative pressures.

Concerns relating to medication management were identified in more than one CMHT, although the severity of issues varied. These included incomplete clinical records and inconsistent monitoring processes. In one service, significant concerns required immediate assurance action.

Environmental and safety risks were also identified across CMHT inspections, including issues relating to building security, ligature risk management, and the suitability of premises not designed for mental health care. These findings indicated inconsistency in how risks were assessed and mitigated across community settings.

Workforce pressures were evident across more than one service, particularly in relation to specialist roles. Staffing shortages and increased demand impacted service capacity, timeliness of care, and access to interventions, including psychology support.

In addition, concerns relating to patient and staff safety were identified, including lone working arrangements, delays in accessing medical input, and the availability of emergency support. Governance arrangements varied between services, with some systems in place to support audit and escalation of risk, but inconsistencies in oversight and assurance were also identified.

Access to services and patient experience were mixed. While some service users reported positive engagement, others described difficulties contacting services, delays in receiving support, and a lack of clarity around crisis access.

Findings from Joint Inspections of Community Learning Disability Teams (CLDTs)

Working jointly with CIW, HIW contributed to inspections of CLDTs where CIW led the inspection approach and reporting arrangements. As a result, findings are presented differently to HIW's usual reporting format and are informed by improvement plans and joint inspection outcomes, with HIW focusing on the health-related aspects of care.

Findings from this joint inspection activity identified a generally positive and collaborative approach to service delivery. Strong partnership working between health boards and local authorities was evident, supported by co-location of teams and effective multidisciplinary working. This enabled improved communication, shared decision-making and a focus on prevention and person-centred care. Staff were described as committed and supportive, and most people reported positive experiences of care, with practitioners demonstrating a good understanding of individual needs and preferences.

There were examples of strengths-based and person-centred planning, with care often tailored to individual needs and supported by inclusive communication approaches. Innovative practice, including reflective forums and co-produced approaches to care planning, contributed to a positive culture focused on improving outcomes for people.

However, a number of areas for improvement were identified across the services inspected.

Across more than one CLDT, care planning and documentation were not consistently recorded, accessible, or person-centred. Records were sometimes difficult to locate across systems, and the voice of the individual was not always clearly reflected within documentation. In addition, care and support plans were not consistently available in accessible formats, such as easy read, limiting engagement for some people.

Workforce and capacity pressures were evident in more than one service. Staffing gaps, including vacancies in key roles and reliance on locum medical staff, impacted on service delivery, continuity of care, and the ability to manage demand effectively. These pressures contributed to increased waiting times, including for nursing and occupational therapy input, reducing the timeliness of care.

Access to physical healthcare was identified as an area requiring improvement. Challenges were reported in accessing primary care services and specialist health support, and annual health checks were not consistently available. Barriers were also identified in accessing appropriate long-term care pathways for individuals with complex physical health needs.

Variability in systems and processes also impacted the delivery of safe and effective care. Staff reported that electronic patient record systems were complex and difficult to navigate, and key documentation, including MHA records, was not always easily accessible. These issues reduced efficiency and limited assurance that information could be accessed promptly to support clinical decision-making.

Environmental concerns were identified within one service, including the condition and accessibility of premises used for clinical appointments. Issues such as poor signage, building maintenance and suitability of the environment did not reflect the quality of care being delivered and required improvement to ensure safe and dignified care.

Further areas for improvement were identified in relation to equity of access and service pathways. Direct payments and alternative models of care were not consistently considered, and there were gaps in supporting individuals' independence and choice. In addition, transitions between children's and adult services were not always well coordinated, impacting continuity of care.

Governance and oversight arrangements were generally established, however, inconsistencies were identified in areas including training compliance, supervision, and quality assurance processes. Improvements were required to ensure systems for monitoring practice, workforce development and professional appraisal were applied consistently to support service improvement.

Overall, findings from this joint inspection activity highlight committed staff and effective partnership working supporting positive outcomes for people with learning disabilities. However, variability in care planning, workforce capacity, access to healthcare, and governance processes indicates the need for continued improvement to ensure services are consistently safe, person-centred and effective.



Findings from the Inspection of Child and Adolescent Mental Health Services (CAMHS)

HIW undertook an unannounced inspection of a specialist inpatient child and adolescent mental health service providing care for young people aged 11 to 18. The service comprised two wards delivering both routine inpatient care and higher levels of observation and support for those requiring more intensive intervention.

