Mental Health Legislation & Mental Capacity Act Committee Meeting

Tue 01 August 2023, 10:00 - 11:45

MS Teams

Agenda

10:00 - 10:01 1 min

1. Welcome & Introductions

Ceri Phillips

10:01 - 10:02 1 min

2. Apologies for Absence

Ceri Phillips

10:02 - 10:03 1 min

3. Declarations of Interest

Ceri Phillips

10:03 - 10:05 2 min

4. Minutes of the Meeting held on 2 May 2023

Ceri Phillips

4. MHLMCA Minutes 02.05.23.pdf (12 pages)

10:05 - 10:07 2 min

5. Action Log from the meeting held on 2 May 2023

Ceri Phillips

5. Action Log 01.08.2023.pdf (1 pages)

10:07 - 10:09 2 min

6. Chair's Action taken since last meeting

Ceri Phillips

10:09 - 10:10 1 min

7. Any Other Urgent Business Agreed with the Chair

Ceri Phillips

10:10 - 10:30 20 min

8. Mental Capacity Act

8.1. Mental Capacity Act Monitoring Report and DoLS monitoring including: Workforce Requirements

20 minutes *Jason Roberts*

8.1 MCA and DoLS report for MHLMCA Apr - Jun 23.pdf (7 pages)

10:30 - 11:05
35 min

9. Mental Health Act

9.1. Mental Health Act Monitoring Exception Report

10 minutes *Paul Bostock / Daniel Crossland*

- 9.1 Cover Report MH Act Monitoring Exception Report.pdf (7 pages)
- 9.1a Mental Health Act Monitoring Report April - June 2023.pdf (49 pages)

9.2. Hospital Managers Power of Discharge Sub Committee Annual Report

10 minutes *Paul Bostock*

- 9.2 PoD Annual Report 2022-2023.pdf (2 pages)

9.3. HIW MHA Inspection Reports

10 minutes *Jason Roberts / Daniel Crossland*

- 9.3a HIW Inspection Report - East 12 & East 16.pdf (35 pages)
- 9.3b HIW Inspection Report - Pine and Ash Wards.pdf (62 pages)

9.4. Public Service Ombudsman Wales Reports

5 minutes *Jason Roberts*

- 9.4 PSOW Report.pdf (3 pages)

11:05 - 11:15
10 min

10. Mental Health Measure

10.1. Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report

10 minutes *Paul Bostock / Daniel Crossland*

- 10.1 Mental Health Measure July 2023.pdf (10 pages)

11:15 - 11:25
10 min

11. Items to bring to the attention of the Committee for Noting / Information

11.1. Corporate Risk Register

5 minutes *James Quance*

- 11.1 MH Corporate Risk Register Report - July 2023.pdf (3 pages)
- 11.1a Detailed Corporate Risk Register - July 2023.pdf (1 pages)

11.2. Sub-Committee Meeting Minutes:

5 minutes *Jeff Champney-Smith / Robert Kidd*

i. Hospital Managers Power of Discharge Sub Committee Minutes
ii. Mental Health Legislation and Governance Group Minutes

- 11.3.1 PoD minutes 11 July 2023.pdf (3 pages)
- 11.3.2 MHLGG minutes 13 July 2023.pdf (9 pages)

11:25 - 11:25
0 min

12. Items for Approval Ratification

No items for approval

11:25 - 11:25
0 min

13. Any Other Business

Ceri Phillips

11:25 - 11:25
0 min

14. Review of the Meeting

Ceri Phillips

11:25 - 11:25
0 min

15. To note the date, time and venue of the next meeting:

31st October 2023 via MS Teams

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 2 May 2023
Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance:		
Daniel Crossland	DC	Director of Operations - Mental Health
Neil Jones	NJ	Clinical Board Director – Mental Health
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
James Quance	JQ	Interim Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Mental Health Act Manager
Catherine Wood	CW	Director of Operations – Children & Women's
Observers:		
Elizabeth Singer	ES	Deputy Chair of the Powers of Discharge sub-Committee
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Susan Elsmore	SE	Independent Member - Council

Item No	Agenda Item	Action
MHLMCA 23/05/001	**Welcome & Introductions** The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHLMCA 23/05/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 23/05/003	**Declarations of Interest** No Declarations of Interest were noted.	
MHLMCA 23/05/004	**Minutes of the Meeting held on 31 January 2023** The Minutes of the Meeting held on 31 January 2023 were received. **The Committee Resolved that:** a) The minutes of the meeting held on 31 January 2023 were agreed as a true and accurate record.	

MHLMCA 23/05/005	**Action Log from the meeting held on 31 January 2023** The Action Log was received and discussed. **The Committee Resolved that:** a) The Action Log was noted.	
MHLMCA 23/05/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 23/05/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHLMCA 23/05/008	**Mental Capacity Act Monitoring Report and DoLS monitoring** The Mental Capacity Act Monitoring Report and Deprivation of Liberty Safeguards (DoLS) monitoring was received. The Executive Director of Nursing (END) advised the Committee that he would take the paper as read and that the report provided a general overview of the Mental Capacity Act and DoLS compliance. He added that as reported previously, IMCA referrals had increased from January 2023 through to March 2023 and referral rates were noted to have increased 15% overall from last year's average. It was noted that the most notable increase had been in relation to the Relative Persons Representative (Health) which had increased over 25%, from 58 last quarter to 73 referrals in the current quarter. The END advised the Committee that in relation to Mental Capacity Training, whilst booking rates had increased in recent months, the Health Board had experienced low attendance rates on the day which was likely due to ongoing clinical pressures and staffing issues. He added that recruitment was underway for two new Mental Capacity Specialist Practitioners to be in post by June 2023. It was noted that the aim would be for those postholders to be able to deliver training directly within clinical areas to try and improve accessibility and to improve compliance with mandatory training. It was noted that DoLS training had recently been commissioned in order to help raise awareness with regards to what amounted to a deprivation of liberty. The training had been arranged in order to ensure that the Health Board was effectively	

	safeguarding vulnerable patients and that staff were completing DoLS referrals where appropriate. The Committee was advised of the DoLS monitoring actions which included: • Annual overview from April 2022- March 2023 - A general increase in applications since August 2022 was reported. Up until 31st July 2022, the mean number of applications was 80 per month, compared with 116 per month from 1st August 2022 onwards. • December 2022 assessment figures were reduced due to increased annual leave and bank holidays. It was noted that the last quarter had shown an increase in capacity using additional funds to address the DoLS backlog. • 78% of applications were within time and 22% had breached for the last quarter (January – March 2023). It was noted that it was an improvement upon the last report's figures, when 34% of applications had breached (November 2022). The END advised the Committee that, as previously outlined, breaches had occurred due to insufficient resources to complete the assessments within the required timeframe. For the last financial year, £90,000 of the LPS funding had been put towards increasing resource for assessments through the use of agency and overtime to address the significant backlog. He added that whilst it appeared to have had a positive effect, the Health Board would need to explore how it could address the need for increased resource over the longer term and maximise use of funding now that the LPS had been delayed indefinitely. The Independent Member – Capital & Estates (IMCE) asked what had contributed to the increase in people undertaking the training. The END responded that the DoLS lead specialist had been implemented 12 months ago and had increased the awareness of the training across the whole organisation. The IMCE noted that the consent to examination e-learning package would be monitored and asked what plans were being held in relation to that. The END responded that the e-learning package was still new and that the teams were still working through the plan on how best to achieve relevant compliance. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	
MHLMCA 23/05/009	**Liberty Protection Safeguards Monitoring Report** The Liberty Protection Safeguards (LPS) Monitoring Report was received.	

	The END advised the Committee that the UK Government had recently announced their decision not to progress the Liberty Protection Safeguards (LPS) or implement the Mental Capacity (Amendment) Act 2019 within the current Parliament. He added that further to the announcement, the Welsh Government had expressed its disappointment to the decision and had committed to continue to provide increased funding to protect the rights of those who lacked mental capacity. It was noted that the focus for the Health Board would remain upon improving understanding and application of the MCA in clinical practice, strengthening the current Deprivation of Liberty Safeguards arrangements and improving ongoing monitoring and reporting. The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) noted that it could mean that the Health Board was left with the DoLS system for up to 15 years and asked how and where would the Health Board want to review the workforce for that system because over the past few years, a few Best Interest Assessors had stepped away from the service. The END responded that the Health Board's focus would be on the fundamental foundations of the 2 systems, and consent Mental Capacity Act training and all of the relevant legislation. He added that it required a unique bespoke area of training and that the unique knowledge required was not held by many staff and so work would need to be undertaken on workforce. It was noted that this would be received by the Committee at a later date. The CC advised the Committee that the Welsh Government's (WG) response to UK Government's abandonment of LPS was one of disappointment and noted that the Health Board should move towards an enhanced DoLS system, even if LPS would not materialise in the future. He added that as a Health Board, work had been undertaken in looking at the workforce requirement for LPS and so that work should continue. It was noted that the recommendations would require amendment due to the implementation of the LPS being halted. **The Committee resolved that:** a) The contents of the report were noted.	**JR**
MHLMCA 23/05/010 	**Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The Mental Health Act Manager (MHAM) advised the Committee that that there had been no fundamentally defective Section 5(2) applications for the quarter but noted that there had been one fundamentally defective report of a Section 5(2) and one invalid use of the Mental Health Act and provided details on those.	

	He added that during the period, the use of 136 Sections had decreased from 119 in the previous quarter to 114 in the current reporting quarter. It was noted that from those 114, 71% were not admitted to hospital and only two were patients of the Child and Adolescent Mental Health Services (CAMHS) which was a decrease from the 8 reported in the previous quarter. The Director of Operations - Mental Health (DOMH) advised the Committee that some cross-validation work had been undertaken with South Wales Police in relation to the 136 Sections to check that the numbers were correct and accurately reported. He added that the only variation seen was around ethnicity recording with the Police having a better recording system for that. The MHAM advised the Committee that face to face hearings had commenced successfully from 01/03/2023. The President of the Mental Health Review Tribunal (MHRT) had confirmed that patients would have a choice via the appeal application form on whether they wished to have a face to face hearing, a virtual hearing or had no preference. However, it did state that although the MHRT would seek to facilitate the patient's choice, it could not always be guaranteed. The Committee Vice Chair (CVC) noted the improvement in the MHRT and asked if the training issue was also resolved. The MHAM responded that there were not issues in training at present. The Committee was advised that the MHA office had continued to run awareness sessions including a monthly MHA training day which was available to all staff within the Health Board, a monthly Consent to Treatment workshop, a quarterly Rights workshop and a quarterly Forensic workshop. The MHAM added that an e-learning module would be created around the Summer time and asked for the Committee's help in ensuring that could be put onto the Electronic Staff Record (ESR) as a mandatory training module. The CC asked for that to be noted as an action. The ICDPPT advised the Committee that it was useful to note that a reduction of repeat 136 Sections had been observed in CAMHS and that was due to greater collaboration between the Adult Mental Health Services and CAMHS. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation as set out in the report, was noted.	**NS**
MHLMCA 23/05/011	**HIW MHA Inspection Reports (verbal)** The Health Inspectorate Wales (HIW) MHA Inspection Reports update was received.	

	The DOMH advised the Committee that since the previous report, a further 2 reports had been received for Ash Ward and Pine Ward and a further 2 inspections had taken place on East12 and East16 Wards. It was noted that the HIW inspection covered a range of areas of interest to the Committee: • Quality of patient experience • Delivery of safe and effective care which included: • Record keeping • Mental Health Act Monitoring • Monitoring of the Mental Health (Wales) Measure 2010 • Quality of management and leadership It was noted that the summary reports included Action Plans, and Immediate Action Plans and that there were no Immediate Actions required. The DOMH advised the Committee that reports from Ash and Pine Wards would be provided at the next meeting. He added that an inspection report had been completed in Adult Services from Cwm Taf Morgannwg University Health Board in relation to discharge for inpatient and community services and that the Health Board would be required to respond by 5th May 2023. The CVC asked if HIW had explained why they were visiting so frequently and asked if they were joining up their findings on what they were seeing across the service. The DOMH responded that the question had been asked as to why the frequency in visits had appeared to increase and HIW had responded that there were no specific concerns and that the East 12 and East 16 Ward visits had been delayed to provide the service with extra time. He added that the HIW had responded that there were no particular concerns and themes across all visits and had noted the quality of care and positive attitudes of staff. The DOMH thanked the MHAM and their team because the feedback on the Mental Health Act Team had been very positive. The CVC asked if the Cwm Taf Morgannwg report was regional. The DOMH responded that the learning was undertaken in Cwm Taf Morgannwg but that the recommendations from that report would be applied nationally across Wales and so each Health Board would be required to supply a response by 5th May 2023. **The Committee Resolved that:** a) The verbal HIW MHA Inspection Reports were noted.	**DC**
MHLMCA 23/05/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.**	

	The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received. The DDOMH advised the Committee that the report was separated into 4 parts and he would take the report as read. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Adult)** It was noted that referrals into the service in March 2023 were the highest ever seen with 1523 referrals. However it was also noted that it was a decrease on the number seen in the previous year Q4 referrals by 2.2%. The DOMH noted that the high number of referrals had affected target compliance with a breach in the compliance target. As of 21st April 2023, the average waiting time was 29 days, with that predicted to reduce to 27 days by the end of May 2023. He added that the longest wait in April 2023 was 42 days, the predicted wait for May was 39 days and a target recovery was predicted for July 2023. Bank Holidays during the period could affect target performance by increasing the waits due to absence of available slots. It was noted that in relation to current performance, CAMHS remained 100% compliant and that the Adult Services for patients aged 18 to 64 was 48% and those aged over 65 was 60%. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Children & Young People)** The Director of Operations – Children & Women's (DOCW) advised the Committee that the CAMHS service had exceeded the 80% target sustainably since November 2022. She added that, like the Adult Service, a 42% increase in referrals during March 2023 had been observed. Those had now stabilised and that the service had remained compliant without the use of external agency staff, which was positive. **Part 1B – 28-day assessment to intervention compliance target of 80% (Adult)** The Committee was advised that Primary Mental Health Support Services continued to be 100% compliant with the Part 1B performance target. **Part 1B – 28-day assessment to intervention compliance target of 80% (Children & Young People)** The Committee was advised that the service continued to face challenges with Part 1B compliance and that the waiting list initiative had focused on both internal and external waiting lists. The DOCW noted that an online intervention would be implemented in May 2023 which would provide an alternative intervention for a number of children and young people suffering with anxiety.	

Part 2 – Care and Treatment Planning (CTP) - Over 18.

The DOMH advised the Committee that compliance had started to slowly decline with Adult services but with an improvement in Mental Health Services for older people performance following focused attention during performance meetings with teams.

He added that a concurrent quality audit had been restarted on a quarterly basis using the NHS Executive audit tool.

Part 2 – Care and Treatment Planning (Children & Young People)

The DOCW advised the Committee that in Quarter 4 2022-23, compliance against the Part 2 target had been consistently maintained as a result of active focus on CTPs within the service.

She added that the service still faced challenges in relation to achievement including poor engagement from patients in the CTP process and a high number of new patients who required one.

The CVC asked if increased compliance was due to use of online interventions.

The DOCW responded that there were multiple reasons for increased compliance which included:

- The online interventions
- The change of the CAMHS offer to more group-based intervention
- Absolute focus on process rather than procedure.

The CVC asked if outcomes could be received to provide assurance.

The ICDPPT responded that outcomes would be received by the Psychological Therapy Management Committee (PTMC) because they had the correct vehicle to hold the outcomes and compare.

He added the Independent Members could be invited to that Committee.

The IMCE noted that despite the increase in referrals in CAMHS for Part1A, the compliance measure had been consistently met and asked if the reduction in compliance in Part1B had any correlation to that and what risks were carried in that arena.

The DOCW responded that there was risk in that cohort but performance was where it had always been with a lot of actions in place to reduce the backlog and noted that there was a blueprint to turn the Part1B compliance around.

Part 3 - Right to request an assessment by self –referral.

The Committee were advised of 4 breaches since the last reporting period.

	The DOMH advised that 2 of those were at 11 days and that teams were receiving an automated report indicating eligible patients for Part 3 sent on a weekly basis and that teams breaching had been notified for improvement. He added that the allocation rate following re-assessment during the period was 16% of Part 3 requests accepted back into Part 2 treatment in February 2023. **Part 4 – Advocacy – standard to have access to an IMHA within 5 working days** The Committee was advised that the service was 100% compliant with no further actions required. **The Committee Resolved that:** a) The contents of the report were noted.	
MHLMCA 23/05/013	**Draft Mental Health Bill - Joint Committee Report** The Draft Mental Health Bill - Joint Committee Report was received. The MHAM advised the Committee that in July 2022, the UK Government established a joint committee to provide pre-legislative scrutiny of the draft Mental Health Bill. The joint committee had provided a response to the UK Government in December 2022. He added that the Health Board was still waiting for a response from the UK Government on that and that within the report he had outlined the key recommendations, some of which included: • The overall approach of the draft Mental Health Bill and its place within the wider picture of Mental Health Act reform – It was noted that the Bill wanted the UK Government to learn and have continuous redevelopment of legislations and codes of practice. • The approach to tackling the racial and ethnic inequalities that were key to the Government's Independent Review. – It was noted that the draft Bill had recommended that there should be a responsible person for each Health organisation whose main role would be to collect and monitor data on the number, the cause and the duration of detentions which would then be broken down by ethnicity and other demographic information. • Community Treatment Orders (CTOs) – It was noted that the draft Bill had recommended that CTOs were abolished for patients under Part 2 of the Mental Health Act and potentially abolished for Part 3 unrestricted patients within 3 years. • The resourcing and implementation plan the Government had laid out to support it – It was noted that the draft Bill wanted a new revised impact assessment because they felt that it not relate to the amount of future resources required to implement the reform as whole.	

	The CVC noted that ethnicity data was a real driver for the draft Bill due to the disproportionality in terms of the use of legislation and asked if there was any way the Health Board could get ahead of any legislative change and if there were timescales in place. The MHAM responded that the issue had been raised at the Mental Health Legislation and Governance group on how the data could be best collected on ethnicity. He added that at the moment in the patient system PARIS, there was no mandatory field for ethnicity but that the digital lead for PARIS would be looking at that. He added that in terms of timescales there were none at present and that a summary had been written on the draft Bill and would be brought to the Committee once received. The CC advised the Committee that a lot of the proposed recommendations and changes outlined in the draft Bill were areas that the Health Board was already looking at which was a positive note. The ICDPPT noted that the Act was the primary legislation but the Code of Practice was just as important. He added that it was worth acknowledging that the investment in workforce for NHS England was substantial and ongoing. The CC noted that the Committee would welcome an update position update at future meetings. **The Committee Resolved that:** a) The key legislative changes proposed by the Joint Committee Report on the draft Mental Health Bill as set out in the report, were noted.	**DS** **DS**
MHLMCA 23/05/014	**Committee Self-Assessment of Effectiveness** The Committee Self-Assessment of Effectiveness was received. The Interim Director of Corporate Governance (IDCG) advised the Committee that he would take the paper as read. He added that 3 responses had been received and that comments had been positive. A particular comment had noted around targeted training or coaching for individual members. The CVC added that one of the areas the Committee had raised previously was that new members should be able to access training on the legislation because the Committee was quite technical and it would be important to empower and enable every new member. **The Committee Resolved that:**	

	a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Mental Health Legislation and Mental Capacity Act Committee were noted.	
MHLMCA 23/05/015	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The IDCG advised the Committee that the report was for noting and that no risks have been identified above the threshold and that the report was to provide assurance that the relevant procedures were in place to monitor risks. **The Committee Resolved that:** a) The Corporate Risk Register update was noted.	
MHLMCA 23/05/016	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes: • Mental Health Act Hospital Managers Power of Discharge Sub Committee The Deputy Chair of the Powers of Discharge sub-Committee advised the Committee that an incident had occurred in the previous reporting quarter where a paper had been submitted for non-disclosure but the information was disclosed in a report that the patient had received. The DOMH added that a not for disclosure element had been added to the weekly MDT meetings which was rolled out across all teams. • Mental Health Legislation and Governance Group (MHLGG) The ICDPPT advised the Committee that the MHLGG had met on 13th April 2023 and that it was the first meeting which had included the new South Wales Police Liaison Officer. He added that an issue around Section 135 warrants was raised which would potentially be brought back to the Committee via Chairs Actions. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
MHLMCA 23/05/017	**Any Other Business** No further business was raised.	
Saunders.Nathan 25/07/2023 16:13:44	**To note the date, time and venue of the next meeting:** 1 August 2023 at 10am Via MS Teams	

ACTION LOG
MENTAL HEALTH LEGISLATION AND MENTAL CAPACITY ACT COMMITTEE – 2 May 2023
(UPDATED FOR 1 AUGUST 2023 MEETING)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
ACTIONS COMPLETED					
MHLMCA 23/01/011	**HIW MHA Inspection Reports**	To ensure the Children & Women's Clinical Board attend all Mental Health Legislation and Mental Capacity Act Committee meetings.	**02.05.2023**	James Quance	**COMPLETED**
MHLMCA 23/01/011	**HIW MHA Inspection Reports**	Once received, the HIW inspection Report in relation to the Beech, Willow and Cedar Wards at Hafan Y Coed Hospital, to be brought back to the Committee	**02.05.2023**	Daniel Crossland	**COMPLETED**
Actions in Progress					
MHLMCA 23/01/010	**Mental Health Act Monitoring Exception Report**	The Mental Health Act Manager to provide update on training on general wards at August Committee meeting.	**01.08.2023**	Daniel Crossland	**Update in August 2023** Agenda item 9.1
MHLMCA 23/05/009	**Liberty Protection Safeguards Monitoring Report**	Workforce requirements to be received by the Committee for Mental Capacity Act training on systems in place of the LPS	**01.08.2023**	Jason Roberts	**Update in August 2023** Agenda item 8.2
MHLMCA 23/05/011	**HIW MHA Inspection Reports**	HIW reports from Ash and Pine wards to be provided at the next meeting.	**01.08.2023**	Jason Roberts / Daniel Crossland	**Update in August 2023** Agenda item 9.3
MHLMCA 23/05/010	**Mental Health Act Monitoring Exception Report**	Mental Health Act e-Learning module to be added to ESR as mandatory module once written.	**31.10.2023**	Jason Roberts / David Seward	**Update in October 2023**
MHLMCA 23/05/013	**Draft Mental Health bill - Joint Committee Report**	Update to be provided at a future meeting to include timescales on implementation of the draft Mental Health Bill	**31.10.2023**	Jason Roberts / David Seward	**Update in October 2023**
ACTIONS REFERRED TO COMMITTEES OF THE BOARD / OTHER					

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring**			Agenda Item no.	**8.1**
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**	Public	x	Meeting Date:	**01.08.2023**
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Deputy Executive Nurse Director**				

Main Report
Background and current situation:

The purpose of this report is to provide a general update on current issues relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The MCA indicators provide a level of detail on the number and type of IMCA referrals along with an overview of Mental Capacity Act training compliance across the UHB. As previously stated, there is additional information contained within this report relating to the further training being provided with the use of additional Welsh Government funding.

The DoLs indicators provide an overview of the applications and assessments received.

In addition, this report provides information relating to the Consent agenda.

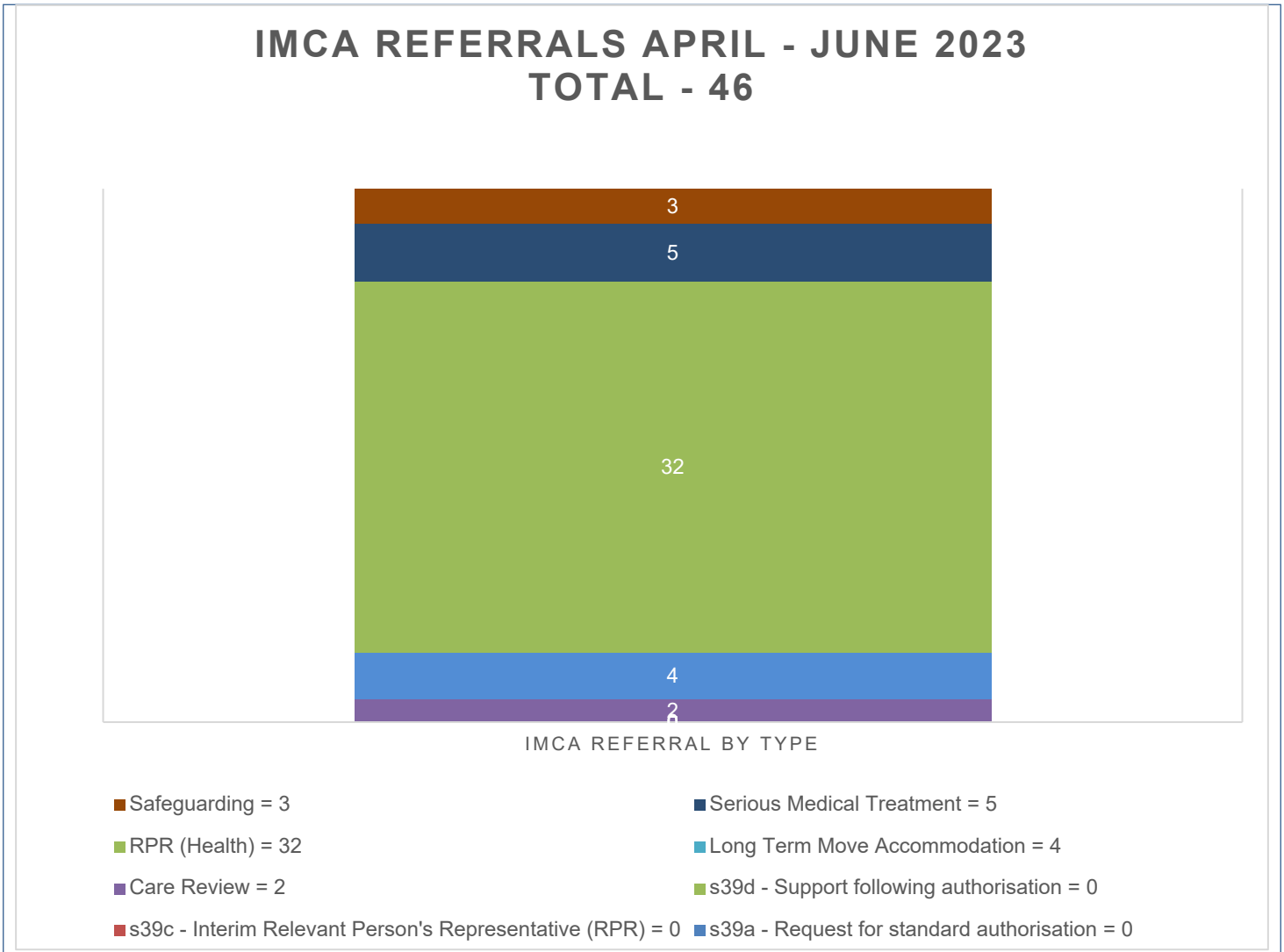
Further to the UK Government's announcement regarding the indefinite delay of the LPS, we will continue to focus on promoting awareness and understanding of the MCA in practice and look at how we can strengthen and improve our current DoLS processes going forward.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Mental Capacity Act Monitoring actions:

- **Mental Capacity IMCA Referral type**

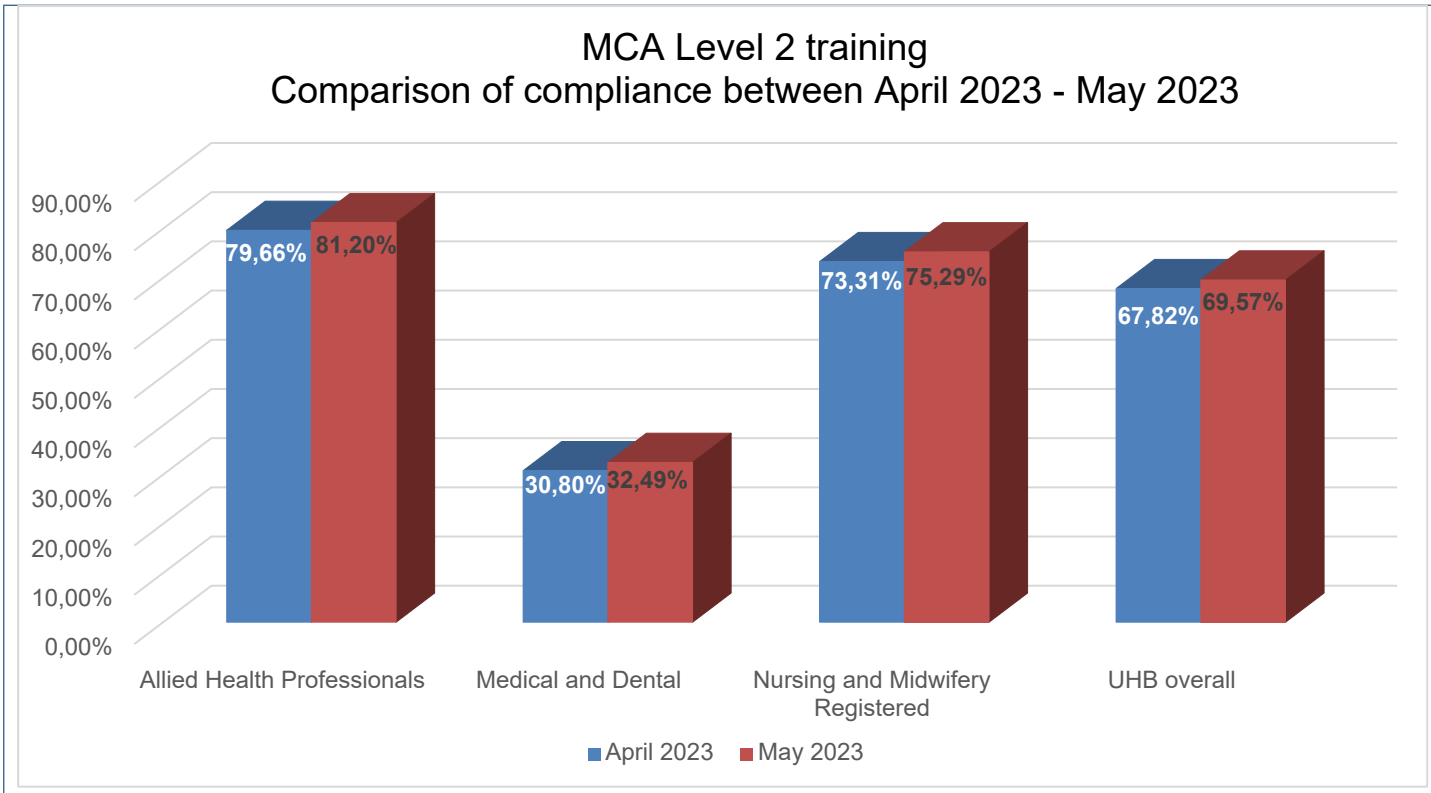
The MCA Indicators outline the breakdown of IMCA referrals for the period from April – June 2023. Referral rates are noted to have decreased. The most notable decrease has been that of the RPR (Health) which has decreased from 73 referrals in March to 32 between April and May. Referrals for Serious Medical Treatment have also decreased slightly from 7 last quarter to 5 this quarter.
The Coordinator has stated that data collection for this quarter has proved challenging to extract due to a change of staff and consequential delay in ability to access usual database software despite best efforts. Every effort will continue to be made to retrieve missing data.
Work is at the final stages of completion, to agree the procurement specification in relation to the provision of the IMCA services for 2024 with colleagues across Health Boards in Wales



- **Mental Capacity Training**

The following graph demonstrates overall compliance by staff group, with a comparison of April 2023 and May 2023 to outline progress since the last report.

Whilst booking rates have increased in recent months, we continue to experience low attendance rates on the day, which is likely due to ongoing clinical pressures and staffing issues.
Recruitment has now been completed for two Mental Capacity Specialist Practitioners, the two successful candidates will be in post by mid-August, both bring a level of expertise and experience in training and development which will enable a far more responsive and tailored response to encourage attendance, improve accessibility and improve mandatory training compliance

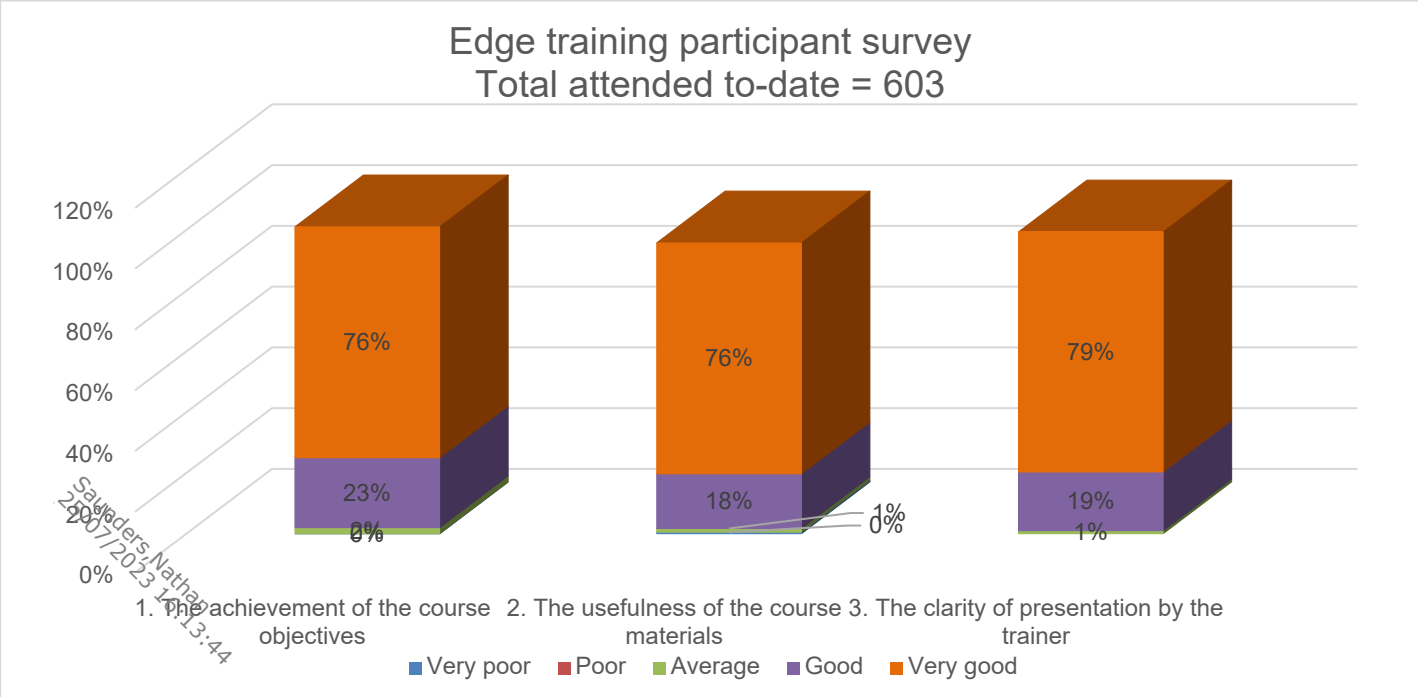


- **Additional training provision**

<u>Mental capacity and best interests training (Edge Training)</u>

This training continues to be well received by staff and has now been extended until September 2023.

The table below provides data relating to feedback on its perceived quality and usefulness. Attendance rates during the later sessions in April were lower than hoped and appear to have been impacted by more senior staff being required to cancel at short notice due to various operational pressures but attendance figures have now recovered.

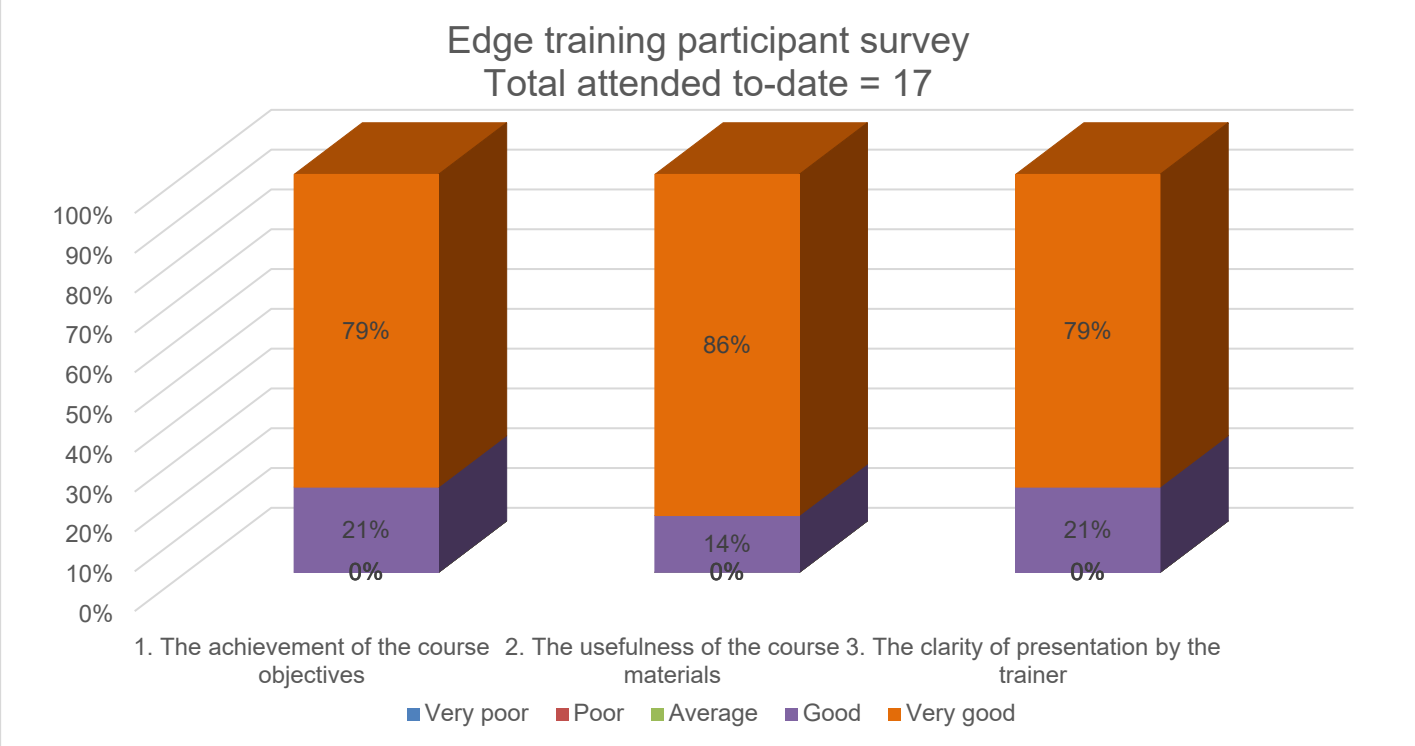


DoLS in Practice Training (Edge Training)

This training has recently been commissioned in order to help raise awareness around what amounts to a deprivation of liberty in order to ensure that we are effectively safeguarding our vulnerable patients and staff are completing DoLS referrals where appropriate.

One session has been held so far with two more to follow in July and September. We have also commissioned a session in November specifically for those working with children and young people, in light of the fact that staff in these areas may not be confident in identifying when a deprivation of liberty is occurring. This was in anticipation of the implementation of the LPS however, it is still felt that this training will be of value to staff.

Feedback from the first session is outlined in the table below:



Assessing decision making capacity MSc module

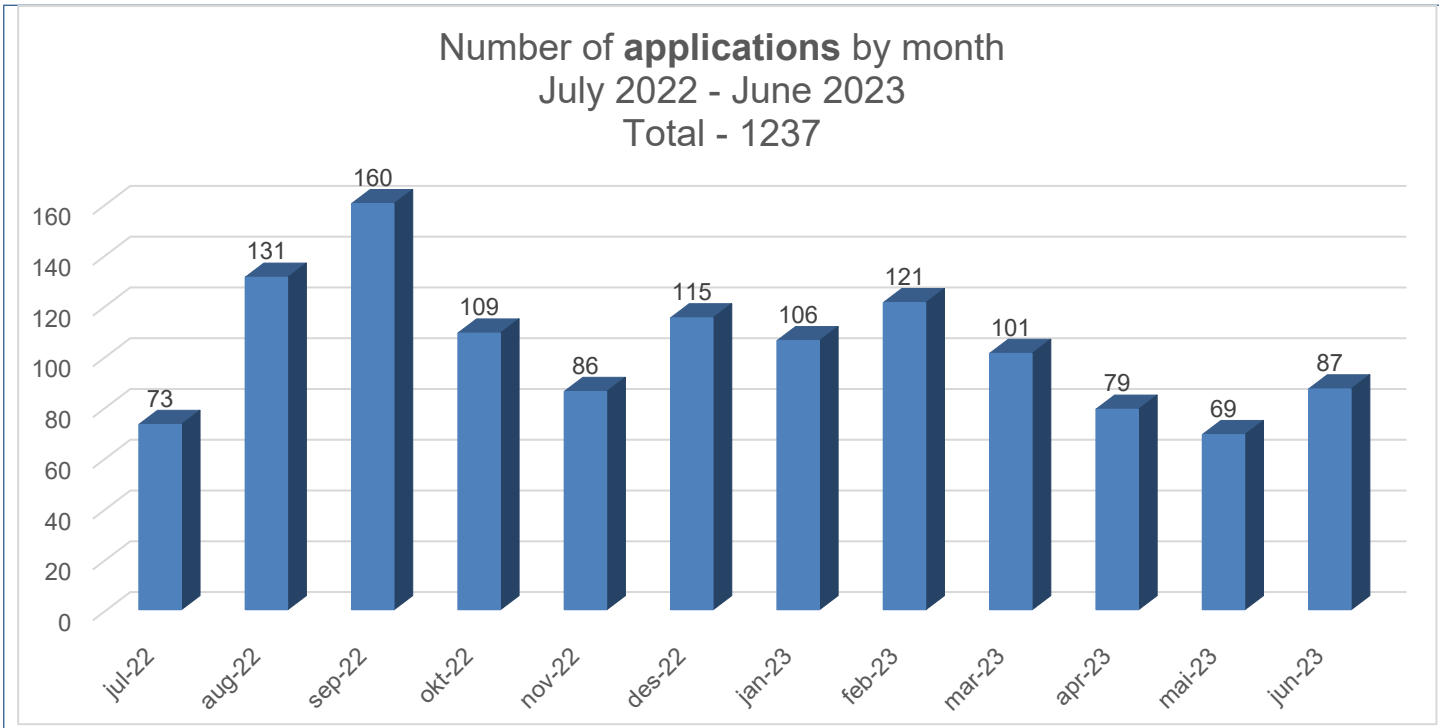
Following the success of the initial cohort of students a further five places for the September cohort have been allocated. Interest has been sufficiently high to warrant the development of a waiting list should more places become available.

- **Deprivation of Liberty Safeguards Monitoring actions:**

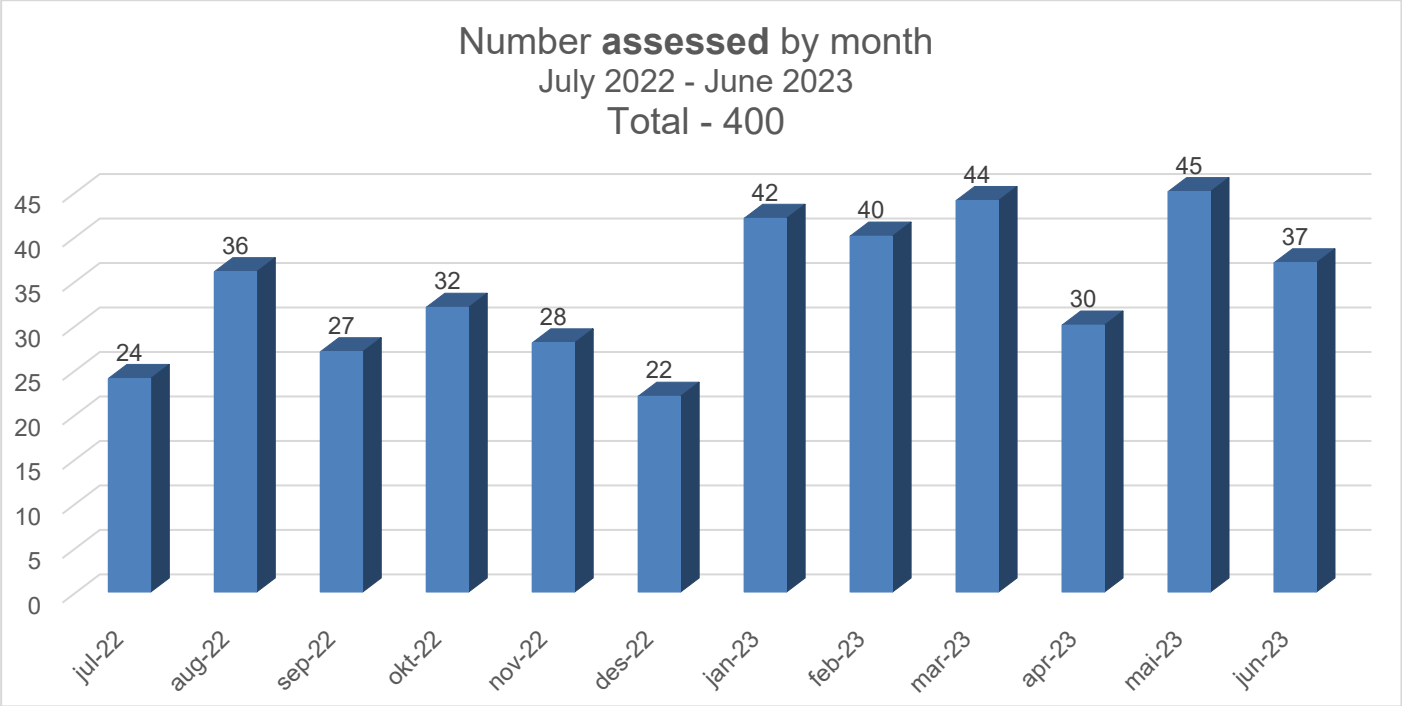
Quarterly overview from April 2023 - June 2023

The below charts provide an overview of the last quarter.

From 1st July the mean number of applications was 103 per month, however there does appear to have been a decrease in applications received during this last quarter.



The below chart provides an overview of the number assessed per month. The number of assessments remains on average above the number assessments being undertaken at beginning of July 2022



Unfortunately, data collection for this quarter in relation to the number of breaches has proved challenging to retrieve due to a change of staff within the DoLs team and consequential delay in ability to access usual database software, despite their best efforts. However, every effort will continue to be made to retrieve accurate data.

As mentioned in previous papers, breaches continue to occur due to insufficient resources to complete the assessments within the required timeframe. Whilst the agreed additional funding continues to have a positive effect, there still appears to be continued room for improvement. With this in mind a collaborative workshop has been arranged to identify any potential gaps in the process and propose improvement plans for the coming year.

- **Actions to identify future Workforce requirements**

The below table provides the details of the current workforce requirements to progress Deprivation of Liberty, which has been supported by WG funding until March 2024, with indications that this funding will continue into 2025.

Staffing costs	
1.0 MCA Senior Nurse/Project lead (Including maternity cover)	52,425
1.0 Safeguarding Nurse Advisor/MCA Practitioner (6 months)	26,175
1.0 Team Administrator 1.0	28,568
0.4 Data Informatics Lead (6 months)	14,203
2.0 MCA Practitioners	87,129
DoLS costs	
Increased assessment capacity	50,000
Reporting and monitoring	7,500
Total	266,000

As previously mentioned the 2.0wte Band 7 MCA practitioners have been appointed and will commence in post Mid-August, which completes the workforce.

However, a Joint workshop with both Cardiff & Vale Local authority partners has been arranged to review the DoLS process, identify efficiencies and future proof the Workforce requirements. This work plan will evolve over coming months and when complete will be shared.

- **Consent to Examination and Treatment**

The appointed part time Consent Lead who will support Education and Training has very recently taken up post and will begin to work with colleagues across the UHB to raise awareness of the Consent to Examination and Treatment E-learning package and encourage staff to utilise it as much as possible, with the aim being that clinical staff undertake the training at least once in each relevant professional revalidation cycle. As a result of improved awareness, the UHB is anticipating its wide use in order to demonstrate our commitment to strengthening consent practices as a UHB and reducing the risk of concerns and costly litigation. Recommendations following the Welsh Risk pool Review : Consent Examination & Treatment will also be progressed.

Recommendation:

The Mental Health and Capacity Legislation Committee is requested to **NOTE** the contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	✓

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Risk of Non-compliance to the Mental Capacity Amendment Act 2019
Safety: No
Financial: No
Workforce: Yes
Risk of inability to recruit to posts
Legal: Yes
Risk of Non-compliance to the Mental Capacity Amendment Act 2019
Reputational: Yes
Risk of Non-compliance to the Mental Capacity Amendment Act 2019
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
25/07/2023 16:13:44

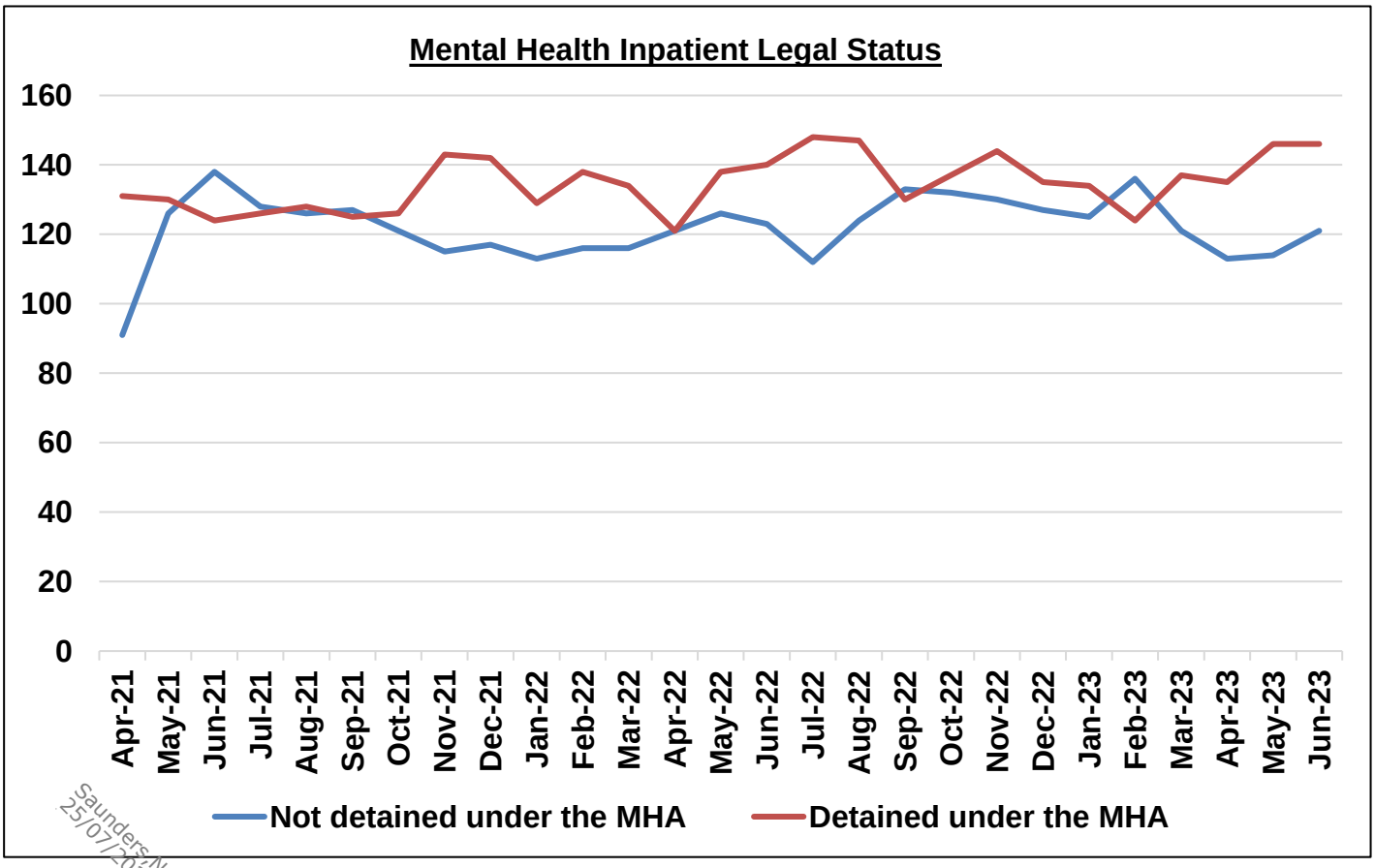
Report Title:	Mental Health Act Monitoring Exception Report				Agenda Item no.	9.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee		Public	X	Meeting Date:	1 August 2023
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Interim Chief Operating Officer					
Report Author (Title):	Mental Health Clinical Board Director of Opertations					

Main Report Background and current situation:

This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to a community treatment order is only as the MHA allows.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Use of the MHA



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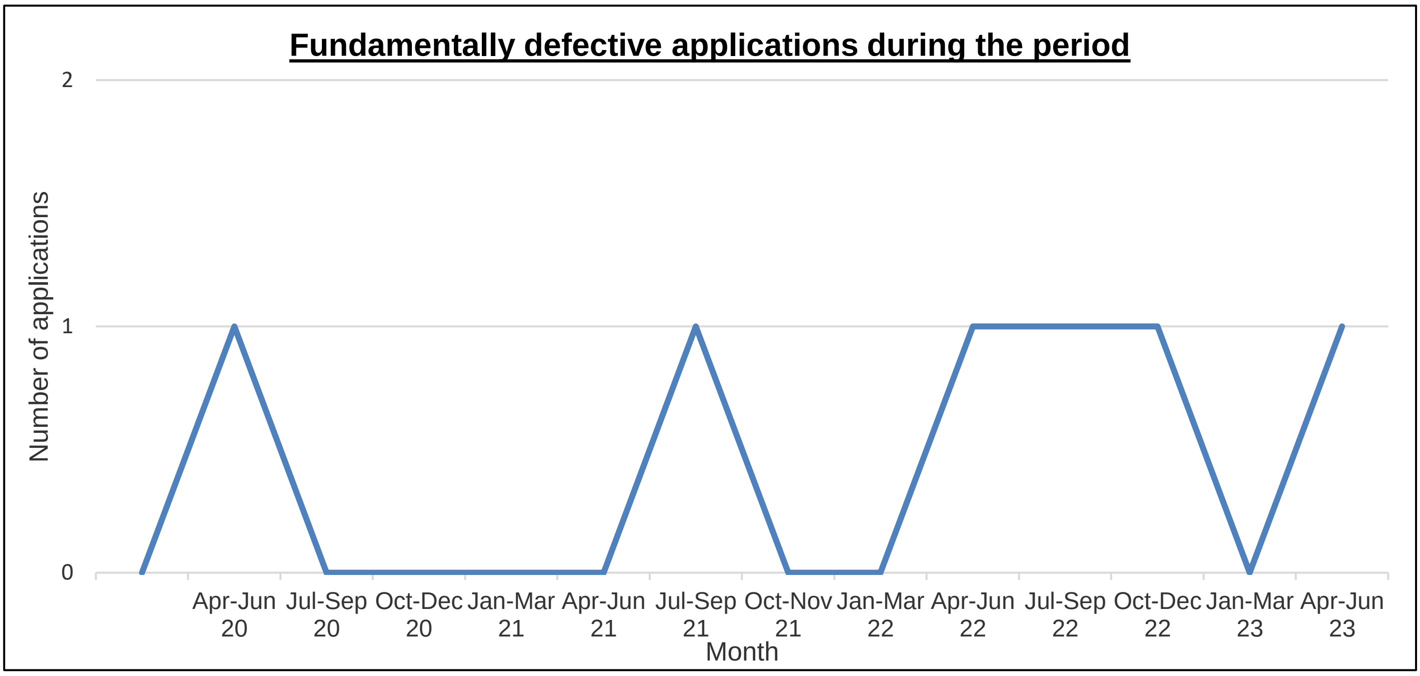
Fundamentally defective applications



During the quarter there was one fundamentally defective application.

