Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Monitoring the use of the Mental Health Act in 2014-2015

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Foreword

I am pleased to introduce the fifth annual report of Healthcare Inspectorate Wales' (HIW) work in monitoring the use of The Mental Health Act 1983 (The Act) across Wales in 2014-15. This is the sixth year that HIW has been responsible for monitoring The Act in Wales.

The Act and the accompanying Code of Practice were introduced to protect individuals who become vulnerable due to their mental health. The current Code of Practice is being revised and the consultation period closed in November 2015. It is envisaged that a new code will be introduced in 2016. The Act is designed to ensure that any decision to compulsorily admit an individual to hospital, therefore depriving them of their liberty, is justified and in the best interests of that individual. The Act allows for medical treatment to be administered to individuals who may not consent to it or have the capacity to consent to it. This is a unique area of healthcare as individuals can be legally detained and treated in hospital. It is therefore crucial that the powers that individuals are subject to are appropriately monitored.

HIW monitors the use of The Act to ensure that those individuals who are detained and liable to be detained and admitted informally are protected, safeguarded, supported and empowered as far as possible to make decisions over their care and treatment. It is also very important to review how organisations are discharging their powers under the Act and that they are appropriate, proportionate and in line with the law.

This report sets out our findings from the monitoring work undertaken by our Reviewers and Second Opinion Appointed Doctors (SOADS) during 2014-15.

We hope that the information in this report is helpful to those responsible for implementing the provisions of the Act and can be used to assist in driving improvement in Mental Health and Learning Disability services. HIW also hopes this report will be beneficial to individuals who are subject to detention under the powers of the Act, their advocates and their families.

Dr Kate Chamberlain
Chief Executive
Healthcare Inspectorate Wales

Chapter 1:
The Mental Health Act and our Role in Monitoring its Use

The role and purpose of the Mental Health Act

The guiding principles to the Code of Practice of the Act are Empowerment, Equity, Effectiveness and Efficiency. The Act says that those using it shall have regard to the Code of Practice.

Mental Health and Learning Disability services in Wales are predominately accessed by people who receive care and treatment voluntarily. This group of people are often referred to as informal patients. Sometimes people are detained against their will or are liable to be detained and are known as formal patients. Some formal patients who are liable to be detained may be in hospital on a voluntary basis. In early 2014 the relationship between The Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA 2005) in relation to those who are incapacitated with respect to voluntary admission, or who were incapacitated and objected to admission, was clarified in the P and Q and Cheshire West Decision. The MCA 2005 provides the statutory framework for acting and making decisions on behalf of people who lack the capacity to make decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) were subsequently introduced to provide a legal framework for situations where someone may be deprived of their liberty within the meaning of article 5 of the European Convention of Human Rights. The safeguards can be applied to individuals over the age of 18 who have a mental disorder and do not have the cognitive ability (mental capacity) to make decisions for themselves. HIW has a pivotal role in monitoring those individuals in hospitals that are subject to (DoLS) and produces an annual report jointly with its colleagues in Care Social Services Inspectorate Wales (CSSIW).

The core purpose of the Act (variously applicable in Wales and also in England) is to ensure that informal and formal patients receive appropriate treatment in an environment conducive to their recovery. The key principle here is on treatment and not containment and to balance risks to the patient and those in society. The Act provides a legal framework to allow for appropriate compulsory medical treatment to be given where it is necessary to the patient's rehabilitation. For detained patients, and those liable to be detained patients in hospital, Part 4 of the Act regulates their treatment including section 57, 58 and 58A type treatments. For a special group of liable to be detained patients, those on community treatment orders where appropriate treatment is available in the community, Part 4A of the Act regulates their treatment with respect to section 58 and 58A type treatments.

Part 4 and Part 4A refer to medical treatment under the Act which include; nursing, psychological intervention, specialist mental health rehabilitation and care. Part 4 of the Act includes: section 57, 58 and 58A type treatments which are particular types of treatments as defined by the "appropriate national authority" (which for Wales are the Ministers of the Welsh Government). Section 57 type treatments require consent and a second opinion. Section 58 type treatments requires consent after three months of medication is given, if there is no consent, or incapacity, a second opinion is required. At any time after detention, section 58A type treatments require consent, or if under age 18, consent and a second opinion irrespective of detained status.

The treatments as outlined above may be given in a range of settings. The Act allows for formal patients to be detained in a hospital environment or to be liable to be detained in hospital but live in the community. This mainly involves Section 17 leave from hospital, Community Treatment Orders (CTOs) and Conditional discharge and all are subject to certain conditions. Some patients are under Guardianship orders in the community although not liable to be detained and therefore neither Part 4 or Part 4A applies to them. It is generally accepted that on recall of a conditionally discharged patient, Part 4 will apply to them starting anew, but that this does not apply to them during Conditional Discharge (Part 4A does not apply in any case to such patients).

Section 60 refers to withdrawal of consent for Part 4 patients (after the "three month rule") and Section 64FA refers to withdrawal of consent for Part 4A patients (after the "28 day rule" or "three month rule" which ever is the later). So if there is a change between incapacity and informed consent or to non consenting and vice versa, to any of the treatments, there should be a reassessment and appropriate action taken with Part 4 and Part 4A patients there is potentially a SOAD referral.

There are mechanisms in Part 4 and Part 4A to allow medication to be continued pending review by a SOAD if necessary.

The Act provides numerous powers and responsibilities on a range of organisations and individuals, including:

- officers and staff of health boards, independent hospitals and social services departments, whether or not they work in mental health services
- police officers
- Ministry of Justice caseworkers
- courts
- advocates
- Welsh Ministers
- the relatives of individuals who may be subject to the Act.

The Act is used in many environments, such as:

- hospitals
- mental health wards
- general medical wards for patients of all ages
- accident and emergency departments
- nursing homes
- patients' homes
- courts
- public places.

Some people can remain under the powers of The Act for considerable periods of time. These include patients who are subject to a hospital order (section 37) that is given by a Crown Court judge when a patient has a mental illness that needs treatment in a hospital and is an alternative to a prison sentence. The judge also has the option of adding a Section 41. The Ministry of Justice has a pivotal role within this process.

The Act is clear in the processes that must be adhered to when an individual is considered for detention, and the processes that must be adhered to when an individual has been detained with either a civil application for admission or a hospital order via the courts. When such a civil order or hospital order is made, the patient is liable to be detained and any medication for mental disorder given starts the three month rule from the date it is given after the patient has become liable to be detained (rather than actually admitted). The Act, and the Code of Practice for Wales, provide safeguards that intend to ensure individuals are not inappropriately detained or inappropriately treated.

How the use of the Mental Health Act is monitored in Wales

Welsh Ministers have a duty to ensure that the Act is lawfully administered in Wales and are required to monitor how services discharge their powers and duties in relation to patients detained under the Act. The patients maybe detained in hospital, subject to CTOs or guardianship. This function is carried out by HIW on behalf of Welsh Ministers who are specifically required to:

- keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained
- produce an annual report
- provide a registered medical practitioner to authorise and review proposed treatment in certain circumstances
- investigate complaints relating to the application of the Act.

HIW has undertaken this role since April 2009. In order to ensure that these responsibilities are effectively undertaken, HIW established the Review Service for Mental Health (RSMH). The responsibilities of the RSMH is as follows:

- visiting detained patients in hospital settings
- reviewing the care and treatment provided to detained patients
- providing a Second Opinion Appointed Doctor (SOAD) service.

The RSMH has many functions but its primary one is to ensure that anyone receiving care and treatment in Wales under the Act is treated with dignity and respect, receives appropriate and lawful treatment and is enabled to lead as fulfilled a life as possible.

Mental Health Act Reviewers

In order for the RSMH to achieve its primary function of ensuring that treatment is lawful and delivered in a way which preserves the dignity and respect of the individual, the service utilises the expertise of Mental Health Act Reviewers (Reviewers). Our Reviewers, who act on behalf of HIW, visit and talk to individuals who are subject to the powers of the Act in psychiatric wards across Wales. Our Reviewers assess the suitability of the environment, talk with a range of staff members and review the statutory documentation of detained patients to establish whether:

- the requirements of the Code of Practice been met
- the privacy and dignity of patients has been preserved
- patients have timely and appropriate access to general healthcare services including a GP, dentist and optician
- care and treatment planning is well organised and meets the individual patients needs
- there are a range of appropriate risk assessments and actions in place
- the food served is nutritious, varied and well presented and takes into account individual preferences and special dietary requirements of patients.