The inspection found a generally positive and well-functioning service. Young people were treated with dignity, respect and compassion, and staff interactions were consistently observed to be supportive and responsive. Young people told us they felt able to access help when needed and were encouraged to participate in decisions about their care. Care was delivered in a person-centred way, with a focus on promoting wellbeing, independence and preparation for discharge. Care and treatment plans reflected individual goals, including those related to physical health, nutrition and daily living skills, and young people were supported to engage in everyday activities to build confidence and independence.

A range of therapeutic and activity-based opportunities were available, supported by occupational therapy input. Facilities such as quiet rooms, sensory areas and a transition flat contributed positively to the therapeutic environment and supported individual needs. Privacy and dignity were promoted through the provision of single en-suite bedrooms and appropriate staff practices. Communication within the service was clear and accessible, with adjustments made to meet individual needs, including the use of structured tools and visual aids. Advocacy services were visible and supported young people to participate in decisions about their care.

The service demonstrated effective systems to support the safety and wellbeing of young people. Risk management processes were well established, with staff using structured assessment tools and safety planning to identify and manage risk. Safeguarding arrangements were embedded, supported by clear escalation processes and specialist input. Young people reported feeling safe within the environment.

Medication management arrangements were safe and well governed. Medicines were stored securely, temperature monitoring was consistent, and pharmacy oversight supported safe prescribing and administration. Young people were involved in decisions about their medication, supporting a person-centred and least restrictive approach. MHA processes were appropriately managed, with documentation completed to a good standard and systems in place to ensure compliance with legal requirements.

However, some areas for improvement were identified. While care and treatment plans were generally comprehensive and reflective of young people's involvement, not all domains of the Mental Health (Wales) Measure were consistently explored. In particular, social, cultural and spiritual needs were not always translated into clear, outcome-focused actions. There were also inconsistencies in the recording of risk management information across different documents, reducing assurance that key information was always readily accessible.

The environment was generally safe and supported therapeutic engagement, with appropriate safety systems in place, including alarms and observation arrangements. Ligature risks were monitored through routine checks. However, some aspects of the physical environment required attention, including damaged furnishings, worn décor and maintenance issues that could impact on cleanliness and infection prevention. A fault with an observation panel was also identified, requiring repair to ensure effective monitoring.

Record keeping systems were secure. However, the continued reliance on paper-based records made navigation of documentation more challenging and reduced efficiency in accessing key information.

The service was supported by a positive and cohesive workforce, with staff reporting good levels of satisfaction and a strong multidisciplinary team culture. Staffing levels and skill mix were generally appropriate, supported by stable teams, structured induction processes and good compliance with mandatory training. Leadership was visible and approachable, and staff felt supported to raise concerns. Governance arrangements were well established, with clear processes for sharing information, reviewing incidents and monitoring quality.

Despite this, improvements were required in aspects of governance and oversight. Although systems were in place to support incident reporting, delays in recording and incomplete documentation reduced assurance that learning was consistently captured and acted upon. Further work was also needed to ensure that policies remained up to date and that electronic systems used to display patient information were consistently maintained. Inconsistencies in electronically displayed observation information were identified as a potential safety risk.

Overall, the inspection found that the service was delivering compassionate, person-centred care within a structured and supportive environment. Strong multidisciplinary working, effective safeguarding arrangements and established governance systems contributed to a positive service. Addressing the areas identified for improvement, including care planning consistency, record keeping, environmental maintenance and aspects of governance, will further strengthen the safety, quality and effectiveness of care provided to young people.

Findings from an Independent Eating Disorder Service

As part of our inspection activity, HIW undertook an inspection of an independent inpatient mental health service providing specialist care and treatment for adults with a primary diagnosis of an eating disorder.

Overall, patients reported a positive experience of care within the service. Patients described feeling safe, supported, and able to approach staff when needed. During the inspection, staff interactions were observed to be respectful, kind, and responsive, with a strong emphasis on relational care. Patients were supported to engage in a wide range of therapeutic and recreational activities, including structured individual and group sessions designed to support recovery and wellbeing.