P was assessed in Bath, detained under Section 2 and transferred straight to Hafan Y Coed. When P arrived with secure transport, the detention papers were given to the MHA office to scrutinise and various errors were found -

- The AMHP had completed an English application instead of a Welsh application
- The AMHP had electronically signed the form and Wales still requires a 'wet' signature
- The date the AMHP last saw the patient wasn't within the 14 day period allowed
- Neither medical recommendations included a description on why P was being detained
- Neither medical recommendations had 'wet' signatures

Due to the nature of these errors we immediately told staff that we were unable to accept the detention and P wasn't detained under the MHA. We tried to contact the detaining AMHP but never got a response.
P agreed to stay informally however, 10 days later a MHA assessment was arranged and they were detained under Section 2.

Section 136 A&E
There could be instances when treatment under a 136 is related to the mental disorder but the patient is not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse, for example,

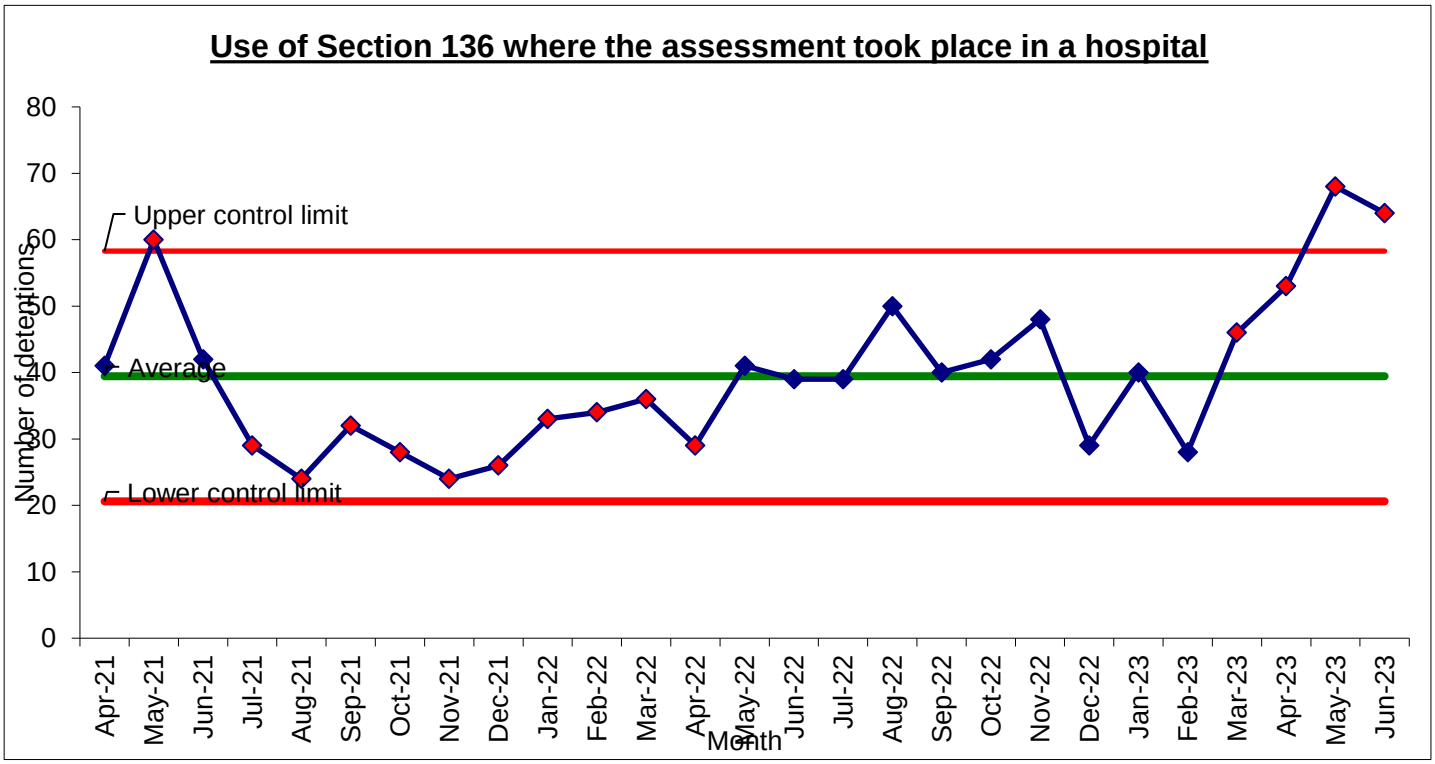
> *Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.*

In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136
During the period, the use of section 136 has decreased.

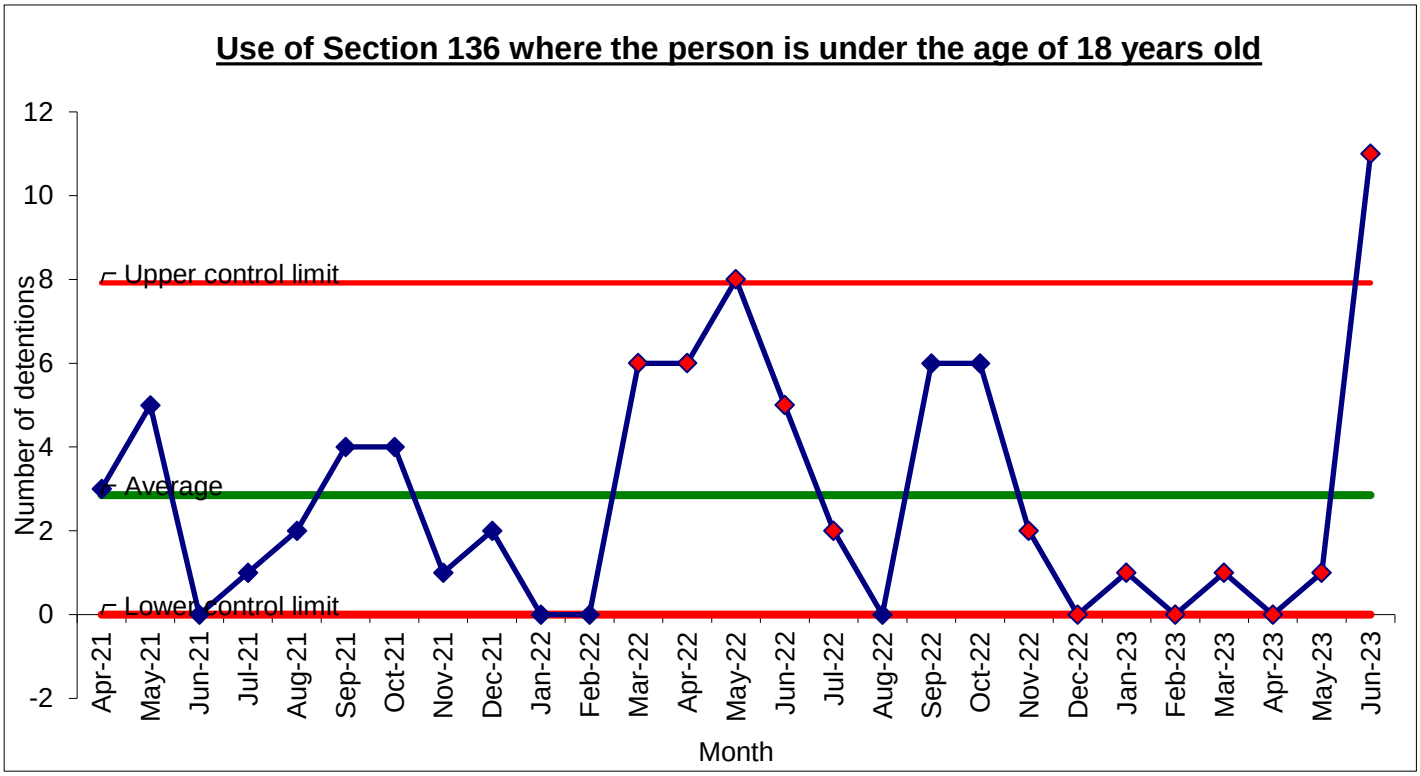
It was noted that 80.4% of individuals assessed were not admitted to hospital, with 59.2% being discharged to community services and 21.2% were discharged with no follow up. Overall during the period 19.0% of patients were admitted to hospital following a 136 assessment which is lower than the previous quarter at 28.1%. One patient's 136 lapsed with no assessment taking place.

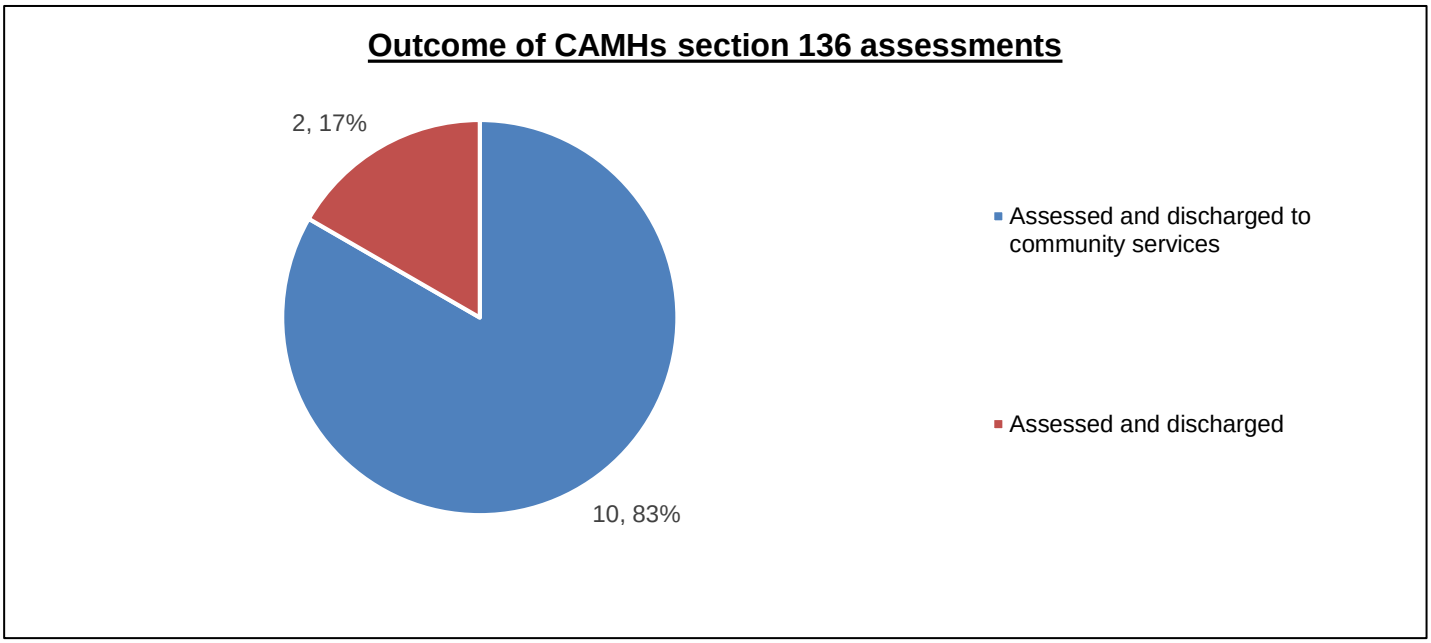
Period	% not admitted to hospital
April – June 2023	80.4%
January – March 2023	71.1%
October – December 2022	73.9%
July – September 2022	69.0%
April – June 2022	71.5%
January – March 2022	63.4%
October – December 2021	68.0%
July – September 2021	74.1%
April – June 2021	73.5%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has increased from 2 in the previous quarter to 12 in this quarter. Ten of these were repeat presentations.





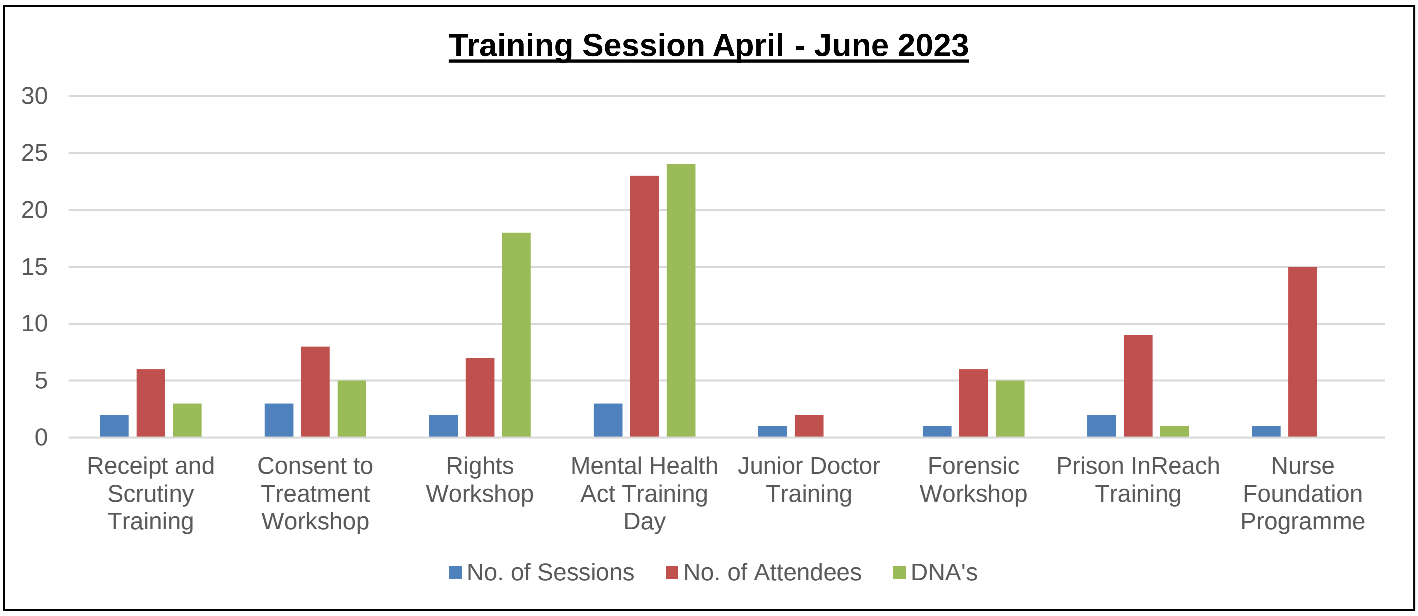
Mental Health Review Tribunal for Wales (MHRT)

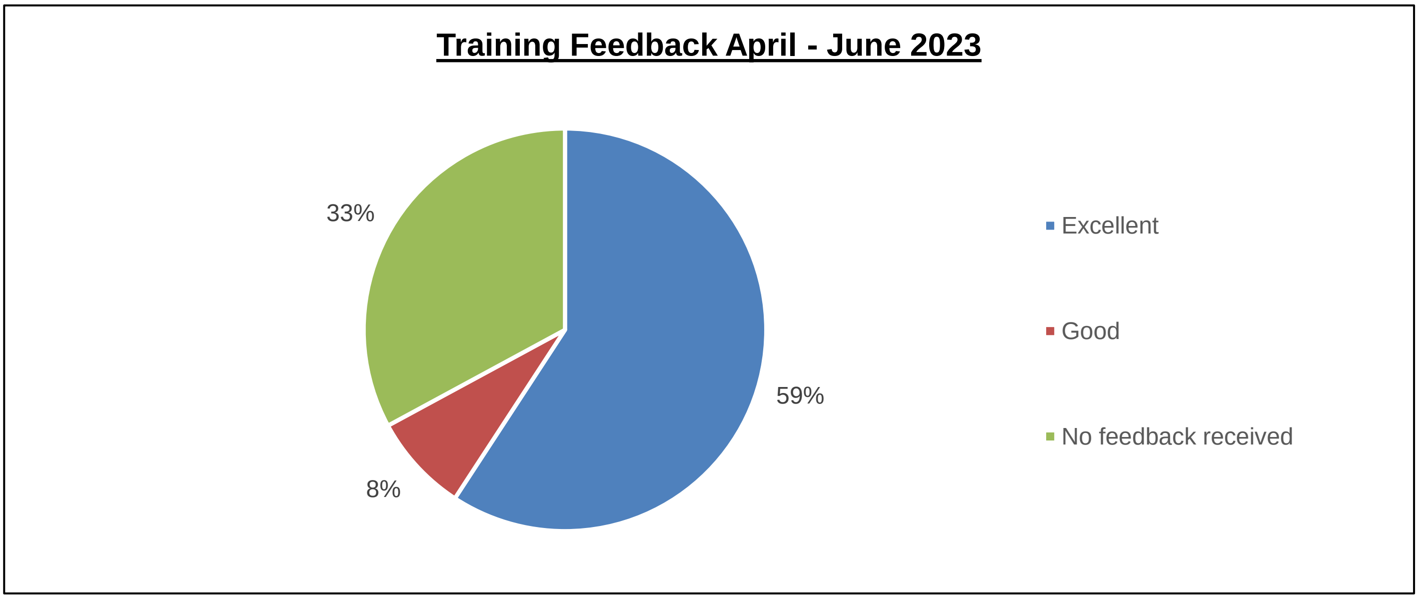
The MHRT have recently been in touch regarding the parking issues they have experienced when coming to Hafan Y Coed for face to face hearings. It was discussed with the MHCB and a response has been provided to the MHRT. We have not had a reply as yet.

The Senior Operations Manager and I have agreed to 'catch-up' every other month to share any issues or trends that we may be seeing on either side which can be discussed further and rectified, however, any urgent matters will be addressed before these meetings.

Development Sessions
The MHA office continues to run awareness sessions including a monthly MHA training day which is available to all staff within the Health Board, a monthly consent to treatment workshop and a quarterly rights and forensic workshop. We also run receipt and scrutiny training for all shift coordinators and we continue to support the Nurse Foundation Programme and Junior Doctor's Inductions with MHA training. This quarter we have delivered a bespoke training session for the prison inreach team.

The viability of recording MHA training workshops is currently being looked into, these will be accessible from our Intranet page where staff can refer to them at anytime. We will then hold quarterly face to face sessions for anyone who prefers this type of training or if anyone has any 'real life' scenarios they wish to run through.





Audits
The MHA office have now audited all the wards and CMHT's within the UHB. This is to ensure compliance with the MHA and best practices are maintained. If any issues are found during the audit we will follow up with an e-mail to the ward manager and/or responsible clinician confirming what is needed to rectify the issue and re-audit within 4-6 weeks.

The Mental Health Clinical Board continues to take the following approach:

Fundamentally defective applications
Continue to ensure effective communication between the Local Authority and the UHB and promote MHA training across the UHB.

Fundamentally defective reports
Continue to ensure effective communication across the UHB and promote MHA training.

Invalid use of the MHA
Continue to ensure effective communication between the Local Authority and the UHB and promote MHA training across the UHB.

Section 136
Continue to monitor with colleagues in South Wales Police and ensure any incidents related to an assessment not being completed within the 24/36-hour period due to physical health issues are reported accordingly.

Section 136 – CAMHS
Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal
Continue to work with the MHRT for Wales to find suitable resolutions to any issues, to ensure that appropriate action is taken to protect the patients' right to a fair hearing and ensure any incidents are reported accordingly.

Development sessions
Continue to develop a robust training rota to ensure that development sessions in relation to all areas of the MHA are available and easily accessible. This will be provided by creating an MHA e-learning module.

Audits
Continue to audit wards and CMHT's, while providing support and guidance on maintaining compliance with the MHA and best practices.

Recommendation:

The Committee is requested to:

a) NOTE the approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X

4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

Yes – there is a potential risk that if a 136 lapses with no assessment being completed the patient will be allowed to leave and could harm themselves or others.

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – communication between the UHB, Local Authority and South Wales Police needs to continue to be monitored to ensure all risks regarding detaining someone without authority are mitigated.

Reputational: Yes/No

No

Socio Economic: Yes/No

No

Equality and Health: Yes/No

No

Decarbonisation: Yes/No

No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Saunders,Nathan
25/07/2023 16:13:44

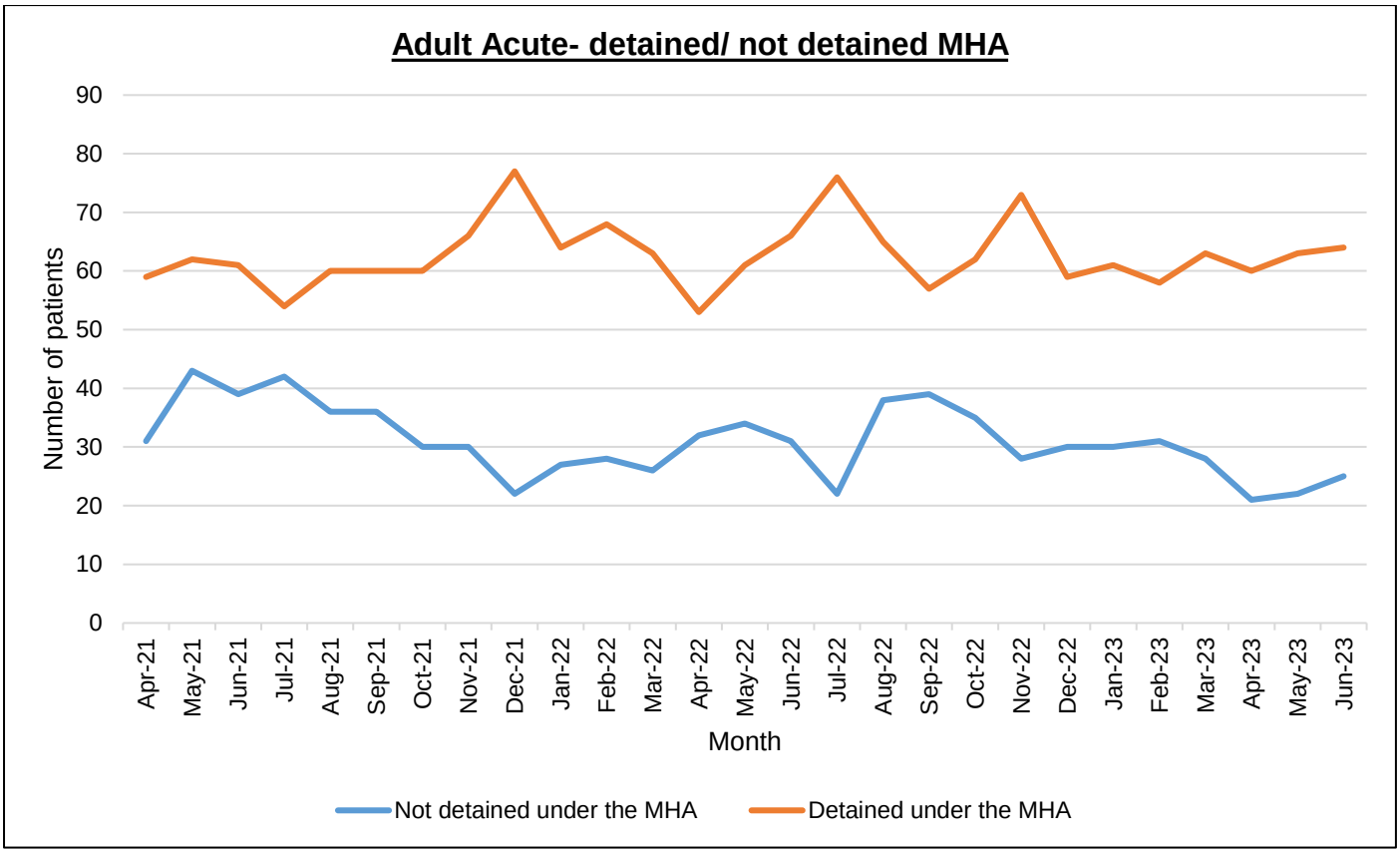
Report to the

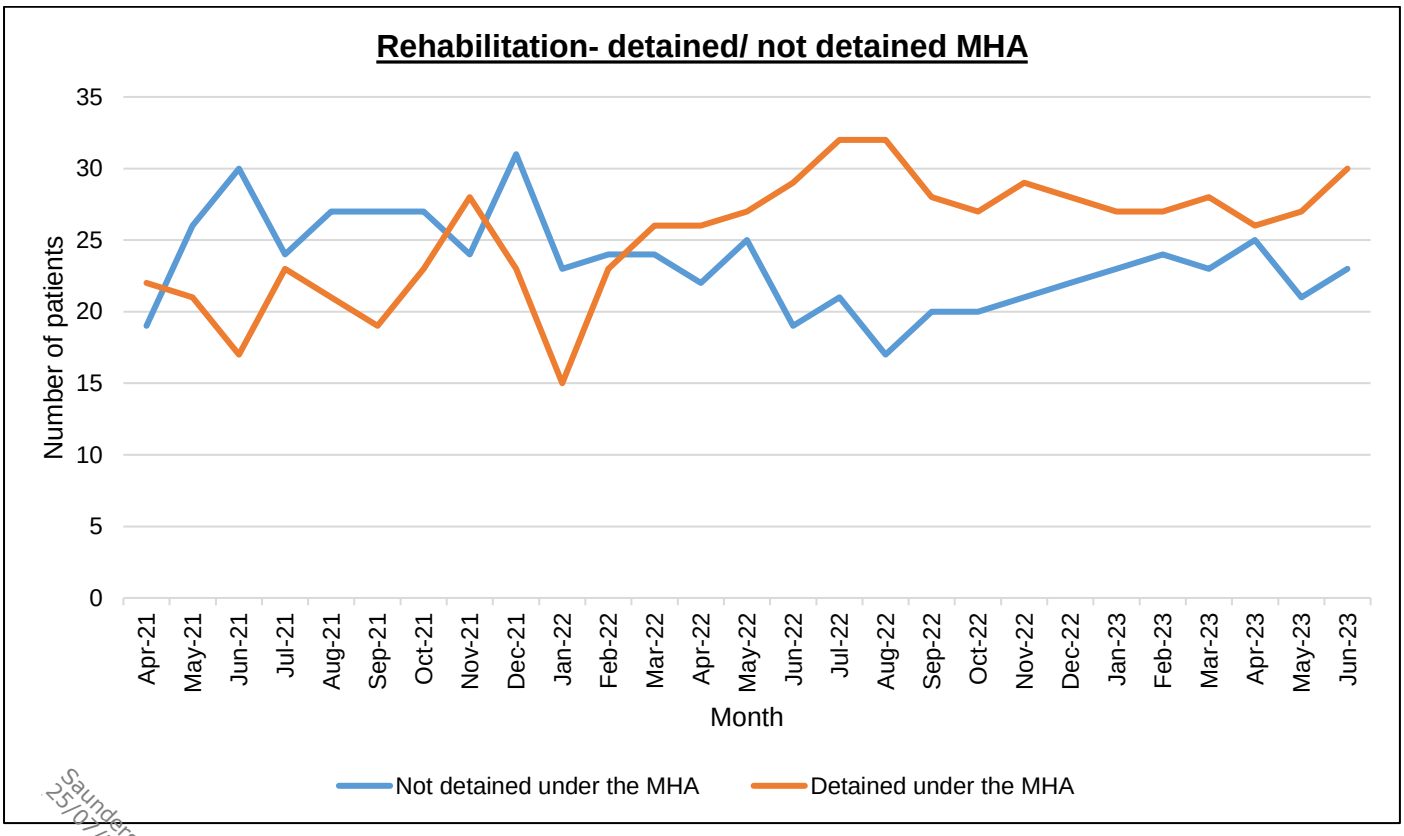
Mental Health Legislation and Mental Capacity Act Committee

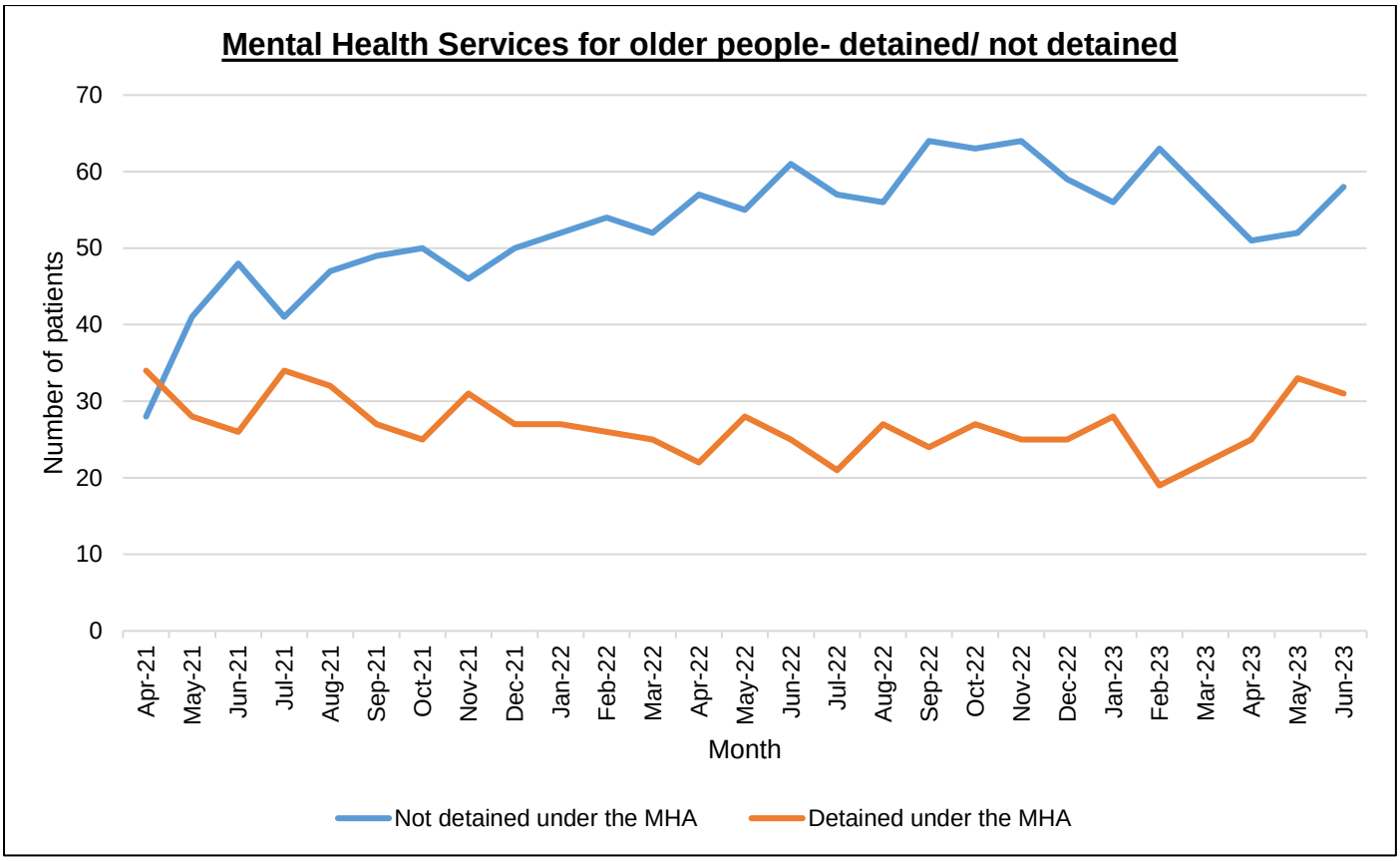
on the use of The Mental Health Act, 1983

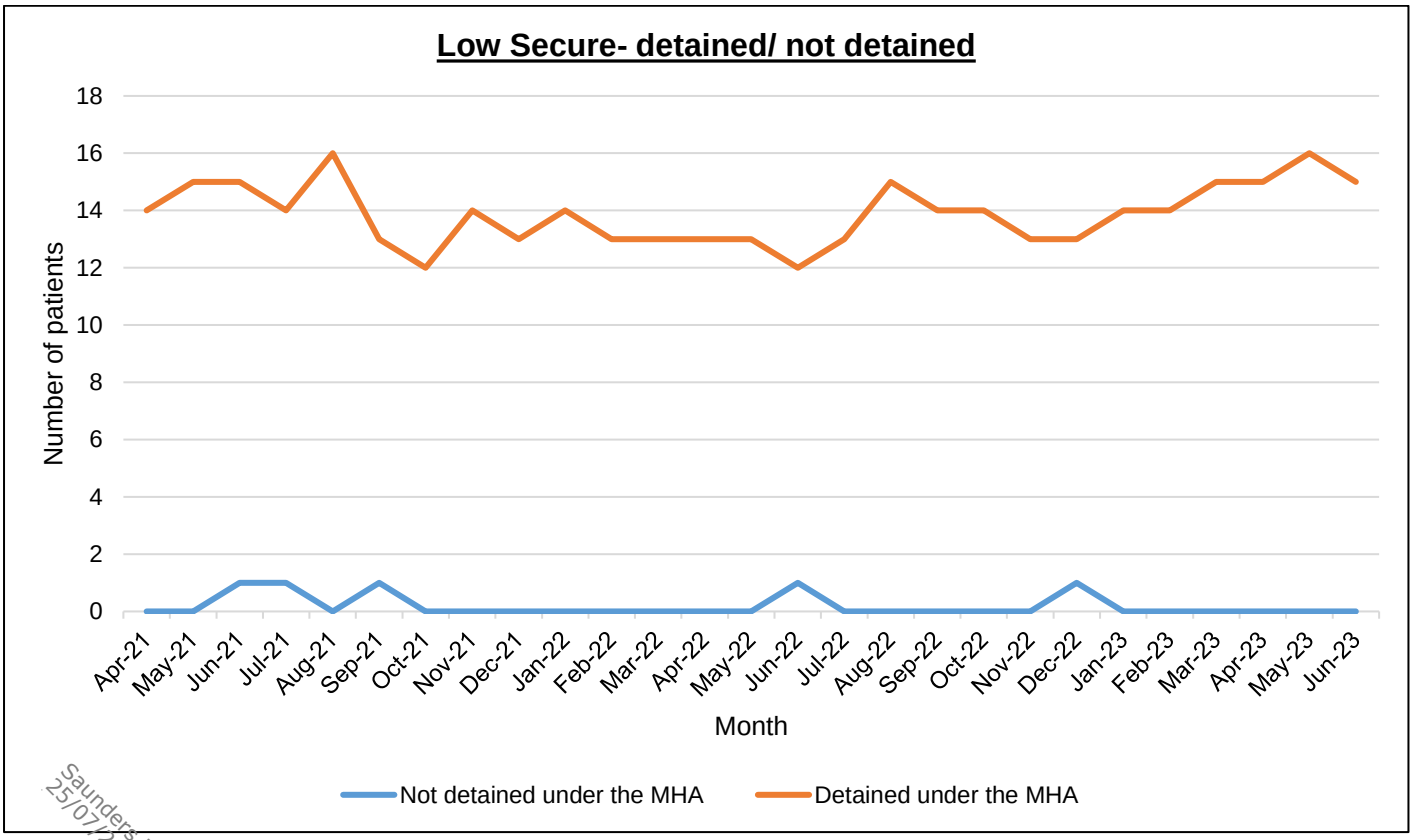
April- June 2023

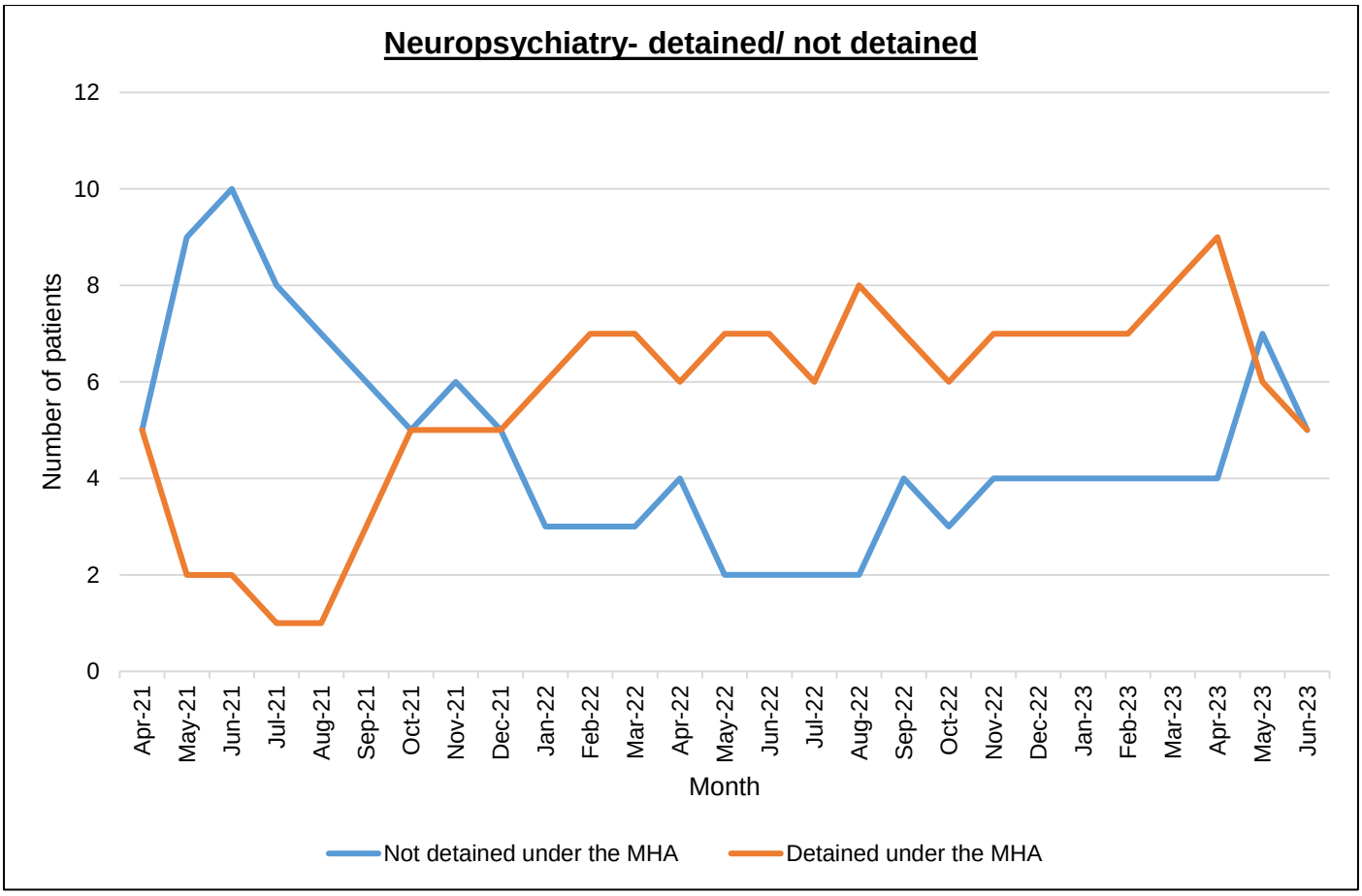
Contents **Page**

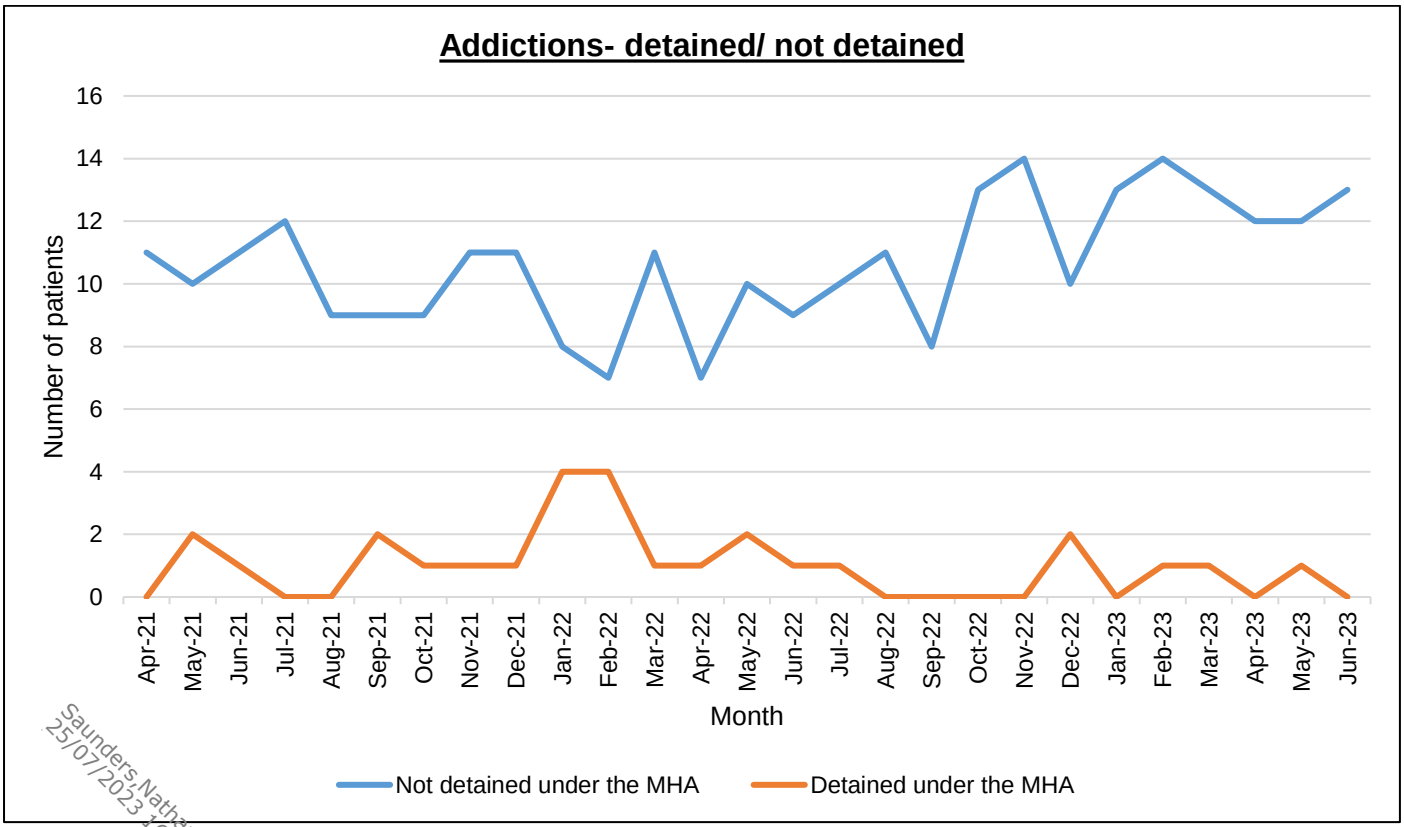








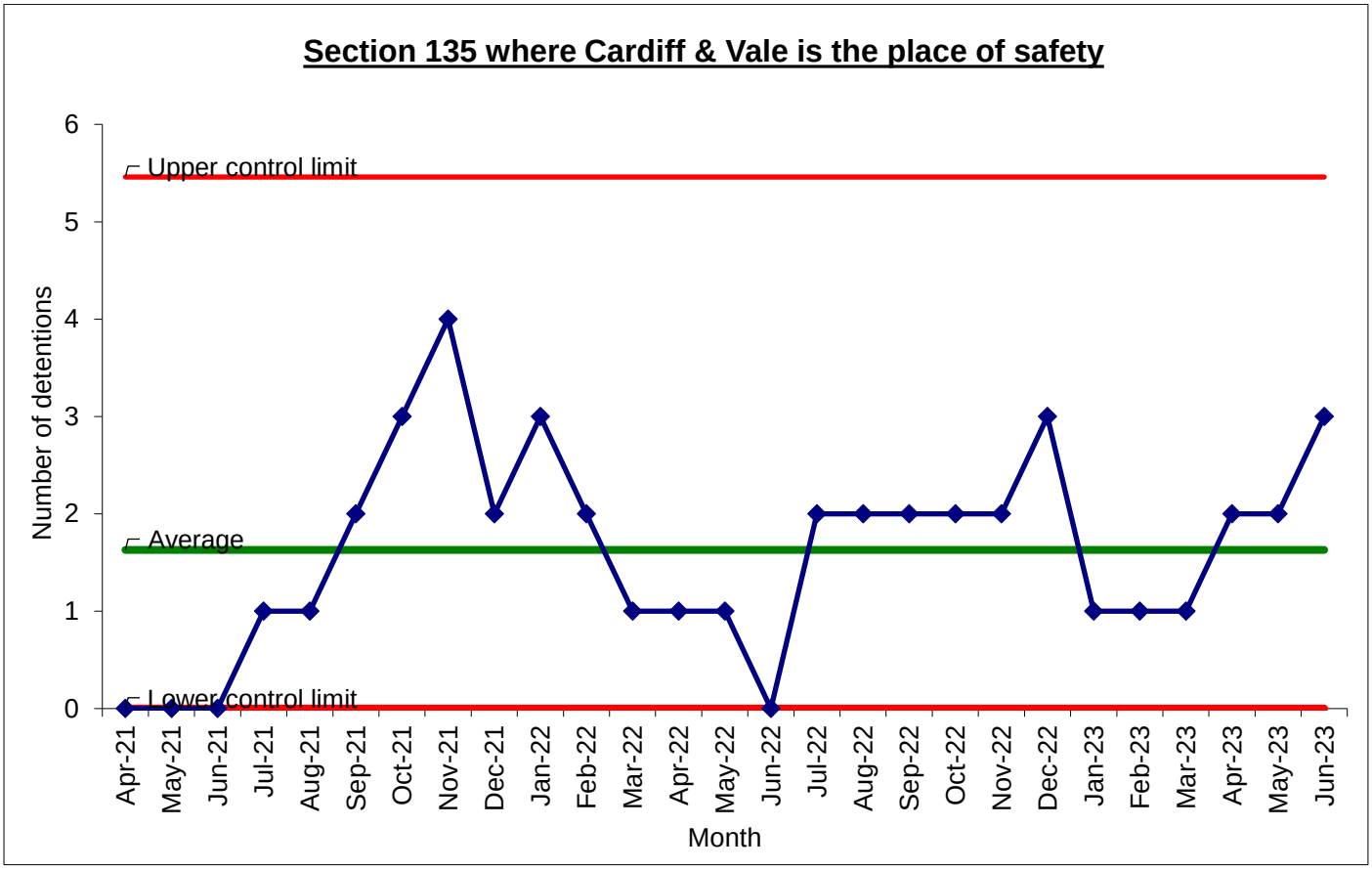




Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used four time. Three uses resulted in a Section 2. One warrant was executed but the patient was not at home.

During the period there were three uses of Section 135(2). Two uses resulted in the patient being returned to hospital under Section 2. One use resulted in the patient being returned to a hospital under different hospital managers under Section 3.



Voluntary Assessment

During Summer 2020, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

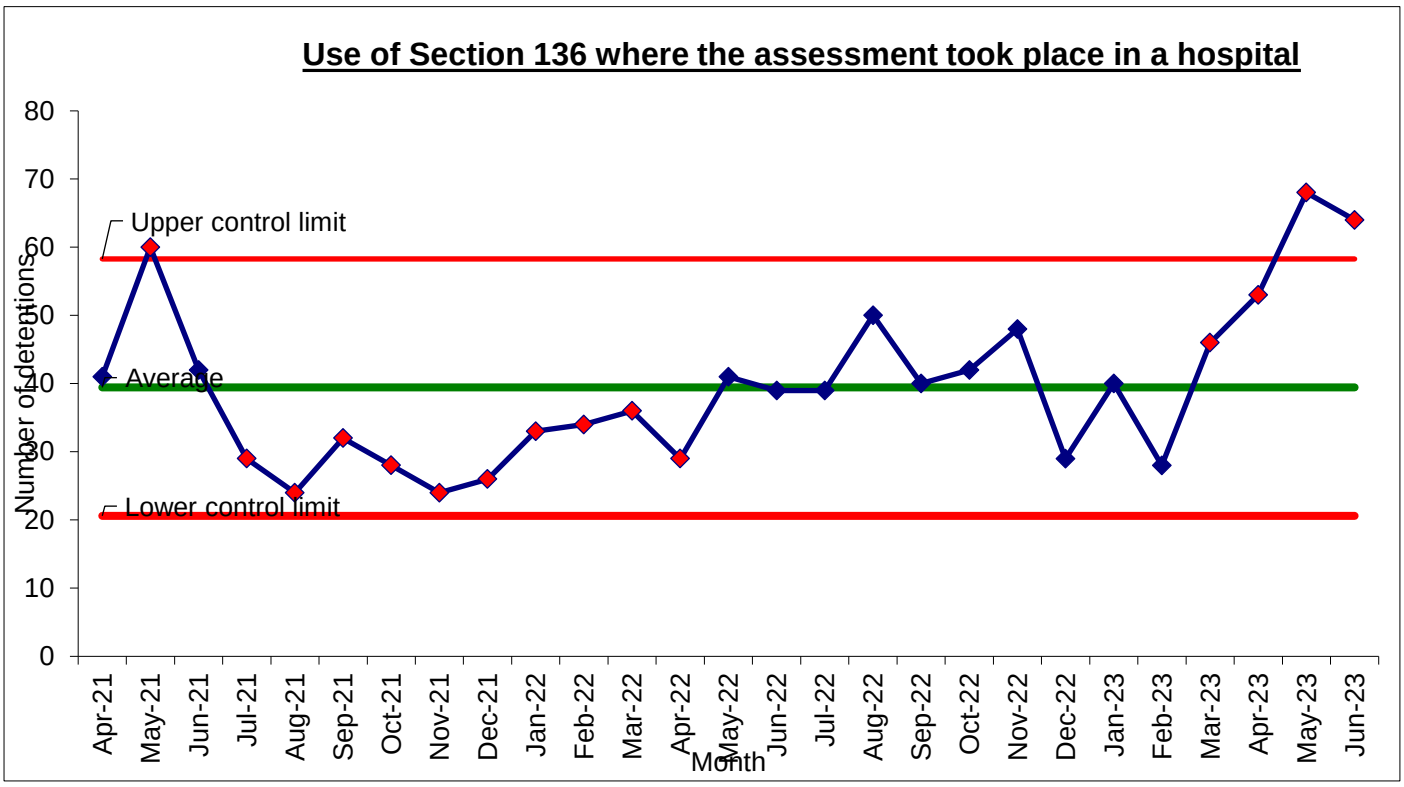
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

We continue to work with South Wales police to ensure the AWMF is completed each time a person is brought to hospital for an assessment and hope to see an improvement in the use of the electronic form going forward.

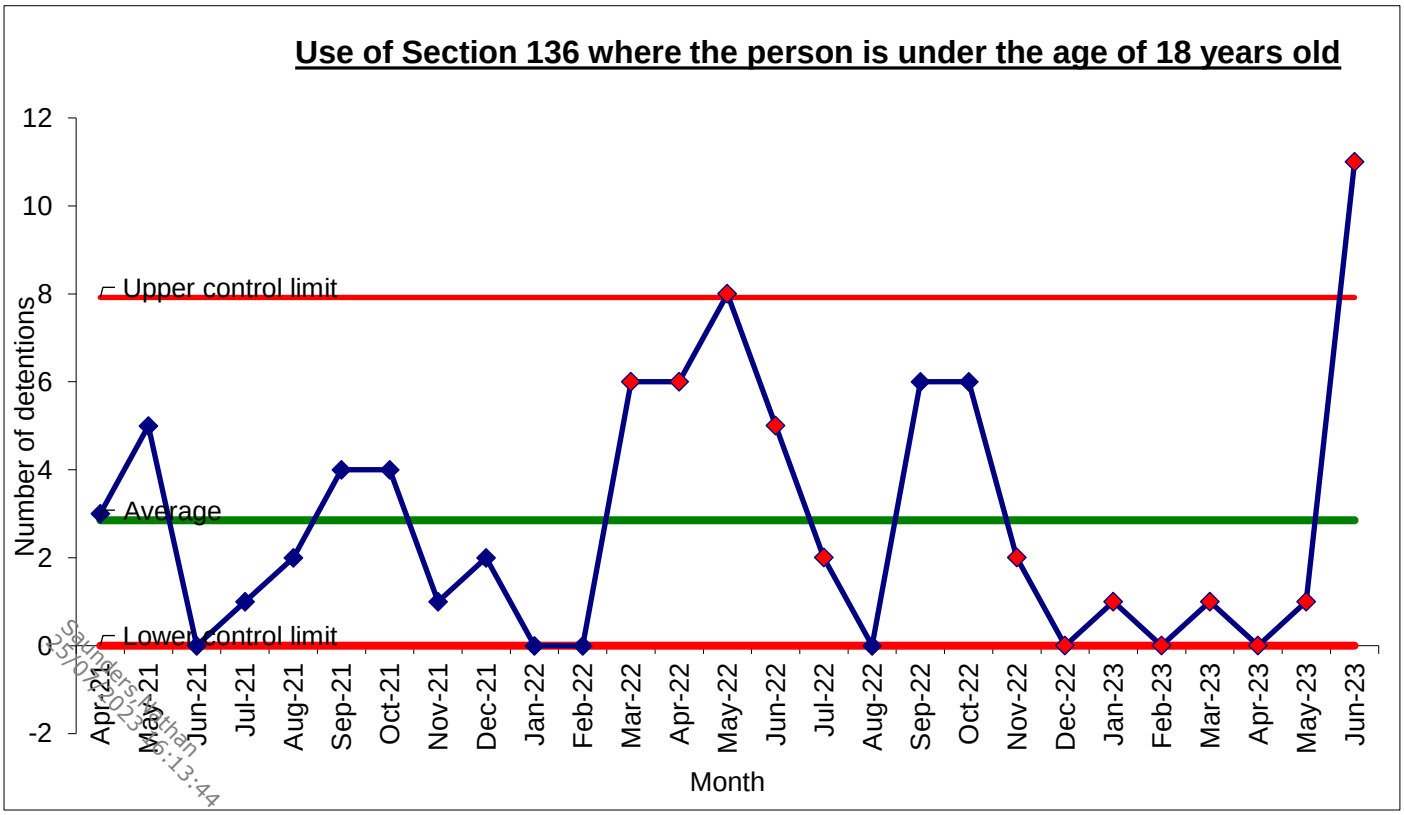
For this period, we have seen three people for a Voluntary Assessment and no one was brought into hospital under the Mental Capacity Act.

Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

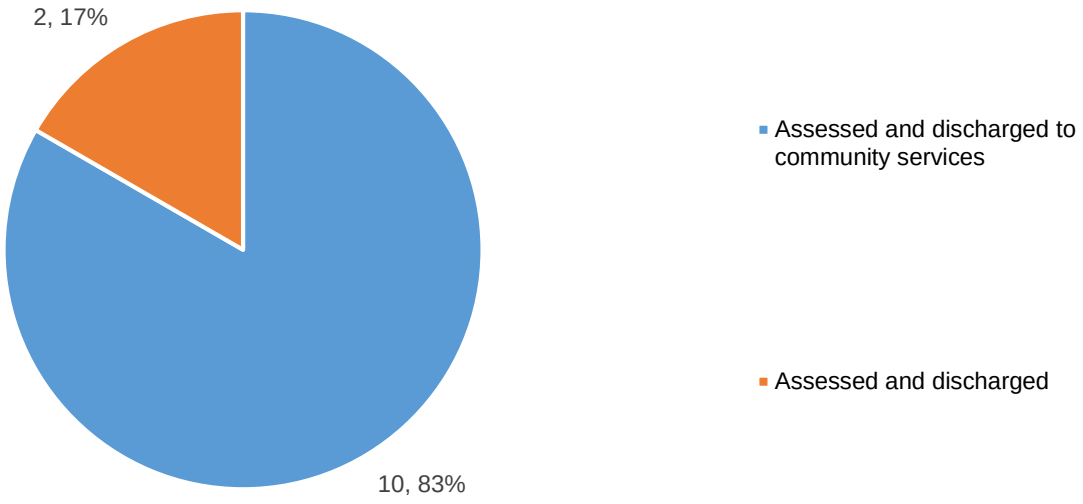
During the period a total of 184 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



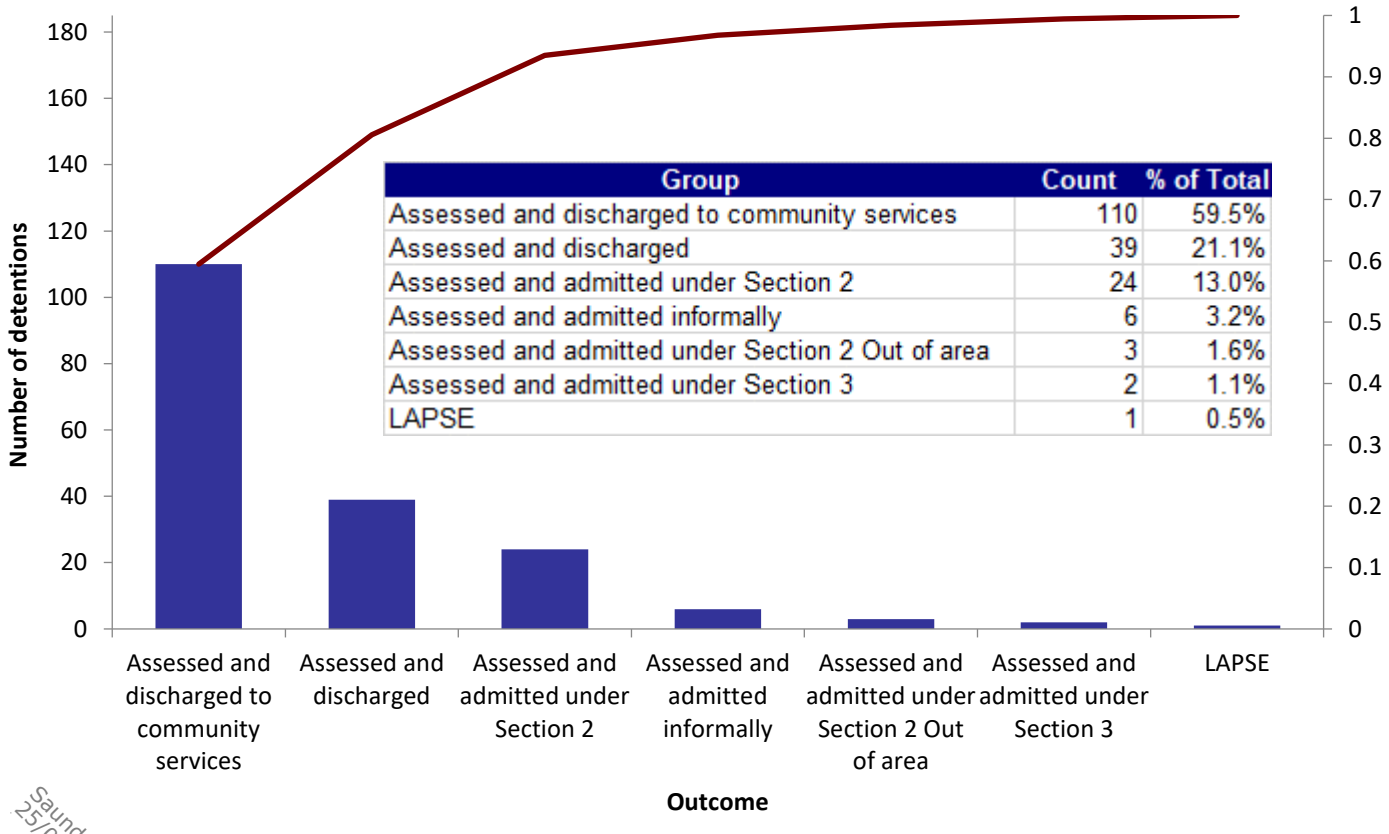
Twelve of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. Nine of these were repeat presentations This is extracted below;-



Outcome of CAMHs section 136 assessments



Outcome of Section 136 assessments which took place in a hospital during the period April - June 2023

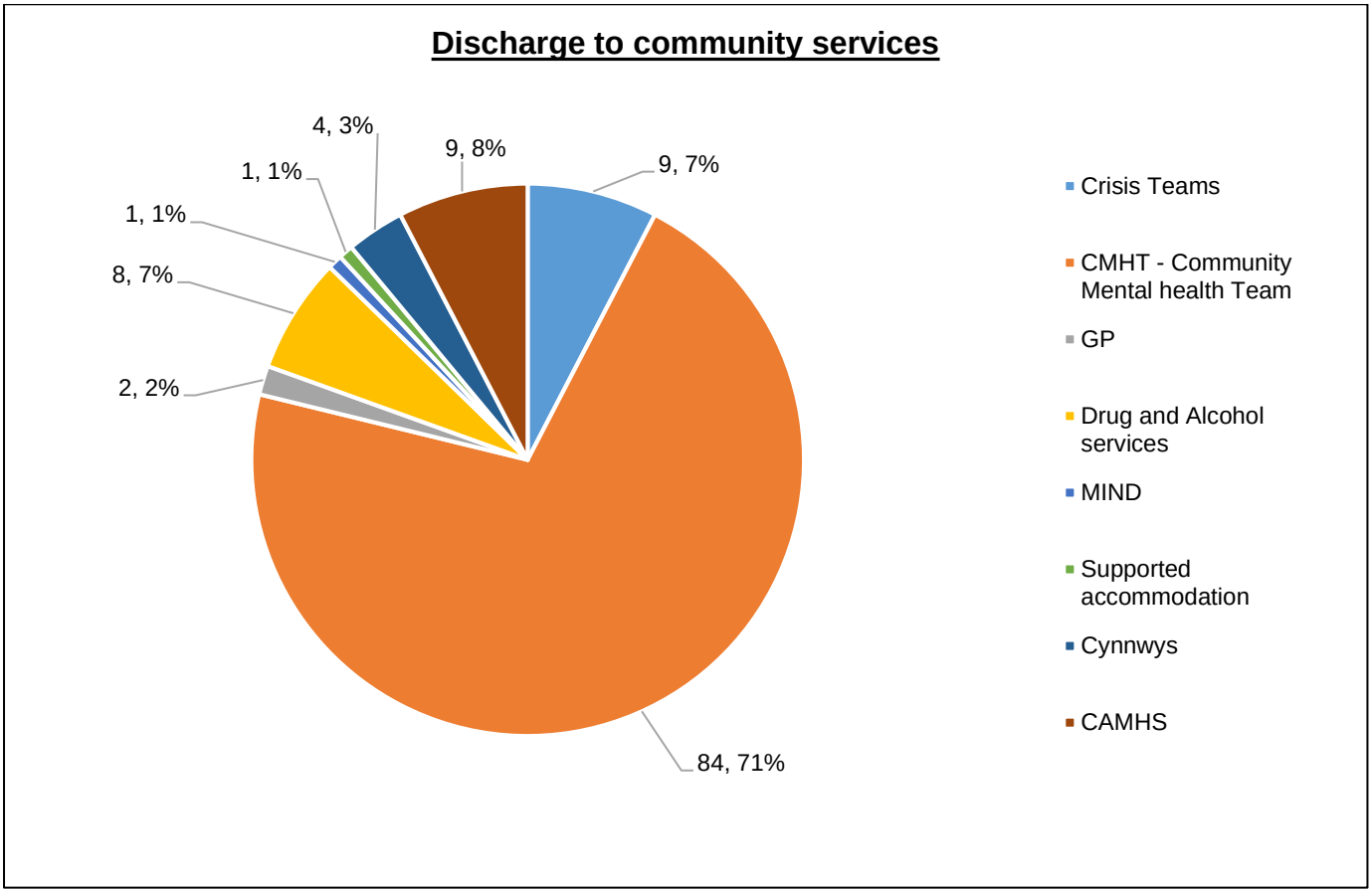


Group	Count	% of Total
Assessed and discharged to community services	110	59.5%
Assessed and discharged	39	21.1%
Assessed and admitted under Section 2	24	13.0%
Assessed and admitted informally	6	3.2%
Assessed and admitted under Section 2 Out of area	3	1.6%
Assessed and admitted under Section 3	2	1.1%
LAPSE	1	0.5%

The pareto chart highlights that 80.4% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

Included in the above data are the outcomes for those under 18 years of age.

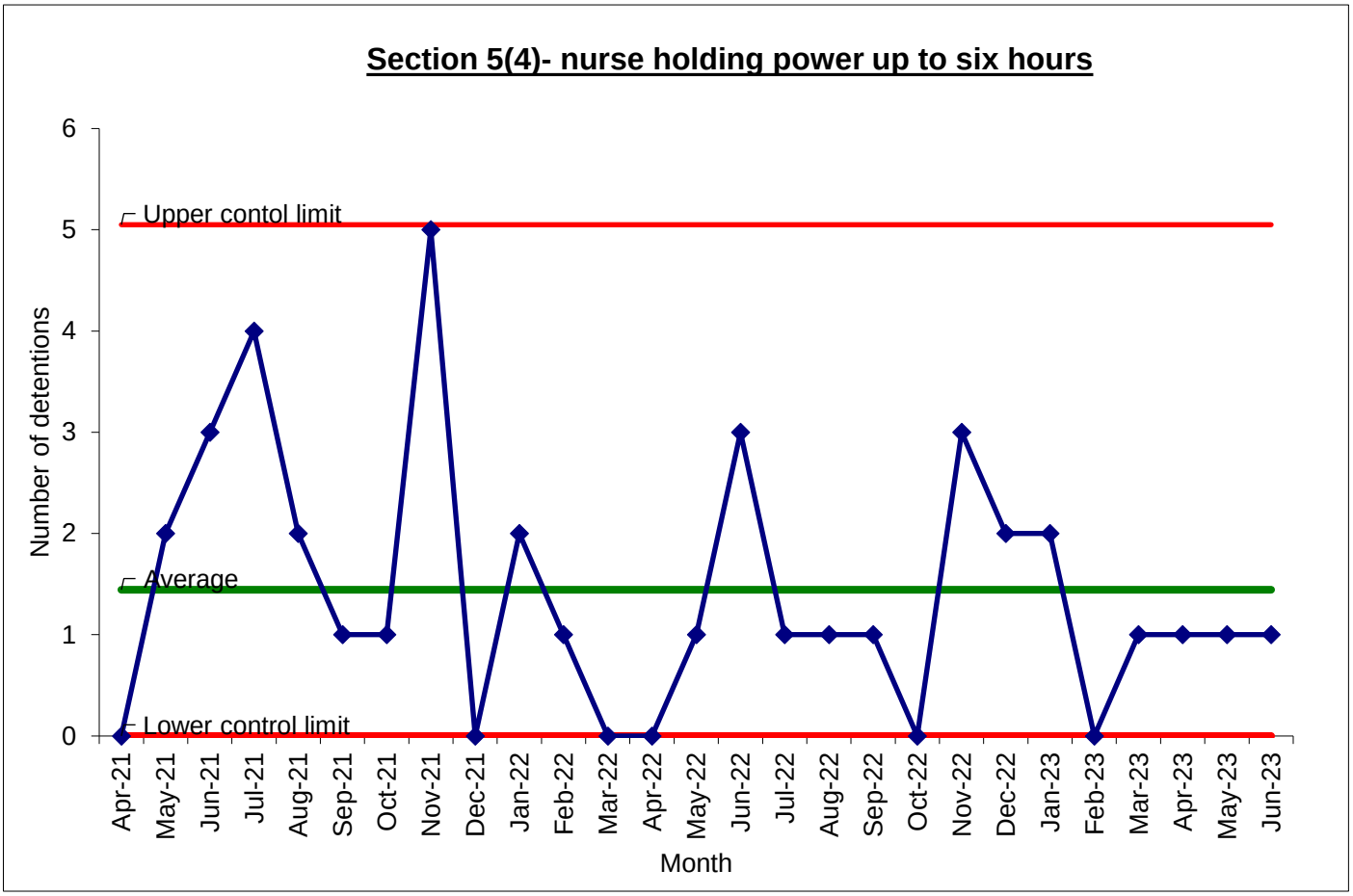
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

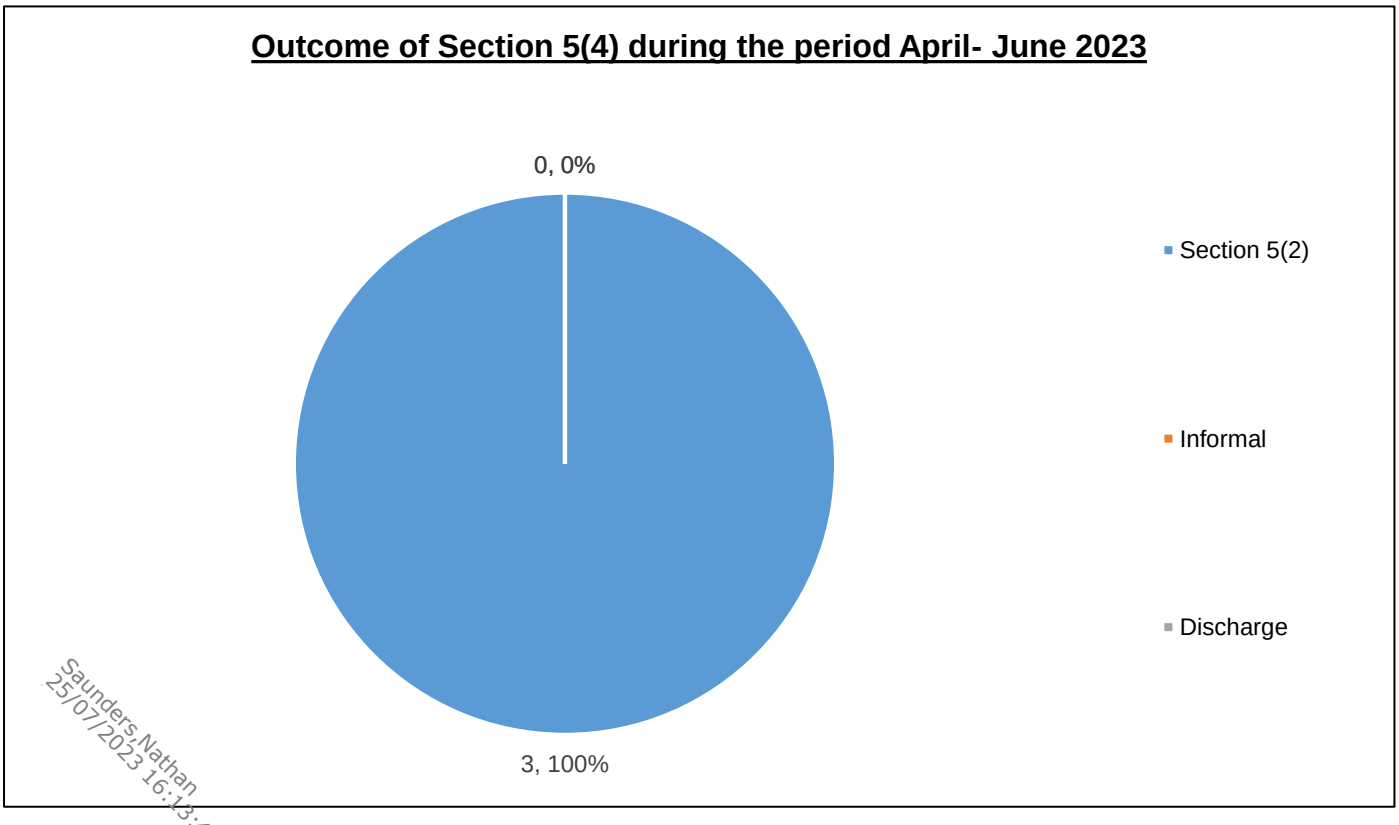


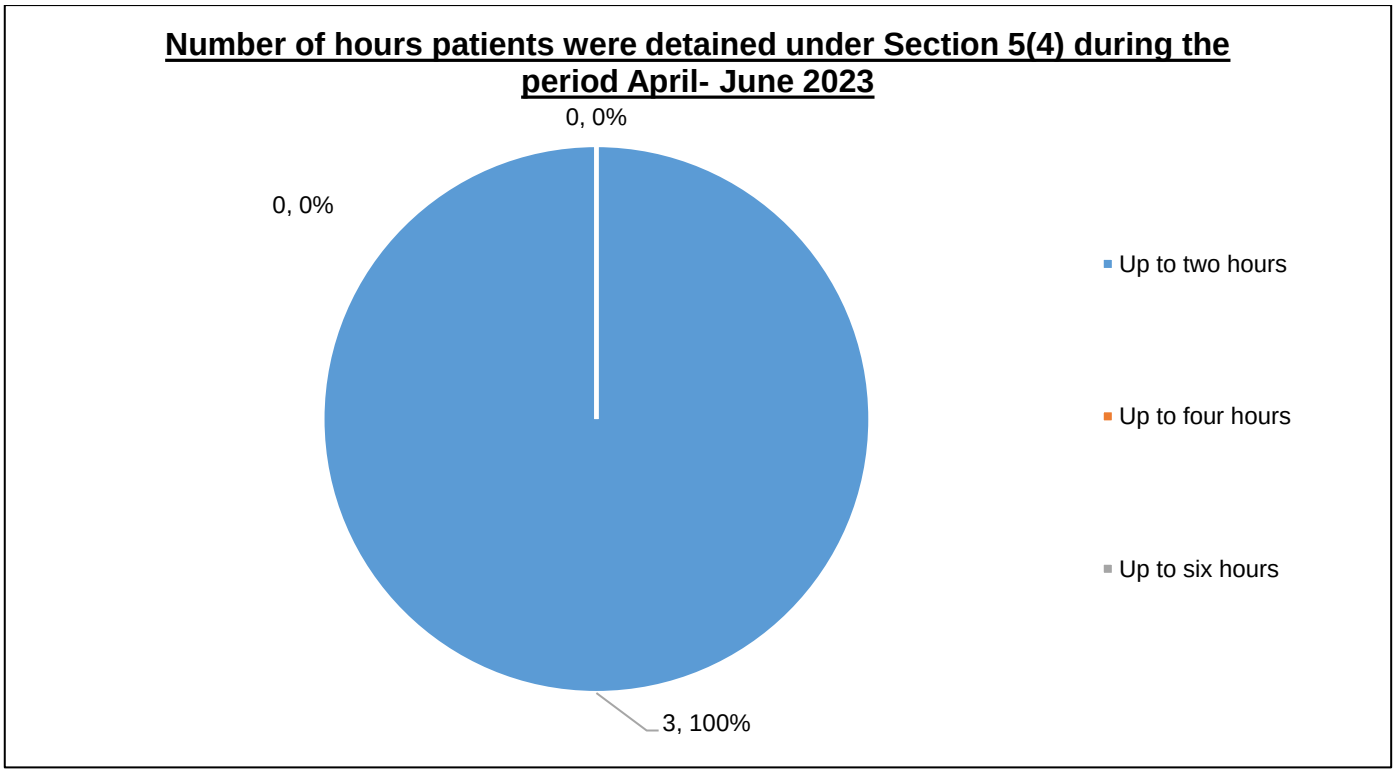
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

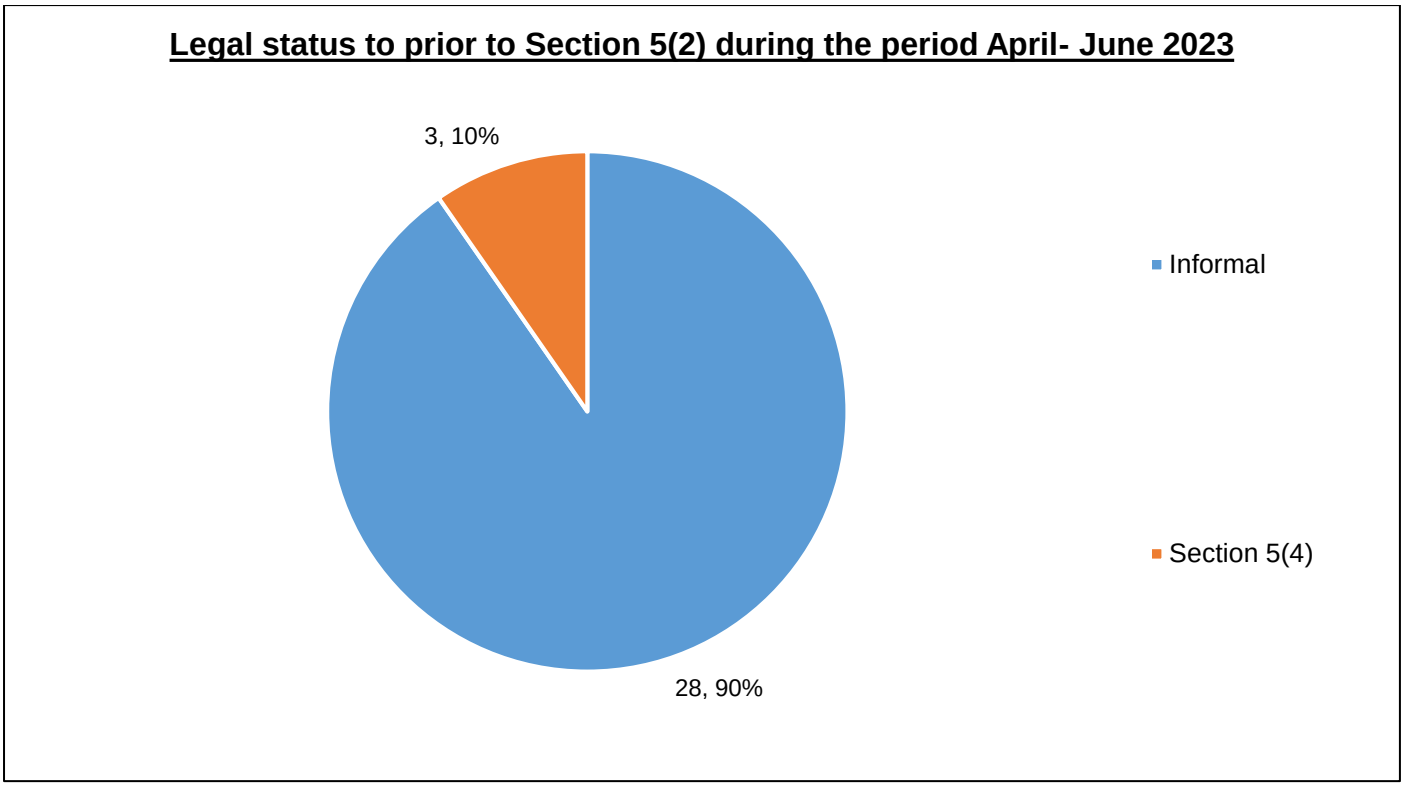
Section 5(4) - Nurses Holding Power

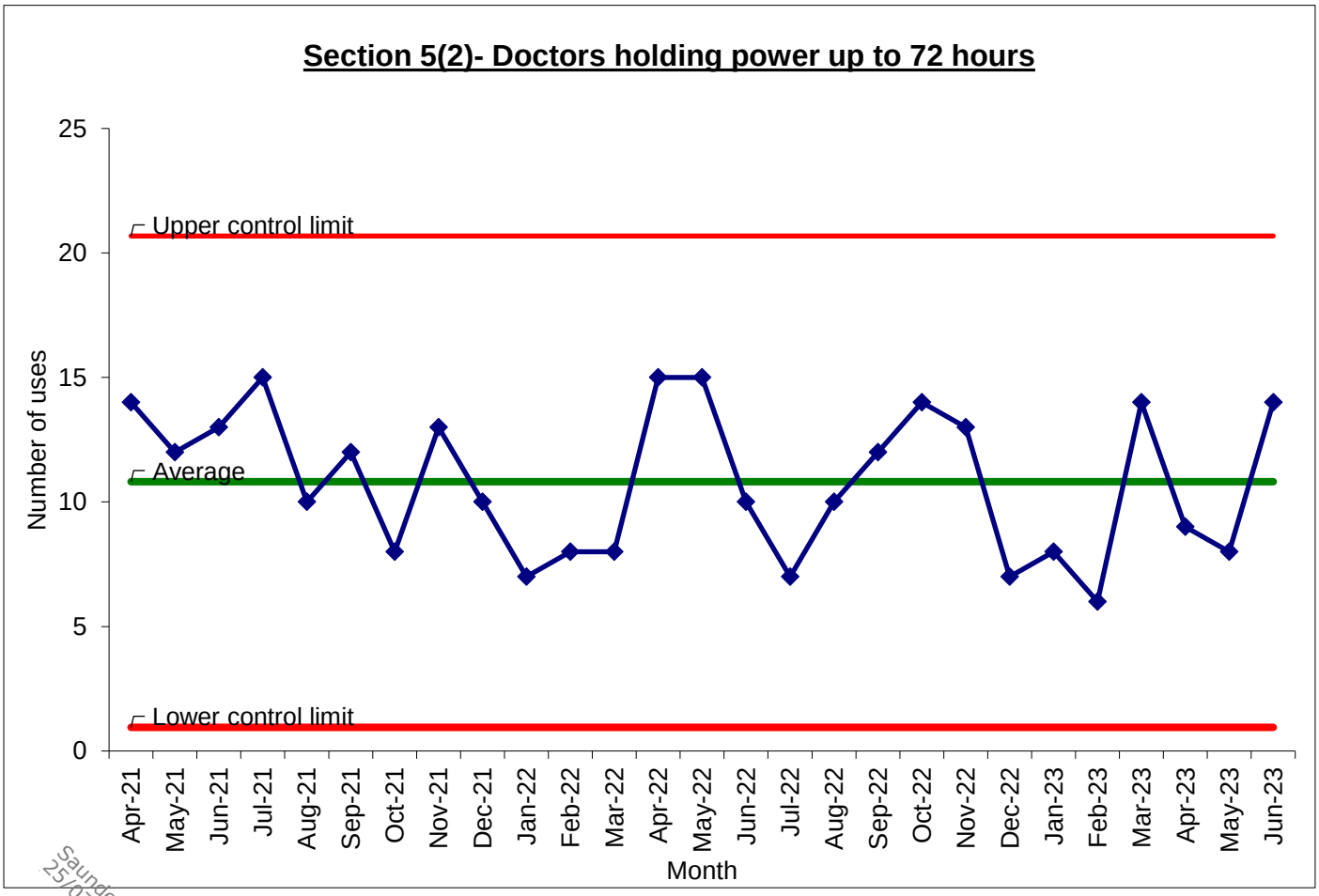




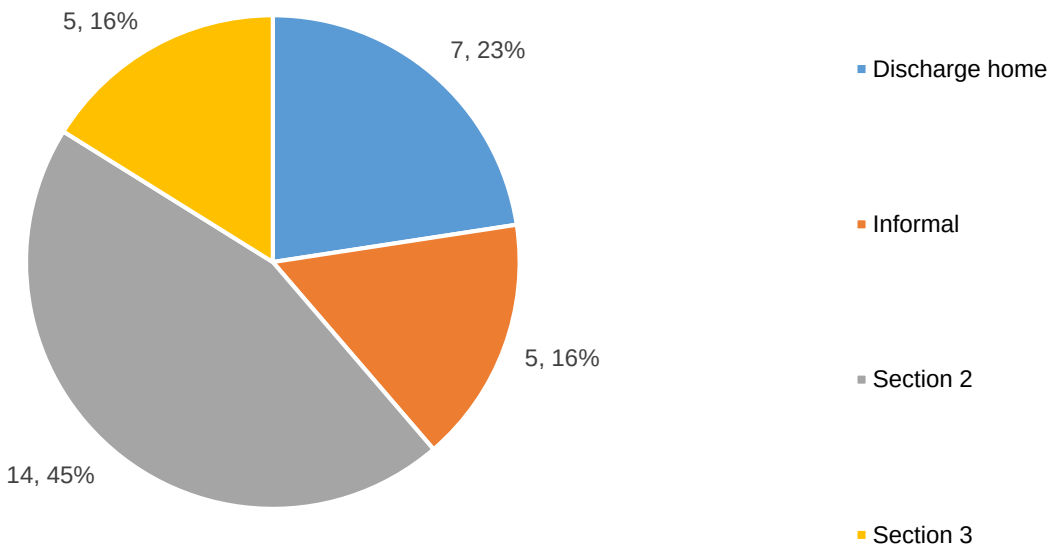


Section 5(2) - Doctors holding power

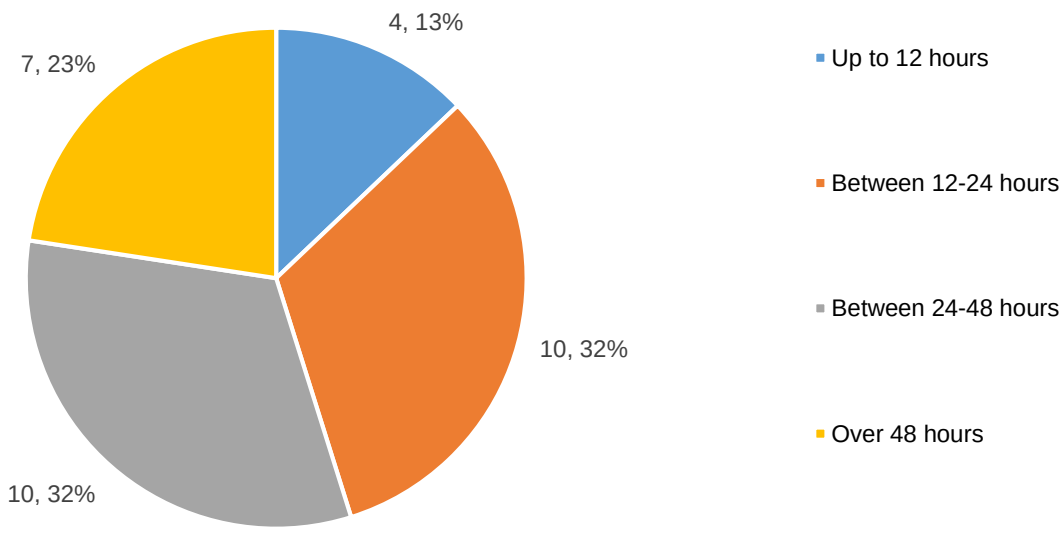




Outcome of section 5(2) during the period April- June 2023



Number of hours patients were detained under Section 5(2) during the period April- June 2023



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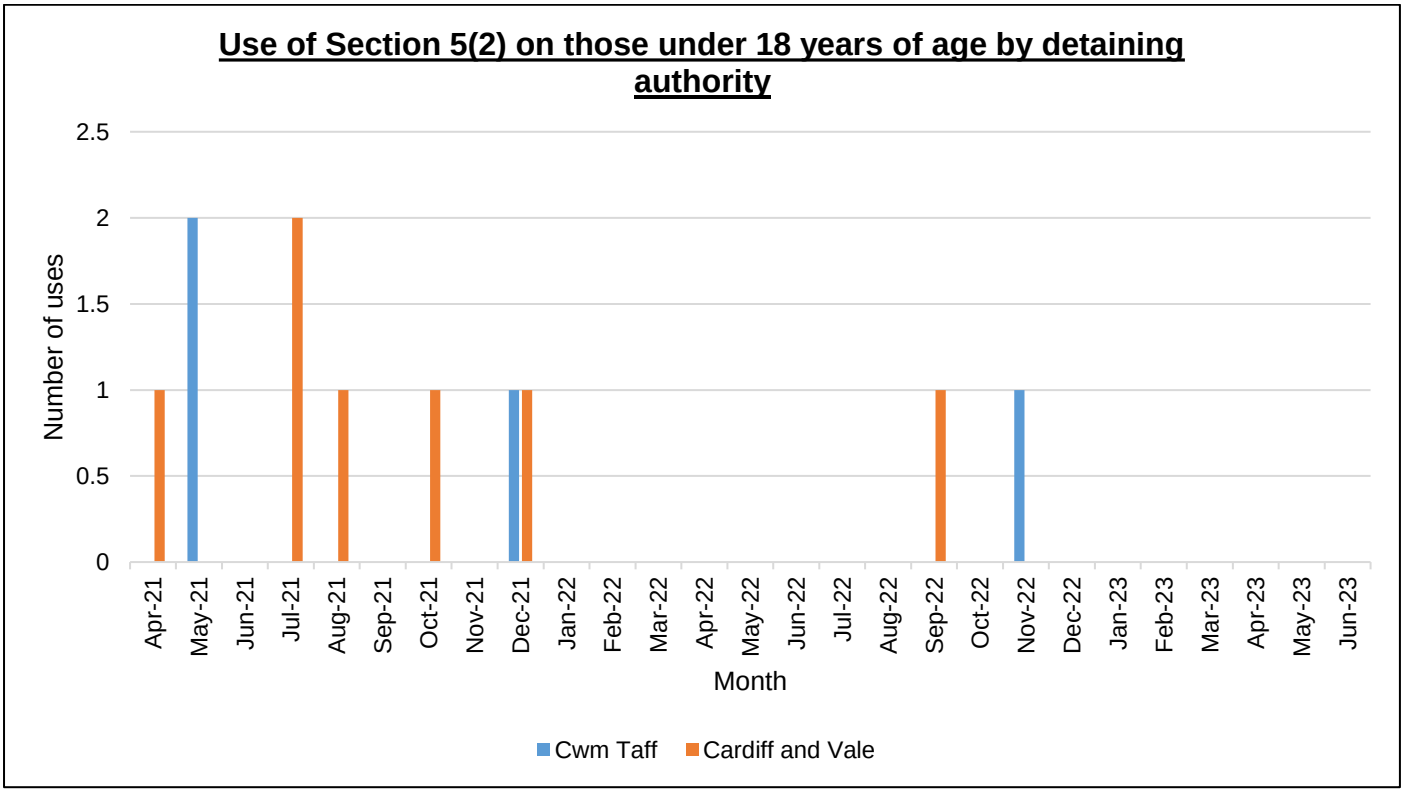
CAMHS Commissioned Inpatient Data

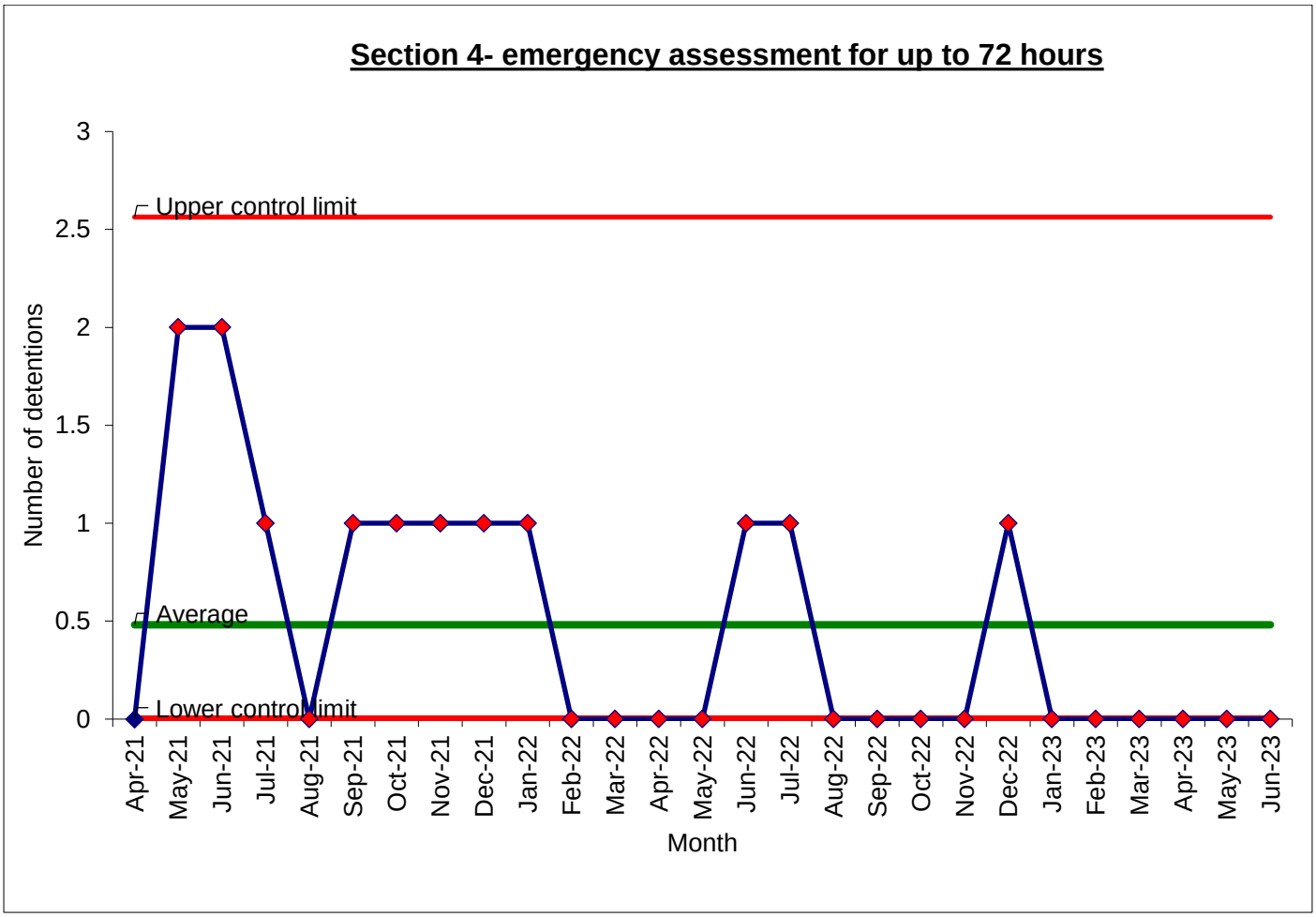
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During the period there were no uses of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB.

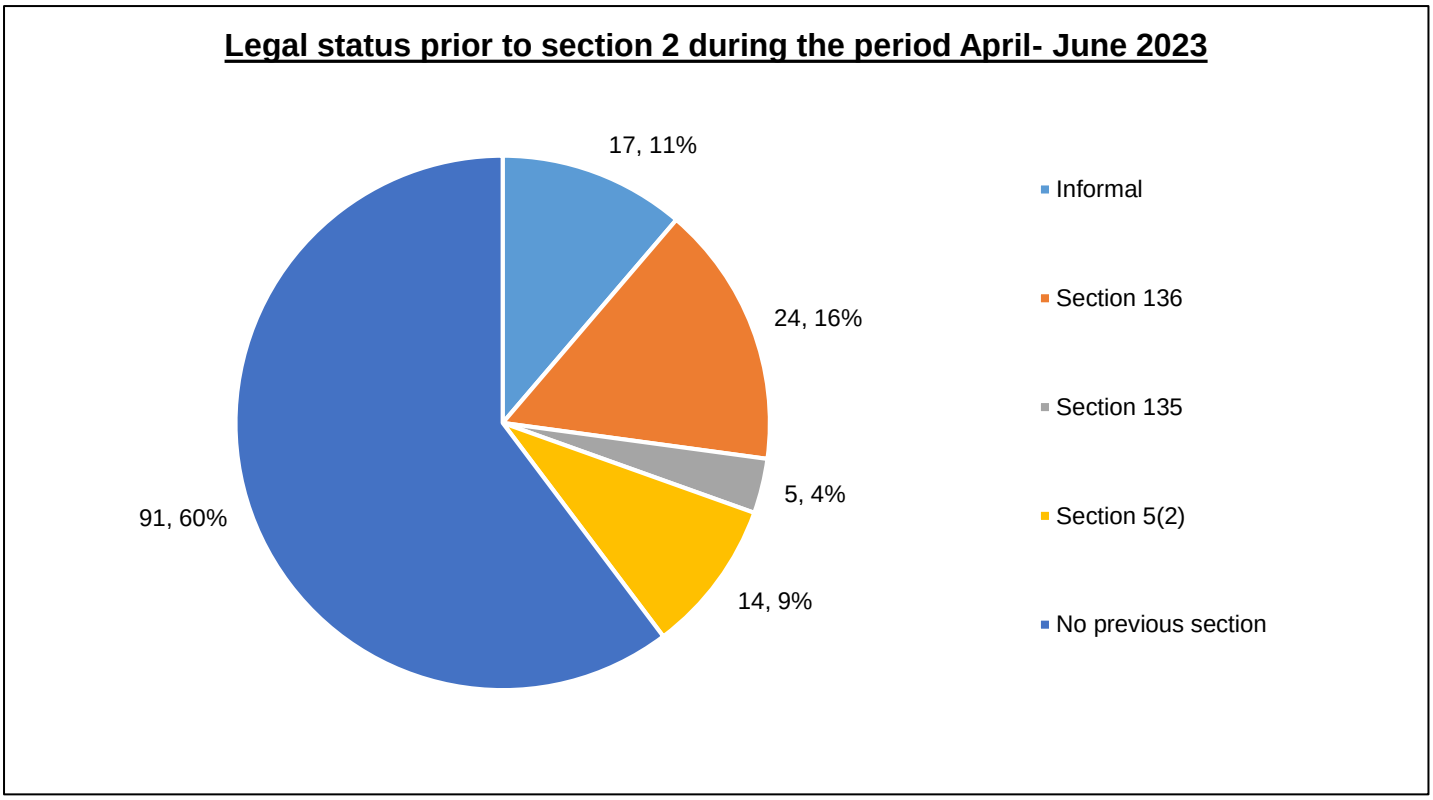


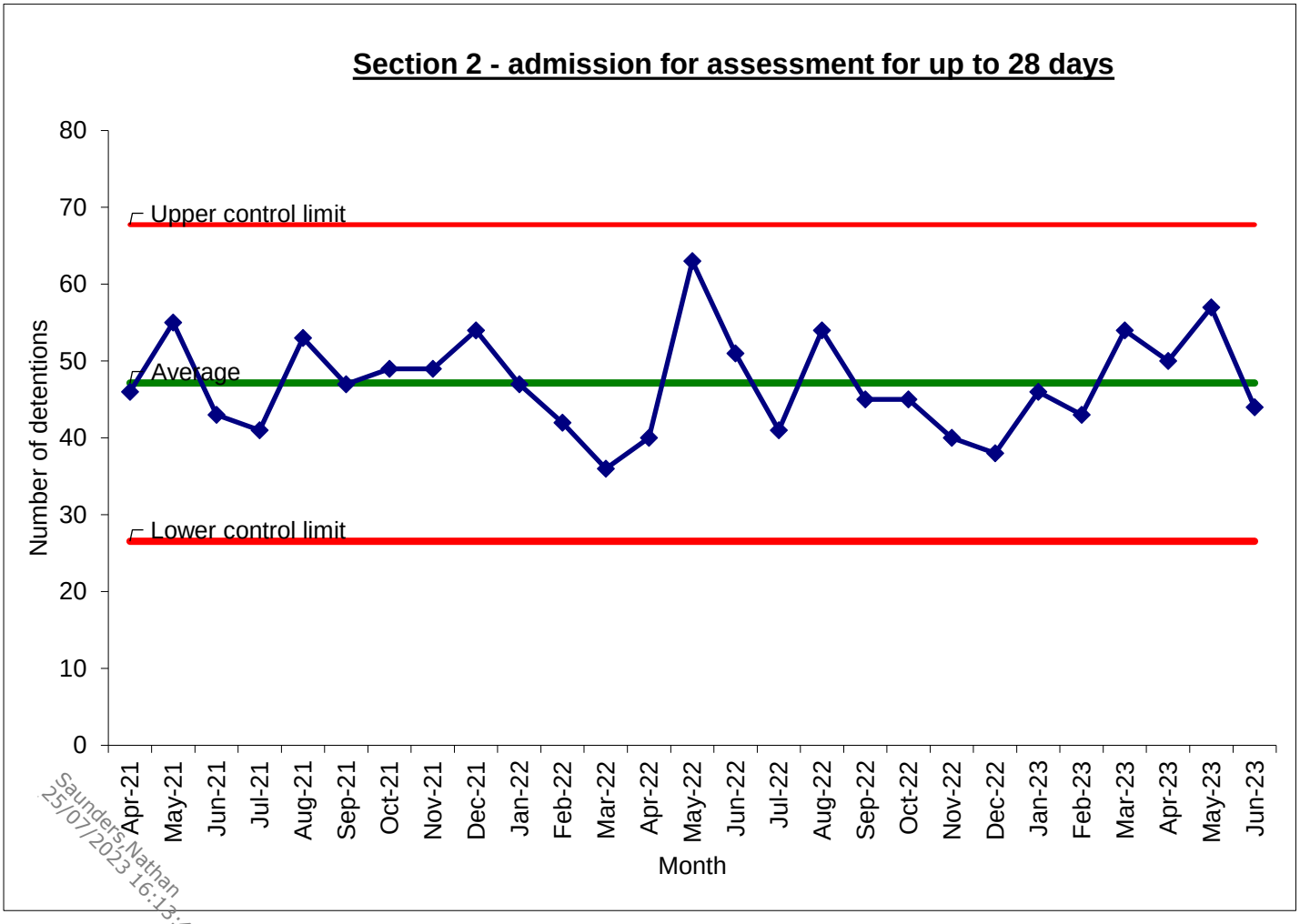
Section 4 - Admission for Assessment in Cases of Emergency

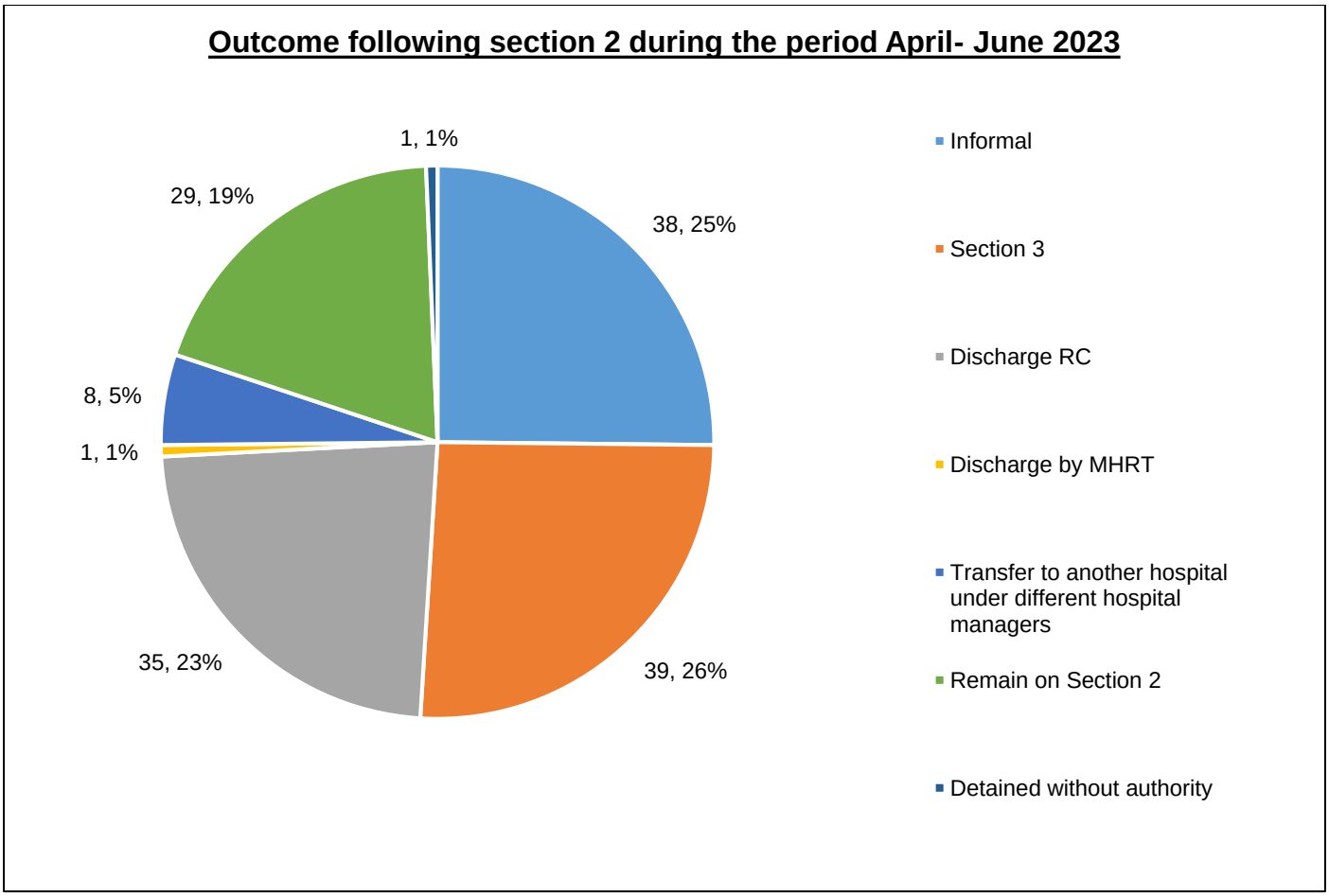
Section 4 wasn't used during the period.