Our Reviewers visit a number of diverse settings each year, both in the NHS and Independent sector, as part of a rolling inspection programme. The vast majority of our visits are unannounced. Organisations visited will receive verbal feedback at the end of the visit from the Reviewer, a management letter detailing our findings and if appropriate an urgent actions letter if significant issues were found.

From 1 April 2015 all Mental Health Act monitoring visits are followed with a report detailing our findings. These are published on our website and accompanied by a detailed action plan from the Registered Provider or health board.

HIW also has a responsibility to monitor the use of Community Treatment Orders (CTOs) and is planning to commence a work programme to monitor their use in a number of health boards in 2015-16.

Second Opinion Appointed Doctor Service (SOAD)

Welsh Ministers are responsible for fulfilling the requirement of the Act to appoint a registered medical practitioner to authorise treatment of detained patients under certain circumstances. HIW have been delegated this function since April 2009 and uses a number of medical practitioners known as Second Opinion Appointed Doctors (SOADs). During 2014-15 HIW undertook a major recruitment exercise to increase the number of SOADs to ensure a timely response to requests.

SOADs are responsible for safeguarding the rights of individuals who are detained under the Act who either refuse, or are considered incapable, to consent to treatment. SOADs do not provide a second clinical opinion about a patient's condition or diagnosis. Instead they decide whether the rights and views of the individual have been fully taken into account by clinicians and whether the proposed treatment is in line with guidelines and is appropriate to that individual.

SOADs are required to consider treatment plans for:

- detained patients of any age who have capacity to consent to medical treatment and have refused to give their consent
- detained patients of any age who lack the capacity to consent to medical treatment
- detained patients over 18 years of age who lack the capacity to consent to electroconvulsive therapy (ECT)
- informal or detained patients under 18 years of age whom ECT is proposed, whether the patient is consenting or lacking capacity to consent
- detained patients on CTOs who lack the capacity to consent to proposed treatment (patients with the capacity to consent now have their CTO authorised by their Responsible Clinician)
- formal and informal patients who are being considered for very serious and invasive treatments such as psychosurgery.

When the SOAD has reviewed the treatment to be prescribed, and is satisfied the patients views and rights have been taken into account, they will issue a statutory certificate which provides legal authority for treatment to be given. SOADs can deviate from the proposed treatment plan if they consider it necessary. For example, a SOAD may only authorise part of the proposed treatment, place conditions or time limits on treatment, set a maximum dose level of medication or place a limit on the number of courses of ECT to be given.

Investigation of complaints

The Welsh Ministers have a duty placed on them by the Act to make arrangements for the investigation of complaints that relate to the exercise and discharge of powers under the Act.

In 2014-15 HIW received a number of contacts by letter, email, telephone and during our hospital visits raising concerns with us. The majority of the concerns received related to:

- detained patients challenging the decision to be detained
- section 17 leave issues
- quality and the variety of food
- attitude of staff
- availability of activities
- lack of a consistent responsible clinician
- privacy and dignity
- cleanliness issues.

Many of the issues that were raised with HIW fell outside our remit and the powers delegated to us. For example, we received complaints in relation to challenging the decision not to grant Section 17 leave, to be released from detention and to have medication changed. In these instances we provide the complainant with the options available to them and how to raise their complaint with the organisation concerned in an attempt for the issue to be resolved locally. We also signposted individuals to other organisations who can assist with such matters, for example advocacy services and the Mental Health Review Tribunal.

Even though not all of the complaints we receive can be investigated by us, we make use of all intelligence received. We maintain an organisational record for all services in Wales and when complaints are received we have a risk and escalation process whereby this information is properly scrutinised, informing and assisting in the development of our annual inspection programme.

Annual reporting

Each year we are required to produce an annual report that gives account of the work that has been undertaken to meet our responsibilities under the Act.

This is our fifth annual report in which we provide an overview of key figures and the findings of our work during 2014-15.

Chapter 2:

Admission of patients to mental health facilities in Wales

The statistics in this chapter are taken from the official statistics published annually by Welsh Government. As they can be subject to revision, for the latest statistics please refer to the statistics on the Welsh Government's website. Healthcare Inspectorate Wales will not be revising this report, or previous versions of this annual report, if the official statistics are revised.

In 2014-15, the total number of admissions to mental health facilities in Wales was 9,762. This is a decrease of 532 (5 per cent) compared with 2013-14.

People who are compulsorily admitted to hospital are called 'formal' patients and people who are admitted to hospital when they are unwell without the use of compulsory powers are called 'informal' patients.

In 2014-15, 1,921 people were admitted formally to a mental health facility in Wales for assessment and/or treatment. This represents an increase of 229 (14 per cent) compared with 2013-14.

Table 1 shows a breakdown of patient admissions to mental health facilities from 2010-11 onwards. Please note that the official statistics were revised by Welsh Government in 2015, following the discovery of a data issue in one of the health boards. As a result, the data for 2010-11 to 2013-14 in the table below has been revised downwards.

Table 1: Number of patient admissions to mental health facilities, 2011-12 to 2014-15

Legal status	2011-12	2012-13	2013-14	2014-15
Formal admissions	1,428	1,453	1,692	1,921
Informal admissions	8,612	8,544	8,602	7,841
All admissions	10,040	9,997	10,294	9,762

Source: P90, Welsh Government Statistics

In 2014-15, formal admissions accounted for 17.6 per cent of all admissions to NHS mental health services and for 87.5 per cent of all admissions to independent mental health hospitals.

While the total number of admissions and informal admissions fell each year from 2011-12 to 2014-15, apart from an increase in 2013-14, formal admissions have increased year on year from 2011-12.

Figures for the total admissions to NHS mental health facilities by health board and independent settings are shown in Table 2.

Table 2: Number of patient admissions to mental health facilities by setting (NHS and Independent Mental Health Hospitals), 2014-15

Local Health Board/ Indpendent Hospital	Rate (a)		Number	
	Informal	Formal	Informal	Formal
Betsi Cadwaladr University LHB	19.9	4.7	1,384	324
Powys Teaching LHB	20.6	4.0	273	53
Hywel Dda University LHB	19.4	5.5	744	213
Abertawe Bro Morgannwg University LHB	39.9	5.0	2,088	263
Cwm Taf University LHB	30.6	13.2	906	390
Aneurin Bevan University LHB	23.9	3.0	1,390	172
Cardiff & Vale University LHB	21.1	5.1	1,019	247
Independent Hospitals	-	-	37	259
Wales	**25.4**	**6.2**	**7,841**	**1,921**

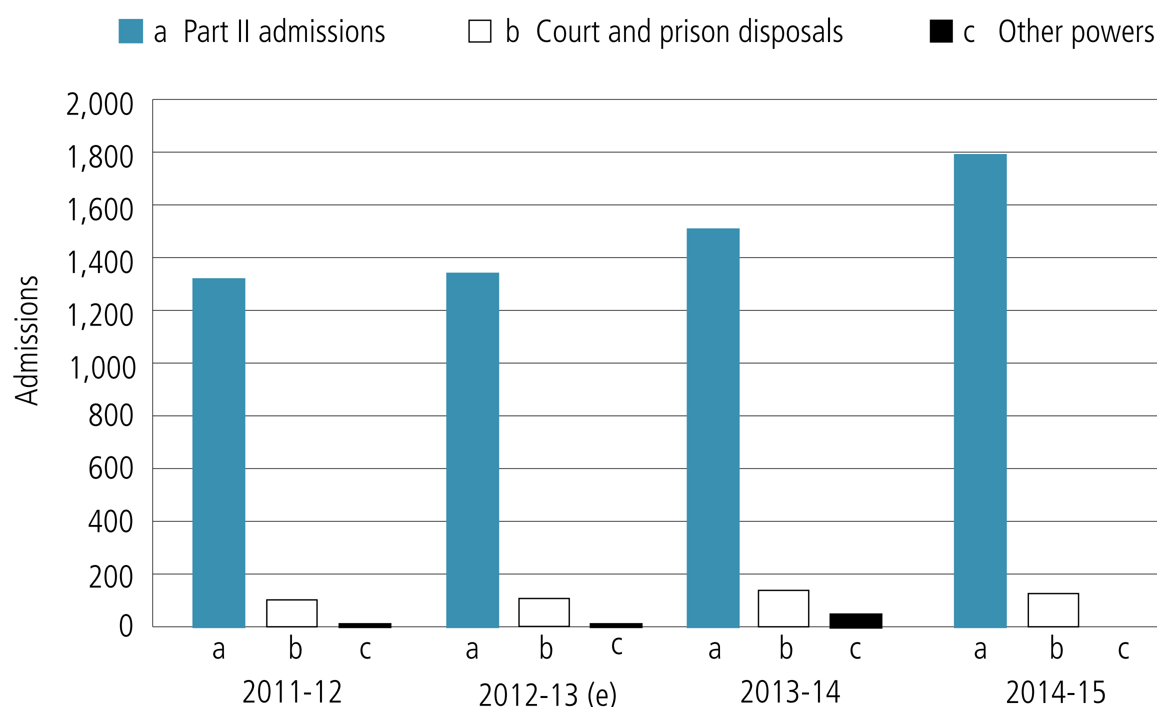
(a) Per 10,000 resident population based on the 2014 mid year estimates.