The inspection identified strong clinical practices in care planning and physical healthcare monitoring. Care and treatment plans were detailed, person-centred, and regularly reviewed to reflect patients' needs and risks. There was clear evidence of ongoing physical health monitoring, including regular assessments and dietetic oversight, with food and fluid intake reviewed daily. Patients were also supported by a multidisciplinary team, with involvement from a range of professionals including dietetics, physiotherapy, and psychological services. Training compliance was high, and staff reported that recent training had enhanced their confidence in supporting patients with eating disorders. The inspection also identified improvements in meal provision and staff engagement around mealtimes compared with findings from the previous inspection.

MHA documentation reviewed during the inspection was found to be compliant, with records well organised and supporting effective oversight. A minor area for improvement was identified in relation to Section 17 leave forms, which did not include a space for patient signatures.

In relation to governance, safety, and systems, the inspection found that appropriate arrangements were generally in place to support safe and effective care. Risk assessments, including ligature point risk assessments, had been completed, and systems were in place to monitor incidents, safeguarding, and clinical quality. Governance structures were clearly defined, and staff described a positive and supportive leadership culture.

However, the inspection also identified specific areas for improvement within the service.

In respect of the environment of care, whilst generally clean, tidy, and welcoming, some environmental risks were identified. These included insufficient seating in communal areas and the inconsistent securing of hazardous substances, which presented a potential safety risk to patients.

The inspection also highlighted issues relating to privacy and dignity. While patients had access to individual bedrooms and staff were generally observed to respect privacy, concerns were raised about occasions where observation blinds had been opened without prior notice, particularly during times when patients may have been changing.

In relation to clinical policy and governance, it was identified that the restrictive intervention policy in use was not sufficiently tailored to the specific needs of the eating disorder patient group. This had also been identified at a previous inspection and remains an area requiring improvement to ensure staff are supported by clear, relevant guidance when managing situations unique to this patient cohort.

The findings from this inspection demonstrate that this independent eating disorder service is providing compassionate, person-centred care supported by strong care planning and physical health monitoring. However, there are specific aspects of environment, policy development, and consistency in practice which require further improvement to strengthen safety, governance, and patient experience within this setting.



8. Monitoring of the Mental Health Act

Alongside its wider inspection and assurance activity, HIW has a statutory responsibility to monitor the operation of the MHA on behalf of Welsh Ministers. Through this work, HIW seeks assurance that individuals subject to the MHA are treated lawfully, safely and with dignity, and that the safeguards set out in legislation are applied effectively in practice.

HIW's monitoring activity includes reviewing how the MHA is applied across a range of healthcare settings, assessing compliance with statutory requirements, and considering how effectively legal safeguards are implemented to protect patients' rights. As part of this work, HIW considers key aspects of care and treatment under the MHA, including the lawfulness of detention, the use of statutory documentation, access to patients' rights and advocacy services, and the application of safeguards designed to protect individuals' dignity and autonomy. This activity is supported by a team of MHA reviewers who engage directly with patients and staff and contribute to inspection and assurance activity across Wales.

The findings presented in this section are drawn from a range of evidence sources, including onsite inspections, review of clinical documentation, engagement with patients and staff, and HIW's statutory functions, including the Second Opinion Appointed Doctor (SOAD) service and the Review Service for Mental Health (RSMH). The following section outlines the key themes identified through HIW's monitoring of the MHA during the 2025-2026 reporting period.

Mental Health Act findings

Across the services inspected, MHA arrangements were generally found to be compliant, with statutory detention documentation supporting lawful detention in many settings. In several services, patients' rights were promoted and upheld in line with legislative requirements, and there was evidence of access to advocacy and legal safeguards. Positive practice was identified where services had clear administrative processes, well-organised documentation and established oversight arrangements, including the involvement of dedicated staff responsible for MHA monitoring.

In some services, governance arrangements supporting the MHA were well developed, with clear audit processes and structured oversight of documentation. These systems provided assurance that statutory requirements were understood and applied consistently, and that they supported staff in maintaining compliance with legal frameworks.

However, inspections also identified a number of recurring areas where practice required improvement.

Documentation and Record Keeping

Issues were identified in relation to the completeness, accessibility and consistency of MHA documentation. This included examples where consent to treatment forms were not consistently attached to medication administration records, legal status was not always recorded accurately, and documentation was not readily accessible across systems. In some services, the implementation of new electronic systems created additional challenges in locating and verifying consent to treatment documentation. These issues reduced assurance that treatment was consistently administered in accordance with the appropriate legal authority.