Section 2 – Admission for Assessment





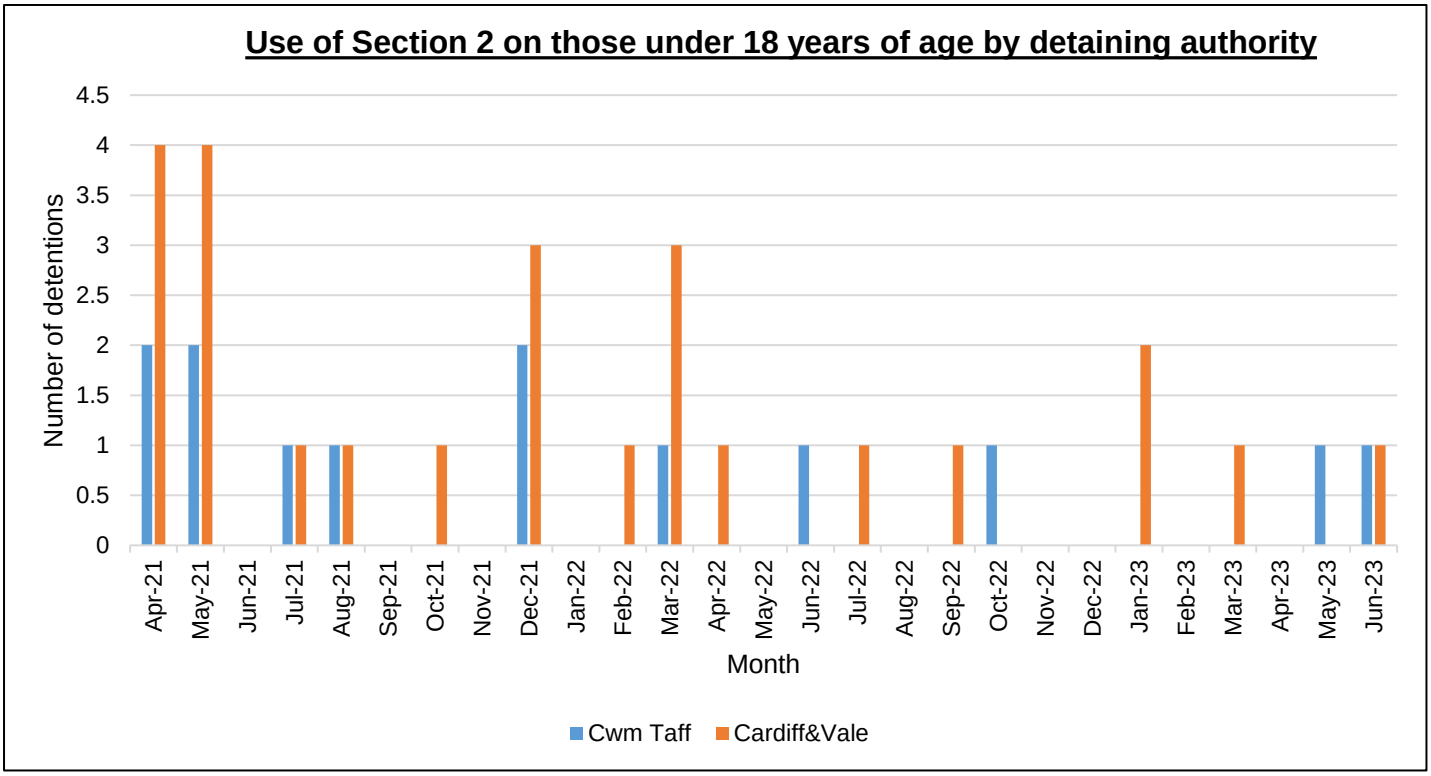


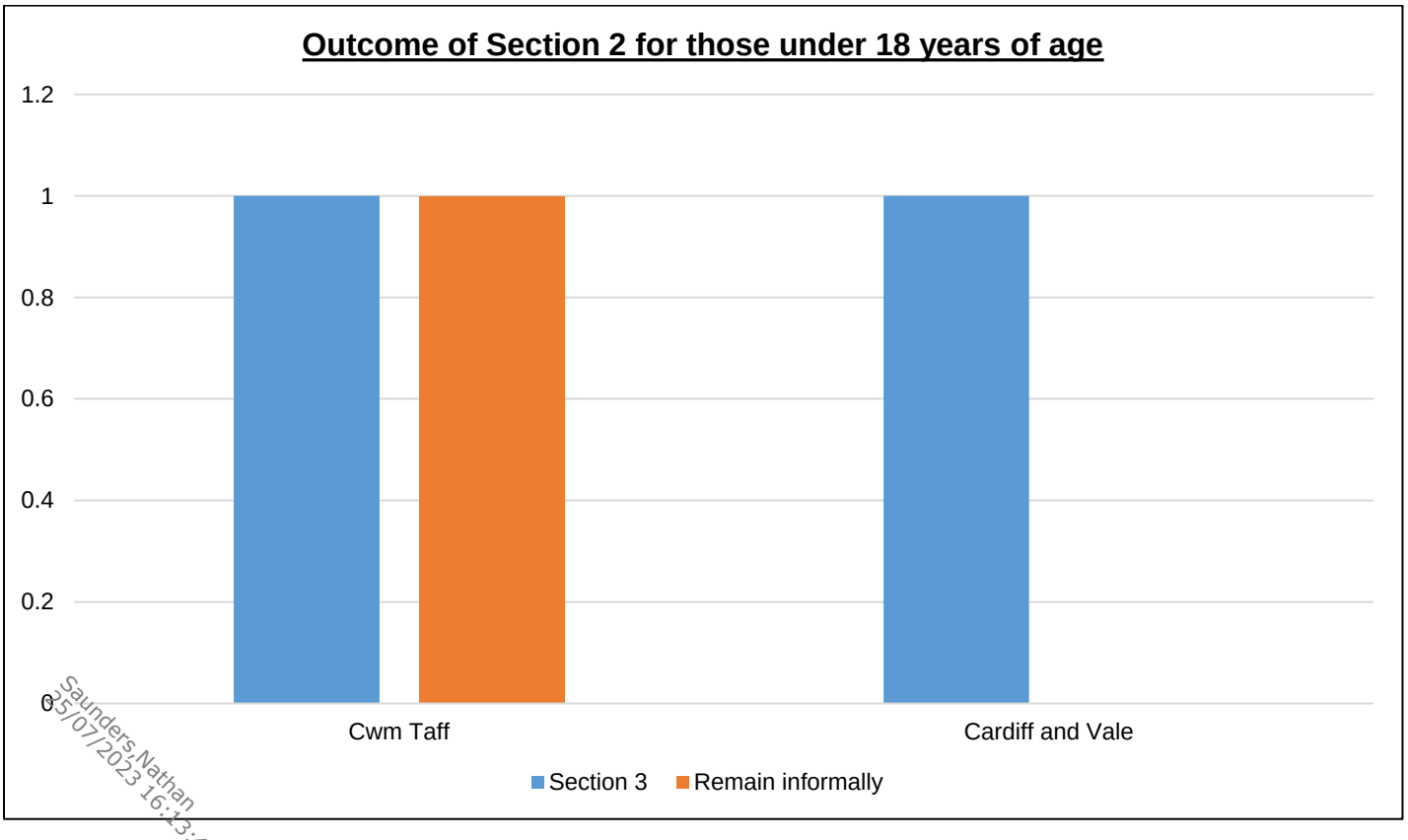
During the period one patient was detained without authority due to the assessment not being recorded in line with the requirements of the Mental Health Act- the detention papers did not meet the necessary criteria.

CAMHS Commissioned Inpatient Data

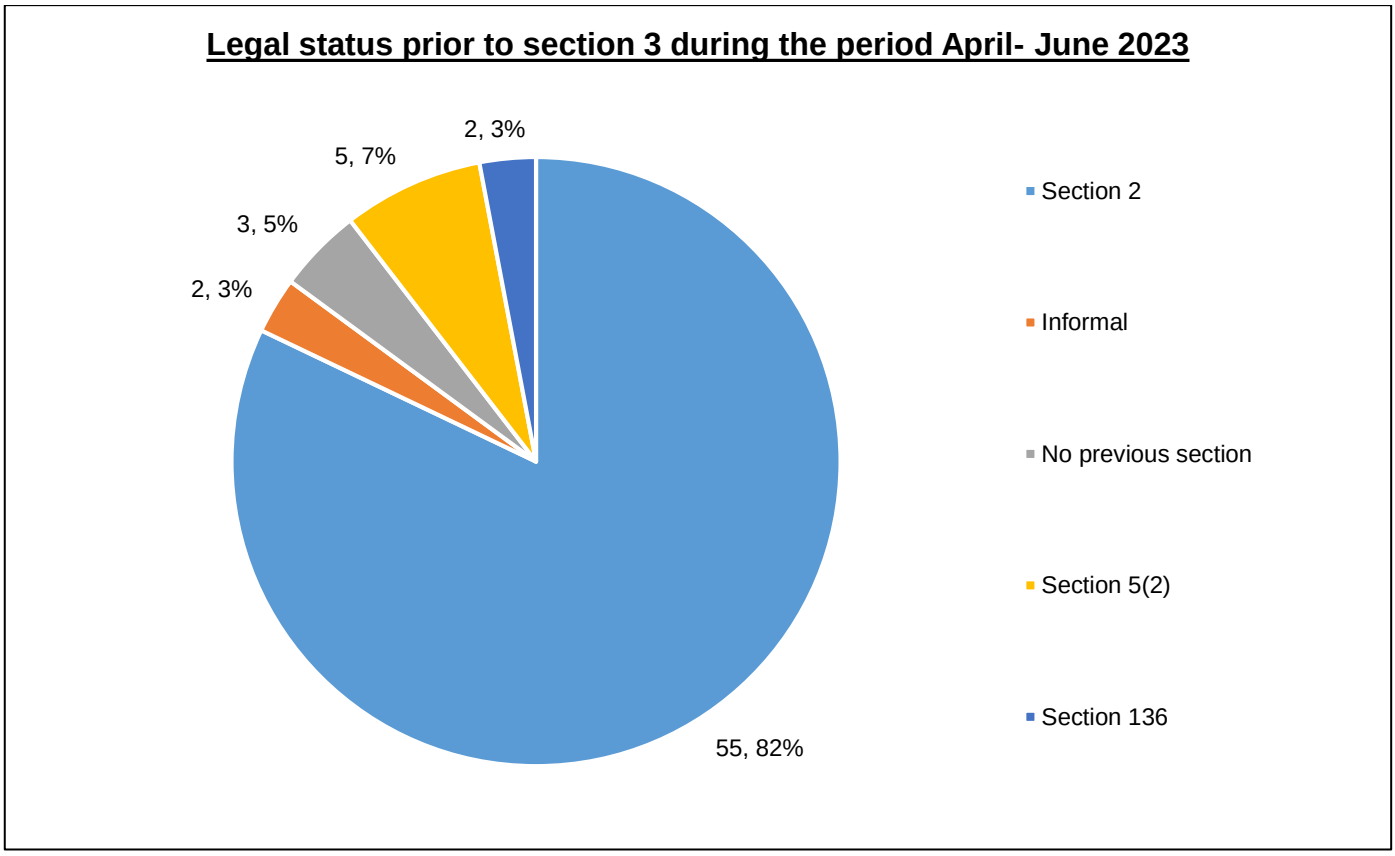
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

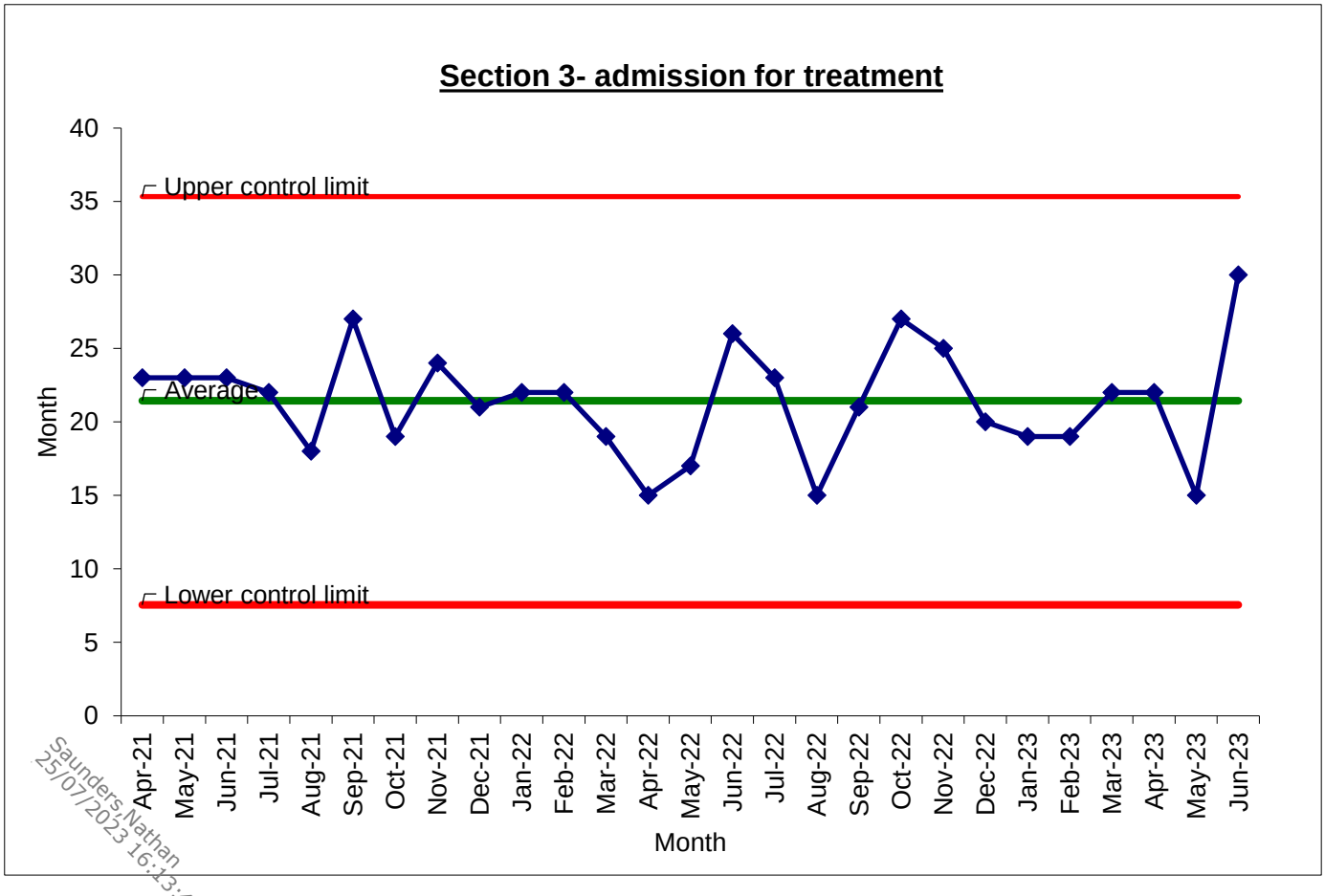
Included in the above data are those under 18 years of age. This is extracted below;-



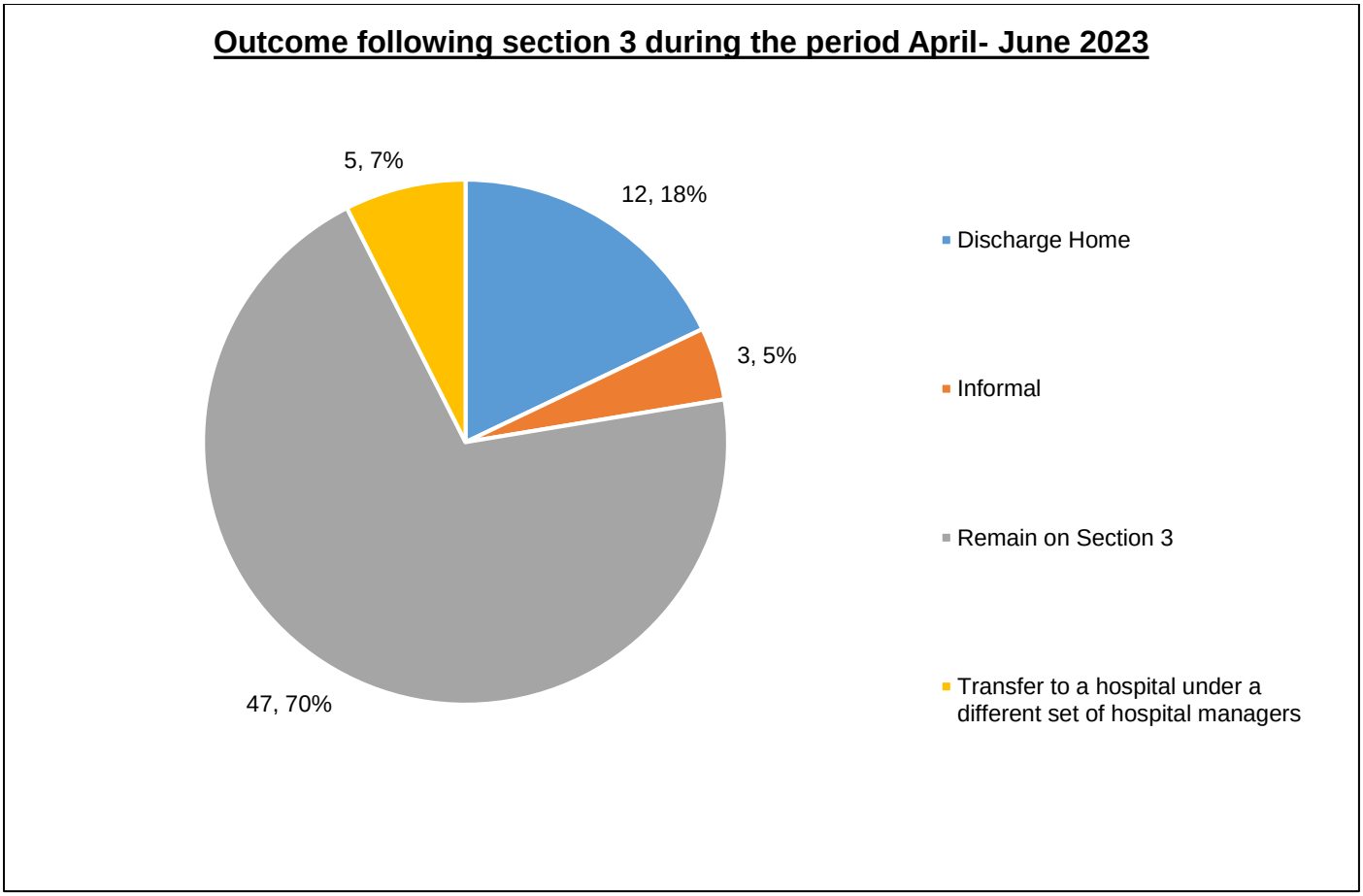


Section 3 – Admission for Treatment



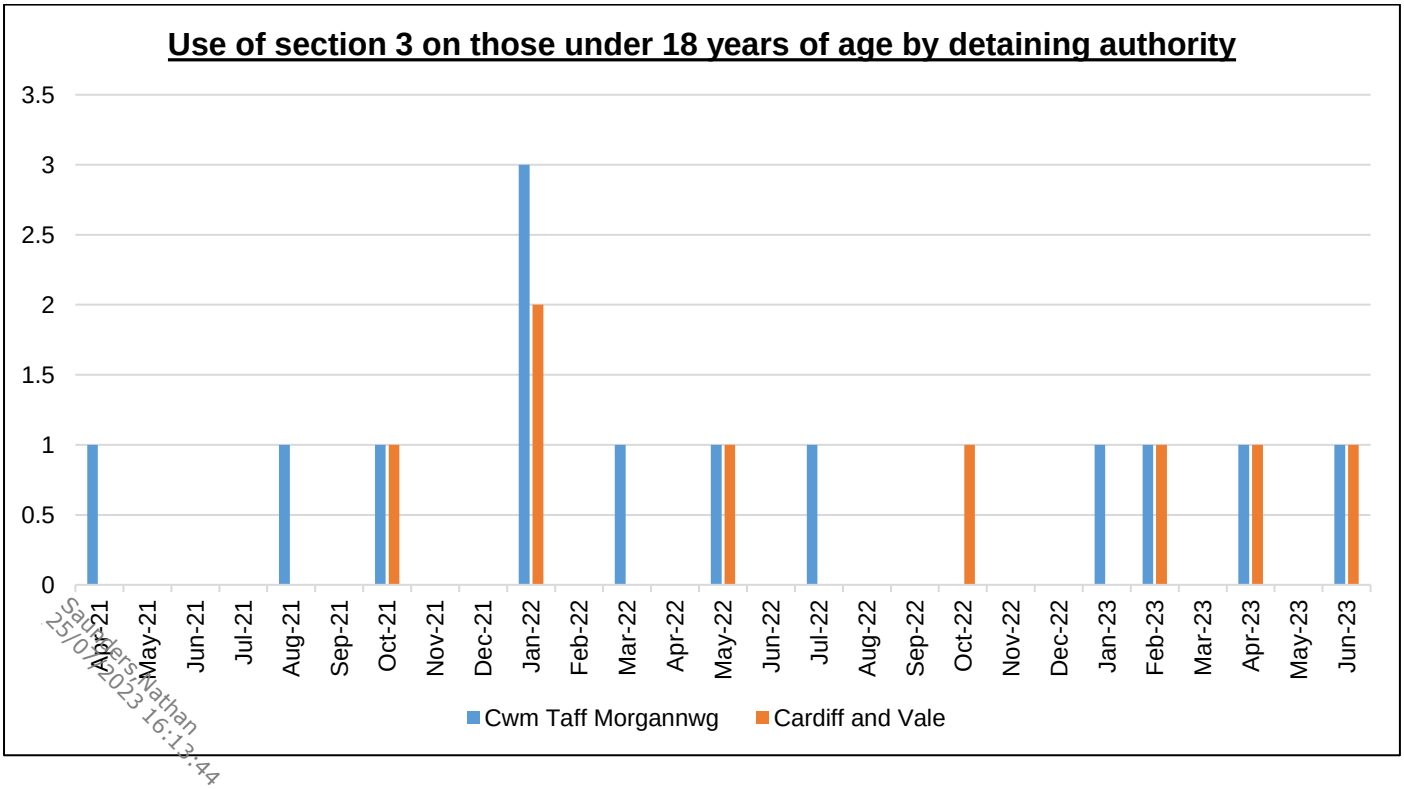


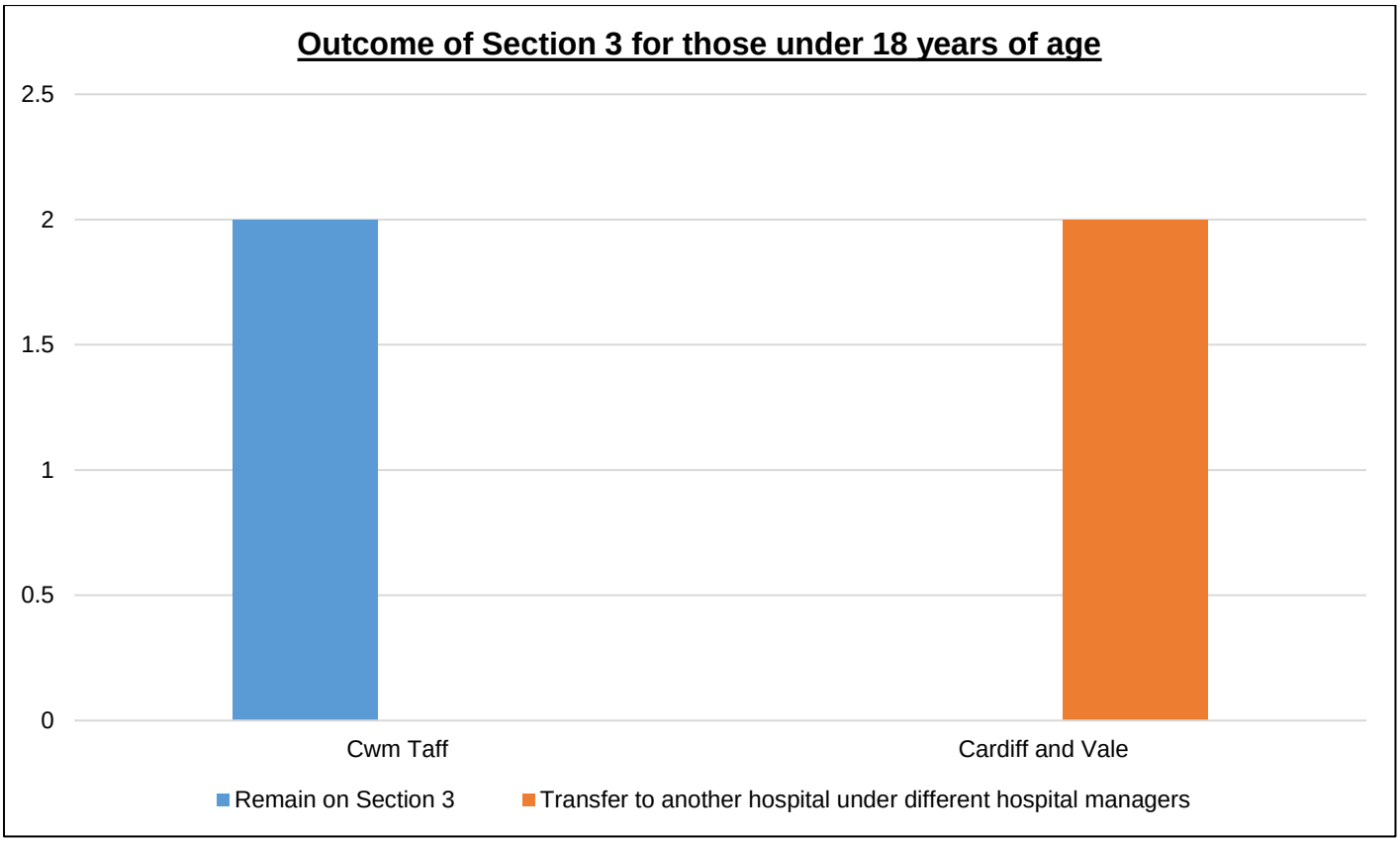
The above data would include those under 18 years of age.



CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

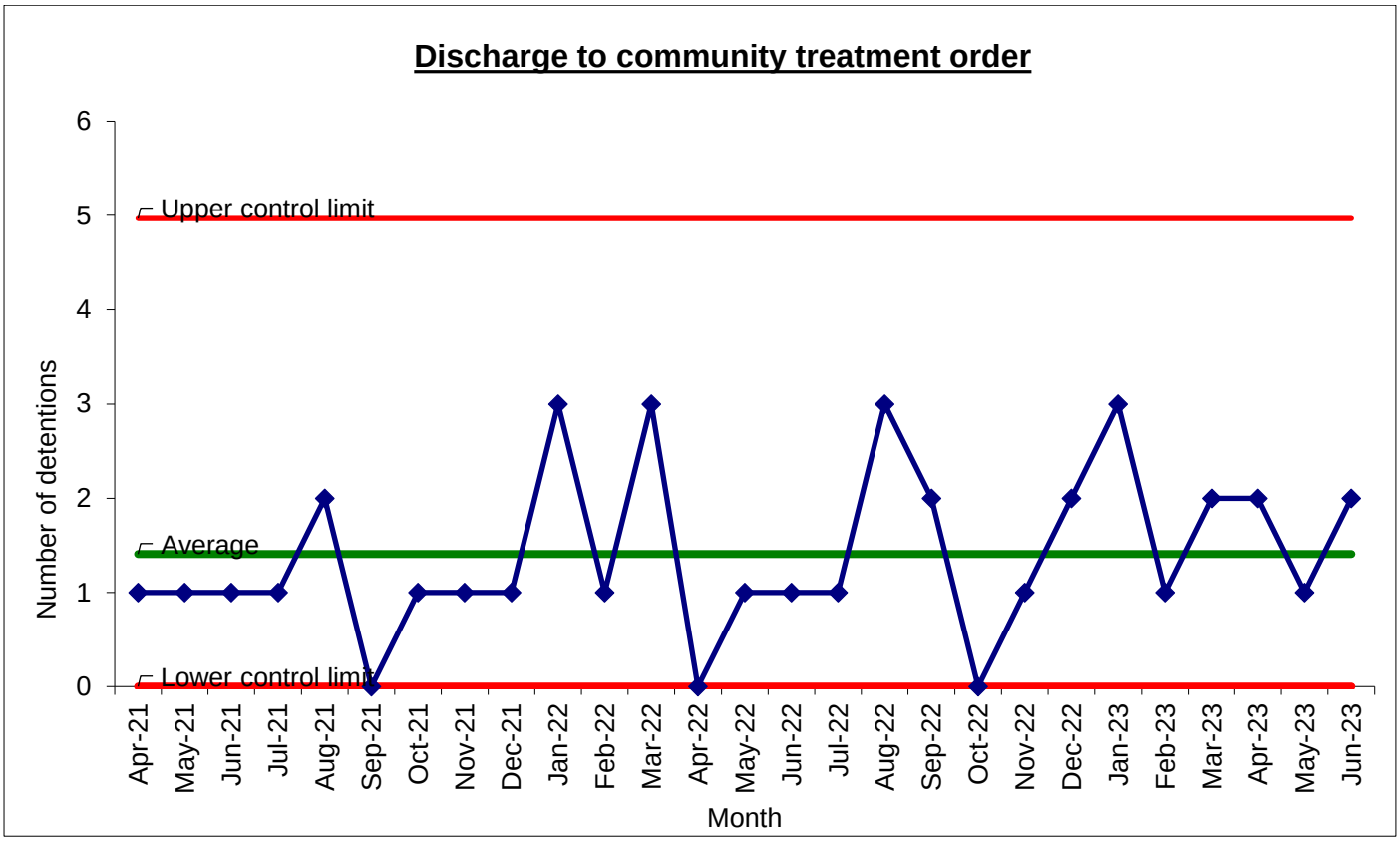


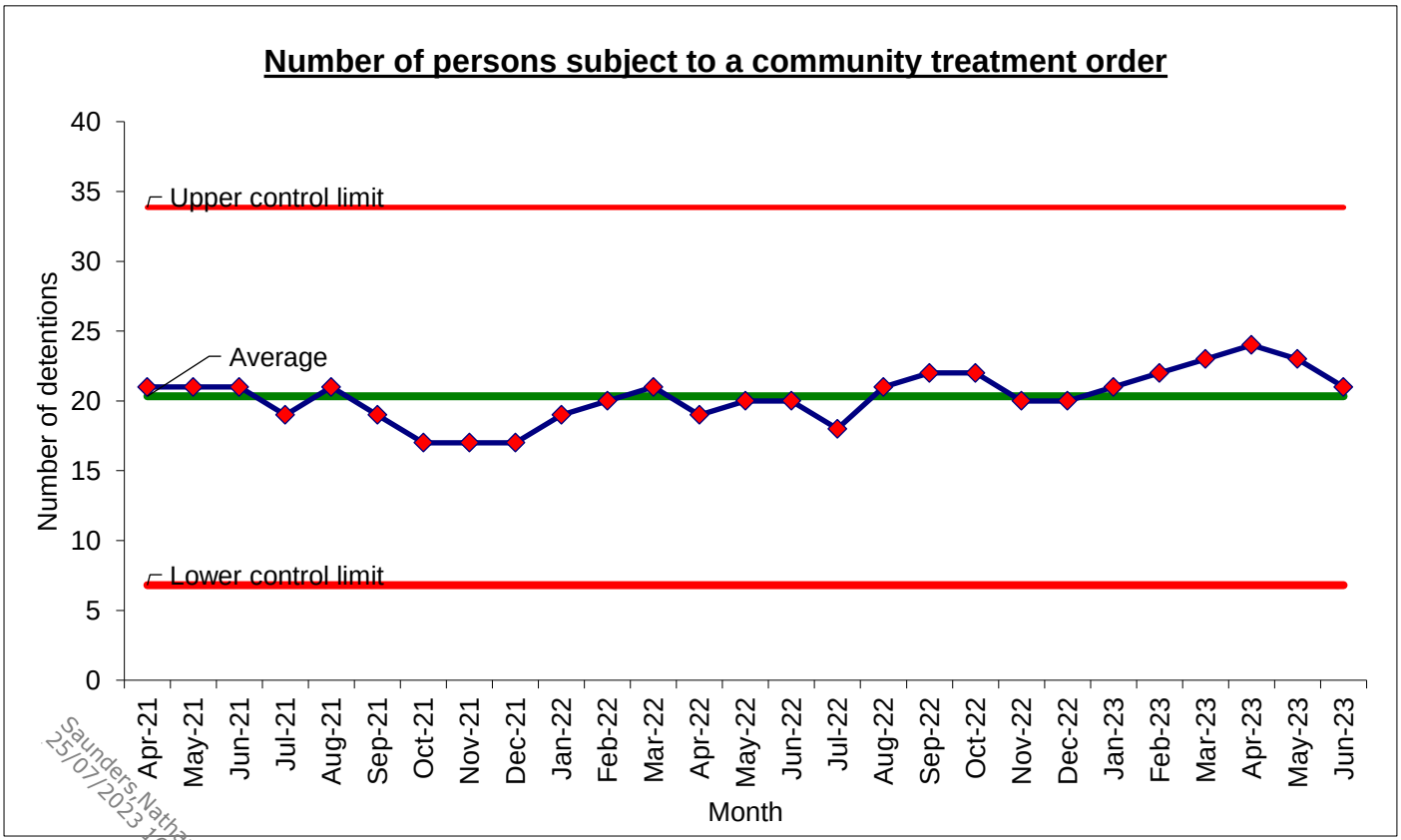


Community Treatment Order

During the period April- June 2023 five patients were discharged to Community Treatment Order.

As at 30th June 2023, twenty-one patients were subject to a Community Treatment Order (CTO).





Recall of a community patient under Section 17E

During the period, the power of recall was used five times. Two recalls were used on the same person – on both occasions this patient was discharge home.

The other three recalls were subsequently revoked.

CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

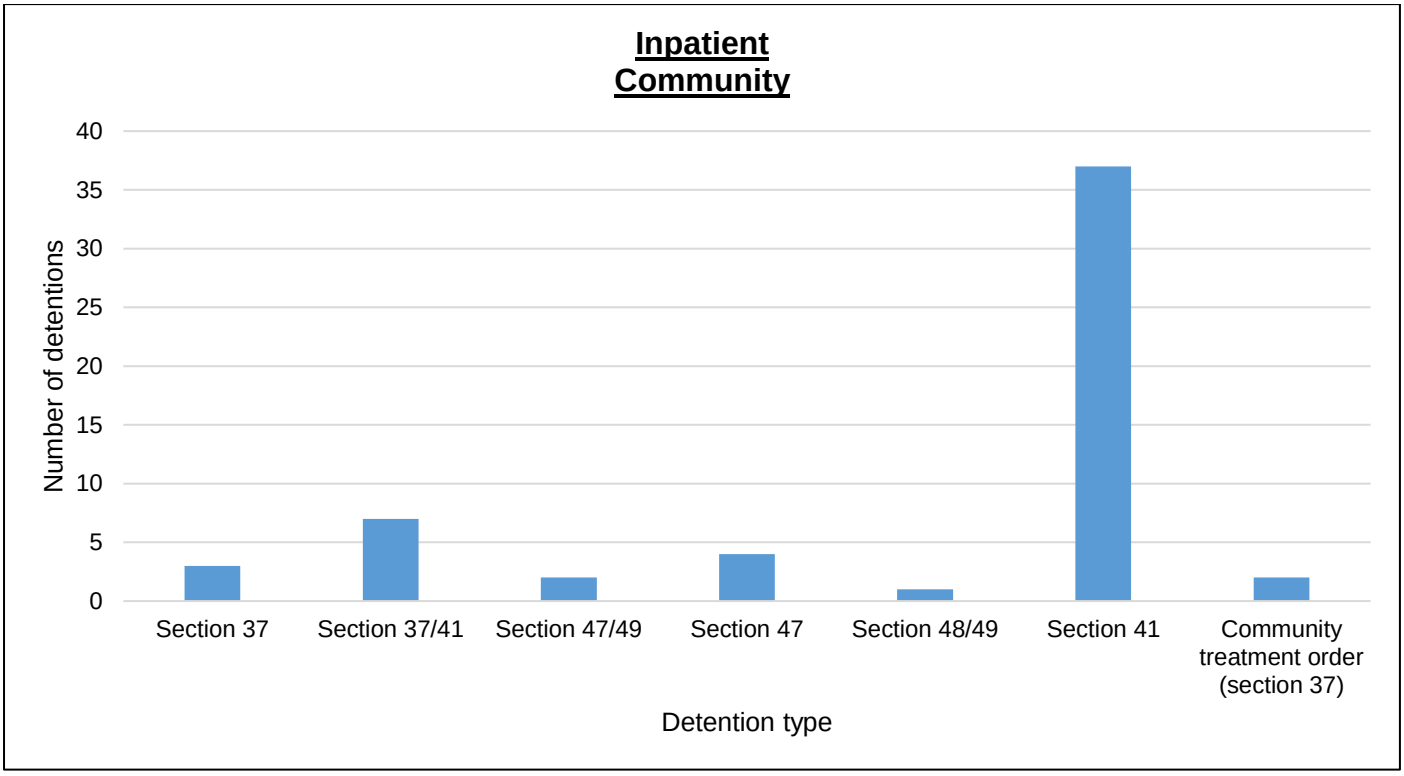
During this period there were no CAMHS patients who became subject to a Community Treatment Order.

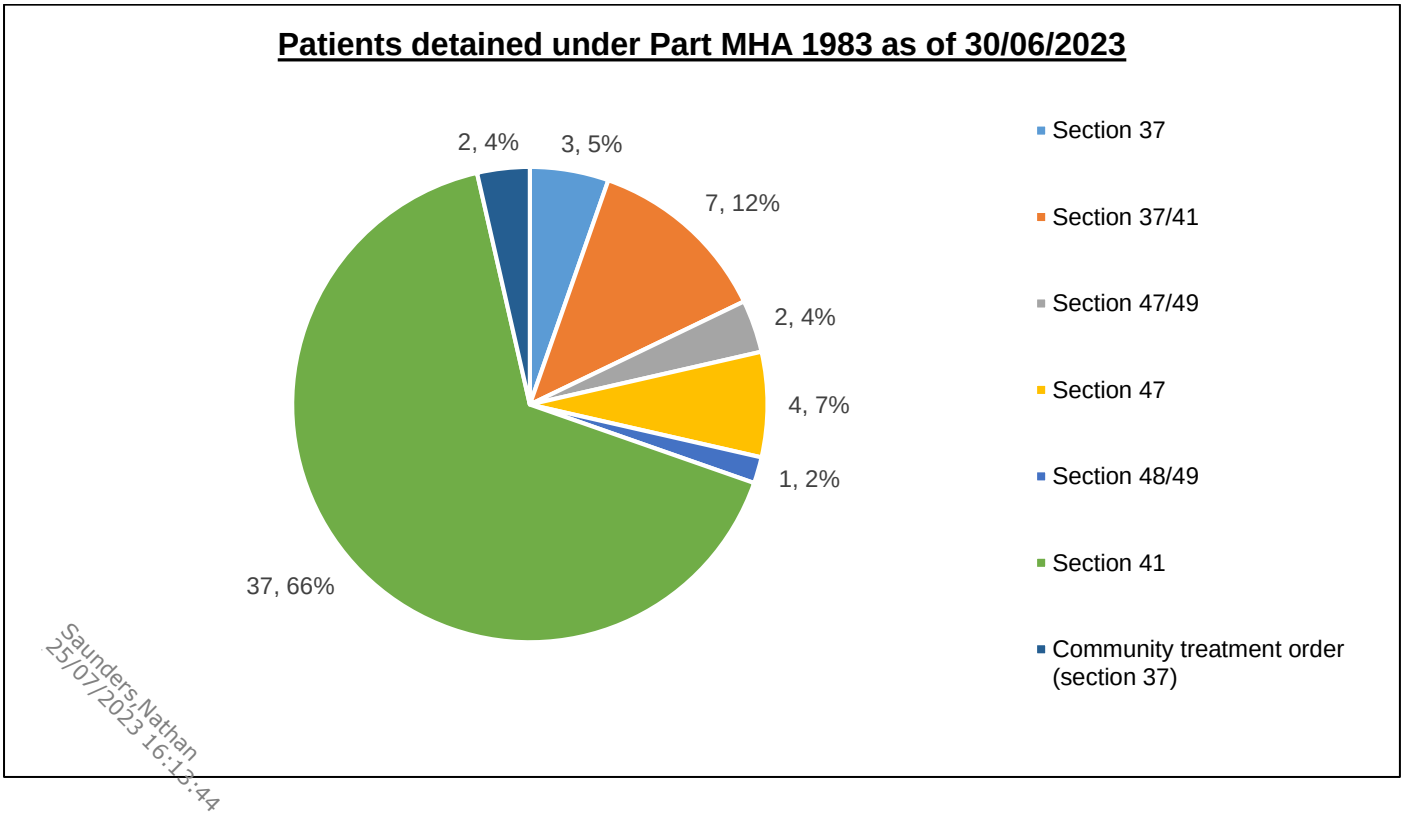
Part 3 of the Mental Health Act 1983

The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 30th June 2023.

During the quarter one section 48/49 patient was transferred back to prison.

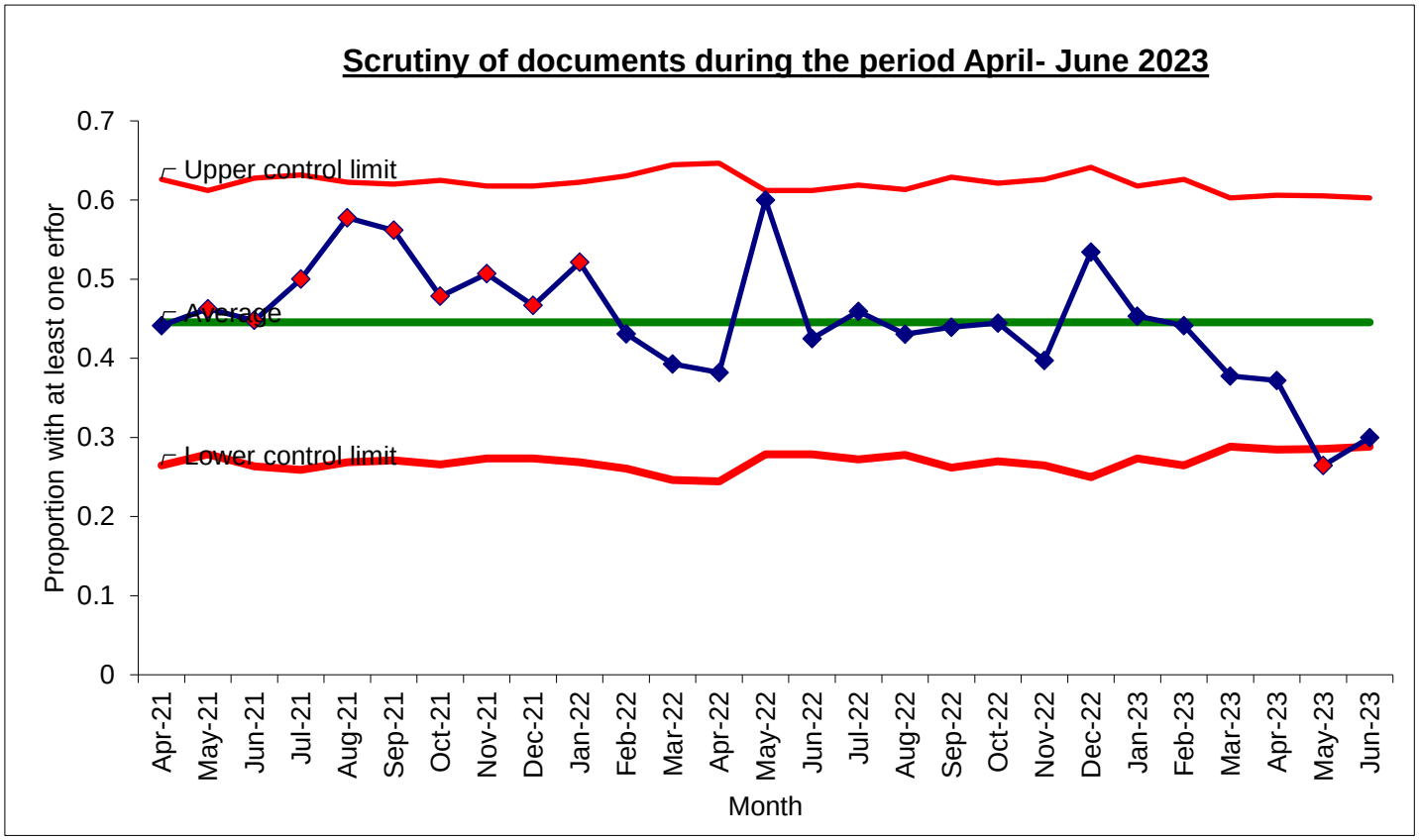
During the quarter one patient went from a restricted 47/49 to an unrestricted section 47.

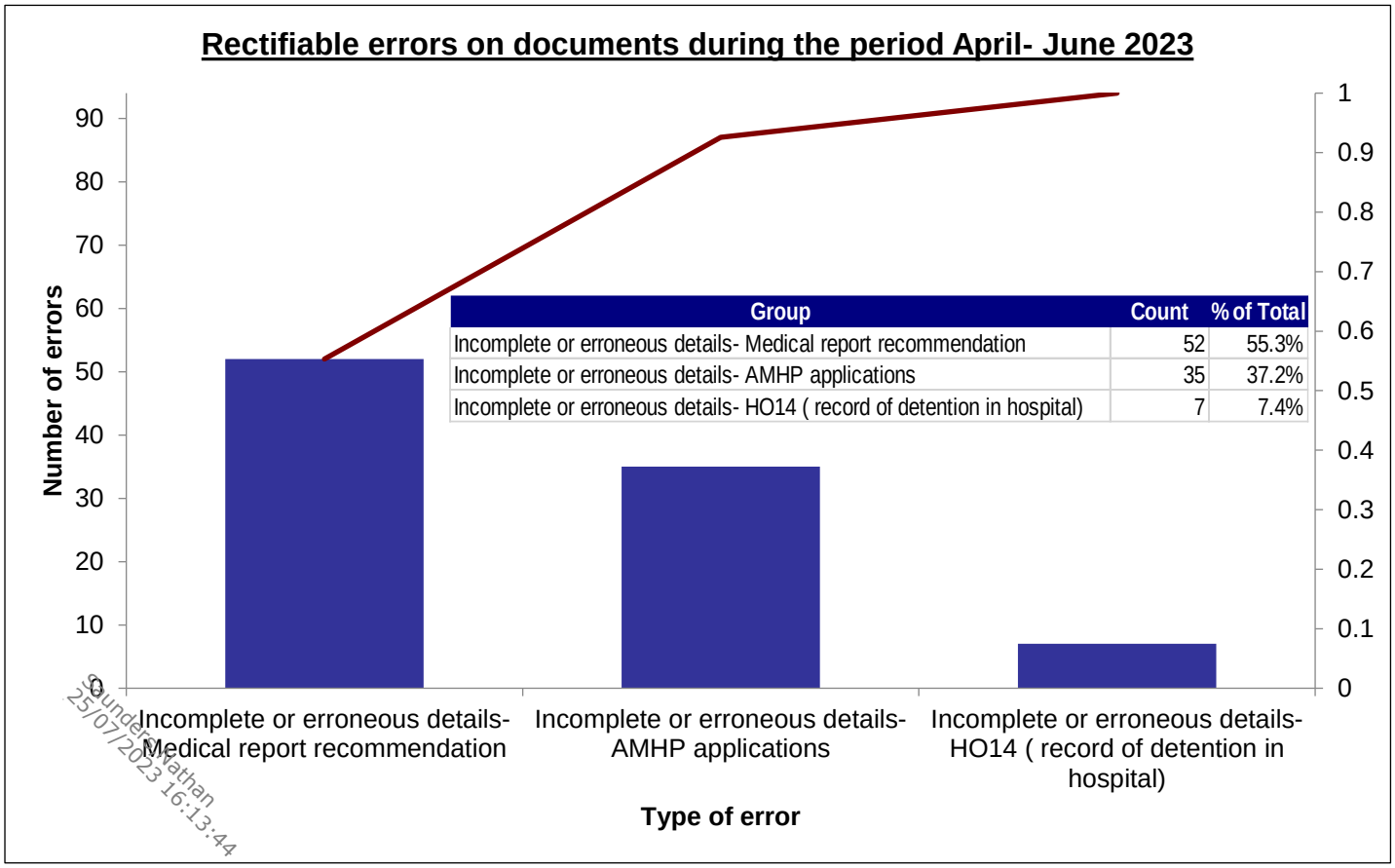




Scrutiny of documents during the period

The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.

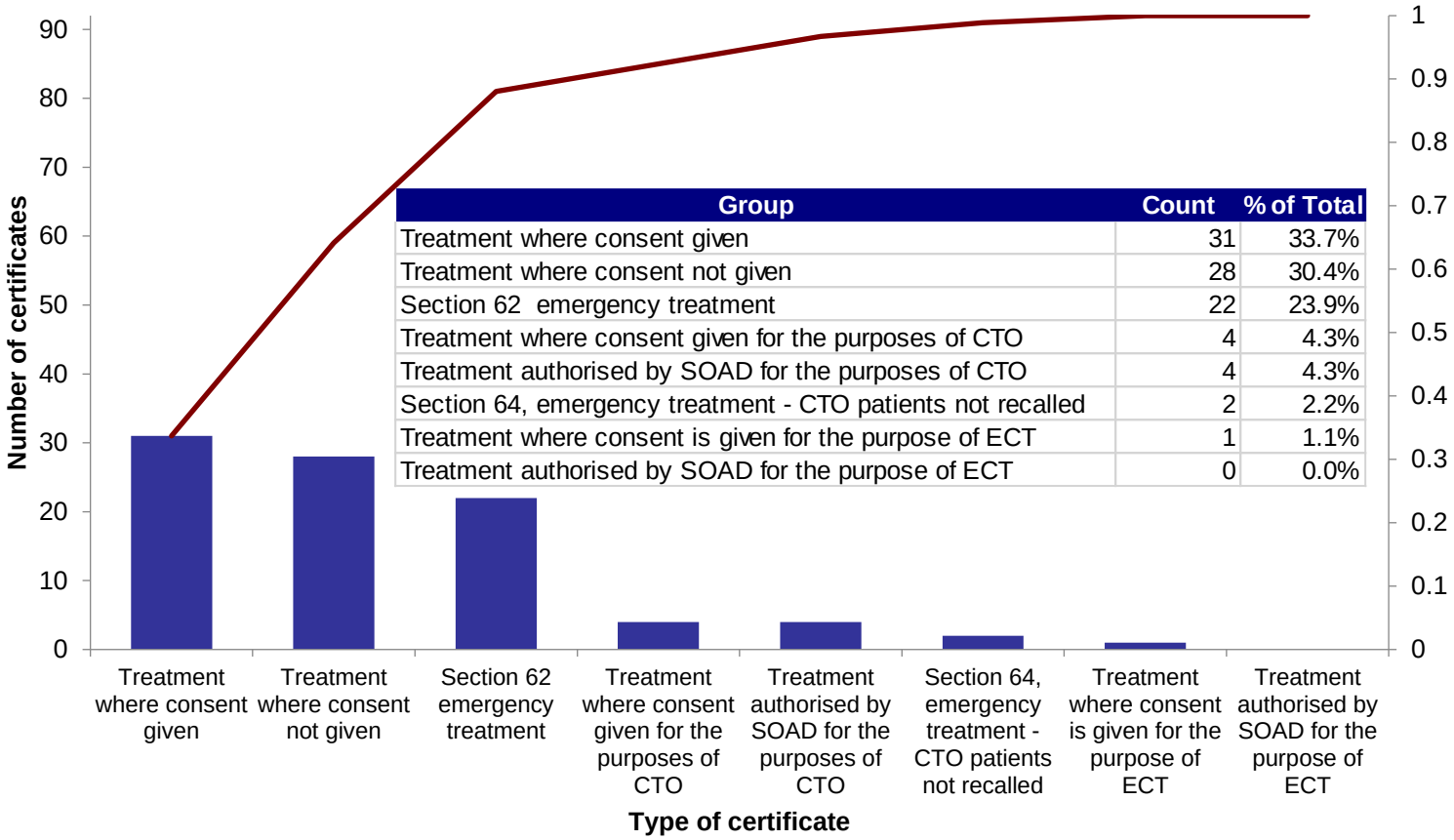




Group	Count	% of Total
Incomplete or erroneous details- Medical report recommendation	52	55.3%
Incomplete or erroneous details- AMHP applications	35	37.2%
Incomplete or erroneous details- HO14 (record of detention in hospital)	7	7.4%

Consent to Treatment

Analysis of the treatment provisions under Part 4/4A MHA during the period April- June 2023



Group	Count	% of Total
Treatment where consent given	31	33.7%
Treatment where consent not given	28	30.4%
Section 62 emergency treatment	22	23.9%
Treatment where consent given for the purposes of CTO	4	4.3%
Treatment authorised by SOAD for the purposes of CTO	4	4.3%
Section 64, emergency treatment - CTO patients not recalled	2	2.2%
Treatment where consent is given for the purpose of ECT	1	1.1%
Treatment authorised by SOAD for the purpose of ECT	0	0.0%

Urgent Treatment

There are some circumstances in which the approved clinician may authorise a detained patient's urgent treatment under section 62 however this applies only to patients whose treatment is covered by Part 4 of the Act which is concerned with the treatment of detained patients and Part 4A supervised community treatment patients recalled to hospital.

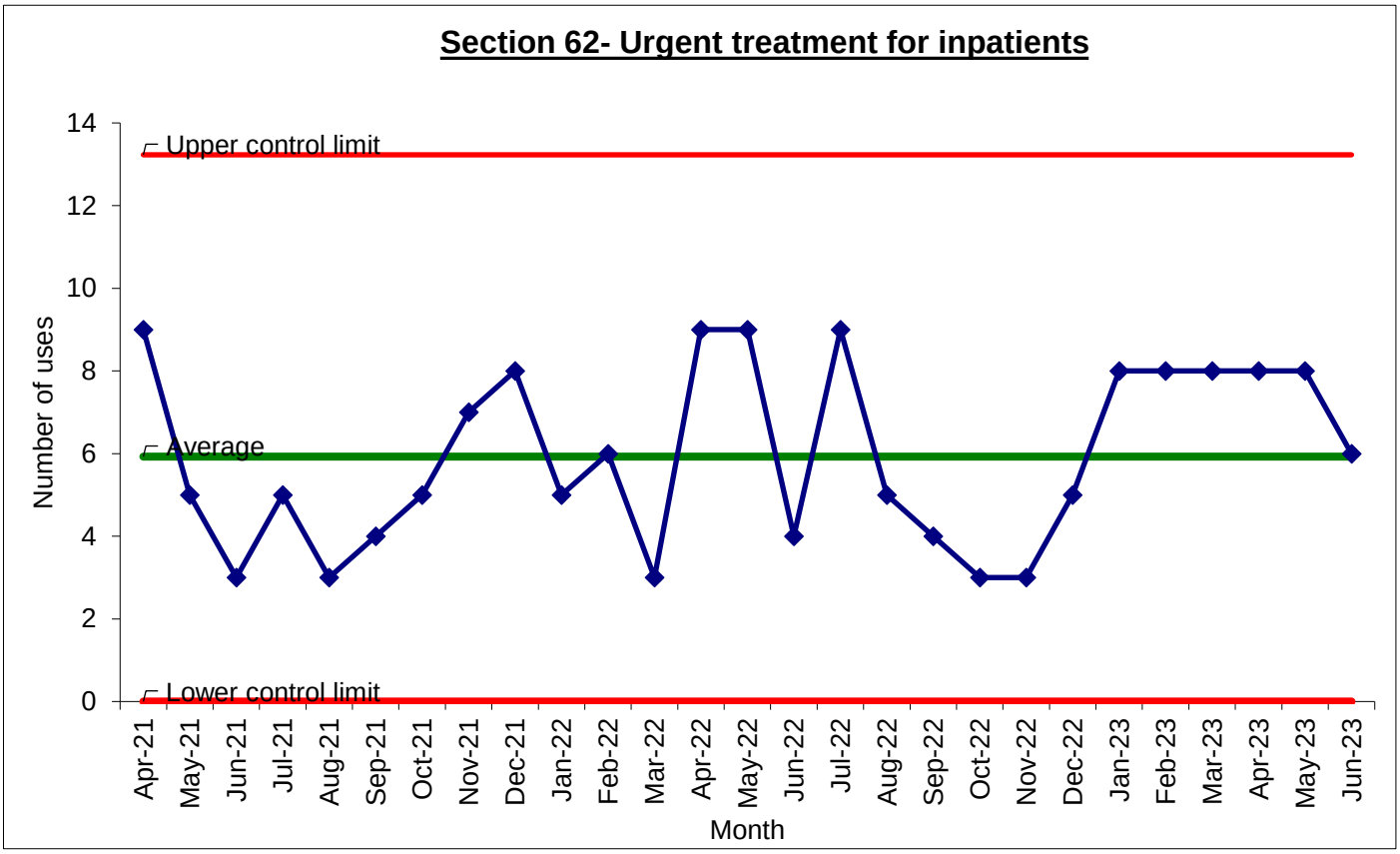
Urgent treatment is defined as treatment that is:

- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That is not irreversible or hazardous but is immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself or others.

A patient's treatment may be continued pending compliance with s.58, if discontinuation would cause serious suffering to the patient.