Source: P90, Welsh Government Statistics

For NHS providers in Wales in 2014-15, Cwm Taf University Health Board had the highest number and rate of formal admissions, (390 and 13.2 respectively) and accounted for one in five of all formal admissions (20 per cent). Abertawe Bro Morgannwg University Health Board had the highest number and rate of informal admissions (2,088 and 39.9 respectively), which accounted for over a quarter of all informal admissions (27 per cent).

As can be seen from Chart 1, the majority of people detained under the Mental Health Act are admitted under Part II. In 2014-15, 93 per cent of patients were admitted under Part II with this figure having risen each year since 2011-12.

Chart 1: Use of the Mental Health Act, 2011-12 to 2014-15



(e) Includes an estimate for independent hospitals.

Source: P90, Welsh Government Statistics

Use of Section 135 and 136 powers – removal of an individual to a place of safety

Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear, to be mentally disordered. Police officers may use powers of entry under Section 135 of the Act to gain access to a mentally disordered individual who is not in a public place. If required, the police officer can remove that person to a place of safety. A place of safety may be a police cell, a hospital based facility or 'any other suitable place, the occupier of which is willing temporarily to receive the patient'.

Section 136 of the Act allows police officers to detain an individual who they find in a public place who appears to be mentally disordered and is in immediate need of care or control.

Both Section 135 and Section 136 allow for an individual to be detained in a place of safety for up to 72 hours. During this time period an assessment is undertaken to determine whether hospital admission, or any other help, is required. Section 136 is used significantly more often than Section 135. Table 3 shows the number of uses of Section 135 and 136 in Wales in 2014-15.

Table 3: Completed Mental Health Act assessments in hospital under Section 135 and 136, 2014-15

	Hospital is first and only Place of Safety Detention	Hospital is subsequent Place of Safety Detention after transfer from:			Unknown	Total Assessments
		Another Hospital	Police Station	Another Place		
Section 135	45	1	0	0	0	46
Section 136	1,073	149	176	0	0	1,398

Source: P90, Welsh Government Statistics

For completed Mental Health Act assessments in hospital under both Section 135 and 136 in 2014-15, a hospital was the first and only place of safety in the majority of cases (100 per cent for Section 135 and 87 per cent for Section 136). However, 13 per cent of completed Mental Health Act assessments in hospital under Section 136 were transferred from a police station.

Community Treatment Orders

Community Treatment Orders (CTOs) were introduced in November 2008. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.

Table 4 shows the health board breakdown of people discharged from hospital under a CTO in 2014-15 and Table 5 shows the outcome of those who are subject to a CTO in 2014-15 (numbers include patients from previous years). In 2014-15, there were 240 people discharged from hospital under Supervised Community Treatment (SCT) in Wales. Of those patients still subject to a CTO in 2014-15, there were 91 recalls to hospital, 78 revocations and 138 discharges.

Table 4: Patients discharged from hospital under Community Treatment Order (CTO), 2014-15

Local Health Board	Legal status prior to SCT		Total
	Section 3	Other sections	
Betsi Cadwaladr University LHB	31	0	31
Powys Teaching LHB	6	0	6
Hywel Dda University LHB	27	*	*
Abertawe Bro Morgannwg University LHB	43	5	48
Cwm Taf University LHB	24	*	*
Aneurin Bevan University LHB	36	*	*
Cardiff & Vale University LHB	39	*	*
Wales (a)	**220**	**20**	**240**

(a) Wales totals include patients discharged from independent hospitals under supervised community treatment.

* Figure under 5 have been suppressed to avoid the risk of disclosing information about individuals. Further figures (5 or more) have also been suppressed to avoid secondary disclosure.

Source: P90, Welsh Government Statistics

Table 5: Community Treatment Order (CTO) patient outcome, 2014-15

Local Health Board/ Independent Hospital	SCT related activity				
	Recall	Revocation	Discharge	Assignment to the hospital of a SCT patient	Assignment from the hospital of a SCT patient
Betsi Cadwaladr University LHB	14	7	28	*	*
Powys Teaching LHB	*	0	*	0	0
Hywel Dda University LHB	20	16	25	*	0
Abertawe Bro Morgannwg University LHB	*	19	7	0	0
Cwm Taf University LHB	20	13	21	*	0
Aneurin Bevan University LHB	12	8	39	0	*
Cardiff & Vale University LHB	17	14	13	0	*
Wales	**91**	**78**	**138**	**5**	**14**

(a) Wales totals include patients discharged from independent hospitals under supervised community treatment.

* Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals.

Source: KP90, Welsh Government Statistics

Each individual that was transferred onto a CTO in Wales was required to see a SOAD to review the proposed care and treatment plan. In June 2012, changes were made to the legislation which meant only patients who lacked the capacity to consent to their treatment were required to be seen by a SOAD. Since June 2012, patients who have the capacity to consent to the proposed treatment can have their CTO authorised by their Responsible Clinician. This mirrors the situation that is in place for inpatients who consent or refuse to medication whilst detained in an inpatient setting.

Chapter 3:
Detained and Liable to be detained Patients and Consent to Treatment

In Wales during 2014-15:

- There were 812 requests for a visit by a SOAD
- 739 SOAD requests related to the certification of medication
- 68 SOAD requests related to the certification of ECT
- 5 SOAD requests related to medication and ECT

Liable to be detained and detained patients – Part 4 patients

Any individual detained under the Act may be given Section 58 type treatment (medication) with or without their consent for a period of up to three months once initiated from the point of being liable to be detained. Shortly before this period ends a SOAD will be required to consider the proposed treatment plan when the treatment is going to be continued beyond three months since initiation of Section 58 type treatment. The relevant approved clinician either considers the person to lack capacity to consent or the patient has capacity but does not consent to the proposed treatment plan. The three month rule does not apply to Section 58A type treatments but rather to patients who do not have capacity and have not made and advanced decision or statement that they do not want ECT.

The role of the SOAD Part 4 Patients

If, after the ‘three month rule’ has expired for a detained patient, the patient has capacity to consent and does consent, either the patient’s approved clinician or a SOAD can certify consent. If a patient lacks the capacity to consent or does not consent, the proposed treatment plan can only be authorised following certification by a SOAD. This measure is in place to ensure patients are safeguarded so that their voice and preferences may be heard by an independent registered medical practitioner.

As detailed in chapter one, SOADs are required to consider treatment plans for patients that are detained under the Act in a variety of circumstances. These relate to their consent status and/or their capacity to consent to proposed treatment, as well as which sections of the Act are relevant.

SOADs will normally only certify and authorise treatment after he/she visits the patient, the clear exceptional justifiable reasons when this has not happened will be provided in the reasons. The only exception to this is where the patient is unwilling or is too disturbed to allow for this, although only a very small number of cases fall into this category. The SOAD must in any case discuss the case with the relevant Approved Clinician and two other statutory consultees. Statutory consultees are professionals who have been professionally concerned/involved in the care or treatment of the particular patient. In the first instance this would be a registered mental nurse and secondly, a professional such as a social worker, psychologist, pharmacist or occupational therapist. For Part 4 patients the responsible clinician, relevant approved clinician, or any doctor cannot be a statutory consultee. The decision to authorise treatment, either full, in part, or not at all, is only taken when all necessary information has been reviewed and evaluated by the SOAD. When authorising treatment the SOAD will clearly specify, with respect to the maximum dosage of each medication, the route of administration and any time limits on the duration treatment can be given. Medication is referred via the British National Formulary categories or individual medication names. The SOAD may also indicate whether a medication is to be given regularly, or as required, and indicate any special form of monitoring of the medication plan. The SOAD authorises an entire medication plan and Approved Clinicians may not add medication beyond the plan, even if the patient consents to the new part or any other part of the plan unless this is under Section 62 or if the patient consents to the whole new plan of Section 58 type treatment.