Application of Mental Health Act Processes

Further improvements were required in relation to the application and recording of specific MHA processes. These included ensuring detention documentation was processed in a timely manner, strengthening staff understanding of legal powers such as holding powers, and ensuring that key decisions, including Section 17 leave, were consistently documented and evidenced. In some instances, required documentation lacked sufficient detail to demonstrate the rationale for continued detention or patient involvement in decision-making.

Consent to Treatment

Consent to treatment was a key theme identified across a number of inspections. While some services demonstrated appropriate processes, including the involvement of Second Opinion Appointed Doctors where required, other findings identified gaps in both the availability and quality of consent to treatment documentation. Missing or inaccessible documentation, alongside inconsistencies in capacity assessments relating to treatment decisions, reduced assurance that safeguards were consistently applied.

Patient Rights and Advocacy

Access to, and understanding of, patients' rights was generally supported across services, with advocacy provision available and evidence that patients were informed of their rights. However, this was not consistently embedded in practice. Findings indicated that, in some settings, patients' understanding of their legal status and rights was limited, suggesting that communication and engagement require strengthening to ensure individuals are supported to understand and exercise their rights effectively.

Staff Training and Knowledge

Staff training and knowledge in relation to the MHA was also identified as an area requiring continued focus. In more than one service, gaps in MHA training were identified, reducing assurance that staff had a consistent understanding of their responsibilities and the practical application of the MHA. This is particularly important in supporting lawful decision-making and ensuring that safeguards are applied appropriately in practice.

Overall, findings indicate that while MHA processes were generally well managed and supported by appropriate governance arrangements, there are recurring areas requiring improvement. These include the quality and accessibility of documentation, the consistent application of consent to treatment processes, staff understanding of legal responsibilities, and the effectiveness of communication with patients about their rights and legal status. Addressing these areas will support greater consistency in the application of legal safeguards and strengthen assurance that individuals subject to the MHA are treated lawfully, safely and with dignity.



9. Oversight and Delivery of the Second Opinion Appointed Doctor (SOAD) Service

Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (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 patients' 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 interventions 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 guidance provided to all SOADs and MHA Administrators and is available on our website. During the year, we published the SOAD Handbook and refreshed our suite of documentation, including guidance on SOAD methodology and the patient information leaflet. These resources support consistency of practice and help patients better understand their rights and the role of the SOAD service. We are also developing an Easy Read version of the patient information leaflet, which is expected to be published during 2026.

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, they will issue a statutory certificate that provides the legal authority for the treatment to be administered.

The SOAD service continues to operate as a hybrid service. The primary focus remains an "in-person first" approach, with every effort made to ensure that patients are interviewed face-to-face wherever possible, except for Community Treatment Order (CTO) cases, where a remote-first methodology continues to be used. Patients retain the right to request an in-person visit from a SOAD in all cases.

Figures for remote and onsite assessments remain broadly consistent with previous years, with approximately equal proportions of assessments being undertaken through each method. In all cases, SOADs must exercise their professional judgement when determining whether a remote assessment can be conducted safely and effectively, and the method of assessment is recorded as part of the rationale documented on the statutory certificate.

The enactment of the Mental Health Act 2025 represents a significant development for the service. During the year, we commenced a review of the expected implications of the legislation and are actively considering how best to prepare the service for future changes in demand, processes and safeguards arising from the new Act.

Training and development activity for SOADs during the year focused on strengthening quality and consistency across the service. This included peer review and standardisation exercises relating to statutory certificates of consent (CO forms), alongside the sharing of good practice and professional learning in relation to ECT assessments.

SOAD Recruitment

Maintaining sufficient SOAD capacity remains a significant challenge.

During the year, we continued an extensive recruitment campaign to increase the number of available SOADs and strengthen resilience within the service. Recruitment activity included engagement through professional networks and attendance at Royal College of Psychiatrists events, alongside the utilisation of several recruitment channels.

Despite these efforts, the campaign was unsuccessful in generating the level of recruitment required to address ongoing workforce pressures. In response, we have begun a structured review of all available measures to improve recruitment and retention. This includes consideration of service design, engagement approaches and reimbursement arrangements, including a review of current fee levels, to ensure the service remains sustainable and able to meet future demand.

SOAD Case Numbers

During the period 1 April 2025 to 31 March 2026, the RSMH received **873 requests** for a visit by a SOAD. This represents an increase from the 782 requests received between 1 April 2024 and 31 March 2025.