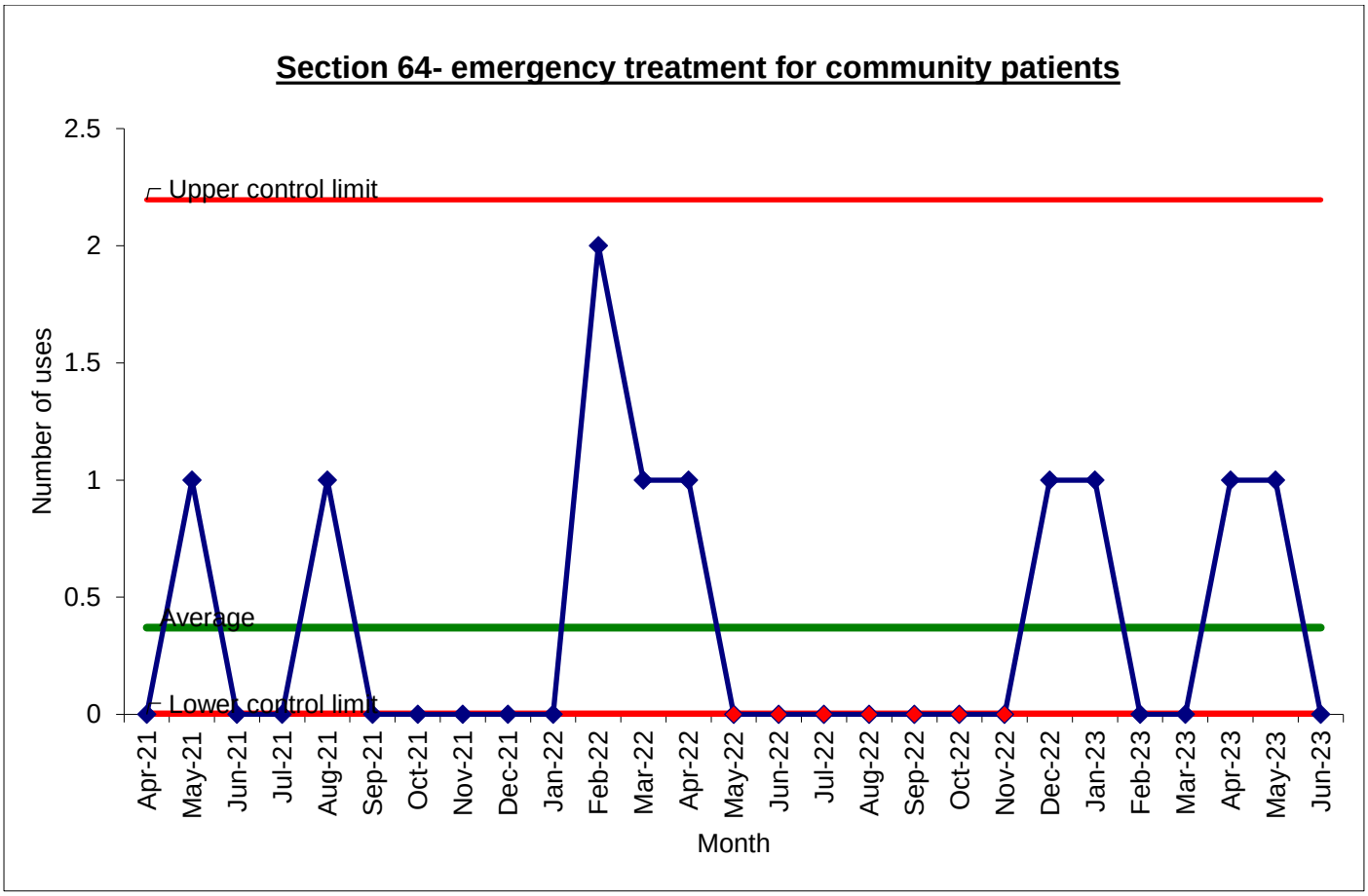
Urgent treatment can be used in any of the following instances:

- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.



The above chart highlights that Section 62 was used on twenty-two occasions for the following reasons:

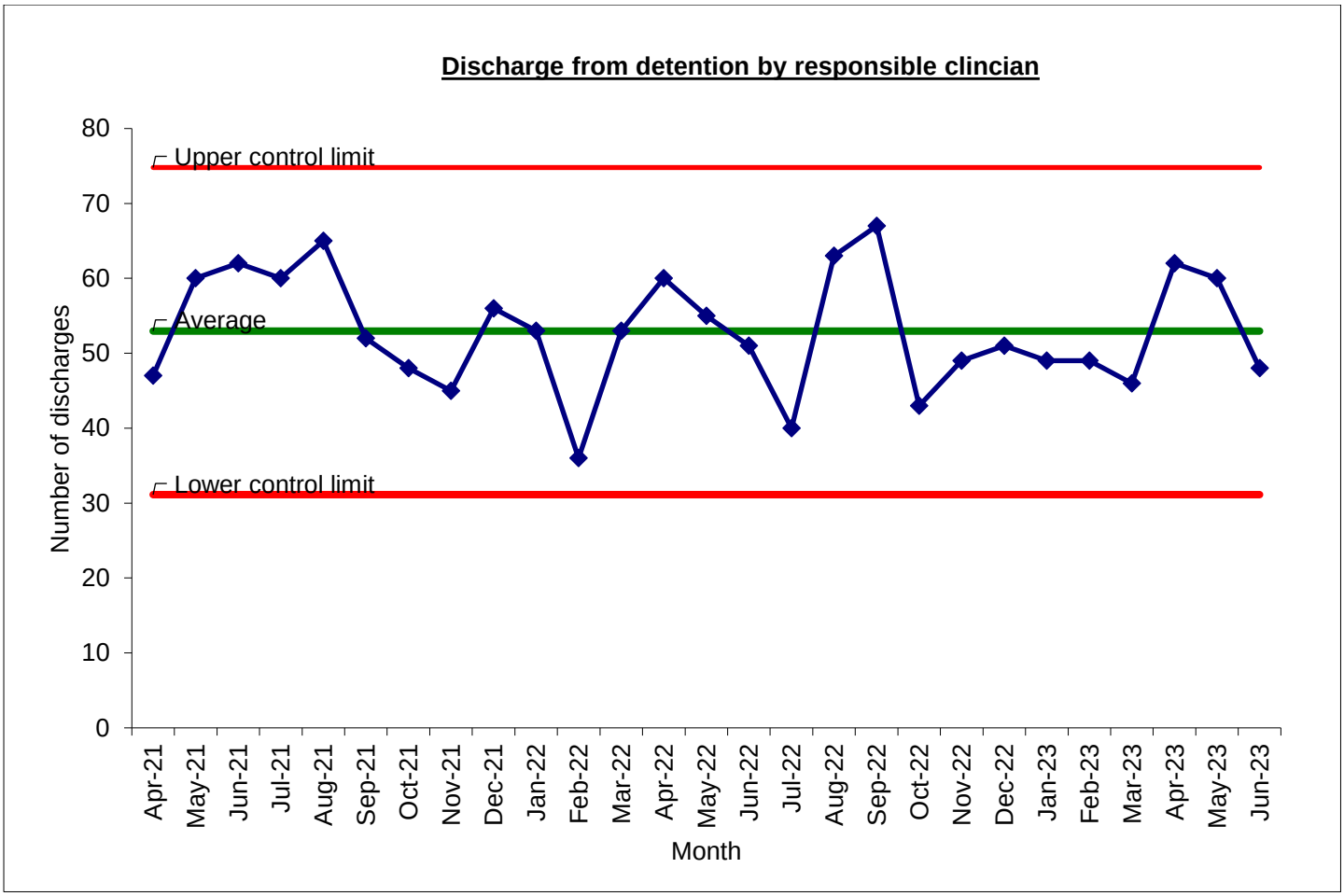
- Pending SOAD – 3 month rule x 14
- Transfer in awaiting SOAD x 2
- Time limited certificate awaiting SOAD x 2
- Change of medication x 2
- Patient lost capacity to consent- awaiting SOAD x 1
- CTO revoke awaiting permanent consent from regular RC x 1

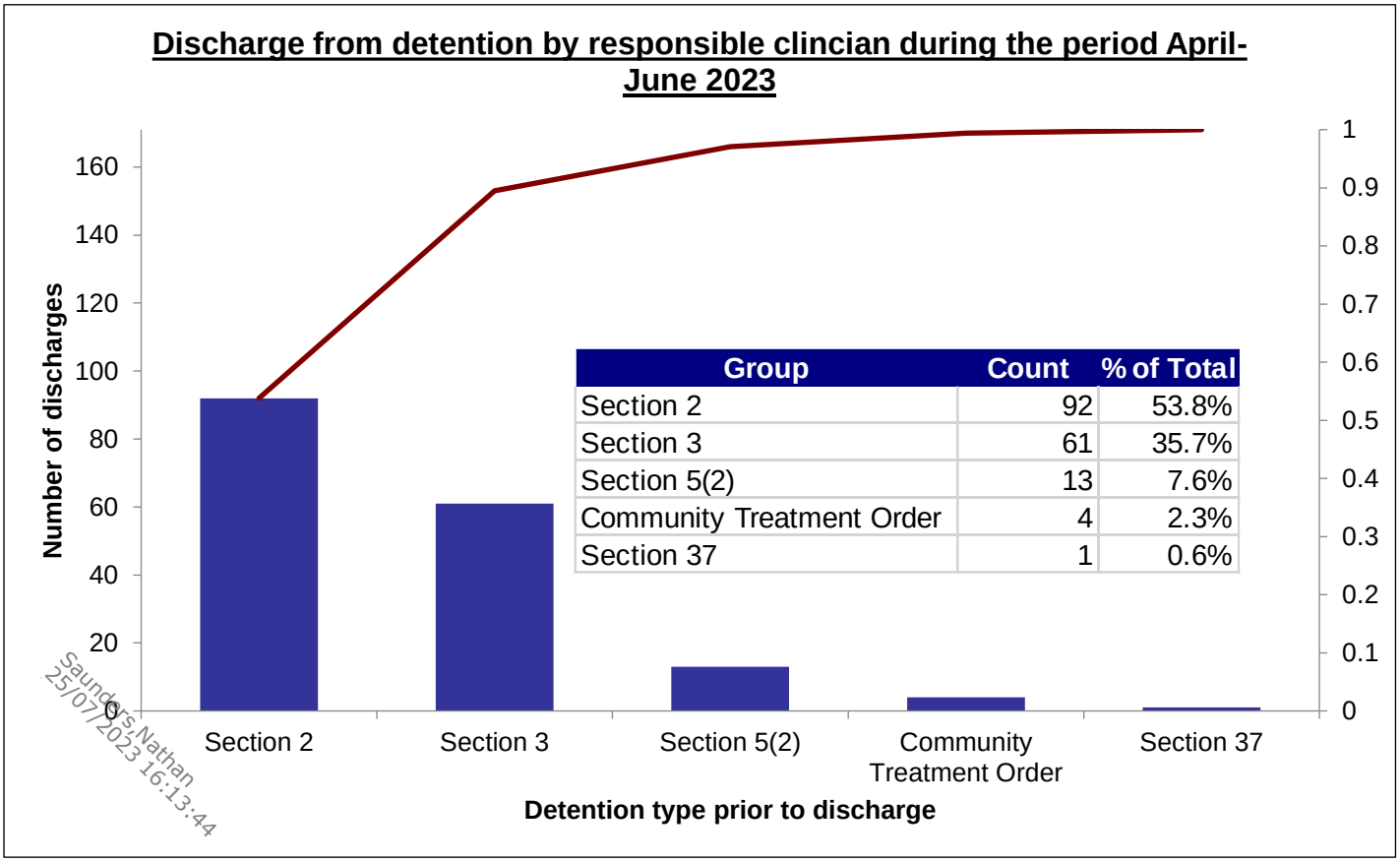


The above chart highlights that Section 64 was used on two occasions for the following reasons:

- Lack of capacity awaiting SOAD x 2

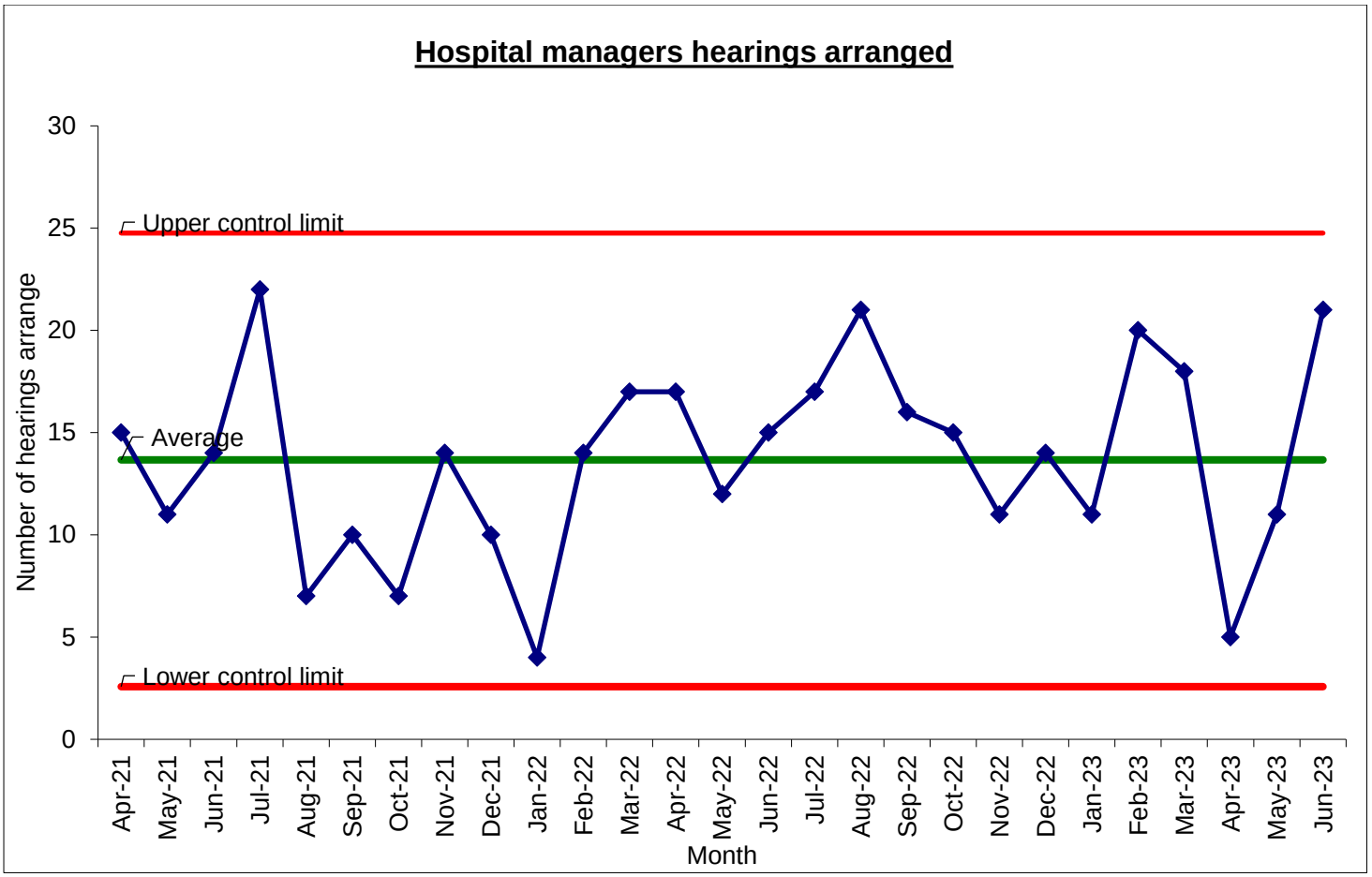
Discharge

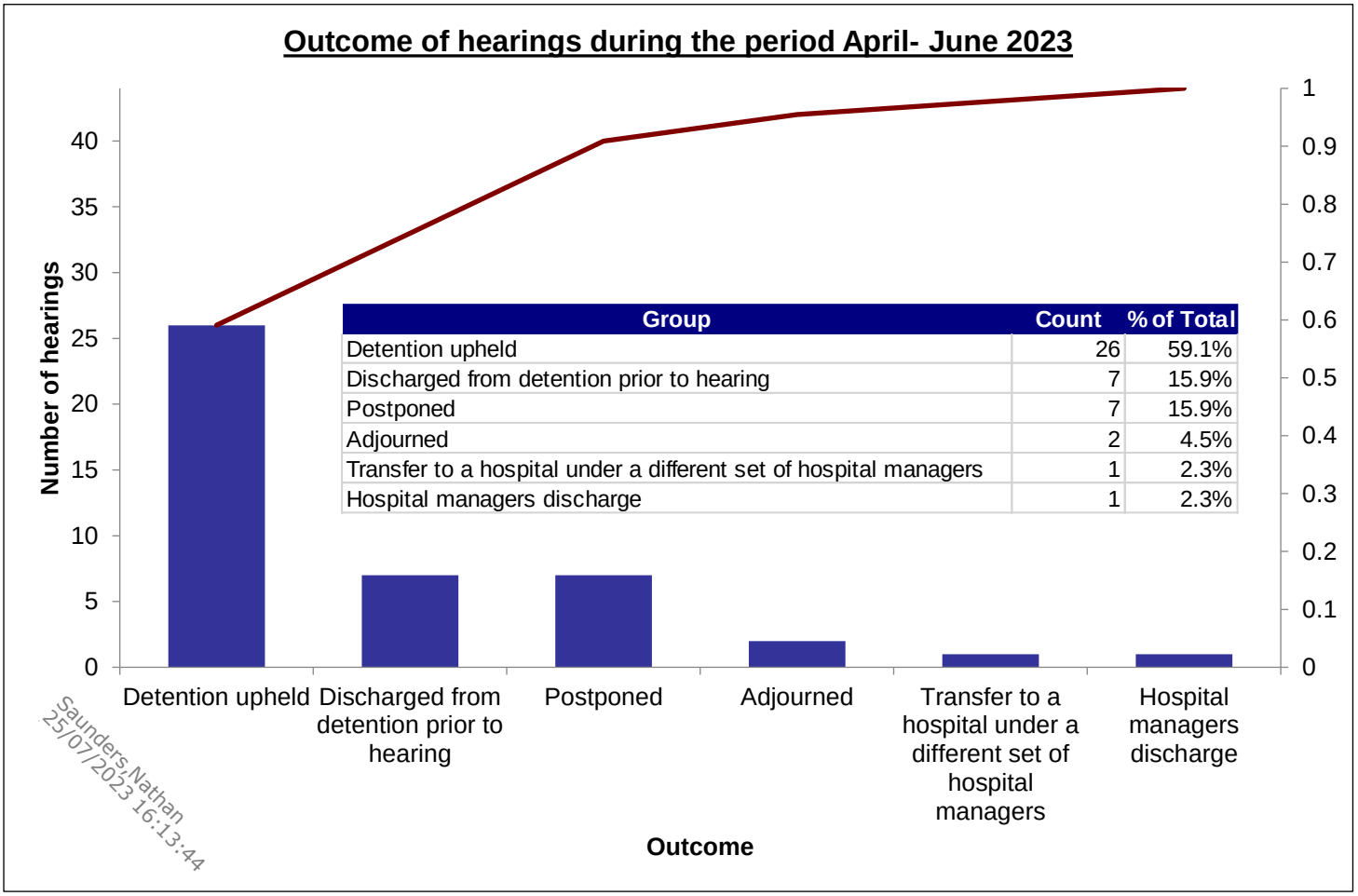




Group	Count	% of Total
Section 2	92	53.8%
Section 3	61	35.7%
Section 5(2)	13	7.6%
Community Treatment Order	4	2.3%
Section 37	1	0.6%

Hospital Managers – Power of Discharge





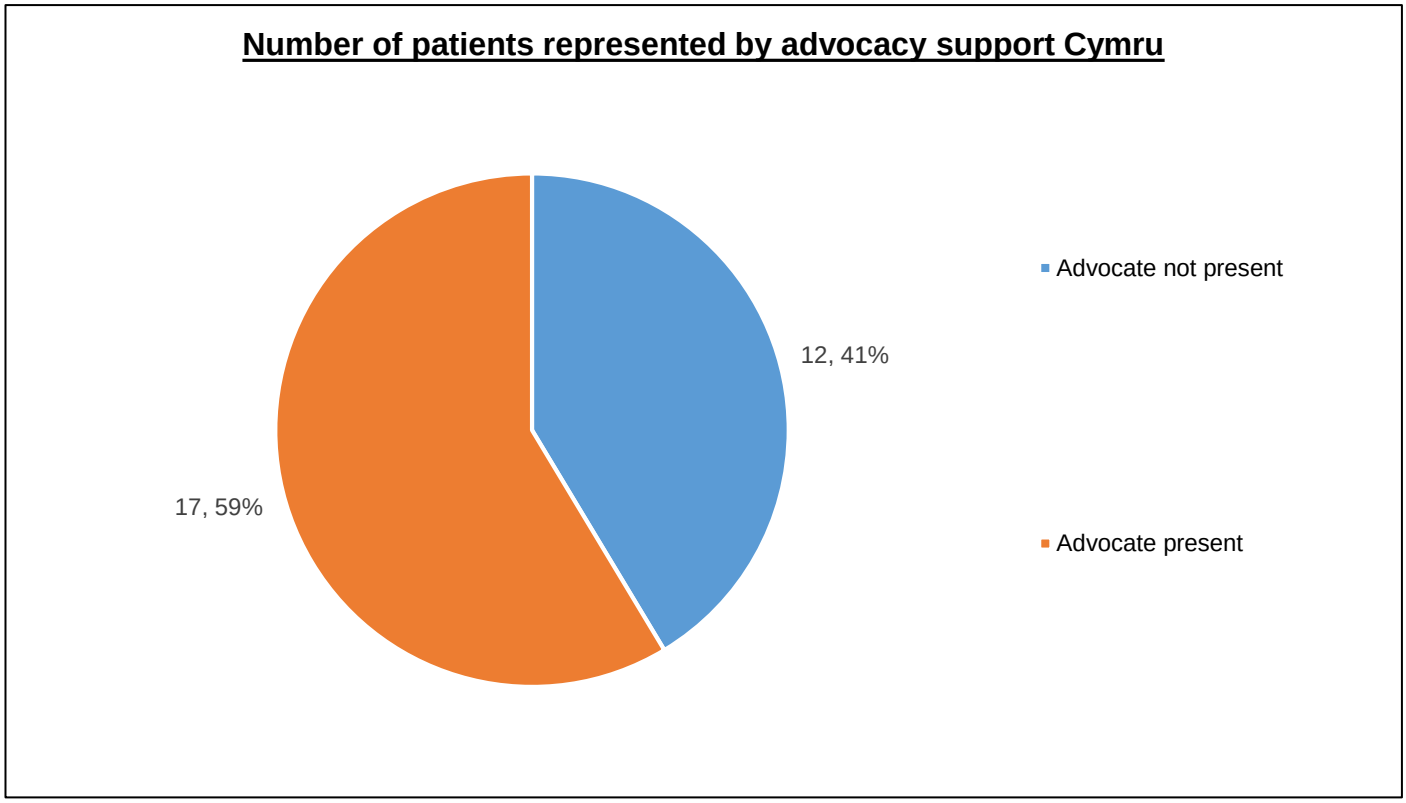
Group	Count	% of Total
Detention upheld	26	59.1%
Discharged from detention prior to hearing	7	15.9%
Postponed	7	15.9%
Adjourned	2	4.5%
Transfer to a hospital under a different set of hospital managers	1	2.3%
Hospital managers discharge	1	2.3%

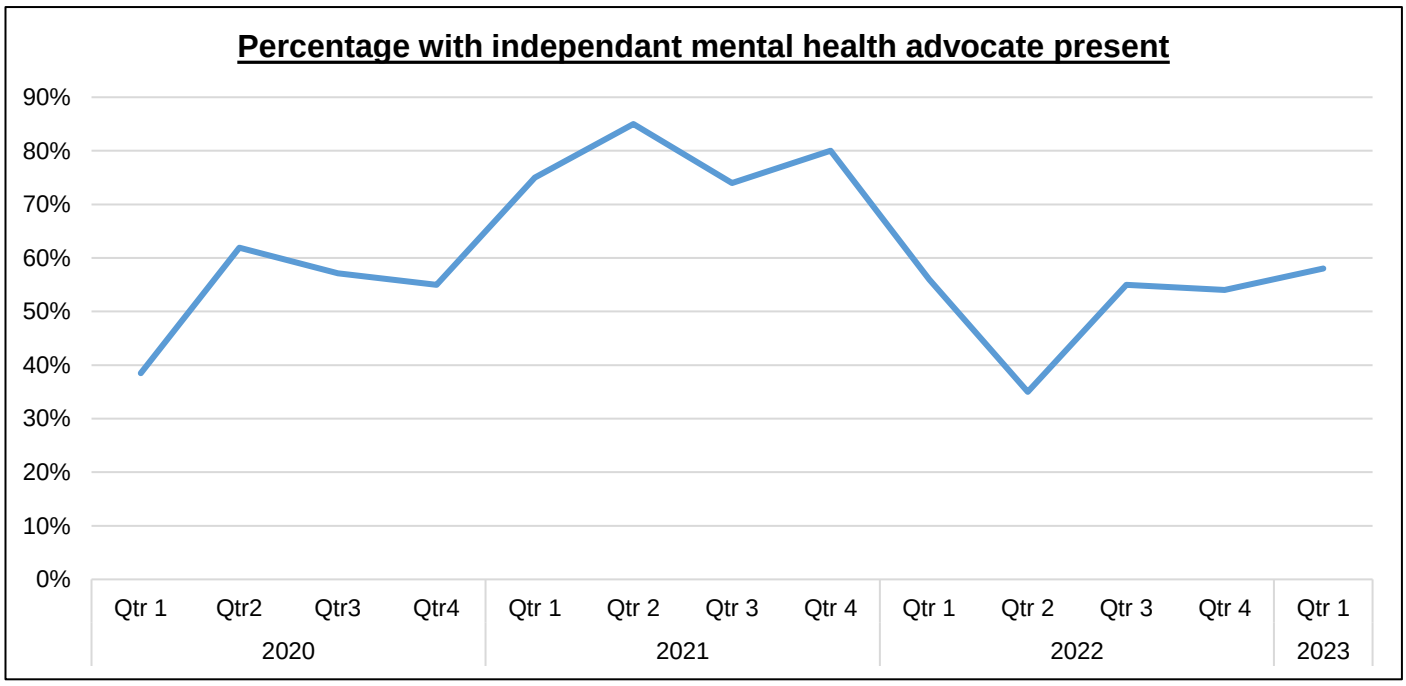
Seven hearings were postponed for the following reasons:

- Nurse strikes x 4
- Advocacy availability x2
- Social worker availability x 1

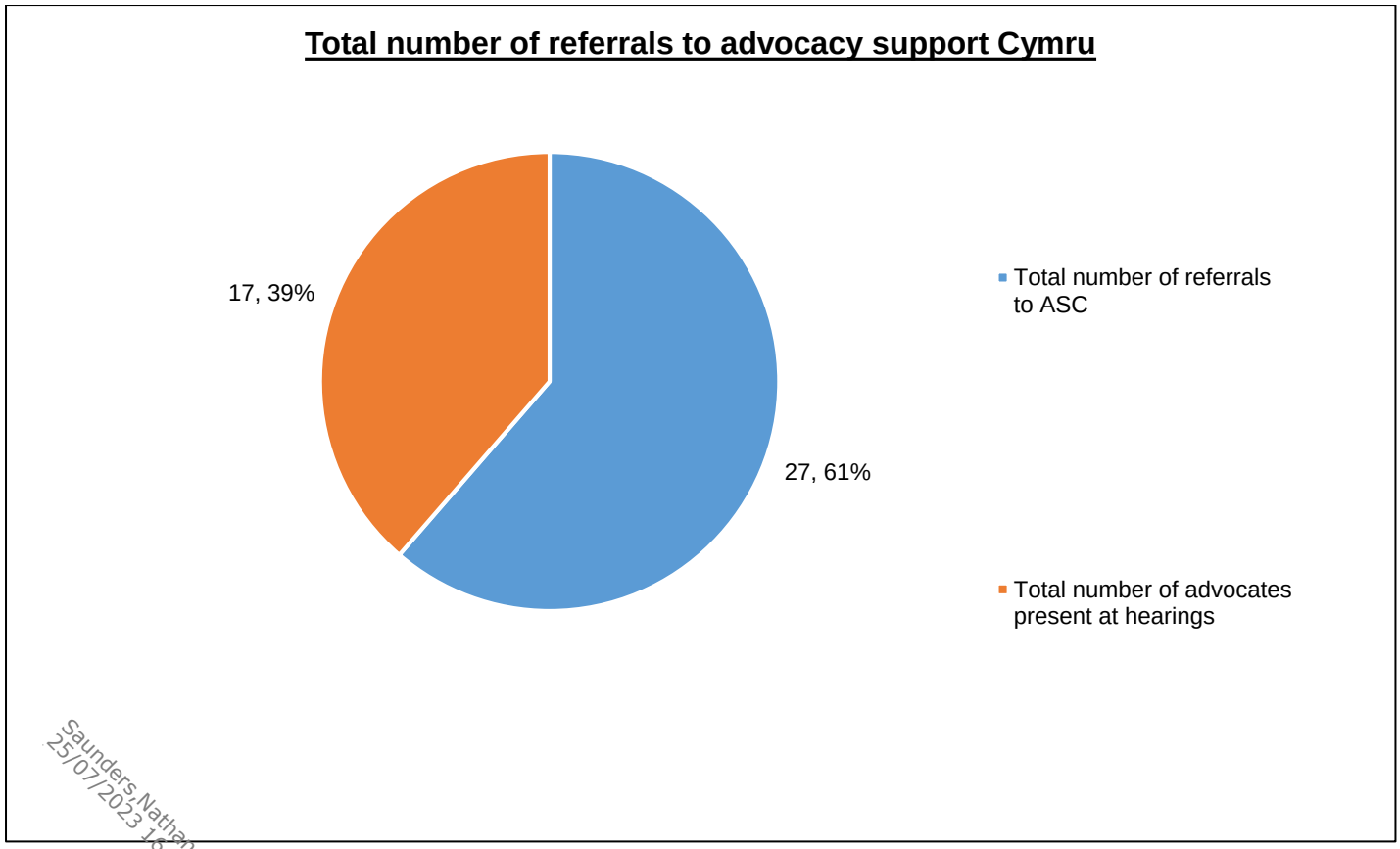
Two hearings were adjourned for the following reasons:

- Capacity of patient queried
- Lack of panel member

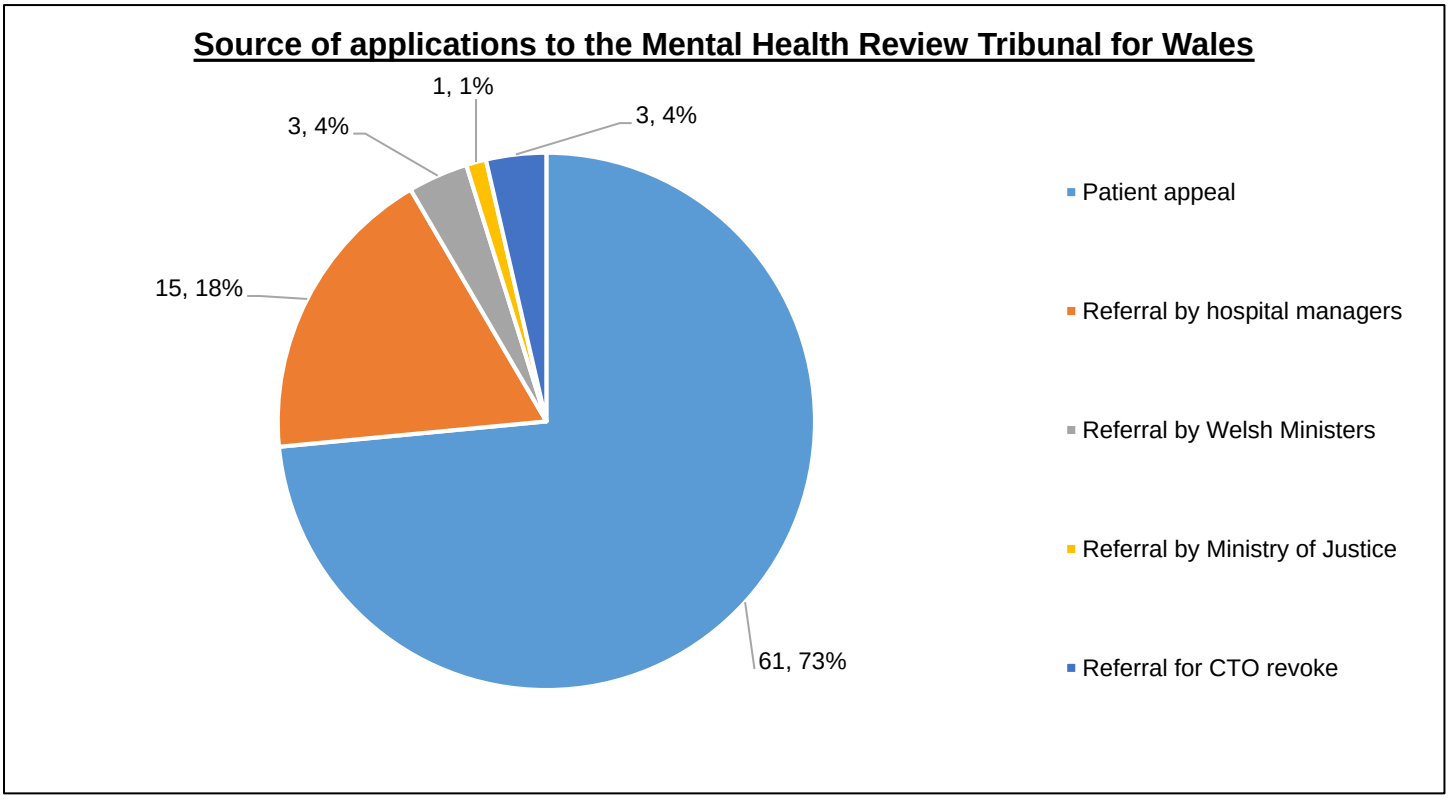


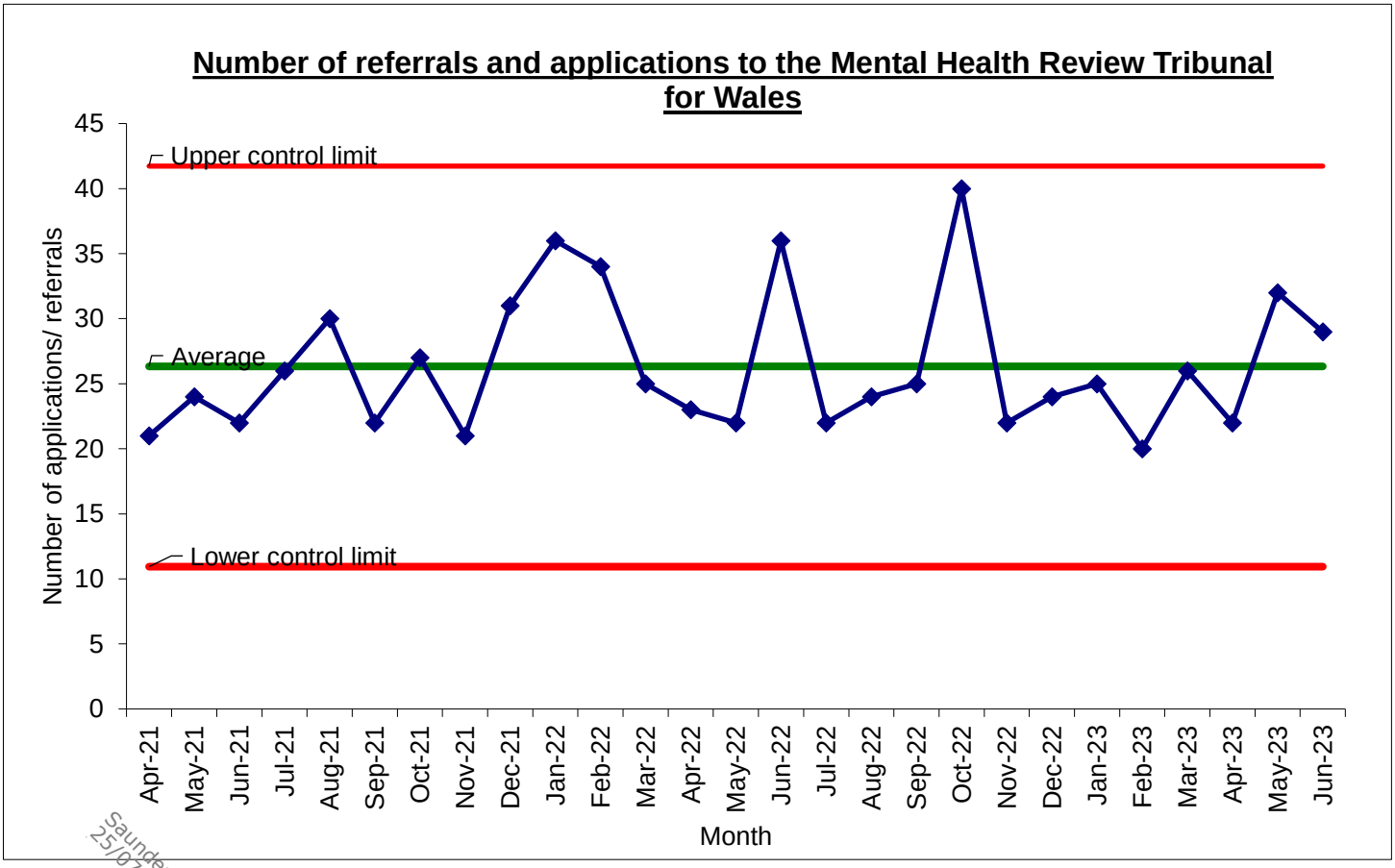


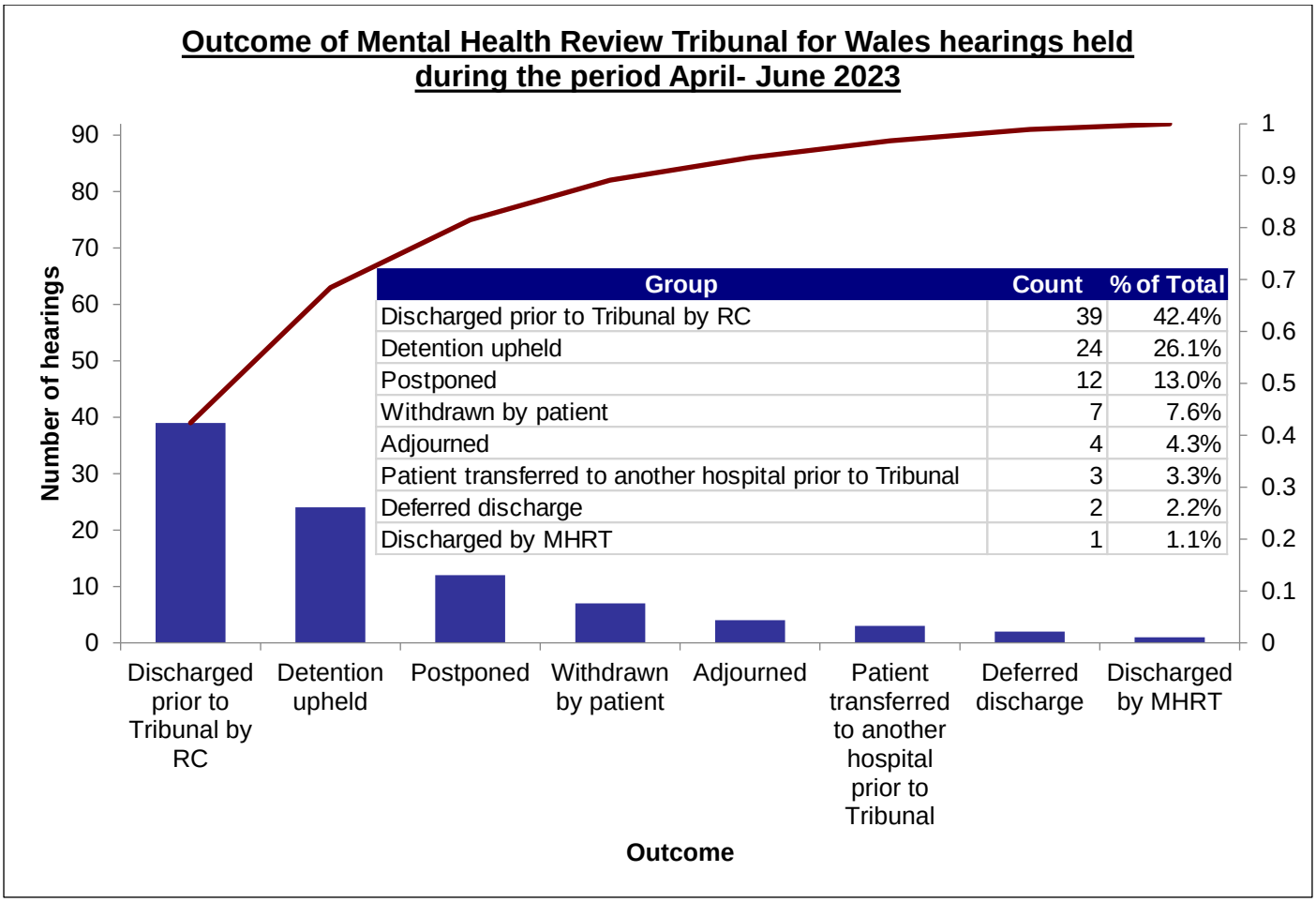
During the period the Mental Health Act Office made twenty-seven referrals to Advocacy Support Cymru where the patient was deemed not to have capacity to make this decision. Ten of the hearings were either postponed/cancelled and therefore weren't attended by an advocate.



Mental Health Review Tribunal (MHRT) for Wales







Group	Count	% of Total
Discharged prior to Tribunal by RC	39	42.4%
Detention upheld	24	26.1%
Postponed	12	13.0%
Withdrawn by patient	7	7.6%
Adjourned	4	4.3%
Patient transferred to another hospital prior to Tribunal	3	3.3%
Deferred discharge	2	2.2%
Discharged by MHRT	1	1.1%

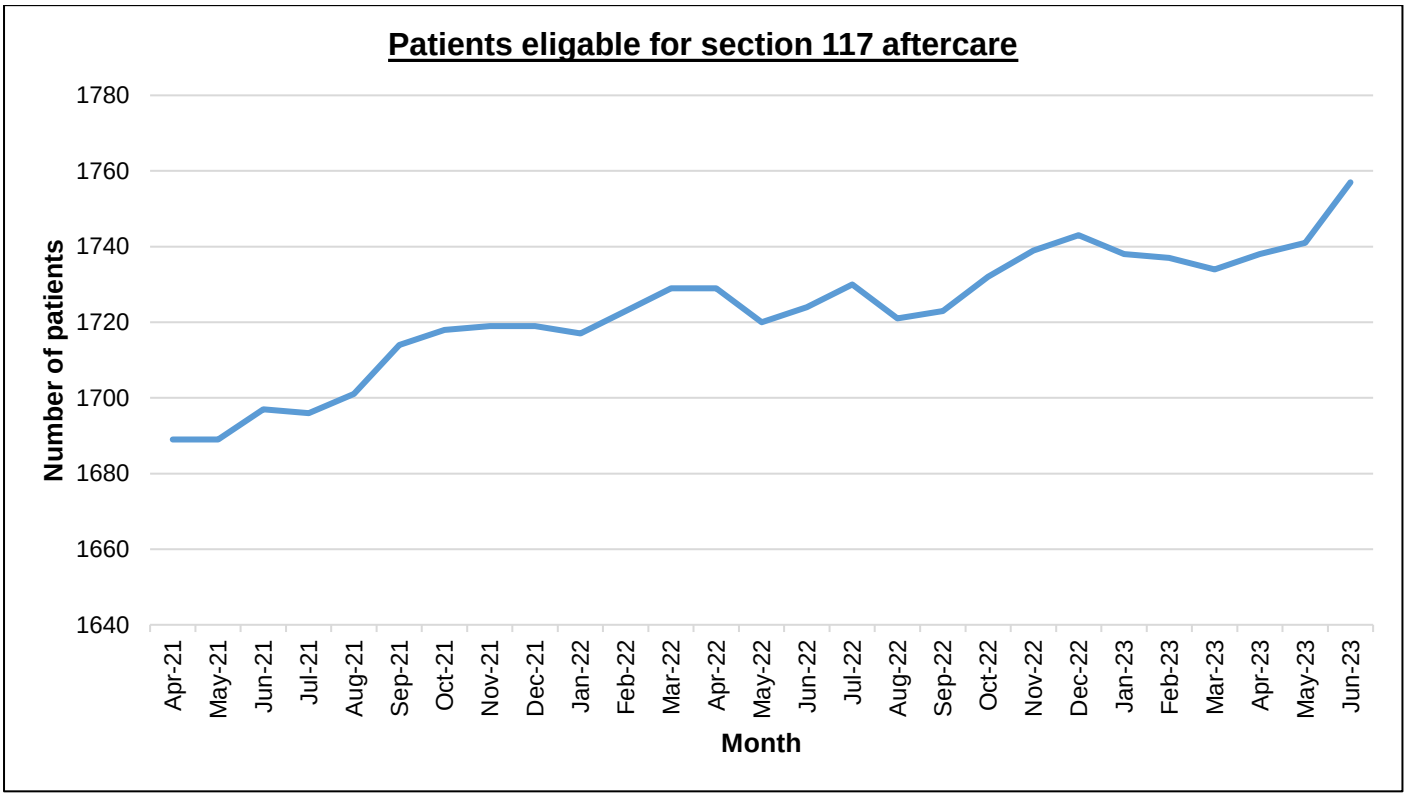
Four hearings were adjourned for the following reasons:

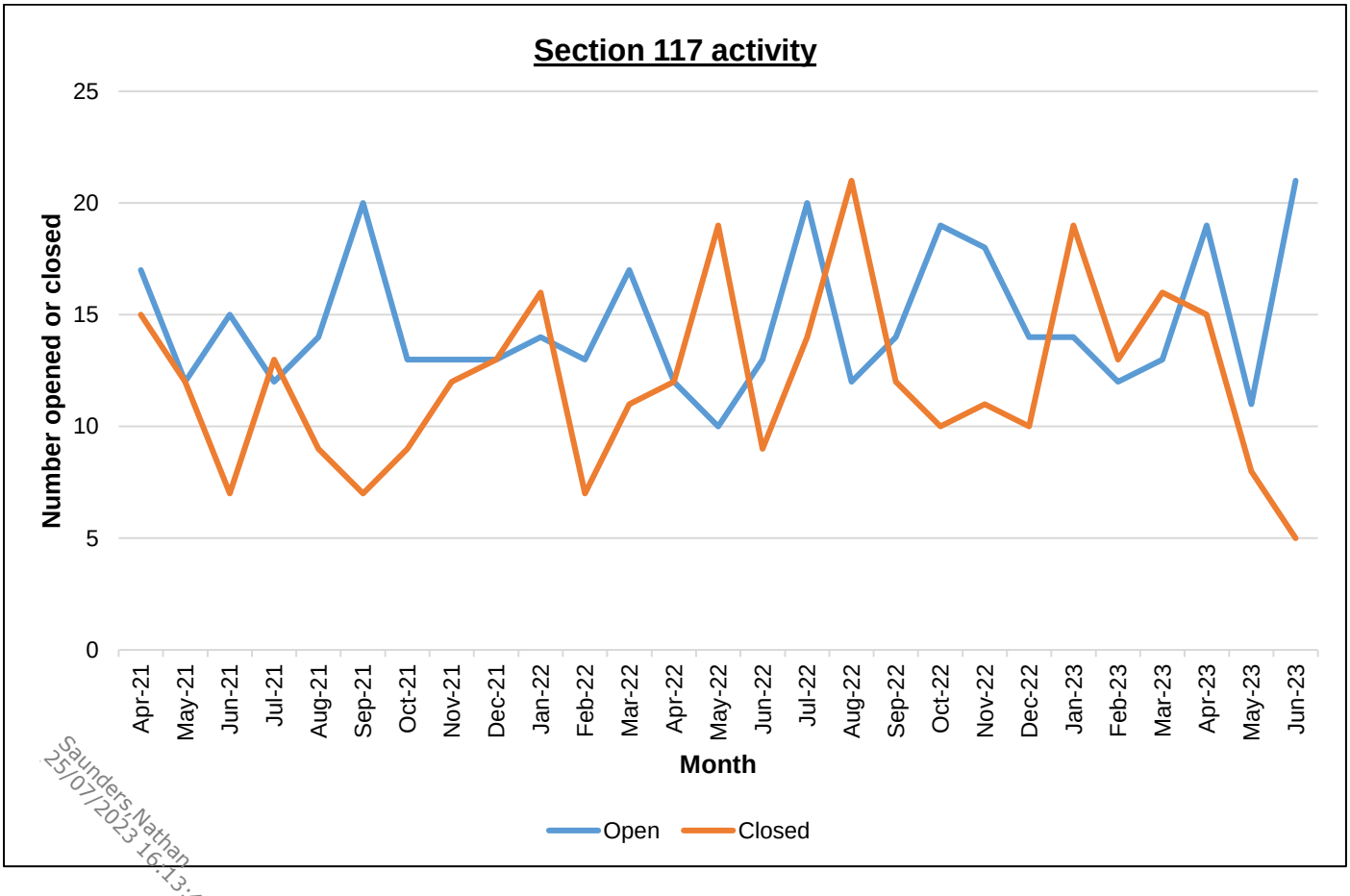
- Updated reports required x1
- Patient potentially wished to withdraw x1
- For extra time to be allocated for the hearing x 1
- Failure to agree a care package x 1

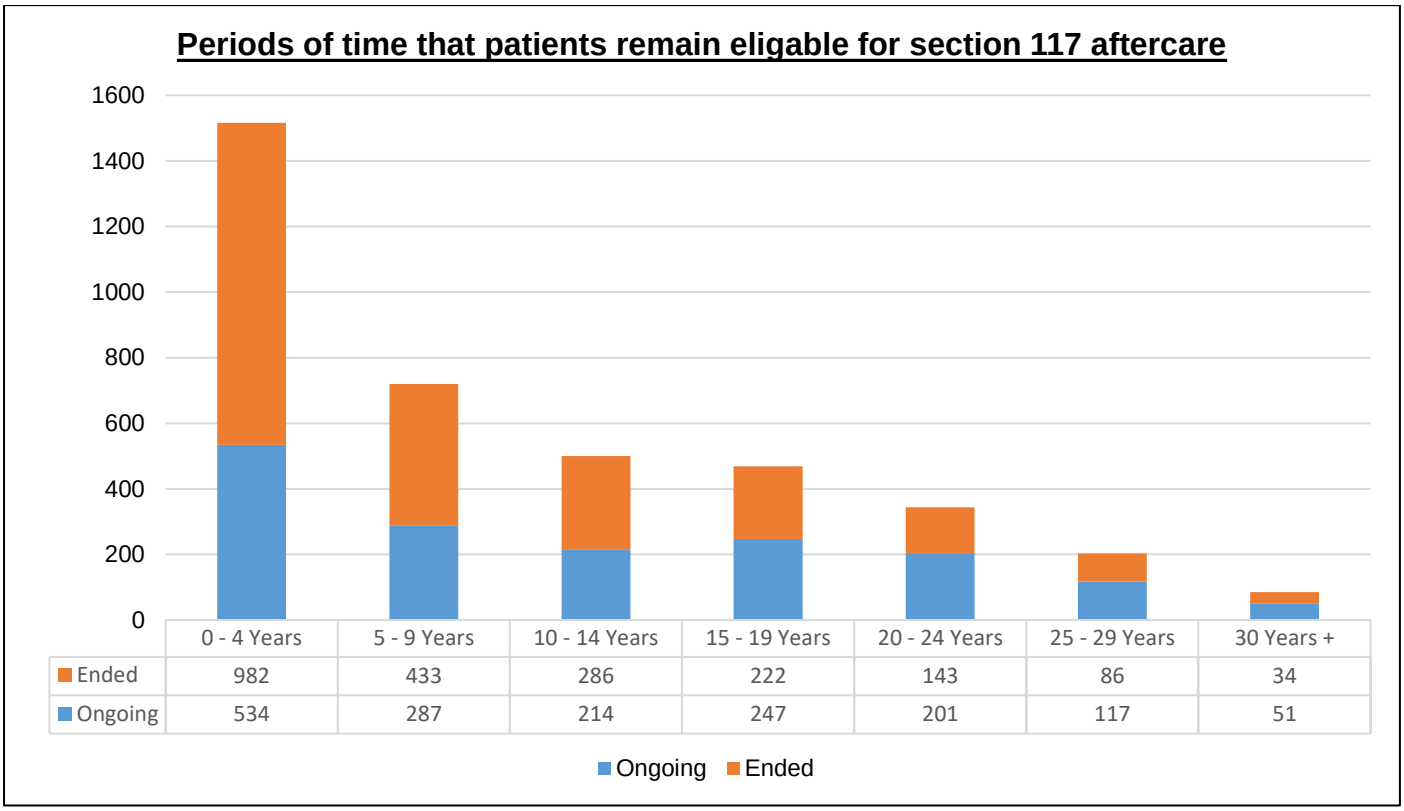
Twelve hearings were postponed for the following reasons:

- Booked on a bank holiday x 1
- Legal representative unable to take instruction due to patient being in general hospital x 1
- RC unavailable x 4
- Solicitor unavailable x 1
- To allow time for the legal representative to go through the reports with the patient x 1
- Awaiting panel meeting to be arranged x 2
- No panel available to sit x 1
- Social worker availability x 1

Section 117 Aftercare







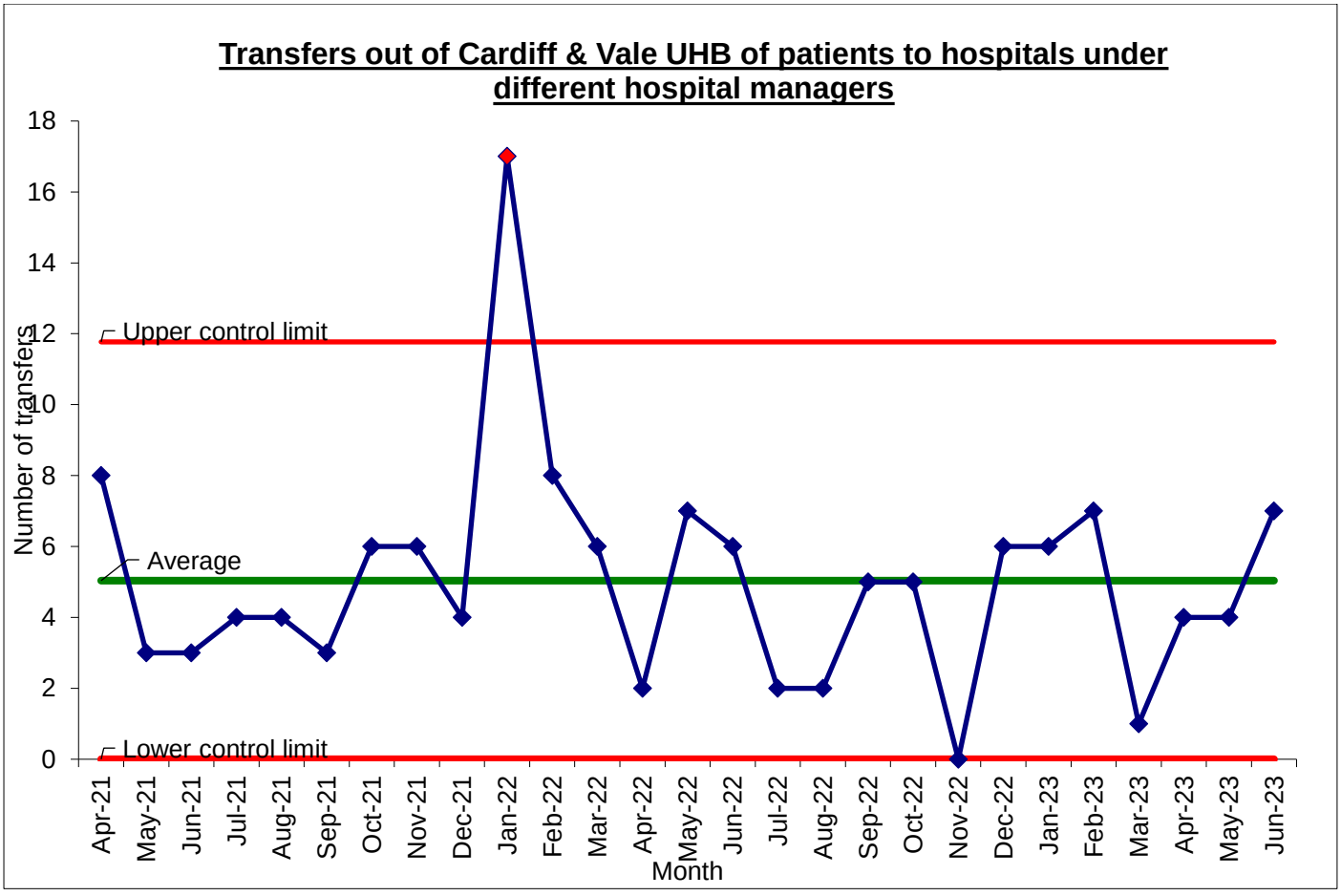
Section 19 transfers to and from Cardiff and Vale UHB

During the period:

Fifteen patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:

- Eight to PICU beds out of area
- Two to specialist placements
- Two to CAMHS beds- one of which was PICU CAMHS
- Two back to their home area
- One due to lack of available beds

No patient detained under Part 3 of the Mental Health Act was transferred from Cardiff and Vale UHB to a medium secure unit.