SOADs play an important role in safeguarding individuals who are subject to detention under the Act and promoting their human rights. SOADs are key to ensuring proposed treatment is in the best interest of the patient and is ethical and appropriate. SOADs are independent from the treating team and organisation and they are an independent "public authority" in so doing and therefore well placed to act independently.

HIW is responsible for operating the SOAD service. Whilst facilitating and appointing SOADs to individual requests HIW has no influence over the outcome of the SOAD's judgement and their opinion is completely independent. This is a further safeguard to the patient to ensure their treatment, and the appropriateness of it, is considered.

In 2014-15 HIW appointed seven new SOADs. The lead SOAD focuses on recruitment of additional SOADs, providing support and guidance to current SOADs and supporting the development of the governance of the SOAD service delegated to HIW by the Welsh Ministers. An annual training day was held in October 2014 and was well attended. There was much discussion about polypharmacy and high dose neuroleptic usage as well as practical issues with the SOAD visits, for example patients not being available when the SOAD visits.

Liable to be detained patients- Community Treatment Order – Part 4A patients

The special class of patients who are liable to be detained relevant to SOADs are those on Community Treatment Orders with respect to Section 58 type treatments and Section 58A type treatments. Once the Community Treatment Order is in place the relevant approved clinician has 28 days (or the end of the three month rule for Part 4 which ever is the later to expire) to consider whether the patient has the capacity to consent to the proposed treatment plan (Section 58 or Section 58A type treatments). The SOAD considers whether the patient consents or not and whether or not they have the capacity to make that decision. A SOAD will make arrangements to see the patient (although the imperative to see the patient is not so strong as with detained patients but is considered good practice) to form their own SOAD opinion as to the appropriateness of the treatment plan. The SOAD will also consider whether the treatment plan should have an element on the recall of the patient to hospital under Section 17E(1) for treatment in hospital.

Although one of the statutory conditions of recall on a Community Treatment Order is to see a SOAD, in Wales, Responsible Clinicians have been reluctant to recall patients to see SOADs. The SOAD does not authorise treatments given in the community to patients who are able to consent but are not consenting to the treatment but rather certifies the appropriateness of the treatment. The effect of incapacity, with reference to the Mental Capacity Act 2005, means that SOADs are authorising treatment to a patient who objects (Section 64J) but not one who refuses (except in an emergency). The SOADs role is to look at the appropriateness of treatment rather than whether the liable to be detained patient does not have capacity or does not consent with capacity. The SOAD (CO7) and Approved Clinician (CO8) Certificates on Community Treatment orders are not interchangeable. The SOAD can also authorise treatment on recall separately on the CO7 form.

The consultation process for community treatment orders can include one doctor who has been professionally (and therefore is professionally qualified) concerned with the patient but not the responsible clinician or relevant approved clinician as well as a nurse, psychologist, social worker, pharmacist or occupational therapist.

Requests for SOAD visits received during 2014-15

Table 2 shows that the number of requests made to HIW for a SOAD in 2014-15 was 812, an increase from 2013-14. This brings to a close the decreasing trend from 2011-12 to 2013-14 which was largely explained by changes where SOADs are no longer required to certify the appropriateness of Section 58 and 58A type treatments for CTOs where the patient has the capacity to consent to treatment. The patient's Responsible Clinician or relevant approved clinician may now fulfil this function and authorise the CTO (since 6th June 2012). With the introduction of Section 58A on

3 November 2008, the number of ECT authorisations had reduced, but there was a slight increase in numbers from 2013-14 to 2014-15.

Table 2: SOAD requests for certification by type of request

	Medication	ECT	Both	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

SOADs play a crucial role in ensuring that the treatment individuals detained under the Act are prescribed is appropriate and ethical according to the Guiding principles of the Code of Practice. HIW has set very tight timescales for the SOAD visits. Once a request is received by HIW for a SOAD, we aim to ensure that it takes place within:

- two working days for a ECT request
- five working days for an inpatient medication request
- ten working days for a CTO request.

In our previous annual reports we have detailed some difficulty in meeting these timescales and in the completion of the process to achieve the relevant "CO" form, this continues to be the case. SOADs have reported difficulties in undertaking requests and this can impact on the timeliness of visits and their completion. SOADs will make arrangements for the visits before attending to see the patient. In principle the patients should be seen alone unless the patient wants an advocate or other person or there are risk management issues which the SOAD needs to be supported with. The difficulties SOADs have reported to us are as follows:

- **Patients unavailable at the time a SOAD assessment was due to take place:** there have been a number of requests where a SOAD has made arrangements to see a patient to review the proposed treatment and the patient is not available when the SOAD visits. For inpatients this can be due to Section 17 leave being given or the patient transferring to a different ward or hospital and HIW (or the SOAD) have not been informed. Sometimes patients are discharged from a section under the Act before the SOAD visits and after the SOAD has made arrangements.

For patients on Community Treatment Orders there have been a number of requests where a patient has failed to attend the scheduled SOAD appointment. CTOs have historically presented problems to SOADs, as patients are to be seen in the community and these visits are difficult to facilitate. There is a reluctance to use recall as one of the statutory conditions on CTOs to promote the patient being seen by the SOAD. This makes it more likely that a Community Treatment Order may be certified without a visit from a SOAD.

- **Responsible Clinicians/Approved Clinicians not available:** SOADs need to discuss the proposed treatment with the patient's Responsible Clinician before it can be legally certified/authorised. There have been some occasions when the Responsible Clinician is not available to discuss the case with the SOAD and this has caused delays. There have been delays in SOADs issuing certificates to authorise treatment as they were unable to contact the Responsible Clinician as a result of them being unavailable due to annual or sick leave. It is expected that arrangements are made so that another Responsible Clinician is put in place to cover any absence of a Responsible Clinician. This helps to avoid any unnecessary delays to issuing statutory certificates when treatment is authorised by a SOAD.
- **Statutory Consultees not available:** SOADs need to discuss the proposed treatment with two professionals who have been professionally involved with the patient's care. A number of visits have either been delayed or cancelled as nominated consultees were not available or have taken a long time to make contact with the consultee after the initial contact by phone. The organisations have a responsibility to submit details of two consultees that have been professionally involved with the patient. The consultees must be available to have a discussion with the SOAD. There have also been instances where the consultees nominated are not aware that their names have been put forward. In addition, sometimes they have not had sufficient professional involvement with the patient to have an informed view about the proposed treatment and some proposed consultees were not professionally qualified. Organisations that submit a request for a SOAD need to ensure the nominated consultees are aware they have been nominated and have had enough involvement with the patient to have a view about proposed treatment.
- **Patient notes and clinical records not available:** SOADs have informed HIW they can often have difficulty locating the notes, Mental Health Act documentation and clinical records of patients where a request has been made. This has led to delays in the SOAD completing a request because the SOAD has to confirm that the person is still subject to the Act (and which Part).
- **Documentation of Capacity/Consent:** Demonstration of this in the clinical notes is poor either within the three month rule expiry date or subsequently in the context of a SOAD visit.

- **Confusion about SOAD role:** in some clinical areas, despite making contact with clinical areas before arrival, SOADs have been confused with DOLS assessors or MHRT members. This clarification may not survive initial explanation when arranging the visit. SOADs have identity lanyards and cards. The significance of this is when the SOAD contacts the ward, or other area, by phone, the patient may already be discharged from section. In addition, some visits were aborted because the patient was not available because the role of the SOAD was not appreciated by some staff and they did not know that the SOAD visit actually required a face to face meeting with the patient.

The Act's Code of Practice states that organisations hold responsibility for making sure arrangements are in place to facilitate a SOAD visit and facilitate contact with consultees. Mental Health Act departments of all organisations have been very helpful throughout the year in facilitating communication and helping to solve problems. These include consultee contact, resolution of difficulties with forms and bringing to light operational difficulties.