These figures can be broken down as follows:

- **781 requests** related to the certification of medication
- **65 requests** related to the certification of ECT
- **27 requests** related to both medication and ECT.

The increase in overall activity continues the upward trend seen following a period of relative stability in demand. The service remains mindful of the potential impact of the MHA 2025 and continues to review capacity and workforce requirements to ensure it is well placed to meet future demand.

In the table below, the number of requests for a SOAD visit shows a continued increase compared with the previous reporting year, whilst remaining below the peak of 954 requests recorded in 2019-20.



Requests for visits by a SOAD, 2006-07 to 2025-26

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
2025-26	781	65	27	873

Timely SOAD assessment

To ensure patients receive appropriate care and treatment, it is important that SOAD assessments are completed in a timely manner. The service continues to operate against three established performance indicators, which remain unchanged:

- two working days for referrals relating to ECT
- five working days for referrals relating to prescribed medication where the patient is detained in hospital
- five working days for referrals relating to patients subject to a Community Treatment Order.

These indicators continue to support effective monitoring of service performance and help ensure that patients receive the safeguards provided by the SOAD process without unnecessary delay. As in previous years, the timely provision of documentation by referring services remains an important factor in supporting prompt assessments.



Appendix A

Hospital/Service	NHS Health Board/ Independent	Date
Maple Ward, Hafan y Coed	Cardiff and Vale University Health Board	14 -16 April 2025
Laurels and Briary	Swansea Bay University Health Board	29 -30 April 2025
Priory Hospital	Independent	12-14 May 2025
Adferiad and Pillmawr Ward, St Cadoc's Hospital	Aneurin Bevan University Health Board	19-21 May 2025
Felindre Ward, Bronllys Hospital	Powys Teaching Health Board	10-12 June 2025
Coed Du Hall Hospital	Independent	30 June-1 July 2025
Ward y Ddol, Ty Glyn Ebwy Hospital	Independent	9-11 July 2025
PCP Hospital	Independent	10 July 2025
Swansea North Community Mental Health Team	Swansea Bay University Health Board	15-16 July 2025
Cemlyn Ward, Cefni Hospital	Betsi Cadwaladr University Health Board	28-30 July 2025
St Teilo House	Independent	18-20 August 2025
Hergest Unit, Ysbyty Gwynedd	Betsi Cadwaladr University Health Board	8-10 September 2025
Ty Gwyn Hall	Independent	8-10 September 2025
Ystradgynlais Community Mental Health Team	Powys Teaching Health Board	16-17 September 2025
Torfaen Community Learning Disability Team	Aneurin Bevan University Health Board	29 September- 1 October 2025

Hospital/Service	NHS Health Board/ Independent	Date
Cefn Coed Hospital	Swansea Bay University Health Board	6-8 October 2025
Ty Skirrid Unit, Maindiff Court Hospital	Aneurin Bevan University Health Board	6-8 October 2025
Cwm Seren	Hywel Dda University Health Board	10-12 November 2025
Carmarthenshire Community Learning Disability Team	Hywel Dda University Health Board	10-12 November 2025
Ty Grosvenor	Independent	15-17 December 2025
Rushcliffe Aberdare Hospital	Independent	5-7 January 2026
Rowan House	Swansea Bay University Health Board	6-7 January 2026
Ty Llidiard	Cwm Taf Morgannwg University Health Board	12-14 January 2026
Taf Ely Community Mental Health Team	Cwm Taf Morgannwg University Health Board	13-14 January 2026
Heatherwood Court Hospital	Independent	26-28 January 2026
Ty Cwm Rhondda	Independent	2-4 February 2026
Conwy Community Learning Disability Team	Betsi Cadwaladr University Health Board	10-11 February 2026
Caswell Clinic	Swansea Bay University Health Board	23-25 February 2026
Seren Gobaith Hospital	Independent	2-4 March 2026
St Peters Hospital	Independent	23-25 March 2026
Ward 10, 14 & 16, Llandough Hospital	Cardiff and Vale University Health Board	23-25 March 2026