Sixteen patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

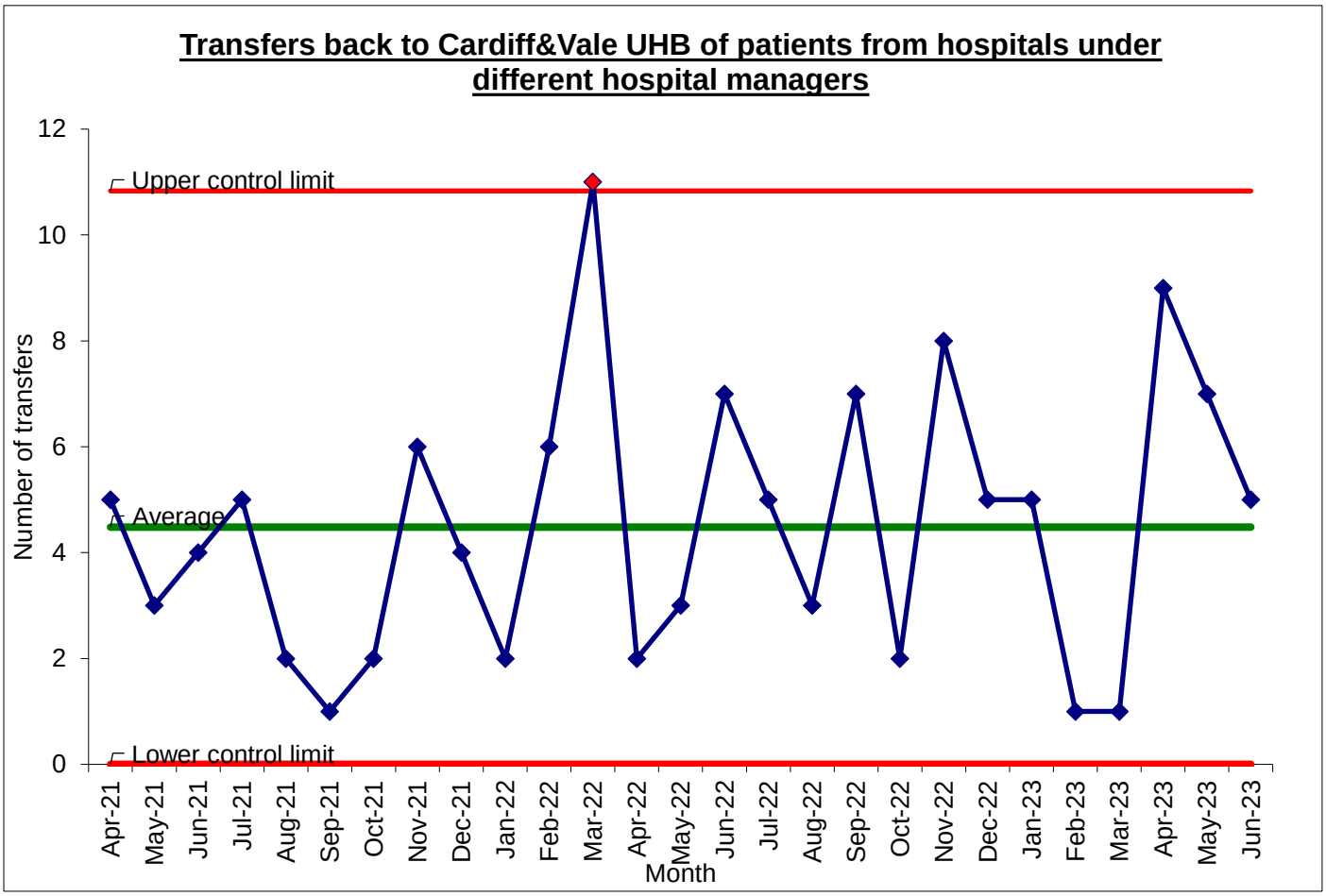
- Thirteen from out of area PICU beds
- Three from out of area beds

Four patients detained under Part 3 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- Four back to home area

One patient detained under Section 17A of the Mental Health Act was transferred back to Cardiff and Vale from a hospital under different set of Managers for the following reasons:

- Back to home area



Summary of other Mental Health Activity which took place during the period

April- June 2023

Exclusion of visitors

Visiting on wards at Hafan Y Coed are allowed but by strict appointment only. This is managed through a booking in system. This is due to the ongoing global pandemic.

Death of detained patients

During the period there were no deaths of detained patients.

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the

	person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety initially for up to 24 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care. The detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place of safety as long as the maximum time period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and supervised community treatment for civil 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. A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.
Section 5(4)	Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required. During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2).

	Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.
Section 5(2)	Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made. The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.
Section 4	In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours. An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor. A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of: • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2

	(admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.
Section 2	Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness

	• The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people.

	• Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.

Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act 	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options:

	• To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for CTO
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion. If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for mental disorder. If the patient lacks capacity to consent SOAD authorisation is required.
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)

Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders.

	The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.
Section 117	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 CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.

Associate Hospital Managers - Power of Discharge Group
Annual Report of Concerns and Compliments July 1st 2022 to June 30th 2023

Introduction

As part of their role, Associate Hospital Managers have an opportunity to raise issues of concern that are identified during the Manager's Hearing. They can also commend/compliment the professional team. The patients, relatives, the professional team and advocacy services are also invited to feedback their comments on the running of the Managers Hearings. This paper outlines the issues and concerns raised by Associate Hospital Managers in the 12 months from the 01 July 2022 and consider any conclusions/lessons learnt. It reviews the compliments to the professional team and the feedback provided to the Managers Hearing.

Concerns

Between the 1 July 2022 and the 30 June 2023 Associate Hospital Managers were involved in 112 Manager's Hearings. 109 concerns were raised from 57 hearings. In the same period in the previous year Associate Hospital Managers raised 75 concerns from 46 hearings. The most common reason for raising concerns is the Measure in relation to both Care and Treatment Plans (CTP) and Risk Assessments (RA). In the previous period 33 concerns were raised that either the CTP was out of date, not outcome focussed or did not reflect the care currently being provided. Similarly, RA were cited as being out of date or not reflecting the current situation. In this period 50% of concerns raised by the Associate Managers relate to the Measure. This is higher than the previous year where 33% of concerns were related to the Measure. The care described to the Associate Managers in Hearings often bears little resemblance to the written care plan which would seem to undervalue the work being done with patents during their recovery journey.

After the Measure, the second most common reason for raising a concern were in the "other's" category (19) with the third most common reason being errors with reports (17). Overall the Measure, issues with reports and "others" account for 83% of concerns raised by Associate Hospital Managers. In the "other" category issues included late starts, unmet need, safeguarding provision of care, etc.

Table 1 Breakdown by quarter of hearings and concerns raised.

1/7/2022- 30/6/2023	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Total number of Hearings	31	18	34	29	112
Number of Hearings where concerns raised	13	8	21	15	57
Total number of concerns	28	14	35	32	109

In common with the previous year's, most concerns arise from hearing for Acute Adult Services. This may in part be due to the fact that the majority of hearings involve Acute Adult Services**.**

A comprehensive response to the concerns raised is made and reviewed at the Power of Discharge Business meetings.

Compliments and feedback

The Associate Hospital Managers are able to pass on their compliments to the professional team as well as receiving feedback from the participants at the Hearing. The Mental Health Act office has a robust procedure to captures feedback from patients, relatives, advocates and the professional team. That said, relatively little feedback has been received in the year in question. However, this is in line with previous years.

The managers offered ten compliments compared with eighteen from the previous year. Compliments covered a range of areas including the quality of reports, the professionalism of staff, verbal updates, quality of the CTP and good communications between the ward and relatives.

Table showing compliments and feedback by quarter

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Feedback	2	1	0	0	3
Compliments	2	1	4	3	10

Conclusion

It would appear that in half the hearings, no concerns are raised that need to be addressed. At the business meeting the Mental Health Act Manager provides an update of the actions taken by the professionals involved in the hearings where concerns are raised. The Chair of the POD group has raised concerns in relation to the Measure at the Mental Health Legislation and Governance Group meeting. The lack of compliance with the Measure in terms of the Care and Treatment Plans and Risk Assessments has been recognised as an issue across the directorate.

The feedback provided by those attending the Manager's Hearings is considered during the Peer Supervision sessions at the start of the Business Meetings and where necessary training has been undertaken. As part of the journey for continuous improvement greater feedback would be welcomed from the participants at the hearing. The Mental Health Act office is looking at ways to improve the feedback from patients and relatives. This would feed into the Annual Review process for Associate Hospital Managers.

Two years ago, a system of post-hearing reviews was introduced. It allows the Associate Hospital Managers to consider their performance as a team and look at areas for improvement. The Mental Health Act office staff who oversee the Hearings contribute to these discussions when the Hearings are via Teams. The Chair of POD has reviewed this process with a small working group and a quarterly audit will be undertaken.

Hospital Managers are aware of their very specific role and remit. The ability to raise issues of concern provides useful feedback for the professional team and assists with the resolution of some patient and family concerns.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ward 12 & Ward 16, Mental Health Services for Older Persons, Llandough Hospital, Cardiff & Vale University Health Board

Inspection date: 20, 21 and 22 March 2023

Publication date: 16 June 2023

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Llandough Hospital, Cardiff & Vale University Health Board on 20, 21 and 22 March 2023. The following hospital wards were reviewed during this inspection:

- Ward 12 - mixed gender ward with 14 beds providing older person dementia care
- Ward 16 – female ward with 14 beds providing older persons dementia care.

Our team for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found a dedicated staff team that were committed to providing a high standard of care to patients. Staff demonstrated a caring, kind and compassionate attitude towards patients.

This is what we recommend the service can improve:

- Display HIW posters
- Replace some of the worn furniture in dining room on both wards.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Staff team communicated well with patients.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Patient care and treatment plans were being kept to a good standard. Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients. Suitable protocols were in place to manage risk, health and safety and infection control. Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

This is what we recommend the service can improve:

- Patient areas require redecorating and new flooring
- Dirty linen storage and disposal processes require review.

This is what the service did well:

- Safe and effective medicine management
- Strategies and intervention for managing aggression (Sima) trainer works on the ward.

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the ward managers. However, some improvements are required in updating policies and compliance with mandatory training.

This is what we recommend the service can improve:

- Mandatory training compliance
- Review and update policies
- Regular staff meetings should take place and be minuted.

This is what the service did well:

- Motivated and patient focussed team
- Staff team were cohesive and positive about the support and leadership they received from ward managers.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Staying Healthy

Health Protection and Improvement
We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received two responses to the questionnaires. However, family members spoken to during the inspection spoke highly of staff and the care provided to their relatives. We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

We noted positive compliments through thank you letters and cards.

We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients also received ongoing physical health checks during their stay such as weight management and monitoring. Measurements were appropriately recorded on National Early Warning Score charts and within physical health and wellbeing care plans.

We checked if patients had access to outdoor spaces for therapeutic time. Both wards had access to a balcony area and there was a garden area located on the ground floor which could be accessed via the lifts. The garden area was overgrown and had a notable number of weeds, with old and worn looking furniture.

We recommend that work is undertaken to improve the appearance and safety of the garden for patients to use.

Dignified care

Dignified care
We noted that all employees; ward staff, senior management, and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with patients and address any needs or concerns the patients raised, this showed that staff had responsive and caring attitudes towards the patients.

It was noted that the ward entrances were locked and an intercom system to the ward prevented any unauthorised access.

Some patients had en-suite bedrooms that provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms. However, we found that some bedrooms on both wards did not have curtains on bedroom windows which may interrupt patients sleep.

The health board must ensure that appropriate and safe curtains are placed in patient bedrooms.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if needed, and digital devices were available for patients to use with support from staff when required.

Ward 12 provided mixed gender care which can present challenges around aspects of dignified care. However, staff were knowledgeable and had effective safeguards and processes in place to manage these challenges to ensure that dignified care was maintained.

Communicating effectively
During the inspection we observed staff engaging and communicating in a positive way with patients.

We saw that staff engaged with patients in a sensitive way and took time to help them understand their care using appropriate language. There was clear mutual respect and strong relational security between staff and patients.

For individual meetings, patients could have help from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers are included in meetings.

There were a number of meetings involving patients and staff. These meetings included formal individual care planning meetings.

Patient information

Written information was displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the wards. Information on visiting times was also displayed.

We saw that there was clear signage within the wards in both Welsh and English.

Patient status at a glance boards were in the nursing offices. The boards were out of sight of patients which helped protect patient confidentiality.

There was no information available on either ward on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

The health board must ensure that information and contact details of HIW are displayed on the ward.

Timely care

Timely Access

The health board held adequate bed status management and patient information meetings to discuss occupancy levels, and any emerging patient issues.

Individual care

Planning care to promote independence

We found that arrangements were in place to promote and protect patients' rights.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private.

We looked at the records for patients who were detained under the Mental Health Act (the Act) and saw that documentation required by legislation was in place within the sample of patients' records we saw. This showed that patients' rights had been promoted and protected as required by the Act.

People's rights

We found that arrangements were in place to promote and protect patient rights.

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation.

Patients who were subject to Deprivation of Liberty Safeguards (DoLS) had received timely assessments and there were processes in place on both wards to ensure reviews take place.

All patients had access to advocacy services. Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

Listening and learning from feedback

There were opportunities for patients, relatives, and carers to provide feedback on the care provided via the NHS Putting Things Right process. Senior ward staff confirmed that wherever possible they would try to resolve complaints immediately.

There was no evidence of regular patient meetings taking place, where patients would have the opportunity to discuss any improvements or patient initiatives. However, senior management confirmed that progress was being made regarding service user engagement and the health board were looking to re-introduce carers groups and are recruiting peer support reviewer roles, all of which will help to improve quality of care for patients and provide additional support to patients relatives.

It was positive to note that the hospital kept a record of thank you cards, and compliments received from patients' family members and friends.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety

Access to the wards was secure to prevent unauthorised access. Staff could enter the ward with swipe cards and visitors rang the buzzer at the ward entrance.

Staff wore personal alarms which they could use to call for help if needed. There were also nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could summon aid if needed. We identified that some patient call buttons in patients bedrooms were not within patients reach from the bed areas.

The health board must ensure that the call bells in patient bedrooms are easily accessible for patients.

We saw evidence of various risk assessments that had been conducted including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of ward manager checks on both wards.

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort. Any use of restraint was documented. Information produced to the inspection team confirmed that restraint data was low.

The SIMA training focusses on positive support and learning from incidents. The philosophy on the ward is very patient centred and staff were observed to treat patients with dignity and respect giving time and space during interactions.

Ward staff spoke highly of the SIMA trainer that was based on the ward. This was an area of good practice and is a beneficial resource for staff.

There was an established electronic system in place for recording, reviewing, and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX).

The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. Overall, the ward appeared clean and tidy, however we identified several decorative and environmental issues that required attention:

- Flooring in corridor outside ward managers office needs replacing on both wards
- Dining room flooring on both wards was worn and untidy

- Some patients' bedrooms don't have magnetic curtains on doors which could interrupt sleep and is a dignity issue
- Both wards would benefit from painting and redecoration
- Internal doors look worn and need refurbishing
- Macerator on Ward 12 needs to be fixed or replaced.

The health board should consider the above environmental issues.

Preventing pressure and tissue damage
We found that appropriate checklists were completed, and any ongoing risks would be monitored. Pressure relieving mattresses and cushions were available when required.

Falls prevention
There were risk assessments in place for patients on the ward. We found that ward staff assessed patients for their risk of falling and made efforts to prevent falls.

Patient falls would be reported via the health board electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control
We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. However, the current arrangements for storage and disposal of dirty linen bags on Ward 12 require review. We were told by staff and visiting family members that the dirty laundry bags are left near the visiting entry and exit points.

The health board must ensure that dirty laundry bags are stored and disposed of appropriately and in a timely manner.

We saw evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the added demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

We also saw that staff had access to, and were using, personal protective equipment (PPE) where appropriate. Staff we spoke to confirmed that PPE was

always readily available. Sufficient hand washing and drying facilities were available.

Nutrition and hydration

The hospital provided patients with meals on the ward, making their choices from the hospital menu. We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind they can usually be accommodated with another option.

Although the dining rooms on both wards were clean, the flooring and furniture looked worn and made the environment appear untidy.

The health board should replace the flooring and furniture to improve the environment for patients.

Medicines management

On the first night of the inspection, we found medication fridges were left unlocked. This was raised with staff and rectified immediately, all fridges remained locked during the inspection.

We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We saw evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer. However, there were some gaps on both wards where temperature checks had not been recorded.

The health board must make sure that temperature checks are consistently recorded.

Overall, the clinical areas were clean, tidy, and well organised.

Boths wards are given good support from the pharmacy department who visit both wards weekly to carry out regular audit of stock and individual medication.

Staff were knowledgeable and confident when administering medication.

The health boards medication policy needs updating and should include the usage of covert medicines.

Safeguarding children and safeguarding adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency. Ligature cutters were currently kept in the clinical room.

The health board should consider having additional ligature cutters placed elsewhere on the wards to ensure that all staff can have easy access in an emergency.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked and robustly supervised.

Quality improvement, research and innovation

During our discussions with ward staff and senior managers, we were provided with many examples where they were reviewing the provision of service on the ward and the wider health board. This was to help in the modernisation of care and implement innovation to develop the service.

There were several ongoing research projects and quality improvements taking place in the health board. Dementia care mapping helped to support staff to

provide person centred and specific individualised care to patients. Plans were also in place for dementia care advisors to be available on the wards.

The health board were also reviewing and aiming to make improvements around discharge planning and how to make this a quicker process.

The forget me not choir was a good resource which patients enjoyed, and it helped bring all patients together. Staff told us that patients really enjoyed this service and participation levels were high.

Information governance and communications technology
The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the wards.

We were told that all staff had their own computer access login to help ensure information governance was maintained. All staff spoken to understand their roles and responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Through examination of training records, we confirmed that staff had received training on information governance.

Record keeping
Patient records were being kept electronically. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the system throughout the inspection and found patient records to be comprehensive and well organised.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring
We reviewed the statutory detention documents for four patients, two from Ward 12, and two from Ward 16.

All patient detentions were found to be legal according to the legislation and well documented. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information. However, we did note that the front of some of the MAR charts were missing some information on mental health act status and dates.

The health board must ensure that all information is completed on the MAR charts.

Patients records also need clarification and explanation regarding Independent Mental Capacity Advocate (IMCA) input when there is no family or lasting power of attorney.

The health board must ensure that patient records reflect IMCA input when no lasting power of attorney or family involvement.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed three care plans across both wards.

The records were well organised, accessible, and easy to navigate via the electronic health record system when familiar with the system.

Overall care plans were comprehensive and well written with clear smart goals. However, certain sections of the electronic records do not encourage comprehensive entries.

Of the care plans we reviewed, we found a lack of reference and planning for discharge in patient notes.

Some of the care plans reviewed had some sections missing, important that all sections are completed.

The health board must ensure that discharge planning is recorded in patient records and that all sections of care plans are completed and not left blank.

There were comprehensive needs and risk assessments completed throughout the patient admission which linked to the plan of care and risk management strategies implemented on the ward. There was evidence of multidisciplinary involvement in the care plans, which reflected the domains of the Mental Health (Wales) Measure.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations.

Quality of Management and Leadership

Governance, Leadership and Accountability
There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

During interviews with staff, they were fully aware of the on-call systems in place at the hospital.

The operation of the hospital was supported by the health board's governance arrangements, policies, and procedures.

We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of patients they were responsible for.

We were also told that team meetings had lapsed due to staff availability and attendance issues. We recommended that further efforts be made to improve staff attendance at team meetings and that when meetings take place, minutes are made available to all staff who should confirm that they have read them.

The health board must ensure that staff meetings are recorded, and minutes can be produced when requested.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Staff described ward managers and deputies as always being approachable and accessible and there appears to be a strong and supportive leadership culture on both wards. This was supported by staff who described the ward managers as supportive, visible, and accessible at all times. However, most staff stated that they would like more visibility, support and engagement, with the senior management team. Responses in the staff questionnaire also reflected these findings and staff also mentioned that they would like to be included in decision making.

The health board must ensure that senior management team are visible and engage with ward staff.

Senior ward staff indicated that due to staff shortages and extra patient care demands there was limited management time which impacts on their ability to manage efficiently and effectively due to competing demands.

The health board need to consider providing ward managers with protected management time.

We found a friendly, professional, and kind staff team who demonstrated a commitment to providing high quality care to patients even though staff shortages were impacting on staff's health and wellbeing and their ability to complete paperwork tasks. Staff were able to describe their roles and appeared knowledgeable about the care needs of the patients they were responsible for.

During our time on the ward, we observed a positive culture with good relationships between staff who we observed working well together as a team. It was clear to see that staff were striving to provide high levels of care to the patient groups.

Workforce

The staffing levels appeared appropriate to support the safety of patients within the hospital at the time of our inspection. However, we were also told that there have been times when the staffing numbers have been below that required to allow staff to effectively support patients. This was due to several factors; agency staff being booked but not turning up for duties and agency staff not being familiar with the patient group complex needs, placed additional demands on regular staff working at the hospital.

The health board must review staffing levels to ensure they meet the demands of the patient group.

The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures indicated that improvements are required with 66.42% overall compliance with mandatory training on Ward 12 and 51.28% on Ward 16. We were told that these figures would be immediately improved as staff had been booked on courses. In addition, fire safety training on Ward 12 was low at 21.88% and safeguarding children on Ward 16 was low at 24.23%. We were provided with evidence that staff had been booked on to courses, however **the health board must ensure that mandatory training compliance figures are improved.**

We were provided with a range of policies, however, upon review most of the versions we received had passed their review date. The following policies were found to be out of date:

- Search of patients personal belongings review date March 2016
- Procedure for NHS staff to raise a concern review April 2015
- Restraint policy review date February 2023
- Environmental policy review date Jan 2022

- Rapid tranquilisation protocol review date March 2022
- Meds management Medicines Code review date 2021
- Prevention and management of Violent and aggressive situations – review date Feb 2016.

The health board must make sure that all policies are updated and reviewed.

Newly appointed staff undertook a period of induction under the supervision of the experienced ward staff. Staff showed us documentary evidence and talked us through the systems of induction in place at the hospital.

There were vacancies on the ward. We were told that positions had been advertised and the management team told us they were trying to fill vacancies and recruit permanent staff to reduce the requirement to use agency staff.

The staffing levels appeared appropriate to support the safety of patients within the hospital at the time of our inspection. However, staff told us that due to the complex needs of the patients, caring for the patients had become more physically demanding, time consuming and as a result was impacting on staff wellbeing.

The health board should consider a review of staffing numbers on the wards based on the complex needs of the patients.

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital.

Some comments raised in the questionnaires were not raised with the inspection team during the inspection, however the comments received are important for the health board to consider and review. Within the questionnaire we asked how the service could be improved, and the following comments were made:

"Listen and act appropriately when staff raise concerns about other staff members".

"Offer more staff and patient feedback to help improve the service".

"There should be no pressure to work on certain numbers which results in nursing staff becoming burnt out and stressed out on shifts".

The questionnaire also asked if staff had faced any discrimination at work within the last month, the following response was made:

"*Lack of support or understanding of women experiencing menopause".*

The health board must reflect on the comments made from the staff questionnaires and ensure that improvements are made to benefit and support staff in the workplace.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Medication fridges were left unlocked.	This presented a risk of unauthorised access to medication.	We raised this with staff.	This issue was rectified immediately, and all fridges were locked.

Appendix B - Immediate improvement plan

Service: Ward 12 & Ward 16 Llandough Hospital - Mental Health Services for Older Persons
Date of inspection: 20 - 22nd March 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No Immediate assurance issues				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Saunders,Nolan 25/07/2023 16:13:44

Appendix C - Improvement plan

Service: Ward 12 & Ward 16 Llandough Hospital - Mental Health Services for Older Persons

Date of inspection: 20 - 22 March 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that improvements are made to the garden area to make it a safe and useable space for patients.	1.1 Health promotion, protection, and improvement	Proposal to carry out same works as East 18/16 garden with Occupational Therapy team.	Directorate Manager	October 23
The health board must ensure that information on the role of Health Care Inspectorate Wales and contact details are displayed on both wards.	4.2 Patient Information	Completed by 16/5/23 HIW Posters laminated provided to all wards.	Ward Mangers Lead and Senior Nurses	Will be audited monthly via Lead and Senior Nurse Audit via Tenable

The health board must ensure that the call bells in patient bedrooms are easily accessible for patients.	2.1 Managing risk and promoting health and safety	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Email to be sent to ward managers to provide to all staff to ensure call bells are easily accessible when staff not in room with patients. Lead and Senior nurse to be informed they must check this during monthly audit via Tendable app.	Ward Managers Executive and clinical board oversight via Tendable	Ongoing monthly lead and senior nurse audit on Tendable app.
The health board must ensure that patient and family meetings take place.	4.2 Patient Information	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Consultants to be informed via Clinical Director. HIW Action plan shared in ward managers Directorate Quality and safety on 5/6/23. Patient and Carer feedback to be collected via Patient Experience Volunteer attending at visiting times. All data to be feedback via Directorate QSE.	Clinical Director Lead Nurse Directorate Manager. Joint Operational Group	June 2023 ongoing

The health board must ensure that the following environmental issues are resolved: • Flooring in corridor outside ward managers office needs replacing on both wards • Dining room flooring on both wards was worn and untidy • Some patients' bedrooms don't have magnetic curtains on doors which could interrupt sleep and is a dignity issue • Both wards would benefit from painting and redecoration • Internal doors look worn and need refurbishing • Macerator on Ward 12 needs to be fixed or replaced.	2.1 Managing risk and promoting health and safety	Liaison with CVUHB Estates Team around adding flooring and redecoration to the Capital programme of works. Audit to be completed to across all wards to establish how many rooms are affected. Provide information to directorate. Maintenance requests submitted to replace any broken locks or handles. Maintenance request submitted to repair macerator.	Directorate Manager Clinical Board Executive Board oversight Ward Manager Senior Nurse	July 2023 June 2023 May 2023 May 2023

The health board must ensure that processes are put in place to ensure that dirty laundry bags are stored and disposed of appropriately and in a timely manner.	2.4 Infection Prevention and Control (IPC) and Decontamination	Liaison with Laundry Services Manager to ensure clear processes are in place.	Directorate Manager	May 2023
The health board must ensure that the dining room furniture and flooring is fixed or replaced on both wards.	2.1 Managing risk and promoting health and safety	Ward Managers to provide information from all wards to establish how many pieces of furniture are affected. Provide information to directorate for replacement.	Ward Manager Senior Nurse Directorate Manager	June 2023
The health board must ensure that fridge temperature checks are consistently recorded and monitored.	2.6 Medicines Management	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Ward Manager to ensure clear process in place and communicated with all staff. Monthly Lead and Senior Nurse Audit of Temperature record. Last Lead Senior Nurse Audit completed 16/5/23.	Ward Manager Night shift Nurse in Charge. Lead and senior nurse oversight	May 2023

The health board should review the current location of ligature cutters to ensure that all staff can have access in an emergency.	2.1 Managing risk and promoting health and safety	Ligature cutters are available on all wards and 3 extra have been ordered to replace any broken or blunt items. Clear protocol for requesting sharpening or replacement and accessibility of cutters to be communicated across all wards. Information on where they are stored to be displayed clearly in treatment room.	Directorate Manager Senior inpatient Nurse Ward Managers	June 2023
The health board must ensure that MAR charts are fully completed.	3.5 Record keeping	Audit of MAR charts.	Clinical Director	June 2023
The health board must ensure that patient's records reflect IMCA input when no lasting power of attorney or family involvement.	3.5 Record keeping	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Audit via Tendable app. Ward Managers to communicate process to all staff.	Ward Manager Lead and Senior Nurse oversight	June 2023

The health board must ensure that discharge planning is reflected in patient records.	3.5 Record keeping	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Lead and Senior Nurse to be informed they must check this during monthly audit via Tendable app. Lead and Senior Nurse to inform Primary Nurse when documentation falls below standard. Monthly Documentation support sessions are available to staff.	Primary Nurses. Senior Nurse Lead Nurse Support from Patient Flow and MDT	May 2023
The health board must ensure that all sections of care planning records are completed.	3.5 Record keeping	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Lead and Senior nurse to be informed they must check this during monthly audit via Tendable app. Lead and senior nurse to inform Primary Nurse when documentation falls below standard.	Primary Nurses. Senior Nurse Lead Nurse Clinical Board Support from Patient Flow and MDT	July 2023

		Monthly Documentation support sessions are available to staff. Clinical Board group looking at quality and process for Care and Treatment Planning throughout the service.		
The health board must ensure that staff meetings are recorded, and minutes can be produced when requested.	Governance, Leadership and Accountability	HIW Action plan shared in ward managers local Quality and safety on 16/5/23. Include staff meetings as part of Ward managers Values Based Appraisals. Request evidence of regular meetings and minutes during ward managers and senior nurse monthly 1:1 support meetings. Feedback overview of staffing issues in in local QSE. Review of ward establishments to include increasing Ward Clerk time.	Ward Managers Deputy Ward Manager Senior Nurse Lead Nurse Directorate Manager Director of Nursing	September 2023

The health board must ensure that senior management team are visible and engage with ward staff.	Governance, Leadership and Accountability	Discussed with ward managers the following in HIW inspection. Add as agenda item on ward meeting. Ask what would support look like?	Ward Mangers Deputy Ward Manager Senior Nurse	May 2023
The health board must ensure that ward managers have protected management duty time. Saunders,Nathan 25/07/2023 16:13:44	Governance, Leadership and Accountability	Ward Managers are currently provided with 2 days management days per week. We recognise ward managers need to be supernumerary 5 days a week with support from increased ward admin time. This has been identified in the bronze establishment which the clinical board are aiming towards. Ward managers have been provided with protected time and encouraged to work off the wards to meet deadline with values based appraisals and Datix compliance.	Ward Mangers Deputy Ward Manager Senior Nurse Lead Nurse Directorate manager Clinical Board Executive Team	Ongoing

The health board must ensure that all staff are compliant with mandatory training.	Governance, Leadership and Accountability	Ward managers to provide action plan to improve compliance via ongoing 1:1 support with Senior Nurse and Local QSE. Ward managers are prioritising Values Based Appraisals in May which will include actions on achieving full compliance. People Informatics provide rolling data on overall ward compliance. This information can be accessed by ward managers via a how to guide. It is also accessible on ESR. This Data can be monitored during local and directorate Quality and Safety meetings.	Ward Mangers Deputy Ward Manager Senior Nurse Lead Nurse Directorate Manager	July 2023 and ongoing evaluation
The health board must review staffing levels to ensure they meet the demands of the patient group.	7.1 Workforce	MHSOP is currently working to numbers that are over agreed establishments due to the acuity.	Ward Mangers Deputy Ward Manager Senior Nurse	Ongoing

		Patient Acuity and Safe staffing are held daily at 8.30 am Monday to Friday. There is representation from the directorate at every meeting. This information is included as part of an overall risk rating score which is feedback and risk mitigation is discussed in the clinical board in twice weekly meetings and daily at the executive site wide meetings. There is an agreed process in place for over time, use of agency and enhanced over time where required. The MHSOP shift Co-ordinator and night sight coordinator is available for support across the wards to support and move staff depending on needs. Professional judgments audits are taking place in June 2023 measuring staffing levels and acuity. This is an ongoing annual piece on work with HEIW to agree a framework for measuring acuity within mental health.	Lead Nurse Directorate managers Clinical Board Executive Team	

		Clinical board and Executive Team are working towards agreeing Bronze Establishments this continues to be explored and remains high on the agenda with clinical board and executive team.		
The health board must ensure that policies are reviewed and updated.	Governance, Leadership and Accountability	The clinical Board have been made aware of the following policies that require update. There is a Controlled Document Oversight Group that takes place monthly and reviews policies and procedures.	Director of Nursing	Ongoing
The health board must review the staff questionnaire comments and ensure that improvements are made to benefit and support staff in the workplace.	Governance, Leadership and Accountability	For discussion in next Directorate Quality and Safety on 5/6/23. For discussion in 8.30 Ward Manager Meeting.	Lead Nurse Directorate Manager	June 2023

		Take to CB Staff Communication and engagement group June 2023. Minutes to confirm issues have been discussed.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Marianne Seabright

Saunders,Nathan
25/07/2023 16:13:44

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Pine and Ash Wards, Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board

Inspection date: 09, 10 and 11 January 2023

Publication date: 20 April 2023

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board on 09, 10 and 11 January 2023. The following hospital wards were reviewed during this inspection:

- Pine Ward - 12 beds providing in-patient detoxification services for adult patients
- Ash Ward – 11 beds providing neuropsychiatry services for adult patients.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers and Mental Health Act peer reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
All patients who completed a HIW questionnaire rated the care and service provided by the hospital as either very good or good. Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patient group.

This is what we recommend the service can improve:

- The health board must ensure that patients adhere to the Welsh Government smoking legislation in the hospital
- The cigarette butts in the raised planters in the garden area of Pine must be removed and the garden maintained for patient use
- A process should be put in place to engage patients and carers in order to gain feedback of their experience on the wards
- All patient bathrooms must have appropriate privacy doors fitted to protect patient privacy and dignity
- Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient.

This is what the service did well:

- We found sufficient and appropriate recreational and social activities provided on the wards for patients
- Both wards provided a calm, therapeutic environment for patients in keeping with their needs.

Delivery of Safe and Effective Care

Overall summary:
We found that staff were committed to providing safe and effective patient care. Various processes were in place to manage and review risks to help maintain the health and safety of the patients, staff and visitors at the hospital. However, we found that some improvements were required in respect of infection prevention and control, training compliance and medications management, to ensure staff and patient safety. Mental Health Act records contained good evidence of visible advocacy involvement in patient care. Patient Care and Treatment Plans and

Addictions Care Plans were well organised and easy to navigate, but we observed that the quality of the care plans was variable across the wards. Improvements were required in respect of governance and record completion.

Immediate assurances:

We examined staff training records, staffing rotas and incident forms. We noted that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 51 per cent on Ash ward and 70 per cent on Pine ward. Following a review of Datix incidents we identified that some staff had been involved in incidents of restraint on Ash ward who were not compliant with their SIMA training. This meant that we were not assured that staff and patients are being fully protected and safeguarded against injury during incidents of restraint.

Further details of the immediate improvements and remedial actions required are provided in Appendix B.

This is what we recommend the service can improve:

- The health board must ensure that working personal alarms are provided for all staff
- The patient practice of placing clothing and bedding on their bedroom doors must be prevented to ensure the safety of patients, staff and visitors
- The security measures for Ash ward must be reviewed and addressed to prevent any potential unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors
- The clinic rooms on the wards must be maintained appropriately, and medication securely stored
- Medication Administration Records must be consistently signed and dated when medication is prescribed and administered
- Measures should be undertaken to ensure that patient care plans are completed correctly, contain sufficiently detailed information and are individualised to patients.

This is what the service did well:

- Legal documentation to detain patients under the Mental Health Act was compliant with the legislation
- Patients were involved in their Care and Treatment Plans where appropriate.

Quality of Management and Leadership

Overall summary:
We witnessed strong team working on both wards throughout our inspection. All staff members who responded to the HIW questionnaire recommended the hospital as a place to work and agreed that they would be happy with the standard of care provided for their friends or family. The leadership team was approachable and appeared supportive to staff and had a good understanding of patient needs, but some staff told us that working practices could be improved with better visibility and involvement form the senior management team. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events.

This is what we recommend the service can improve:

This is what the service did well:

- Most staff who completed a HIW online questionnaire agreed they were able to meet the conflicting demands on their time at work
- Staff demonstrated that they had a desire to improve the quality of services and care delivered to patients.

3. What we found

Quality of Patient Experience

We gave HIW questionnaires to patients during the inspection to obtain their views on the service provided at the hospital. In total, we received seven completed questionnaires. All patients who completed a questionnaire rated the care and service provided by the hospital as either good or very good.

Staying Healthy

Health Protection and Improvement
We observed that all patients received a physical health assessment upon admission to the hospital. Following admission, physical healthcare plans documented any required ongoing health promotion and preventative interventions, such as dietician support and access to GPs.

During our evening tour of the wards we found that the environment of care was clean and clutter free. Both wards provided a calm, therapeutic environment for patients in keeping with their needs. Patients had access to their bedrooms, communal lounges and outside garden areas. All patients who completed our questionnaire agreed that they were able to go outside for exercise or wellbeing. We found that within the garden areas of the wards there was evidence of patients smoking on hospital grounds, which contravenes current Welsh Government legislation. The health board must ensure that patients adhere to the Welsh Government smoking legislation on hospital grounds. Furthermore, on Pine ward we observed that there were numerous cigarette butts in the raised planters in the garden area which presented as unsightly and unhygienic. We highlighted this issue to staff during the inspection and we recommend that the area must be cleaned and maintained for patient use.

Most patients who completed a questionnaire agreed that there were sufficient and appropriate recreational and social activities on the wards. It was pleasing to observe that both wards were supported by occupational therapists (OTs) who undertook therapeutic activities with patients. Ash ward had an activities room for patients offering a range of activities including board games, puzzles and art therapy, as well as a pool table for supervised patient use. We saw information notice boards advertising meaningful activities for patients which encouraged them to gather, socialise and utilise physical and cognitive skills.

On Pine ward, the Therapeutic Day Unit (TDU) provided a Therapeutic Day Programme (TDP) which offered specialist addictions support and meaningful recreational activities for patients. The TDP was an asset to the ward, providing opportunities for patients to develop valuable life skills and to connect with community services which assist in their ongoing recovery from addiction. During our inspection, patients on Pine ward told us they would like additional activities on the main ward after their therapy sessions at the TDU. We discussed this matter with staff, and it was pleasing to hear that a table football and a pool table had been purchased for the ward.

During the inspection, we observed that both wards offered limited opportunities for patients to undertake physical exercise. Patients and staff confirmed that there were hospital gym facilities located outside of the wards available for patient use, but there was no information displayed on the wards about how and when each patient could use the gym facilities. We recommend that this information should be displayed on both wards to raise patient awareness and promote a healthy lifestyle.

We observed that Ash ward had an exercise bike available for patient use, but there was no additional gym equipment on the ward. On Pine ward, we saw a small room which offered limited gym facilities for patients. Staff advised us that this gym was not often used by patients because the off-ward hospital gym was better equipped. Patients were given a morning timeslot to make use of the hospital gym facilities but could only visit the gym if a member of staff was available to escort them. If staffing levels were low, patients were not able to visit the gym. We recommend that the current arrangements regarding patient gym access be reviewed, with a view to offering patients more regular access to the gym facilities over a wider time period of the day.

During our inspection, we generally found there was a lack of health promotion information on display on the wards. For example, no information relating to healthy eating and exercise was displayed on the wards. We recommend that health promotion information should be displayed on both wards for patient awareness.

Dignified care

Dignified care

Throughout the inspection, we observed committed and respectful interactions between staff and patients on both wards. Staff demonstrated a caring and understanding attitude to patients and communicated using appropriate and effective language. Staff and patients we spoke with during the inspection, and all patients who completed our questionnaire confirmed that staff listen to patients

and treat them with dignity and respect. Patients we spoke with told us that staff knocked on their door before entering their rooms, which evidences the respect of staff for patient privacy.

During our inspection we generally found that sufficient measures were in place to protect patient privacy. Both wards provided mixed gender accommodation and there were no gender segregation areas on the wards, but each patient had their own room with ensuite shower facilities. We saw an appropriate mix of staff working on the wards who were supportive in meeting the needs of the patient group. It was positive to observe patient needs being met immediately, particularly in relation to patient personal care. However, in one bedroom on Pine ward, we saw that the ensuite bathroom privacy doors were missing and we highlighted this issue to staff. The health board must ensure that all patient bathrooms have appropriate privacy doors to ensure patient privacy and dignity is protected on the wards.

During the inspection we saw that patient bedroom doors had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping. It was positive to see that patients could close the vision panels from inside their rooms if they wished. We also saw staff closing the vision panels following observations, which evidences the respect of staff for patient privacy.

Communicating effectively

Daily handover meetings were held for nursing staff to share patient information and to update the multidisciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. Staff demonstrated a good level of understanding of the individuals they were caring for, and that discussions focused on what was best for the patient. The wards used digital technology as a tool to support effective communication by way of online meetings, telephone discussions and email exchanges to ensure timely patient care.

During the inspection we generally observed effective and sensitive communication between staff and patients, but some improvements were required in respect of how the hospital addresses patient language and communication needs. We saw limited examples of patient information provided in Welsh and English on the wards. Staff advised us that there were no patients who required services in Welsh on the wards at the time of our inspection. However, one Welsh-speaking patient who completed our questionnaire told us that their preferred language was Welsh but that they were not actively offered the opportunity to speak Welsh throughout their patient journey. We further observed that a non-English speaking patient was being cared for at the hospital and this situation caused communication difficulties between the patient and ward staff. Staff told us that the patient had access to an

interpreter and an Independent Mental Health advocate who supported them in relevant formal meetings concerning their care and treatment. We were assured that the patient was receiving good care at the hospital, but it was apparent that there was lack of continuous engagement and support for the patient in their own language consistently throughout the day. We were informed that that the ongoing communication barrier was being addressed informally, by utilising two members of ward staff who spoke the same language to ensure effective communication. However, unless these members of staff were on duty and available, the patient was unable to communicate with staff on an unplanned day-to-day basis, or in any emergency situation. We further learned that relevant information, including the patient's care plan and other documentation, had not been provided to the patient in their own language. We highlighted our concerns to staff during the inspection and we recommend the following:

- The hospital should offer language services that meet patient needs throughout their care
- Relevant patient information should be provided to the patient in their preferred language
- Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient.

Patient information

We generally found a lack of information displayed for patients, families and carers on the wards. It was pleasing to see an organisational staff chart which displayed individual staff names and photographs on Ash ward. However, we were advised that family and carers only enter the visitors room of the ward and not the ward itself, so they would not have access to this information. There was no organisational staff chart displayed on Pine ward for patient, staff and visitor awareness. We recommend that both wards should display up-to-date organisational staff charts in a location where they can be viewed by patients, staff and visitors.

On Pine ward we saw some limited information which included posters for advocacy and drug and alcohol services. However, there was no similar patient information on Ash ward. On both wards we saw that no information was displayed regarding the role of Healthcare Inspectorate Wales, the Mental Health Act, complaints processes nor translation services. Staff advised us that this information was available to patients, but it was not clearly displayed on the wards where it would benefit patients, in a format that would be accessible to patients with communication difficulties or cognitive impairment. The health board should ensure that relevant and up to date patient information is displayed in the communal areas of the wards. Patient information should be provided in an

accessible format for patients with communication difficulties or cognitive impairment.

Timely care

Timely Access

The wards held daily handover meetings to establish bed occupancy levels and to discuss patients care needs. Nursing staff also attended regular multidisciplinary (MDT) meetings in which information was shared to ensure the timely care of patients. We observed that there were many additional meetings and processes that supported the effective care of patients. These included weekly ward rounds, weekly discharge planning meetings and monthly Quality, Safety and Experience meetings. Staff also attended multi-professional Sentinels and Lessons Learned meetings to discuss adverse incidents and near misses in order to identify trends and opportunities for wider organisational learning. We observed that patients were regularly monitored and received timely care in accordance with clinical need.

Individual care

Planning care to promote independence

During the inspection we reviewed the care and treatment plans (CTPs) and Addictions Care Plans (ACPs) of four patients across both wards. Within the care plans there was evidence of comprehensive risk assessments with supportive MDT involvement. The quality of care plan completion was variable across the wards, but it was positive to see that the plans were focused on the individual recovery and rehabilitation of patients. It was evident that patients had been involved in the development of their care plans wherever possible. On Pine ward, patients spoke highly of their involvement in their Addictions Care Plan, stating they had as much involvement in the process as they wanted. We saw evidence of patients, their representatives and community services involvement in the care planning process. All the patients who completed our questionnaire told us they felt very involved or quite involved in the development of their care plan. More findings on the patient care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: care planning and provision section of this report.

We found that patients on both wards were supported to make their own decisions wherever possible. It was positive to learn that patients on Pine ward attended regular therapy sessions involving external organisations who would support them after discharge. On both wards we observed patients making their own food and clothing choices and maintaining regular contact with family and friends with the support of ward staff. Both wards had visiting rooms for patients to see their families in private. Patients had access to their own mobile phones where

appropriate, and hospital electronic devices were available for virtual patient meetings with friends and family. Patients also had access to a landline telephone room and there were suitable areas where patients could speak privately with staff if required. All patients who completed our questionnaire told us they had had contact with friends or family within the past month. Rooms were also available for patients to spend time away from other patients according to their needs and wishes.

During our inspection we noted that all patients on Pine ward and some on Ash ward were provided with key to their bedrooms based on individual patient risk assessment, which supported their independence.

People's rights

During the inspection, we reviewed four records of patients who had been detained at the hospital under the Mental Health Act. The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Patients had access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

We found that satisfactory arrangements were in place to promote and protect patient rights. Regular ward meetings were held to review and discuss practices to minimise the restrictions on patients based on individual patient risks. Patient care was generally consistent in accordance with the patient age group and requirements. The hospital had established policies to help ensure that patient equality and diversity were respected, and their human rights maintained. Reasonable adjustments were in place so that everyone could access and use services on an equal basis. The doors to the main unit and the internal corridors were wide enough to accommodate wheelchair access. A lift was available for use to access the first floor. Mechanical hoists and specialist equipment such as motorised wheelchairs were available to be used by patients where required. Both wards had communal bathrooms with specialist bathing equipment for patients. During our evening tour of Pine ward, we noted that the light in the communal bathroom was faulty, which prevented patients from using these facilities. We were informed that the matter had been previously reported but the light had not yet been repaired. We recommend that the Pine communal bathroom ceiling light be repaired to allow patients to use the bathroom facilities safely.

Listening and learning from feedback

The health board had a process in place where patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior staff on both

wards confirmed that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately. However, we found there was no Putting Things Right information regarding the process of making a complaint displayed on the wards. This means patients were not clearly signposted to the complaints process. Patients we spoke to during the inspection told us they would speak directly to staff if they had any concerns or complaints to discuss. Staff told us that they regularly speak to patients to gain their views and to ensure therapies and activities were appropriate. Any complaints from a patient or visitors would be referred to a qualified member of staff for further action. We recommend that Putting Things Right information should be displayed on the ward for the information of patients and visitors.

During our discussions with staff, we learned that there was no official process in place whereby patients could discuss issues and provide feedback. Half of the staff members who completed our online questionnaire disagreed that patient experience feedback was collected and that their organisation acts on concerns raised by patients. Only one member of staff agreed that that they received regular updates on patient experience feedback. All the staff who completed our online questionnaire stated that they did not know whether feedback from patients was used to make informed decisions within the hospital.

During our inspection, we saw no evidence of patient meeting arrangements, feedback forms nor suggestion boxes which would demonstrate that feedback is routinely captured and acted upon as necessary. In the visitor's room of Ash ward, we saw an encased notice board containing outdated patient comments which had fallen from the board into the bottom of the case, leaving the board itself empty. In the visitor's room of Pine ward, the patient information boards displaying health board information, nurse staffing arrangements and a 'how are we doing?' board inviting patient feedback were all entirely empty at the time of our inspection. We discussed this issue with staff and it was positive to note that the Pine board was fully completed prior to the end of our inspection. We recommend that a process be put in place to engage patients and carers to gain feedback of their experience on the ward, and that the patient feedback boards should be kept up to date.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We observed that the hospital had processes in place to manage and review risks to help maintain the health and safety of the patients, staff and visitors at the hospital. Patients had call buttons or alarm strips in their bedrooms to alert staff if needed. The environment was generally well maintained, fit for purpose and appropriate for the patient group. All patients that completed a questionnaire told us that they felt safe while at the hospital. All staff who completed an online questionnaire agreed that they were satisfied with the quality of care they give to patients. However, we noted some potential risks to staff and patient safety which required improvement.

During our evening tour of the ward, we found that the electronic door dividing Pine ward and its Day Unit was insecure. Staff initially advised that it was faulty but later confirmed that this was not the case, and that the door had accidentally been left been insecure by staff. We recommend that measures are undertaken to ensure the ongoing security of this door to protect staff and patient safety.

We were assured that there was a sufficient number of personal alarms and access cards for all staff, including bank and agency staff working on the wards. However, we were told that while regular staff were provided with working lanyard personal alarms, bank and agency staff were given a different type of personal alarm. Staff told us that not all of the alarms work and there is no way of testing them. It was concerning to learn that ward staff could not be assured that they were using working personal alarms and the potential risk this posed to staff and patient safety. We were further advised there was no health board policy in place in respect of personal alarms which would provide guidance for staff. The health board must ensure that working personal alarms are provided for all staff. We further recommend that a personal alarm policy is drafted to ensure the safety of staff, patients and visitors.

On Ash ward, we saw good evidence of daily environmental and health and safety checks carried out by an allocated member of staff. However, we noted that these were simply visual checks, and no supplementary documentation was completed as record of the checks being done. Additionally, we did not find evidence of any maintenance requests for remedial work following any issues identified. We recommend that a record of the daily environmental and health and safety checks is made, to ensure any issues identified are raised and addressed appropriately. We further noted that the ligature audit on Ash ward was thoroughly completed

regarding risks and ligature point scoring but provided very little evidence of the action taken to mitigate the risks. The health board must ensure that the ligature audits are fully completed to reflect the risks and any mitigating actions taken.

On Ash ward, we identified an ongoing risk to patient safety in that patients were placing clothing and bedding over their bedroom doors to prevent them from slamming shut. Staff told us the noise caused by the door slamming disturbed and upset the patients. It was concerning to note that this practice presented as a potential fire safety risk in the hospital, and we highlighted this issue to staff during the inspection. We recommend that the health board should seek to find a long-term solution to reduce the sound of the doors closing on Ash ward, and the patient practice of placing clothing and bedding on their bedroom doors must be reviewed and prevented to ensure the safety of patients, staff and visitors on the ward.

During the inspection, we saw that the main ward entrances were secured from unauthorised access, but Ash ward patients had access to an outside garden area which was shared with Ash Day Unit. We noted that the door to Ash ward from the communal garden via its Day Unit was kept unlocked during the day. We were advised that the day unit is staffed throughout the day and that patients from Ash ward who presented as an absconsion risk were supervised whilst using the garden area. Staff stated that they monitor the situation and exercise additional caution, but it was possible that patients could abscond or that unauthorised persons could enter the ward from the garden. It was concerning to note that there was no formal governance process in place in respect of this risk. We recommend that the security measures for Ash ward be reviewed and addressed to prevent any unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors.

Preventing pressure and tissue damage

We looked at a sample of patient records on both wards and generally found evidence that patients received appropriate physical assessments upon their admission, and ongoing physical health checks including monitoring of pressure areas during their stay. The physical healthcare monitoring included Waterlow risk assessments to help staff assess the risk and prevent patients from developing pressure ulcers.

Falls prevention

We saw that the physical healthcare monitoring of patients included monitoring their risk of falls. We found that the assessments were generally evidenced based and reflected best practice.

Infection prevention and control

All of the patients who completed a questionnaire agreed that the environment was very clean or fairly clean and this was evidenced throughout our inspection. We generally found suitable infection prevention and control (IPC) arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to help keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and compliance with hospital procedures. We saw the wards being cleaned regularly throughout our inspection, and cleaning equipment was stored and organised appropriately. Daily environmental checks were conducted by ward staff, and monthly cleaning audits were completed by IPC team. There was evidence of easily available cleaning products, gloves and PPE. It was pleasing to see that the wards had an appointed IPC lead and staff we spoke to during the inspection demonstrated a good knowledge of IPC.

During the inspection it was positive to see that hand hygiene facilities were available for staff, patients and visitors. We witnessed staff washing hands regularly, including following interventions with patients. However, some staff we spoke to were unaware of the IPC policy and where to find it. We further did not see appropriate signage regarding hand washing and other infection control issues on display during the inspection. We recommend that the health board ensure ongoing staff awareness of the IPC policy and provide adequate signage on the wards in respect of IPC and hand washing.