Although HIW continues to recruit SOADs actively, delays still occur in them being appointed to visits, either due to unavailability of SOADs for particular areas of Wales or where there is a conflict of interest. HIW and the lead SOAD are working with the available SOADs to improve response times and the timely completion of forms/documentation.

An increasing number of forms are now typed by SOADs and by Approved Clinicians. This has improved communication, enhancing the safety and effectiveness of practice. This will allow the voice and preferences of patients to be more clearly expressed and explored, so promoting better engagement of patients in treatment that maybe imposed on them. This is particularly important with respect to polypharmacy and high dose prescribing with respect to patient safety and prescribing allowed by the use of the Act. SOADs are very aware of the difficult prescribing circumstances for some patients and also of the difficulties and evidence of polypharmacy and high dose prescribing. SOADs will continue to work with the relevant approved clinician within the guiding principles expressed in the Code of Practice.

Chapter 4:
Patient Experience

Individuals who are detained under the Act can be very unwell and due to their illness can be profoundly vulnerable. Detention under the Act can be a difficult experience for them and their family. In view of this, our Reviewers provide a safeguard to detained patients, visiting settings where patients are liable to be detained under the Act. The purpose of these visits is to review whether the Act is being applied appropriately in line with legislation and that the rights and views of patients are respected. Reviewers also measure the settings visited against the Code of Practice to ascertain if services are focused on promoting recovery, protecting them and others from harm and keeping restrictions to a minimum.

In 2014-15 we undertook 77 visits to settings where patients are liable to be detained across Wales. A total of 59 of these visits were undertaken as part of our in-depth mental health and learning disability reviews. The organisation visited was provided with feedback at the end of the visit. This feedback was then followed by a report or management letter which was sent to the Chief Executive or Responsible Manager. Any issues of immediate concern led to an urgent action letter being sent to the organisation to seek assurances that the concern would be remedied in an appropriate timeframe.

Our visits focused on ensuring that any individual who is subject to detention under the Act is:

- treated fairly, with dignity and respect
- made aware of their rights
- cared for in a suitable and appropriate environment
- given care and treatment with respect of relevant guidelines
- involved in their care and treatment planning as far as possible.

As part of our visits our Reviewers:

- examined and scrutinised legal documentation, care and treatment plans and risk assessments to form a judgement about compliance with the requirements of the Act
- met and interviewed patients
- interviewed staff to test their knowledge and attitudes and to assess how organisations are operating (issues such as staff training, supervision/appraisal and staff knowledge are explored)

- assessed the environment where patients are cared for to ascertain that it is appropriate, clean and offered the individual patients privacy and dignity
- reviewed policies and procedures to ensure the powers of the Act are discharged and delegated appropriately.

The remainder of this chapter provides a summary of the findings from our visits. The key themes are summarised under the areas that our Reviewers look to test during each of our visits.

Have the correct legal processes been followed?

In the majority of our visits, we observed that the correct legal processes and scrutiny of statutory documentation had been followed.

Our reviews of detention documentation found that at least one of the doctors completing recommendations for detention knew the patient and the other was Section 12 approved. The documentation captured clear reasons for the detention of patients and why detention under the Act was the most appropriate way of providing care. We found that Approved Mental Health Professional (AMHP[1]) reports were available in the patient notes and the AMHP had identified and contacted the patient's Nearest Relative.

However, during one inspection we identified difficulties in undertaking assessments "out-of-hours". The AMHP recorded that the assessment started during the evening time and this meant that the patient could not be directly admitted to Hospital A because there were no doctors available on this admission ward out of hours. Following the conclusion of the assessment the patient was admitted to Hospital B approximately 4 hours later. Hospital B was approximately 45 miles from the patient's home and the patient was completely unfamiliar with Hospital B. The patient was then transported back to Hospital A the following day. Within a 24 hour period the patient had been transported at least 75 miles with a total journey time of over 2 hours simply because of the location of a doctor who could complete the admission procedure.

This patient told us that being familiar with Hospital A their experience of the admission to Hospital B was one of complete bewilderment. They found themselves in an unknown hospital, in the middle of the night, that they had never previously been to and everything was unfamiliar.

This patient's experience was not an isolated event as it was established from conversations with various staff, and in reviewing records, that if a patient requires admission to Hospital A outside the hours of 9-5 or at weekends there is no doctor

1 www.legislation.gov.uk/ukpga/2007/12/part/1/chapter/2

on duty to admit them. Patients were therefore admitted to Hospital B as this is where the medical cover is provided out of hours.

To move people who are already in a distressed state to various hospitals, over many miles and during night-time hours, in order for them to see a resident doctor, cannot be considered to be patient focussed care.

In the vast majority of occasions where a patient had been subject to the renewal of detention the correct forms had been completed within the required timescales. The statutory documentation stated why detention under the Act was still the most appropriate way of providing care for the patient. However, it was highlighted during one inspection of the historical documentation that on the renewal of one patient's detention in January 2013 there was an error on the HO15 form. The patient's Responsible Clinician at the time had written the incorrect year on the HO15 form (2012 instead of 2013) at Part 3. It is imperative that staff completing and auditing detention papers use due diligence to ensure that applications for detentions and their renewals are completed legally.

Are adequate records kept?

We raised a number of issues to organisations about the quality of record keeping and management of records.

During a number of our visits HIW found disparity between the legal documentation held centrally by the Mental Health Act Administration teams and the documentation available on the individual wards. This disparity in two sets of detention documentation could result in ward based staff having an inaccurate perception of a patient's detention status and ensuring that individual patients are treated legally under the Act.

Our inspections highlighted that on a number of visits individual patient detention records were not systematically maintained and finding specific information was challenging.

In many organisations we examined a number of incomplete and outdated files of Mental Health Act documentation. Again this makes it difficult for ward based staff to have an accurate picture of detention under The Act. Current detention documentation must be maintained in the current patient notes.

Where we found inadequate detention documentation being maintained we requested organisations to improve their audit processes to ensure compliance with the Act and Code of Practice.

Where appropriate has consent been obtained and the assessments of capacity undertaken?

The Mental Health Act defines clear procedures in relation to capacity and consent. A patients' Responsible Clinician must try to get consent from a patient prior to the commencement of any proposed treatment. However, patients can be treated without consent during the first three months of their admission but this does not mean that clinicians should not make every effort to obtain consent from individual patients. As set out in the Code paragraph 17.26:

> *"Even though the Act allows treatment to be given without consent during the first three months, the clinician in charge of the treatment should ensure that the patient's valid consent is sought before any medication is administered. The patient's consent or refusal should be recorded in the case notes …"*

The underlying principle of the The Mental Capacity Act (2005) is that every adult must be assumed to have capacity unless it is proved otherwise. It cannot therefore be assumed that just because an individual has a mental disorder and is detained under the Act that they do not have the capacity to consent to treatment.

Again this year during our visits the overall quality of records of assessment of capacity were variable and many lacked sufficient detail. Similar to last year there remained a lack of evidence that attempts had been made to obtain consent from patients at the first administration of treatment. Again there remained a lack of clear entries in patient's notes by Responsible Clinicians documenting any discussions held about proposed treatment and the views of the patient about it.

During our visits we found good examples of how consent and assessments of capacity had been followed.

In one case reviewed, the Responsible Clinician at the time of this assessment made detailed notes of the patient's capacity and whether they were freely consenting. This is practice that is advised in the Code of Practice for Wales (17.28). It was pleasing to see that it had been done with such detail and consideration. As a result of this assessment a CO2 certificate of treatment was issued. When the treatment plan changed a month later similar detailed entries with regard to capacity and consent were found in the notes from the Responsible Clinician at that time. This allowed for a different CO2 certificate of treatment to be issued. Three days after this certificate was issued the Responsible Clinician noted that the patient had withdrawn their consent for part of their treatment plan. Immediately, a request was made to HIW for a Second Opinion Appointed Doctor (SOAD) to visit. When the visit took place we found that the patient was receiving their treatment under the authority of a CO3 issued by the SOAD.

The prescribed medication complied with the CO3 certificate of treatment. In addition, it was clear that the pharmacist had provided high dosage advice directly onto the prescription card to guide the clinical staff as to safe limits of a particular medication. The actions and practice of this Responsible Clinician are exactly what the Act and the Code of Practice require.