Glossary

Advocacy	Support provided to help individuals understand their rights, express their views and participate in decisions about their care and treatment.
CAMHS	Child and Adolescent Mental Health Services. Specialist services providing assessment, treatment and support for children and young people experiencing mental health difficulties.
Care and Treatment Plan (CTP)	A care plan developed in accordance with the Mental Health (Wales) Measure 2010 which identifies an individual's needs, outcomes and support arrangements.
CCTV	Closed-Circuit Television. Surveillance systems that may be used within healthcare settings where there is a clear and lawful justification, supported by appropriate governance and safeguards.
CIW	Care Inspectorate Wales. The independent regulator of social care and childcare in Wales. HIW undertakes joint inspection activity with CIW in a number of community mental health and learning disability services.
CLDT	Community Learning Disability Team. A multidisciplinary team providing specialist health support and intervention for people with learning disabilities living in the community.
CMHT	Community Mental Health Team. A multidisciplinary team providing assessment, treatment, care coordination and ongoing support for people with mental health needs in the community.
Community Treatment Order (CTO)	A legal arrangement under the Mental Health Act allowing certain patients to receive treatment in the community whilst remaining subject to specific conditions.
Concern	Information received by HIW from patients, carers, staff or members of the public regarding the quality, safety or experience of care.
Deprivation of Liberty Safeguards (DoLS)	Legal safeguards designed to protect individuals who lack capacity and may be deprived of their liberty in their best interests for care or treatment.

Governance	The systems, processes and oversight arrangements used by organisations to ensure care is safe, effective, lawful and continually improving.
Health Board	An NHS organisation responsible for planning and delivering healthcare services within a geographical area of Wales.
HIW	Healthcare Inspectorate Wales. The independent inspectorate and regulator of healthcare in Wales.
Immediate Assurance (IA)	A process used by HIW where immediate action is required to address significant risks identified during inspection activity.
Independent Mental Health Advocate (IMHA)	An advocate who provides support to qualifying patients under the Mental Health Act to help them understand and exercise their rights.
Independent Provider	A healthcare service that is privately operated and regulated by HIW under the Independent Health Care (Wales) Regulations 2011.
Learning Disability	A learning disability is a lifelong condition that affects a person's ability to understand information, learn new skills and live independently. It develops before adulthood and has a lasting effect on development.
Least Restrictive Practice	An approach to care that minimises restrictions on an individual's rights, freedoms and independence while maintaining safety.
Mental Health Act (MHA) 1983	The legislation governing the assessment, detention, treatment and protection of individuals with mental disorder in England and Wales.
Mental Health (Wales) Measure 2010	Legislation designed to improve mental health services in Wales, including care and treatment planning, primary mental health support services and access to advocacy.
Mental Health Act Reviewer	An individual authorised by HIW to monitor the operation of the Mental Health Act and provide assurance regarding the application of legal safeguards.
Multidisciplinary Team (MDT)	A group of professionals from different disciplines working together to assess, plan and deliver care and treatment.
National Preventive Mechanism (NPM)	The group of organisations designated to monitor places where people may be deprived of their liberty, in line with the United Kingdom's international obligations.

Non-Compliance Notice (NCN)	A formal notice issued by HIW requiring action where regulatory requirements have not been met.
Person-Centred Care	Care that is planned and delivered around the individual's needs, preferences, goals and circumstances.
Regulation 30 and 31 Notifications	Statutory notifications that independent healthcare providers are required to submit to HIW regarding specified events such as deaths, serious injuries, unauthorised absences and other significant incidents.
Restrictive Practice	Any intervention that restricts an individual's movement, liberty or freedom to act independently.
Review Service for Mental Health (RSMH)	A statutory service overseen by HIW that supports elements of Mental Health Act monitoring and safeguards in Wales.
Risk Assessment	A structured process used to identify, evaluate and manage risks to a person's health, safety and wellbeing.
Section 17 Leave	Leave of absence from hospital granted under Section 17 of the Mental Health Act, subject to conditions determined by the responsible clinician.
Section 117 Aftercare	Aftercare services provided jointly by health and social care bodies for eligible patients following discharge from detention under certain sections of the Mental Health Act.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed to provide a second opinion on certain treatments under the Mental Health Act where consent cannot be given or has been withheld.
Statutory Notification	A notification that providers are legally required to submit to HIW under relevant regulations.
Therapeutic Activity	Structured activities designed to promote recovery, wellbeing, independence, engagement and rehabilitation.
WAST	Welsh Ambulance Services University NHS Trust. The NHS organisation responsible for ambulance and urgent care services across Wales.
Whistleblowing Disclosure	Information raised by a worker regarding concerns about wrongdoing, risk, patient safety or failures in care within a service.

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

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