We found that some IPC improvements were required on both wards during our inspection. During our evening tour of the wards, we noted that the updated guidance regarding the wearing of PPE was not being adhered to. Some staff were observed not wearing masks consistently in clinical areas despite the signage and recent guidance issued by the corporate IPC team advising them to do so. We discussed this matter with nursing staff and it was positive to note that staff correctly adhered to the IPC guidance for the remainder of our inspection. We recommend that the hospital IPC guidance in relation to the wearing of masks on the wards should be reinforced with staff to ensure safety of patients, staff and visitors.

On Ash ward we found that there was a general lack of documentary evidence of cleaning equipment being cleaned after patient use. We saw hoists and bathing equipment which did not display labels or stickers which indicated the date and time the equipment was sanitised, and we highlighted this issue to staff. We recommend that the health board must ensure that communal patient facilities are promptly cleaned and adequately labelled after use, to ensure the safety of patients and staff.

On Ash Ward, we found that the patient fridge in the Activities of Daily Living (ADL) kitchen was dirty and odorous. We raised this issue to staff and we recommend that the communal patient fridges must be regularly cleaned and maintained for patient use. During our tour of Ash ward, we saw drainage panels on the floor of the clinic room and dining room which were sealed with industrial tape stuck to the floors. Staff told us that there was a sewage pipe under the floor and the panels had been taped to prevent drainage odour from escaping into the rooms. We identified this as an IPC issue which prevented the area from being cleaned effectively. We recommend that this issue be rectified to allow for effective cleaning and ensure the safety of patients and staff.

We were advised that the communal patient facilities were in working order on both wards. However, we saw that there was an apparent leak from the washing machine in the ADL kitchen on Ash ward which we highlighted to staff during the inspection. We recommend that the washing machine be repaired on Ash ward for patient use. We further found that the linen room on Pine ward was in an untidy and disorganised state, with patient clothes unlabelled or bagged and strewn about. Similarly, the patient laundry area on Pine was in an untidy state, with unlabelled or unbagged patient clothing scattered on shelves and surfaces.
We recommend that the laundry areas of Pine ward be tidied and maintained for patient use. We also saw that the spout of the hot water dispenser in the Pine lounge was heavily corroded, and we recommend that it must be repaired or replaced to ensure patient safety.

Nutrition and hydration
Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. We observed that patient nutritional and hydration needs were assessed, recorded and addressed. Diabetes Specialist Nurses were available on site for patients. We saw examples of dietician involvement and of staff appropriately recording patient fluids and food intake. We saw evidence of Malnutrition Universal Screen Tool (MUST) assessments and observed a Speech and Language Therapist (SALT) interacting with patients during the inspection. Comprehensive physical health assessments were undertaken by the ward doctor on admission to the wards. Weight management and monitoring was evident in the patient care and treatment plans we viewed. Patient care plans detailed any swallowing concerns for staff awareness.

Both wards had patient facilities where they could access food and drinks throughout the day. It was positive to note that there were communal areas where patients could store their own food items on the wards. However, on both wards we observed that most of the communal cereals in the dining rooms were kept in unlabelled, undated containers which prevented the expiry date from being

viewed. On Pine ward, we saw one boxed cereal which had an expiry date of September 2022. We also saw some patient food items in the lounge fridge of Pine ward which were opened and unpackaged, so it was impossible to see the expiry dates. We recommend that the communal food on the wards must be regularly checked and labelled appropriately, to ensure patient safety.

During the inspection we observed that staff were supportive of individual patient food choices and were seen to assist and support patients at mealtimes. However, staff told they told us they were concerned about the poor quality of the food served to patients on the wards. Some of the patients who completed a HIW questionnaire and patients we spoke with during the inspection told us that the quality of the food was not good in the hospital. We were advised that the quality and quantity of the food has been the subject of several patient complaints. Staff and patients confirmed that the food choices on both wards were limited, repetitive and of insufficient quantity. We were advised that the hot food served to patients was pre-cooked in the main hospital and then sent to the wards for serving. Menus were not provided in advance for patient awareness, they could only make their food choice when the food arrived on the wards. Only two meal choices were provided in an equal number of each option for the total number of ward patients, on a first-come-first-served basis. There was no alternative option for patients if the more popular choice had had been taken. We were further advised of one recent occasion when no food was brought to patients on the wards from the main hospital, resulting in the patients being provided with snacks in place of a meal. We recommend that the health board must undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it meets patient satisfaction and dietary requirements.

Medicines management

We observed that relevant policies, such as Medicines Management and Rapid Tranquillisation, were available to staff electronically on computers but were out of date. We noted that the health board's Medicines Management Policy expired in March 2021. Rapid Tranquilisation guidelines were incorporated into the health board's Prevention and Management of Violent and aggressive Situations Procedure which had expired in 2016. The health board must review any out-dated policies and ensure that policies and procedures are kept up to date and reviewed to support staff in their roles.

During our evening tour of the hospital, we inspected the clinic rooms on both wards. We found that the clinic room was well organised on Pine ward. Medications were stored appropriately, and controlled drugs were sufficiently secured within the clinic and treatment rooms. We noted that the fridge alarm in the clinic room was sounding at the time of our inspection, but the matter was

addressed over the course of inspection and the fridge alarm was confirmed to be working correctly on the final day of our inspection.

On Ash ward, we found that the clinic room was cluttered and disorganised. The medication trolley was not fixed to the wall and was insecure in that one of its drawers was unlocked. The drugs fridge was found to be unlocked with medication inside and we saw prescribed medication left out of work surfaces. There were numerous gaps in the fridge temperature check chart and there was no clinical waste bin in the clinic room. We discussed our concerns with staff and over the course of our inspection and it was positive to see that these issues were rectified, and the clinic room was reorganised prior to the end of our inspection. However, no clinical waste bin was provided in the medication room throughout the inspection. The health board must ensure that the clinic rooms on the wards are maintained appropriately, and that medication is securely stored.

During the inspection we saw evidence of regular medication reviews completed during weekly ward rounds. Staff told us that there was good pharmacy involvement with weekly pharmacy medication audits. However, we were advised there were no ward-based audits in place to ensure nursing compliance with medicines management and we recommend that an audit process be put in place in respect of this.

On both wards, medical and nursing staff conducted a regular review of patients on the wards we observed sensitive and appropriate prescribing of medication. We saw examples of good practice on Ash ward in that patients received medication privately in accordance with their needs. On Pine ward it was positive to see specific guidelines being developed to support the prescribing practices. Patients had individualised medication regimes and there were specific patient information leaflets available to support their understanding of these medications. We saw good collaboration between addiction services and the Diabetes Nurse Specialist in reviewing more complex medication regimes.

Overall, we generally found that Medication Administration Records (MAR) were completed adequately, and controlled drugs were administered correctly, according to legislation and guidance. However, some improvements were required in respect of MAR completion. On Pine ward, we reviewed a sample of five patient Medication Administration Records (MAR) and found that in two of the records the Mental Health Act (MHA) status of the patients was not indicated, although one of the patients was detained under the MHA. We also found that the same two MAR charts had an overall total of five missing signatures during December 2022.

On Ash Ward we found several missing signatures within the MAR charts, and some missing counter signatures in the Controlled Drugs (CD) records we viewed. On

discussing the matter with staff they could not confirm whether the medication in question had been administered to the patients concerned. We further found that Consent to Treatment forms were not attached to MAR charts and we highlighted this issue to staff during the inspection. The health board must ensure that MAR charts and Controlled Drugs (CD) records are consistently signed and dated when medication is prescribed and administered. Consent to Treatments forms should be attached to MAR charts and regularly reviewed.

Safeguarding children and safeguarding adults at risk
Both wards provided care to adults only. There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required. Staff had access to the health board safeguarding procedures on the intranet. During the inspection, we viewed samples of safeguarding referrals and spoke to senior staff, who confirmed that staff were aware of the correct procedure to follow should they have a safeguarding concern. During our discussions with ward staff, they were able to show understanding of the All Wales safeguarding requirements and the process of making a safeguarding referral to the Safeguarding Team. Senior staff showed good understanding of their duties and responsibilities in respect of safeguarding the particular vulnerabilities of the patient group.

Patients we spoke with during the inspection told us they felt supported on the ward and able to report any concerns to the ward staff. Advocacy arrangements were in place for patients to raise concerns, and patients were supported by third sector services which could also address any issues they might have.

During the inspection we confirmed that all ward staff would require Adult Safeguarding Training at levels two and three, however, we were not provided with the ward training record compliance which related to the appropriate level of safeguarding training expected for ward staff. Therefore, we could not determine if staff were fully compliant with mandatory safeguarding training.

Medical devices, equipment and diagnostic systems
We found appropriate resuscitation equipment in place on both wards. We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present and in date.

Effective care

Safe and clinically effective care
Over the course of our inspection, we looked at the systems and governance arrangements in place to help ensure that staff provided safe and clinically

effective care for patients. There was an established filing system in place for recording, reviewing, and monitoring patient safety incidents. Discussions with staff and evidence obtained during the inspection confirmed that incidents were investigated and managed appropriately. There was a process of incident management and escalation in place to ensure that incident reports were reviewed in a timely manner. Staff confirmed that debriefs take place following incidents and relevant learning was shared with staff verbally and electronically.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents within the unit and the wider organisation. In our discussions with staff, it was reassuring to see that staff felt confident in reporting and raising these issues, which demonstrated professional integrity. All the staff who completed our online survey agreed that they would know to report concerns about unsafe practices and that the hospital encourages them to report errors, near misses or incidents. This culture of reporting should be encouraged and supported by the health board so that staff feel valued in contributing to change and are confident in reporting issues that affect staff and patient safety.

We witnessed therapeutic observations of patients being conducted and recorded correctly throughout our inspection, with good staff coordination and team support. However, we noted that the health board's Observation and Enhanced Engagement Procedure was out of date and the review date was November 2021. Some staff we spoke to during the inspection did not know where to access this policy. The health board must review the Observation and Enhanced Engagement Procedure to ensure staff awareness and patient safety.

It was positive to note that the wards used 'Safewards' as a preventative measure and appropriate strategies were in place to reduce the need for restrictive practices. During our conversations with staff, they showed good understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We witnessed positive engagement between staff and patients and saw evidence of restrictive practices being used as a last resort, with thorough monitoring around therapeutic effect and risk, and diversionary tactics in place as a method of de-escalation. It was evident from observations and discussions with staff that challenging behaviours were being managed effectively. However, we found that immediate improvements were required in respect of restrictive practices.

During our inspection, it was identified that some staff had been involved in incidents of restraint who were not compliant with their Strategies and Interventions for Managing Aggression (SIMA) training. We note that there had been ten incidents of restraint on Ash Ward within the last six months, and four of these

had involved staff who were not compliant with their SIMA training. We further noted that some of the ten Datix reports did not correctly and fully record the details of involved staff, so it was not possible to identify if any further incidents of restraint had occurred which involved untrained or non-compliant staff during our inspection. On Pine ward, most of the patients were elective patients who were consenting to the ward restrictions and had signed a contract which outlined the expectations on the ward. We were told that there had been no incidents of restraint on Pine Ward within the last six months prior to our inspection. Because staff had engaged in incidents of restraint who were not compliant with SIMA training, we were not assured that staff and patients were being fully protected and safeguarded against injury. Furthermore, the health board's Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure was out of date; we noted the review date for the policy was 21 February 2016.

Through additional examination of mandatory training compliance, we identified that 51% of staff on Ash ward and 70% of staff on Pine ward were compliant with training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator. Because of the low level of staff compliance with these training courses, we were not assured that staff and patients were being fully protected and safeguarded on the wards.

Our concerns regarding this issue were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Quality improvement, research and innovation

During our inspection we were provided with many examples where the Senior management were reviewing the provision of service on the wards and the wider health board with a view to improving patient care. There were various meetings held to identify issues, points of learning, themes and trends in order to share information with staff. It was positive to hear the future plans for both wards during the inspection. The identity of Pine ward was being re-established solely as an Addictions Unit following a period during which the ward had also cared for different patient groups. Ward staff spoke warmly about the ongoing decorative and environmental improvements on the ward which aimed to improve the patient experience. On Ash ward, senior staff spoke passionately of the wider ongoing business plan to transform and expand the Welsh Neuropsychiatry Service into a national liaison service which will work closely with partners to develop pathways that provide an equitable Neuropsychiatric rehabilitation service to patients across Wales.

We were pleased to learn of recent staffing appointments in Education and Quality which provide additional oversight of nursing governance, training and staff development. We noted the future Adult Directorate plans to create an inpatient senior management post within the hospital which will have complete oversight of the services provided on all wards at Hafan Y Coed.

During our inspection we learned that the MHA Team has put forward an initiative to appoint MHA champions on each ward at Hafan Y Coed and we recommend that that active consideration is being given to this.

Record keeping

We generally found well-organised paper and electronic records completed on both wards, which were easy to navigate through clearly marked sections. Records were easy to find and accessible to all staff. However, we noted that information was recorded on two separate patient health record systems which could cause confusion for unfamiliar staff. We recommend that measures are taken to ensure that patient information is recorded on one patient health system to avoid confusion or duplication.

During our evening tour of the wards, it was positive to observe that Patient Status at a Glance Boards were mounted in the secure nursing offices of the wards in a position where they could not be seen from outside, which protected patient confidentiality. Paper records were adequately secured in nursing offices, while electronic notes were password protected within the Patient Record Information System (PaRIS). In this way, we were assured that patient privacy and confidentiality was protected.

However, we noted that the health board's Patient Records Management Procedure (including retention and destruction schedule) expired in August 2021. The health board must review this policy to ensure compliance with legislation and provide clear guidance to staff.

Mental Health Act Monitoring

It was pleasing to learn that there is an effective Mental Health Act Team at Hafan Y Coed which comprises a Mental Health Act Administrator, a deputy Mental Health Act Administrator and additional administrative support assistants. We found that all these staff members were highly motivated and appropriately trained in all areas of the Mental Health Act (MHA). The team provided valuable training to ward staff and to Mental Health Review Panel members.

We examined four records of patients who were detained under the Mental Health Act and found that legal documentation to detain patients under the Act was

compliant with the MHA and Code of Practice. Robust monitoring and audit processes were in place in relation to MHA documentation. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information. Patients were legally detained, and the documentation supported this. There was good evidence of Independent Mental Capacity Advocate and Independent Mental Health Advocacy involvement in patient case work. It was positive to learn that when MHA document completion issues had previously been identified at Hafan Y Coed, the Mental Health Team had good governance oversight of the situation and had put training processes place to share learning and prevent reoccurrence.

During the inspection we noted that section 17 leave forms were completed appropriately, conditions of the leave were clearly outlined and patient risks were broadly assessed within the patient Care and Treatment Plans (CTPs).

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed a sample of Care and Treatment Plans (CTPs) and found that they were completed in accordance with the Mental Health (Wales) Measure 2010. We also reviewed a sample of patient Addictions Care Plans (ACPs). The records were well organised and easy to navigate via the PaRIS electronic health record system. It was pleasing to see that the care plans were person-centred, with evidence of patient and family involvement where appropriate. To support patient care plans, there was an extensive range of assessments to identify and monitor the provision of patient care, along with risk assessments which set out the identified risks and how to mitigate and manage them. Multidisciplinary team (MDT) participation was evident across both wards and included the involvement of external agencies where required. Discharge planning and preparation was evident on both wards, and this included community professionals and resources appropriate to the patient. Advocacy services were available to patients on both wards. However, we found that the quality of the care plans was variable across the wards and some improvements were required in respect of care plan completion.

On Ash ward, the CTPs contained insufficient information which did not clearly outline the patient interventions and rationale behind them. Some areas of the CTPs were comprised of only a few sentences, which could result in confusion and misunderstanding by unfamiliar staff. Due to the lack of information within the CTPs we were not assured that any unfamiliar or irregular ward staff members would be able to provide the most appropriate patient care. We further did not see evidence that patients were provided with copies of their CTPs. We recommend that more detailed information be recorded within the CTPS to reflect

patient needs and reasons for interventions in order to ensure safe patient care. We further recommend that patients are provided with copies of their CTPs.

It was positive to see that the Wales Applied Risk Research Network (WARRN) risk assessment process had been introduced to the hospital and within the patient records there was evidence of comprehensive assessments and risk assessment. On Ash ward we saw that WARRN risk assessments were being completed, however it was difficult to determine when they were being reviewed and it was not always clear that the WARRN was being updated in conjunction with the CTP. We saw one CTP in which we could not find evidence of specific physical health assessments being completed within the CTP nor within other domains of the clinical notes. We recommend that WARRN risk assessments are completed and updated in conjunction with the CTPs.

On Pine ward, we found that the completion of the patient Addictions Care Plans was relevant and proportionate to the nature of the admissions and length of patient stays. We found a range of evidence-based assessment tools in the patient records, and it was positive to note a robust approach to the physical health monitoring of patients. However, we found the ACPs lacked individuality in their completion. We saw one ACP on Pine which had clearly been cut and pasted from another patient care plan, as it contained the incorrect patient name and health board references. We recommend that measures are taken to ensure that care plans are correctly completed and individualised to patients.

Within some of the care plans we viewed during the inspection, we found there were inconsistencies between what was recorded in the plans and in risk assessments regarding the observation levels of patients. We recommend that measures must be undertaken to ensure that the information recorded in care plans corresponds to the information recorded in risk assessments, to ensure they do not provide conflicting information which could compromise staff and patient safety.

Quality of Management and Leadership

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received four responses from staff at the setting.

Staff responses were mostly positive, with all respondents recommending the hospital as a place to work and most agreed that they would be happy with the standard of care provided for their friends or family. Some of the questionnaire results and comments from staff members appear throughout the report.

Governance, Leadership and Accountability
It was positive to observe strong team working on both wards throughout our inspection. Staff were respectful of each other and there was a positive approach to team working with clear lines of responsibility for certain tasks. We witnessed positive interactions between staff within the ward and with external professionals visiting.

The staff members we interviewed during the inspection spoke passionately about their roles. Staff told us that they felt supported in their roles and described the leadership team as being approachable. All staff members who completed our online survey agreed their organisation encourages teamwork and that their organisation was supportive and helpful to them.

However, half of the staff members who completed our online questionnaire disagreed that the senior management team was visible to staff and that communication between senior management and staff was effective. Half of the respondents told us that they did not feel that senior managers try to involve staff in important decisions. Some staff we spoke to during our inspection advised us that they felt that working practices would be improved with better visibility and involvement form the senior management team. In our online staff questionnaire, we asked how the setting could improve the service it provides and received the following response:

> *"Senior management (not ward manager) should be more visible and share decision making with the staff to ensure cohesive and effective work. Offer more staff and patient feedback to help improve the service. Listen and act appropriately when staff raise concerns about other staff members"*

Senior staff we spoke to during the inspection confirmed that there are regular health board wide staff surveys to obtain staff feedback on their experience in the

workplace, and that processes were in place to identify and address any staff wellbeing and welfare issues. We recommend that the health board conduct further discussions with staff to gain their feedback on ways in which the involvement and visibility of the senior management team can be improved on the wards.

During our inspection, it was pleasing to find an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward events. However, we found that some improvements were required in respect of mandatory training compliance governance during our inspection.

Most staff who participated in our online survey agreed that training helped them do their job more effectively and deliver a better patient experience. They further agreed that training helped them stay up to date with professional requirements. However, during our inspection we found that staff had difficulty in retrieving training compliance data and we were not provided with an accurate overall picture of staff mandatory compliance throughout the inspection. We noted that majority of staff training compliance records were monitored on the Electronic Staff Record (ESR) system. However, their SIMA, Basic Life Support and AED training was recorded by other means and did not form part of their overall ESR training compliance score. We were provided with ESR overall training compliance figures which indicated that training compliance was 68% on Pine ward an 77% on Ash Ward. However, the overall compliance figures recorded the ESR system did not display the staff compliance with some mandatory training courses including Safeguarding level 2 and 3, Resuscitation level 2 and Infection and Prevention Control level 2 which would be required. We further noted that some mandatory training courses were marked as ‘not required’ for some staff on the ESR system which would certainly be required, and in our discussions with staff they could not explain the reasoning for this.

Because we were not provided with accurate mandatory training compliance figures during the inspection, we could not be assured that ward staff were compliant with their mandatory training, nor that there was robust governance oversight in respect of this. We discussed this matter with senior staff who agreed that the ESR system was difficult to operate and that there were often delays in the system which prevented accurate data retrieval. Senior staff advised us that had been challenges with the provision of mandatory training for staff during the Covid-19 pandemic, but that they were now offering regular training sessions for staff. We recommend the following improvements in respect of mandatory training:

- The health board must implement a robust program of governance oversight in respect of mandatory training compliance to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training
- Supervisory staff should be trained to utilise the training matrix system so that they can access staff training information and provide oversight of particular training areas
- The training matrix system should be reviewed to ensure that current and accurate training compliance figures can be retrieved, for the effective management of staff training levels and the safety of patients and staff
- The training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring.

We discussed these issues with staff during the inspection and were advised that arrangements were ongoing to resolve the training deficiencies of staff. We were further advised that the annual staff appraisal percentage on both wards was approximately 50% and we recommend that efforts must be made to complete these as soon as possible.

During our inspection, we reviewed several health board policies in addition to those not previously mentioned in this report. We noted that the Adult in Patient Sleeping out Guidance policy was still in draft format since our previous inspections of the setting, but we were advised that the policy is in full use and due to be ratified in January 2023. We further noted that the Procedure for NHS staff to Raise Concerns Policy had not been reviewed since 2017. We recommend that any outdated policies and procedures are reviewed and kept up to date in order to provide clear guidance to staff. We were told that ward staff refer to the intranet to access the relevant health board policies, but some staff we spoke to during the inspection did not know how to access the relevant clinical policies, procedures and professional guidelines relevant to their roles. We recommend that all staff should receive additional guidance on where and how they access the most up to date health board policies to support them in their roles.

Workforce

Most staff who completed a HIW online survey agreed they were able to meet the conflicting demands on their time at work. However, staff we spoke to during our inspection, and all staff who completed our online survey, told us there were not enough staff on the wards to enable them to do their job properly. Staff told us:

"Staff are taken to cover other areas of the hospital daily. This puts extra strain on those on shift. We are therefore unable to spend as much time with patients"

"The health board are more concerned with saving money than about safe staffing levels, staff wellbeing, the care patients receive. I suppose what can be expected though when the NHS is run by this current government"

Senior staff we spoke to during the inspection cited low staffing levels as being the biggest challenge of working on the wards, particularly since the COVID-19 pandemic and the ongoing staff absence and sickness which followed. They told us that the ongoing use of bank and agency staff to alleviate the staffing pressures was higher than desired, but robust recruitment processes were ongoing within the hospital and wider health board to recruit into vacant posts.

At the time of our inspection, there were no nursing staff vacancies on Pine Ward. Staff told us that the staffing situation was planned around weekly patient admissions to the unit, with additional bank or agency staff members arranged as necessary. We noted that the health board operates a 'sleeping out' practice where in the event of bed shortages, patients are required to spend a night on another ward. We reviewed current sleeping out arrangements for patients sleeping out on Pine Ward and noted that that the restrictions placed upon patients were individualised and care planned appropriately, with consideration for the impact on the rights of individual patients in accordance with the Sleeping Out Policy. However, staff we spoke to during the inspection expressed their concern at the risks posed and the additional workload presented by them having to care for detained Sleeping Out patients from acute mental health wards who were routinely placed on Pine ward, which is a less restrictive detoxification ward for informal patients. Staff advised us that this situation placed additional pressure on staff and other patients on the ward in terms of staff numbers, skills and training. We recommend that the health board undertake measures to ensure that a sufficient number and skill mix of staff are provided to manage the additional demands of caring for sleeping out patients as appropriate.

We were advised that there were 0.6 registered nurse vacancies and 2.96 Healthcare Support worker vacancies on Ash Ward. Recent staff sickness had created additional pressure for staff, but the ward was sufficiently staffed at the time of our inspection. We recommend that the health board should actively continue to recruit permanent staff into vacant posts in on the wards.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During our inspection we found the clinic room on Ash ward was cluttered and disorganised. The medication trolley was not fixed to the wall and was insecure, with one of its drawers unlocked. The drugs fridge was unlocked with medication inside and prescribed medication was left out of work surfaces. There were numerous gaps in the fridge temperature check chart and there was no clinical waste bin in the clinic room.	Because medication was not securely and safely stored, we were not assured that patients were not at risk of harm	We discussed our concerns with staff	Over the course of our inspection it was positive to see that these issues were rectified, and the clinic room was reorganised prior to the end of our inspection. However, no clinical waste bin was provided in the medication room throughout the inspection.

Appendix B - Immediate improvement plan

Service: Hafan y Coed - Ash and Pine Wards

Date of inspection: 9, 10 and 11 January 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
During the inspection we examined staff training records, staffing rotas and incident forms. We noted that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 51% on Ash ward and 70% on Pine ward. Through a review of Datix incidents it was identified that some staff had been involved in incidents of restraint on Ash ward who were not compliant with their SIMA training. We found four Datix incidents of restraint involving non-compliant				

staff on Ash Ward within the past six months but noted that some Datix reports did not fully record the details of involved staff. Because staff had engaged in incidents of restraint who were not compliant with SIMA training, we were not assured that staff and patients are being fully protected and safeguarded against injury.

Furthermore, the health board's Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure was out of date; we noted the review date for the policy was 21 February 2016.

Through additional examination of mandatory training compliance, we identified that 51% of staff on Ash ward and 70% of staff on Pine ward were compliant with mandatory training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator. Because of the low

level of staff compliance with these mandatory training courses, we were not assured that staff and patients are being fully protected and safeguarded on the wards. The Health Board must:				
Ensure that all staff are compliant with Strategies and Interventions for Managing Aggression training		A review has been undertaken to identify the staff that are out of compliance with the SIMA training on Ash and Pine wards to prioritise attendance on training. Additional training dates have been made available to fast track these members of staff dependant on rotas. Staff will also be offered overtime or time owing to attend in their own time when it is not possible to be released from the rota! A review of compliance with SIMA training will also take place across all areas of Mental Health Clinical Board to prioritise staff attendance on SIMA training where needed The frequency of training sessions is increasing from March 2023 which will	Lead Nurse for Adult MH/Lead Nurse for MHOP	April 2023

		allow greater accessibility to training SIMA training compliance has been included on ESR to support improved monitoring		
Provide assurance that staff and patients will be fully protected to ensure only staff that are compliant with their Strategies and Interventions for Managing Aggression training are involved in incidents of restraint		In the interim whilst addressing training compliance consideration will be given to ensure that SIMA trained staff are available on each shift to ensure where possible trained staff only participate in this procedure. Staff will also be reminded through email and safety briefing at handover.	Senior Nurse for Adult Mental Health/MHOP	Complete/ongoing
Ensure that the details of all staff involved in restraints are fully documented in Datix reports		All incidents of restraint are recorded in detail on Datix and are reviewed on a regular basis by the senior nurse. An audit will be undertaken to evaluate the quality of details provided on Datix	Senior Nurse for Adult Mental Health/MHOP	March 2023
Ensure that all staff are compliant with mandatory training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator		Basic life support which includes training for Automated External Defibrillator is provided during the SIMA training. Advanced life support is not a mandatory requirement for these areas, however senior clinical staff attend Intermediate life support training. In addition to fast	SIMA Lead Nurse	March 2023

		tracking staff through SIMA training, we will also provide additional Basic Life Support training on Ash and Pine Ward to maintain patient safety		
Ensure that the Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure is reviewed to provide clear guidance to staff.		There is a wider piece of work in progress evaluating all policies, guidance and strategies in Mental Health Clinical Board. This includes 'Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure'. To ensure that we maintain patient Safety this procedure will be discussed in next Controlled Documents and Polices Group to evaluate if the procedure remains in line with best practice and consider any interim measures that may be needed to mitigate any risks to staff and patients.	Director of Nursing for Mental Health Clinical Board	February 2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Mark Doherty

Job role: Director of Nursing for Mental Health Clinical Board

Date: 19 January 2023

Appendix C - Improvement plan

Service: Hafan y Coed - Ash and Pine Wards

Date of inspection: 9, 10 and 11 January 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that patients adhere to the Welsh Government smoking legislation in the hospital	Staying Healthy	Due to the complexity related to this recommendation within Mental Health Services, a phased approach is being taken in line with best practice to minimise the risk of any unintended consequences and ensure progress towards a smoke free environment. This includes actions including: Director of Operations Clinical 1. Engagement with patients regarding smoking cessation and co - produced meetings will be arranged with	Director of Operations	May 2023

		patients to provide environmentally safe and recovery focused alternatives. 2. A Patient Group Directive for nicotine replacement therapies has now been approved by the Health Board which will improve availability of Nicotine replacement therapies for patients. 3. Smoking champions have been identified to lead on this work in ward areas to provide direct support to patients who wish to stop smoking. 4. Identity availability of safe vaping products to support patients transitioning from smoking. 5. Smoking cessation training is being tested by two key members of staff who will lead on this. Staff will be enrolled on to the training once the leads have clarified the numbers and commitment required. Environmental		Complete Complete May 2023 May 2023

		6. Ferrous sensors are being procured. These support the staff to detect hidden ignition sources to prevent covert smoking and consequently, unwanted fire notices and the risk of deliberate or accidental fires. 7. A speaker broadcasting an automated message is due to be installed at the front entrance of hospital to discourage smoking May 2023 Procurement tender by April 2023 Procurement tender by April 202 3 8. Removal of all smoking shelters by Estates on completion of actions.		Procurement tender by April 2023 Procurement tender by April 2023 By September 2023
The cigarette butts in the raised planters in the garden area of Pine must be removed, and the garden maintained for patient use	Staying Healthy	The area has been cleaned, a cleaning schedule created and receptacles for cigarette butts has been provided during the transition period to a smoke free unit continues.	Estates and Ward Manager	April 2023
The current arrangements regarding patient gym access should be reviewed, with a view to offering patients more regular	Staying Healthy	Availability and access arrangements to the gym will be explored and a detailed information leaflet will be developed to inform all relevant	Directorate Manager, Adult Mental Health	April 2023

access to the gym facilities over a wider time period of the day		patient groups of what is available to them and can use to its fullest extent. Staffing for the area is provided by CD&T Clinical Board. This work was discussed at the Q&S meeting in April.		
Health promotion information should be displayed on both wards for patient awareness.	Staying Healthy	Review of all relevant health promotion material to be conducted, sourced and displayed prominently in all wards.	Lead Nurses, Adult Mental Health and MHSOP	April 2023
		Information for relatives and patients in ward lobbies has been updated.	Ward Manager	Completed
		A roll-out of Releasing Time to Care across Hafan Y Coed is planned, this is an evaluation over a 6-week period of all patient information available, ward ergonomics and exploration of which activities give quality and which can be scaled back.	Nurse Development Office	Completion of first round - May 2023
		Viewpoint patient feedback and experience device has been reinstalled	Lead Nurse Adult Directorate	Completed

		and rotated round wards. Order for anchor points to facilitate this.		
The health board must ensure that all patient bathrooms have appropriate privacy doors to ensure patient privacy and dignity is protected on the wards.	Dignified Care	A maintenance request has been raised, and the Estates Department will replace the missing door.	Ward manager	March 2023
The hospital should offer language services that meet patient needs throughout their care	Communicating effectively	The UHB have several different methods for accessing interpreters for patients. Ash ward use a face-to-face interpreter service frequently on the ward which can be used within the day. For more urgent requirements Language Line can be accessed when required at key points of care. Language Line information for patients will be displayed on wards to ensure	Ward Manager	March 2023

		that they are aware of the services that are available to them. The care and treatment plan is also being translated.		
Relevant patient information should be provided to the patient in their preferred language	Communicating effectively	One Care and Treatment Plan awaiting return of Polish translation.	Ward Manager	March 2023
Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient	Communicating effectively	This review of patient information has been undertaken. Translators are booked for clinicians to communicate with patients on ward rounds and other key occasions. Language Line is available for more urgent situations or out of hours. Speech and Language Therapists are also available to Ash Ward. Diverse Cymru have been commissioned to provide training for diversity awareness for the implementation of Black and Ethnic Minority Mental Health Good Practice Certification Scheme and will be rolled-out for staff within Mental Health Clinical Board.	Ward manager	Initial review complete September 2023

Both wards should display up-to-date organisational staff charts in a location where they can be viewed by patients, staff and visitors	Patient information	Information boards have been updated in ward lobbies. Organisational charts will be developed and displayed in visitor areas as well as patient only areas.	Ward Managers Lead Nurses, Adult Mental Health and MHSOP	Complete April 2023
The health board should ensure that relevant and up to date patient information is displayed in the communal areas of the wards including health promotion, the role of the HIW, Mental Health Act information, how to raise a complaint and translation services. Patient information should be provided in an accessible format for patients with communication difficulties or cognitive impairment	Patient information	Information boards have been updated in ward lobbies. A review will take place of all relevant patient information, the required information will be sourced and displayed prominently in all ward areas.	Ward Managers Lead Nurses, Adult Mental Health and MHSOP	Complete April 2023
The Pine communal bathroom ceiling light must be repaired to allow patients to use the bathroom facilities safely.	People's rights	A maintenance request has been submitted to the Estates Department to repair/replace the ceiling light.	Inpatient Operational Manager	March 2023

A process should be put in place to engage patients and carers to gain feedback of their experience on the ward, and that the patient feedback board should be kept up to date	Listening and learning from feedback	The “Good feedback” Viewpoint push button system has been installed. Feedback from patients is discussed in the monthly Q&S meetings.	Directorate Team	Complete
		A directorate workstream will be developed to focus on patient experience, feedback, monitor completion of any actions and evaluate and address any emerging themes.	Director of Mental Health Nursing	May 2023
		The Clinical Board will work with the Lead for Co-production and Caniad (commissioned service user and carer representatives) to develop a process for gathering and processing patient and carer experience feedback.	Director of Mental Health Nursing	May 2023
Putting Things Right information should be displayed on the ward for the information of patients and visitors	Listening and learning from feedback	Information boards have been updated in ward lobbies with PTR information.	Ward Managers	Complete

Measures must be undertaken to ensure the security of the door dividing Pine ward and its Day Unit	Safe Care	Daily checks of the security door have been added to the ward daily checking schedule to ensuring all staff are aware of the override key on keychains.	Ward Manager	Complete
The health board must ensure that working personal alarms are provided for all staff. We further recommend that a personal alarm policy is drafted to ensure the safety of staff, patients and visitors	Safe Care	An audit to be undertaken of all current alarm devices in all in-patient areas. Any faulty devices will be replaced immediately where necessary. Checking of personal alarm systems also been added to the daily schedule of the 'safe to start' checklist. A personal alarm policy/protocol will be developed which will provide clear information to staff regarding the appropriate use, maintenance and safety checks required regarding personal alarm systems. This will go through the Controlled Document Process meeting for ratification.	Directorate Managers, Adult Mental Health and MHSOP Lead Nurses, Adult Mental Health and MHSOP Lead Nurses, Adult Mental Health and MHSOP	April 2023 Complete June 2023

The health board must ensure that the ligature audits are fully completed to reflect the risks and any mitigating actions taken	Safe Care	Risk mitigation has been included in the audit documentation and risk assessment for ligature audits and a report has been sent to H&S.	Ward Managers	Complete
		The audit results are reviewed by the directorates, any risks identified are escalated to the directorate management team and added to the risk register, depending on the level of risk this may also be escalated to the Clinical Board and added to the Corporate Risk Register. Decisions are supported by the Observation Policy, Daily Environmental Checks and Ligature Risk Policy for Hafan Y Coed.	Ward Managers	April 2023
		Completed ligature audits will be transferred to the AMaT system which will enhance oversight of the audit and monitoring of progress and completions actions.	Ward Managers	April 2023
		Initial discussions have taken place between the Mental Health Clinical Board and the Estates Department to	Mental Health Clinical Board	Complete

		evaluate available options around minimising environmental risks. This work is ongoing.		
The health board should seek to find a long-term solution to reduce the sound of the doors closing on Ash ward, and the patient practice of placing clothing and bedding on their doors must be reviewed and prevented in order to ensure the safety of patients, staff and visitors	Safe Care	A meeting has taken place with the Estates Department to explore solutions available, A meeting has also taken place with an external company to look at alternative doors and closers. The directorate manager is to meet with the Estates Department for an update. To ensure the safety staff and visitors the use of bedding or other artefacts to prevent doors from closing has been stopped and shared with staff via the safe to start meetings.	Directorate manager Directorate manager Ward Managers	Complete March 2023
The security measures for Ash ward must be reviewed and addressed to prevent any unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors.	Safe Care	Review of the security measures has taken place, and conversations with the Day Unit Manager. Security doors are now locked at all times. New	Service Manager	Complete

		notices are in place regarding this requirement.		
The health board should ensure ongoing staff awareness of the IPC policy and provide adequate signage on the wards in respect of IPC and hand washing.	Infection prevention and control	Latest IP&C guidance related to (COVID-19) is accessible to all staff via the IP&C page on the UHB intranet site which is regularly updated by the IP&C Department. All staff will be reminded to ensure that they are familiar and up-to-date with the guidance. Infection Prevention and Control Policy to be disseminated throughout nursing governance structures and to all wards. Discussions to take place between the Lead Nurses and IP&C team regarding undertaking IP&C audits and agree an appropriate schedule of audit to be added to Tenable or AMaT depending on requirements.	Ward Managers Director of Nursing Mental Health Lead Nurses, Adult Mental Health and MHSOP	Complete March 2023 March 2023 April 2023

		IP&C and hand washing signage/posters to be updated and distributed in the appropriate areas.	Directorate Managers, Adult Mental Health and MHSOP/IP&C team	March 2023
The hospital IPC guidance in relation to the wearing of masks on the wards should be reinforced with staff to ensure safety of patients, staff and visitors.	Infection prevention and control	Staff have been reminded regarding the importance of adhering the latest guidance on wearing PPE by email and on daily handover. This Is also accessible via the UHB IP&C intranet page. Memorandum to be distributed reminding staff of current PPE requirements, and spot checks to be undertaken.	Ward Managers Director of Nursing / Lead Nurses	Completed March 2023
Communal patient facilities must be promptly cleaned and adequately labelled after use, to ensure the safety of patients and staff.	Infection prevention and control	Discussion has taken place with Infection Prevention and Control. Labels/Stickers have been ordered. Spot checks will take place as part of the daily checks to ensure compliance.	Ward Managers	Complete
The Pine hot water dispenser must be repaired or replaced to ensure patient safety.	Infection prevention and control	Maintenance request has been submitted to the Estates Department.	Ward Manager	March 2023

The communal patient fridges must be regularly cleaned and maintained for patient use	Infection prevention and control	New cleanliness monitoring sheets have been developed are now in use to ensure the cleanliness of the communal areas, this has also been added to the daily check list.	Ward Managers	Complete
The industrial tape stuck to the drainage panels in the clinic room and dining room of Ash ward must be removed and the drainage issue addressed to ensure effective cleaning and to protect the safety of patients and staff	Infection prevention and control	A maintenance request was raised and the Estates Department replaced tape. Second maintenance request was raised 23/2/23 to make fix more permanent.	Ward Manager Ash	March 2023
The washing machine must be repaired on Ash ward to ensure patient safety.	Infection prevention and control	Washing machine has been repaired and is in full working order.	Ward Manager	Completed
The laundry areas of Pine ward be tidied and maintained for patient use.	Infection prevention and control	The laundry room has been tidied and is on a daily schedule of checks to ensure this is maintained.	Ward Manager	Completed
The communal food on the wards must be regularly checked and labelled appropriately, to ensure patient safety.	Nutrition and hydration	Food storage containers are now labelled with regular checks completed by kitchen staff.	Ward managers	Completed

The health board should undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it meets patient satisfaction and dietary requirements.	Nutrition and hydration	Meeting held with Catering managers. UHL kitchens will be operational in April 23, when a full menu choice will return. In the meantime, a more varied choice has been agreed.	Director of Operations Mental Health Clinical Board	Complete
The health board must review any out-dated policies and ensure that policies and procedures are kept up to date and reviewed to support staff in their roles.	Medicines management	The process for oversight, scrutiny and ratification of all controlled documents, to be reinstituted. The Medicines Management Code Policy is currently under review and will be subject to the UHB policy and ratification process.	Director of Nursing, Mental Health Senior Nurse for Medicines Management	Completed June 2023
The clinic rooms on the wards must be maintained appropriately, and that medication must be securely stored.	Medicines management	Locks have been installed where required. An audit of medicines management and storage has been undertaken and added to the ward audit schedule on Tendable.	Lead Nurse MHSOP Directorate	Complete
Ward-based audits should be put in place to ensure nursing compliance with medicines management	Medicines management	A programme of audits of practice to be rolled out across all in-patient areas, conducted by the Practice Development Nurses.	Deputy Director of Nursing, Mental Health	Completed

		Medicine chart audits are completed by pharmacy – this will be discussed with Pharmacy Lead and added to Tendable ward audit system.		
The health board must ensure that MAR charts and Controlled Drugs records are consistently signed and dated when medication is prescribed and administered. We further recommend that that Consent to Treatments forms should be attached to MAR charts and regularly reviewed.	Medicines management	A MAR charts audit has been completed. MAR chart and CD record compliance are to be incorporated into Tendable audits.	Ward Manager Lead Nurses, Adult Mental Health and MHSO	Completed May 2023
The health board must review the Observation and Enhanced Engagement Procedure to ensure staff awareness and patient safety.	Safe and clinically effective care	The Observation and Engagement Policy is to be reviewed and taken through Mental Health Clinical Board ratification process and disseminated to staff.	Deputy Director of Nursing, Mental	Completed
Measures should be taken to ensure that patient information is recorded on one patient health record system to avoid confusion or duplication.	Record keeping	Staff have been reminded by the lead nurses regarding the risks associated with cut and pasting information into care plans and that this is not in line with best practice. An audit of care	Lead Nurses in Directorates	Complete

		plans has been added to AMaT and the results will be presented at Q&S.		
The Patient Records Management Procedure (including retention and destruction schedule) expired in August 2021. The health board must review this policy to ensure compliance with legislation and provide clear guidance to staff	Record keeping	The UHB The Patient Records Management Procedure is currently in the ratification process which is expected to be completed by the end of April 2023	Directorate Manager for Patient Records/Information Governance Manager	May 2023
More detailed information must be recorded within the CTPs to reflect patient needs and reasons for interventions in order to ensure safe patient care.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Audit to be completed by the ward manager and lead nurse practitioner on the 10/03/2023.	Ward Manager	March 2023
We recommend that patients are provided with copies of their CTPs.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the	Director of Nursing, Mental Health	September 2023

		senior nurses for education and quality, and the practice development nurses.		
WARRN risk assessments should be completed and updated in conjunction with the CTPs	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023
Measures must be taken to ensure that care plans are correctly completed and individualised to patients	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023

Measures must be undertaken to ensure that the information recorded in care plans corresponds to the information recorded in risk assessments, to ensure they do not provide conflicting information which could compromise staff and patient safety.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023
The health board should conduct further discussions with staff to gain their feedback on ways in which the involvement and visibility of senior management can be improved	Governance, Leadership and Accountability	Preliminary discussions have taken place for the Mental Health Clinical Board, People Services and Staff Side Representation to work collaboratively to implement a number of "Engagement Workshops" across all grades and disciplinary categories. MHCB will also develop a programme of "Clinical Board Walkabouts" to take place through the year 2023. MHCB will also be guided by the outcome of staff experience surveys conducted by the University Health Board.	Director of Operations, Mental Health and Director of Nursing, Mental Health	December 2023

The health board must implement a robust program of governance oversight in respect of mandatory training compliance to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training	Governance, Leadership and Accountability	Mental Health Clinical Board are Working Collaboratively with Education Culture and Organisational Development (ECOD) to undertake a review of the specific requirements for MHCB mandatory training and undertake the necessary modifications to the ESR to ensure that there is oversight of all staff mandatory training and support staff to achieve compliance.	Director of Nursing for Mental Health Clinical Board / ECOD department	June 2023
Supervisory staff should be trained to utilise the training matrix system so that they can obtain the relevant information and provide oversight of staff training	Governance, Leadership and Accountability	A list of SIMA trained staff (including compliance with Basic Life Support and Defibrillator training) is available which will be added to ESR. In addition, SIMA trained staff compliance will be raised with the Health Roster as a safety net (Electronic rostering) to ensure SIMA strained staff are always on shift.	Directorate Lead Nurses Director of Nursing	Complete September 2023
The training matrix system should be reviewed to ensure that true and accurate training compliance figures can be retrieved for the	Governance, Leadership and Accountability	"Mapping" of core training needs and current information on training matrix has been commenced to ensure accuracy and updated where	Lead Nurses for Adult Mental Health and MHSOP, supported by Senior	July 2023

effective management of staff training levels and the safety of patients and staff		necessary. Working collaboratively with ECOD so that ESR can be modified accordingly.	Nurses for Education and Quality	
The training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring	Governance, Leadership and Accountability	MHCB are working collaboratively with ECOD to develop a 'how to' guide to view training compliance which can be disseminated to managers.	Director of Nursing	Complete
Annual staff appraisals must be completed for all ward staff	Governance, Leadership and Accountability	MHCB is committed to a 10% per month improvement in appraisal compliance, following a decline over the period of COVID. We will achieve 80% compliance by August 2023.	Directorate Managers, Adult Mental Health and MHSOP	August 2023
Any outdated policies and procedures must be reviewed and kept up to date in order to provide clear guidance to staff	Governance, Leadership and Accountability	The process for oversight, scrutiny and ratification of all controlled documents, has been reinstated. The process of full review and updating of all relevant policies is in progress will take approximately 12 months to complete. High priority policies will be identified and processed first (such as risk assessment, Observations and Engagement Policy)	Director of Nursing, Mental Health	Complete Ongoing December 2023

All staff should receive additional guidance on where and how they access the most up to date health board policies to support them in their roles	Governance, Leadership and Accountability	The Mental Health Clinical Board will work with Corporate Governance and the Communications Department within the UHB to develop an interactive and accessible map of all relevant policies.	Director of Operations, Mental Health/Senior Corporate Governance Office	March 2024
The health board should undertake measures to ensure that a sufficient numbers and skill mix of staff are provided to manage the additional demands of caring for sleeping out patients as appropriate	Workforce	Work is taking place at a national level in support of safe staffing levels. Recommendations that emerge from this work will need to be considered when developing an in-patient staffing establishment that is safe, skilled and therapeutic. The revised in-patient establishment will be submitted to the Executive Board in line with the UHB's Establishment Sign-Off Process. The Outliers Policy has been reviewed and will to be taken to next Controlled Document Group for ratification which will address the issues raised.	Director of Nursing Director of Nursing	July 2023 April 2023
The health board should actively continue to recruit permanent staff into vacant posts in on the wards	Workforce	There is active recruitment process in place throughout the year which includes:	Mental Health Clinical Board	Complete Ongoing

		Generic posts being advertised on a frequent basis. • Mental health specific open days twice a year. • Engagement at national recruitment events and with universities for newly registered band 5's. • Wards with vacancies including Ash and Pine attend the open days to engage with potential students who will be recruited through streamlining. Rolling adverts. • Exit questionnaires are reviewed and management engage with staff prior to leaving wherever possible to evaluate if any measures can be taken for individuals to remain in their roles.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative: Director of Nursing Mental Health Clinical Board

Name (print): Mark Doherty Job role: Director of Nursing for Mental Health Clinical Board Date: 20/3/23

Report Title:	PSOW-Public Service Ombudsman for Wales -Mental Health Clinical Board				Agenda Item no.	9.4	
Meeting:	Mental Health legislation and mental capacity act committee	Public	X		Meeting Date:	1 August 23	
		Private					
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Assitant Director of Patient Experience						

Main Report
Background and current situation:

The Public Service Ombudsman in Wales is an independent and impartial official who investigates complaints against public service providers in Wales. The role of the Ombudsman is to ensure that public services are accountable and deliver high-quality services to the citizens of Wales.

Some key aspects of the Public Service Ombudsman's role in Wales are:

Handling Complaints: The Ombudsman receives complaints from individuals who believe they have been treated unfairly or have received poor service from public bodies in Wales. These public bodies may include government departments, local authorities, health boards, the police, and other public service providers.

Investigation: The Ombudsman investigates complaints thoroughly and impartially. They gather relevant evidence, conduct interviews, review documents, and engage with all parties involved. The investigation aims to determine whether the public body has acted in accordance with the law, policies, and standards.

Redress and Resolution: If the Ombudsman finds that the public body has acted wrongly or unfairly, they can recommend appropriate remedies or redress for the complainant. This may include financial compensation, apologies, changes in policies or procedures, or any other necessary actions to rectify the situation.

Promoting Good Practice: The Ombudsman also plays a role in promoting good practice among public service providers. They may issue reports and recommendations to highlight systemic issues or shortcomings in public services, with the goal of driving improvements and ensuring that similar problems do not recur.

Accessibility and Education: The Ombudsman's office strives to make its services accessible to all members of the public. They provide information and guidance to individuals who wish to make complaints, helping them understand their rights and the complaint process. The office also raises awareness about its role and functions through outreach activities and public education.
. Independence and Accountability: The Ombudsman operates independently of the government and public service providers. This ensures that investigations are conducted impartially and that the Ombudsman can make fair and unbiased determinations. The Ombudsman is accountable to the National Assembly for Wales, and their work is subject to scrutiny by elected representatives.

It's important to note that the specific powers and responsibilities of the Public Service Ombudsman in Wales are outlined in legislation and regulations. The Ombudsman's office is committed to upholding standards of fairness, transparency, and integrity in its work to ensure public confidence in the accountability of public services in Wales.

20 cases in total since October 21

Of those

7 were enquires -pre-concerns investigation by the Health Board and premature to the Ombudsman and referred back for local review
8 the ombudsman decided not to investigate
4 led to full investigations
1 we agreed to instruct an independent expert to review the care provided

Themes

Access to treatment

Access to second opinions

Patients who are acutely unwell and unable to clarify concerns- the Putting Things Right Regulations do not address this issue which can occur when someone is acutely unwell-the process we adopt is to review the concerns and to discuss with them when they are able to articulate any issues. All concerns are reviewed on receipt to ensure we do not miss any potential safeguarding issues etc.

Access to psychology services and community mental health services have been identified in the cluster of concerns

To date we have not received any upheld reports in this cluster in relation to nay investigations undertaken

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Recommendation:

The Committee is requested to: **Note** the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	X	Long term		Integration		Collaboration		Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
25/07/2023 16:13:44

Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2				Agenda Item no.	**10.1**
Meeting:	Mental Health Legislation and Mental Capacity Act Committee		Public	X	Meeting Date:	1st August 2023
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Chief Operating Officer					
Report Author (Title):	Director of Operations, Mental Health					

Main Report
Background and current situation:

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee. For the information of the Committee the Delivery Unit has restarted its 90 day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

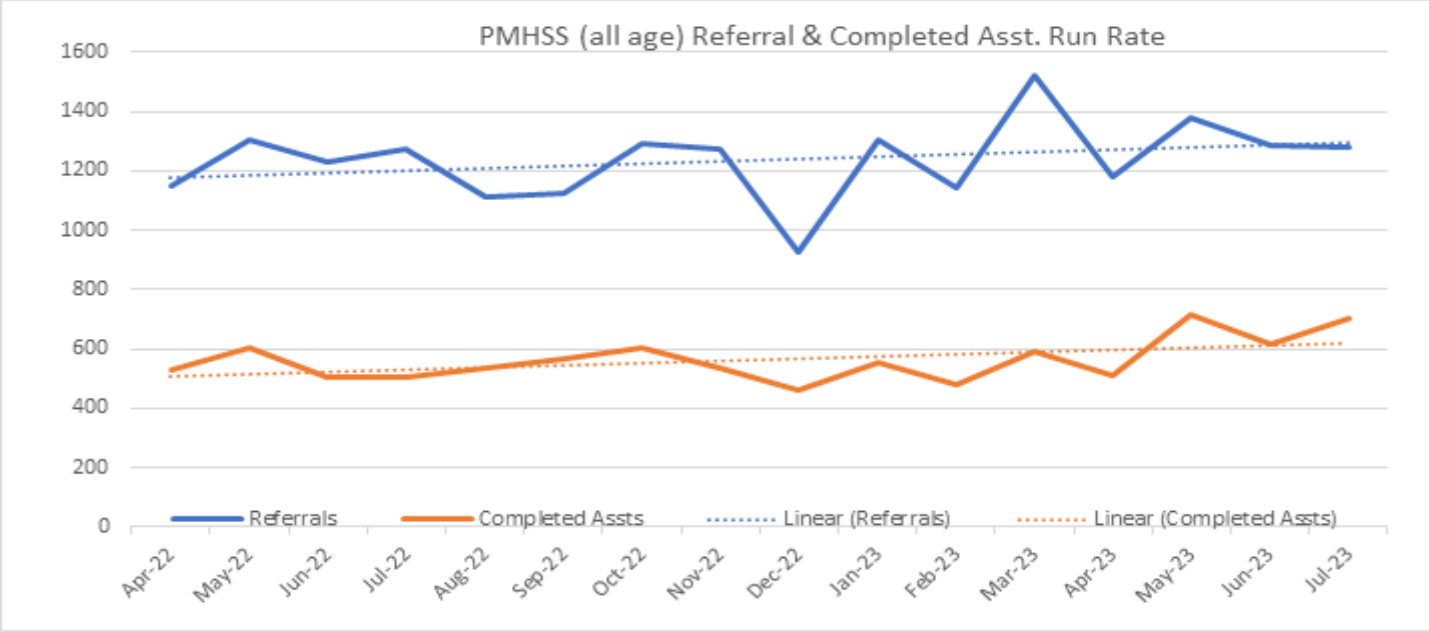
Part 1: PMHSS

Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)
Q4 in 2022-2023 referrals made up 27% of the total referrals in 2022-23. The trajectory for increasing referrals remains into Q1 with a XXX% increase in referrals compared to the Q1 2022. May 2023 saw the highest ever number of completed assessments (713) to return the trajectory to target in May 2023. March 2023 represented the highest ever number of referrals into PMHSS with 1523 all age referrals. The highest previous referral rate in one month was XXXX in XXXX.