However, on a number of occasions we reviewed notes where Section 62 certificates for urgent treatment had been misused. In each case it was unclear why Section 62 had been used, as the provisions of the Act for medication within the first three months meant that the clinical team had the authority to impose treatment (Code of Practice for Wales paragraphs 17.26). Section 62 is reserved for use in specific circumstances as stated in the Code of Practice for Wales, and when urgent treatment is necessary for example to save a patients life (paragraphs 17.54 – 17.59).

Are individuals detained under the Act aware of their rights under Section 132 of the Act?

Patients detained under the Act should be made aware of their rights in line with Section 132 and 132A. Patients detained clearly have rights in relation to; detention, any restrictions, renewal and discharge, information about consent to treatment and accessing independent mental health advocates (IMHAs). In addition, the Code of Practice for Wales (Paragraph 22.30) states: *Patients should regularly be given an explanation of their rights and restrictions*.

When we undertake a Mental Health Act monitoring visit to an organisation we routinely speak with patients to establish if they are aware of their rights whilst being detained under The Act. We also examine the individual patient notes to establish if there is evidence that their rights have been explained to them, or that attempts have been made to do so.

In general on the majority of wards visited we found patients had been informed of their rights at regular intervals and this was well documented.

Unfortunately, we did however find examples where patients were not aware of their rights whist being detained under the Act. In addition, it could not be established from examining their clinical notes that these discussions had taken place.

Do individuals have access to an independent mental health advocate?

Access to an Independent Mental Health Advocate (IMHA) is a statutory right for patients detained under the Mental Health Act. IMHAs provide independent support to patients to ensure they know their rights and can help patients have their opinions and concerns heard.

Nearly all the organisations we visited displayed information and posters regarding advocacy services and how patients could engage with the local service. The patients we spoke to were aware of the advocacy service and how they could access them.

The small number of services we identified as having a lack of awareness of advocacy services were asked to raise awareness among patients and staff to ensure compliance with the Act.

Is the environment of care appropriate and conducive to recovery?

It is important that hospitals have the right environments for patients, especially when many patients can be detained for long periods and in some circumstances unable to leave the ward due to their illness. The environment therefore can have a major effect on the mood and recovery of an individual.

Whilst we have identified a number of hospitals with clean, safe, well maintained and therapeutic environments, we have identified a significant number of issues in some settings. The most common issues we have identified include:

- unacceptable levels of cleanliness, including marked/stained flooring and walls, dirty bathroom facilities and unpleasant odours.
- damaged furniture and fittings
- environments requiring refurbishment.

Outside spaces are vital for patients to access fresh air, especially when a patient is unable to leave a hospital. We identified a number of outside spaces that were conducive to an individual's needs with seating and well maintained garden areas. However, there were some settings in which the gardens were in need of maintenance because paving was uneven or not suitable for the patient group. Some garden areas were unkempt and littered with cigarette ends and required general maintenance to improve the appearance.

During one inspection we found one ward was accommodating patients from another hospital within the health board for over a month since it's temporary closure due to insufficient staffing. We were informed that the decision had been made to combine the wards to ensure the safety of patients.

Whilst we appreciated the basis for this decision, the closing of the one hospital reduced the number of in patient beds available within the health board and had a detrimental effect on the provision of care for a number of months. It was pleasing to note that when we undertook a follow up inspection to the closed hospital a number of months later that the service was fully operational.

Is the environment of care safe?

Our visits highlighted a significant number of hospitals in which staff were not wearing a personal alarm whilst on duty. We identified a number of reasons for this including staff not electing to wear an alarm, not enough alarms available for staff to use and alarms that did not work. The wearing of alarms by staff, in order to protect their safety and that of patients, represents good practice.

Many of the hospitals we visited did not have a nurse call system in patient areas including bedrooms. Some of the hospitals with a nurse call system had them placed inappropriately which would be difficult to reach if a patient needed to use it. A nurse call system enables patients to call for assistance from a member of staff should the need arise.

On one psychiatric intensive care unit, we observed the seclusion room as not fit for purpose. The room had blind spots which made observations by staff difficult in certain areas. Seclusion rooms are for patients experiencing acute episodes of illness and require rooms in which staff can clearly observe the patient.

We also noted that on some wards, where exit from the ward was controlled by a locked door, there was not always information displayed explaining to informal patients how they could leave the ward if they so wished, as set out in the Code of Practice for Wales, paragraph 19.52.

During one inspection, we identified that the front entrance door of a standalone unit had a magnetic door closure mechanism that can be locked at night to secure the ward for patients and staff. However, on entering the unit we noticed that a padlock hasp was in-place on the inside of the entrance door. Staff informed us that this was installed as an emergency temporary measure by the health board's estates department as the magnetic locking mechanism had broken. This temporary locking system remained in place for five months despite regular follow-up enquiries to the Estates Department by ward staff. When the magnetic lock was repaired, the padlock hasp was not removed.

Whilst HIW acknowledge that the installation of the padlock hasp was an emergency measure to secure the unit and protect patients and staff when the ward requires locking during the night, the installation was intended as an immediate remedy. To leave the front entrance of a unit, with vulnerable patients within it, only secured at night with a padlock hasp and padlock for approximately five months cannot be considered acceptable from a safety and fire risk point of view.

In addition, the impression of a padlock hasp on the front entrance door of the unit can only be considered as disconcerting for the patients on the unit and for any visitors to the ward, including relatives and friends. The length of time to rectify the fault with the locking mechanism and the padlock hasp remaining in place is wholly unacceptable.

The padlock hasp was removed with immediate effect when HIW brought this to the attention of senior managers at the health board.

Are patients afforded privacy and dignity?

On the whole we found that the hospitals we visited made every effort to maintain a patient's privacy, dignity and respect, but we did find some issues regarding privacy and dignity.

A number of hospitals that had dormitory style bedrooms did not provide patients with an acceptable degree of privacy because patients' beds were only separated by curtains. This situation did not allow for private conversations with staff.

We identified some wards in which patients had no curtains on their bedroom windows, therefore compromising the patients dignity and respect. Some issues were identified regarding vision panels on bedroom doors. Some panels were broken and covered with paper, therefore staff would be unable to undertake observations without disturbing the patient by going into their bedroom. Some vision panels could not be operated from inside a bedroom should the patient want privacy.

Unfortunately there remained similar issues that were reported in the last Annual Report where we observed on some wards patient information displayed on whiteboards in the nursing station which was visible to patients and visitors. It is unacceptable that confidential and sensitive information was not safeguarded to ensure patients' confidentiality is protected. Where we have identified this practice we have raised the issue and insisted that when not in use patient information is covered.

Are bathroom and toilet facilities adequate?

As part of our inspection process we review the bathroom and toilet facilities available to patients, which can be en-suite or shared bathrooms and toilets. Most of the amenities we have observed have provided patients with adequate and appropriate conveniences.

Although most bathrooms and toilets have been satisfactory, we have identified a number of common issues:

- Dirty and/or stained facilities
- Stained/marked flooring
- Unpleasant odours
- Poor water pressure in showers
- Shared bath plugs between two bathrooms
- Broken/unusable facilities.

Some hospitals have not had appropriate hoists available therefore limiting the bathing options available to some patients. In addition, some bathroom and toilet facilities have had handrails removed. This has stopped some patients being able to use these facilities unaided.

Do patients have access to phones and rooms for private conversations?

It is essential that patients have the opportunity to maintain contact with family and friends whilst staying in hospital. Although we found that patients were able to telephone friends and relatives, we did identify variations in the way this opportunity was offered.

Patients had increased opportunities to make and receive calls in private in hospitals that allowed patients to use mobile phones. Some hospitals restricted patient access to phone chargers, with one hospital in particular unwilling to charge mobile phones once the battery had no charge left. Many of the hospitals we visited allowed patients to use their office telephones. Not all the telephones were cordless and all were situated in the nurses' office. This situation did not allow for total privacy but did provide patients with a means of maintaining contact with relatives.

Some hospitals had payphones on the wards, with some situated in specific telephone booths that allowed patients the ability to have private conversations. Some payphones were situated in public areas providing little privacy to undertake personal calls.

We identified at some hospitals that payphones were not working and this left patients with limited or no means of contacting family and friends. When we have identified this situation we have raised the issue with senior staff in order that facilities are fixed and/or alternative arrangements put in place.

Patient access to rooms for meeting family and friends in private was again varied, with many hospitals providing limited visitor rooms. Discussions with patients highlighted that areas including lounges and dining rooms were often used to host visits from relatives. Although many hospitals are limited on space, we have requested settings to review their environments with a view to increasing space for their patient group.

Do patients have access to regular activities and the therapies they need?

Are adequate activities provided?

A wide-ranging programme of meaningful activity and therapies can have positive effects upon a patients recovery. Our inspections have highlighted vast variations regarding the provision of activities and therapies and as a result mixed views from patients.

Common themes resulting from services/hospitals that are providing meaningful activities/therapies include:

- dedicated and regular input from disciplines including occupational therapy (OT) and psychology
- innovative and personalised assessments resulting in individual patient activity programmes/timetables
- patient empowerment and feedback into what activities and therapies patients want to be involved in
- regular reviews of the activities being offered, ensuring changes are representative and suitable for the patient group and continue to be therapeutic and stimulating
- sufficient staffing levels to ensure activities and therapies are continually delivered
- a range of facilities on site as well as access to community based activities
- mix of group and individual sessions taking place
- displays of patient artwork and craft throughout the hospital.

Many of the patients we spoke to told us they had experienced periods of boredom due to activities being cancelled or not available at weekends or during the evenings. The themes identified which have resulted in negative views include:

- under utilised facilities and/or activity rooms being locked/patients unable to gain regular access
- a lack of staff to deliver programmes/facilitate sessions
- activities which are not suitable for the patient group and deemed childish
- lack of opportunities to engage in community/vocational activities
- limited input from specialist disciplines, such as OT and psychology to ensure activities and therapies are patient specific
- lack of encouragement to take part in activities and therapies.

During our visits we observe patient involvement in activities and therapies as well as review activity schedules. Our observations have been varied. During the majority of visits we have observed limited or no patient activity taking place.

When we have observed this we have asked the organisation to address the issue and provide an action plan on how and when it will be improved.

Is the approach to care planning appropriate/are well developed care plans in place?

Are the care plans detailed and appropriate?

During visits we always review the care and treatment plans (CTP) of individual patients. CTPs of patients are considered against the Mental Health (Wales) Measure 2010 (the Measure). Part 2 of the Measure places duties on mental health providers in relation to the preparation, content, consultation and review of CTPs. Although we have reviewed CTPs which have been comprehensive and detailed, with considerable patient involvement, we have found a number of CTPs with issues, which were raised with the organisations.

The issues we have identified regarding care and treatment plans have included:

- out of date care and treatment plans, some with no indication of when a review was due
- some patients with no CTP in place and/or no evidence of any patient involvement in the care planning process
- a lack of patient and staff signatures on care plans, including the Care Co-ordinator
- the standard of the Mental Health (Wales) Measure not being detailed nor embedded in some hospitals
- difficulties in ascertaining the level of discussions and agreement of care plans for patients due to key areas being left blank.

Are adequate risk management and safeguarding arrangements in place?

The assessment of risks, and developing risk assessments to mitigate and manage such risks, is a vital part of care planning for each individual patient. Our reviews of risk assessments have highlighted variations in the quality and detail of assessments.

The hospitals in which we have identified noteworthy practices in relation to their risk management have included:

- comprehensive risk assessments that have been devised by a number of disciplines in which their views and different perspectives feed into the process
- engagement with patients, carers and relatives
- regular reviews of risk assessments in which recommendations are actioned in a timely manner.

Throughout our visits we have identified a significant number of occasions when there has been no risk assessments formulated for patients. When this has been identified we have asked hospitals to implement a plan as a matter of urgency.

A common theme we have identified is a lack of engagement with patients, carers and relatives in relation to identifying potential risk areas, from which strategies can be developed to help minimise and manage the risks. We identified a lack of written evidence that the patient had been involved or had the opportunity to be involved in the risk assessment process.

Some risk assessment outcomes had not been transferred into care and treatment plans and we identified a lack of review and action from risk plans. As risks cannot be eliminated, it is good practice to regularly review patient risk plans because risks may decrease in one area only to increase in another. Without regular review this could have negative consequences for patients and staff.

We observed a number of areas in which risk and safeguarding arrangements have been unacceptable and have included:

- gaps identified in patient observation records, with a number of records not being fully completed and lacking sufficient detail
- some patient admissions, and the diverse range of illnesses found in a setting, have not been appropriate and have not met conditions of registration for independent settings. Patient admissions and patient mix need to be appropriate to ensure patients receive the correct care and treatment
- a lack of staff knowledge and understanding can compromise risk and safeguarding arrangements because staff have not had up to date skills. Areas identified have included the Mental Health Act, Mental Capacity Act 2005 and restraint training
- some hospitals have had a lack of robust governance and audit processes in place. This has led to poor early identification of patient risks and issues
- numerous medication issues have been identified resulting in risk and safeguarding concerns. The issues we have identified have included unclear medication instructions, responsible clinicians not signing for all medication on prescription sheets, expired medications and out of stock medication
- arbitrary decisions made by hospitals and applying them to all patients, rather than individually dealing with the risks posed for each patient.

Are the physical healthcare needs of patients being met?

Care and treatment plans for detained patients should consider all aspects of a patients healthcare including how physical needs are being met. Detained patients may well have a range of physical health problems in addition to issues with their mental health. Many patients with enduring health care problems may have neglected their physical healthcare needs for many years prior to admission to hospital. Our monitoring of the Act includes consideration of how plans of care address physical healthcare needs.

We found overall that patients had access to healthcare services and were registered with local GPs and dentists. Specific healthcare appointments would be made on behalf of the patient and patients generally spoke positively about their care and treatment. It was pleasing to note that some hospitals have physical healthcare nurses to oversee this area of care for patients.

However, we identified a significant number of instances in which the physical health care needs of patients were not being monitored appropriately. In these incidents we have asked settings to immediately address the issues to ensure patients are accessing the care and treatment they need. The issues we have identified include:

- a patient requiring a scan had their appointment cancelled by the hospital providing the procedure. At the time of our visit no date had been arranged and we recommended to staff that a new appointment was scheduled to ensure the patient received the scan and any appropriate treatment
- wound care for a number of patients identified a lack of detail in care plans. There have been no descriptions of the wound, size and colour to determine whether the wound was healing or not
- care plans for patients with diabetes having had limited or no information regarding blood glucose levels and regular monitoring results. Foot care and other physical health complications have been absent from patient care plans
- poor evaluation of weight management plans for patients. Care plans have had no weight recorded and have lacked specific goals around achieving a target weight
- a patient had complained of earache and it took several requests, during the visit by HIW, for the patient to be examined
- several patients had no care plans in place to indicate how their pain was being assessed and managed, despite some having recently had minor surgery
- a patient did not have access to podiatry services and their toe nails desperately required cutting
- A Do Not Attempt Resuscitation (DNAR) (in-patient) authorisation form was completed for a patient. However, there were omissions on the form, including the completion date, that meant that staff had not followed its organisation’s policy for DNAR authorisation.

Is Section 17 leave managed appropriately?

Patients detained under The Act can be granted a leave of absence from the ward and hospital by their Responsible Clinician under Section 17. However, patients who are on detention orders as a result of criminal proceedings must also have authorisation from the Ministry of Justice. The leave granted is based upon a number of factors including; the level of risk and the progress of the patient with the treatment regime. This leave granted can vary from a couple of hours, days or even weeks.

Sometimes one of the conditions of granting the Section 17 leave may be that patients will be escorted when taking leave. Section 17 leave is an important piece of a patients' treatment plan that promotes independence.

Part of the monitoring of The Act means that we routinely review the Section 17 leave documentation and it is appropriately completed which includes:

- specific details regarding the timescales allocated to patient on leave
- a thorough risk assessments of the leave taking into account how identified risks will be managed
- that any restrictions in place have been discussed and agreed with the patient
- a clear reason based on clinical criteria for the granting or refusal of leave.

We found many good examples where Section 17 leave was well documented and the forms completed to a high standard including:

- comprehensive risk assessments with any conditions of leave clearly set out
- forms signed by the patient's Responsible Clinician
- individual patient expired or cancelled leave forms were clearly indicated as no longer effective.

However, similarly to our findings of 2013-14 we again found numerous examples of where Section 17 leave had not been appropriately managed.