Saunders.Nathan
25/07/2023 16:13:44

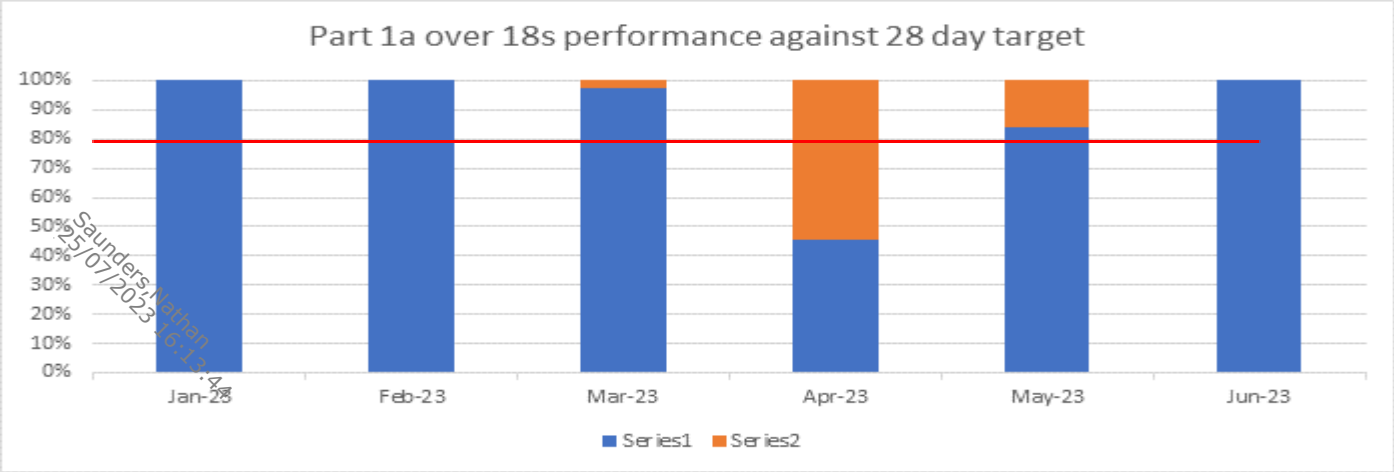
Graph 1

Graph 2



85% compliance was returned in May 2023, with 100% compliance a month earlier than anticipated in June 2023 (see Graph 3). Ongoing trajectory is predicted at 100%.

Graph 3

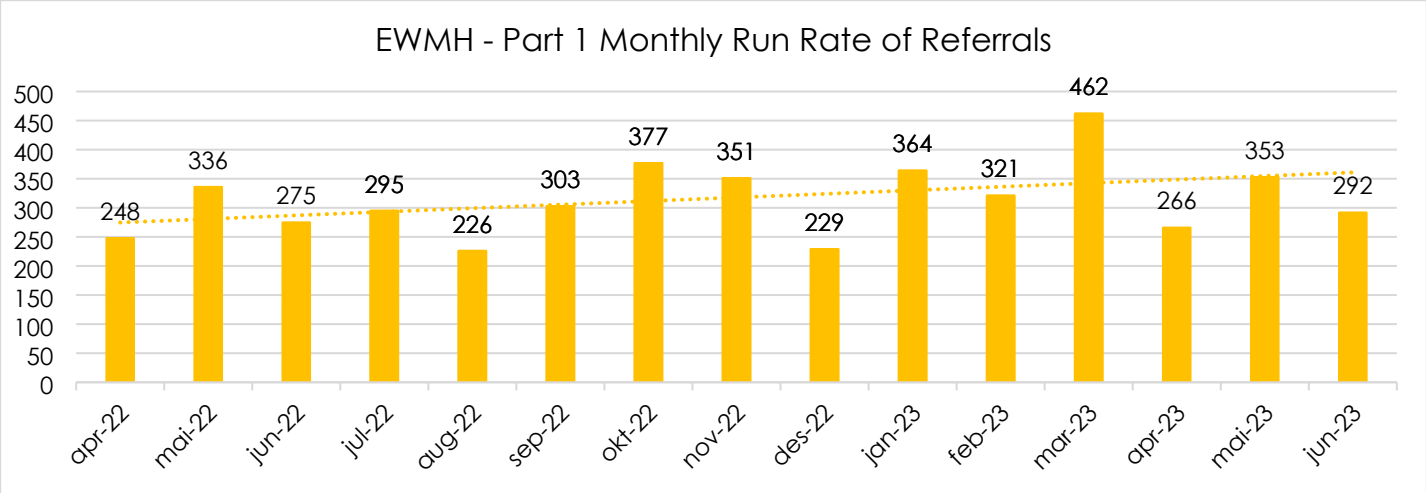


Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

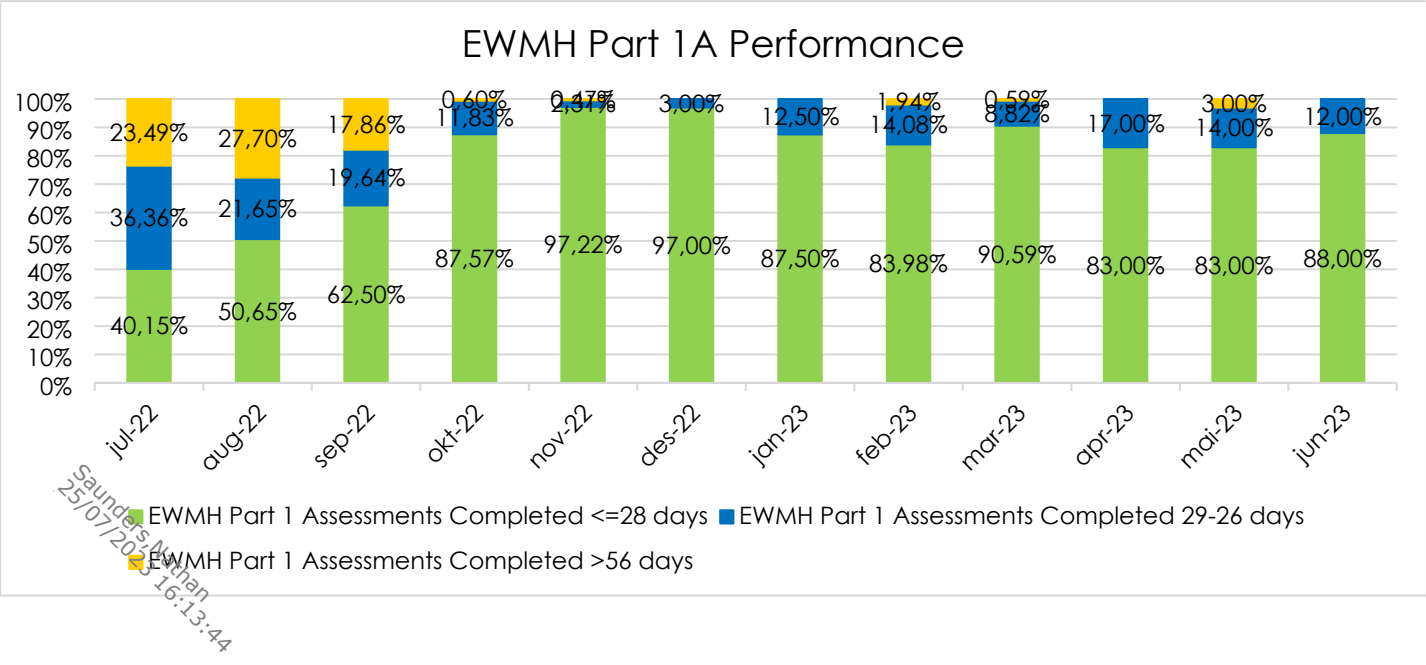
The service continues to maintain compliance with the target. Following a 43% increase in referrals in March, performance has dipped slightly but remains within compliance levels and is showing a steady increase from June. The implementation of the new Assessment Team has had a significant impact on the service's ability to meet the incoming demand and proactive work is ongoing with regards to monitoring the capacity of the team in line with the incoming demand and our seasonal peaks. Similarly, the implementation of the Single Point of Access and the joint triage with Local Authority has ensured that children and young people are being appropriately referred into services that will best meet their needs.

The average wait for assessment currently fluctuates between 3-4 weeks.

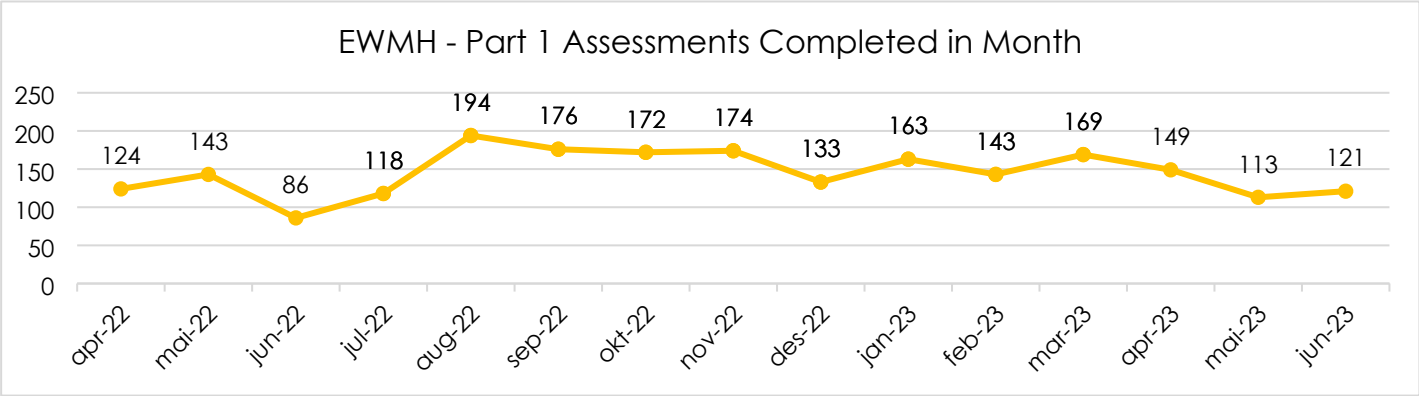
Graph 4



Graph 5



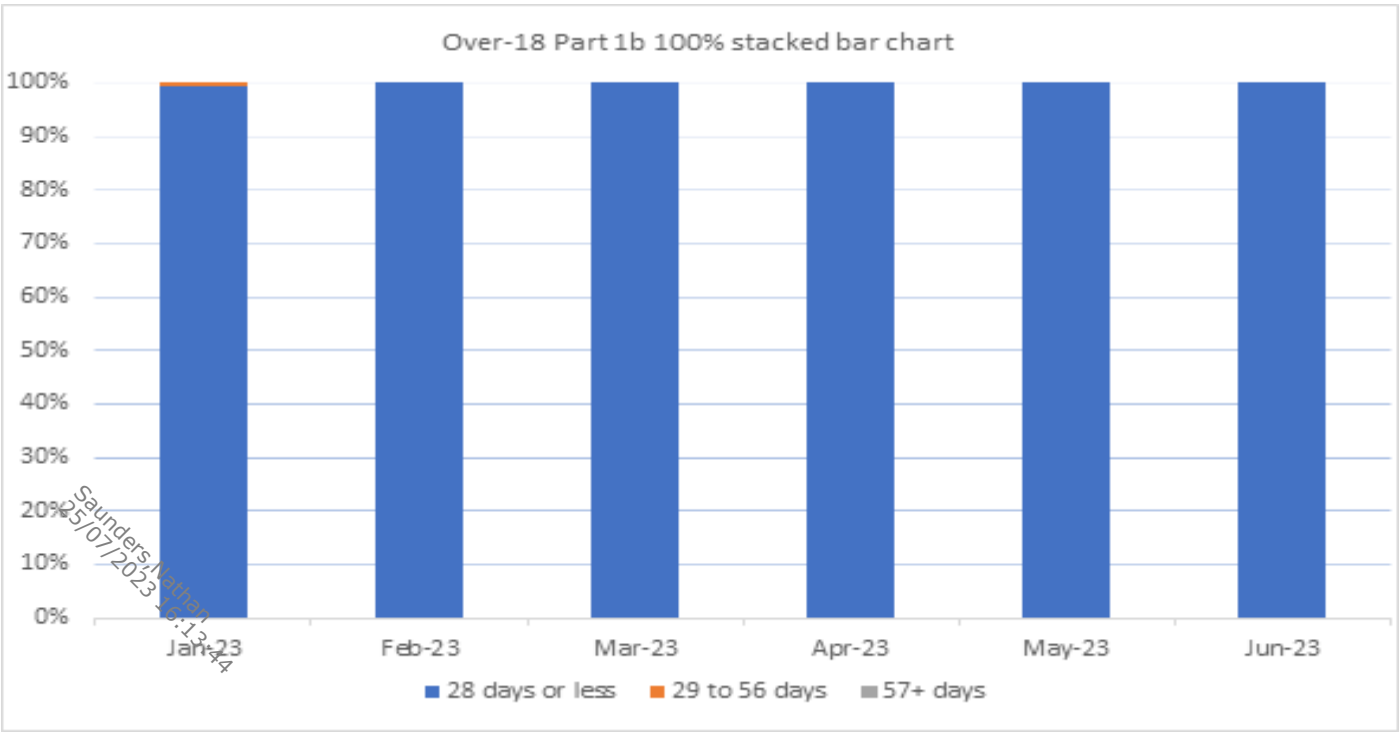
Graph 6



Part 1b – 28 day assessment to intervention compliance target of 80% (Adult)

PMHSS continues compliance with Part 1b performance target (See Graph 7). Group interventions include our CBT Living Life to the Full group – the team runs over 30 of these groups per calendar year. In addition, the team run Behavioural Activation, Anger Awareness and ACT for Wellbeing run quarterly while Understanding Me (a compassion focused group) runs on an ongoing consistent basis. For example, in September 2023 PMHSS will run 4x Living Life to the Full, 1 x ACT for Wellbeing and 1x Understanding Me which offers 90 places to service users in one month. Clinicians from the team support both the trauma and depression pathways in the service by offering time to deliver one to one SPRING (an online guided self-help 1:1 course for single event PTSD), CBT and EMDR therapy (single event treatments for more complex PTSD) in conjunction with the counselling and the traumatic stress services. 1:1 CBT for depression is also offered by the team, supervision, training and governance to support the delivery in the team is provided for all CBT, EMDR and other treatment modalities, such as Acceptance and Commitment Therapy (ACT).

Graph 7:



Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)

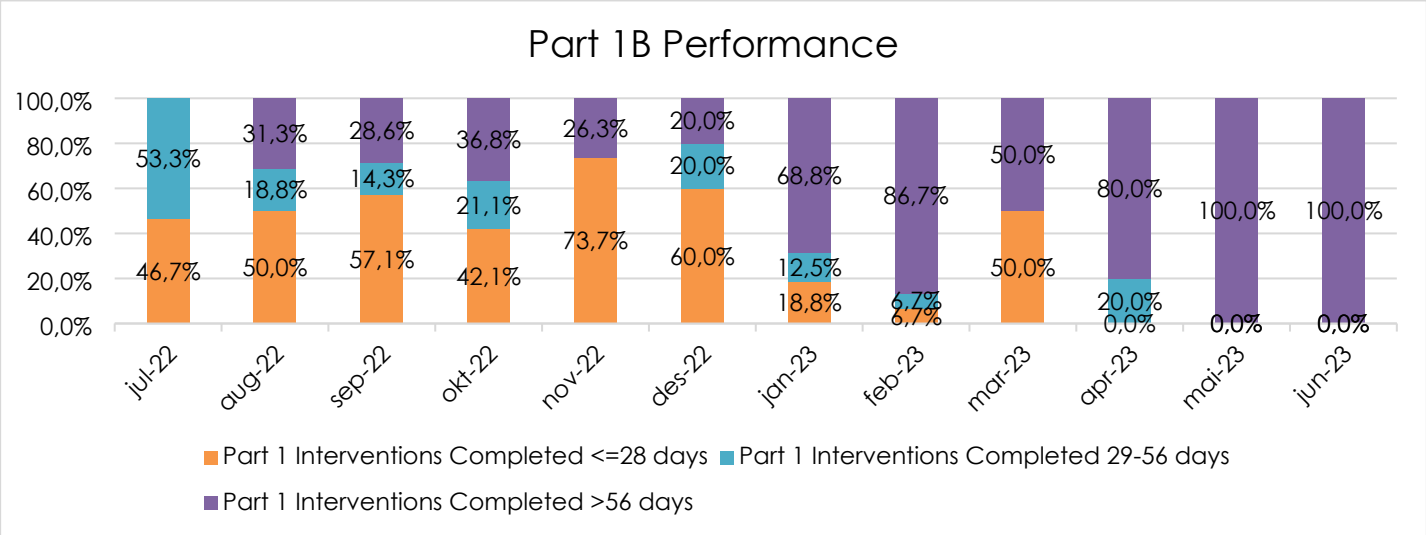
There are ongoing issues with the achievement of the Part 1B target, which is largely as a result of the volume of assessments which have been undertaken through the previous waiting list initiative where the focus had been on the external waiting list. There has also been an additional impact as a result of the significant increase in referrals for assessment in March 23, with increased numbers requiring follow on intervention.

In addition, the service has had ongoing capacity issues as a result of vacancies and sickness. Due to staff leaving, as well as the bulk of the waiting list initiative and Healios intervention coming to an end, a number of young people on these caseloads remained in the service requiring treatment to be completed – this was prioritised, thus delaying treatment starts for those on the waiting list. A number of agency staff have been retained to provide capacity into the service whilst vacancies are filled and new starters onboarded.

A full demand and capacity review has been completed and revised job plans for improved maximization of clinical activity against demand have been identified. It is expected that the revised job plans can begin to be mobilised in the next quarter once exisiting caseloads have been worked through.

Furthermore, there have been some data quality issues both in terms of the PARIS system and how clinicians have been recording activity. A full waiting list validation has been completed and weekly internal monitoring has been implemented to monitor capacity and demand. Work is ongoing with PARIS for the implementation of a full new module of recording and reporting, this is expected to go live in September and interim solutions are being worked through.

Graph 8



Actions to improve compliance against the target include:

- Work with PARIS and clinical team to address data capature, recording and reporting quality
- Active sickness monitoring and wellbeing support to the team
- Ongoing capacity and demand monitoring
- Recruitment to vacant posts

- Active work on clinical pathways to ensure a clear model that allows for clear capacity and demand planning
- Active monitoring of caseloads and supporting the process of letting go through peer group
- Launch of an anxiety group in May 23 which has provided an alternative intervention offer for a number of children and young people
- Regular triage of the internal waiting list and waiting list validation
- Additional capacity through the use of agency staff
- Engagement with Silvercloud re developing the refer in offer for support offer for anxiety, depression and low mood

Part 2 – Care and Treatment Planning (over 18)

Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

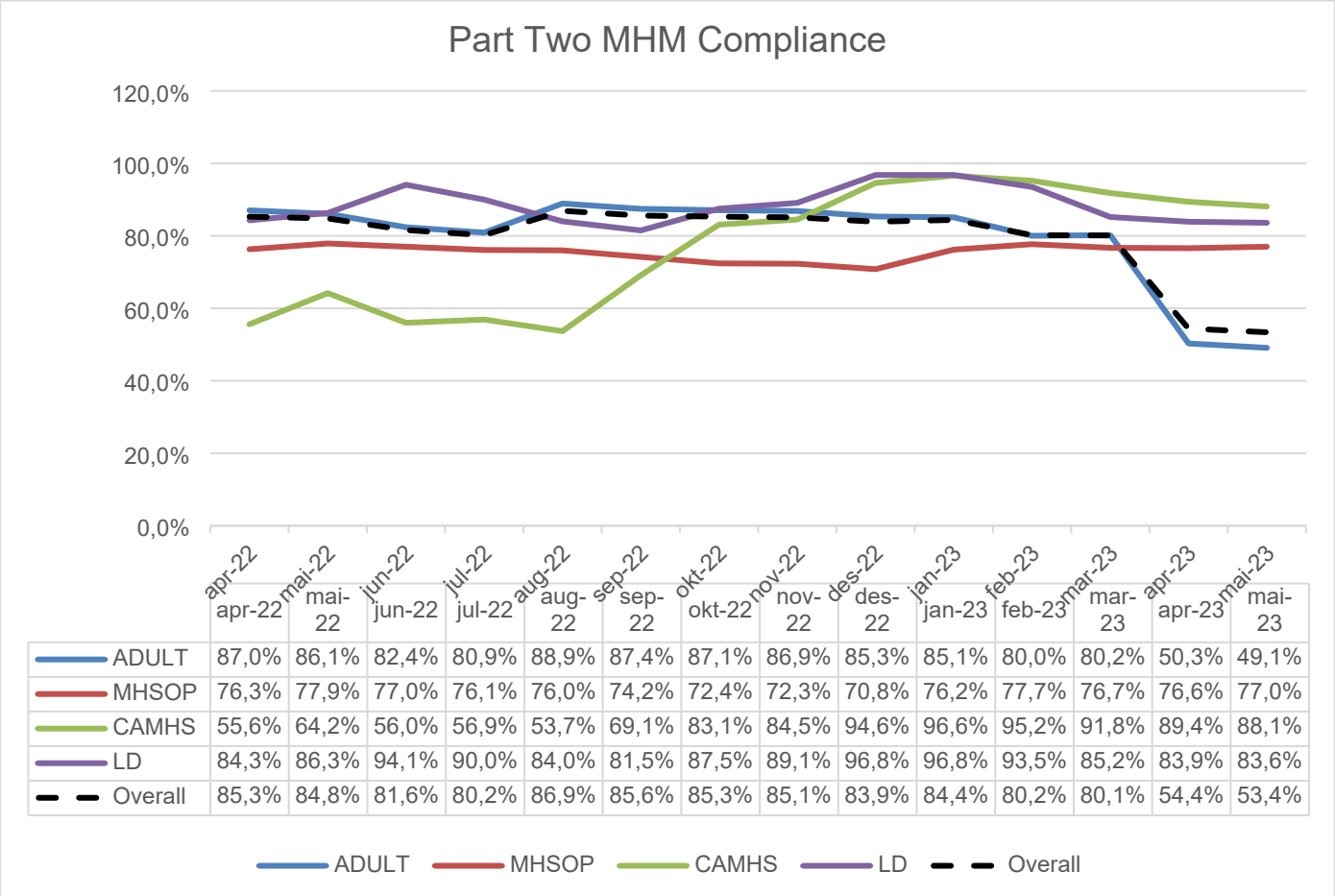
Compliance continues to MHSOP teams. A concurrent quality audit has been restarted on a quarterly basis using the NHS Executive audit tool. The drop in adult performance has been raised with the NHS executive. The MH Clinical Board was concerned that the reporting of the activity was inaccurate based on a calculation of all the care and treatment plans cumulatively in the PARIS system. The MHCB has undertaken some testing with the NHS Executive team through the MHCB Digital Lead and has flagged concerns about the performance rate.

There are a number of key factors in the actual performance that explains the current position:

1. There are large numbers of stable severe on caseloads in CMHT that cannot be discharged. This means some medics have caseloads of 150+ for whom they are care coordinators. The Recovery and Maintenance Protocol is one way to mitigate these numbers but in the long term, with increasing numbers of outpatient appointments being requested for ADHD medication administration, this is an unsustainable position for Adult CMHTs.
2. Following Covid there are a number of areas where demand has risen and workforce numbers have dropped. The areas most affected in the MHCB are CMHTs. This means much of the focus has transferred to emergency and urgent care provision and away from routine practice. There is increased acuity across all areas of the MHCB meaning these patients are prioritised. A number of key leadership positions are also unfilled while recruitment is ongoing. Some positions are still not filled despite repeated recruitment drives.
3. The new reporting means that previous compliance rates were not highlighted.
4. CMHTs are integrated teams. There are a mixture of Health and Local Authority Care Coordinators. Compliance is an issue for both providers.

Work within the Mental Health Clinical Board across services has started to develop and approach to altering the Part 1 Scheme (a document each Health Board holds to define what services are included as a Part 1 service). A set of principles have been developed, however, service user and carer engagement is critical in developing an approach that supports service efficiency while ensuring there are safeguards to rights under the Mental Health (Wales) Measure and that the spirit of the Measure as it is referred to in policy documents is adhered to. Service user and Carer involvers have now been requested, once these are allocated we can progress with this as a workstream.

Graph 9

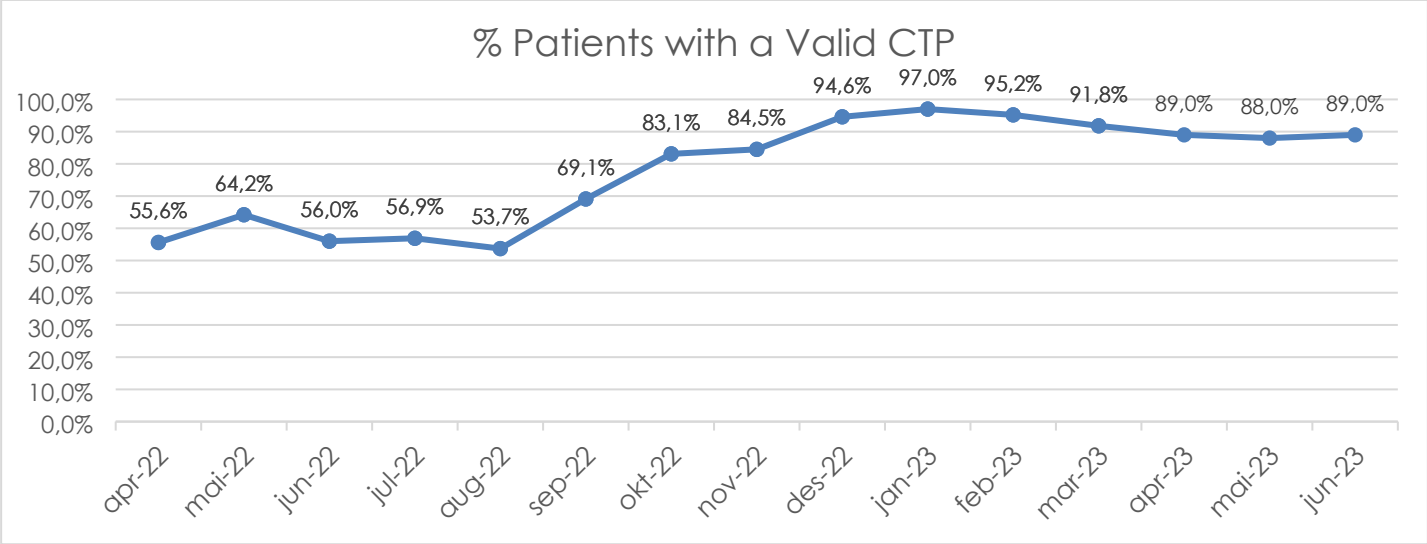


	apr-22	mai-22	jun-22	jul-22	aug-22	sep-22	okt-22	nov-22	des-22	jan-23	feb-23	mar-23	apr-23	mai-23
ADULT	87,0%	86,1%	82,4%	80,9%	88,9%	87,4%	87,1%	86,9%	85,3%	85,1%	80,0%	80,2%	50,3%	49,1%
MHSOP	76,3%	77,9%	77,0%	76,1%	76,0%	74,2%	72,4%	72,3%	70,8%	76,2%	77,7%	76,7%	76,6%	77,0%
CAMHS	55,6%	64,2%	56,0%	56,9%	53,7%	69,1%	83,1%	84,5%	94,6%	96,6%	95,2%	91,8%	89,4%	88,1%
LD	84,3%	86,3%	94,1%	90,0%	84,0%	81,5%	87,5%	89,1%	96,8%	96,8%	93,5%	85,2%	83,9%	83,6%
Overall	85,3%	84,8%	81,6%	80,2%	86,9%	85,6%	85,3%	85,1%	83,9%	84,4%	80,2%	80,1%	54,4%	53,4%

<u>Part 2 – Care and Treatment Planning (Children & Young People)</u>

For the last quarter, compliance has been just below target. The service, continued to face challenges in relation to achievement including poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable to be facilitated as a result of wider system issues e.g. social care placements not being in agreed leading to delays in completion. The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate and in a supportive multi-agency approach.
It is anticipated that the implementation of the new service model, with clearer identification of those children and young people requiring a CTP will have a positive longer-term impact on the achievement of the target. This will be supported through clearer mechanisms on PARIS to capture this data. The service is currently in the process of developing robust training for the full team in their obligations under part 2 of the measure (nothing available nationally) and we expect this to also positively impact on compliance when completed. Similarly, there have been some initial conversations regarding how we can make the CTP paperwork and process more child friendly and engaging and we will be exploring this with our Youth Board over the coming months.
Sustaining compliance remains a priority for the service.

Graph 10



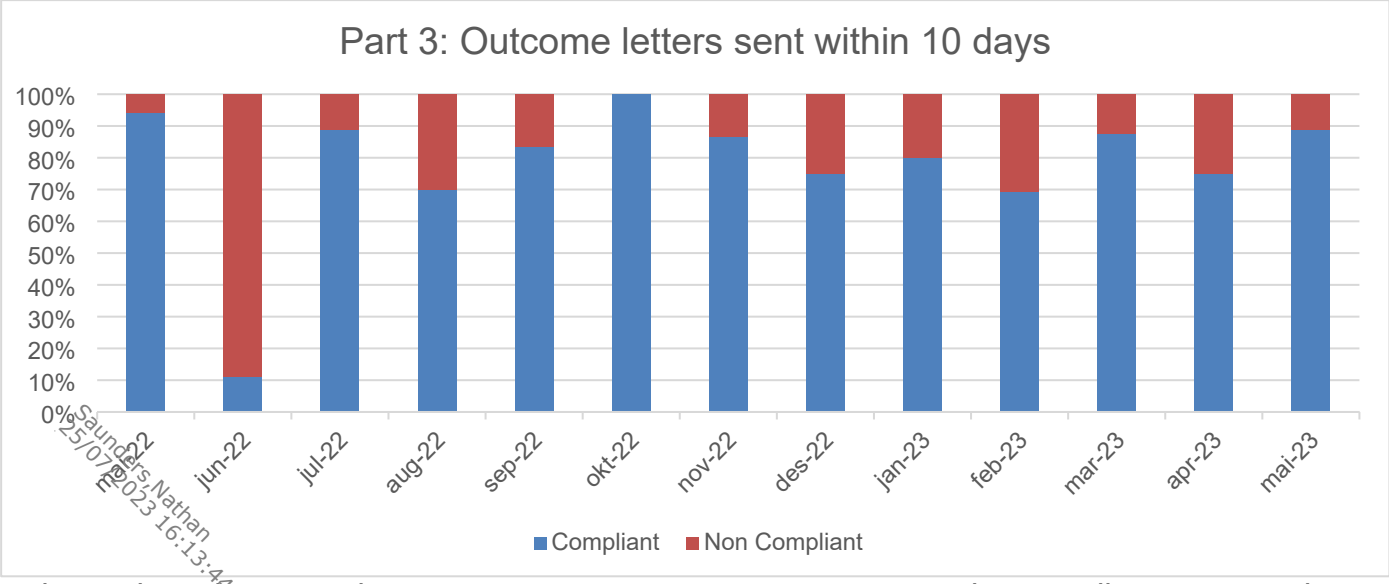
Actions to improve compliance against the target include:

- Staff training
- Develop improved data capture and reporting mechanisms through PARIS
- Engagement with Youth Board re ensuring a child and young person friendly approach to the CTP process.

<u>Part 3 - Right to request an assessment by self –referral</u>.

The target relates to service users who have self-referred, having a confirmation letter regarding the outcome of their assessment within 10 days. Graph 11 details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 11



Only one breach occurred in May 2023, an improvement on 3 in April 2023. Allocation rates have increased with 50% allocated in May 2023.

Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

Part 4:
100% compliance, no further actions.

The following comments provided by Advocacy Support Cymru for January to March 2023

Staff nurses advocating for the patients views and speaking against the views of the consultant.

Solicitors reaching out to clients and advocates to work together to prepare for tribunals and providing clients with every opportunity to share their views for hearings.

All concerns raised continue to be shared with appropriate staff directly by ASC and through monitoring of services.

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:
Part 1:
Return performance in Adult. Recovery of target with mitigating actions expected in July 2023.
Reasons for target non-compliance largely due to the highest ever referral rate in March 2023.

Part 2:
PARIS report changes now being reviewed. There is some ongoing work in the Inpatient setting to improve CTP compliance and use in preference to inpatient care plans.

Part 3:
Continue to flag any performance issues to teams locally for improvement.

Part 4:
100% compliance, no further actions.

The following comments provided by Advocacy Support Cymru for January to March 2023

Staff nurses advocating for the patients views and speaking against the views of the consultant.

Solicitors reaching out to clients and advocates to work together to prepare for tribunals and providing clients with every opportunity to share their views for hearings.

All concerns raised continue to be shared with appropriate staff directly by ASC and through monitoring of services.

Recommendation:

The Committee is requested to:
Committee to note the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1.	Reduce health inequalities	X	6.	Have a planned care system where demand and capacity are in balance	
2.	Deliver outcomes that matter to people	X	7.	Be a great place to work and learn	

3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
Yes
Socio Economic: Yes/No
No
Equality and Health: Yes/No
Yes – In report
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Corporate Risk Register			Agenda Item no.	11.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	01.08.2023
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.

Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to Mental Health Capacity and Legislation Committee ("the Committee") are attached at Appendix A for further scrutiny and to provide assurance to the committee that relevant risks are being appropriately recorded, managed and escalated.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board. The Risk and Regulation team regularly meet with Risk Leads within the Mental Health Clinical Board and with the support of the Clinical Board Director of Operations, are beginning to see improved consistency in risk descriptions and scoring. There continues to be room for improvement in this area and the Committee can take assurance from the Clinical Board's ongoing commitment to working with the Risk and Regulation team to achieve improvements.

At the July 2023 Board meeting 1 Extreme Risk reported to the Board was linked to the Mental Health Capacity and Legislation Committee for assurance purposes. The risks reported is summarised as follows:

Risk Description Summary	Risk Score (1 to 25)
Risk of patient and public harm due to an inability to discharge patients from Mental Health Services.	20

Controls are in place to mitigate this risk however due to fluctuating patient numbers and ongoing hurdles discharging patients from Mental Health Services the Current Risk rating score for this risk has not reduced. Work remains ongoing with external stakeholders and partners to mitigate this risk however some of the problems contributing the current rating are linked to wider health and social care issues which will take time to be resolved.

ASSURANCE is provided by:

- Ongoing discussions with the Mental Health Clinical Board regarding the scoring and management of risks.
- The provision of Risk Management training and support that the Head of Risk and Regulation and his team continue to deliver.

Recommendation:

The Committee is requested to:

NOTE the Corporate Risk Register risk entries linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which is now progressing with Clinical Board.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Ongoing risk management discussions and support provided to the Mental Health Clinical Board will strengthen the Clinical Board's risk management processes.

Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
N/A	

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Mental Health	35	01/06/2023	Patient Flow: Due to in inability to discharge patients from Mental Health Services into appropriate placements, step down to locality ward from PICU or find beds when patients are requiring admission or detention there is a risk of patient and public harm, delayed discharge and admission or patients being held for extensive periods in the Emergency Assessment Suite.	5	4	**20**	Escalation card actions developed. Daily bed management meetings. Twice weekly CB bed management meetings. Patient flow teams in place.	5	4	**20**	New risk included on risk registers. Actions reviewed twice weekly.	5	2	**10**	Aug-23	**QSE**	Patient Safety

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 2PM on JULY 11th 2023 MENTAL HEALTH ACT OFFICE AND VIA TEAMS

Present:
Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer - Vice Chair, PoD Group
Alex Nute - PoD member
Carol Thomas- PoD member via TEAMS
Peter Kelly – PoD member
John Copley – PoD member via TEAMS
Margaret Jones – PoD member
Mair Rawle - PoD member
Mary Williams – PoD member via TEAMS
John Owen - PoD member via TEAMS
Alan Parker - PoD member
Gerrie Hughes – PoD member via TEAMS
Sheila Hunt – PoD member
Mike Lewis – PoD member

In attendance:
David Seward – Mental Health Act Manager
Henry Green – Assistant Mental Health Act Administrator
Nicola Jones – Assistant Mental Health Act Administrator

Apologies:
Sharon Dixon – PoD member
Wendy Hewitt-Sayer - PoD member
Amanda Morgan -PoD Member
Sarah Vetter - PoD member

1. Welcome and Introductions
The meeting was held in the MHA office and via Teams and the Chair welcomed all to the meeting.

2. New Members and Independent Members
There had been no new appointments since the last meeting.

3. Apologies
Apologies were received and noted.

4. Members points for open discussion
The Chair outline the issue that had been brought to the attention of the Mental Health Act Manager by one of the consultant psychiatrists. They were concerned about the Panels questions on the patient's physical health issues. After discussion it was agreed that there is a clear link between physical and mental health and often poor physical health impacted on a patient's mental well-being. In situations where reports brought to the attention of the Panel physical health concerns it was appropriate to question the clinical team. A recent example was given of a patient with a suspected heart murmur and the possible impact of antipsychotic prescription medication. The Chair agreed to raise at the Mental Health Legislation and Governance Group (MHLGG). **Action – Chair**

Dangerousness arising from a Barring Hearing – it was agreed to bring the issue to the next meeting once the outcome from the Hearing, that had been adjourned, was finalised. **Action – MHA Manager**

5. Minutes of Meeting held on10th January 2023
The minutes were confirmed as an accurate record of the meeting. The correct spelling of Dr John Copley was noted. **Action – MHA Manager**

6. Matters Arising

- Feedback after hearings – the Chair and the Mental Health Act Manager had revised the minutes and Panels were encouraged to complete the feedback section. Chair to do a sample audit before the next Business Meeting. **Action - Chair and MHA Manager.**
- Non – disclosure **–** the Chair had raised this at MHLGG. Local procedures are being implemented to ensure the professional team discuss possible non-disclosure prior to the submission of reports and the patient's Hearing. The group were reminded that it was a decision of the panel whether to disclose or not but there needed to be a clear link of risk to the individual or other. MHRT Rules around non-disclosure **Action – All**
- Professionals leaving the hearing **–** The issue of professionals leaving after presenting their evidence was raised by the Chair at the MHLGG. There are occasions when this was acceptable however, in general all participants should remain to the end of the Hearing. If the panel agree that a professional can leave they do need to be available on the telephone in the event that other issues arise that need clarification. **Action - All**

7. Operational Issues
The issue of third parties being present in an office when a Hearing is taking place was discussed. The patient has a right to confidentiality and it was a matter for the Chair and panel to ensure this is upheld. **Action – All**
A comparison of fees has been done with other Health Boards in Wales and we are on par or above average. These aren't able to be increased as yet but will be kept under observation. **Action – Chair and MHA Manager**
It was confirmed that how we process minutes/decision via CJSM is the correct way for Cardiff & Vale Health Board which ensures the digital signature trail.

8. Lessons Learnt
Barring and dangerousness to be discussed at the next meeting. **Action – MHA Manager**

9. MHA Activity Monitoring Reports
Activity reports were provided for the periods January to March 2023 and April to June 2023 for both Hospital Managers and Tribunals. The contents of the reports were noted with the following issues highlighted:
- Representation by advocacy had improved
- June had been a busy month for Managers Hearings
- There had been 1 discharge by the Hospital Managers
- Patients are being given the option of face to face or teams for their Tribunal Hearings
- The high number of discharges prior to Hearings and Tribunals were noted and some discussions as to why that was the case.

10. Concerns/compliments from Power of Discharge group Hearings
These were noted and discussed. The quality of risk assessments and CTP's remain one of the most common areas of concerns. The Committee were content that there had been quite detailed responses to the concerns raised. **Action - All**

11. Committee and Sub-Committee Feedback
The Chair had nothing further to add. The minutes from these meetings were attached. The Chair, as had been agreed at the last meeting, raised the following issues:
- Non-disclosure
- CTP and risk assessments
- Professional's attendance for the duration of a Managers Hearings.

12. Training
Training on Human Rights and Acquired Brain Injuries will be delivered by Alex Nute at the next Business Meetings. Apologies that the Human Rights training had not gone ahead today. Further WARNN training had been delivered on the 4th May 2023.
Training on S117 to be deferred pending the outcome of the Supreme Court decision. **Action – MHA Manager to advise**
The All Wales Conference is planned for March 2024. Any suggestions for topics to be sent to the Mental Health Act Manager. **Action - All**

13. A.O.B
Annual Reviews – The Chair thanked everyone for their participation in the process. Some had been more diligent than others in completing the self-reflection. The Chair advised that next year he would expect all Managers to revisit their responses rather than replicate previous year's responses. **Action - All**
Annual Report – this was noted and discussed.
Mental Health Act reform - currently awaiting a response from the UK government to the Joint Committee which is overdue.

Date and time of future meetings to be held at **2pm** in the MHA Office, Hafan Y Coed.

10th October 2023
9th January 2024

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 13 July 2023 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
David Seward	Mental Health Act Manager
Bianca Simpson Lepore	Deputy Mental Health Act Manager
Morgan Bellamy	Deputy Mental Health Act Manager
Katherine Lewis	Consultant Social Worker DOLS/ AMHP Lead, Cardiff LA
Marianne Seabright	Lead Nurse, MHSOP
Jeff Champney-Smith	Chair, PoD Group
Callista Hettiarachichi	Consultant Representative, CAMHs
Alec Thomas	Consultant Representative, Adult Acute
Claire Thomas	South Wales Police Representative
Ceri Lovell	CAMHs Representative
Philip Ball	Senior Nurse Community
Noel Martinez Walsh	Lead Social Worker, Vale LA
Andrea Sullivan	Senior Nurse for Quality, Safety & Education

Apologies

Katie Fergus	Consultant Representative
Simon McDonald	Digital Lead for Mental Health
Adele Watkins	CAMHs representative, UHW
Kelle Al-Shayei	Shift Coordinator Representative
Lynda Woodley	Operational Manager, Vale of Glamorgan
Ceri Phillips	Vice Chair, Cardiff and Vale UHB

1 Welcome and Introductions

Everyone was welcomed to the meeting and the most recent terms of reference were briefly discussed. It was noted that these may need to be altered as the Senior Nurse structure within Adult has changed. The purpose of the group was discussed for the benefit of new attendees.

2 Apologies for absence

Apologies were noted.

3 Minutes of meeting held on 13 April 2023

No points of correction have been highlighted from the previous minutes.

4 MHA Activity

The MHA monitoring report hasn't highlighted any big changes in activity other than in the use of S135. Neither of the AMHPs knew of any clear rationale behind this increase. The increase was still within the control limits. It was agreed that a reminder will be sent to all AMHPs of the importance of sending all applications for S135 to the MHA department so that can keep track of their usage more thoroughly.

The exception report detained one fundamentally defective detention which was discussed. The various errors were made by an English AMHP and it was agreed that learning should be concentrated to our own professionals. Attempts were made to contact the relevant AMHP without success. The patient was informed of the defective detention and stayed as an informal patient for 10 days after this.

The amount of section 136s has stayed broadly similar but has been skewed by the increase in CAMHs S136's this quarter. Many of these CAMHs 136's were repeat presentations and management plans have since been put in place. The two young people involved in repeat presentations were discussed at length and it was agreed that the use of S136 was not always appropriate in the circumstances. A meeting has been agreed in August to try and find a better way forward for these kinds of incidences. One of these cases has also been reported as an NRI to ensure Welsh Government is aware what is happening as it is likely not confined to CaV. CAMHs, children's and women's services and mental health services are all involved.

There was one lapse of a S136 due to the patient not being fit for assessment during the thirty-six-hour period. These incidences are quite rare and a Datix is raised. Legal advice has been sought in relation to S136's. It is proposed that these incidences should be collated and discussed more thoroughly, perhaps annually.

The crisis sanctuary for young people has been open for a number of months and runs alongside of the crisis team hours, evenings and weekends mostly. This has been named 'The Hangout' by service users and a launch date will be going ahead in September.

A couple of incident forms have been submitted by children's services whereby a young person was taken to A&E under unknown legislation when a S136 perhaps should have been utilised. The SWP Representative requested that all incidences like this be highlighted to her for her to inform the officers involved as a learning exercise. It was also agreed that the CAMHs representative and the Lead Nurse for Quality, Safety and Education liaise with one another in relation to both misuse and lack of use of appropriate legislation when dealing with young people in crisis.

The MHRT has recently submitted a complaint in relation to the parking situation within Hafan Y Coed. Tribunal members had requested that they be allocated four spaces within the car park purely for their usage. Unfortunately, this is not a feasible option. We have yet to receive a response from the MHRT in relation to this.

The previous Consultant Representative for this group wanted to raise her concerns that junior doctors are still being refused permission to observe Tribunals as part of their training. The MHA Manager asked that anyone who wishes to observe a hearing let him know so that he can put together a more robust argument in relation to people being declined entry. Without the information he is unable to put forward an argument. It was noted that this is probably affecting student nurses and social workers.

Regular training is still being undertaken by the MHA department and all those present were encouraged to attend relevant training.

5 Matters for Action

After discussion between various members of the group it was decided that the alert for repeated S136's should be kept on the action log. This is on the rationale that PARIS is difficult to navigate for professionals not overly familiar to it. It is felt that having an alert which is readily available would be of benefit. At present finding the relevant information can be time consuming and depends on a person's knowledge of PARIS. It was also noted that the MHA module is not on CAMHs PARIS system so this group of individuals will need to be considered separately.

Action – Chair to discuss with digital lead

Allocation of CAMHs responsible clinicians on PARIS has been progressed by the Digital Lead who has met with his equivalent in the Children and Young People Clinical Board who has raised the matter with her management.

Action - Chair to discuss with digital lead

Ethnicity on PARIS is being merged with the "nag screen" work so that if ethnicity data is missing when a professional enters a case note they will be prompted to add ethnicity. This will be removed from our action log.

S117 knowledge for CAMHs professionals is still lacking but there has been progress with Cardiff LA- the Consultant Social Worker and MHA Manager met with the Operational Managers for children's services to unpick what the specific issues are. Cardiff LA has allocated a social worker specifically to CAMHs and it is hoped that she

will attend a further scheduled meeting in August. The CAMHs Representative has also asked to be part of this working group and it is proposed that the CAMHS Consultant Representative may also be invited to attend. The Lead Social Worker for the Vale has asked to participate with this however, it was initially an issue with Cardiff's Children's Services as both Local Authorities are structured quite differently and may need to approach things differently. The Operational Manager for the Vale has previously offered S117 training to Vale LA. The Lead Social Worker will take his back to Vale Locality.

The S136 flow chart is now felt not to be of such urgency as clarification on the time that the twenty-four-hour clock starts ticking has been widely circulated to all relevant agencies and hasn't caused the confusion that was first envisaged. It was clarified to all those present that the joint stance of both the Health Board and SWP is that if someone is taken to A&E for a physical matter related to their mental health that the clock starts when they reach A&E. If they are taken to A&E for a matter unrelated to their mental health the clock will start once they are medically fit.

The Lead Social Worker for the Vale LA mentioned some training that his AMHPs have recently undertook in relation to positive risk taking. The training proposed that on some occasions a S136 assessment could be undertaken by one doctor and an AMHP rather than two doctors. It was discussed amongst the group that in the various locations they have worked that this was considered the default approach to S136 assessments. CaV UHB have in recent history used two doctors and it was proposed that this may already lean the professionals towards detention rather than discharge as the necessary professionals were already present. It was agreed that this would need further discussion and that medical colleagues would need to be included in any decision making. The Consultant Representative for Adult agreed to take this to the next MAC (Consultants) meeting.

Action – Consultant Representative for Adult to discuss at MAC meeting.

At the last MHLGG it was noted that there may be a delay in getting appointments in the Magistrates Courts for S135's however, the Chair informed everyone that there is access to a magistrate twenty-four hours a day, 7 days a week and thus that there shouldn't be a problem in accessing S135 warrants.

No progress has been made regarding SPRs taking assessments after 4pm.

No progress has been made in relation to staffing levels in EAS.

There is no update in relation to Advocacy Support Cymru - the previous Advocacy Manager has left his post and has so far not been replaced.

Statements within patient reports that are not for disclosure were discussed and the Deputy Director of Nursing (Mental Health) has disseminated a reminder across the board that any not for disclosure statements should be discussed in MDT's.

The police service representative has received a copy of the Health Boards missing person policy and this has been incorporated in to the SWP equivalent.

6 Feedback on operational issues and incidents

It was agreed that it is beneficial for students to be able to observe Tribunals as part of their learning.

There is currently no feedback in relation to the meetings about Hafan Y Coed locked doors. A previous meeting was cancelled but this does need to be followed up on since the UK governments decision not to progress with the LPS safeguards.

The group were informed that Sunni Webb (Service Manager for Inpatients & Rehab) has taken over the progression of the S140 policy. The piece of work has become significantly more complicated than first envisaged as it has been amalgamated with the out of area policy and bed management policy. The Consultant Social Worker for Cardiff LA raised some queries in relation to S140 and the out of area/ bed management policy. It was explained that due to a number of caveats and considerations the policy is still being worked on by Sunni. We still need to ascertain the Health Boards S140 position as at present this still isn't clear. For clinicians on the ground there is still a lack of clear approach about what to do in situations where no bed can be found but the grounds for detention are met.

Action – Chair to liaise with Sunni re: S140/ OOA/ bed management policy

7 Feedback

No feedback from advocacy services today.

The last AMHP forum in the Vale highlighted a specific case in relation to a young person who has ASD and the safety of both himself and the clinicians involved with his detention being left on their own. Concerns were raised in regard to the use of restraint and the lack of police presence.

The ongoing bed shortage still causes problems for AMHPs. There are still many assessments carried out that would result in a person's detention were a bed available.

Conveyance for patients with learning disability was also briefly mentioned. A question has recently been proposed as to who pays for this. Swansea Bay has stated that this not part of their commissioning and that they would not pay for this.

Action – Chair to look into LD commissioning

No feedback from SWP meetings.

Dr Alec Thomas was introduced to the meeting but nothing further was brought to this meeting from the Consultant's Group.

8 Power of Discharge Group comments, compliments and feedback

Disappointingly the amount of completed care and treatment plans has dramatically decreased. Incomplete care plans at present constitute problems in 50% of hospital managers hearings. There has however, been a pleasing decrease in the number of queries relating to the nearest relative safeguards within the MAH. The PoD member's

interest in a person's physical health was recently discussed at their quarterly meeting. The consensus was that a person's physical and mental health cannot be fully separated and that it is appropriate for members to query a person's physical health treatment in relation to ascertaining appropriate treatment and continuing detention.

For CTO patients, PoD members receive reports from a person's responsible clinician and their care coordinator. The expectation being that the care coordinator report will also contain details of a person's social circumstances. On a couple of occasions reports have been lacking the social circumstances element which has almost led to a couple of hearings being adjourned. At present the MHA department do not provide report writing training but templates are available. Both Cardiff and Vale LA are likely to have slightly different templates so these can be re-sent. The problems with staff retention at CMHTs was highlighted as a possible cause for the problems recently experienced. The Senior Nurse for Community commented that any available training is appreciated.

Action – the MHA Manager will send out the Rules around report writing

9 External reviews

A review by the Royal College of Psychiatrists is due in September. There haven't been any HIW inspections since our last meeting.

10 Interface MHA/MCA/DOLS

The LPS are currently on hold with this current Government so the UHB will need to reconsider its approach to DoLs and the workload it places on clinicians. Disagreements about which Legislation to use do occur but are often seen more in older people services. A new Code of Practice in relation to MCA/ DoLs is being worked on as there has been extensive amounts of case law since the last one was issued. It was confirmed that the UHB has provided extra training in relation to the MCA which has been helpful. New staff have been taken on by the MCA team and they are willing to provide bespoke training where required.

11 Quality indicators and audit activities

This will be refreshed due to the new consultant lead joining the group.

12 Any other business

No feedback or movement on the draft Mental Health Bill or the Joint Committee Report.

A S12 approved doctors app was briefly mentioned as being commissioned by several Health Boards in England.

The PARIS AMHP report format also needs to be amended as it does not currently conform with the Code of Practice. This has been raised previously and will be chased up again.

Action – Lead Social Worker for the Vale to liaise with the Digital Lead

13 Date of future meetings

12th October 2023

11th January 2024

Mental Health Legislation & Governance Group Action Log

Key:	Red: Outstanding	Amber: In progress	Green: Completed

ACTIONS FROM PREVIOUS MEETINGS

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	Understanding the AMaT software	Deputy MHA Manager to go on the AMaT training and understand how to use it	**MB**
Revised below	Viewing the repeat 136 admissions in PARIS	MHA office to show where they can view repeat 136 admissions to anyone who requests it	**DS**
	Allocating CAMHs RC on PARIS	Digital Lead to liaise with his counterpart on how CAMHs use PARIS to resolve issue	**SM**
Revised below	Section 140/ Out of area procedure	Health and LA to get together to iron out final points in order to be sent out for comments	**MS/LW/SW/KL/MR/ LW/NM-L**
To be removed	~~Ethnicity data on PARIS~~	~~Digital Lead to confirm developer has completed ethnicity checklist on PARIS~~	~~**SM**~~
Revised below	117 knowledge gaps in CAMHs LA teams	CAMHS rep to raise the issue again with her seniors. Lead AMHP for Cardiff LA to raise the issue with her seniors. Vale LA operations manager to offer training to Vale children services	**CH/KL/LW/RK**
To be removed	~~Create an easy to follow flow chart for the 136 process~~	~~Create an easy to follow flow chart for the 136 process with discussion from SWP and shifty manager~~	~~**DS, C LT, JJ, GM**~~
To be removed	~~Issues securing 135 warrant slots with the courts~~	~~To be raised at the MHLMCAC as issue may impinge on our ability to carry out MHA functions~~	~~**RK**~~
	SPR's taking assessments after 4pm	Investigate the agreed position surrounding assessments	**RK**
	Section 135 incident – no cover in EAS. SecureCare had to manage patient	Fact finding in order to establish the issues surrounding this incident.	**TR**
	Advocacy not being told about ward reviews	Investigate how best to include Advocacy when setting up ward reviews etc	**TR**
To be removed	~~Non-disclosures not being discussed in MDT~~	~~Forensics have put reminder to discuss in weekly MDT's. Needs to be taken forward for all Directorates to do~~	~~**TR**~~

To be removed	~~Updated copy of missing persons procedure~~	~~To be forwarded to the SWP Representative~~	~~**TR**~~

ACTIONS FROM THIS MEETING – 13TH July 2023

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	Viewing the repeat 136 admissions in PARIS	PARIS needs alert on main screen that all directorates can see including CAMHs	**SM/RK**
	Section 140/ Out of area procedure	Further update needed on S140/out of area/bed management policy	**SW**
	117 knowledge gaps in CAMHs LA teams	Further meetings have been scheduled to give training and guidance to CYP	**DS/KL/CH/CL**
	136 assessments with one doctor	Discussion to be had at next MAC meeting and at the 136 policy group	**AT/DS**
	Conveyancing for LD patients	Chair to investigate LD commissioning with Swansea Bay UHB	**RK**
	Content for social circumstances report	MHA Manager to send out the Rules around report writing	**DS**