Again, this year during our monitoring visits a number of patients stated that section 17 leave was often cancelled at short notice due to inadequate staff numbers and in some cases Section 17 leave that had been planned for some time had to be cancelled. Clearly when Section 17 leave is cancelled this can have a very detrimental effect on patients' therapeutic programmes.

As part of our monitoring visits we reviewed a selection of Section 17 leave forms for patients who were on detention orders as a result of criminal proceedings. Any leave for these patients has to be agreed by the Ministry of Justice and it is good practice for the leave authorisation to be filed alongside the current Section 17 leave form. This ensures that staff has all the information they need in terms of the leave granted

and any restrictions that are in place. Unfortunately this practice was not evident in all the records reviewed.

Again this year we found a number of section 17 leave forms where the patient had not signed the form to confirm they were in agreement with the leave and any restrictions detailed on the form. We also noted that on the forms there was no explanation provided about why the patient had not signed and so it was difficult to establish if the leave had been discussed with the individual patient.

In addition, on occasions the Section 17 leave forms on the patient files did not record whether patients had been given copies of their Section 17 leave form or not.

We also found examples of where the outcomes of leave for the patient were not recorded and this did not demonstrate adequate monitoring of the success or otherwise of the planned leave. The Code of Practice states the outcome of leave, for example if it went well or whether the patient or staff had concerns about it, should be recorded in the patient's notes and patients should be involved in discussions about their leave.

Are staff aware of their responsibilities and are there sufficient staff in place to manage the case mix?

All disciplines of staff have a vital role in delivering safe and effective care to their patients. We have observed throughout our visits many examples of good staff and patient interactions, particularly with complex and challenging patient groups. It is disappointing therefore to highlight issues that have been raised in previous years.

One of the most common issues highlighted to us by both staff and patients is staffing levels. On many occasions we have identified inadequate staffing levels for the numbers of patients on the wards. In addition, when patients have been placed on enhanced observational levels, for example on a one to one, the staff that undertake this have been taken out of the core staffing numbers for that shift leaving the ward in an unsafe position should an incident occur.

The additional impact we have identified and observed from low staffing levels has included:

- poor staff morale
- tired staff members suffering from burnout
- a lack of staff supervision, training and reflective practice taking place
- a lack of nurse led activities and 1:1 therapeutic time with patients
- higher sickness levels.

All the hospitals we have visited have had programmes of mandatory training in place which are delivered by online and/or class room style methods. Many of the staff we have spoken to told us that they had not received up to date training in the past 12 months and an analysis of training statistics across many of the hospitals visited has highlighted significant issues regarding staff knowledge and compliance rates.

The issues we have identified for staff having significant gaps in their training have been:

- A lack of trainers to facilitate training sessions
- A lack of spaces on some courses
- Ward demands and a lack of staff to cover
- No central system to coordinate staff attendance
- Financial constraints.

Significant gaps in essential training, including restraint, basic life support and health and safety, has left some wards vulnerable. The absence, or limited levels of staff training in key areas has left staff unable to deliver safe and effective care. When training and staff knowledge has been poor we have asked hospitals to address the shortages urgently.

We identified that a number of Mental Health Act administrators had not received specific training in the Act and that some administrators had their duties diluted because they were expected to undertake additional roles and responsibilities. All Mental Health Act administrators need to be provided with up to date training to ensure compliance with the Act.

Chapter 5:
Conclusion and Next Steps

The findings contained within this report identify the distinct and important role HIW has in the monitoring of the use of the Mental Health Act in Wales. The findings evidence the important role of the SOAD service provided by HIW and the crucial role of our reviewers in upholding the rights of patients who are detained under The Act through its robust monitoring systems.

This report identifies concerns and issues that HIW observed during our visits in 2014-15 and by direct patient contact with ourselves. In addition, the report also contains areas of noteworthy practice. We encourage all relevant organisations to read this report and learn from both the issues and the noteworthy practice to help drive improvement in services.

We will continue to work with the organisations we visit with the aim of raising any concerns we have and ensuring these are rectified so the experience of patients is improved.

HIW are exceptionally disappointed that many of the issues identified within this report are not new and many were identified within our 2013-14 annual report.

From 1 April 2015 we moved to publishing all reports of our findings, along with the action plans submitted by the health boards and Registered Providers. This move has been welcomed by many organisations and patient groups and will provide a valuable insight into this key area of HIW's role in monitoring the use of The Mental Health Act.

In 2015-16 HIW commence a programme to inspect the provision of CTOs in a number of health boards. This is the first time that we have inspected this area of community detention and it is envisaged that this programme will continue each subsequent year. We will take the opportunity to report on the findings of this significant piece of work in our next annual monitoring report.

Appendix A

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*.
After-care	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under Section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to Supervised Community Treatment (SCT) patients and conditionally discharged patients, as well as those who have been absolutely discharged.
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Appropriate National Authority	This refers to the Ministers of the Welsh Government.
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.
Approved Mental Health Professional	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
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 Programme Approach (CPA)	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.
Carer	Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs.
Child and Adolescent Mental Health Services (CAMHS)	Specialist mental health services for children and adolescents. CAMHS covers all types of provision and intervention – from mental health promotion and primary prevention and specialist community-based services through to very specialist care, such as that provided by inpatient units for children and young people with mental disorder.
CO1 form	Certificate of consent to treatment and second opinion (Section 57).
CO2 form	Certificate of consent to treatment (Section 58(3) (a)).
CO3 form	Certificate of second opinion (Section 58(3) (b)).
CO4 form	Certificate of consent to treatment – patients at least 18 years of age (Section 58A (3) (c)).
CO5 form	Certificate of consent to treatment and second opinion – patients under 18 years of age (Section 58A (4) (c)).
CO6 form	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment).
CO7 form	Part 4A certificate of appropriateness of treatment to be given to a community patient.
CO8 form	Certificate of consent to treatment for community patient – (Approved Clinician Part 4A certificate).
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Compulsory treatment	Medical treatment for mental disorder given under the Act.
Consent	Agreeing to allow someone else to do something to or for you: Particularly consent to treatment.
Deprivation 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.
Doctor approved under section 12 (also 'section 12 doctor')	A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under Section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under Section 12.
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
GP	A patient's general practitioner (or '*family doctor*').
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.
Holding powers	The powers in section 5 of the Act which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.

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.
Hospital order	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under Section 37 of the Act.
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder 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.
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*'.
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.
Local Social Services Authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country.
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 habilitation, 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 disorder	Any disorder or disability of the mind. As well as mental illness, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities.
Mental Health Act Commission (MHAC)	The independent body which was responsible for monitoring the operation of the Act. The Health and Social Care Act 2008 abolished the MHAC. Its functions in relation to Wales transferred to the Welsh Ministers who delegated them to Healthcare Inspectorate Wales (HIW).
Mental Health Review Tribunal for Wales (MHRT for Wales)	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
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.
Ministry of Justice	Responsible for the Home Office's Mental Health caseworker section along with the public protection caseworker section.
Nearest relative	A person defined by section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.
P & Q and Cheshire West	The judgment, following the court case provides much needed clarity on the issue of deprivation of liberty. The Supreme Court provided a simple test to decide if the individual is deprived of their liberty which will be far easier to apply than the previous test and which will afford far greater protection to vulnerable people. This case now sets a precedent that anyone who meets the new legal test will be considered to be deprived of their liberty and subject to a protective care regime. People in P's situation who lack the mental capacity to make decisions for themselves, whether as a result of dementia, learning disabilities, brain injury or mental health problems, should have the benefit of regular independent reviews to ensure that their placement and any restrictions on their movement are still in their best interests.
Part 2	The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.

Part 3	The Part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for Treatment.
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.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under Section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Polypharmacy	The concurrent use of multiply medications by one individual.
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.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49. The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Revocation (and revoke)	Term used in the Act to describe the rescinding of a community treatment order (CTO) when a supervised community treatment patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made.
SCT patient	A patient who is on supervised community treatment.

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 12 doctor	See doctor approved under Section 12.
Section 37	This is an hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient must be a risk to the public. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function.
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety.
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety 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.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Supervised Community Treatment (SCT)	Arrangements under which patients can be discharged from detention in hospital under the Act but remain subject to the Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again.
Three month period	The period of three months from when treatments to which section 58 of the Act would apply are first administered.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.